**Module 22 – Gender and GBV-Responsive Nutrition programs in Emergencies**

Time: This module can be adapted to be delivered during 1, 2 or 3 days depending on the assigned time for the workshop and the profile of participants.

**Session Purpose:**

Participants will be able to apply the guidance for an improved Gender and GBV responsive programming in nutrition humanitarian response.

**Learning Objectives:**

By the end of this session, participants will be able to:

1. Explain the linkage between Gender/GBV and Nutrition.
2. Identify key elements for gender and GBV responsive nutrition programs
3. Utilize guidance to integrate Gender and GBV lens into the different stages of the humanitarian program cycle

**Outline of the workshop:**

1-day training workshop

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| Target Audience | Topic | Time | Content of the session | Slide numbers |
| Staff who do not directly manage projects. E.g.: cluster coordinators, working group coordinator, etc. | Introductory definitions | 60 min | Quick revision of definitions and the power walk exercise | 1 - 9 |
|  | Linkages between gender, GBV and nutrition | 30 min | Discussion of four case studies in plenary and overview of literature review | 10- 13 |
|  | Gender and GBV responsive nutrition programming | 40 min | Discussion on gender and GBV integration within the project cycle and preparedness phase and an introduction to the AAAQ framework and key tools for integration | 18- 29 |
|  | The role of the nutrition cluster coordinators | 20 min | Discussion around the specific role of the coordination to integrate Gender and GBV in nutrition programs | 30- 35 |
|  | Gender and GBV risk assessment and analysis | 60 min | Introduction to the different methods and steps of GBV and gender risk analysis and assessment in addition to examples and an exercise. | 36- 57  Excluding: 36 & 53 |
|  | Strategic planning of gender and GBV issues in nutrition programs | 15 min | Introduction to the steps of strategic planning and an example | 58- 60 |
|  | Resource mobilization for gender and GBV issues within nutrition programs | 30 min | Introduction to the objective of resource mobilization and the gender marker | 61-63 |
|  | Implementation of nutrition programs using gender and GBV lens | 30 min | Introduction on implementation and examples | 70- 82 |
|  | Monitoring of gender and GBV issues in nutrition programming | 30 min | Introduction to monitoring and safety audits and examples | 84 to 92 |
|  | Take home messages and questions | 20 min | summary of key concepts and guidance | 94- 96 |

2- day workshop

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| Target Audience | Topic | Time | Content of the session | Slide numbers |
| Staff that oversee and/or directly manage projects and who have minimum knowledge on GBV core concepts. E.g.: program coordinators, managers, officers, etc.. | Introductory definitions | 60 min | Quick revision of definitions and the power walk exercise | 1 - 9 |
|  | Linkages between gender, GBV and nutrition | 60 min | Group exercise on case studies and literature review | 10 - 17 |
|  | Gender and GBV responsive nutrition programming | 40 min | Discussion on gender and GBV integration within the project cycle and preparedness phase and an introduction to the AAAQ framework and key tools for integration | 18 - 29 |
|  | Gender and GBV risk assessment and analysis | 2 hours | Introduction to the different methods of GBV and gender risk analysis and assessment, in-depth discussions on the steps, one exercise on analyzing the AAAQ framework and one exercise on integrating gender and GBV in nutrition assessments in addition to examples | 36- 57 |
|  | Strategic planning of gender and GBV issues in nutrition programs | 15 min | Introduction to the steps of strategic planning and an example | 58-60 |
|  | Resource mobilization for gender and GBV issues within nutrition programs | 2 hours | Introduction to the objective of resource mobilization and the gender marker, GBV and gender responsive proposals and budgeting, in addition to an exercise on integration of gender and GBV in proposals | 61- 69 |
|  | Implementation of nutrition programs using gender and GBV lens | 1.5 hour | Introduction on implementation and examples as well as an exercise to integrate gender and GBV in project interventions | 70- 83 |
|  | Monitoring of gender and GBV issues in nutrition programming | 1.5 hour | Introduction to monitoring and safety audits and examples as well as an exercise on integrating gender and GBV indicators in an M&E plan | 84- 93 |
|  | Take home messages and questions | 20 min | Summary of key concepts and guidance | 94-96 |

3- day workshop

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| Target Audience | Topic | Time | Content of the session | Slide numbers |
| Staff that oversee and/or directly manage projects and who DO NOT have minimum knowledge on GBV core concepts. E.g.: program coordinators, managers, officers, etc.. | GBV core concepts and referrals module | 1 full day | * Overview of the of the key concepts that underpin the participants’ understanding of GBV * Root causes and contributing factor of GBV as well as the different consequences * Reflecting on GBV women and girls, men and boys, children as well as the LGBTI community. * Supporting GBV survivors and GBV referrals | The full GBV CC and referrals PowerPoint presentation[[1]](#footnote-1) |
|  | Introductory definitions | 60 min | Quick revision of definitions and the power walk exercise | 1 - 9 |
|  | Linkages between gender, GBV and nutrition | 60 min | Group exercise on case studies and literature review | 10 - 17 |
|  | Gender and GBV responsive nutrition programming | 40 min | Discussion on gender and GBV integration within the project cycle and preparedness phase and an introduction to the AAAQ framework and key tools for integration | 18 - 29 |
|  | Gender and GBV risk assessment and analysis | 2 hours | Introduction to the different methods of GBV and gender risk analysis and assessment, in-depth discussions on the steps, one exercise on analyzing the AAAQ framework and one exercise on integrating gender and GBV in nutrition assessments in addition to examples | 36- 57 |
|  | Strategic planning of gender and GBV issues in nutrition programs | 15 min | Introduction to the steps of strategic planning and an example | 58-60 |
|  | Resource mobilization for gender and GBV issues within nutrition programs | 2 hours | Introduction to the objective of resource mobilization and the gender marker, GBV and gender responsive proposals and budgeting, in addition to an exercise on integration of gender and GBV in proposals | 61- 69 |
|  | Implementation of nutrition programs using gender and GBV lens | 1.5 hour | Introduction on implementation and examples as well as an exercise to integrate gender and GBV in project interventions | 70- 83 |
|  | Monitoring of gender and GBV issues in nutrition programming | 1.5 hour | Introduction to monitoring and safety audits and examples as well as an exercise on integrating gender and GBV indicators in an M&E plan | 84- 93 |
|  | Take home messages and questions | 20 min | summary of key concepts and guidance | 94-96 |

**Session materials:**

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| **General** | **HO=Handouts and**  **R =Resources** | **Electronic References** |

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| * PPT Presentation * Flip charts * Markers | * HO= power walk characters, AAAQ framework, Nutrition questionnaire sample, Nutrition proposal sample, IASC gender marker tip sheet for nutrition, resource mobilization discussion guide, implementation discussions guide, M&E discussions guide * R=Nutrition cluster framework on AAP, GBV guidelines Nutrition TAG | * Electronic copy of the GBV guidelines, gender handbook, GBV pocket guide |

**Facilitator notes**

* There are three suggested modules in this training package as outlined above. The 1 -day workshop module is aimed towards nutrition staff that strictly work in coordination and the material is designed based on their role and needs. The 2 -day workshop module is aimed towards nutrition staff who work in programs and are responsible of developing and overseeing nutrition projects, in addition this module is designed for staff that have basic knowledge on GBV whether this has been achieved through a formal training, online resourcing or experience. Lastly, the 3- day workshop module is aimed towards nutrition staff who work in programs and are responsible of developing and overseeing nutrition projects and who do not have any prior knowledge about GBV. It is recommended that the facilitator conducts a brief review of the profile of the participants to decide on either using the 2 or 3- day module. In the 3- day module a full day on GBV core concepts is added to ensure that all participants have the same base level of information and allows the workshop to start at an intermediate level of the GBV core concepts; the focus becomes on understanding and operationalizing the GBV core concepts versus starting from scratch. The training
* The facilitator of this module should be a gender and/or GBV specialist with preferably knowledge working in GBV and gender mainstreaming.
* The facilitator is advised to familiarize her/himself with the GBV guidelines/Nutrition TAG and the gender handbook prior to the workshop
* The exercise on the Integration of gender/GBV questions into routine assessments requires the facilitator to use a sample of a real nutrition assessment or questionnaire. There is a sample in the handouts that can be used, however it is recommended to look for context specific assessments that the participants are familiar with and use them for this exercise.
* The exercise on drafting gender and GBV responsive proposals requires the facilitator to use a sample of a real nutrition proposal. There is a sample in the handouts that can be used, however it is recommended to find a new context related proposal that can be used during this exercise. The Sample should be containing all the sections of a proposal including the implementation and M&E since the same proposal is going to be used for the rest of the exercises.
* In this training package, there are a lot of examples and success stories that you can refer to throughout the workshop, however it is highly recommended to look up for other examples that are context specific. This can be done through either a consultation with the nutrition cluster in your country or with the participants themselves prior to the training.

**Introductory definitions**

This part of the session focuses on explaining the definition of Gender, Gender equality, GBV and the types of GBV interventions as well as presenting UNICEF conceptual framework for the causes for malnutrition at the aim of linking the introductory definitions to nutrition programs. In addition, there is a group exercise that highlights the different vulnerabilities to accessing nutrition services.

Definition of Gender:

* Ask participants to define gender and to identify the difference between gender and sex.
* Explain from slide 3 that the formal WHO definition is the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men.
* It varies from society to society and across time. Provide examples such as the change of women’s role in the family over time and throughout different locations/cultures.
* It is used interchangeably with sex, however sex refers to the biological characteristic that people are born with and can not be changed. (male and female)

Definition of Gender equality

* Explain from slide 4 that gender equality refers to the equality between women and men which includes the equal enjoyment by women, girls, men and boys — of all ages, sexual orientations and gender identities — of rights, goods, opportunities, resources, rewards and quality of life.
* Ask participants to reflect on the definition by asking them to agree or disagree if there is a gender inequality across different cultures
* Conclude that gender inequality is present almost everywhere and it is of great importance to consider when designing programs

Definition of Gender based Violence (GBV)

* Ask volunteers to define GBV in their own words. After a couple minutes of discussion, introduce and use the following terms to describe GBV:

Gender, Power, Violence, Informed consent, Human rights

* Show and read the official definition of GBV from slide 5 and refer the participants to the GBV guidelines Nutrition TAG
* Explain: Rape and sexual violence are the most immediate and widely recognized type of GBV and it is a serious, life-threatening protection issue, primarily affecting women and girls. However, all forms of GBV can increase in humanitarian contexts, including but not limited to intimate partner violence, trafficking for the purpose of sexual exploitation, early and forced marriage, harmful traditional practices, sexual exploitation and forced prostitution.

GBV Prevention, response and risk mitigation

* Show slides 6 & 7 and explain the following while allowing participants to provide examples:
* Addressing GBV in emergencies requires working across the following 3 areas: prevention, risk mitigation and response.
* Prevention means preventing GBV from occurring in the first place, and is often focused on promoting positive gender norms and equal power dynamics (i.e.: addressing root causes of GBV). For example, if an individual believes men and women are equal and have similar levels of power, regardless of the emergency dynamics, there will be no reason for GBV. This transformational change takes time, however, supportive actions can be incorporated into humanitarian programming - for example, actively promoting women and girls’ participation.
* Risk mitigation means reducing the immediate risk of exposure to GBV. This is a critical area of focus for ALL humanitarian actors, providing great opportunity to reduce risk and improve sectoral practices. Here the focus is on addressing contributing factors – such as overcrowding, safety of access points (NFI, water, health services), representation of at-risk groups – and how they may mediate immediate risk - for example, ensuring appropriate shelter division according to family structure; providing safe livelihood options; ensuring educational/recreational access for at-risk groups.
* Response means putting in place specialized services to respond to incidents of GBV after they have occurred, in a survivor-centred manner (meaning that survivors are informed, safe, are non discriminated against and are referred to appropriate services). The actors in this area of GBV work are specialized - for example, health, legal, psychosocial, security – and therefore received specialized training. However, each and every humanitarian actor has a role to play in the response to an incident of GBV and the support of a survivor, inclusive of basic psychological first aid and knowing how to safely provide referrals.
* Ensure that participants understand that the focus of this workshop and non-GBV specialists more broadly is GBV risk mitigation. Prevention and response activities are the responsibility of GBV specialists with specialized training.

The UNICEF conceptual framework of causes of malnutrition

* Show the Framework on slide 8 and ask one of the participants to explain it
* Ask participants to reflect on the framework and relate to it by identifying the root causes of ‘lack of nutrition’ for certain groups, particularly women.
* Ensure that participants identify gender inequality and GBV as potential causes of malnutrition.

The power walk exercise- slide 9

* Explain the exercise briefly to participants: We are going to do an exercise about how different vulnerabilities contribute to the nutrition status. I am going to give each one of you a paper that outlines a specific character and than based on what you know about your character I will ask you to step forward or backward
* Give each of the participants a piece of paper with a character written on it. If there are more than 15 participants, ask the rest of the participants to act as an observant to this exercise
* Request the participants to join at an open space for the exercise
* Ask participants to stand in a row
* Give an instruction to participants to take one step forward/backward if the statement applies to his/her given character.
* Read the following statements:
* Take one step forward if you or your family fled with enough money to buy food
* Take one step backward if you have a disability or chronic disease that may compromise your access to nutrition services
* Take one step forward if you can reach the nutrition services on your own
* Take one step forward if you are able to seek information about the nutrition services
* Take one step forward if you are not at a risk of malnutrition
* Take one step backward if you do not want to access nutrition services because you are worried about experiencing sexual violence
* Take one step forward if you have enough time during the day to go to the nutrition centers
* Take one step backward if you are at an increased risk of sexual exploitation in return of food
* Take one step backward if you cannot access the location of the nutrition centers
* Take one step backward if you are not able to read the information about the nutrition services in the language in your host country.
* Take one step backwards if you are not able to decide what food items to buy
* Take a step forward if you can take your children to nutrition services
* While the participants are still standing open a discussion with them using the following key questions:
* What do you think are the factors that could contribute to lower nutrition status?
* How do you think the different vulnerabilities are linked to poor nutrition status?
* What did you learn from this exercise?

**Linkages between gender, GBV and nutrition**

This part of the session focuses on helping the participants to identify the linkages between gender, GBV and nutrition outcomes through case studies and examples and providing them with brief literature review about the impact of GBV experience on nutrition outcomes. It also serves as a solid introduction to the importance of gender and GBV responsive nutrition programming

* Case studies: linkages between gender, GBV and nutrition- slide 10
* Do a plenary discussion of the case studies if you are doing the 1- day workshop module, otherwise do a small group exercise using the questions below to guide the discussion/exercise
* Ensure that the participants identify gender inequality and gender norms (case studies 1, 2 and 3) and risk of GBV (case study 4) as contributing factors to poor nutrition outcomes
* Case study 1- In some contexts, if a woman who eats before the husband, she is not “a good wife”.
* What is the reason behind this tradition?
* How does this tradition affect of the nutrition outcomes for women during humanitarian crisis, when food supply is limited?
* Case study 2- In some contexts, women are expected to take care of their children, husband and do the housework, in addition to farming and being responsible for fetching water and firewood.
* What is the reason behind the women’s heavy workload?
* How does the heavy workload affect the nutrition related outcomes for the women and children? And why?
* Case study 3- In some contexts, women are not allowed to go out alone to access services.
* What is the reason behind it?
* How does it affect nutrition outcomes for the women, girls and their children?
* Case study 4- When nutrition centered are located in remote areas and near check points, women and girls might not feel safe to access the services
* How does the safety perceptions of women and girls affect the nutrition outcomes?
* What are the safety risks on women and girls that are associated with locating the centers in unsafe areas?
* Explain using slide 11 that GBV, gender and nutrition are interlinked
* Humanitarian crises have different impacts on the levels of nutrition available to women, girls, men and boys, their feeding practices as well as their access to nutrition services. This is partly due to gender inequality and GBV and or the increased risk of GBV during the humanitarian crisis.
* Using a flipchart, brainstorm with the participants about their experience by asking:
* Have you ever encountered an obstacle to achieving your programmatic outcomes due to gender norms?
* Explain using slides 12 and 13 that Gender social norms are detrimental in shaping food and nutrition related practices and gender/power dynamics in the home have major implications for effectiveness of nutrition interventions and uptake of the services. Give few examples:
* In some cultures, women and girls may reduce or skip their food intake, while men and boys are favored as a coping strategy in support of other household members or when there is a tradition for women and girls to eat their meals only after men and boys do places them at an increased risk of malnutrition.
* Single men and boys who have been separated from their families can also be at risk of undernutrition if they are unable to cook or access food distribution points. Single male caregivers may not have sufficient information to provide adequate feeding support to their children or may be overlooked by nutrition services and messaging
* In some contexts, certain supplementation food that are socially believed to increase men sexual activity are removed from the hands of women which may contribute to the risk if women and child malnutrition.
* Women’s aggregated work overload, often the result of gender inequality, has been strongly found to be as a major factor contributing directly to child undernutrition
* Constraints on women’s mobility can hamper their access to food distribution sites and ability to access adequate and consistent amounts of nutritious food to meet their own needs as well as those of their families.
* Women and girls usually have more constraints to accessing food security than men and boys during their menstrual cycles, this may also prevent them to participate in other social activities and public gatherings like food distribution points.
* Explain that in addition to the above the links between nutrition and the risks of GBV may also become particularly pronounced where food and basic needs are in short supply for example girls, and women are at heightened risk of child marriage exchanging sex for food and or sexual exploitation and abuse. Disagreements about how to manage limited household food supplies or assign food rations may contribute to intimate partner violence and other forms of domestic violence.
* GBV survivors in particular— those who are socially isolated and/or have physical limitations— access to nutrition support services may be difficult. This can be especially detrimental for survivors who have physical injuries and/or need to take medication that must be accompanied by food.
* Location and timing of nutrition services/distribution points can increase GBV risk if the programs did not take into consideration the safety of women and girls in accessing the services.
* GBV has a clear positive association with child malnutrition especially stunting which is a marker of chronic malnutrition, in addition there is evidence that points at a statistically significant association between GBV, especially Intimate Partner Violence, and the initiation of breastfeeding and child mortality
* Ask participants if they have other examples
* Show slide 14 and explain: Our review finds 12 studies examining the association between GBV and child malnutrition (See table 1). Studies were from both low and high-income countries and examined the association of GBV with child underweight, stunting, wasting (moderate to severe and severe), and low BMI. Most of the studies were based on Demographic Health Surveys or National Surveys with a few studies using observational study designs. All of them show a positive association between maternal exposure to physical, sexual, verbal or emotional abuse by their partners and child nutrition indicators. Stunting – low height of age- is a well-established risk marker of poor child development and predicts poorer cognitive and educational outcomes in later childhood and adolescence. Acute Malnutrition in the form of wasting can have long-term consequences for linear growth, depending on the severity, duration and recurrence, particularly if there is insufficient nourishment to support recovery. A significant association between stunting and maternal exposure to IPV was seen in countries like Kenya, India, Bangladesh and Malawi
* Show slide 15 and explain: The review found 10 studies examining the association of LBW with exposure to IPV. Studies show that there is a positive association between LBW and the outcome. Low weight at birth (less than 2500 grams) is strongly associated with child malnutrition, neonatal mortality, cognitive and neurological impairment, and stunting as adolescents and adults. LBW is also associated with other outcomes like hypothermia, small for gestational age, low immunity and consequent morbidity. LBW may also have intergenerational effects as LBW girls who survive tend to be undernourished when pregnant with relatively high incidence of LBW children (Alderman & Behrman, 2004).
* Show slide 16 and explain: Interventions towards infant and young child feeding are critical for improving nutrition during emergencies. Immediate initiation of breast feeding, exclusive breast feeding for 6 months, timely initiation of complementary feeding at 6 months, minimum dietary diversity and minimum feed frequency (age appropriate) are recommended for child health and nutrition during the first 2 years of life. Our review found 11 studies that explored the impact of GBV on child feeding. Women who experienced any form of IPV during pregnancy were more likely to stop exclusive breast feeding within 6 months after birth. There was an association between IPV and immediate initiation of BF. Misch et al found that Indian mothers who were exposed to IPV had higher odds of feeding their children liquids within 24 hours of birth compared to those who were not (OR 0.74, 95% CI 0.58–0.95). The results show that psychological abuse was strongly associated with negative feeding behaviors.
* Explain the last example from slide 17 on intimate partner violence and its impact on child nutrition

**Gender and GBV responsive nutrition programming**

This part of the session focuses on explaining the meaning and objectives of gender and GBV mainstreaming and briefly unpacking the main entry points at the project cycle level. It also informs participants of key global tools that are useful for the integration.

* Introduce the subject from slide 18 by explaining that GBV integration is different from GBV programming. Nutrition specialists are not required to develop a GBV program and interventions which is usually done by the GBV specialists. For example, they are not required to design case management services for GBV survivors or provide clinical management of rape, etc.
* Gender and GBV integration are about good nutrition programming- slide 19
* Effectively reaching all segments of the affected population with nutrition interventions.
* Better addressing the different needs of women, men, girls and boys.
* Promoting the safety of women, girls and at risk groups and mitigating GBV risks that are related to the nutrition programs.
* Show slide 20 and explain how gender and GBV responsive nutrition programming looks like:
* At the right. What needs to know/analyse to do gender and GBV responsive nutrition programme (feel free to change the contents in a way that harmonized with technical note)
* At the middle. It’s intervention level. Nothing concrete but emphasizing that the interventions need to be designed based on the through analysis of norms and context and by participation of women.
* At the left: the results
* The circle shows different level of interventions and results.
* The last box of women’s access to services and GBV services are connected to the first part of women are well-taken care of. Women well-taken care of is in the nutrition causality analysis.
* Show slides 21 and 22 and explain that since Gender and GBV integration are about good programming the Availability, Accessibility, Acceptability and Quality (AAAQ framework) is recommended to be used throughout each step of the program cycle as it can be used for barrier analysis
* Ask the participants if they are familiar with the AAAQ framework
* Distribute the AAAQ framework handout and allow few minutes for reading and familiarizing
* Ask volunteers who are comfortable to explain the AAAQ framework and show the slide
* Ensure that the following have been explained about the AAAQ framework:
* Availability: Whether the service in question is available? For instance, is the health service available?
* Accessibility: Whether the service is accessible i.e. women and girls? Are there any groups of people who cannot access to the service due to the accessibility barriers (physical, financial, admin, social, information)? For example, a refugee woman from conservative countries may not be able to access health service where there are no female health staff and may not have enough money to pay the health services, may not have an insurance to access the health service and her husband may not allow her to access to the health service provided by male doctors, and may not have any information about the service or cannot read the information she received.
* Acceptability: Even if there are no accessibility barriers, if the service is not acceptable to the intended user due to their culture or norms, people still cannot access to the services.
* Quality: Even if people access to the service, if the quality is not up to standards, the users may not receive what s/he needs to receive or have negative impact.
* Highlight that you will get back to this framework throughout the remaining of the workshop to pinpoint its practical implementation throughout the project cycle
* Explain through slide 23 that the AAAQ framework is good for barrier analysis, however it is equally important to consider the different areas in which risk of GBV exists in the programming and take appropriate actions to mitigate these risks
* Show slide 24 of the project cycle and explain the following:
* The Gender and GBV responsive nutrition programming should be addressed throughout the Humanitarian Program Cycle steps.
* These are the key elements for gender and GBV responsive nutrition programs
* Read from the slide the key elements of each step
* Explain that at the heart of the project cycle there should be ethical considerations, do No harm principles and safe and ethical GBV referrals, which means that these elements should be present throughout the project cycle
* Allow questions while highlighting that each element will be discussed thoroughly for the remaining of the workshop
* Show slides 25 & 26 and explain the following on the preparedness phase of an emergency
* The integration of gender and GBV need to be featured in all stages of the humanitarian project cycle and in the emergency preparedness as well.
* It is very important to integrate gender and GBV when you are doing contingency plans, designing interventions and mobilizing resources to secure funding for an emergency. Doing it right from the beginning saves you a lot of time and ensures that your preparedness plans are inclusive of the segments of the affected population including women and girls and other at risk groups.
* There are key areas that should be tackled in any preparedness phase including:
* Include Gender and GBV risk mitigation measures in the nutrition contingency planning and preparedness actions
* Prepare nutrition assessments that are gender and GBV responsive at the onset of an emergency
* Set up a strong monitoring system that addresses the gender issues and GBV risks.
* Integrate GBV risk mitigation into the nutrition coordination structures, work plan and their preparedness plans.
* Advocate funding for nutrition related GBV risk mitigation and specific needs of women and girls and other at-risk groups.
* Show slides 27, 28 and 29 and highlight that there are tools and guidance that are useful to develop a gender and GBV responsive nutrition programs
* The gender handbook; guidance on using a gender lens throughout the project cycle. It has a dedicated chapter for the nutrition sector
* The GBV guidelines; nutrition specific chapter on GBV integration throughout the project cycle. Introduce participants to the website: gbvguidelines.com. They can find in the website a lot of tools and accompanied resources for GBV integration
* Mainstreaming AAP and core people related issues in the humanitarian program cycle- developed by the global food security and nutrition clusters.

**The role of nutrition coordinators**

This part of the session focuses on unpacking the key role of nutrition coordinators in the integration of gender and GBV in programs.

* Read slide 30 about the role of the global nutrition cluster in general
* Ask participants to discuss in plenary how each of the 3 major roles can be unpacked to support the Gender and GBV integration
* Show slides 31,32 & 33 and discuss suggested roles that the nutrition cluster can play within their ToRs
* Show examples- slides 34 & 35
* Open a discussion in plenary on additional examples and suggestions

**Gender and GBV risk assessment and analysis**

This part of the session focuses on explaining and unpacking the major steps of Gender/GBV risk assessment and analysis using different techniques and methods. It also provides real examples and case studies and gives the participants an opportunity to apply what they have learned through interactive exercises.

* Show the introductory slide number 36 in this section and explain:
* Gender and GBV risk assessment and analysis can be done using different methods. While you are not required to use all of them as standalone techniques, it is important to ensure that they are integrated and become part of each assessment and analysis that you conduct for the nutrition program.
* These methods yield to Sex-disaggregated data and gender-sensitive information about the population concerned and exploring when, why and how GBV-related safety issues might arise, particularly as the result of delivery or use of nutrition services
* The ultimate goal is to have this data be analyzed and used for highlighting priorities and gaps that need to be addressed when planning new nutrition programs or adjusting existing programs.
* Explain from slide 37 that the common gender and GBV related bottlenecks and barriers to nutrition services that can be anticipated are:
* Masculine and feminine ideals & expectations
* Lack of resources and decision making
* Limited access to knowledge, information and technology
* Lack of safety and mobility
* Excessive time burden
* Dual responsibilities for women and girls
* Others that the participants can think of
* Show slide 38 and highlight that nutrition specialists are neither required to do a GBV assessment nor develop a standalone assessment per say.
* Explain the difference between GBV assessment and GBV risk assessment
* A GBV assessment may look at the GBV incidents for example sexual violence or intimate partner violence, its prevalence and the response needed.
* A GBV risk assessment looks at the safety of the vulnerable groups mainly women and girls in accessing nutrition services. It assesses if the services are increasing the likelihood of GBV (timing, location, etc…)
* GBV-specific assessments are conducted by GBV actors. However, non-GBV specialized sectors can integrate a GBV lens in assessments, to make their programme safer and accessible to all.
* Highlight that there are GBV risks in all settings and that is why it is necessary to ask GBV risk-related questions in any type of assessment: it is an opportunity to identify GBV risks and to prevent/mitigate them later in the project
* Needs assessment/analysis is a strategic opportunity to identify GBV risks and suitable GBV risk mitigation measures related to nutrition programs
* Distribute the Nutrition cluster AAP framework and highlight in the document key commitments related to gender and GBV risk assessment (pages 17/18)
* Consult with available gender, protection, age, disability, communicating with communities (CwC) and accountability specialized agencies and focal points when developing plans and designing assessments to seek expert input.
* Advocate for these areas in joint/interagency assessment design.
* Ensure Sex and Age Disaggregated Data (SADD) is routinely collected, analyzed and used to set a baseline and throughout the response, including an appropriate breakdown of older age groups. Advocate for the inclusion of data on disability.
* Facilitate the implementation and utilization of a context analysis of local culture, customs, beliefs, taking into account the differing needs of women, men, girls and boys, including older people, persons with disability and other vulnerable groups.
* Apply a protection and “Do No Harm” analysis.
* Advocate for the inclusion of key findings inclusive of AAP and core people-related issues analysis in the response framework and strategic planning.
* Highlight from slide 40 the steps of Gender and GBV risk assessment and analysis

1. Find existing data about Gender and GBV issues that might affect equal and safe access to nutrition programs through a desk review
2. Collect missing information through informational interviews and FGDs and analyze the findings
3. Develop recommendations and action plans based on the results

* Explain Step 1: finding existing data using slides 41, 42 and 43: Information to look for:
* **Population demographics:** What was the demographic profile of the population disaggregated by sex and age *before the crisis*? What has changed since the crisis or program began? Look at the number of households and average family size, number of single- and child-headed households by sex and age, number of people by age and sex with specific needs, number of pregnant and lactating women. Are there polygamous family structures?
* **Gender roles:** What were the roles of women, girls, men and boys relating to nutrition before the crisis? How have the roles of women, girls, men and boys relating to nutrition changed since the onset of the crisis? What are the new roles of women, girls, men and boys and how do they interact? How much time do these roles require?
* **Decision-making structures:** What structures did the community use to make decisions relating to nutrition before the crisis and what are these now? Who participates in decision-making spaces? Do women and men have an equal voice? How do adolescent girls and boys participate?
* **Protection:** What protection risks did specific groups of women, girls, men and boys face before the crisis? What information is available about protection risks since the crisis began or the program started? How do legal frameworks affect gender and protection needs and access to justice?
* **Gendered needs, capacities and aspirations:** What are the nutrition-related needs, capacities and aspirations of women, girls, men and boys in the affected population and/or program? This should include an assessment of whether nutritional requirements are being met for specific groups, for example, women and girls sometimes eat only after the men and boys and if there is not much food available, they reduce their consumption or go without. It should also include an assessment of breastfeeding practices. Women may fail to breastfeed due to perceptions that breast-milk substitutes are better, or not having enough nutrition or because they have neither time, space nor support.
* Sources of information: read briefly from slide 42 the sources of information
* The latest country situation analysis for information on: 1) the status of women and girls (e.g. sex-disaggregated school enrolment, workforce and political representation, health status, gender-based violence) and 2) the roles and policies of ministries and other institutions in addressing gender-responsive development.
* Gender equality goals and targets in the Country Program Document.
* Country program work plan review report
* Documents and assessments related to any existing gender-responsive Nutrition programs in the country or region.
* Any evaluation of Nutrition programs that included an assessment of equity, including gender dimensions.
* Population assessments with SADD such as MICS, DHS and SMART nutrition surveys
* Sex and Age Desegregated Data (SADD)- slide 43
* Emphasize that the value of SADD is that it can tell which population groups are more vulnerable to nutrition issues and have less access to nutrition services
* Sex- and Age- Disaggregated Data (SADD) are a core component of any gender analysis and essential for monitoring and measuring outcomes.
* To be effective, SADD must be both collected and analyzed to inform programming.
* In circumstances where collection of SADD is difficult, estimates can be provided based on national and international statistics, data gathered by other humanitarian and development actors or through small sample surveys.
* Data should be disaggregated by gender and age, at user level e.g. 0-6 months, but also disaggregate by the gender and age of the head of households, age and gender of the care takers so that it tells which population groups are more vulnerable to nutrition issues and have less access to nutrition services.
* A number of nutrition information systems/data streams have SADD including nutrition surveys/surveillance/rapid assessments based on SMART methodology and, in some instances, routine health data (such as OTP/SFP admissions and/or OTP/SFP performance indicators).
* Example of Analyzing existing data- slide 44
* In a recent article published by ACF, a meta-analysis was recently conducted on 27 Link NCAs to assess the influence of women’s social status in the pathways to undernutrition. The result showed – among other findings- that the heavy workload of women is spontaneously and strongly identified by communities as one of the most important contributors to child undernutrition.
* Explain Step 2 -collecting data using slides 45- 50: If any information is missing from the literature review start collecting the missing information through informational interviews and focused group discussions.
* Use the Availability, Accessibility, Acceptability, Quality (AAAQ) framework for identifying and analyzing barriers to services that may not be immediately apparent.
* Collected data should always be desegregated by gender and age
* Exercise- slide 46: Ask the participants in small groups to select one service that they provide or know well and review the service using the AAAQ framework. Explain that they need to go through each of the components of the framework and question if it applies to the service that they are reviewing and highlight the gaps. Allow brief presentations and highlight that one of the methods to collect gender and GBV data related to the nutrition programs is through using the AAAQ framework because it generates information about how the services are being designed to be gender and GBV responsive.
* Explain from slide 48 that in addition, there are several questions that can be used to assess GBV risks.
* Distribute the GBV guidelines- nutrition thematic guide and guide the participants to assessment section and allow five minutes reading of the questions
* Explain and highlight from slide 49 that during assessments it’s very important to pay particular attention to women and girls as they often excluded from consultation.
* Talking to male community leaders, community groups largely represented by male do not means that their opinions are reflective of women and girls or other vulnerable groups.
* Participation of women and girls does not only mean that females are consulted but rather it is reaching out to the most vulnerable women and girls that often go un-noticed due to their limited access to services, isolation or certain social norms (e.g. identifying ways for female heads of households and married adolescent girls who may have limited mobility to join a focused group discussion). Meaningful participation also includes creating a space for consultations that is safe, confidential and secure based on social, gender, cultural and other norms and concerns
* Example of collecting data through routine assessments- slide 50: At the aim of ensuring systematic collection of data related to gender inequality and GBV through regular nutrition assessments. Action Against Hunger (ACF) has adapted the commonly used Knowledge, Attitudes and Practices (KAP) questionnaires and combined it with the breastfeeding Questionnaire and added questions around gender inequality and GBV to better understand gender roles, norms and responsibilities and GBV risks. Examples of questions that were added in the adapted tool include:
* Composition of household (by sex and age)
* The roles and responsibilities of women and men in the household
* Who has access and control over food resources
* Food taboos as well as who eats first and last in the household
* Knowledge of complications from GBV
* Existence of water management committees and women's role in water management and chores
* Exercise on the integration of gender/GBV questions into routine assessments- slide 51: Ask participants to split into small groups. Distribute the nutrition questionnaire samples and ask each group to 1) review the questions from the assessment section of the GBV guidelines- nutrition tag pages 41 & 42 and 2) compare the questions in the tag with the questionnaire at the aim of identifying gender/GBV risks and considerations that are already integrated in the questionnaire as well as highlighting the gaps and 3) propose few questions to be included in the questionnaire that better address the potential GBV risks. Allow time for presentations and discussions.
* Explain Step 3- analyzing data and developing recommendations through slide 52: Analysis should follow the collection of gender information on the aspects of gender, age and diversity to develop an overview of nutrition issues in the affected area by age and gender.
* Ensure the analysis of SADD.
* Use the results of the analysis to do strategic planning
* Case study on analyzing data and developing recommendations- slide 53
* Present briefly a key finding of a gender analysis done in Yemen in 2016 by OXFAM that revealed that in some places women can be reached directly with humanitarian assistance, whilst in others aid is received through their male relatives. Challenges women face in accessing assistance, especially outside their communities, are even more acute for female-headed households, which comprise over 30% of displaced households in some areas.
* Ask participants to split into small groups and discuss potential implications of this finding in the nutrition programs in terms of reaching, targeting and nutrition outcomes.
* Instruct participants to highlight 2- 3 recommendations that need to be outlined in nutrition programs to ensure overcoming this barrier.
* Ensure that participants formulate recommendations that are related to the location of the services and targeting to ensure equal access to services especially to the most vulnerable.
* Explain the ethical and safety considerations in data collection- slides 54- 57: Apply ethical and safety standards that are age-, gender-, and culturally sensitive and prioritize the well-being of all those engaged in the assessment process.
* Design and undertake the data collection according to participatory processes that engage the entire community, and most particularly women, girls, and other at-risk groups.
* Despite the fact that all at risk groups including women, girls and people living with disabilities should participate in assessments- ensure that you do not try to form groups from people who have common characteristics as this could potentially expose and stigmatize them. Example: GBV survivors, adolescents with physical disabilities
* Location – close to where women can easily access. Make use of existing forum i.e. WFS
* Timing – organize assessment during the time when women are least busy. For girls, make sure that the assessment will not have during school time.
* Female staff – female staff is needed to conduct interview and FGD for women and girls.
* Power dynamics – balance participation and potential conflict at home and communities
* Topics – never collect any information about their GBV experience or incident. Focus on the information you need in your sector and safety issues.
* Highlight from slide 56 that while questions about GBV incidents will not be asked, the discussion around safety and security concerns may trigger a GBV disclosure that is why it is important to be prepared with updated referral GBV pathway as well as the knowledge of the staff on responding to GBV disclosures
* Introduce and refer participants to the GBV pocket guide- slide 57
* Step by step guide for non-GBV specialists on GBV referrals in case of disclosure
* Has Key messages that can be used with the survivor
* It is available as a mobile application

**Strategic planning of gender and GBV issues in nutrition programs**

This part of the session focuses on how to use the gender and GBV data in planning programs and provides participants with a real example.

* Explain from slide 58 that after an assessment and analysis are done, it’s very important to utilize the data and incorporate it into the planning phase of the project
* The gender and GBV data and information should be used to strategically plan the response intended to address them. This is done by establishing a demonstrable and logical link between the program activities and their intended results in the nutrition sector, thus ensuring that the identified needs are addressed.
* At the strategic planning stage, gender markers should be applied- highlight that you will discuss later the gender markers thoroughly
* Explain that at this stage as well indicators should be developed to measure change for women, girls, men and boys and monitor safety and security issues related to the nutrition services. All indicators should be sex- and age-sensitive to measure if all groups’ needs are being met. In addition, the indicators should be developed to check the following: expected results; provision of quality assistance with respect to gendered needs; monitoring rates of service access; satisfaction with the assistance provided; safety and security of the assistance provided; how the facilities were used; and what has changed due to the assistance, for whom and in what timeframe- highlight that you will discuss later how to practically formulate gender and GBV related indicators
* Show slide 59 on the example of gender and GBV related strategic planning and explain the following: The identified issue here is barrier of access to nutrition services for women and girls. To ensure that this issue is addressed in your program you need to:
* Formulate an objective to overcome it- such as increase in access through attendance or delivery of services
* Articulate the objective into an indicator such as: Number and percentage of women and girls who gain access to nutrition services via one of the distribution channels
* Set the results that you are expecting- low attendance barriers are addressed and women and girls feel safe to access nutrition services
* Formulate output indicators to measure your intervention- number of distribution channels identified and percentage of women and girls feeling safe to access the services
* Translate your plan into activities such as: development of special transportation arrangements and service delivery methods
* Present the successful integration of gender and GBV issues into the nutrition cluster response plan in Nigeria from slide 60
* Ask participants to give other real examples if any

**Resource mobilization for gender and GBV issues within nutrition programs**

This part of the session focuses on how to mobilize resources to address gender and GBV issues in the nutrition programs including the utilization of gender and age markers, drafting of gender and GBV sensitive proposals and an overview of Gender and GBV budgeting. It also provides the participants with an opportunity to apply what they have learned through an exercise.

* Following the strategic planning phase and the production of a results-based framework based on the needs assessment and analysis, the next phase in the HPC is resource mobilization.
* Ask the participants what does resource mobilization mean?
* Highlight from slide 61 that resource mobilization refers not only to accessing funding, but also to scaling up human resources, supplies and donor commitment.
* Key steps to be taken for effective gender and GBV-sensitive resource mobilization include:
* Humanitarian actors need to engage in advocacy and partnership with donors to mobilize funds for addressing gaps in the particular needs, priorities and capacities of women, girls, men and boys.
* Mobilizing resources around priority actions, support the nutrition cluster with information and key messages on the distinct needs of women, girls, men and boys and plans developed to meet these needs. This will help to strength the advocacy for nutrition resource mobilization, as ultimately the mainstreaming of gender and GBV will increase the impact of nutrition programming.
* Using gender markers to assess how well a program incorporates gender equality into planning and implementation and provide guidance on how to improve the process.
* Ask the participants if they have used before or are familiar with gender and age markers. If there is anyone who have used the markers before ask them to describe how and when they have been used in the programs
* Distribute the IASC Gender marker tip sheet for Nutrition and give some time for participants to read
* Explain from slide 62 that gender markers are used to assess how well a program incorporates gender equality into planning and implementation and provide guidance on how to improve the process. Examples of commitments of gender markers may include:
* Analyze the impact of the crisis on women, girls, men and boys, ensuring that all strategies include a gender analysis, i.e., identification of the differences in nutritional requirements, feeding practices and access to nutritional services for women, girls, men and boys;
* Take specific actions to prevent GBV;
* Ensure that women and men benefit equally from training or other skills development
* Ensure that distinct needs of women, girls, men and boys that may hinder their access to nutritional services are met e.g. provision of menstrual kits
* Ensure that fathers and mothers are targeted equally by food education activities.
* The example of the IASC Gender with Age Marker: Show slide 63 and explain the following:
* The IASC Gender with Age Marker (GAM) looks at the extent to which essential programming actions address gender- and age-related differences in humanitarian response. It was developed in response to requests to strengthen the original IASC Gender Marker by including age and, most significantly, by adding a monitoring component. In addition to measuring program effectiveness, it is a valuable teaching and self-monitoring tool, allowing organizations to learn by doing in developing programs that respond to all aspects of diversity.
* With the 2019 Humanitarian Planning Cycle (HPC), the GAM replaces the previous IASC Gender Marker applied to appeal projects since 2009. Its use will be similarly required in the Financial Tracking System (FTS), and Member States asked to commit to only funding partners who report to the FTS using the IASC Gender with Age Marker, and subsequently update the marker based on monitoring data.
* Highlight that it is also very important to reflect gender and GBV issues properly when drafting a proposal. There is guidance on important considerations for mobilizing gender and GBV-related resources when drafting proposals for nutrition programming.
* Read the slides 64 and 65 on some key considerations and emphasize that gender and GBV considerations should be well articulated and elaborated in the different parts of the proposal (overview, needs analysis, rational, implementation and M&E)
* Read slides 66 & 67 on good practice in GBV risk mitigation budgeting
* Highlight that many GBV prevention/risk mitigation actions don’t require additional budgets
* Explain that there would be still some hardware and software interventions that are more serious and require a dedicated budgeting
* Read slide 68 on examples of interventions that need money
* Summarize with key main points about GBV risk mitigation budgeting
* Don’t be afraid to budget for GBV-related interventions
* A strong proposal that outlines GBV risk and risk mitigation strategies at each stage of project design should be able to justify funding requests
* Donors are increasingly requesting that grantees account for GBV risk mitigation in their proposals
* Be prepared to push back if you face a skeptical donor
* Exercise- Drafting gender and GBV responsive proposals- slide 69: During this exercise, participants will look at a real sample proposals and recommend improvements that ensure integrating GBV risk mitigation into the proposal. Instructions are as follows:
* Split the participants into 4 groups. Each group will get a proposal sample and a resource mobilization template
* Review the overview, needs analysis and rational components of the proposal and discuss how it can better reflect GBV risk mitigation considerations across each proposal component. Use the template/discussion guide to frame your work. Ideally have someone in your group keep track of your recommendations for the presentation.
* Use the Resource Mobilization section of the GBV Guidelines- nutrition TAG page 43 to help guide you
* Prepare a 5-minute presentation on your recommendations

**Implementation of nutrition programs using gender and GBV lens**

This part of the session focuses on the design of gender and GBV responsive nutrition programs in terms of activities and real examples as well as ethical considerations. It also provides the participants with an opportunity to apply what they have learned through an exercise.

* Remind the participants that gender and GBV responsive nutrition programs is about good programming, hence one of the ways to address gender inequality and mitigate GBV risks in nutrition programming is done through strengthening the availability, accessibility, acceptability and quality of the nutrition services and programs. Slides 70 and 71.
* Explain and unpack each component of the AAAQ framework for nutrition programs- slide 72.
* Availability: There are sufficient quantity of functioning nutrition facilities, goods and services, and programs which cover gaps and ensure an acceptable ratio of skilled nutrition workers to the population needs
* Accessibility: There are nutrition facilities, goods, and services that are safely accessible, affordable and that there is enough information about them communicated to the population without discrimination
* Acceptability: There are nutrition facilities, goods, and services that are culturally appropriate, sensitive to gender and age, respect confidentiality and improve the nutrition status of those concerned
* Quality: There are nutrition facilities, goods, and services that are scientifically and medically approved and of good quality.
* There are some common gender and GBV-related considerations when implementing nutrition programming that include three areas of responsibilities: programming, policies and communication. These considerations should be adapted to each context, always taking into account the essential rights, expressed needs and identified resources of the target community.
* Read from slides 73 and 74 examples of key considerations
* Emphasize and explain from slide 75 that nutrition activities and services should be guided by the concept of Do No Harm. The concept of ‘do no harm’ means that humanitarian organizations must strive to “minimize the harm they may inadvertently be doing by being present and providing assistance.” Such unintended negative consequences may be wide-ranging and extremely complex. Nutrition actors can reinforce the ‘do no harm’ principle in their gender and GBV-related work through careful attention to the human rights-based, survivor-centered, community-based and systems approaches.
* Explain that Do No Harm should be applied based on the ethics, dignity and safety framework- slide 76
* Ethical considerations include – but not limited to- ensuring that all staff including frontline workers are trained on CoC, GBV principles and referrals. Nutrition staff may face disclosures of GBV incidents from the beneficiaries who are coming to receive nutrition services. This is particularly why staff should be trained and updated on GBV safe and ethical referrals.
* Preserving and promoting dignity means that the opinions of the affected population i.e. girls and women are reflected in the project and facility design which should be culturally acceptable and they know that they have rights to the humanitarian services.
* Promoting safety means that for the affected population i.e.: girls and women enjoy “safe” access to and usage of the facilities/services through addressing the physical and social barriers of access.
* Explain the survivor centered approach key principles- slide 77
* Respecting the wishes of the survivor might mean that you do not refer to services if you do not have approval, do not impose priorities on the survivor or decide on his/her behalf
* Safety means that all actions that are done with the survivor need to take into consideration her safety. It might mean that need to secure a safe space to talk to the survivor or protect him/her from disclosing a GBV incident inform of others
* Confidentiality refers to the right of the survivor to tell her story to whom he/she wishes. This includes not sharing her information and story with anyone without a consent. In case of referrals the survivor decides on the level of information to be shared and with whom
* Non- discrimination refers to equal and fair treatment to all survivors regardless of the age, nationality, race, etc.
* Staff need to be trained on survivor-centered principles and how to refer a survivor for care and support.
* Highlight real examples and promising practice for gender and GBV responsive interventions. Slides 78-82
* South Sudan 1: Since frontline nutrition staff are trusted by the community and nutrition programming is sometimes the only humanitarian service that women and girls regularly access, UNICEF has identiﬁed nutrition workers as a key target group for capacity building on GBV. Over the past year, UNICEF has supported its implementing partners and the broader Nutrition Cluster on:

promoting the recruitment and retention of female staff, ensuring that nutrition workers are familiar with the available GBV response services and are trained on how to safely and appropriately provide referrals to survivors, encouraging all nutrition workers to have codes of conduct in place, and engaging in multi sector safety audits.

UNICEF has also supported the South Sudan Ministry of Health to incorporate key messages on the linkage between child marriage/early pregnancy and nutrition outcomes into their standard Infant and Young Child Feeding IEC materials. Going forward, UNICEF and partners will work with mother support groups at select stabilization centers and OTPs to raise awareness of available GBV services.

* Bangladesh: Based on recommendations from the Inter-Agency Standing Committee (IASC), Action Against Hunger (ACF) have developed a guidance note to assist nutrition and Mental Health and Care Practices (MHCP) staff to provide safe, confidential and compassionate referrals to GBV services. After receiving a basic training, the frontline nutrition staff will use the guidance note to offer referral services to clients from ACF nutrition centers who require and request support for GBV services. This in turn will allow the centers to be entry points for women and girls who come to receive nutrition services and who disclose a GBV incident and request help.
* Nigeria: It has been observed by INTERSOS that host communities in Magumeri LGA, especially women and girls, face immense risks to their safety to access nutrition services. Women and girls, along with their children and younger siblings, are less likely to reach nutrition services due to safety concerns and, in some instances, men restricting or refusing women’s travel to these services. Existing data sources indicate that these factors exacerbate existing disparities in malnutrition rates and increased risk of morbidity and mortality.

Intensive consultations with women and girls to better understand (1) how to place OTP sites in convenient, reachable and safe locations, (2) how to deliver services in a manner that is culturally appropriate for women and children with a diversity of needs and protection concerns and (3) the community’s perceptions of existing interventions.

As a result, INTERSOS expanded nutrition services in Magumeri LGA via seven additional OTP centers with linked mother-to-mother support groups. In consultation and close coordination with INTERSOS’ protection team, shelter options were provided through nutrition/livelihood/protection services to those survivors who chose to disclose their experiences to INTERSOS personnel

* Ethiopia: A GBV case worker stays in IYCF centers and provide information on GBV to the users. Any people who want to access GBV services can seek support from the GBV case worker or directly access to services this will lead to increase in women who access women friendly space and survivors of GBV who seek support through the case worker. A simple collaboration like this can save life. When women receive adequate care, there is positive effect to nutrition outcome of children and the women.
* South Sudan 2: The nutrition cluster has Integrated GBV messages into IYCF card. Since nutrition has bigger and different outreach from GBV actors. This integration can disseminate critical message.
* Exercise- Formulating gender and GBV responsive interventions- slide 83: During this exercise, participants will look at a real sample proposals and recommend improvements that ensure integrating GBV risk mitigation into the implementation section of the proposal. Instructions are as follows:
* Split the participants into the same 4 groups that worked on the resource mobilization exercise.
* Ask each group to review the description and implementation section of the proposal sample and discuss how it can better reflect GBV risk mitigation considerations. Use the implementation discussion guide to frame your work. Ideally have someone in your group keep track of your recommendations for the presentation.
* Use the implementation section of the GBV Guidelines- nutrition TAG pages 44- 47 to help guide you
* Prepare a 5-minute presentation on your recommendations

**Monitoring of gender and GBV issues in nutrition programming**

This last part of the session focuses on explaining the importance of monitoring the activities including conducting safety audits as well as setting gender and GBV related indicators. It also provides participants with real examples and an opportunity to apply what they have learned through an exercise.

* Introduce the topic by explaining from slides 84, 85 and 86 that the monitoring of the gender considerations and GBV risks should look at the participation of and accountability to women and girls and the gender, social and cultural norms affecting nutrition and feeding practices and the safety and access risks for women, girls and other vulnerable groups related to nutrition services. Continuous routine monitoring is recommended and can take place at the different steps of the project cycle. E.g.: strategic planning and resource mobilization, implementation and at the end of the project.
* A good way to do monitoring is through integrating Gender and GBV lens into the regular monitoring of the markers of good programming – such as access, acceptability, availability, quality of services.
* The gender and safety issues related to the availability, accessibility, acceptability and quality of services can be done through safety audits and/or examining safety perceptions of the affected communities.
* Depending in which step of the project the safety monitoring takes place, it can either look at GBV risks related to nutrition programs or the effectiveness of the gender considerations and the GBV risk mitigation strategies that are implemented.
* The routine monitoring data along with community consultation and the collected SADD should jointly be used to enhance nutrition programs safety, achieve nutrition-specific goals and targets, address needs of affected communities and ensure accountability to affected communities.
* Pinpoint that the generated data should be handled with caution due to its sensitivity. It is the responsibility of all nutrition actors to ensure safety, confidentiality and informed consent when collecting or sharing data. In general, data gathered around individual GBV cases and quantitative GBV incident data should not be shared for coordination, donor reports, advocacy material, or used for making decisions on GBV risk mitigation strategies. The most appropriate and safe data to be shared and used to inform nutrition programs, advocacy, coordination and feed into donor reports, sitreps, etc. is the qualitative data around gender considerations and GBV risks that is gathered through monitoring and community feedback mechanisms.
* Explain and highlight from slide 87 that safety means in service delivery means that the service does not cause or increase the likelihood of GBV, proactively facilitates and monitors vulnerable groups’ equal access to services and is responsive to gender and GBV risks in the environment. Safety considerations include staff/volunteers, programs, coordination, operations etc.
* Ask why is this important and how safety concerns affect our programs and take few answers
* Show slides 88 and 89 and explain: Safety Audit is a simple and practical way to collect information related to GBV-related safety risks and can be incorporated into regular nutrition assessment/monitoring activities. It includes an observation component where physical/hardware GBV related risks are identified and consultations through focused group discussions and key informant interviews to understand accessibility challenges and safety concerns.
* Example of promising practice- South Sudan- slide 90:
* Action Against Hunger (ACF) has developed a tool to identify potential GBV related risks at and around the nutrition centers. This tool focuses on three sectors (WASH, Nutrition/Health and Protection/GBV). It allows ACF to identify key issues that could affect the safety of the beneficiaries and consequently find ways to mitigate and prevent these risks as well as identify effective program elements to ensure safety of the beneficiaries at the sites of operation. The key components of this toolkit include:
* An observation checklist
* Interview questionnaires that can be used in focus group discussions with beneficiaries
* Key informant interviews questionnaires with the staff at the site of operation
* Show slide 91 and explain that in addition to the routine monitoring, it is important to use both quantitative and qualitative indicators and integrate them into the existing nutrition M&E framework to measure the outcomes of activities undertaken across the program cycle, with the ultimate aim of maintaining effective programs and improving accountability
* Show slide 92 and read the sample of gender and GBV related indicators, while stressing that both quantitative and qualitative indicators are important
* Inform the participants that the full sample of indicators can be found in the M&E section of the GBV Guidelines Nutrition TAG.
* Exercise on reviewing an M&E plan- slide 93: During this exercise, participants will look at a real sample proposals and recommend improvements that ensure integrating GBV risk mitigation into the M&E section of the proposal. Instructions are as follows:
* Split the participants into the same 4 groups that worked on the implementation exercise.
* Ask each group to review the M&E section of the proposal sample and discuss how it can better reflect monitoring measures and gender/GBV sensitive indicators. Use the M&E discussion guide to frame your work. Ideally have someone in your group keep track of your recommendations for the presentation.
* Use the M&E section of the GBV Guidelines- nutrition TAG pages 52- 55 to help guide you
* Prepare a 5-minute presentation on your recommendations
* Read and discuss with participants the take home messages from slides 94-96
* Allow questions and ensure that all key messages are clear and well understood.

1. The facilitator note of the GBV CC and referral module can be found in a separate document in the training package [↑](#footnote-ref-1)