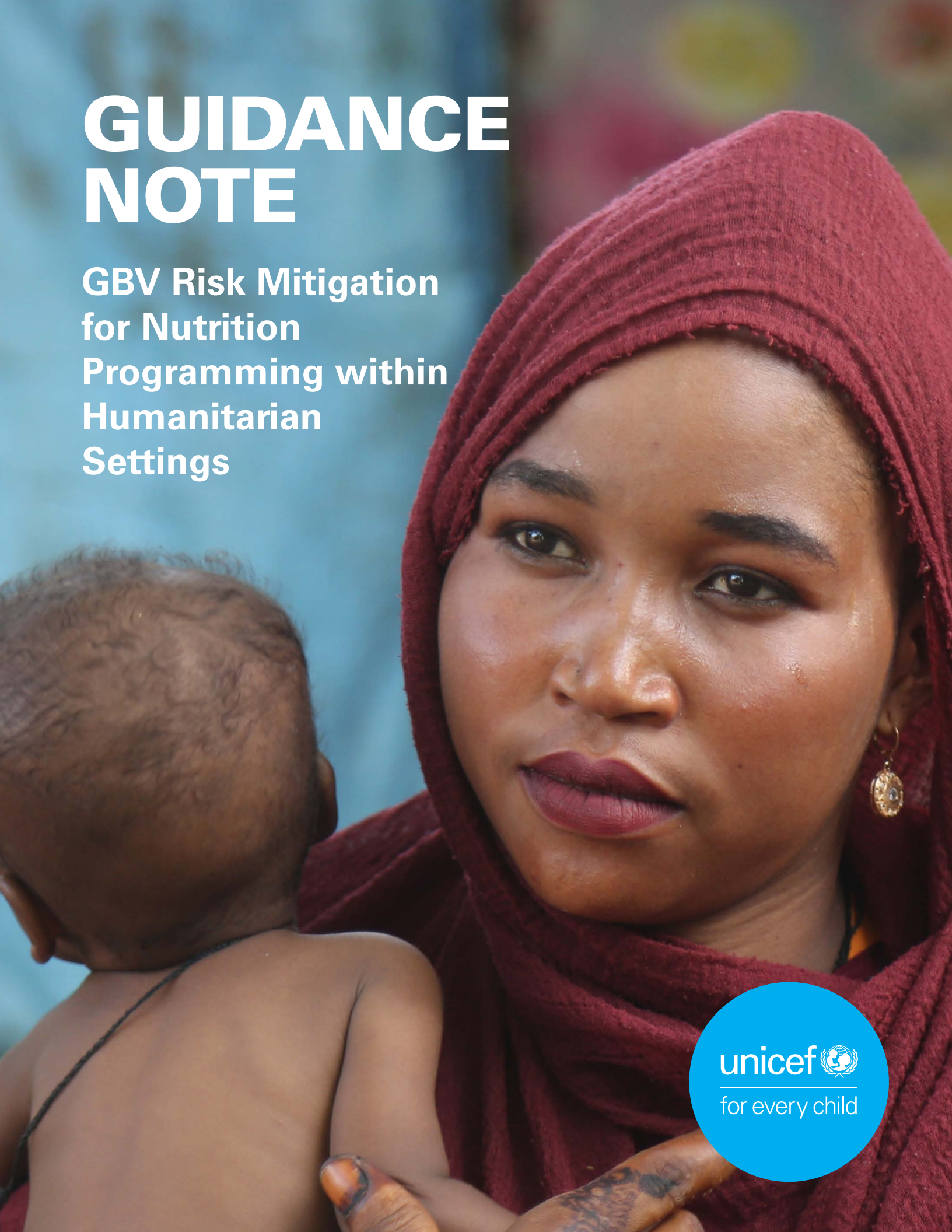
GUIDANCE NOTE

GBV Risk Mitigation for Nutrition Programming within Humanitarian Settings



unicef
for every child

Contents

Safety and dignity as a non-negotiable component of humanitarian response

Integrating gender-based violence risk mitigation within nutrition programming

In alignment with the fundamental 'do no harm' principle of humanitarian response, women and girls have the right to be safe while accessing assistance and services. The Inter-Agency Standing Committee (IASC) has explicitly stated that "all humanitarian actors must be aware of the risks of gender-based violence (GBV) and – acting collectively to ensure a comprehensive response – prevent and mitigate these risks as quickly as possible within their areas of operation. Failure to take action against GBV represents a failure by humanitarian actors to meet their most basic responsibilities for promoting and protecting the rights of affected populations."

As such, the safety of women and girls must be a non-negotiable component of how UNICEF designs and delivers all humanitarian programming, and how it defines and measures its 'success' across all sectors, including but not limited to nutrition.

While important progress has been made in integrating GBV risk mitigation into nutrition programming in humanitarian settings – in alignment with the IASC Guidelines on Integrating Gender-based Violence Risk Mitigation in Humanitarian Action – technical experts across both sectors agree there is significant potential to make GBV considerations a more systematic feature of how the nutrition sector operates.

This Guidance Note describes the recommended package of GBV risk mitigation actions that nutrition programmes can and should take to ensure that programming is safe for women and girls. The full package is designed to be implemented in contexts where both nutrition programming and GBV services are in place, but the guidance also provides recommendations for how to adapt the package in other contextual scenarios, such as where GBV services are not readily available, or where both nutrition and GBV services are extremely hard to reach.

Who is this for?

This Guidance Note is meant for nutrition programme designers and managers in humanitarian contexts, but it can also be relevant in development contexts and other fragile settings. It can also provide guidance for the nutrition sector/cluster coordination team in its role of supporting integration and capacity strengthening of nutrition partners.

What are the linkages between gender-based violence and nutrition?

In most settings, women and girls are the primary users of nutrition services. Of these women and girls, **at least one in three will experience GBV at some point in their lives,** according to global statistics. Because nutrition services tend to be highly valued and trusted within communities, they are a likely place for GBV survivors to seek support to address the consequences of violence, particularly in locations where specialized GBV response services are not available.

Nutrition professionals across varied humanitarian contexts have described how GBV affects their daily work – for example, when the consequences of GBV result in child neglect or when the risk of GBV is exacerbated by the way nutrition services are delivered (e.g., inconvenient operating hours, far away location, long wait time, etc.).

In addition to practice-based knowledge, the linkages between GBV and nutrition are captured in academic literature. A recent evidence review commissioned by UNICEF highlights numerous important findings, including that women who experience intimate partner violence (IPV) are more likely to have children born with low birthweight, more likely to have children affected by wasting and/or stunting, and less likely to engage in recommended breastfeeding practices. For a more detailed summary of findings from this rapid evidence assessment, please see the following learning briefs: overall findings; IPV and breastfeeding; IPV and child growth indicators; findings specific to adolescent girls.

What is GBV risk mitigation?

UNICEF's work on GBV in emergencies focuses on three main pillars: (i) supporting survivors with access to a comprehensive set of services; (ii) mitigating the risks of GBV across humanitarian sectors; and (iii) preventing GBV by addressing its underlying conditions and drivers. Under all three pillars, UNICEF aims to deliver humanitarian services that are safe for and responsive to the needs of women and girls.[1]

In 2015, the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action ('GBV Guidelines')[2] were launched as a resource to support all humanitarian sectors seeking to integrate GBV risk mitigation into their respective areas of work, Corresponding to pillar 2 of UNICEF's programme model for gender-based violence in emergencies. UNICEF co-led the revision of the GBV Guidelines and leads the global interagency rollout of this resource.

The objective of GBV risk mitigation is to make humanitarian systems and services safe, effective and responsive to the needs and rights of women and girls. Concretely, this means ensuring that humanitarian service delivery:

(1) does not increase the likelihood of GBV occurring;

(2) seeks to identify and mitigate GBV risks; and

(3) conducts ongoing monitoring of access and barriers to services, particularly those faced by women and girls.

GBV risk mitigation is everyone's responsibility, cutting across all sectors of humanitarian response. It is distinct from – but complementary to – GBV-specialized programming, which focuses on response services for GBV survivors (such as clinical care and psychosocial support) and longer-term prevention interventions.

1 See the UNICEF Gender-Based Violence Operational Guide for further information https://www.unicef.org/documents/gender-based-violence-emergencies-operational-guide

2 Learn more about and download the GBV Guidelines at www.gbvguidelines.org.

Theory of change

GBV risk mitigation interventions are actions taken to reduce **risks that are directly related to accessing humanitarian services.** Below are some examples related to nutrition programming.

Example 1

GBV risk: The route to a nutrition centre passes through an area occupied by armed groups/checkpoints.

Implications: Women and children have difficulty accessing services due to fear and/or experience of assault and harassment.

GBV risk mitigation intervention: In some settings, it may be possible to move the facility to a safer location. In others, nutrition actors can set up mobile outreach modalities that provide services closer to target communities and minimize the need for service users to travel on unsafe routes.

Example 2

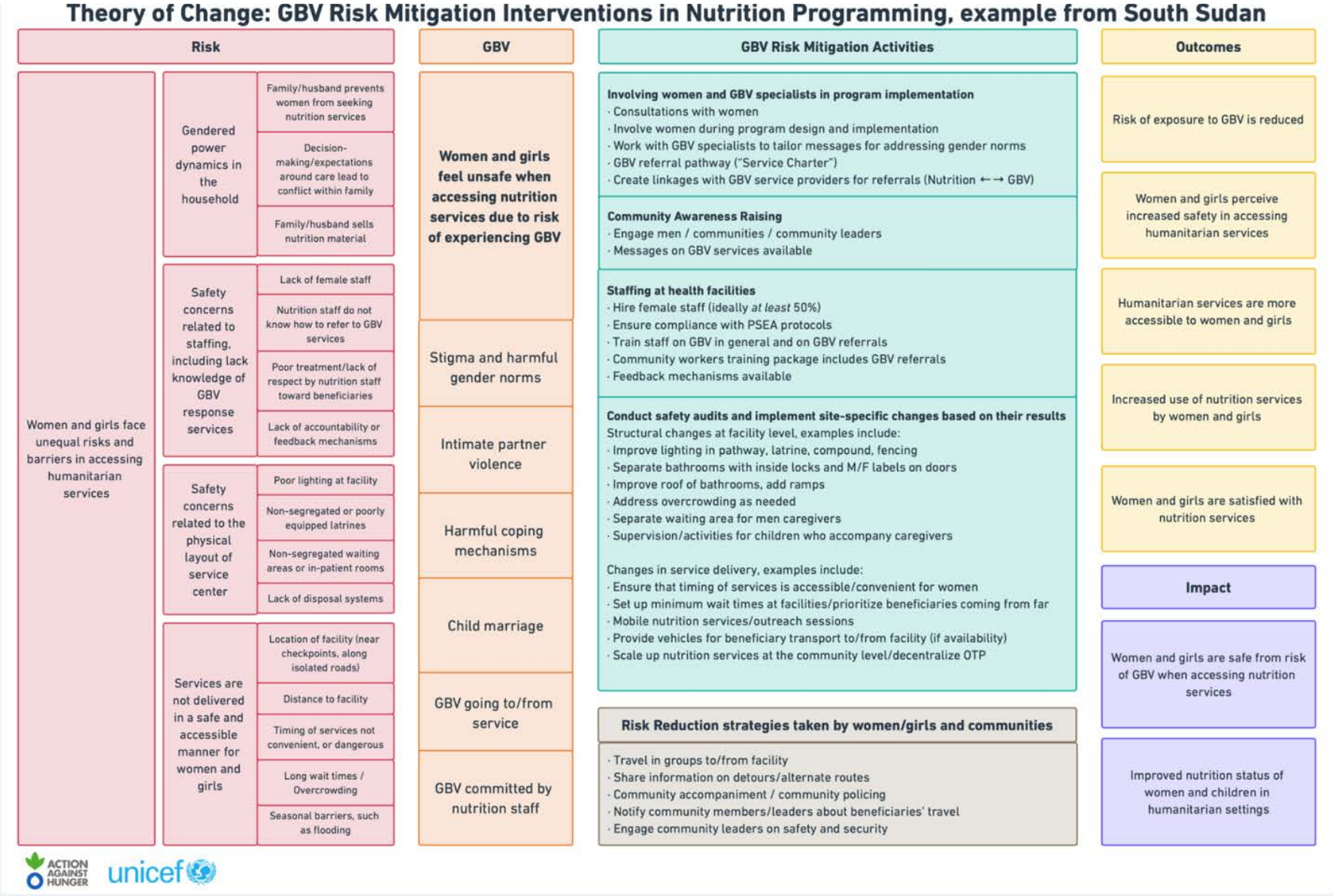
GBV risk: Movement of women and girls is controlled by their husbands or other male family members.

Implications: Severely malnourished children cannot stay overnight in stabilization centres because their mothers are not allowed to be away from home to accompany them. Mothers who do stay over with their children may face increased violence in the home.

GBV risk mitigation intervention: Consult with women and girls about potential options to help address the situation. For example, they can advise if and how nutrition programme staff could help male relatives and/or community leaders better understand nutrition service delivery.

The theory of change (**Figure 1**) elaborates on the pathway that connects GBV risks related to nutrition services ➔ women's and girls' feelings of safety ➔ women's and girls' access to and use of nutrition services ➔ women's and girls' nutrition status.

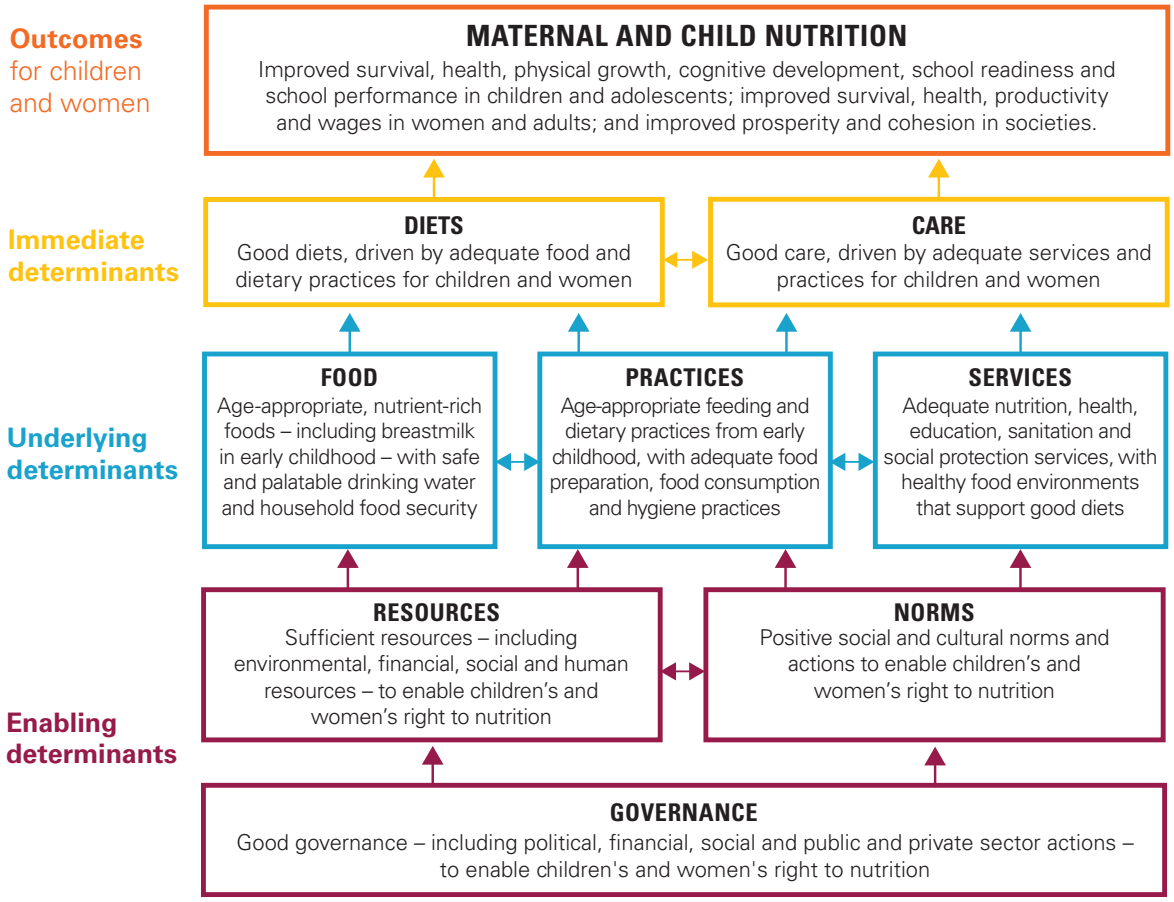
FIGURE 1. **Theory of change: GBV risk mitigation interventions in nutrition programming***



*From a multi-year study conducted in South Sudan

The GBV risk mitigation theory of change also fits within the UNICEF Nutrition Strategy 2020–2030 Conceptual Framework, most directly within the enabling determinant of 'norms', the underlying determinant of 'environments', and to a certain extent, 'governance'.

FIGURE 2. **UNICEF Conceptual Framework on the Determinants of Maternal and Child Nutrition**



GBV risk mitigation programmatic package

Coordination

While this package focuses on programmatic implementation, leveraging coordination structures and processes can also help advance GBV/Nutrition integration and collaboration more broadly. At country level, there is generally an interagency structure for GBV coordinated by UNFPA (in IDP settings) or UNHCR (in refugee settings). At global level, GBV coordination is led by the GBV AoR.

For Nutrition, UNICEF is the Cluster Lead Agency. In most fragile settings, there is either a nutrition cluster or sector coordination mechanism that is led by the national government with support from UNICEF country office. At global level, the Global Nutrition Cluster provides holistic support to nutrition practitioners preparing, responding, or recovering from a crisis.

Some concrete ways either or both coordination structures can contribute to this area of work include:

- GBV coordination mechanism delegating a focal point to attend Nutrition coordination meetings and be available to answer Nutrition partners' questions on GBV.
- Nutrition coordination mechanism designating a focal point to attend GBV coordination meetings and answer GBV partners' questions on Nutrition.
- Joint advocacy for topics of common interest to both sectors (gender norms around feeding practices, safety concerns accessing services, etc.) to be included in multisectoral needs assessments and other opportunities.
- Leveraging Nutrition coordination and communication channels to make GBV risk mitigation materials widely available to all Nutrition partners.
- Establishing systems to ensure Nutrition partners have access to GBV referral information and that this information gets updated/recirculated on a regular basis.
- Making GBV risk mitigation training available to Nutrition partners through the Nutrition coordination mechanism.
- Bringing together GBV and Nutrition partners to conduct joint analysis of secondary data and/or discuss trends and challenges related to both areas of work.
- Setting up a joint GBV/Nutrition working group consisting of members from both coordination mechanisms.

Overview of the GBV risk mitigation programmatic package for Nutrition

As part of UNICEF's broader workstream on strengthening GBV risk mitigation in nutrition programming, this programmatic package was first implemented as part of an operational study on the effectiveness of GBV risk mitigation interventions in nutrition programming in South Sudan.[3]

3 The GBV/nutrition study in South Sudan was conducted by the Ministry of Health; Ministry of Gender, Child and Social Welfare; UNICEF; Action Against Hunger; The Organization for Child Harmony (TOCH); and Africa Initiative for Rural Development (AIRD).

The GBV risk mitigation actions are organized in six categories, described in Table 1: *(see page 11)*

1) safety audits (identification of GBV risks);
2) changes in nutrition services based on safety audit findings;
3) staffing/capacity considerations;
4) consultations with women and girls and community feedback mechanisms;
5) strengthening referrals between nutrition and GBV programming; and
6) community awareness.

As explained in the introduction section, this programmatic package was designed for locations where both nutrition and GBV response services are available. To support with adaptation and implementation of the package in contexts with different levels of GBV programming/expertise, some activities have been assigned one or more symbols from the list below. When selecting which activities to implement, colleagues are encouraged to review both the activities list and the corresponding symbols.

● **GBV specialist:** Involving a GBV specialist[4] in the planning, implementation and monitoring of the full GBV risk mitigation package is ideal. In contexts where access to a GBV specialist is limited, the table indicates which actions can be done safely by nutrition programmers without the involvement of a GBV specialist, and which actions require the support of a GBV specialist before implementing. Activities marked with the ● symbol should **only** be implemented if a GBV specialist is involved.

■ **GBV programming collaboration:** The full GBV risk mitigation package was designed to be implemented in collaboration with existing GBV programming, if it is available. For example, in some contexts, nutrition services and GBV prevention and response services may sit within the same health structure or be located within very close geographical proximity, facilitating a higher level of collaboration between the two. Activities marked with ■ should **only** be implemented in locations where close collaboration between the nutrition programme and GBV programme is possible.

▲ **GBV referral pathway:** Even if close collaboration with GBV programming is not possible, some of the actions in the GBV risk mitigation pathway require at least the option to refer survivors who disclose an incident of GBV to get help from specialized GBV service providers. Actions marked with ▲ on the table require an operational GBV referral pathway and cannot be implemented without it.

4 A GBV specialist is someone who has GBV-specific training and expertise. GBV specialists are often in the role of providing direct response services, overseeing specialized GBV prevention and response programming and/or coordinating GBV activities at the interagency level (e.g., the GBV sub-cluster or working group coordinator). The GBV specialist may be employed by the nutrition implementing partner, or may be in the form of technical support by UNICEF staff or assistance by the GBV sub-cluster.

TABLE 1. **GBV risk mitigation categories and activities**
Activities shaded in green reflect the components of the package that are considered "minimum" – intended for locations with limited resources or where collaboration with GBV programming is not possible. Please see page 25 for more information.

CATEGORIES		GBV RISK MITIGATION ACTIVITIES
1	**Safety audits**	1.1 Conduct safety audits at nutrition facilities to identify access barriers and GBV-related safety risks in/around the facility.
		1.2 Conduct community-based consultations to identify broader gender dynamics linked to nutrition programming.
2	**Changes in nutrition services, adapted based on safety audit findings**	2.1 Make structural improvements, such as: • Constructing and/or repairing fencing around the compound • Establishing sex-segregated waiting areas • Installing locks and/or lighting on latrines and/or other bathroom facilities • Constructing and/or rehabilitate sex-segregated latrines, including accessibility considerations for people with disabilities. *NOTE: this is a non-exhaustive list that will vary depending on the context and can be adapted based on findings of the safety audits.*
		2.2 Adapt service delivery, including by: • Providing mobile nutrition services and/or community outreach sessions. • Adjusting the service delivery schedule to reflect timing that is most convenient/preferred by women and girls in the community. • Taking targeted action to minimize overall wait times at nutrition facilities and/or using a queueing system that gives priority to those who have travelled the furthest and/or have specific vulnerability factors (people with disabilities, female-headed households, etc.). • Making nutrition facility vehicles available for urgent GBV referrals, as feasible and where GBV services are present.
3	**Staffing/capacity considerations**	3.1 Take targeted action to increase the proportion of female staff delivering nutrition services (e.g., community health workers, community nutrition volunteers, nutrition assistants, hygiene volunteers, nutrition staff), with an aim to reach 50 per cent or more.
		● 3.2 Train all frontline nutrition and water, sanitation and hygiene (WASH) staff and volunteers on GBV risk mitigation, the GBV referral pathway (if available) and how to safely and appropriately respond to survivor disclosures (GBV Pocket Guide).
		3.3 Disseminate and discuss safety audit findings and other GBV safety risks with nutrition staff and volunteers; facilitate joint brainstorming to identify options to mitigate risks.
		3.4 Strengthen knowledge of and compliance with Protection from Sexual Exploitation and Abuse (PSEA) protocols (e.g., spot checks incorporated into monitoring and evaluation (M&E), refresher sessions, etc.).

4	**Consultations with women and girls and community feedback mechanisms**	4.1 Consult with women and girls who access nutrition services regarding their opinions of (and/or experience related to) the risk mitigation intervention actions taken.
		■ 4.2 Utilize women's and girls' safe spaces (WGSS) for ongoing consultations with women and girls focused on safety, access/barriers and GBV risks linked to nutrition programming.
		● 4.3 Strengthen community feedback mechanisms (CFM) to make them sensitive to GBV-related feedback (e.g., ensure multiple, accessible entry points for submitting complaints; develop standard operating procedures (SOPs) for how to respond to GBV-related issues reported through the CFM; and include questions on safety considerations in regular CFM interviews and focus group discussions).
5	**Strengthening referrals between nutrition and GBV programming**	■ ▲ 5.1 Strengthen coordination/communication linkages between Nutrition services and GBV response services, including SOPs for cross-referrals.
		■ 5.2 Train GBV service providers on how to identify and refer children and women with malnutrition (including, but not limited to, GBV survivors and children of survivors).
		▲ ● 5.3 Make information about GBV response services available in various visual formats within nutrition facilities (posters, pocket cards, informational sessions in waiting areas, etc.).
		■ 5.4 Utilize WGSS as a platform for community outreach on nutrition.
		● ▲ 5.5 Set up a system for safe and ethical tracking of referrals 1) from nutrition services to GBV services; and 2) from GBV services to nutrition services.
6	**Community awareness**	● ▲ 6.1 Integrate information on available GBV services/referral pathway into materials for nutrition community outreach; maternal, infant and young child nutrition activities; mother-to-mother support groups; father support groups; nurturing care groups; etc.
		● or ■ 6.2 Develop messages specific to nutrition-related gender norms raised during safety audits/consultations to be integrated into nutrition outreach/awareness activities at nutrition sites and within the community.
		● or ■ 6.3 Organize dedicated sessions on GBV (facilitated by GBV service providers) to take place at nutrition facilities on a regular basis.
		6.4 Facilitate opportunities for women accessing nutrition services to exchange safety-/resilience-related information with one another.

Detailed description of GBV risk mitigation actions

1. Safety audits

1.1 Conduct safety audits at nutrition facilities to identify access barriers and GBV-related safety risks in/around the facility.

Conduct safety audits at nutrition facilities and community settings to actively identify access barriers and GBV-related risks. Use these audits to target and resolve specific issues that may compromise the safety and effectiveness of nutrition services. Assess critical factors, such as location, infrastructure and operating hours, to address potential GBV risks. Once audits are completed, act on the findings to adapt nutrition services, implement structural changes, adjust service delivery, and strengthen messaging on GBV risk mitigation and referrals.

1.2 Conduct community-based consultations to identify broader gender dynamics linked to nutrition programming.

Conduct community-based safety audits as participatory assessments to identify broader gender dynamics and potential GBV issues linked to nutrition programming. Engage community leaders, especially women and girls, to pinpoint safety risks and barriers in accessing nutrition services. Empower communities by involving them in the identification process, fostering ownership of their safety and ensuring interventions are contextually appropriate and responsive to women's and girls' specific needs.

2. Changes in nutrition services in alignment with GBV Guidelines, adapted based on safety audit findings

2.1 Make structural improvements at facilities.

Incorporate practical measures into the design and maintenance of humanitarian facilities to reduce the risk of GBV and promote a safer, more dignified experience for all service users. Service delivery adaptations to ensure women's and girls' safety, especially structural improvements, should be implemented automatically (with or without a safety audit), however safety audit findings and consultations with women and girls on GBV risks can help identify gaps in service delivery.

Improvements may include building or repairing fencing around the compound to create secure, well-defined areas that protect women, girls and other vulnerable groups. Constructing sex-segregated latrines, installing locks, and ensuring proper lighting in bathroom facilities can help bolster security, especially at night when the risks of violence and harassment increase. Establishing sex-segregated waiting areas can also enhance privacy and safety for women and girls, reducing GBV risks in crowded areas. Ensure that facilities are accessible to people with disabilities by incorporating ramps, handrails and sufficient space within the latrines to accommodate mobility aids. By doing so, the facilities become safer and more inclusive, providing a secure environment for all individuals.[5]

5 This is a non-exhaustive list that will vary depending on the context and should be adapted based on findings of the safety audits.

2.2 Adapt service delivery.

Service delivery adjustments at nutrition facilities should be guided by safety audit results and feedback from women and girls on GBV risks. Key changes could include aligning service delivery schedules with the times that best suit women and girls, minimizing wait times, or implementing a queueing system that prioritizes individuals who have travelled long distances or face specific vulnerabilities – such as people with disabilities or female-headed households. Mobile nutrition services and outreach sessions can further extend the reach of these programmes, ensuring that more individuals in remote areas receive the support they need. Scaling up nutrition services at the community level and decentralizing outpatient therapeutic programmes can enhance accessibility for women and girls.

3. Staffing/capacity considerations

3.1 Take targeted action to increase the proportion of female staff delivering nutrition services.

Hire female staff at nutrition facilities to help ensure that nutrition services meet the unique needs of women and girls and to enhance comfort and trust among beneficiaries. This increases the effectiveness of GBV referrals and reduces the risk of sexual harassment. Aim for at least 50 per cent female staff, adjusting this ratio based on local labour laws and service demands, such as facility overcrowding or extended wait times. Staff roles include community health workers, nutrition volunteers, assistants, hygiene volunteers and other nutrition personnel.

At the same time, female service providers face important gender-related barriers. In humanitarian contexts, female staff at nutrition facilities may face significant risks, including safety and security threats. In all contexts, cultural and gender norms can restrict women's participation in the workforce and put them at risk if they defy gender norms related to women's work, further limiting recruitment and retention. Female staff may also encounter GBV, such as harassment or sexual exploitation from colleagues, violence from intimate partners or stigma from community members, further complicating their ability to work effectively. Additionally, inadequate infrastructure, such as the lack of separate toilets or safe spaces, creates uncomfortable and unsafe work environments for women staff as well as beneficiaries. Moreover, women often have fewer opportunities for career development and may struggle with the double burden of professional and domestic responsibilities. Addressing these challenges requires the implementation of gender-sensitive policies and the creation of safer, more supportive work environments for female staff.

To encourage female participation in nutrition staff roles, implement adaptations in human resource hiring policies, such as setting quotas or targeting female-only job advertisements. Establish mentorship programmes to promote women from community nutrition volunteer roles to staff positions. Address cultural barriers by integrating messaging into community awareness activities about the value of female staff at nutrition facilities. And create a supportive environment that allows women to thrive professionally while minimizing risks.

Additionally, appoint a GBV focal point within nutrition programmes – a trained case worker who will manage GBV-related issues, lead discussions and coordinate with GBV service providers. This role ensures effective referral handling and follow-up, bridging gaps in support for GBV survivors.

3.2 Train all frontline nutrition staff and volunteers on GBV risk mitigation, the GBV referral pathway and how to safely and appropriately respond to survivor disclosures.
Training staff on GBV and referral mechanisms is essential in humanitarian settings (see GBV Pocket Guide). Community nutrition volunteers and nutrition staff are often trusted sources of support within communities, which may lead to survivors disclosing GBV incidents to them. To avoid overburdening these staff and ensure adherence to the 'do no harm' principle, it is important to clearly define their responsibilities and ensure GBV case management is handled by trained specialists.

Develop a concrete training plan for sector staff, involving both GBV and nutrition professionals, to ensure relevance. Input from GBV experts is crucial, but nutrition sector staff should also contribute to make the training practical and effective. Equip nutrition staff with basic GBV response skills using the IASC GBV Guidelines Pocket Guide, enabling them to support survivors and refer them to specialized GBV case workers. Training packages for community workers should include GBV referral procedures for a holistic approach.[6]

Lessons from South Sudan show that such training enhances the capacity of both GBV service providers and nutrition staff. Providers reported they were better able to assist survivors, while nutrition staff gained confidence and effectiveness in referring GBV cases, leading to better service delivery.

3.3 Disseminate and discuss safety audit findings and other GBV safety risks with nutrition staff and volunteers; facilitate joint brainstorming to identify options for mitigating risks.
Actively disseminate and discuss safety audit findings and GBV safety risks with nutrition staff and volunteers by sharing assessment results and engaging stakeholders in focused brainstorming sessions. Drive the development of actionable strategies that address identified risks and improve safety for beneficiaries, ensuring that frontline workers are well-informed and directly involved in crafting solutions.

3.4 Strengthen knowledge of and compliance with Protection from Sexual Exploitation and Abuse (PSEA) protocols.
Enforce strict adherence to PSEA protocols to maintain a zero-tolerance stance on exploitation and abuse, protecting the dignity of beneficiaries, staff and partners. Implement regular spot checks to provide immediate feedback and identify deviations from standards, enabling swift corrective actions. Schedule periodic refresher sessions to keep staff updated on protocols and best practices that will enhance their effectiveness. These measures should be integrated within routine M&E activities to strengthen programme quality, increase accountability and foster a safer environment for communities.

6 Further training materials are under currently development. See Resources section for existing trainings.

4. Consultations with women and girls and community feedback mechanisms

4.1 Consult with women and girls **who access nutrition services regarding their opinions of (and/or experience related to) the risk mitigation intervention actions taken.**
Actively engage female nutrition beneficiaries and involve women in programme design and implementation to ensure nutrition services are more effective and responsive. Consulting women and girls directly brings their unique needs and experiences into focus, aligning services with the realities they face. This approach not only improves service relevance but also empowers women by giving them a voice in key decisions that affect their lives.

Involving women in the design process fosters ownership and accountability, driving higher participation and satisfaction. Their insights help identify barriers that might otherwise be overlooked, such as inconvenient hours or unsuitable locations, which can be addressed to enhance accessibility and user experience. Additionally, incorporating women's feedback helps mitigate GBV risks within nutrition services. Women can offer critical input on how to improve safety in service areas and processes, fostering a secure and respectful environment that reduces the likelihood of GBV incidents.

4.2 Utilize women's and girls' safe spaces for ongoing consultations with women and girls focused on safety, access/barriers and GBV risks linked to nutrition programming.
Women's and girls' safe spaces (WGSS) are often the foundation for specialized GBV programming in humanitarian settings, offering critical protection, support and empowerment. Managed by humanitarian organizations, NGOs or local women's groups, WGSS are staffed by trained professionals who provide psychosocial support, counselling, legal aid, health services and educational programmes. These safe spaces create a sanctuary where women and girls can find community, reduce isolation and receive mutual support, while also raising awareness of GBV and facilitating access to essential services. WGSS are central to promoting a survivor-centred approach in emergencies and conflict zones.

Where collaboration with GBV programming is possible, WGSS serve as an ideal venue for ongoing consultations with women and girls on safety, access barriers and GBV risks tied to nutrition programming. These spaces ensure women and girls can voice their concerns in a confidential and supportive setting, fostering their active participation in decisions affecting their safety and well-being.

4.3 Strengthen community feedback mechanisms (CFM) to make sure they are sensitive to GBV-related feedback.
Develop SOP for how to respond to reports of GBV received through CFMs, including linkages to referral pathways. Strengthen CFMs by involving a GBV specialist in reviewing protocols and ensuring sensitivity to GBV concerns. Integrate GBV-related topics into regular CFM interviews and focus group discussions for a more thorough understanding of community issues. Establish multiple entry points that accommodate diverse needs for submitting complaints to ensure CFMs are fully accessible to all community members. Make these mechanisms inclusive to capture the broad spectrum of experiences within the population.

By systematically addressing GBV risks in these interactions, nutrition staff can proactively tackle underlying factors, turning CFMs into a vital tool for combating GBV alongside other community challenges.

5. Strengthening referrals between nutrition and GBV programming

5.1 Strengthen coordination/communication linkages between nutrition services and GBV response services.
Develop an SOP for cross-referrals and joint activities to enhance collaboration between GBV prevention and response programming. This SOP enables seamless coordination between sectors, ensuring that when nutrition staff identify a need, they can quickly and safely refer survivors to GBV services through an established pathway. Additionally, make nutrition facility vehicles available for urgent GBV referrals whenever possible, providing essential support to those in immediate need, especially when GBV services are located far from the nutrition facility. Collaborate on awareness-raising initiatives to educate communities about the links between GBV and nutrition. These joint efforts will strengthen connections between programmes, boosting their collective ability to tackle the intertwined issues of malnutrition and GBV.

5.2 Train GBV service providers on how to detect wasted children, and nutritionally at-risk women, and refer for nutrition services.
Since many GBV survivors and their children are likely to also require nutrition services, train GBV caseworkers to recognize signs of malnutrition and ensure timely referrals to nutrition services. Empower caseworkers to provide comprehensive support and improve health outcomes for survivors by strengthening their capacity and fostering closer collaboration between GBV and nutrition services.

5.3 Make information about GBV response services available in various visual formats within nutrition facilities.
Ensure clear and accessible GBV referral pathways within nutrition services to build trust and provide critical support. At nutrition service points such as outpatient treatment programmes, prominently display posters and pocket cards to share essential information on GBV risks and available services. Enhance awareness by conducting information sessions in waiting areas, making it easier for survivors to access the support they need. Facilitate small group discussions with women waiting in line to create a supportive environment.

5.4 Utilize WGSS as a platform for community outreach on nutrition.
Leverage WGSS as a platform to drive essential information sessions on infant and young child feeding, maternal nutrition and other critical nutrition topics. Ensure that only female nutrition staff lead these sessions, maintaining the exclusivity of WGSS to women and girls to preserve a safe and supportive environment. This approach empowers women and girls with the knowledge and skills needed to improve nutritional outcomes for themselves and their families.

5.5 Set up a system for safe and ethical tracking of referrals.
In humanitarian contexts, actively implement a system to track cross-referrals between nutrition and GBV services, prioritizing safety and confidentiality. Recognize the sensitive nature of both GBV and nutrition, and ensure the system effectively channels referrals in both directions, providing

comprehensive care for GBV survivors. Enhance support for individuals, particularly women and girls, by creating robust cross-referral systems. Uphold confidentiality to protect survivor identities and experiences, building a trusted environment for seeking and receiving help. This may require adapting referral slips with a secure coding system, accessible only to essential staff, to discreetly manage GBV-related referrals.[7]

6. Community awareness

6.1 Integrate information on available GBV services/referral pathways into materials for nutrition community outreach.
Integrate information on GBV services and referral pathways into community outreach materials and maternal, infant and young child nutrition activities, such as mother-to-mother support groups, father support groups, and nurturing care groups. These community-based initiatives are not just about nutrition; they become trusted spaces where survivors of GBV can find help.

6.2 Develop messages specific to nutrition-related gender norms raised during consultations with women and girls to be integrated into nutrition outreach/awareness activities.
Gender norms related to nutrition require careful and strategic messaging to be effectively addressed.[8] Integrate action-oriented and strategic messaging into broader nutrition programmes to actively challenge and transform harmful gender norms associated with nutrition. Develop information, education and communication materials and behaviour change communication materials as part of a comprehensive plan that details staff training schedules, specifying who will be trained and when. Partner with GBV specialists to tailor these messages appropriately and ensure that they adhere to the 'do no harm' principle.

In community outreach efforts, consider including messages that encourage men to accompany women to nutrition or water/firewood sites, promote men's involvement in children's health and care, and highlight the importance of women working as staff in nutrition facilities. Tailor messages to specific contexts and audiences using various formats, such as posters, radio broadcasts and other media. Actively engage male community members and leaders to create a supportive environment.

Focus on driving specific behavioural changes, such as enhancing women's access to nutrition services, securing men's consent for women to access these services, reducing harmful coping mechanisms, and promoting men's accompaniment to nutrition services. Recognize that community engagement centred on GBV prevention is part of GBV-specialized programming and should not be independently undertaken by nutrition actors.

7 Management if GBV data must be in line with global ethical principles, such as WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies

8 For example, cultural norms around nutrition often prioritize men and boys during meals, with women, girls, and children eating last and receiving less nutritious food. Pregnant and breastfeeding women may face food restrictions due to beliefs that certain foods could harm the baby, while menstruating women may be excluded from certain foods or communal spaces. Women typically handle food preparation but may lack control over what they eat, as men often make decisions about food distribution and household resources. Additionally, religious practices such as fasting can further limit women's access to nutritious food, impacting their health and well-being.

6.3 Organize dedicated sessions on GBV (facilitated by GBV service providers) to take place at nutrition facilities on a regular basis.

Schedule and conduct dedicated sessions on GBV led by GBV service providers within nutrition facilities. These sessions should be organized regularly, focusing on educating staff and beneficiaries about GBV risks, prevention strategies and available support services. By embedding GBV discussions into nutrition programming, organizations can actively raise awareness, empower participants, connect survivors to vital response services, and enhance the safety and well-being of women and girls.

6.4 Facilitate opportunities for women accessing nutrition services to exchange safety-related information with one another.

Create opportunities for dialogue and peer support among women accessing nutrition services to actively exchange safety information. Establish spaces where women can share experiences, insights and strategies for addressing safety concerns, such as walking together in groups or identifying safer routes to nutrition facilities. Facilitate these exchanges through group discussions, support groups or community meetings to bolster resilience and enhance community responses to GBV and other safety challenges.

Adapting to programming scenarios

Humanitarian nutrition programmes, and the GBV risk mitigation activities implemented within them, must adapt strategies to these types of varying contexts, ensuring flexibility and sensitivity to the local environment and the specific needs of affected populations.

Adaptations based on availability of resources, GBV referral pathway and collaboration with GBV programming

The programmatic package Table 1 above can and should be adapted to nutrition programming based on contextual, capacity and resource factors. The guidance below gives recommendations on how to implement and adapt the GBV risk mitigation programmatic package based on whether GBV referral pathways and collaboration with GBV specialists are available, as well as considerations for available resources.

Locations where nutrition services are accessible, a GBV referral pathway is functional, and collaboration with GBV programming is possible: Implement the full package of GBV risk mitigation activities

Nutrition programmes should strive to implement the full package of GBV risk mitigation activities. This is only possible in contexts where there is an operational GBV referral pathway and close collaboration with GBV prevention and response services. This generally requires a context of regular and accessible nutrition programming (compared to hard-to-reach contexts, contexts of high insecurity or mobile nutrition programmes).

In terms of capacity, this scenario also requires technical leadership and buy-in from both sectors, commitment to train nutrition staff on the implementation of GBV risk mitigation activities, as well as technical capacity to monitor the GBV risk mitigation activities. Ideally, the nutrition programme would have full-time engagement of a GBV specialist during the planning, implementation and monitoring of the GBV risk mitigation activities to ensure that the team has the necessary tools and guidance.

"All humanitarian actors must be aware of the risks of GBV and – acting collectively to ensure a comprehensive response – prevent and mitigate these risks as quickly as possible within their areas of operation." – *IASC GBV Guidelines*

All humanitarian nutrition programmes should proactively take action to mitigate GBV risks. However, the specific actions to take may vary by context, capacity, and resources.

CONTEXT: Is there an operational GBV referral pathway? Is there GBV prevention and response programming near the nutrition services? Is nutrition programming regular and accessible?

CAPACITY: Is there technical leadership for both sectors? Are there possibilities for coordination/collaboration with GBV service providers? What additional training/ orientation will staff require to implement the GBV risk mitigation actions?

RESOURCES: What additional funding is needed to support GBV risk mitigation? Is there donor interest to support or expand GBV risk mitigation activities? Do teams have the guidance and tools they require?

Programmes should also have adequate funding to support the full package of GBV risk mitigation activities. Recently, there has been increased donor interest in supporting or expanding GBV risk mitigation activities, so this may be an entry point for collaboration in some contexts.

This programming scenario also lends itself to opportunities for more in-depth integration of nutrition services with GBV services and activities such as GBV prevention or referrals from GBV services back to nutrition, beyond what is outlined in the GBV risk mitigation package.[9]

Locations with limited resources, or where collaboration with GBV programming is not possible: Minimum GBV risk mitigation activities

In some contexts, nutrition programming may not have the human, technical or financial resources to implement a full package of GBV risk mitigation activities. In other contexts, a phased approach may make sense; rather than implementing all actions at once, the nutrition programme can start with core GBV risk mitigation actions and add the full package at a later phase. This may also apply to contexts in which GBV services are available but located far from the nutrition facilities, meaning that closer collaboration with GBV programming is not possible. **Recommendations for minimum GBV risk mitigation actions** are indicated on the full table (*Refer to Table 1 presently on page 11 and page 12*) and in the condensed table below (*highlighted in* **light blue)**.

To implement this minimum package, nutrition programmes will still need support from a GBV specialist to train nutrition staff, and a basic GBV services referral pathway will need to be in place to refer survivors to services.

TABLE 3. **Minimum package of GBV risk mitigation activities**

	CATEGORIES	MINIMUM GBV RISK MITIGATION ACTIVITIES
1	**Safety audits**	1.1 Conduct safety audits at nutrition facilities to identify access barriers and GBV-related safety risks in/around the facility
2	**Changes in nutrition services based on safety audit findings**	2.1 Make structural improvements
		2.2 Adapt service delivery
3	**Staffing/capacity considerations**	● 3.2 Train all frontline nutrition and WASH staff and volunteers on GBV risk mitigation, the GBV referral pathway (if available) and how to safely and appropriately respond to survivor disclosures (GBV Pocket Guide)
4	**Consultations with women and girls and community feedback mechanisms**	4.1 Consult with women and girls who access nutrition services regarding their opinions of (and/or experience related to) the risk mitigation intervention actions taken
6	**Community awareness**	● ▲ 6.1 Integrate information on available GBV services/referral pathway into materials for nutrition community outreach; maternal, infant and young child nutrition activities; mother-to-mother support groups; father support groups; nurturing care groups, etc.

9 UNICEF and International Medical Corps are in the process of developing another GBV/nutrition programmatic package that is complementary to this one. While the package summarized here focuses on GBV risk mitigation within nutrition service delivery, the forthcoming package will cover joint delivery of nutrition and GBV response services.

Locations with minimum humanitarian presence or weak infrastructure, where nutrition programming is hard to reach and GBV services do not exist

In extreme contexts, there may be no option for GBV programming collaboration or even referrals to GBV services. In these contexts, nutrition services may also be extremely limited; for example, mobile services rather than permanent structures due to insecurity or isolated or remote locations. Recommendations for minimum GBV risk mitigation actions, even in extreme hard-to-reach locations, are indicated in Table 4.

In contexts where services are limited, and GBV referrals are not possible, nutrition programmes should still conduct safety audits and consultations with women and girls where safe and possible, adapting this activity to the types of services available, and utilizing the result to identify potential GBV risks and adjust service delivery. For example, tools can be adapted for use in camps for internally displaced persons or refugees, urban slums or mobile nutrition services.

Frontline staff should still be trained on how to safely and appropriately respond to survivor disclosures of GBV where GBV referral services are not available.

TABLE 4. **Minimum GBV risk mitigation activities in extremely limited contexts**

CATEGORIES		MINIMUM GBV RISK MITIGATION ACTIVITIES in extremely limited contexts
1	**Safety audits**	1.1 Conduct safety audits at nutrition facilities to identify access barriers and GBV-related safety risks in/around the facility
2	**Changes in nutrition services based on safety audit findings**	2.1 Make structural improvements
		2.2 Adapt service delivery
3	**Staffing/capacity considerations**	● 3.2 Train all frontline nutrition and WASH staff and volunteers on GBV risk mitigation and how to safely and appropriately respond to survivor disclosures when GBV referral services are not available (GBV Pocket Guide)
4	**Consultations with women and girls and community feedback mechanisms**	4.1 Consult with women and girls who access nutrition services regarding their opinions of (and/or experience related to) the risk mitigation intervention actions taken

Adaptations based on humanitarian contexts

Humanitarian nutrition programmes operate in a wide range of challenging contexts where various factors impact their design and implementation. Key factors include government involvement, accessibility, infrastructure and security conditions.

The guidance below lists the types of humanitarian contexts where nutrition programmes typically work, with recommendations for ways in which actions in the GBV risk mitigation package can be adapted according to the context. Further adaptations can be made depending on the availability of resources, GBV referral pathways and collaboration with GBV programming, as noted in the section above.

It is important to note that this continues to be an evolving area of work and these recommendations should always be considered within specific contexts.

1. Conflict zones

CONTEXT	
Government involvement	Often limited or fragmented, with multiple factions controlling different areas.
Accessibility	Access to affected populations may be restricted due to ongoing violence, checkpoints and roadblocks.
Infrastructure	Often severely damaged or destroyed, including health facilities, roads and communication networks.
Security	High risk of attacks on civilians and humanitarian workers, necessitating security protocols and coordination with military or peacekeeping forces. Women and girls are at heightened risk of GBV.
Nutrition services	May include partnerships with local security forces and peacekeeping missions, mobile nutrition services to reach displaced populations, and training for staff on conflict-sensitive approaches and emergency evacuation procedures.
GBV RISK MITIGATION PACKAGE ADAPTATIONS	
Safety audits	Conduct remote safety audits where access is restricted due to conflict, using local partners or technology (e.g., mobile surveys).
Structural improvements	Focus on mobile and flexible infrastructure solutions to adjust quickly to changing security situations.
Staffing and capacity	Provide remote training for staff on GBV risk mitigation and referrals due to movement restrictions.
Consultations	Consider whether safe and feasible to use secure and discreet communication methods (e.g., encrypted messaging apps) for consultations with women and girls.
Strengthening referrals	Explore options for virtual referral pathways and partnerships with organizations operating in safer areas.
Community awareness	Disseminate GBV referral awareness messages through radio broadcasts and community leaders.
M&E	Increase emphasis on safety-related indicators and track displacement patterns affecting access to nutrition services.

2. Natural disaster areas

CONTEXT	
Government involvement	Variable, depending on the country's capacity to respond to disasters. Some governments may actively coordinate relief efforts, while others may lack the resources.
Accessibility	May be constrained by earthquakes, floods or hurricanes, which can isolate communities by damaging infrastructure and creating logistical challenges.
Infrastructure	Often compromised, with transportation networks, water supply and health facilities affected.
Security	May be compromised due to chaos and competition for scarce resources, but is usually less of a factor than in conflict zones.
Nutrition services	May include rapid deployment of emergency nutrition teams, temporary nutrition sites in safe areas.
GBV RISK MITIGATION PACKAGE ADAPTATIONS	
Safety audits	Conduct rapid safety audits as part of initial disaster response assessments.
Structural improvements	Use temporary structures (tents, mobile units) with proper safety features (locks, segregated areas).
Staffing and capacity	Deploy surge capacity teams trained in GBV risk mitigation and referrals, with female staff.
Consultations	Use existing community structures (e.g., schools, churches) for safe spaces and consultations.
Strengthening referrals	Create emergency referral pathways and train first responders on GBV referrals and the Pocket Guide.
Community awareness	Integrate GBV messages into broader disaster response communication strategies.
M&E	Increase emphasis on monitoring changes in access to services due to infrastructure damage.

3. Protracted crises

CONTEXT	
Government involvement	Can be weak, with chronic instability and limited capacity to provide public services.
Accessibility	Persistent challenges in accessing remote or underserved areas due to poor infrastructure and ongoing instability.
Infrastructure	May be chronically underdeveloped, with inadequate health, sanitation and transportation systems.
Security	Long-term instability can lead to periodic violence and threats to humanitarian operations.
Nutrition services	May include integrating long-term capacity-building for local health workers and establishing community-based nutrition programmes.
GBV RISK MITIGATION PACKAGE ADAPTATIONS	
Safety audits	Conduct regular safety audits to adapt to evolving GBV risks over time.
Structural improvements	Focus on sustainable infrastructure improvements (e.g., permanent lighting, sturdy latrines).

Staffing and capacity	Build long-term capacity of local staff and volunteers on GBV referrals and risk mitigation.
Consultations	Establish long-term consultation mechanisms with women and girls (e.g., regular focus groups).
Strengthening referrals	Develop robust referral networks and SOPs for cross-sectoral referrals. Support more in-depth collaboration with GBV programming where possible.
Community awareness	Use ongoing community engagement and education campaigns to raise awareness on GBV risk mitigation and referrals.
M&E	Conduct longitudinal studies and baseline/endline surveys to measure long-term nutrition and GBV risk mitigation indicators, and focus on capacity of staff and quality of service delivery (training completion certificates).

4. Refugee and internally displaced persons camps

CONTEXT	
Government involvement	Varies; host governments may provide support in collaboration with international agencies like the United Nations High Commissioner for Refugees.
Accessibility	Camps may be in remote or border areas, with access dependent on security and political agreements.
Infrastructure	Often temporary and inadequate, with makeshift shelters, limited water and sanitation facilities, and overstretched health services.
Security	Potential for violence within camps, including GBV and threats from external armed groups or tensions with host communities.
Nutrition services	May include adapting GBV risk mitigation strategies tailored to camp settings, such as safe spaces for women and girls.
GBV RISK MITIGATION PACKAGE ADAPTATIONS	
Safety audits	Conduct safety audits in temporary shelters and camps to identify specific GBV risks.
Structural improvements	Ensure facilities in camps have adequate lighting and secure, sex-segregated areas.
Staffing and capacity	Recruit and train refugees and internally displaced persons to support GBV risk mitigation.
Consultations	Hold consultations in accessible locations within the camps.
Strengthening referrals	Establish clear referral pathways within the camp and ensure residents are aware of them.
Community awareness	Use camp-wide communication systems (e.g., notice boards, loudspeakers) for GBV messaging.
M&E	Increase emphasis on safety-related indicators and access/utilization rates of nutrition services by women and girls.

5. Remote and isolated communities

CONTEXT	
Government involvement	Can be limited due to geographical barriers and logistical challenges.
Accessibility	Significant logistical challenges in reaching remote areas, often requiring air transport or long overland journeys.
Infrastructure	Can be very poor, with minimal health services, schools, roads and communication networks.
Security	Generally low levels of insecurity but can vary depending on regional dynamics and presence of any criminal or insurgent activities.
Nutrition services	May rely on community health workers and mobile units.
GBV RISK MITIGATION PACKAGE ADAPTATIONS	
Safety audits	Use community representatives to conduct safety audits and report findings.
Structural improvements	Implement low-cost, community-built solutions (e.g., locally-sourced materials for fences).
Staffing and capacity	**T**rain community health workers and volunteers to recognize and mitigate GBV risks.
Consultations	Establish women's and girls' groups that meet regularly in safe, central locations.
Strengthening referrals	Develop informal support networks and use technology (e.g., mobile phones) for referrals, where safe and possible.
Community awareness	Leverage local communication channels (e.g., village meetings, local radio) for GBV awareness.
M&E	Focus on measuring access and coverage rates for nutrition services, as well as community perceptions of safety when accessing services.

6. Urban slums

CONTEXT	
Government involvement	Variable, often complicated by urban governance issues and informal settlements.
Accessibility	Physical access might be easier, but social and political barriers can impede service delivery.
Infrastructure	Overcrowded and inadequate, with poor housing, sanitation and health facilities.
Security	May face high levels of crime and violence, including GBV, which can affect both residents and aid workers.
Nutrition services	May include collaborating with urban local authorities and community leaders, adapting nutrition services to urban settings, such as extended service hours.
GBV RISK MITIGATION PACKAGE ADAPTATIONS	
Safety audits	Conduct safety audits focusing on densely populated areas and informal settlements.
Structural improvements	Retrofit existing structures to improve safety (e.g., better lighting, secure latrines).

Staffing and capacity	Train local health workers and volunteers from urban communities.
Consultations	Use community centres and local NGOs to facilitate consultations.
Strengthening referrals	Strengthen linkages with urban GBV response services and legal aid providers.
Community awareness	Use social media, local radio and community events to raise GBV awareness.
M&E	Identify GBV risks reported in and around nutrition sites using safety audits and consultations, such as urban-specific challenges like overcrowding.

7. Health emergencies (e.g., epidemics)

CONTEXT	
Government involvement	Active involvement in coordination with international health organizations.
Accessibility	Isolation measures and quarantines that create access challenges.
Infrastructure	Health systems often overwhelmed, with critical shortages of medical supplies and personnel.
Security	Varies, but fear and misinformation can lead to community resistance against health workers (who are often majority women) and women in general.
Nutrition services	May include equipping nutrition sites with necessary health and hygiene measures, contingency plans for service continuity.
GBV RISK MITIGATION PACKAGE ADAPTATIONS	
Safety audits	Include GBV risks in health emergency response assessments.
Structural improvements	Ensure health facilities have proper infection control measures and safe spaces for women.
Staffing and capacity	Train health workers on GBV referrals and risk mitigation alongside epidemic response protocols.
Consultations	Use telehealth and mobile consultations to engage with women and girls safely.
Strengthening referrals	Establish remote referral systems and collaborate with telehealth services.
Community awareness	Integrate GBV messaging into public health campaigns and community health outreach.
M&E	Focus on changes in service utilization due to health emergency measures and consider GBV risks linked to health service provision.

Adapting the package of GBV risk mitigation interventions for different programming contexts ensures that the activities remain relevant and effective, addressing the unique challenges and leveraging the strengths of each context.

Monitoring and evaluation

To effectively monitor GBV risk mitigation interventions integrated into humanitarian nutrition programming, M&E indicators should cover various aspects, including service performance, access and utilization of facilities, and beneficiaries' feelings of safety. By monitoring these indicators, humanitarian nutrition programmes can assess the effectiveness of their GBV risk mitigation interventions, ensure they meet the needs of the beneficiaries, and continuously improve the safety and quality of the services provided.

In addition to routine indicators, and as part of established situation analysis processes wherever possible, nutrition programmes should track broader situational factors that might influence nutrition outcomes or incidence of GBV, such as seasonal flooding, outbreaks of communal violence, external GBV prevention activities being implemented by GBV-specialized programmes, or the commencement or cessation of food security and livelihood programming. This ongoing, dynamic monitoring enables the adaptation of interventions as external conditions evolve, ensuring that GBV risk mitigation efforts are not only proactive but also responsive, addressing both current and emergent needs effectively.

Programme indicators

A set of key indicators are proposed to monitor progress against implementation of the guidance and specifically, the programmatic package.

Important to note is that nutrition performance indicators (reflected in Table C) can be used to give inference or as a proxy as they are typically affected by a range of programmatic issues that may not be directly to GBV or the risk mitigation package. There is need to have contextual understanding as well as interpretation of indicators in Tables A and B to make inference of Table C. Table D describes indicators to monitor the GBV risk mitigation intervention specifically.

TABLE 5A. **Beneficiaries' feelings of safety**

Objective	Indicators	Means of verification	Assumptions
To enhance beneficiaries' feelings of safety at nutrition facilities	Perceived safety • % beneficiaries who feel safe accessing the nutrition facilities, disaggregated by sex and age	• Beneficiary surveys (menu of measures) • Focus group discussions	Implementation of safety measures and GBV risk mitigation strategies.
To increase awareness of GBV services	GBV referrals awareness • % beneficiaries who are aware of GBV referral pathways • Types of information and materials about GBV response services available within nutrition facilities, qualitative descriptions (posters, pocket cards, informational sessions in waiting areas, etc.)	• Awareness session records • Beneficiary surveys	Regular awareness campaigns and sessions conducted.

TABLE 5B. **Access to and utilization of facilities**

Objective	Indicators	Means of verification	Assumptions
To enhance access and utilization of nutrition facilities	Facility attendance rates • # of new admissions to nutrition facilities per month, disaggregated by sex, age and type of service	• Facility attendance logs • Service usage records	Facilities remain accessible and open, with adequate supply of nutrition commodities
To minimize waiting time for nutrition services	Waiting time • Average waiting time for beneficiaries to receive nutrition services	• Time tracking logs • Beneficiary feedback	Efficient service delivery and process optimization.
To ensure accessibility of services	Service Accessibility • % beneficiaries who report that nutrition services are easily accessible (e.g., within a reasonable distance or time)	• Beneficiary surveys (menu of measures) • Community feedback sessions	Geographic and security conditions remain stable.
To enhance users' feelings that nutrition services are beneficial	Perceived effectiveness • % of beneficiaries who report noticing a positive change in themselves or their child due to the nutrition services	• Beneficiary surveys (menu of measures) • Beneficiary feedback	Adequate and consistent nutrition services are tailored to specific needs and circumstances.

TABLE 5C. **Nutrition performance indicators**

Objective	Indicators	Means of verification	Assumptions
To improve nutrition outcomes for children under 5 years of age and pregnant and breastfeeding women	Recovery rates from malnutrition • % of children under 5 who recover from severe acute malnutrition after receiving treatment • % of children who have reached the discharge criteria for moderate acute malnutrition treatment • % of pregnant and breastfeeding women who show improved nutritional status after intervention	• Health facility records • Treatment reports	Timely and adequate provision of nutrition services. These indicators may see improvement linked to better access to nutrition services after implementation of GBV risk mitigation actions.
To reduce defaulter rates	Defaulter rates • % of beneficiaries who default (i.e., are absent for two consecutive visits) from the nutrition programme before completion • % of defaulters who drop out for reasons related to GBV risks or safety concerns	• Attendance records • Follow-up reports (e.g., a Semi-Quantitative Evaluation of Access and Coverage)	Regular follow-up and community engagement activities.

To increase coverage of nutrition programmes	Coverage rates • % of target population (e.g., children under 5, pregnant and breastfeeding women) covered by the nutrition programme	• Programme enrolment records • Surveys	Adequate resources and outreach activities.
To prevent relapse into malnutrition	Relapse rates • % of beneficiaries who relapse into malnutrition (re-admitted to therapeutic feeding programme) after being discharged as cured	• Post-discharge monitoring reports	Continuous support and monitoring post-discharge.

TABLE 5D. **GBV risk mitigation interventions**

Objective	Indicators	Means of verification	Assumptions
To improve overall service quality and safe referrals	Training coverage • % of nutrition programme staff trained on GBV risk mitigation including referrals and the GBV Pocket Guide • # of non-staff trained on GBV risk mitigation or GBV referrals (e.g., mother-to-mother groups, men's groups) • % of training participants who are competent on GBV referrals • # of GBV service providers trained on how to identify and refer cases of malnutrition	• Training attendance records • Training reports	Availability of trainers and training resources.
To establish and utilize feedback mechanisms	Feedback mechanisms • # of feedback and complaint mechanisms in place at nutrition facilities, and the proportion of grievances related to GBV and sexual assault and exploitation	• Feedback logs • Resolution reports	Beneficiaries feel comfortable and safe using feedback mechanisms.

To engage communities in GBV risk mitigation	Community engagement • # of community awareness sessions on GBV risk mitigation conducted • # of consultations with women and girls on GBV risk mitigation conducted • # of beneficiaries reached through community awareness sessions that include information on GBV referral pathways • Types of messages on GBV risk mitigation are integrated into content of the community awareness raising (qualitative descriptions)	• Session records • Community feedback	Community willingness to participate and engage.
To ensure high beneficiary satisfaction	Satisfaction with services • % of beneficiaries satisfied with the nutrition services provided, including aspects of safety and respect • % of beneficiaries who are aware of available mitigation measures at the nutrition facilities (such as referrals)	• Satisfaction surveys • Feedback sessions • Beneficiary surveys (menu of measures)	Continuous improvement based on beneficiary feedback.
To ensure female staff are in place at nutrition facilities	Ratio of male/female staff • % of staff delivering nutrition services are women, by type (e.g., community health workers, community nutrition volunteers, nutrition assistants, hygiene volunteers, nutrition and WASH staff) • Track any human resource policy changes (e.g., quotas, adjustments to the hiring process)	• Human resource records	Sufficient interest and willingness among qualified women to apply for and accept positions within the nutrition facilities.
To ensure that the GBV risks are systematically identified and addressed	Safety audits administered • # of safety audits administered, by location • % of actions identified in safety audits implemented • Types of structural improvements and service delivery adaptations implemented based on safety audit results (qualitative descriptions)	• Safety audit reports	Adequate funding and resources available to implement the actions identified in the safety audits.

Additional resources

The following sources provide relevant information and guidelines that were used to inform this guidance:

1. Menu of measures https://gbvguidelines.org/en/im/effectiveness/

2. **IASC Guidelines**: These guidelines offer comprehensive instructions on integrating GBV interventions within humanitarian action, including specific recommendations for different sectors, such as nutrition.

    - Source: Inter-Agency Standing Committee. (2015). *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action.* IASC Guidelines

3. **UNICEF's GBV risk mitigation resources**: provides extensive resources and frameworks for GBV risk mitigation in various humanitarian contexts, highlighting key indicators and strategies for integration.

    - Source: United Nations Children's Fund. (2020). *Integrating Gender-Based Violence Risk Mitigation in Humanitarian Action: Training Manual.* UNICEF GBV Risk Mitigation
    - UNICEF Sharepoint (for Internal UNICEF Users). GBV and Nutrition
    - UNICEF Humanitarian Programme Cycle Toolkit on GBV Risk Mitigation for Nutrition Cluster
    - UNICEF Data Collection for GBV Risk Mitigation

4. **Safety audits:**

    - Safety Audits: A How-to Guide.
    - Online training. Monitoring GBV risks in nutrition programming: Safety Audits and safe consultation
    - Sample safety audit tools, outpatient therapeutic programme and targeted supplementary feeding programme and stabilization center. South Sudan Nutrition Cluster.

Technical support

This Guidance Note was developed by the UNICEF GBV in Emergencies unit, through collaboration with the UNICEF Nutrition Section. For further guidance on GBV & nutrition programme integration, please contact: Christine Heckman (checkman@unicef.org), Megan Gayford (mgayford@unicef.org), or Victoria Mwenda (vmwenda@unicef.org).

Please contact the Global Nutrition Cluster through the GNC webpage for technical questions and support related to all phases of the nutrition response.

This document was developed by UNICEF in 2024 and the lead author was Katie Robinette.

For additional information on UNICEF's ongoing work on GBV/Nutrition integration, please contact Megan Gayford, mgayford@unicef.org; Victoria Mwenda, vmwenda@unicef.org or Christine Heckman, checkman@unicef.org.

December 2024

Published by:
UNICEF
Child Nutrition and Development Section
Programme Group
3 United Nations Plaza
New York, NY 10017, USA

unicef | for every child