Gender Guidance for Nutrition-Related Programmes

This guide provides information for actors from various sectors who are designing, implementing or reviewing nutrition-related projects, to ensure **gender** is given appropriate attention for minimum harm and maximum benefit. It highlights gender's impacts on nutrition pathways and **gender integration** in nutrition-related programming. It also suggests how—in nutrition-related projects—to appropriately fulfil the 2014 UK International Development Gender Equality Act (UK Government 2014) by *meaningfully, proportionally considering gender* to inform nutrition-related investments. See Annex A for a glossary of terms in bold.

Key messages of this guide

- ***Gender sensitivity***. The 2014 Act requires documentation of gender considerations in all programmes. Beyond this, a ***gender-responsive*** (or—where feasible—***gender-transformative***) approach may be needed to achieve ***equality of opportunity*** and ***equity of outcomes*** in nutrition.
- ***Gender's importance to good nutrition***. Gender is ubiquitous in the nutrition impact pathways. Socially constructed gender norms influence dynamics, roles, time burdens, mobility, resources and decisions (e.g. about food allocation, health, care practices, livelihoods, education, water, sanitation and hygiene), impacting diet and disease—nutrition's immediate drivers.
- ***Gender's inclusion of men and boys***. Gender not only means 'women and girls' but also considers the roles of and outcomes for men and boys. Targeting the former may leave aside the nutritionally vulnerable amongst the latter and may minimise key actors' positive contributions.
- ***Gender assumptions' impact***. To support positive outcomes for gender and nutrition, gender assumptions should be considered, documented and addressed through preventive or mitigative actions at all stages of a project.

Maximising the Quality of Scaling Up Nutrition Plus

Following on the success of Maximising the Quality of Scaling Up Nutrition, or MQSUN (2012–2016), MQSUN+, funded by the UK's Foreign, Commonwealth and Development Office (FCDO) (2016–2020), provides technical assistance to FCDO, Scaling Up Nutrition (SUN) countries and the SUN Movement Secretariat to catalyse multisectoral country efforts to scale up nutrition impact, maximise the quality and effectiveness of nutrition-related programmes, increase innovation in nutrition, support evidence generation and knowledge uptake and develop technical capacity. MQSUN+ is a consortium of five expert organisations: PATH (lead), Aga Khan University, DAI Global Health, Development Initiatives and NutritionWorks.

MQSUN+

Gender considerations in nutrition-related work

The 2014 Act works towards ensuring equality of opportunity by requiring aid efforts at least consider gender-related barriers and document this consideration (in business cases, annual reviews, etc.). However, equity of outcomes is the end goal (DFID 2008). Achieving this will likely require not only avoiding a **gender-blind** approach (which is at times erroneously assumed to be a **gender-neutral** one), to instead being at least gender-sensitive (considering gender), or—preferably—being gender-responsive (taking action to address gender norms, roles and inequalities). The step beyond that—being gender-transformative—should only be taken where appropriate and whilst carefully considering unintended consequences. Further, consideration of how gender intersects with other equity dimensions (e.g. sexual orientation, race, ethnicity, poverty, age and disability) can help minimise the risk of exacerbating those vulnerabilities.

A gender lens is imperative to advancing global goals such as the Sustainable Development Goals (SDGs), including SDG 2 on hunger and SDG 3 on health as well as the 2025 World Health Assembly nutrition targets (DFID 2018). As with gender, nutrition is a multifaceted strategic priority for FCDO, and formerly Department for International Development—DFID (DFID 2017). Since 2011 FCDO has served 30 million pregnant or lactating women and young children through nutrition-related projects (DFID 2018), which in 2017 numbered 147 (MQSUN+ 2019). Such projects are recommended to focus on the most impactful interventions for the most vulnerable people (Independent Commission for Aid Impact 2014).

Gender-related risks and barriers pervade the pathways to nutrition (Annex B), whether the drivers are immediate (diets and health), underlying (food security, caring practices and health services/environments) or structural (sociocultural and economic factors, such as access to resources and other contextual factors) (UNICEF 1998). Annex C explores some key, interrelated themes (based on a rapid literature review and key informant interviews) in which socially constructed gender norms may influence nutritional status or its drivers. In brief, these are as follows: HH dynamics and roles, time use, mobility, control over resources and HH decision making and food-allocation norms. They are touched upon in sectoral tables below; however, the major points of evidence—being more universal than sector-specific—are kept to Annex C. The various actors—individuals, communities, governments, businesses and aid practitioners—hold gender norms. When designing, implementing, monitoring or evaluating nutrition-related investments, it is important to consider how these norms are embedded within the context and what design or mitigation strategies can help address them.

Considering context-specific gender-related norms is essential to appropriate targeting and to addressing barriers to access, uptake and impact. Key points on gendered targeting in nutrition-related programming include: (1) Simply targeting women does not make a programme gender-responsive; targeting should be based on formative research to consider broader dynamics which will impact whether the most vulnerable individuals will be able to access, uptake or benefit from interventions (The Cash Learning Partnership 2018; Schramm et al. 2016; Hopwood, Porter, and Saum 2018; Yoong, Rabinovich, and Diepeveen 2012). (2) Gendered targeting may have unintended consequences, such as adding to women's time burden, excluding vulnerable men and boys or reinforcing norms around who provides care (Hopwood, Porter, and Saum 2018; Adato et al. 2011; Fotso, Higgins-steele, and Mohanty 2015). More research is needed, but emerging evidence from social protection, for example, indicates that assumptions about gendered targeting may hinder the achievement of desired impacts or catalyse harm (Hagen-Zanker et al. 2017; J. Scott et al. 2017).

There are valid reasons for projects to target by sex or gender (e.g. life-course effects of maternal malnutrition). However, there is a growing recognition in humanitarian and development spaces that gender does not mean only 'women and girls' but includes roles of and outcomes for men and boys. This is important to nutrition for many reasons (e.g. preliminary evidence reveals that boys may experience high levels of malnutrition). Corroborated by other sources (Development Initiatives 2018), Maximising the Quality of Scaling Up Nutrition Plus (MQSUN+) found in Demographic and Health Surveys a higher prevalence of stunting, wasting, underweight or overweight in male children under 5 years old. Emerging research has found a biological plausibility of intergenerational

impacts of malnutrition in male individuals (Schagdarsurengin and Steger 2016; Hart and Tadros 2019; Ly et al. 2017). The difference in outcomes by **sex** continues into adolescence, as 88 percent of countries recorded a higher prevalence of wasting amongst male individuals aged 15 to 19 years. Amongst 20- to 29-year-old individuals, the trend reverses, with 63 percent of countries recording higher prevalence of low Body Mass Index (<18.5) amongst female individuals, important given the fecundity in this age group. In 94 percent of countries, there is a higher prevalence of overweight in female than in male individuals of reproductive age (15 to 49 years old).

Given this information, projects may wish to rethink traditional assumptions about **gender equality** in terms of targeting and nutritional vulnerabilities by sex. Instead, the context-specific realities should be documented, considered and addressed as appropriate to enhance projects and improve intermediate outcomes for all **gender identities** as well as outcomes by sex. This could have positive effects on both gender and nutrition outcomes. See Annex E, case study 1, for an example of reaching boys as well as girls with an intervention.

Integration of gender into nutrition-related projects

Table 1 outlines actions to ensure gender integration at each stage of a nutrition-related project. For example, monitoring and evaluation (M&E) that is intentional about documenting the linkages can help move forward the evidence base and improve equality in and equity from such projects (Annex D). This guidance is generally for country programmes, but Annex E, case study 2, offers a global project example.

Subsequently, this section offers simplified Theories of Change (ToCs) for illustrative nutrition-related interventions from various sectors, including examples of gender-related assumptions within. These are each followed by a matrix of potential unintended consequences and approaches to mitigating against those consequences and/or risk that the assumptions are unfounded. Advisors can use these as inspiration to search for, consider and document gender assumptions and then (as appropriate) take a gender-responsive or gender-transformative approach to improve how their projects support equality of opportunity and equity in nutrition outcomes. See Annex E, case study 3, for an example of how a nutrition project can start integrating gender.

The ToC and assumption matrices are meant to support the development of gender- and nutrition-responsive logframes and projects. They can aid in the development of a business case's (1) ToC, including assumptions made and possible unintended consequences; (2) logframe assumptions by indicator/activity; and (3) risk matrix, including approaches to monitoring, mitigating or managing the risk that the ToC assumptions are invalid. Rather than representing all possible interventions, assumptions and mitigation options, the tables are illustrative. The means to be informed about contexts (e.g. through reviewing secondary data, consultation with stakeholders) are similar across interventions, so these analyses are covered in Table 1.

Table 1. Integrating gender during the phases of nutrition-related projects.*

Stage	Action
Design	
Formation of a business case	Review **sex-disaggregated** nutrition (see Demographic Health and Multiple Indicator Cluster surveys) and gender data (e.g. differences in **agency**, needs, priorities, experiences, opportunities and barriers, such as child marriage, gender-based violence and migration) to consider how they may influence approach. Document these considerations in the strategic and appraisal cases, ToC, logframe and risk matrix and weigh whether to pursue gender sensitivity, responsiveness or transformation.
Mobilisation	
Engagement	Engage a range of stakeholders (e.g. project staff, government offices, beneficiary representatives, partner organisations, media) who will influence or be impacted by the project for help in identifying/addressing gender issues which may impact nutrition and the project. Review proposals for adequate gender consideration.

Stage	Action
Design	
Formative or baseline studies	Further disaggregate secondary data by age, wealth, education and other factors to consider differences in nutrition outcomes and access to nutrition-related resources. Conduct gender analysis on differences and norms to understand knowledge/attitudes, drivers, decision-making agency, influencers, time/safety/physical access (and other barriers) to uptake/maintain nutrition-related practices in order to plan targeting, scale and synergy with other projects.
Revision of logframe & establish monitoring	Ensure logframe adequately considers gender. Include sector, population or intervention activities to address gender and nutrition, as well as assumptions which could impede nutrition; establish mitigation options (e.g. through household-level approaches; see ToC assumption matrices). Also include key context-relevant, sector- or intervention-related, sex-disaggregated and gender-sensitive indicators, which beneficiaries and other stakeholders should help design or select. Then establish a gender-integrated M&E plan, including qualitative and quantitative methods, systems for data collection and analysis and indicators for measuring whether obstacles are being addressed. Train staff, including on adaptive management (i.e. addressing inequities or unintended consequences in a timely manner).
Delivery	
Oversight / monitoring	Whilst implementing the project, collect, analyse and discuss disaggregated data, including on subgroups of beneficiaries and influencers. Document gender-related factors which may influence participation/uptake/outcomes to assess gaps, track progress on gender and nutrition and mitigate unintended consequences. Review during Annual Reviews and carry out ongoing adaptive management (to adjust to minimise unintended consequences and maximise equitable outcomes for nutrition). Monitor operations and process of gender and nutrition integration to document lessons learned in differences in uptake/benefit to adapt and inform future projects.
Closure	
Evaluation and research	Undertake a gender-responsive evaluation to assess the gender and nutrition outcomes and impacts. Such evaluations can (1) demonstrate results and accountability to stakeholders regarding integration; (2) provide reliable evidence for decision making about design, implementation and resource allocation to ensure gender-equitable access to—and impact of—nutrition projects; and (3) generate lessons about what works in addressing gender dimensions of nutrition.
Reporting and disseminate	Document and disseminate positive and negative results and experiences with gender integration in nutrition-related projects (i.e. report sex-disaggregated data, gender-related outcomes, gender-equality indicators and learnings on the operational aspects to establish future expectations).

*References for hyperlinks are detailed in **Annex F**. Abbreviation: M&E, monitoring and evaluation; ToC, Theory of Change.

The ToC assumption matrices focus more on mitigating (or managing) mobilisation- or delivery-stage risks from inaccurate assumptions or unintended consequences. Advisors should review the examples from other sectors (particularly the first one), as the themes are universal and so examples cross sectors. Any studies cited are instances where the researchers have considered these issues, rather than evidence that the assumption is incorrect/correct or that the mitigation will always work; instead, they elucidate where these have been looked at, often qualitatively, in a given context.

Table 2 (with accompanying figure) illustrates a social protection-sector intervention, cash transfers. These transfers often target women, assuming them to be likely to invest in products and/or services that will benefit nutrition (or a similar aim). However, such projects have taught us that simply targeting women is insufficient; assumptions regarding agency, safety, feasibility, knowledge and access may be inaccurate (The Cash Learning Partnership 2018).

Table 2 with accompanying figure. Social protection intervention theory of change and assumption matrix.

Gender assumption	Challenge or consequence	Illustrative mitigating action to manage risks/consequences	Areas to monitor*
1 It is / is not safe and feasible for target recipient (regardless of gender) to receive the transfer.	It may be dangerous/impossible to collect/use transfer; household (HH) member(s) may be abusive due to concerns about power.	Introduce activities to increase safety / physical accessibility of collecting or using the transfer and minimise the conflicts over the power dynamic of the woman holding the transfer (Buller et al. 2016).	Attitudes regarding gender-based violence (GBV); incidents of GBV.
2 Recipient (regardless of gender) knows / is interested and has agency to spend to benefit nutrition.	The woman is not involved in decision making (J. Scott et al. 2017).	Readjust targeting or include the promotion of joint decision making within other activities. Strengthen messaging to target influencers and associate transfer with pro-nutrition uses. Facilitate market links.	Decision-making power; awareness of nutrition; father's participation. (See Annex E, case study 4.)
3 Transfer is sufficient and holder (regardless of gender) has market access to nutrition-positive items.	Nutrition-positive items may not be in accessible markets, or transfer may be small or prices high (Levay et al. 2013).	Encourage activities to improve recipients' market access. Adjust size of transfer or messaging about what it can/should cover.	Market access and expenditure of transfer.
4 Recipient (regardless of gender) has access to skills/resources and agency to acquire and properly use nutrition-positive items.	There is lack of agency, willingness, skills and/or knowledge (e.g. of pregnant or lactating women's or children's nutrition needs) for equitable intra-HH allocation, in part due to norms (Pilla and Dantas 2016).	Include men and women in opportunities to build these skills, including around intra-HH nutritious food allocation, agency and knowledge to make allocation more equitable. Choose timing and tactics to reach influencers; where recommendations challenge tradition, offer joint training.	% of transfer recipients (by gender) who demonstrate the ability to use the transfer to benefit HH nutrition.

*For specific, illustrative indicators, refer to Annex D.

Table 3 (and accompanying figure) illustrates a water, sanitation and hygiene (WASH) intervention, *community construction of latrines*. This intervention often relies on many assumptions around perceived and actual desirability, knowledge, skills, mobility, access and safety in using such facilities.

Table 3 with accompanying figure. WASH intervention theory of change and assumption matrix.

Gender assumption	Challenge or consequence	Illustrative mitigating action to manage risks/consequences	Areas to monitor
1 Latrines constructed are adequate for all targeted users and are maintained.	Latrines may not be of good quality (e.g. include handwashing station), properly maintained, appropriate for key populations' needs (e.g. comfortable menstrual hygiene management) or safely and conveniently accessible (DFID 2013; Amnesty International 2010).	Select context-appropriate latrine types. Apply a Community-Led Total Sanitation or Participatory Hygiene and Sanitation Transformation approach, including representation by (and opportunities for listening to) all genders in decision making around constructing and maintaining latrines.	Different qualities of latrines (Demographic and Health Survey and Joint WASH monitoring data).
2 Community members (all genders) have knowledge and desire to use latrines.	Communities may be unaware or unconvinced of benefits of using latrines, or the latrines might not be adequate for use (as above) or might not be desirable to use (e.g. concerns about insects with some types of latrines) (DFID 2013).	Train and market to the community on value (aspirational). Incorporate behaviour change activities (e.g. maintenance) to address the barriers. Promote shared responsibilities across genders.	Perceptions (by gender) on different types of latrines in use. Coverage with safely-managed latrines.
3 Latrines will be safely used by all genders/ages.	If latrines are not properly maintained, or clean handwashing water is not available, people could become ill (with implications for nutrition) (DFID 2013).	Structure activities to include representation by (and opportunities for listening to) all gender identities regarding safe latrine use.	Use of latrines; users/nonusers (by gender) and reasons why. Prevalence of sanitation-related illnesses in children (sex-disaggregated).

Table 4 (and accompanying figure) illustrates an agriculture/livelihoods-sector intervention, access to *inputs for production of safe, nutritious foods* (SNF). Such an intervention can be nutrition-sensitive, but many gendered assumptions can impede the ability to have an impact and/or could cause harm. The assumptions around agency to decide how resources will be used have largely been addressed in the social protection example above and so are addressed only briefly here. Additionally, only some of the assumptions are considered within this illustrative pathway, leaving aside complex issues, such as exposure to toxins.

Table 4 with accompanying figure. Agriculture/livelihoods theory of change and assumption matrix.

Gender assumption	Challenge or consequence	Illustrative mitigating action to manage risks/consequences	Areas to monitor
1 Farmers (regardless of gender) have access to and obtain inputs to produce SNF for markets and home consumption.	Women may not have equitable, adequate access to those inputs (due to targeting, mobility or time) or agency to decide about them (Haider, Smale, and Theriault 2018).	Conduct gender sensitisation for implementers on the potential exclusion of women; address this in the selection of farmers and how they are supported.	Access to inputs, including extension services.
2 Farmers (regardless of gender) have access to inputs (e.g. tools or techniques) which minimise time and calorie-burning labour.	These strategies may not exist, or women may not have access to them and so may engage in significant physical labour which, coupled with low dietary intake, can lead to negative birth outcomes and knock-on nutritional effects (Vir 2016; Balagamwala, Gazdar, and Mallah 2015).	Promote tools and techniques (e.g. efficient threshers) to reduce labour. Promote shared responsibilities by men and women.	Time use and labour (by gender). See Annex E, case studies 4 and 5.
3 Farmers will produce sufficient adequate-quality SNF for the market and keep some for home consumption and have agency over what to do with produce.	Women may not have agency regarding what to do with products (e.g. whether and when to slaughter and whether to keep or sell SNF produced) (Dumas et al. 2018).	Train implementers and communicate to families on the importance of farmers keeping some of their own production for consumption (Sanghvi et al. 2013).	Quantities and types of produce kept for home consumption.
4 Farmers or purchasers (regardless of gender) will be able to access markets to sell or buy affordable, appealing SNF.	Farmers/purchasers may have limited ability to reach markets to sell/buy SNF or may do so at the expense of responsibilities at home. SNF may be expensive, and woman may not have agency to justify consumption (Wood et al. 2017; Levay et al. 2013).	Implement activities to help overcome market access barriers for farmers/purchasers.	Market and resource and other barriers to purchasing SNF. Time use and control over resources.

Nutrition-specific projects, which focus on immediate determinants (diet and disease), have often assumed but not documented links with gender. Table 5 (and figure) illustrates a nutrition-specific health-sector intervention, social behaviour change (SBC) efforts to *educate about frequency and diversity of complementary feeds and/or women's dietary diversity* in improving infant and young child feeding (IYCF) and the diets of women of reproductive age. SBC works to influence psychological determinants (i.e. attitude, risk perception, self-efficacy and habit) of behaviours (Avis 2016). Efforts to improve diets are common nutrition SBC interventions. Improving IYCF and the minimum dietary diversity of women (MDD-W) often involves gendered assumptions around time, mobility, HH dynamics, gender roles, skills, knowledge, access and agency. A few are considered here.

Table 5 with accompanying figure. Social behaviour change for IYCF theory of change and assumption matrix.

Gender assumption	Challenge or consequence	Illustrative mitigating action to manage risks/consequences	Areas to monitor
1 Caregiver (regardless of gender) will believe that s/he has skills to affect behaviour and that others in the household (HH) will welcome new behaviour.	Influencers in the HH/community might be the key decision-makers and/or disagree with uptake (Ickes et al. 2016; Pilla and Dantas 2016).	Enlist grandmothers as advocates for good nutrition practices (Girard et al. 2017). Conduct context-sensitive joint training (Annex E, case study 6, shows involving fathers in IYCF initiatives).	Awareness of and support for specific maternal, child and nutrition behaviours.
2 Caregiver (regardless of gender) will have access to the items needed (food items, time) to take on the new behaviour.	Nutritious foods recommended may be unfamiliar, expensive or otherwise inaccessible (Wood et al. 2017; Pilla and Dantas 2016). Caregiver may not have the support to implement the behaviour (Nabwera et al. 2018).	Ensure recommendations are context-appropriate and equip both men and women with resources to implement new dietary behaviours (e.g. engage in discussions on task shifting within HHs).	Time use (by age and gender) and barriers to uptake/maintenance of new behaviour. Fathers' participation.
3 Women of reproductive age (WRA) and infants/children will be willing to consume per intended frequency / diversity.	WRA may be uncomfortable prioritising themselves for safe, nutritious food, or SNF (Ali and Vallianatos 2017), or children may be unwilling to consume SNFs.	Build practical skills on how to encourage the target populations (IYC and WRA) to consume diverse SNF.	Dietary diversity amongst IYC and WRA.
4 Caregivers (regardless of gender) will have resources to uptake related behaviours (e.g. to prevent disease).	Due to poverty, conflict or other vulnerability, HHs may not have access to; health services; or accompaniments to support effective utilisation of SNF.	Build skills of implementers around supporting these other services to ensure the benefits of improved diets.	Prevalence of related behaviours.

Table 6 (and accompanying figure) illustrates a nutrition-specific health-sector intervention, *community management of acute malnutrition.* This may involve gendered assumptions around time and mobility, access, skills and knowledge, control over resources and HH decision making.

Table 6 with accompanying figure. Nutrition-related health services theory of change and assumption matrix.

Gender assumption	Challenge or consequence	Illustrative mitigating action to manage risks/consequences	Areas to monitor
1 Access to these services will be available regardless of the gender of caregiver or child.	Women who are particularly poor or busy might not feel they have time to take the child to be checked; likewise, a child whose father controls household decisions and chooses not to have the child taken to the facility will also be excluded (Zuza et al. 2017). Also, families from communities where traditional medicine is the first treatment given may not access community management of acute malnutrition (CMAM) services in a timely manner (Pilla and Dantas 2016).	Provide equity sensitisation for implementers to ensure they understand the importance of reaching/assessing/supporting all children in need.	Coverage data (e.g. from Semi-Quantitative Evaluation of Access and Coverage and/or Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage, which are beginning to look at gender reasons for coverage).
2 High-quality services are equitably provided to boys and girls.	Training and supervision may be unnecessarily gendered. Some services may be inadequate or inequitably provided, and so stockouts of necessary items—such as ready to use therapeutic food (RUTF) and antibiotics—may be common, impacting certain groups harder in times of scarcity.	Provide gender-sensitive training on quality CMAM service provision, including proper screening, appropriate individual skills building and supportive supervision.	Coverage data and acute malnutrition levels by sex.
3 Community/health workers (regardless of gender) provide quality infant and young child feeding (IYCF) and maternal diet counselling.	Services may not be part of the standard package or provided. The education/skills training may be targeted to mothers (assumed primary caregiver), whereas fathers, grandmothers or other influencers might need the information and skills. There may be gendered issues about how caregivers provide the RUTF or IYCF practices (Pilla and Dantas 2016).	Provide gender-sensitive training on quality CMAM service provision, including counselling skills building,	Gender-sensitive services and training.

Conclusions, gaps and opportunities

Evidence regarding and attention to equity in nutrition-related health outcomes by sex is growing, yet gaps remain. It is not clear why male rather than female children under five years old often appear to be more malnourished. Data rarely exists for children 5 to 15 years old, and data for adolescents are included with data for men and women. Surveys could collect and offer sex- and age-disaggregated (5 to 9, 10 to 14 and 15 to 19) nutritional status data to allow a better consideration of how undernutrition shifts from childhood (in which male individuals have higher levels) to adulthood (in which female individuals do) and the intergenerational impacts. Similarly, further data on men's nutritional practices and status could be helpful, as could information about how nutritional status changes with a rural-to-urban move or a shift from a crisis to a postcrisis circumstance.

Likewise, evidence is emerging about inequalities of opportunity to address the drivers of nutrition. In particular, cultural norms may limit agency and access to adequate services and uptake of practices which could support nutrition, but further data is needed in these areas:

Whether interventions to increase agency (e.g. promotion of joint decision making) can actually be linked to nutrition outcomes. Similarly, how to successfully engage influencers whose active support is needed for uptake, particularly where positive practices conflict with norms.

Access to/coverage with nutrition-related services by gender, how targeting based on gender may reinforce potentially harmful norms, how time and mobility may impact the ability to uptake/maintain practices, how gendered food allocation norms impact nutrition, how participation in decision making may restrict capacity to improve nutrition and how men/grandmothers can be brought into task-sharing and other support roles.

How these norms might change during rural-to-urban migration, postcrisis situations or transitions (positive or negative) brought about by humanitarian or development programming.

Despite gaps, considering the emerging evidence, project design should be informed by an explicit review of nutrition-related data disaggregated by gender, sex and other key factors (age, wealth, education) to identify differences in access to nutrition-related resources and in nutritional status. During design, participatory approaches involving varied stakeholders (e.g. adolescent girls, men, pregnant women) should be used to identify gender-related barriers to good nutrition. Gender analysis should look at underlying issues such as agency, time and mobility to support an understanding of norms, decision making and barriers which can impact success. Further, designs should not only consider but also look for appropriate opportunities to shift those norms.

Subsequently, during mobilisation, delivery and closure, integrating gender into the M&E of nutrition programmes involves more than providing gender- or sex-disaggregated data. It should include information on gender equality to allow a further understanding of how an intervention influences or enforces existing gendered elements. Gender-integrated nutrition M&E should include measuring nutrition and **gender equity** outcomes and looking for any possible associations between the two.

The link between gender and nutrition is a critical and emerging area, as is the evidence that sheds light on how gender considerations can improve nutrition. At the very least, programming should be gender-sensitive, though gender-responsive and even gender-transformative approaches may be necessary to achieve gender equality in opportunities and gender equity in nutrition outcomes.

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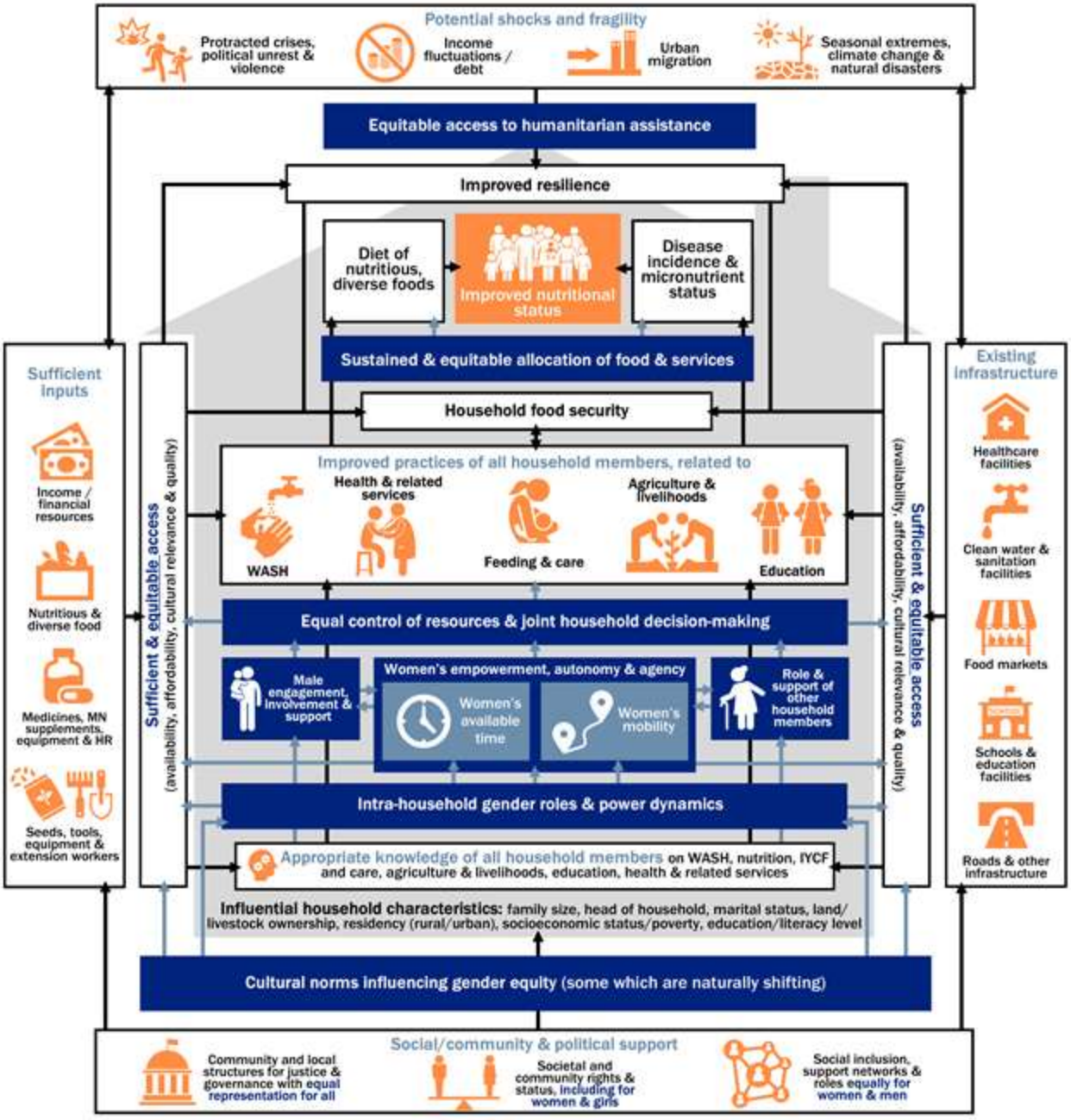
Annex A. Glossary

Table 7. Terms used in this guide.

Term	Meaning
Agency	Capacity to make and act upon decisions to achieve a desired outcome (World Bank 2014).
Equality of opportunity	Different gender identities (see below) having equal entitlements to human, social, economic and cultural development and voice in civic and political life (DFID 2008).
Equity of outcomes	Exercise of rights, entitlements and voice leading to fair and just outcomes (DFID 2008). Ensuring that these are equal may not suffice to obtain equitable outcomes, particularly where an individual/group begins at a disadvantage; therefore, it is necessary to focus on equity, providing additional support to those individuals/groups.
Gender	Social attributes and opportunities associated with being of a certain gender identity (see below) and the relationships between and amongst gender identities. These are socially constructed, learned through socialisation processes, context- and time-specific and changeable and determine what is expected, allowed and valued in each gender category in a given context. In most societies, there are inequalities by gender identity, in terms of responsibilities assigned, activities undertaken, access to and control over resources and decision-making opportunities. Differences stem from what society considers appropriate [roles, behaviours, activities] for each gender. This can be compounded by class, race, poverty level, ethnicity and age (UN Office of the Special Advisor on Gender Issues and Advancement of Women 2001; DFID 2008).
Gender analysis	The systematic process used to identify, understand and describe gender differences and the relevance of roles and power dynamics in a context (UK Aid Direct 2016).
Gender blind or gender neutral	Not accounting for diverse needs given the different roles and responsibilities assigned by social, cultural, economic and political contexts to individuals of different gender identities. Also (usually incorrectly) assumed to equally impact gender identities (UK Aid Direct 2016), these may maintain the status quo rather than help bring transformation (UN Department of Economic and Social Affairs 2016).
Gender equality	Equal rights, responsibilities and opportunities of individuals of different gender identities. This does not mean that individuals from different gender identities are the same but that their responsibilities and opportunities will not depend on whether they are born female or male. It implies that the interests, needs and priorities of each gender category are taken into consideration and recognises the diversity of different groups of women and men. This is not a women's issue as it should engage men, as well. Distinct from equity.
Gender equity	Fairness in the distribution of benefits and responsibilities between gender identities, recognising that different gender identities may have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalances between them (Payne 2009). Having rights, entitlements and voice be equal may not bring equitable outcomes, particularly where an individual or group begins at a disadvantage, requiring additional support to experience equity.
Gender identity	The way in which an individual identifies with (or is identified with) a gender category (women, men, girls, boys and 'third gender'—not exclusively identifying or identified as male or female) (UK Aid Direct 2016). This is based on perception, and the gender category with which a person identifies (or is identified) may not match the (biological) sex they were assigned at birth (Office for National Statistics Census Transformation Programme 2016).
Gender integration	Identifying relevant differences (e.g. in participation, opportunities, agency, concerns, experiences, benefits and outcomes) by gender &/or sex and addressing these throughout a project (Faramand, Ivankovich, and Holtmeyer 2017; UK Aid Direct 2016; DFID 2008).
Gender responsive	Programmes and policies in which gender norms, roles and inequalities are considered and measures are taken to actively address them. They go beyond raising awareness and actually do something about gender inequality (World Health Organization 2009).

Term	Meaning
Gender sensitive (also gender aware)	Programmes and policies which take into account differences and inequality between gender identities (DFID 2008), important as gendered roles and gender norms touch most drivers of nutrition. Nutrition is unlikely to improve where gender issues are not considered. These projects specifically assess gender-related norms, beliefs and barriers and assess how project activities influence underlying gender dimensions. Gender-sensitive indicators can help to assess gender-related project objectives and further assess the influence of an intervention on, for example, gender equality (Faramand, Ivankovich, and Holtmeyer 2017; Fehringer et al. 2017; FAO 2014).
Gender transformative	Beyond gender sensitive, also working to transform (slowly if needed) the gender-related underlying causes and context of an issue. It engages all gender identities to examine and change norms that perpetuate inequalities, ultimately helping everyone (Rubin and Manfre 2015; FHI360 2012). This requires time and a theory-guided approach that is thoughtful in efforts towards dismantling gender norms to avoid harm along the way.
Nutrition-specific	Interventions/actions addressing the immediate determinants of malnutrition, i.e. diet and disease (Shekar, Ruel-Bergeron, and Herforth 2013).
Nutrition-sensitive	Interventions/actions conducted for other purposes but having nutrition-related objectives and activities and addressing malnutrition's underlying (i.e. food, health and care) or structural (i.e. sociocultural, economic and other contextual factors in the enabling environment) drivers, or at least trying to minimise harm related to those drivers (Maternal and Child Nutrition Study Group 2013; Shekar, Ruel-Bergeron, and Herforth 2013; UNICEF 1998). Per the SUN [Scaling Up Nutrition] Donor Network methodology, a nutrition-sensitive project must (1) be aimed at individuals (specifically, women, adolescent girls or children), (2) include nutrition as a significant objective or indicator and (3) contribute to at least one nutrition-sensitive outcome as per the SUN Donor Network methodology (e.g. women's purchasing power; access to education for adolescent girls; access to nutritious foods, primary health care, WASH, and/or a good-quality diet for women/adolescent girls/children; access to childcare; relevant knowledge/awareness; and/or improved women's empowerment).
Sex	The physical and biological characteristics that distinguish male versus female. It refers to a person's anatomy and physical attributes such as external and internal reproductive sex organs (Inter-Agency Standing Committee Working Group 2018). These sets of biological characteristics are not always mutually exclusive.
Sex disaggregated	Disaggregation of relevant indicators by sex and age and other key characteristics as possible (e.g. socioeconomic status, education), to enable quantification of differences.

Annex B. Gendered pathways to nutrition



Abbreviations: HR, human resources; IYCF, infant and young child feeding; MN, micronutrient; WASH, water, sanitation and hygiene.

Annex C's table describes evidence from a rapid literature review and stakeholder consultation, particularly with regards to key themes found. Here is a brief description of the pathways in the infographic above: From the bottom, cultural and political contexts (structural drivers) shape *gender norms*. Advisors must consider how these influence the contexts in which they work to determine whether a gender-sensitive, gender-responsive or gender-transformative approach is most appropriate. Appropriately addressing these norms can help change socioeconomic characteristics, such as household (HH) members' education levels, which have been found to influence nutritional status (Komatsu, Malapit, and Theis 2018; Jin and Iannotti 2014).

When these characteristics change, they can sometimes bring about changes in gender roles and power dynamics within the HH, such as men's and boys' engagement, support amongst HH members, time and mobility, though results vary between communities, even within the same country (Semahegn, Tesfaye, and Bogale 2014; K. Scott et al. 2017; Nabwera et al. 2018; Ochieng et al. 2017; Richards et al. 2013). In resource-poor contexts, HH members face multiple, competing time burdens, resulting in conflicting priorities (e.g. producing food, generating income and/or upholding childcare responsibilities (Nabwera et al. 2018; Mbekenga et al. 2011; Komatsu, Malapit, and Theis 2015, 2018; Balagamwala, Gazdar, and Mallah 2015). In addition, evidence suggests that physical mobility can impact a woman's ability to nourish herself and her HH (Levay et al. 2013; Fotso, Higgins-steele, and Mohanty 2015).

Amongst dynamics which may change are those on HH decision making (Richards et al. 2013; Pilla and Dantas 2016; Ickes et al. 2016) and control over resources (Dumas et al. 2018; Abate and Belachew 2017; Richards et al. 2013; Jin and Iannotti 2014; Taukobong et al. 2016), which may then impact nutrition-related behaviours (e.g. whether girls go to school, whether women can make a livelihood on and/or input into what food is produced or purchased and who eats what, whether HH members go for health services and use positive water, sanitation, and hygiene practices, all of which could impact nutrition. There may be a fallacy in the assumption that—resources being equal—women will better address nutrition than will men (Yoong, Rabinovich, and Diepeveen 2012). However, where women have the agency to influence decisions related to (underlying drivers of) food, health and care, they have an opportunity to contribute to better practices. Dynamics are complex, so joint decision making may be more useful than shifting power to women.

To bring about nutrition outcomes, equitable allocation of food and services is important. Where malnutrition is high, women and girls often experience inequality of opportunity in that they cannot source and consume nutritious food. For example, in some countries, there is an expectation that men receive preferred foods and/or eat first, which can negatively impact nutrition (Dumas et al. 2018; Adato et al. 2011; Ali and Vallianatos 2017; Alemayehu et al. 2015; Jin and Iannotti 2014). To increase access to nutritious foods, donors and implementers must understand and act upon the related gendered dimensions.

Relatedly, gender roles and power dynamics will influence (and are influenced by) uptake of services and positive practices in agriculture and livelihoods, care and health as well as environment. Programmes that focus on social protection and social behaviour change may fail to acknowledge that families seek to do the best that they can with the resources that they have. Though all of these factors are at play in both development and humanitarian contexts, with the latter there are also elements of *equitable access to assistance* and how shocks may differently impact each gender category and the ability to bounce back from a crisis. Those also influence and are influenced by first HH food security and then diet and disease, the immediate drivers. Regardless, as mentioned, nutritional status may also be associated with an individual's sex.

Annex C. Themes merging from rapid literature review and interviews on gender norms and nutrition

Table 7. Themes emerging from literature and key informant interviews (KII) around gender norms and pathways to nutrition.

Norm and pathway	Studied examples	Mitigation example
Household (HH) roles and dynamics: Within and across countries there are variations in gender norms about roles—as well as interpretations of those roles—in child-rearing and nutrition. *These may influence nutrition-related behaviours and agency over HH resource use and decisions (e.g. about food, health and care), potentially impacting nutrition.*	A study in rural Tanzania explored factors contributing to HH and individual dietary diversity. Cultural beliefs around men as the decision-makers were exemplified by men commenting that they would not bring home certain foods (such as vegetables or meat) so as not to be perceived as being 'controlled' by their wives. This paper also cites a previous study in Kenya which found that men eating meals away from the home were more exposed to diverse diets than were women and children (Ochieng et al. 2017). A study in Kenya noted that the practice of men and women eating separately seemed to result in men having very little knowledge of the dietary requirements of infants and pregnant women (Pilla and Dantas 2016). A mixed-methods study in The Gambia found that, in many cases, husbands did not support their wives with childcare, which was deemed the wife's responsibility, despite competing time demands. However, it noted that younger fathers acknowledged and were eager to engage in these roles (Nabwera et al. 2018). Relatedly, researchers in Tanzania noted first-time fathers were deeply disappointed about missed opportunities to take on childcare responsibilities due to their own work far from home (Mbekenga et al. 2011). Grandmothers' roles also influence childcare and decision making in some contexts (Wood et al. 2017; Pilla and Dantas 2016). Other examples of such studies: (Semahegn, Tesfaye, and Bogale 2014; K. Scott et al. 2017; Richards et al. 2013).	Annex E, case study 3, discusses identifying activities to address these gendered roles—for example, engaging men and targeting men and women together for training on dietary diversity in pregnancy. Case studies 2, 5 and 6 also address some of these issues.
Time burden: Competing time burdens, particularly for women, can result in conflicting priorities between, for example, food production, income generation and childcare. *This time conflict can reduce the ability to provide food, health and care, impacting nutrition.*	The mixed-methods study in The Gambia on severe wasting risk factors found that women's time burdens influenced the ability to supervise children and ensure safe and sufficient food consumption (Nabwera et al. 2018). In a qualitative study in western Uganda, women discussed conflicting responsibilities and time demands. When asked about changes they would like in their husbands' role, they noted their desire to see increased involvement in child feeding (Ickes et al. 2016). A review of several countries' data noted that women's time allocation and nutrition impacts resulting from agricultural interventions vary according to context and socioeconomic status. For instance, a regression analysis from Ghana showed that women's time in agriculture is negatively correlated with their own dietary diversity, but this did not impact children's minimum acceptable diet. Further, women's time spent on domestic duties was associated with increased dietary diversity in Cambodia, Nepal, Bangladesh and Ghana. As nutritional impacts within and amongst HHs are nuanced, the authors suggested gathering additional—including qualitative—data (Komatsu, Malapit, and Theis 2015). Other examples: (Cunningham et al. 2015; Pilla and Dantas 2016; Mbekenga et al. 2011).	Annex E, case studies 3 and 4, consider women's time burdens.

Norm and pathway	Studied examples	Mitigation example
Mobility: Physical mobility or lack thereof in some contexts may impact a woman's ability to access services or markets. *Such restriction may influence a woman's ability to provide food, health and care, impacting nutrition.*	A cross-sectional qualitative study of ultra-poor women who were heads of HH in Bangladesh noted traditional gender norms constrained women's ability to work outside the home, impeding their income generation opportunities and contributing to food insecurity (Mcintyre et al. 2011). In India, women mentioned the benefit of increased mobility as men who were Accredited Social Health Activists helping women gain access to health facilities, offering them increased security and better transport and communication (Fotso, Higgins-steele, and Mohanty 2015). Another South Asia study mentioned increased mobility due to the relaxing of gender norms in urban settings but that high food prices negated positive nutritional impacts (Levay et al. 2013). In Ethiopia, researchers found no significant association between maternal mobility and child wasting or stunting (Abate and Belachew 2017). Again, context is important.	**Annex E**, case study 4, mentions adding mobility to an index. Stakeholders noted that mobility can impede access to services, assistance and markets, and such restrictions on adolescent girls make it difficult to go to school, access services or gain employment.
Dynamics around control over resources and HH decision making: Decision-making power within HHs and access to and control over HH resources may influence choices about food, health, care and other practices that support them. *Decisions about these underlying drivers (food, health, care) could influence nutrition outcomes.*	A narrative review of 32 studies from diverse low- and middle-income country contexts observed that women's decision-making power, along with access to and control over HH resources and HH structure and composition, intertwine and contribute to how resources and decisions funnel to nutrition inputs for children. For example, in Brazil and Bangladesh, an association was found between the control of financial assets by mothers and child health and nutrition outcomes. Another study using Demographic and Health Survey data demonstrated positive effects of women's decision-making power on short-term child nutrition in Latin America and the Caribbean and on both short-and long-term child nutrition in South Asia. Variations across studies highlight that sociocultural context matters in the relationship between women's status and child nutrition outcomes (Richards et al. 2013). It is also important to note that that the literature does not state that men will not make nutrition-promoting choices but rather that "differences in preferences, incentives and bargaining power about how to use resources might be important to HH nutrition" (Akresh, De Walque, and Kazianga 2012; Yoong, Rabinovich, and Diepeveen 2012). A cross-sectional study in rural Kenya tested the hypothesis that women's ownership/co-ownership of livestock influences children's animal-sourced food intake, contributing to growth and development outcomes, and found an association with reduced stunting and underweight (but not wasting) amongst children 6 months to five years old. Men's ownership of livestock was not significantly associated (Jin and Iannotti 2014). A literature review exploring whether addressing gender inequalities influences health or development outcomes found a significant positive relationship between women's decision making and improved child nutrition. Seven of the ten relevant articles found that multivariate analysis suggested that women	**Annex E**, case studies 2, 3, 4 and 5 mention this issue. Stakeholders noted livelihoods-related groups strengthening women's decision-making power and the importance of intergenerational issues (e.g. older women holding power or being a positive source of information).

Norm and pathway	Studied examples	Mitigation example
	with more decision-making power are less likely to have a stunted child and more likely to have a child with improved nutritional status. Two of the included studies found the relationship to be insignificant, and one found no contribution to either outcome (Taukobong et al. 2016). A qualitative study in rural Tajikistan discussed the influence of mothers-in-law (especially where men migrated for work) on HH decision making regarding food purchases and cooking and noted a mother's agency for HH decision making varies depending on the HH composition (Wood et al. 2017). An exploratory qualitative study of Maasai families in Kenya found that decision-making power between husband, wife, grandmother and extended HH plays into how mothers and children access food and health care, including during instances of acute malnutrition or illness (Pilla and Dantas 2016). Other examples: (Abate and Belachew 2017; Dumas et al. 2018; Buller et al. 2016; Ickes et al. 2016; Levay et al. 2013; Vaezghasemi et al. 2014).	
Food allocation: Norms around food allocation directly influence food consumption. *Diet is an immediate driver of nutrition.*	A mixed-method cross-sectional study in Bangladesh found that the traditional cultural norm that men should be fed first influenced women to ensure adequate feeding of men in the HH, even if the women had not eaten (Ali and Vallianatos 2017). A community-based cross-sectional study in Northern Ethiopia found that children in HHs where fathers are prioritised for key foods are four times more likely to be stunted, as compared with HHs with more equal food distribution amongst HH members (Alemayehu et al. 2015). An ethnographic qualitative study in Kenya of women who were smallholder livestock owners noted how gender norms influence the benefits of livestock ownership—for example, through unequal intra-HH distribution and consumption of animal-sourced food, with men typically receiving the best pieces and/or largest portions due to expectations (Dumas et al. 2018). Other examples: (Levay et al. 2013; Dumas et al. 2018; Buller et al. 2016; Ickes et al. 2016; Abate and Belachew 2017; Vaezghasemi et al. 2014).	A Sierra Leone quasi-experimental proof of concept study trained elder women in positive maternal and IYCF practices, finding better dietary diversity and greater meal frequency and consumption of food in pregnant women, mothers of young children and children (Girard et al. 2017).

Annex D. Monitoring and evaluation (M&E)

Gender analysis and gender-sensitive M&E for nutrition-related projects ensures sex and gender topics are measured as part of a project's inputs, outputs and outcomes and helps with accountability for integration (Fehringer et al. 2017). Where projects have not given this sufficient attention, they may fail to strengthen nutrition, gender or both. A couple of projects in Rwanda faced challenges in connecting activities and outcomes. In one, girls were targeted to establish gardens but the project did not fully communicate the intended purpose (to strengthen the household diet) and so these were largely seen as a way to generate income; the project found that only 21 percent of girls could identify a balanced diet. However, in terms of gender impact, participants had strengthened confidence and negotiation skills, which could prepare them for future advocacy. In the other project, there was funding for 'enhanced supply and access to affordable and nutritious food', seen as a gender and nutrition activity. However, it focused on gardens and provision of cows, and the data do not seem to tie out to nutrition or gender. Both projects could have benefitted from gender analysis and/or gender-sensitive M&E on their nutrition aspects.

At a minimum, collection, analysis and reporting of sex-disaggregated data are important for understanding differences in outcomes across subgroups (e.g. whether a change in wasting amongst children under five years old differs by sex). Further, gender-disaggregated data can provide evidence on differences in uptake, benefits and outcomes as well as unintended consequences. Beyond this, gender-related indicators can help assess the influence of a project on gender and allow learning of, for instance, the need to account for gendered roles in care, food preparation or dietary choices. They can also help explain how an intervention may influence the gender context. Qualitative data provide an opportunity to better understand the complexities and mechanisms affecting nutrition or other outcomes by sex and gender (Fehringer et al. 2017). With an increased use of gender assessments and analyses and gender-sensitive M&E, projects are generating new information about, and deeper consideration of, context-specific gendered social norms which may influence household nutrition practices and, subsequently, changes in nutritional status.

The FCDO's gender manual provides project life-cycle guidance (e.g. key issues to consider in a logframe, with questions to ask regarding verifiable indicators, means of verification and risks and assumptions for the goal/purpose, outputs, activities and inputs). This includes considering whether indicators measure the benefit to women and men and whether sex-disaggregated data are part of management information systems (DFID 2008).

Given the complexity and context-specific nature of gender norms, a single set of indicators will not be useful to all projects. Rather, indicators should be selected based on formative research, stakeholder consultation and the project's aims. A participatory approach can help ensure indicators reflect the context, are appropriately framed and can capture important and realistic change given the context (Demetriades 2007). It may be useful to consider indicators that (1) assess sex and gender differences in outcomes, (2) capture changes in inequality of opportunity and (3) assess project influence on gender-related barriers. For example, if a project aims to increase men's involvement in infant and young child feeding, an indicator could capture the percentage of fathers attending such sessions (Fehringer et al. 2017). Table 9 offers illustrative indicators for gendered aspects of pathways to nutrition.

Table 9. Illustrative Indicators for nutrition and gender.

Nutrition outcomes (all disaggregated by sex and by age, as relevant)
and % of individuals assessed for malnutrition using mid-upper arm circumference and/or body mass index (Faramand, Ivankovich, and Holtmeyer 2017).
and % of children under 5 years old admitted for treatment of acute malnutrition (ECHO 2017).
and % of children under 5 years old who recover from malnutrition, disaggregated by sex and age (Faramand, Ivankovich, and Holtmeyer 2017).
and % of children under 5 years old who are stunted or wasted (USG Feed the Future 2018).
Immediate and underlying driver outcomes (disaggregated by sex)
% of infants under 6 months old who are exclusively breastfed (USG Feed the Future 2018).
% of children 6–23 months old (disaggregated by sex) who have a minimum acceptable diet (USG Feed the Future 2018).
% of men/women who have a diverse diet (FAO 2014).
% of women with minimum dietary diversity (Food and Agriculture Organization & FHI 360 2016).
% of children 6–23 months old (disaggregated by sex) who are continuing to breastfeed for the first year (CORE Group Nutrition Working Group, FANTA, and Save the Children 2015).
% of children 6–23 months old (disaggregated by sex) who are introduced to complementary foods (CORE Group Nutrition Working Group, FANTA, and Save the Children 2015).
% of community members surveyed who are aware of [nutritional] needs during pregnancy (Yinger et al. 2002).
% of men/women enabled to meet their basic food needs (ECHO 2017).
Structural drivers: Household (HH) dynamics and roles, time, mobility and control over decision making and resources (including food allocation)
% of women reporting that their partners accompanied them for at least one antenatal care visit during their pregnancy (Faramand, Ivankovich, and Holtmeyer 2017).
% of men or HH with men attending health and nutrition education sessions/opportunities (Yinger et al. 2002).
% of facilities providing infant care and feeding counselling to first-time fathers (Women's Empowerment Impact Measurement Initiative 2012).
% of community health workers trained on gender-sensitive nutrition messaging (Fehringer et al. 2017).
Women's Empowerment in Agriculture Index, or WEAI (autonomy on production/income/credit, asset ownership, access to credit, group leadership and time) (Malapit et al. 2018).
Indicators from WEAI's Health and Nutrition module (control over own/child's health/diet, including breastfeeding, ability to access health care / food) (Malapit et al. 2018).
% of women who have control or joint control over (their own or) HH income and farm products (Danida 2006; Fehringer et al. 2017).
% of men/women holding key attitudes regarding violence against women (Yinger et al. 2002).
% of men participating in HH chores (People in Need 2019).
Structural drivers: Access to resources/services/interventions/markets/political power
% of men/women/boys/girls being reached by activities (USG Feed the Future 2018).
% of men/women amongst beneficiaries of post-conflict land (re)distribution, including land allocation to ex-combatants (Ospina 2006; Moser 2007).
% of farmers (by sex) obtaining resources (loans, training, technology) that could enable them to protect/build/rebuild assets (ECHO 2017).
% of men/women involved in employment / income-generation schemes (e.g. distributing seeds and tools, providing extension services) (Ospina 2006; Moser 2007).
% of farmer association members who are women (Fehringer et al. 2017).
Coping Strategies Index, by sex of head of HH (WFP 2016).

Annex E. Case studies

1. Addressing anaemia in adolescent boys

In India, half of female adolescents are anaemic (Dureja 2016b). In 2000, UNICEF initiated a five-year school-based pilot project providing weekly iron and folic acid (IFA) supplementation, targeting adolescent girls in 20 districts of 5 states (Dureja 2016b). Activities included the distribution of IFA tablets, biannual deworming and nutrition education. In one year, the prevalence of anaemia fell from 78 to 54 percent (Aguayo, Paintal, and Singh 2013). UNICEF expanded the project's geographic focus from 2006 to 2011 to include all districts in 13 states. The Government took over in 2012, implementing a national project targeting adolescent girls enrolled and not enrolled in school as part of a 'continuum-of-care' to ensure iron deficiency was addressed at different life-cycle stages—such as pregnant and lactating women, children 6 to 60 months old and women of reproductive age, including adolescent girls (Ministry of Health & Family Welfare 2013). Beyond the traditional approach—given the evidence from the 2005/06 National Health Survey, which found 30 percent of male adolescents to be anaemic—and recognising implications of anaemia for the physical and cognitive development of boys, as well, the IFA programming broadened to include adolescent boys (Dureja 2016a; World Health Organization 2011). Any impact of targeting both boys and girls with this approach has yet to be documented, but it potentially could be, as supposedly both male and female adolescents are monitored for anaemia, though not prior to distribution (Dureja 2016b).To effectively measure impact and build the evidence base for an intervention targeting adolescents, collecting both sex- and age-disaggregated data is critical, as is reporting that information in the literature.

2. Providing guidance on how to integrate gender

The FCDO-funded Technical Assistance for Nutrition (TAN) programme, helps strengthen Scaling Up Nutrition (SUN) Movement country capacity to deliver policies and projects to reduce malnutrition. Its anticipated impact is increased coverage of quality multisectoral plans and interventions that address the underlying and immediate causes of malnutrition. It aims to deliver coordinated technical assistance (TA) to help national SUN Focal Points overcome capacity gaps to design and deliver multisectoral national nutrition plans; improve learning and accountability influencing decision making in the Movement's leadership, networks and national governments; and drive prioritisation of and investment in nutrition. The two TA providers are Nutrition International and the PATH-led Maximising the Quality of Scaling Up Nutrition Plus (MQSUN+), the latter of which also provides similar support to FCDO. Both providers guide their consultants, partners and staff on how to fulfil the requirement to meaningfully, proportionally consider gender in all FCDO investments.

For example, during landscape analysis, Nutrition International consultants use a checklist including gender analyses; noting gender issues in relevant policies, legislation and strategic plans; using data specific to and disaggregated by age and sex or gender; and considering gender roles, norms, power and decision making. It also includes ensuring that, men, women, gender groups and advocates are meaningfully engaged; that gender is discussed as a factor in nutrition; the inclusion of interventions to address gender in nutrition; and that participation barriers are considered.

In addition to such guidance, MQSUN+ also asks its teams to: (1) discuss and document gender considerations during design, (2) share in reports any examples of gender considerations, (3) ensure deliverables appropriately consider gender, (4) provide details during closeout regarding how gender was considered throughout the assignment. MQSUN+ also has conducted a review of gender in multisectoral nutrition action plans. It also prepared this guide.

3. Identifying interventions to address gender barriers

Zambia's National Food and Nutrition Council, along with FCDO, Irish Aid and the Swedish International Development Cooperation Agency, collaboratively developed and funded the first round of the First 1,000 Most Critical Days Programme to address malnutrition in the time from conception to two years old. Interventions included water, sanitation and hygiene practices, IFA and other micronutrient supplementation, promoting infant

and young child feeding and dietary diversity for pregnant and lactating women and promoting local foods. However, gender was not planned as a major consideration until a rapid qualitative assessment at the start of the project identified the need to improve caregivers' knowledge base, access to and availability of local foods and water, sanitation and hygiene practices, all whilst acknowledging women's limited time and complex contextual factors (Roopnaraine and Reeves 2014). Per information from interviewees, subsequently, partners developed a strategy to apply a gender and women's empowerment lens to expected nutrition outcomes and identified a minimum package of interventions to address barriers, including women's time and resource constraints and men's engagement.

4. Measuring women's empowerment

Tools introduced in recent years focus on assessing women's empowerment in areas potentially relevant to nutrition. The US Agency for International Development, International Food Policy Research Institute (IFPRI) and Oxford Poverty and Human Development Initiative developed the Women's Empowerment in Agriculture Index (WEAI), launched in 2012. It looks at input into productive decisions and autonomy in production, ownership and control of assets and access to credit, control over the use of income, leadership, workload and leisure time. Survey data from both men and women in the same households (HHs) in 13 countries provided helpful information, but the survey length made it difficult to use. There were also calls for the inclusion of nutrition. Responding to these requests, IFPRI developed a shorter version known as the pro-WEAI and created a Health and Nutrition module (Malapit et al. 2018). The pro-WEAI added indicators on self-efficacy, domestic violence, mobility and intra-HH relationships (IFPRI 2018). The nutrition-related indicators are control over one's own health and diet, control over health and diet during pregnancy, control of child's diet, control over weaning and breastfeeding, freedom to seek health care, freedom to purchase food and health products and access to food and health products. As this piece is relatively new, it is being tested and refined through the ongoing Gender, Agriculture and Assets Project.

Recently, the Women's Empowerment in Nutrition Index project was funded through a small grant by the FCDO-funded Innovative Methods and Metrics for Agriculture and Nutrition Action. The index defines women's nutritional empowerment as 'the capacity for a woman, and not just her children, to be well-fed and healthy; to have a meaningful say in HH nutritional practices; and to receive support in implementing them' (Lentz 2017). The focus is on women's nutritional status, and the development of the index is led by factors that tend to be overlooked, including domains of food, health, work, structural conditions and institutions. The team is developing and validating the index. Initial qualitative research in Bangladesh showed variation between and within communities and HHs, demonstrating that women often absorb impacts on nutrition which tend to be negative.

5. Leveraging Agriculture for Nutrition in South Asia

Funded by FCDO, Leveraging Agriculture for Nutrition in South Asia had gender and nutrition as one of three crosscutting research themes. The project learned that in some areas women were disempowered to act within food systems, due partially to their reproductive role. Obtaining information through a gender analysis on power, negotiation and decision making around nutrition in the HH is critical for identifying interventions that can lead to impact (Rao 2015). A study in Pakistan focused on how agricultural work impacts nutritional status; women comprised almost 75 percent of the agricultural workforce, and children of mothers engaged in agriculture had higher levels of stunting and wasting (Balagamwala, Gazdar, and Mallah 2015). The researchers examined agricultural work and the nutrition implications for care and consumption amongst women. In looking at women involved in HH food production as well as non-HH cash crop production of cotton, a key finding was the negative impact on health and nutrition of labour linked to cotton. However, the researchers noted variations in impacts due to social norms, which differed by region and HH. In some instances, work in agriculture led to positive nutritional outcomes. For example, working outside of the HH may also offer health gains as women create new social linkages that aid with the uptake of services; as well, it can offer benefits if women earn and keep income. However, this gendered income-earning may be restricted to employment areas in which it is socially acceptable for women to keep and spend their income (in this context, cotton production and harvesting).

6. Incorporating fathers in the Baby-Friendly Community

The Baby-Friendly Community Initiative (BFCI) grew out of the 1995 Baby-Friendly Hospital Initiative in The Gambia as a means to ensure babies continue to be well-fed, primarily through breastfeeding, once at home (CORE Group 2012). It offers support to new mothers, fathers and other caregivers. It has been replicated in Kenya and Cambodia (Ministry of Health Kenya 2016) and, although implementation varies between countries, the BFCI uses a Training of Trainers model in which local extension workers are trained on maternal, infant and young child nutrition and then train a cadre of volunteer community members on these practices. Once trained, the volunteers provide guidance to parents and caregivers, such as spouses and mothers/grandmothers, through personal home visits and targeted meetings. Secondary audiences—including health professionals, the media and community influencers, such as religious leaders—are targeted through community events. Whilst the BFCI is most notably known for its community-based approach, it also demonstrates gender integration, with fathers deemed a key determinant to success, participating in childcare and becoming more interested in family planning (Kimani-Murage, E.W., Goudet, S., Samburu, B., Wangui, C., Njoki, T., Njeri, M., Wekesah, F.M., Muriuki, P., Nganga, R., Adero, D., Griffiths n.d.).

Annex F. Tools

Table 11. Tools indicated in Table 1 on gender integration in the phases of nutrition-related programmes.

Stage	Tools
Design	
Develop a business case	FHI360. 2012. 'Gender Integration Framework: How to Integrate Gender in Every Aspect of Our Work.' https://www.fhi360.org/sites/default/files/media/documents/FHI%20360_Gender%20Integration%20Framework_3.8%20%2528no%20photos%2529.pdf ICF. 2019. 'Demographic and Health Surveys.' 2019. https://dhsprogram.com/What-We-Do/Survey-Types/DHS.cfm. UNICEF. 2019. 'Multiple Indicator Cluster Surveys.' 2019. http://mics.unicef.org/. World Bank. n.d. 'Gender Data Portal.' Accessed December 31, 2019. http://datatopics.worldbank.org/gender/.
Mobilisation and Delivery	
Engage	DFID. 2008. 'The Gender Manual: A Practical Guide.' http://webarchive.nationalarchives.gov.uk/+/http:/www.dfid.gov.uk/Documents/publications/dfid-gender-manual-2008.pdf. Fehringer, Jessica, Brittany Iskarpatyoti, Bridgit Adamou, and Jessica Levy. 2017. 'Integrating Gender in the Monitoring and Evaluation of Health Programs: A Toolkit.' MEASURE Evaluation. https://www.measureevaluation.org/resources/publications/ms-17-122-en/at_download/document. UK Aid Direct. 2016. 'What We Do We Mean by Gender?' https://www.ukaiddirect.org/wp-content/uploads/2016/04/What-do-we-mean-by-gender.pdf.
Conduct formative or baseline studies	Faramand, T, M Ivankovich, and J Holtmeyer. 2017. 'A Guide to Integrating Gender in Improvement.' USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, University Research Co., LLC. https://www.usaidassist.org/sites/default/files/assist_gender_integration_guide_final_aug2017.pdf. Government of Canada. 2019. 'Gender Analysis.' 2019. https://www.international.gc.ca/world-monde/funding-financement/gender_analysis-analyse_comparative.aspx?lang=eng . Integrating Gender and Nutrition within Agricultural Extension. 2018. 'INGENAES Library.' 2018. http://ingenaes.illinois.edu/library/. Malapit, Hazel, Jessica Heckert, Elena Martinez, and Agnes Quisumbing. 2018. 'Using the Project-Level Women's Empowerment in Agriculture Index (pro-WEAI) for Nutrition Sensitive Programming.' https://www.slideshare.net/CGIAR/using-the-projectlevel-womens-empowerment-in-agriculture-index-proweai-for-nutrition-sensitive-programming. People in Need. Indikit. Development: Gender equality webpage https://www.indikit.net/sector/78-gender-equality. Swedish International Development Cooperation Agency. 2015. 'Gender Analysis - Principles and Elements.' https://www.sida.se/contentassets/3a820dbd152f4fca98bacde8a8101e15/gender-tool-analysis.pdf.

Stage	Tools
	USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project. 2017. 'How to Conduct a Gender Analysis.' https://www.usaidassist.org/resources/how-to-conduct-gender-analysis. WFP. 2016. 'Gender and Food Security Analysis Guidance Document.' https://docs.wfp.org/api/documents/WFP-0000019670/download/?_ga=2.177060645.149619650.1545346143-1606769324.1545346143.
Revise log frame & establish monitoring	Bishop-Sambrook, Clare, and Cathy Rozel Farnworth. 2014. 'How to Do Household Methodologies: Gender, Targeting and Social Inclusion.' https://www.ifad.org/documents/38714170/40198517/How+To+Do+Household+Methodologies.pdf/564875ac-af4b-4409-9271-0c90ff464b3b. CORE Group Nutrition Working Group, FANTA, and Save the Children. 2015. 'Nutrition Program Design Assistant, A Tool for Program Planners: Reference Guide.' https://coregroup.org/wp-content/uploads/media-backup/documents/Resources/Tools/NPDA/NPDA-Reference-Guide-April2015.pdf. Danida. 2006. 'Gender-Sensitive Monitoring and Indicators.' Vol. Technical. Copenhagen. http://eugender.itcilo.org/toolkit/online/story_content/external_files/TA_Edu_DANIDA.pdf. Demetriades, Justina. 2007. 'Gender Indicators : What , Why and How ?' http://www.oecd.org/dac/gender-development/43041409.pdf. DFID. 2008. 'The Gender Manual: A Practical Guide.' http://webarchive.nationalarchives.gov.uk/+/http:/www.dfid.gov.uk/Documents/publications/dfid-gender-manual-2008.pdf. ECHO. 2017. 'Single Form Guidelines, Annex SF5 List of Key Results Indicators.' http://echo-elearninghfa.eu/wp-content/uploads/2015/10/single_form_guidelines_final.pdf. FAO. 2014. 'Gender in Food and Nutrition Security Programming: Gender-Sensitive Monitoring and Evaluation for FNS.' Rome. http://www.fao.org/elearning/Course/FG/en/pdf/1240_text_only_1240.pdf. Faramand, T, M Ivankovich, and J Holtmeyer. 2017. 'A Guide to Integrating Gender in Improvement.' USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, University Research Co., LLC. https://www.usaidassist.org/sites/default/files/assist_gender_integration_guide_final_aug2017.pdf. Fehringer, Jessica, Brittany Iskarpatyoti, Bridgit Adamou, and Jessica Levy. 2017. 'Integrating Gender in the Monitoring and Evaluation of Health Programs: A Toolkit.' MEASURE Evaluation. https://www.measureevaluation.org/resources/publications/ms-17-122-en/at_download/document. Global Forum for Rural Advisory Services. 2019. 'Nutrition-Sensitive Extension Library: Gender.' 2019. https://www.g-fras.org/en/home-nwg-library/itemlist/filter.html?fitem_all=gender&moduleId=719&Itemid=3468. IFPRI Agriculture for Nutrition and Health. 2019. 'Gender-Nutrition Idea Exchange.' 2019. http://a4nh.cgiar.org/category/gender-2/gender-nutrition-idea-exchange/. Ospina, Sofi. 2006. 'Using Indicators to Seize the Opportunity for Promoting Gender Equality in Post-Conflict Settings.' In Development Bulletin 71: Measuring Gender Equality, 45. Canberra. https://crawford.anu.edu.au/rmap/devnet/devnet/db-71.pdf.

Stage	Tools
	USAID ASSIST Project. 2015. 'Excel Databases for Improvement.' https://www.usaidassist.org/sites/default/files/sex-disagg_district_databasetemplate_june2016.xlsx. USG Feed the Future. 2018. 'Feed the Future Indicator Handbook.' Washington, D.C. https://www.agrilinks.org/sites/default/files/ftf-indicator-handbook-march-2018-508.pdf. WHO. 2018. 'Guideline: Implementing Effective Actions for Improving Adolescent Nutrition.' http://apps.who.int/iris/bitstream/handle/10665/260297/9789241513708-eng.pdf?sequence=1. Yinger, Nancy, Anne Peterson, Michal Avni, Jill Gay, Rebecca Firestone, Karen Hardee, Britt Herstad, and Charlotte Johnson-welch. 2002. 'A Framework To Identify Gender Indicators For Reproductive Health and Nutrition Programming Prepared.' Washington D.C. https://assets.prb.org/pdf/FramewkIdentGendrIndic.pdf.
Closure	
Evaluate and Research	Moser, Annalise. 2007. 'Gender and Indicators Overview Report.' Brighton. https://www.bridge.ids.ac.uk/reports/IndicatorsORfinal.pdf. UN Women. 2015. 'How to Manage Gender-Responsive Evaluation: Evaluation Handbook.' http://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2015/un-women-evaluation-handbook-en.pdf?la=en&vs=1401. UNICEF and Liverpool School of Tropical Medicine. 2011. 'Guidance on Methodologies for Researching Gender Influences on Child Survival, Health and Nutrition.' https://www.unicef.org/gender/files/Guidance_on_Methodologies_for_researching_Gender_influences_on_Child_Survival.pdf.
Report and disseminate	Women's Empowerment Impact Measurement Initiative. 2012. 'Defining Measurement Elements of the Theory of Change (Part II).' https://insights.careinternational.org.uk/images/in-practice/GEWV/WEIMI-Guide-2012.pdf.

About MQSUN+
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