Ethiopia:
Gender and Nutrition Analysis

Gender and Nutrition Analysis and Action Plan with a focus on Borena Region

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About the Global Nutrition Cluster Technical Alliance

The Global Nutrition Cluster Technical Alliance (GNC Technical Alliance or Alliance) is an initiative for the mutual benefit of the nutrition community, and affected populations, to improve the quality of nutrition in emergency preparedness, response, and recovery. The GNC Technical Alliance Partners are made up of the GNC partners and other individuals, organisations, initiatives, and academia at global, regional, and national levels that hold nutrition technical expertise across the humanitarian and development spheres. The Alliance Technical Support Team (TST) is led by Action Against Hunger Canada and funded by USAID/BHA, SIDA, Irish Aid, UNICEF, and Save the Children.

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Cover photo: Brooke Bauer (2023), Dubluk IDP Camp, Borena, Oromia Region, Ethiopia

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Executive Summary

The 2023 Humanitarian Response Plan (HRP) indicates that 7.4 million people are estimated to need nutrition assistance in Ethiopia. South-eastern Ethiopia where Borena region is located is facing the worst drought in 40 years after an unprecedented fifth failed rainy reason. Severe drought conditions have destroyed crops and dried up water sources, leading to widespread livestock deaths and forcing hundreds of thousands of people to give up their traditional pastoral lifestyle. The current drought is one of the key drivers of increased malnutrition in southern Ethiopia, enhanced by structural factors, including the low levels of education of women and girls, inadequate health infrastructure, a weak economic landscape, low immunisation rates, land policies, and flawed systems of governance.

With regards to gender-based violence, the GBV in emergencies coordination mechanism in Ethiopia has highlighted that the drought and the resulting displacement leave young girls especially vulnerable to sexual and physical violence and coercion, child labour, and early marriage. Cases of intimate partner violence, sexual harassment, assault, and rape have been reported as well. It was suggested that the risk of GBV increases in drought-affected areas as women and girls are forced to travel far distances to fetch water, while in other cases they are often left alone while family members are away looking for food or livelihood.[1]

Gender inequality exacerbates food insecurity, malnutrition, and poverty in humanitarian crises. Despite improvements in several health and development indicators, Ethiopia remains as one of the countries with the highest prevalence of maternal undernutrition.

To address this, the Ethiopia Nutrition Cluster and ENCU requested support from the Global Nutrition Cluster Technical Alliance and UNICEF from March to June of 2023. The aim was to conduct the GNC's first specific gender and nutrition mission by analysing the situation in Ethiopia to identify gaps and opportunities for gender and nutrition and to highlight ways that the cluster, government, and partners best come together across all sectors to address these issues to better improve the situation of women and girls is in Ethiopia. To do this, key informant interviews and site visits were conducted over a period of six weeks.

Key findings were a need for stronger leadership and coordination within gender and nutrition, a focus on resource mobilisation and prioritisation of gender within nutrition programmes, stronger accountability to affected people by nutrition actors, building capacity of gender and GBV risk mitigation for nutrition actors as well as sensitising other sectors on the linkages between gender and nutrition, ensuring meaningful participation of local and national organisations especially women rights and women and indigenous led organisations, and a better

[1] iMMAP and Gender-Based Violence Area of Responsibility Ethiopia (2023) *Ethiopia GBV Secondary Data Review, February 2023*

understanding and response to vulnerabilities especially the elderly, people living with disabilities, and those who have diverse genders.

1. Introduction

Gender Inequality and Nutrition Globally

Despite the international community's ambition of achieving Zero Hunger by 2030, nearly 670 million people are projected to still be facing hunger in 2030.[2] However, this hunger is not experienced equally. Age, gender, disability, and other factors shape individuals' vulnerability to hunger and to its wider impacts. And while access to good nutrition is a basic human right and a fundamental component of human dignity, the prevalence of moderate or severe food insecurity, across all continents, is higher for women than for men.[3]

When crises strike, gender inequalities are often exacerbated and women and girls are overlooked.[4] Increased levels of gender-based violence, exclusion from life-saving services and decision-making processes due to discriminatory social norms, such as food hierarchies, and limited mobility to get help due to physical insecurity take place[5] contributing to reduced life expectancy, higher maternal mortality, morbidity and malnutrition, and increased gender-based violence.[6] The impacts are even more acute for older and indigenous women, gender-diverse persons, persons with disabilities, and those living in rural and remote areas.[7]

Food insecurity is 10% higher among women than among men and globally 8% of adolescent girls and 10% of women are underweight.

Gender inequality and the inability to exercise individual human rights[8] makes women, girls, and gender diverse people more vulnerable to poverty and food and nutrition insecurity[9] caused by shocks.[10] Women and girls often eat less, eat last, and their nutrition needs are often side-lined. Additionally, undernutrition, micronutrient deficiencies and anaemia amplify gender inequalities by lowering learning potential, wages and life opportunities for adolescent girls and women,

[2] FAO, IFAD, UNICEF (2022) *The State of Food Security and Nutrition in the World 2022: Repurposing Food and Agricultural Policies to Make Healthy Diets More Affordable*

[3] FAO (2019) *The State of Food Insecurity and Nutrition in the World*

[4] UNFPA (2023) *Humanitarian Action 2023 Overview* https://www.unfpa.org/sites/default/files/pub-pdf/Humanitarian_Action_2023_Overview_UNFPA-PDF version.pdf.3

[5] OCHA (2021) *Policy Instruction on Gender Equality 2021-2025*

[6] Ibid.

[7] United Nations ECOSOC (2022) *Achieving gender equality and the empowerment of all women and girls in the context of climate change, environmental and disaster risk reduction policies and programmes. Report of the Secretary-General*

[8] FAO (2019) *State of Food Insecurity and Nutrition in the World*

[9] FAO (2011) *The State of Food and Agriculture: Closing the Gender Gap for Development*

[10] WFP (2020) The power of gender equality for food security: Closing another gender data gap with a new quantitative measure

weakening their immunity to infections, and increasing their risk of life-threatening complications during pregnancy and childbirth.

As such, **gender inequality is both a cause and a consequence of malnutrition** and achieving gender equality will not be possible as long as women and girls experience malnutrition at a much higher rate than men and boys.

Despite that, when it comes to humanitarian assistance, gender equality is too often not prioritised, and this inequality becomes a major barrier to equitable access to humanitarian assistance. Humanitarian activities must not be gender blind and instead be equitable and transformative to avoid reinforcing existing inequalities.[11]

Gender, age, displacement status, disability, and marital status are also factors that exposed the population to GBV risks. Gender based violence has a direct impact on nutrition of women, girls, and children.[12] Evidence indicates that a maternal caregiver's experience of intimate partner violence negatively affects breastfeeding practices and is also linked to low birthweight, stunting and severe malnutrition in her children. Women who experience intimate partner violence are less likely to practise exclusive breastfeeding or engage in early initiation of breastfeeding and are more likely to have children who are undernourished.[13]

Added vulnerability and risk that must also be taken into consideration are amongst those with diverse sexual orientation, gender identity and expression, and sex characteristics (SOGIESC).[14] Studies from around the world reveal alarming rates of violence based on SOGIESC. This also is an important consideration when understanding the need and incorporating the voices of local actors with regards to gender, GBV, and humanitarian response.

Global Gaps

Despite all the evidence highlighting the need to prioritise women and girls' nutrition, gaps exist globally. There is a lack of implementation guidance for women's nutrition in humanitarian settings and a lack of a clear decision tool for Balanced Energy Protein (BEP) decision tool for programming for Pregnant and breastfeeding women and girls.

There is a lack of globally agreed upon MUAC cut-off for women, girls, and the elderly. There is also a lack of evidence for options to consider the separate groups such as pregnant women, breastfeeding women, pregnant adolescents, breastfeeding adolescents as there is a stronger evidence base where options to include pregnant women are much clearer.

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[11] CARE International *Gender in Emergencies - CARE Toolkit* https://www.careemergencytoolkit.org/gender/gender-in-emergencies/

[12] UNICEF (2022) *Evidence on the Linkages Between Gender-based Violence and Nutrition: Summary of Findings Specific to Adolescent Girls*

[13] UNICEF (2022) Intimate Partner Violence and Child Growth: A summary of the evidence base

[14] SOGIESC is an umbrella term for all people whose sexual orientations, gender identities, gender expressions and/or sex characteristics place them outside culturally mainstream categories. LGBTIQ+ An acronym for lesbian, gay, bisexual, transgender, intersex and queer.

There is also a lack of agreement and understanding on which existing assessment methodologies already include indicators on women and which indicators these are. There are mixed views on the inclusion of women's MUAC within SMART surveys as it is an optional indicator. The need for the inclusion of women's MUAC as a standard indicator is highlighted by many, as was the case in Ethiopia when it was included in the SMART Plus of this year, it isn't always included.

While localisation has been a focus for humanitarian organisations, engagement with women led (WLO) and women rights organsiations (WRO) has remained a gap. Engagement with WLO and WRO is critical to addressing the needs of women and girls. At the global level, cluster specific tools are being developed to enable/support the meaningful engagement of women's organizations in UNICEF-led/co-led clusters and Area of Responsibility. The tools are intended to be incorporated in the next iteration of Inter-Agency Toolkit on Localization in Humanitarian Coordination.[15]

Ethiopia Policy Landscape for Women and Girls Nutrition

Policy for adolescent girls' and women's nutrition is key to the protection from undernutrition. According to UNICEF only 8% of countries have policies in place that commit to actions and resources to decrease barriers to nutrition diets and essential nutrition services[16]. Ethiopia is within that 8% with key policies for health[17], food[18], and social protection[19] in place.

Recognising the importance of good nutrition, the Government of Ethiopia has made ending malnutrition a national priority. Ethiopia started implementing its first National Nutrition Program in 2008[20] with the second phase of the programme, from 2011 to 2016, focused on a multisectoral approach aimed at accelerating progress in reducing malnutrition.[21] Additionally, Ethiopia's first Food and Nutrition Policy was endorsed in 2018[22], followed the National Food and Nutrition Strategy[23] which was launched in 2021 to provide a framework for the operationalisation of the policy.

More broadly, the Rural Productive Safety Net Programme V (2021–2026) is Ethiopia's largest national social safety net programme aimed to improve nutrition outcomes for participating

[15] https://resourcecentre.savethechildren.net/document/inter-agency-toolkit-on-localisation-in-humanitarian-coordination/

[16] UNICEF (2023) *Undernourished and Overlooked: A Global Nutrition Crisis in Adolescent Girls and Women.* UNICEF Child Nutrition Report Series

[17] Nutrition counselling during pregnancy, iron supplementation during pregnancy, adoption of 2016 WHO antenatal care recommendations

[18] Mandatory salt iodization, mandatory wheat flour fortification, mandatory vegetable oil fortification

[19] Policy/plan/strategy with nutrition components, targets pregnant and breastfeeding women

[20] Federal Democratic Republic of Ethiopia (2013) *National nutrition program: 2013-2015*

[21] Federal Democratic Republic of Ethiopia (2016) *National nutrition program: 2016-2020*

[22] Federal Democratic Republic of Ethiopia (2018) F*ood and Nutrition Policy*

[23] Federal Democratic Republic of Ethiopia (2021) *National food and nutrition strategy (2021-2023)*

women while focusing on working conditions, childcare for return to work, and daily meals and early childhood education. However, despite these significant gains and signs of progress in the last decade, maternal undernutrition remains a major public health problem in Ethiopia.[24]

Ethiopia Gender Roadmap

In 2022, the IASC GenCap project reviewed the functioning of the humanitarian response in Ethiopia with regards to Gender Equality Programming in Emergencies (GEPiE). It does not mention any specific clusters, including nutrition, but provides an overview of gender equality within humanitarian response. It was found that there was a high level of interest in commitment to gender equality programming and outlined opportunities and challenges in leadership, programming, coordination, localization, and accountability to affected people in areas that are achievable in the next 2-3 years.

Within the roadmap inception report a Gender with Age Marker (GAM) Analysis was conducted for all clusters for the 2022 HNO and HRP. Nutrition scored an overall GAM score of 2 meaning that there was overall consideration and response for age and/or disability in key areas, but not gender.

The recommendations within this analysis and action plan correspond with the desired changes outlined within the Gender Roadmap.

The State of Women and Girls Nutrition in Ethiopia

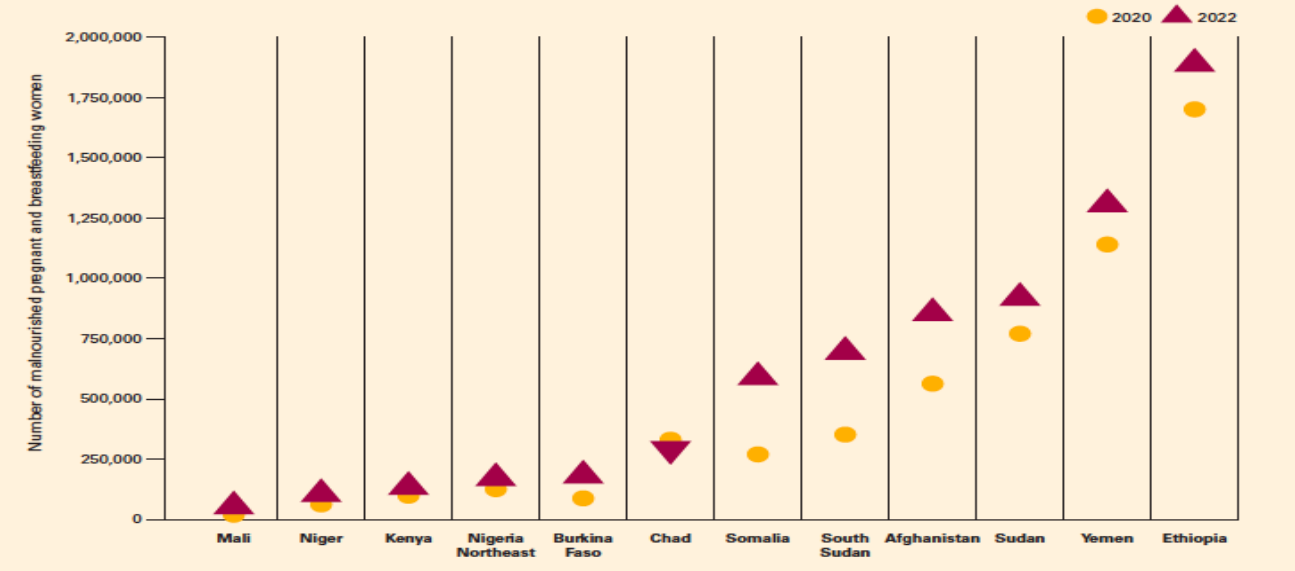

FIGURE 1: **Number of acutely malnourished pregnant and breastfeeding women in 12 countries affected by the food and nutrition crisis, 2020 and 2022**

Source: Integrated Food Security Phase Classification Acute Malnutrition reports; Humanitarian Needs Overview reports; Humanitarian Response Plans; Standardized Monitoring and Assessment of Relief and Transitions surveys; and nutrition and food security surveillance.

[24] Gebre B, et al. (2018) *Determinants of malnutrition among pregnant and lactating women under humanitarian setting in Ethiopia* BMC Nutrition 2018;4(1):11

Women's diets are influenced by various factors, especially food access and affordability, gender inequality and social and cultural norms that may constrain women's ability to make decisions about their nutrition and care. Hence, it is important to know the level of malnutrition for pregnant women and lactating mothers either using BMI or MUAC measurement.

The past consecutive Ethiopian Demographic Health Surveys (EDHS) showed a marginal decline in the magnitude of Chronic Energy Deficiency (CED) among non-pregnant and non-lactating women of reproductive age at 30.5%, 26.9%, 27% and 21.4% in 2000, 2005, 2011, and 2016 EDHS, respectively based on BMI.[25]

When identifying underweight pregnant and breastfeeding women using a MUAC cut-off of < 21 cm the numbers were slightly higher with nearly 25% of pregnant and lactating mothers who were found to have acute malnutrition. [26]

The Ethiopian Food Based Dietary Guidelines (FBDG) recommend that adults consume six food groups in a day. However, overall, very few (0.1%) women of reductive age (WRA) consumed the recommended six food groups in a day.

The prevalence of anaemia among WRA in Ethiopia is 13%[27] and according to the 2019 EMDHS, 40% of women with a child born in the last 5 years did not take any iron tablets during their most recent pregnancy.

Gender Based Violence in Ethiopia

The 2022 HRP noted the disproportionate and gender-specific effects of multiple shocks and compounded crisis on girls and women, and increased risk of mostly unreported and unaddressed Gender Based Violence (GBV) in Ethiopia[28].

The number of people in need for GBV response as per 2022 HNO increased from 3.5M in 2021 to 5.8M spread across the conflict, drought and flood affected regions. In Ethiopia, GBV is highly prevalent with 35% of ever married women aged 15-49 experiencing physical, emotional, or sexual violence from their husband or partner, 68% agreeing that wife beating can be justified and about 65% of women aged 15-49 having undergone FGM[29]. It is demonstrated that girls and especially young women are disproportionately affected by GBV.

[25] BMI <17.0: thinness, BMI <18.5: underweight, BMI 18.5-24.9: normal weight, BMI ≥25.0: overweight, BMI ≥30.0: obesity

[26] Gebre B, et al. (2018) *Determinants of malnutrition among pregnant and lactating women under humanitarian setting in Ethiopia* BMC Nutrition 2018;4(1):11

[27] Government of Ethiopia National Food and Nutrition Strategy Baseline Survey - Key Findings Preliminary Report (2023)

[28] OCHA (2022) *Ethiopia Humanitarian Response Plan*

[29] Ethiopia DHS 2016

The GBV in emergencies coordination mechanism in Ethiopia has highlighted that the drought and the resulting displacement leave young girls especially vulnerable to sexual and physical violence and coercion, child labour, and early marriage. Cases of intimate partner violence, sexual harassment, assault, and rape have been reported as well. The one-stop-center for GBV survivors in Jigiiga, for instance, handled 60 cases of rape during the first quarter of 2022. It was suggested that the risk of GBV increases in drought-affected areas as women and girls are forced to travel far distances to fetch water, while in other cases they are often left alone while family members are away looking for food or livelihood.

Within Ethiopia, lifesaving interventions are in place and there is a focus to strengthen access to multi-sectoral GBV services in One Stop Centers (OSCs)[30] through support of entry points such as safe spaces for women and girls and mobile health and nutrition teams. However, there are still gaps.

The 2023 HRP prioritises a multi-sectoral response approach to GBV response includes GBV case management, Psychosocial Support (PSS), integrating Sexual Reproductive Health, and referrals to specialised health services such as Mental health, and to safe houses while targeting support to areas of high return, displacement, and vulnerable host communities, including the drought and flood affected areas through increased participation of local/national actors.

The ENCU recognised the gaps between gender and nutrition and in the 2023 HRP called for a multi-sectoral coordinated effort to improve nutrition within the communities. Specifically, the Nutrition Cluster prioritised maternal nutrition and close coordination with the Health Cluster as well as close coordination with affected people, local and national actors to for a comprehensive gender approach.

Women and Girls Nutrition in Oromia Region, Borena Zone

In Ethiopia, three years consecutive shortage of rain has resulted in a critical drought. As a result, all communities lost their livelihood that was based on livestock and its products. Grain supply to market is also affected as terms of trade are seriously deteriorated. On top of this, there is the fear of cholera due to lack of clean and safe water. The sum up of all those factors compromises the food security and nutrition situation of the communities and may lead to critical situations.

In the 2023 SMART Plus survey from Borena Region of Ethiopia all women aged 15-49 years were measured using MUAC to estimate level of malnutrition by using national level cut off point for MUAC of 230mm. Prevalence of MUAC malnutrition in non-pregnant, non-breastfeeding women was 46.8% while prevalence of MUAC malnutrition in pregnant and breastfeeding women with an infant less than 6 months was 43.5%. Compared to the 2016 rates among non-pregnant or breastfeeding women of 21.4%, this indicates an alarming situation. According to the SMART Plus

[30] One Stop Centers offer a holistic set of services ranging from health, psychosocial support, legal and police services to GBV survivors under one roof and free of charge.

non-pregnant, non-lactating women were more vulnerable than women who were pregnant and breastfeeding an infant less than 6 months. In Borena culture, mothers giving birth were treated in special cases for the first 49 days after birth. This may reduce the vulnerability of pregnant and breastfeeding women over non-pregnant and breastfeeding women.

Borena Zone has been seeing a dramatic increase of malnutrition in pregnant and breastfeeding women.

In Dubluk stabilization center the number of women treated in February and March of 2023 is nearly five times higher than the same time two years ago with an increase from 297 (2021) to 900 (2022) to 1450 (2023).

The Nutritional Causal Analysis (NCA) that was undertaken for Borena zone, Oromia region in 2016 points to major risk factors for malnutrition such as women's heavy workload, low food intake of mothers during pregnancy and lactation, low rate of exclusive breastfeeding under six months, practice of prelacteal feeding[31] and inadequate access to safe drinking water[32].

When women's workload is the highest, a mother is less available for her children, which has an impact on feeding practices as well as on children's stimulation. In addition, excessive energy expenditure in the absence of increased caloric intake can result in poor maternal nutritional status.

Additionally, in Borena, due to tradition, the intra-household food allocation disfavours women: children eat first, men second and women eat the leftovers if any. The diet of Borena was based on animal milk, maize, and beans, which was completely disrupted as a result of the drought.

In March of this year ENCU sent out a Call to Action[33] that calls attention to the deteriorating nutrition situation of the pastoral and agro-pastoral people in Borena. It highlights results from the SMART Plus stating that, "The need for wasting treatment in children has increased by 40 percent and the needs for undernourished pregnant and lactating women had doubled." It called for a rapid, integrated, and comprehensive response to avoid a growing and critical situation of malnutrition for women and children.

[31] The World Health Organization (WHO) defines prelacteal feeding as any fluid given to a child before breastfeeding starts, generally within the first three days after birth

[32] Action Against Hunger (2016) *Link NCA: Ethiopia Borena Zone, Oromia Region*

[33] ENCU Nutrition Cluster (2023) *Borena Call to Action March 2023*

2. Gender and Nutrition Analysis

As a result of all of the crisis, the ENCU and the Ethiopia Nutrition Cluster requested support from the Global Nutrition Cluster Technical Alliance and UNICEF to provide technical assistance by conducting a Gender and Nutrition Analysis from March to June of 2023. Within this period, a joint mission between the GNC Technical Alliance and UNICEF was undertaken from April 23 to May 7 to support the articulation of GBV risk mitigation related elements in the situation analysis and action plan.

Methodology

To ensure that a holistic, multi-sectoral analysis was conducted it was important to incorporate several methods including desk reviews, interviews, community consultation and participatory activities from national to regional level.

The analysis began with a desk review and bi-lateral meetings with key stakeholders to support the development of the mission. Consultation and key informant interviews were then conducted with 14 stakeholders from 11 agencies including the government, national NGOs, INGO, UN and donors. The first site visit to Borena was conducted from April 18 to 20th where two focus group discussions were conducted with community members in Dubluk IDP camp. A multi-sector action planning workshop with 22 participants representing 16 organisations including local and national actors, UN, INGO, and donors was held on April 25th in Addis Ababa. Participants were experts across multiple sectors including gender, nutrition, assessment, food security, and protection.

The second site visit to Borena was conducted 1 to 4th of May during a **joint mission between the Global Nutrition Cluster advisor and the UNICEF Gender-based Violence in Emergencies specialist**. During that visit, on May 3, a regional action planning workshop was held with 14 participants from 12 organisations including national NGO, INGO, and UN. Additionally, during the regional visit community consultations and participatory sessions were held again in Dubluk IDP camp where women were consulted to identify accountability and feedback methods, understand the responsibility of their daily lives, and needs that they have.

Site Visits

Site visits were conducted to the Yebello General Hospital Stabilization Center, the Dubluk Stabilization Center, and the One Stop Center at Yebello General Hospital. These visits were led by staff within the facilities and, apart from the One Stop Center where there were currently no patients in the facility, opportunity was given to speak with the families who were using the centres.

Engagement and leadership from local and national NGOs

During the analysis it was particularly important to ensure the input and leadership from local and national actors, specifically with NGOs that are women and indigenous led.

Engagement and leadership from communities

Community input and leadership was also especially important throughout the process. A key aim of the mission was to ensure that the lived experience of those directly affected by the crisis and subsequent humanitarian response led to the direction of the analysis.

3. Gender and Nutrition Analysis Key Findings

During the analysis of key informant interviews, bi-lateral discussions, and community consultation key themes were outlined and are described below.

National Level Bi-lateral discussions and KII Key Themes

Over three weeks during April, 14 multi-sectoral stakeholders from 11 agencies including the government, national NGOs, INGO, UN, and donors were consulted for bi-lateral key informant interviews. The interviews were unstructured, and the direction of the interviews was led by the interviewee to allow for personal experience and perspective to be the core of the discussions.

Challenges were identified with regards to gender and nutrition. The themes underscore experiences where humanitarian response lacks in understanding and coordination where women's ability to access impactful services and support is hindered.

Gender transformative programming: The humanitarian response must work harder to have a better understanding of gender roles and division of labour and develop programmes that are informed and led by affected communities.

Societal roles came up in all interviews as a challenge for the humanitarian response. Respondents discussed that there is a division of labour in the household that puts heavy responsibility on the women and girls. The respondents also highlighted barriers for men to participate in household activities due to social norms. This included discussion of preference for men and boys within feeding practices creating additional workload on

women as the person within the home who is responsible for the food planning, shopping, and preparation but with the husbands or men in the household responsible for the control of the household resources.

However, when asked about programme implementation such as Family MUAC, IYCF programmes such as breastfeeding or complementary feeding education and who is the focus of these programmes for the humanitarian response, all respondents answered "the mother" which highlights perpetuating the social norms rather than working with the whole family unit to support the mother.

There was an identified need for the integration of father support groups and outreach from multiple partners. Interviews highlighted that identification and screening for malnutrition (in the form of Family MUAC) was the main responsibility of the mothers and there was a need to include all family members in the training and outreach for this activity. It was also noted that the father's engagement into programming must be more integrated into nutrition programmes to reduce the burden and workload on the mothers.

Gender balance, localization, and leadership in humanitarian response: Leadership from women and indigenous led and women rights organisations should be prioritized and have a key role in the humanitarian nutrition response.

A gap within leadership from women and locally led organisations within humanitarian response as well as the lack of balance among frontline staff was noted by multiple partners. Partners noted that women led organisations are not used in the capacity as experts as they should be and that the inclusion of local actors, especially women rights or women led organisations, is more of a checkmark on paper rather than meaningful engagement.

Safer Programming: A holistic approach to GBV risk mitigation needs to be in place and safer programmes should be prioritised and implemented across the board.

The incorporation of Safety Risk Audits and GBV Risk mitigation programmes within nutrition programming was highlighted as well as the need for capacity building and understanding from all partners on roles and responsibilities for GBV programmes.

Interviews highlighted the need for further engagement and clear direction from the GBV AoR. There was a lack of knowledge on referral mechanism, service mapping, understanding of services for survivors and lack of trained staff in disclosures and referrals.

It is important to note that in one consultation with three UN humanitarian actors whose work focused on access, there was discussion on the belief that false disclosures of GBV

were reported by women with the purpose of accessing cash and benefits such as better housing and that the humanitarian response shouldn't be so generous to those who disclose experiences of GBV. This is a harmful and gender-negative narrative and indicates a need to ensure that at all levels GBV sensitization is included to all humanitarian responders.

Accountability: There is a clear need for stronger accountability mechanisms and understanding of accountability beyond just feedback mechanisms. Nutrition partners must engage in meaningful dialogue with affected communities.

While there has been a focus on implementing more comprehensive accountability and feedback mechanisms from the AAP taskforce and much has been done in a short time, partners still felt that the nutrition response had a clear gap in this area this included coordination among partners for AAP, community consultations and site visits outside of distribution monitoring to engage with the community and directly hear feedback, and the inclusion of vulnerable persons who have diverse Sexual Orientation, Gender Identity, and Gender Expression (SOGIE) within the vulnerability criteria. Humanitarian partners noted the lack of inclusion of local NGOs within the accountability work that is being done as well as a lack of engagement with the field level response from partners in Addis.

Leadership and Coordination

A lack of understanding of gender considerations among humanitarian actors was noted and a lack of coordination to address this was highlighted. Respondents mentioned that there was a need for technical support to partners with regards to gendered approaches and guidance on response. There was a noted need for monitoring and reporting capacity support and leadership among humanitarian coordination specific for nutrition and gender. A need for technical guidance for the nutrition cluster specifically was noted to fully understand the issues and implement appropriate programmes.

Addis Action Planning Workshop

Workshop participants in Addis Ababa creating action plans.

During the action planning workshop, the above themes from the KII were presented to the workshop participants. The workshop had very strong representation of women led, women's right, and indigenous led organisations. In that, a discussion of additional experiences of workshop participants occurred and additional input on the highlighted themes was noted.

Localisation

The lack of coordinated engagement was strongly agreed with and the need to have a meaningful relationship with women led, women rights, local NGOs was highlighted. It was stated that the

most common mode of engagement is one of implementing partners rather than reciprocal experts and leaders.

Social norms

Participants took time to discuss the social norms within which they work and the challenges that this brings. They noted that women are not entitled to food production leaving additional vulnerability for women headed households, single women, and widows. There was also a discussion on a need for better understanding on how the household consumes food and what practices are in place in the various contexts within Ethiopia.

Participants noted that women are expected to care for the home and men are income generating. It was identified as a challenge as it can be seen as an issue if men care for the children and that programmes must work with families to fully understand this dynamic and to ensure the programmes that are implemented are transformative in nature and led by community input to be accepted and appropriate.

Poor access to food is related to gender inequality and gender norms. Participants noted that women prepare food but aren't able to always access or eat it.

Multiple shocks

Nutrition interventions must consider the impact of multiple shocks on women and their nutritional status and the effect that it has on their care practices. Displacements, drought, impact on women and girls, resilience implications should be better explored and understood.

Religion

Religion is an important consideration that is often overlooked. Participants noted gaps within current knowledge that should be explored more such as the weight of religious leaders to change attitudes and behaviours and the incorporation of religious leaders in the nutrition response. It was stated that there is an important role for religion within the humanitarian response, but it must be done with understanding for vulnerability and inclusivity.

Training and sensitization

At the national level it was recognized that training and sensitization on the linkages between gender and nutrition was lacking. It was noted that this is also the case for frontline workers and health extension workers at the regional level. Local orgs should lead and be supported alongside international orgs to lead these trainings.

Borena Focus Group Discussions

> **"The tents are getting older. There is no protection from the cold. Many of us are very old. All of our livestock have died because of the drought. They call us displaced people. We are not displaced. We are strong pastoralists. But we are in trouble."**
>
> ***-Community member Dubluk, Borena zone***

In Borena two focus group discussions were held in Dubluk IDP camp. The first discussion was held with 6 women whose ages ranged from 43 to 70. All participants had a three or more children. The second was among 7 men whose ages ranged from 35- 80 as with the women, all with multiple children ranging from infant to adult.

Focus group discussions were semi-structured (*see Annex A*) and allowed for participants to direct the conversation where they were the most comfortable. The discussions took place in a classroom within the camp, however due to the lack of women translators, there was a mixed gender context which likely created barriers to openly discussing some of the gender dynamics. Nonetheless, conversations were robust.

When asked if they had ever had the opportunity to provide feedback to humanitarian responders all participants stated that they had not had anyone conduct feedback sessions previously that they could remember and that the only feedback that they have been engaged in the past were post-distribution surveys where they were asked what was given but not asked in what way was it appropriate, or asked what any additional needs there might be.

Women: The key themes from the discussion with the women were dignity, household responsibility, and accountability of humanitarian actors and the appropriateness of the response.

> **"As women we are suffering a lot."**
>
> ***Community member Dubluk, Borena***

The women stated that food is not available to them other than what is distributed which is a mixture of powdered corn and wheat meal. They stated that this was not edible for the elderly, and it was not appropriate as a complementary food for the children. The participants highlighted that they noticed that both the elderly and young children within their community were very malnourished and stated that it was because the food that was distributed was not appropriate for either food group. In addition to highlighting the appropriateness of the distribution it was noted that distribution was not regular and the amount that is distributed is not enough. They stated that the men within the community would divide and prioritise distributions amongst the community members to

address this. Culturally they stated that pregnant and breastfeeding mothers are given good care with priority given for food and rest, this is not possible given the current circumstances.

A shelter in Dubluk IDP camp

A central point of discussion focused on shelters and the lack of privacy and protection that they provided. Shelters were not weather-proof, tarps were weathered and torn, recent rains were going into the tents and families stated they were having to move to share shelters with other families, a move that put women and girls at risk of GBV. It was noted that the shelters were not appropriate for breastfeeding especially at night as it was cold and offered no privacy.

They discussed the difficulty of elderly women in the camp and the lack of support that is available for them. They said that there is a lack of specific services, lack of appropriate humanitarian response, and lack of protection.

There are many unaccompanied children and while community members support the children it is difficult. School was an additional concern and respondents stated that while it was available it was overcrowded. And while mobile health teams and health extension workers were available; there were not as many women as men health workers available to the community.

Women are responsible for gathering firewood, water, and going to the market if available. This heavy workload away from the home requires women to leave children with neighbours when collecting water or firewood for long periods of time.

Substance use among men, mainly a type of homemade alcohol, was also noted and there was no support available for this within the camp. The women noted that men would use the money given from humanitarian organisations to buy this alcohol, sometimes instead of food for the family.

Men: The key themes surrounded distribution of resources, livelihoods, and returning to their homes.

> **"We are pastoralists, but we have nothing to farm here. Even if it rains, we still can't farm."**
>
> ***Community member Dubluk, Borena***

Men spoke about their key role in livelihoods and income generation and how with the drought this was now gone. They stated that it affects their mental health and role within the community.

Men reported mental health consequences and concerns in the community and stated that there were reports of people ending their lives in the camp. They stated that they were unaware of any specific mental health resources available to them. Substance use was also discussed amongst the men saying that some of the men were using this as they had nothing else to do during their day.

Men reported that women were responsible for the childcare and domestic tasks, the responsibility of the men was the livestock and livelihoods, but this is not possible any longer.

The men highlighted the deterioration of the shelters as one of their main concerns. The tents are cold, the rain comes into the shelter, they are not large enough for the number of people inside the shelter and it is just generally not adequate.

Water was previously accessible from water trucks but since rain began the trucking stopped. Now the men reported drinking surface water that women gathered.

Distributed grain in Dubluk IDP Camp

Food distribution is not adequate. It's not enough. Some people are receiving it and others are not. The men reported that it was their responsibility within the community to prioritise and distribute what is being distributed. The culture in Borena is one of sharing and this is a focus for the community and the men reported that this mode of distribution is accepted by the community. Old age and disability was highlighted as a specific vulnerability for these distributions as they are populations that are overlooked.

The children do not have enough or appropriate clothes to wear, which is a barrier to going to school.

Participants highlighted the need for livelihood programmes. They require not only the livestock but the tools for farming as well as they don't have these any longer. If they had the tools and livestock, they would return to their homes.

Service Provision

Yebello General Hospital Stabilization Center

Families reported that fathers weren't always able to stay with the mothers and this caused an issue as there was no food provided aside from powdered corn and wheat meal which was meant to be taken back home rather than prepared on site.

Staff were concerned about the dramatic increase in SAM cases and the lack of resources available as stock was insecure. In Yebello, F75 was given by UNICEF but F100 was supplied by MSF.

Bottles, a cause of diarrhoea due to the inability to clean and sterilise, were used by many families at the centre.

Distributed grain in Yebello Stabilization Center

Dubluk Stabilization Center

Dubluk Stabilization Center

Staff highlighted a lack of resources available. There was a lack of staff and a large increase of cases in the last two years.

Within the centre, adolescent girls were staying with mother and siblings to provide support meaning that they were missing school. No food was provided to families who were in the centre, which was a concern for staff as they had no support available for this resource.

One Stop Center: Yabello General Hospital

Frontline nutrition workers stated that there was no clear referral pathway from community level to the one-stop centre and that they did not know exactly the steps for a referral.

Staff within the centre highlighted that greater collaboration is required. They saw 70 GBV cases - past 9 months. They had a lack of dedicated human resources and operational funds. There was misunderstanding on exactly what was GBV and definition seemed limited mainly to rape.

Yebello General Hospital One Stop Center

Community Consultations

A participatory community consultation exercise was held in Dubluk IDP camp where the Clock Exercise was used (*see Annex B)* to lead the conversation. The aim of the exercise was to center discussion around the clock exercise and the participants led discussion into a more general conversation on their daily workload outside of the exercise. Women who had children under five years of age were invited to participate in the exercise. In total fifteen women participated in the exercise.

The exercise was held outside under the shade of a tree and a translator who was a woman who was a health extension worker. Health extension workers and colleagues who were men were asked to help keep the group private from men and children by providing crowd control during the time of the consultation.

Clock exercise

Women stated that they woke up before the sun came up to begin to prepare food for the family. This involved gathering water for cooking. They fed their husbands and children first before taking their own meal.

Clock exercise in Dubluk IDP Camp

Women were then responsible for gathering firewood, although they stated that women with infants under six months were exempt from this task and they stayed home with their children and other women gathered firewood for them. Women who were gathering firewood left their children with other women who remained in the camp. Husbands remain at home, sometimes sleeping. Men would use a donkey and cart when they were required to carry heavy items but the women generally didn't use this. They would carry the bundle sometimes very long distances and up large hills back to the camp.

With regards to water collection, women generally walked one hour a day to collect water. This was the responsibility of women and girls within the camp.

4. Action Planning Workshops

Two action planning workshops were held. Within these workshops a general overview of gender and nutrition was given as well as an overview of GBV risk mitigation tools that are available to partners. The first workshop was held in Addis Ababa and then verified in the workshop in Borena where participants identified actions that they saw as a priority.

It is important to note that participants in both workshops included GBV resource mapping. It was discussed that this had already taken place and was the responsibility of the GBV AOR rather than nutrition actors and should be shared by the GBV AOR. Mapping documents were shared with workshop participants in both national and regional workshops.

The aim of the action plans was to identify five or six key, concrete multi-sectoral actions to implement that would improve the gender and nutrition situation over the next year.

National: Addis Ababa

Participants in the workshop worked together to identify opportunities that they could leverage and build the actions on. The goal then was to cost the plan for implementation. As the participants were not able to fully cost the actions, this is recommended to be completed by the nutrition cluster.

Gender and Nutrition Action Planning								
Goal: Improve nutrition outcomes for women, adolescent girls, and children through integrated, gender transformative nutrition programmes								
Action Description	**Lead Agency**	**Date to Begin**	**Review Date**	**Completion Date**	**Technical support needed**	**Funding required**	**Possible Barriers and challenges**	**Indicators**
Assessments								
Incorporate gender in nutrition assessments	• ENCU/Nutrition Cluster	July 2023	August 2023	Sept 2023	• GNC, UNICE • Goal Gender	Funding for three months support	• Availability of participants	• Tools developed/revised/used

Adapt assessment tools Review and agree on gender and nutrition assessment methodology	• NISTWG				Focal Point • WFP		• continuous tech support • emerging emergency • funding	• Number of gender inclusive assessments conducted
Advocacy								
Resource mobilisation to implement recommendations Identify global events, campaigns	• ENCU/Nutrition cluster • SAG • Nutrition Partners	October 2023	November 2023	December 2023	• Remote support from GNC • collaboration with other clusters • CLA • OCHA	• Funding needed for meetings • campaign visibility • funding for events	• Seasonal limitations • rainy season • political dynamics and will power • conflict of roles and responsibilities	• # of funding committed and secured • # advocacy events conducted • # partners participated • # of community participated
IEC/BCC Material								
Develop Key Messages IEC Material Development	GBV AOR, ENCU/Nutrition Cluster, MOH, Local and national orgs	July 2023			• GNC • SBC Colleagues	180,000 USD	Literacy rate	# Number of material distributed
Capacity Building								
Capacity Assessment Training package	UNICEF, FMOH, consultant to lead, GBV AOR	June 2023	December 2023	June 2024	ENCU/Nutrition Cluster	• $20,000 consultant • $30,000 training	• Budget • Competing priorities	• # training modules developed

developed for gender, GBV and nutrition						material development • 50,000 implementation		• # ToT trained actors • # trainings conducted
Sensitization sessions for non-nutrition actors								
National level training on Gender, GBV, and nutrition								
Regional level training on Gender, GBV, and nutrition								
Training for affected communities on nutrition education, income generation, and women empowerment	CSO, ENCU, GBV AOR	June 2023		May 2024	MOH, Protection Sector, Labour and Skill Office	$80,000	• Funding barrier	# of individuals trained
Management of Maternal Malnutrition								
Institutionalisation and implementation of maternal acute malnutrition management (wasting)	UNICEF, consultant	June 2023 preconception	August 2023 workshop	December 2023 work plan development/implementation	Wasting GTWG	• 20,000 consultant support • $50,000 roll out trainings	• Funding • Household food insecurity	• # of SAM mother treated by RUTF • # tools developed • # mothers attending PD Hearth for mothers
Advocacy and consensus								

building workshop								
Supply RUTF to mothers (alternative for MAM Mx)								
Cooking demonstrations for mothers using PD Hearth approach								
Prepare implementation tool (MAM)								
Start implementation based on consensus								

Regional: Borena

Within the Borena regional workshop priorities were discussed that linked with the national level action plan. They are outlined below. A strong focus of resource mobilisation emerged from partners. They noted they did not have enough funding, enough staff, enough resources, and enough technical support. Participants also noted a need for resource mapping and clearer referral mechanisms including transportation responsibility for referrals. When mapping services the locations were indicated by a latitude and longitude rather than the name or location of the facility where the services were located, which was difficult for frontline workers to use.

Gender and Nutrition Action Planning	
Goal: Improve nutrition outcomes for women, adolescent girls, and children through integrated, gender transformative nutrition programmes	
Action Area	**Activity**
Coordination	Identify an actor to lead on action plan within Borena
	Coordinate more closely with women and child affairs
	Strengthen nutrition cluster capabilities on GBV risk mitigation including training of frontline nutrition staff/partners on how to safely receive GBV disclosures
Assessment	Review all assessments to ensure SAAD incorporated into all assessments
	Conduct assessments to better understand food consumption and feeding practices
	Conduct Availability, Accessibility, Acceptability, Quality (AAAQ) assessments with communities
Capacity Building	Understand capacity of nutrition workers on GBV
	Implement on the job coaching
Programme	Implement cooking demonstration
	Identify best practices for Gender, GBV, and nutrition
	Strengthen MHPSS response within nutrition support
	Strengthen referral mechanisms
Resource mobilisation	Work with organisations to ensure that resources reach regional level
	Require technical support for disability from Addis level

5. Analysis

There were key areas of focus that became apparent during the analysis.

- Leadership and coordination
- Resource mobilisation and prioritisation
- Service Provision
- Accountability
- Capacity
- Localisation
- Vulnerability

Leadership and Coordination

There is a lack of understanding of GBV risk mitigation tools and services available for GBV survivors indicating a need for stronger engagement with the GBV AOR and need for sensitization and training on gender and GBV risk mitigation.

It is crucial to recognize that according to the IASC Gender Policy and its accountability framework, all humanitarian actors and leadership should have a minimum understanding of gender equality, GBV risk mitigation and the empowerment of women and girls in humanitarian action. It is important to emphasise this requirement to ensure that gender analysis and gender equality humanitarian programming are not neglected due to the lack of dedicated gender expertise or weak leadership.

Also, a lack of guidance on integration at ICCG does not allow for consistent and quality gender needs analysis and programme design. While the ICCG has gender focal points identified for each cluster, there seems to be a lack of guidance in how to use the focal points.

As meetings and TWGs are already abundant and heavy within the coordination system, there is a hesitancy to recommend another focused on gender and nutrition. However, if partners identify that there is capacity with regards to time and workload this might be an appropriate measure. Alternatively, inviting gender focal points, especially from local women led and women's rights organisations, to join the nutrition TWGs and share their expertise in the cluster meetings would be greatly beneficial.

Resource Mobilization and Prioritization

As the Gender Roadmap Work Plan is being developed and there is a call for budgetary contributions to implement the gender road map work plan, perhaps it may be more strategic to prioritise the costing and resourcing of the nutrition-specific action plan and then nutrition cluster can report its activities/accomplishments as counterpart to this gender road map.

Another approach may be to explore the feasibility of topping up funding for selected activities such as conducting assessments in all regions considering practices surrounding gender and nutrition in close collaboration with local women led and women rights organisations and working closely with the communities to develop a deeper understanding of vulnerability and need.

Service Provision

Resources are lacking for dedicated GBV staff in facilities and operational costs and referral pathways are unclear.

Families receiving inpatient treatment for SAM do not have food provision while in the facility.

Accountability

While accountability systems are in place with the AAP taskforce and integration into sectors, it remains weak within the nutrition response. Community members stated that they had never been consulted on their opinions, experiences, or feedback and were rather only asked questions related to distribution monitoring. It is important to not only rely on feedback mechanisms, but rather to truly engage and consult with women, girls and vulnerable groups.

There is also a lack of clarity regarding the specific strategies to address the gender dimensions of accountability to affected people and community feedback and complaint mechanisms among nutrition actors.

Developing safe and anonymous feedback mechanisms for vulnerable people including the elderly, people living with disability and people with diverse sexual orientation, gender identity and expression, and sex characteristics is needed to ensure that all people are included within the nutrition response. Within accountability mechanisms it's important to foster accountability while preserving confidentiality, especially with those who are extremely vulnerable like women, girls, and diverse and marginalised people.

When setting up accountability mechanisms conducting preliminary needs assessments to support the establishment of formal or informal peer support groups or using existing peer support groups within nutrition programmes to determine how humanitarian actors can support vulnerable people the most. Using these support group networks can also be helpful for working with community members to develop protocols for urgent cases, emergency situations, and imminent immediate threats faced by women, girls, and other vulnerable people, and setting aside funds to carry out these protocols.

Capacity

Key informant interviewed revealed a lack of capacity for gender and GBV risk mitigation amongst nutrition programming staff. There is a strong appetite for capacity development and integration for gender and GBV risk mitigation into programming,

Localisation

Women's rights and women and indigenous lead organisations are often the first to respond to the needs of their communities when a crisis occurs and within the nutrition cluster these local partners focus on women, girls, and other marginalised groups. However, it was highlighted within interviews that they are not fully included in decision making spaces, leadership, and funding opportunities. This undermines the effectiveness of humanitarian action and slows impact. In the national level workshop women rights organisations were strong with their expertise and experience. It is key to draw upon this to have a transformative impact on the nutrition of women and girls. Additionally, by having meaningful inclusion of women led and women's rights organisations in assessments and capacity development or other nutrition actors we ensure greater insight into what is contextually appropriate and risk reducing for women and girls. Additionally, with this inclusion humanitarian response is led by local leaders and strengthens community trust and by in.

Vulnerability

It is important to include data gathering on gender, age, and disability and to ensure interventions take into consideration distinct vulnerabilities and are appropriately designed. The community highlighted strong concern about the nutritional status of the elderly community members as well as a lack of support for people living with disability. Also discussed within the key informant interviews is the inclusion of people with diverse sexual orientation, gender identity and expression, and sex characteristics (SOGIESC).

6. Recommendations

Looking ahead it will be important to ensure to **leverage the already strong interest** and buy in for partners across all sectors and levels. This **multi-sectoral approach** will be required to develop the intersectional, cross cutting response that is required to improve the nutrition of women and girls. Continued **strong collaboration with the GBV AoR and Child Protection AoR** will make this possible.

Develop **integrated national nutrition guidelines for pregnant and lactating women** and **infants under 6 months** based on global guidelines.

Review and finalise the action plan and identify regional action plans and priorities.

Ensure **resources and funding reaches regional levels** and coordination with regional actors is strengthened.

Train frontline staff of nutrition partners on how to **safely receive disclosures of gender-based violence**. In collaboration with UNICEF, ICCG, GBV AoR and Child Protection AoR, **ensure that all nutrition staff have the up-to-date information on available GBV services**.[34] This may include information about available transportation options that GBV and/or Child Protection partners may provide for GBV survivors.

Nutrition cluster to lead conduct learning around **assessments and safety audits** for nutrition partners with the support of UNICEF, WFP gender and protection focal points and cluster responsibility, and gender focal points within local and international NGOs.

Nutrition Cluster to ensure that funding and budget are identified for trainings for nutrition cluster partners and **nutrition partners ensure** identify funding through **fundraising and inclusion of gender and GBV risk mitigation in organisational budgets**.

Roll out **training on GBV Risk Mitigation and the AAAQ framework** to all partners as well as sensitise all clusters on the cross-cutting nature of gender and nutrition.

Ensure **ongoing discussions and consultations with community members**. Train and engage women from the community to work in a meaningful way within nutrition programmes in the camps and settlements.

Ensure that nutrition partners are **gathering Sex, Age, and Disability Disaggregated Data (SADDD)** and that this is incorporated into the nutrition cluster's reporting and monitoring and evaluation mechanisms.

Within programming partners to **target fathers for nutrition education and programmes**, including Infant and Young Child Feeding, Family MUAC, and cooking demonstrations.

Conduct **consultations with communities** on project design. Work to identify the barriers that women, girls, and marginalised and vulnerable groups face.

Meaningfully engage with, learn from, and **ensure leadership from local women rights organisations and women and indigenous lead organisations.**

[34] · The GBV Pocket Guide - our main resource on orienting non-GBV actors on how to safely receive GBV disclosures - has been translated into Amharic.

Ensure that actors from **women rights and women led organisations have a clear voice and space within both the TWG and cluster meetings**. Ensure ongoing discussions and consultations with women led and women rights orgs.

Look for local and regional **advice and consultation from people and organisations leading in people with diverse SOGIESC** to ensure the humanitarian response is being accountable and not perpetuating the vulnerability of specific groups.

Review and develop nutrition assessments through a gender lens. Conduct comprehensive qualitative assessments developed with communities to understand more in depth the needs of women and girls in the community.

Grow a deeper **understanding of all vulnerabilities with respect to nutrition** including elderly and people living with disability by working with local and national actors to conduct analysis, assessments, and community discussions.

Ensure to have a **gender person included in the IYCF TWG and nutrition cluster meetings.**

Annex A: Focus Group Discussions

Oral consent was received from all participants for the focus group discussions prior to beginning the discussion.

The FGD was semi-structured and focused on daily life, division of labour, humanitarian response, nutrition, and services for GBV survivors.

Daily life
Please describe your daily life.
What are your main responsibilities during the day?
Please describe your environment; access to water and firewood, the camp setting, services available.
Can you describe some of the services available to you? Have they changed recently?

Division of labour
Who is responsible for the nutrition of the family?
Who is responsible for food and resources associated with nutrition?
What can a woman's family do to help her in the household? Who is usually the most helpful?

Humanitarian response
What kind of aid do you receive?
Do you feel that anything is missing?
Have you been asked for your feedback before?
What can humanitarian organisations do to improve the situation?

Nutrition
Who is responsible for keeping the family healthy?
How do we keep the infants healthy?
What are the babies generally fed?
What does a pregnant woman do to stay healthy?
What do women generally eat and when? Does this change at all in her life? During pregnancy? With age?
What happens when a woman isn't healthy in pregnancy?
How much rest does a woman get after birth? Has this changed recently?
What can be done to improve the nutrition situation?

GBV
Are people vulnerable to violence? Who?
How do people protect themselves against violence?

What services are available for people who experience GBV? Where are they located? What barriers are there?

Annex 2: Community Consultation Overview Daily Clock Exercise

Purpose of the Activity
The Daily Activity Clock activity illustrates all the different kinds of activities carried out in one day by a particular group of people.

It is useful for looking at relative workloads between different groups of people in the community, e.g. women, men, adolescents, elderly.

Comparisons between Daily Activity Clocks show who works the longest hours, who must divide their time for a multitude of activities, and who has the most leisure time and sleep.

This knowledge can be very helpful during programme planning or evaluation to determine who should be targeted by what activity and assess the potential and actual impact of a programme activity on community member's workload. It can also be a powerful activity to bring to light unequal distribution of labour within a household or community and to encourage men and women to share work more fairly.

Activity Steps
Introduce the topic of a daily clock to the participants.

Starting with when a participant wakes up, have them mark the clock with key activities. Mark the start and end of activities with times and label them. If used retrospectively, the inside of the clock can be used for the past, and the outside can be used as the present. If participants struggle to define an average day, pick a particular day (e.g. Monday).

Ask participants to then mark each activity with either a smile 🙂 or frown 😕 as a point of enjoyment or a point of displeasure. Speak with participant(s) to understand their decisions.

If in an appropriate group setting, allow participants to share their ideas with the wider group for discussion.

During the activity, make a note of important aspects that are useful for analysis: age, status, gender, role, religion, ethnicity, experiences. If applicable and with consent, take photos of the canvases for your records.