GBV Safety Audit for Nutrition Facilities

A mixed-method assessment report

Photo: NS/2022

Nutrition Sector & GBV Sub-Sector

Cox's Bazar, Bangladesh

September 2023

Acknowledgements

In alignment with the Nutrition Sector (NS) Strategy 2023-25, the Nutrition Sector and partners are committed to streamlining cross-cutting public health issues, such as disability inclusion, gender, environment, etc., in the nutrition programme. To enhance the knowledge of GBV risks related to the NS services and beneficiaries, the Cox's Bazar Nutrition Sector (NS) and GBV Sub-Sector (GBVSS) carried out a mixed-method GBV safety audit analysis. The analysis aimed to explore the community members' views on the main GBV risks in accessing and using the NS services, comprehend the suggestions of community and frontline humanitarian workers to address the GBV needs and gaps, and provide a solid evidence base to support advocacy efforts for a better GBV prevention and response for the NS.

This GBV safety audit was conducted in collaboration with the GBVSS, who offered great technical support during refresher training on GBV safety audit tools for data collection, analysis, and reporting.

Our special recognition goes to all the GBVSS members and its partners, who contributed their valuable time and expertise to the GBV safety audit process.

Special thanks to all the nutrition partners, who have participated in data collection and provided a wealth of technical details, programme information and context details through various consultative meetings with them.

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List of Acronyms

AAP	Accountability to Affected Population
ACF	Action Contre la Faim/Action Against Hunger
BSFP	Blanket Supplementary Feeding Programmes
CD	Community Dialogue
CFM	Complaints and Feedback Mechanism
CMAM	Community-based Management of Acute Malnutrition
CNV	Community Nutrition Volunteers
ECCD	Early Childhood Care & Development
ESDO	Eco-Social Development Organisation
FDMN	Forcible Displaced Myanmar Nationals
FGDs	Focal Group Discussions
GAM	Global Acute Malnutrition
GBVSS	GBV Sub-Sector
GiHA WG	Gender in Humanitarian Action Working Group
GK	Gonoshasthaya Kendra
GMP	Growth Monitoring and Promotion
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IEC	Information Education Communication
IMO	Information Management Officer
INF	Integrated Nutrition Facilities
INGOs	International Non-governmental Organisations
IYCF	Infant and Young Child Feeding
JRP	Joint Response Plan
KII	Key Informant Interview
M:F	Male:Female
MAM	Moderate Acute Malnutrition
MB	*Mukhe Bhaat*
MHPSS	Mental Health and Psychosocial Support
MMF	Minimum Meal Frequency
NPW	Non-Pregnant Women
NS	Nutrition Sector
OTP	Outpatient Therapeutic Treatment
PLW	Pregnant and Lactating Women
PSEA	Prevention of Sexual Exploitation and Abuse
RI	Islamic Relief
RRRC	Office of the Refugee Relief and Repatriation Commissioner
RUSF	Ready-to-Use Supplementary Foods
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SARPV	Social Assistance and Rehabilitation for the Physically Vulnerable
SBCC	Social Behaviour Change Communication Strategy
SC	Stabilisation Centres
SCI	Save the Children International
SEA	Sexual Exploitation and Abuse
SENS	Standardised Expanded Nutrition Survey
SGBV	Sexual and Gender-based Violence
SHED	Society for Health Extension and Development
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
SRHR	Sexual Reproductive Health and Rights
TSFP	Targeted Supplementary Feeding Programme

Executive Summary

The Cox's Bazar Nutrition Sector (NS) and GBV Sub-Sector (GBVSS) conducted a mix-method GBV safety audit analysis, aiming to expand the understanding of GBV risks associated with the Nutrition Sector services and beneficiaries among refugees/FDMN. The objectives of the analysis were to identify the GBV risks related to the NS services and their key contributing factors; understand community and frontline humanitarian workers' recommendations to address the GBV needs and gaps; and provide an evidence base to support advocacy initiatives for a stronger GBV prevention and response for the NS. Two checklists (Reflection and Observational) and consultation questionnaire methods of qualitative and quantitative data collection were used for the analysis. A total of 35 FGDs and 9 KIIs were conducted in the survey.

Some of the key FDG and KII findings are as follows:

1. Some 97.7 per cent of nutrition sites are accessible to the beneficiaries (caregivers for children U5, PLW and adolescent) with the exception of very few hilly blocks within the camps that are risky for pregnant and lactating women (PLW) during the rainy season. Only 15.9 per cent of the observed facilities are not fully disability-accessible (7 out of 44 nutrition sites).
2. 100 per cent of nutrition sites reported having no safety concerns.
3. 100 per cent of nutrition sites reported having a private consultation/counselling room.
4. Female staff consist of more than 50 per cent in all nutrition sites. The M:F ratio among the leadership is 3:1 in more than 50 per cent nutrition sites. Among these, in 23 per cent nutrition sites men exclusively hold managerial or leadership positions.
5. No requests for payment/favours - including sexual favours - to have access to nutrition assistance or food items were reported. However, some groups of people need permission, to get access to nutrition assistance, e.g., from authorities, *mahji*, husband, mother-in-law, etc.
6. Husbands/men decide what to eat in 75 per cent of households (HH); while wife/women or mothers-in-law in 25 per cent.
7. If there is not enough food in the HH, children and elderly (80 per cent of responses) get priority and are followed by husbands/men. Wives/women and girls are reported to be least prioritised.
8. Beneficiary data is disaggregated based on age, gender, and disabilities.
9. All nutrition personnel and community volunteers are trained on the Code of Conduct, including on child safeguarding and protection from sexual exploitation and abuse (PSEA), gender, and GBV.
10. Complaints and feedback mechanism (CFM) is in place and the communities are informed about the zero tolerance towards sexual exploitation and abuse (SEA) and appropriate reporting channels.
11. As high as 40 per cent of facilities assessed have only partial staff (nutrition personnel and community volunteers) trained/oriented on basic issues related to gender, GBV, women's/human rights, and social exclusion.
12. In 80 per cent of the assessed facilities, staff did not perceive that sexual reproductive health and rights (SRHR)-GBV integrated messages[1] are incorporated into nutrition

[1] including prevention, where to report risk and how to access GBV multisectoral services

outreach and awareness-raising activities, using multiple formats and dissemination channels to ensure accessibility.

13. Some 11.4 per cent of nutrition facilities did not have any GBV referral pathways/hotlines displayed inside the nutrition facility.

Recognising the importance of diverse perspectives and experiences, the NS partners believe that empowering women in leadership roles will contribute to a more inclusive and equitable environment. Thus, the NS partners will actively promote female leadership appointments within their organisations. The partners will increase awareness-raising sessions on GBV and PSEA at nutrition sites and outreach programmes to ensure the safety and well-being of the beneficiaries. To address GBV effectively, the NS will continue to display GBV referral pathways and hotlines within nutrition facilities and at the community level.

In dedication to inclusivity, the NS will maintain disability-accessible nutrition facilities by removing physical barriers, striving to create an inclusive environment that accommodates the needs of all individuals, and promoting equal access to nutrition services. To improve the effectiveness of nutrition programming, the NS partners will strengthen the community dialogue (CD) and "*mukhe bhaat*" (MB) at the block level within camps - aiming to increase community participation and gather valuable insights and feedback. "*Mukhe bhaat*" literally means "feeding rice" in English. It symbolises the beginning of the weaning period in a baby's life. The baby is gradually introduced to semi solid and solid foods following this ceremony. It is followed in most part of the country, and while some rituals may differ slightly, it essentially celebrates the transition to semi solid and solid foods.

In conclusion, the survey confirmed that the nutrition programmes' safety and accessibility are excellent. The participation of female staff and volunteers in the provision of nutrition services is outstanding as well. To encourage diversity and gender equality, however, there needs to be a greater representation of women in leadership positions.

Photo: NS/2022

Introduction

The Cox's Bazar Nutrition Sector (NS) and GBV Sub-Sector (GBVSS) conducted a mix-method GBV safety audit analysis - aiming at expanding the understanding of GBV risks associated with the NS services and beneficiaries. The objectives of the analysis were to identify community members' perception of the key GBV risks in accessing and utilising the NS services, understand community and frontline humanitarian workers' recommendations to address the GBV needs and gaps, and provide an evidence base to support advocacy initiatives for a stronger GBV prevention and response for the NS.

The analysis drew on a total of six NS implementing partners, who have conducted FGDs and KIIs, covering a total of 49 nutrition sites, including 45 integrated nutrition facilities (INF) and four stabilisation centres (SC) across all 33 camps of Cox's Bazar district in Bangladesh, where more than 930,000 FDMN/Rohingya refugees reside. The GBVSS and NS members contributed to the training on data collection tools/checklist, analysis and finalisation of this report. The data was collected in August-September 2023.

The humanitarian context in Cox's Bazar remains protracted and under-funded. Further and more in-depth analysis of GBV needs and risks as well as opportunities for an improved GBV prevention and response is required along with a continued enhancement of GBV risk mitigation across all sectors.

Background

Humanitarian context and crisis background

Large-scale forced displacement of the Rohingyas — an ethnic, linguistic and religious minority from Myanmar's northern Rakhine State — into Bangladesh has occurred in 1978, 1992, 2012 and again in 2016. On all occasions, Bangladesh has generously provided temporary shelter to the Rohingya refugees.

The largest forced displacement from Myanmar into Bangladesh began in August 2017. As of 30 September 2023, a total of 965,467 Rohingya refugees/FDMN – mostly women and children — are residing in 33 camps in Ukhiya and Teknaf upazilas of the Cox's Bazar district as well as on the island of Bhasan Char. (Source: *UNHCR Population Statistics; September 2023)*

Under the leadership of the Government of Bangladesh, the humanitarian response has supported thousands of refugees since August 2017. Today, more than 116 partners. including 10 UN agencies, and 106 international and national NGOs, are working closely with the government in supporting one million Rohingya Refugees and half a million Bangladeshi host communities waiting for a durable solution (2023 JRP).

Overall protection issues

The Rohingya refugees need continued life-saving assistance, and both the Rohingya refugees and vulnerable host community members need to be protected from abuse, exploitation and trafficking. The following are some excerpts from recent documents concerning refugee needs and protection:

- Protection for the refugees, especially women and children, who constitute over 75 per cent of the population and are most vulnerable, are at risk of gender-based violence and physical, psychosocial, and social vulnerabilities of child and human trafficking.[2]

- Priority needs include fresh foods (top priority), household items, utilities, livelihood concerns, income-generation activities, and decent shelter.[3] Therefore, ensuring safe access to the nutrition sector services is critical for addressing the vulnerabilities the community is faced with, especially women and girls.

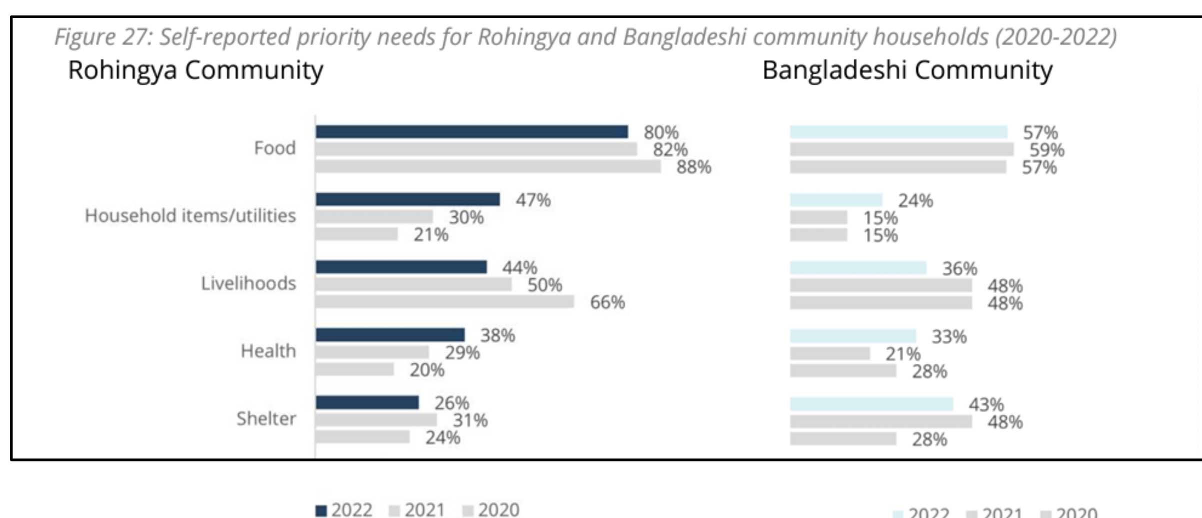

Figure 27: Self-reported priority needs for Rohingya and Bangladeshi community households (2020-2022)

- The top protection risks include safety concerns that affect the freedom of movement for household members or their access to services, including food and livelihoods. The second most common security concerns are movement limitations, thefts and robberies. Besides, killings or murders and harassment are also cited as protection concerns. Furthermore, discrimination is another protection concern. Safety concerns appear more prominent in the registered refugee camps than in the makeshift camps.[4]

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[2] IOM 2023. Rising Needs Among Rohingya Refugees and Host Communities: IOM Appeals for USD 125 Million, IOM UN Migration Regional Office for Asia and the Pacific, 07 March 2023, https://roasiapacific.iom.int/news/rising-needs-among-rohingya-refugees-and-host-communities-iom-appeals-usd-125-million, accessed 29.09.2023.

[3] WFP 2023. Refugee Influx Emergency Vulnerability Assessment (REVA-6) Report, June 2023, chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://fscluster.org/sites/default/files/documents/refugee_influx_emergency_vulnerability_assessment_reva-6_report_june_2023_0.pdf. Accessed 30.09.2023.

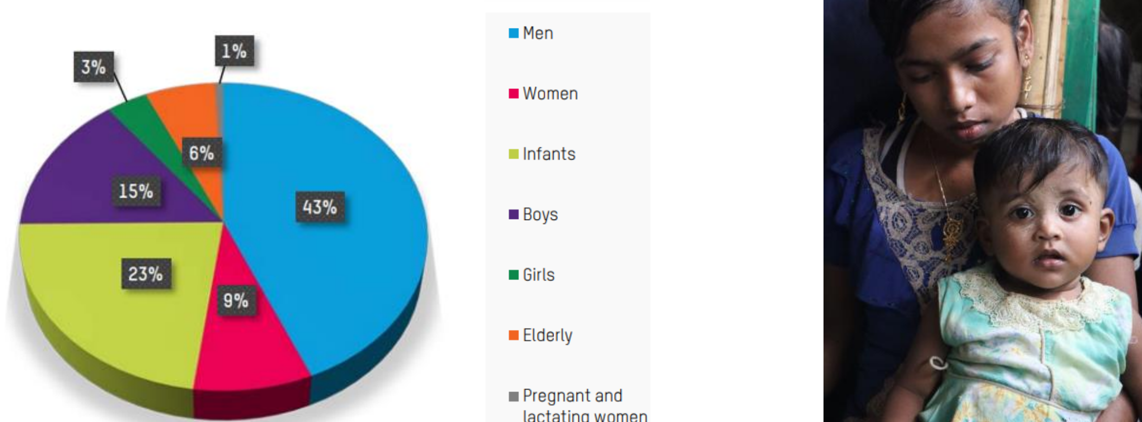
[4] Ibid.

Protection needs and risks - Nutrition perspective

Both girls and boys are provided with equal access to nutrition services. Children's eligibility for nutrition programmes is determined solely by criteria such as nutrition anthropometric measurements, without any consideration for their gender.

Recognising and responding to gender inequalities revealed that children inside the camps established in 2017, especially those under the age of five, are suffering from more undernutrition problems than children in the registered camps established in 2012 and in the host community. Some children are enrolled in treatment and prevention programmes, but awareness and positive nutrition practices were both found to be significantly less widespread among caregivers, who lack the resources to prevent malnutrition. Nutritious food and timely food intake are both important to protect children from malnutrition. The survey explored cultural practices that affect food intake by gender. It showed that men (43 per cent) and boys (15 per cent) are more often prioritised to eat first in the family, ahead of women (nine per cent) and girls (three per cent). Elderly people received priority in only six per cent of cases.[5]

Figure: Prioritisation of family food intake (FDMN/refugees)



Therefore, women and young children, especially girls, as well as elderly people might be at higher risk of undernutrition due to lack of minimum acceptable diet, low-nutrition food, and lack of dietary diversity. Men, infants and boys are served first due to likely beliefs prevalent in the community that men and boys deserve better food as breadwinners and require more nutrition as they perform heavier work, despite the huge burden of care work placed on women within the household. As food is in short supply, women and girls eat last in the household, while men and boys are prioritised. Even pregnant and lactating women are discouraged from eating before men, and in addition they face harmful practices, such as prohibitions on eating different types of nutritious food during pregnancy and lactation, e.g. different types of fish, vegetables and spinach that are believed to cause allergies. Women taking part in FGDs and KIIs knew about the importance of continuing breastfeeding up to two years of age, but they also said that they had limited time for childcare due to the high burden of responsibility for family care, which limits their ability to do this. Nutrition workers on the ground have noticed a lack of prioritisation for infant and young child feeding (IYCF), which puts children at risk of

[5] Data in this paragraph is from the Joint Agency Research Report on Rohingya Refugee Response Gender Analysis. https://drive.google.com/drive/folders/1ScW1kc1t9pu85WJH-1f8YtFW_BpTHjoe?usp=sharing

undernutrition. The survey revealed that men were the decision-makers in the family when it came to purchasing food or groceries (65 per cent) and were also in charge of receiving food vouchers (48 per cent). Men, therefore, play an important role in purchase of nutritious food.[5]

In response to such challenges, the Nutrition Sector partners have been focusing on implementing the following activities:

- Monitor gender-specific and other harmful practices linked to gender dynamics to prevent undernutrition, and support access to nutrition treatments.
- Develop tailored and gender-inclusive information, education and communication (IEC) materials on nutrition, adapted to the context.
- Include elderly people, especially mothers-in-law, in nutrition education and behaviour change activities, including by engaging fathers/male caregivers to attend nutrition sessions and to learn the benefits of infant and young child feeding (IYCF) practices and the nutrition requirements for children under five.
- Include cooking demonstrations led by men as well as women, with a focus on gender- and age-specific nutritional requirements.
- Sensitise communities on IYCF services and reinforce family and community support, with a special focus on the barriers or challenges to IYCF practices.
- Support mothers through counselling on IYCF, specifically breastfeeding practices, and psychosocial support, and involve influential family members to create an enabling environment for caregiving.
- Promote involvement of men in sharing caregiving responsibilities to reduce women's workload within the household and to encourage more equal sharing of parenting responsibilities.
- Promote participation of women in the provision of nutrition services and maintaining 50 per cent proportion of female nutrition staff and volunteers in INF.

Current Nutrition Sector service provision and response

The Government of Bangladesh, together with the nutrition partners (NGOs and UN), has established integrated nutrition facilities (INFs) to address systemic malnutrition in the camps and in Bangladeshi communities, with a specific focus on children under five years, pregnant and lactating mothers, adolescents and mothers of children under two years.

The three priority programme areas in the camps for 2023 include: (1) Life-saving and preventive essential nutrition services provided for the target population, including children, adolescents, and pregnant and lactating women (PLW). Preventative nutrition services will include counselling of infant and young child feeding for women and men caregivers, and provision of blanket supplementary feeding for children under five as well as PLW. Micronutrient supplementation will also be provided to children under five, adolescent girls, PLW, and other extremely vulnerable individuals. (2) Additional treatment services for acute malnutrition targeting children under five and PLW will be given, following screening, referral, and enrolment into respective nutrition programmes. (3) Nutrition information management will be promoted through periodic assessment of nutrition status of the target population, administered through surveys and monthly data collection and analysis activities.

Initiatives for emergency preparedness and response are still supported by the NS and its partners, mainstreaming gender-responsive and disability-inclusive programming as well as facilitating appropriate referrals between other sectors of the humanitarian response. This will ensure appropriate access to and provision of quality nutrition services.

In 2022, a total of 60,065 (100 per cent of the target) caregivers/women of under-2 children were reached with counselling on appropriate infant and young child feeding in the refugee/FDMN camps. A total of 144,794 (96 per cent of the target; 70,909 girls) U5 children supplemented with Vitamin A in two rounds in the camps. Besides, a total of 51,780 (over 90 per cent target; 29,113 girls) U5 children with severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) and PLW at nutritional risk are treated, with a cure rate of over 90 per cent. Strengthened collaboration between UNHCR, UNICEF, WFP and all implementing partners (ACF, Concern, ESDO, GK, SARPV) in management of acute malnutrition ensured continuum of care through seamless referral mechanisms for girls and boys across the different treatment programmes for children with moderate and severe acute malnutrition. The NS partners have been conducting standardised expanded nutrition survey (SENS) annually to be used for evidence-based planning. The analysis of monthly nutrition data collected has been instrumental in supporting camp-level quality services improvement. Despite intense counselling on IYCF being implemented as one of the malnutrition prevention strategies among U5 children, there has been no discernible improvement in providing equal care and feeding for boys and girls in households.

Objectives of Analysis

The Nutrition Sector Safety Audit for GBV risks in Cox's Bazar was conducted to:

- Identify GBV risks related to the Nutrition Sector
- Understand GBV risks related to the Nutrition Sector and their key contributing factors
- Identify field-driven recommendations to address identified GBV needs and gaps
- Allow the Nutrition Sector to self-assess the status of GBV risk mitigation programme integration and identify priority areas for action[6]
- Provide an evidence base to support advocacy initiatives with the donors, clusters and partners for stronger inter-sectoral GBV prevention and risk mitigation.

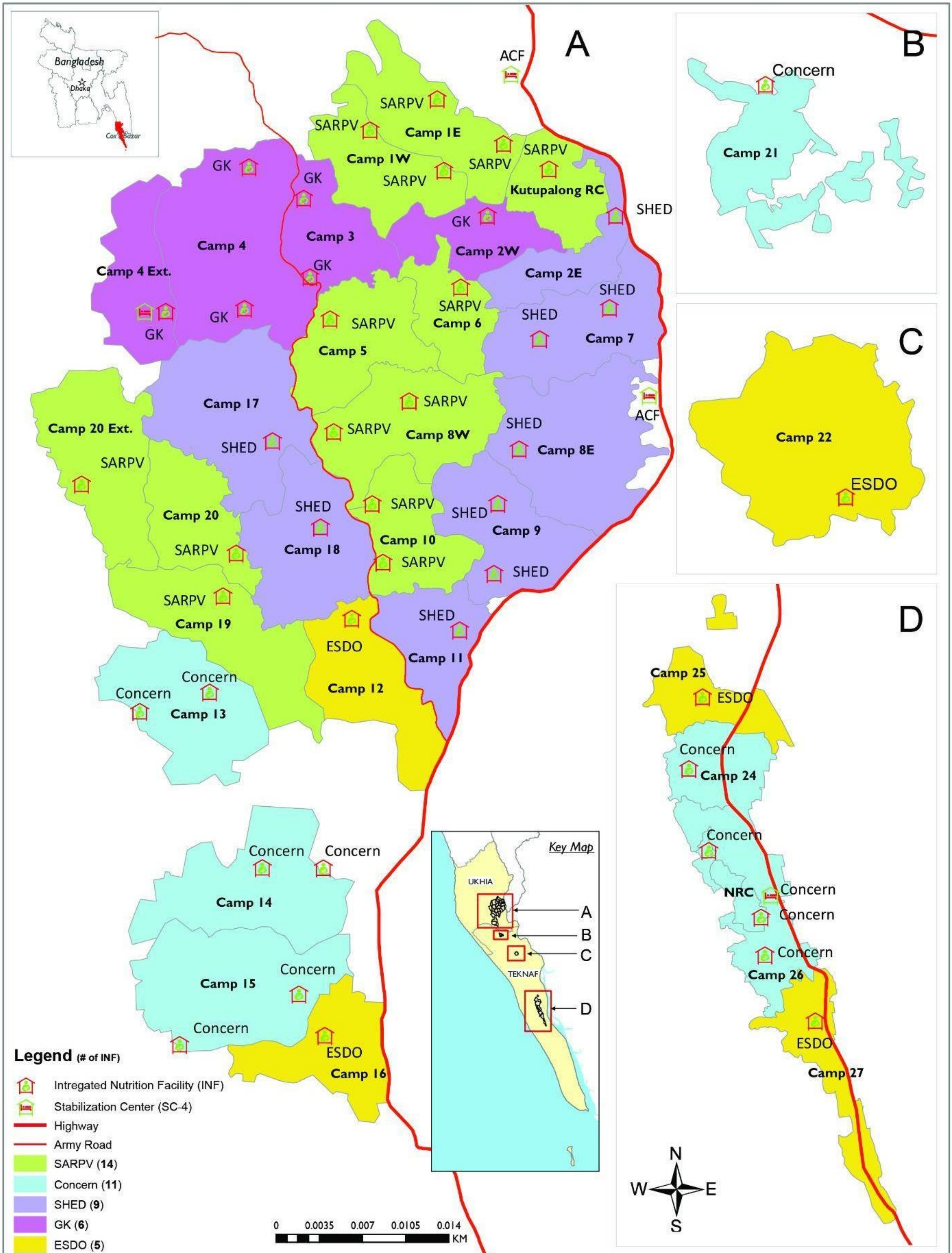
Geographic Coverage

The analysis drew on safety of the six NS implementing partners, who have conducted FGDs and KIIs, covering a total of 44 nutrition sites, including 42 integrated nutrition facilities (INF) and two stabilisation centres (SC) across all 33 camps of Cox's Bazar district in Bangladesh, where more than 930,000 FDMN/Rohingya refugees reside. The GBV Sub-Sector and Nutrition Sector members contributed to the training, analysis and finalisation of this report.

[6] The tool draws from the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, which is the main GBV mainstreaming tool used for the Cox's Bazar GBV Sub-Sector's risk mitigation mainstreaming efforts. The IASC Guidelines provide guidance tailored to specific GBV risks faced in each humanitarian sector, help to identify gaps, and indicate which actions should be taken. Link here to the resource

Bangladesh: Cox's Bazar Nutrition Sector Partner Presence Map October 2023

Cox's Bazar, Bangladesh
NUTRITION SECTOR



Creation Date: 19 July 2023 | Sources: ISCG, Nutrition Sector, SMSD Sector | Coordinate System: WGS 1984 UTM Zone 46N I Map prepared by Mohd Mostakim Ali, IMO, Nutrition Sector.
Disclaimer: The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

Methodology

Data from assessments, documents, and reports (both quantitative and qualitative) were collected at community level and consolidated for the analysis. The following qualitative and quantitative data collection methods were used for the analysis:

1. **Reflection Checklist:** A tailored checklist was used as part of a desk review at the programmatic level, aiming to assess the integration of GBV risk mitigation in assessment, analysis, planning, implementation, coordination, monitoring and evaluation as related to the nutrition facilities and programming in the Rohingya refugee camps surveyed.
2. **Observational Checklist:** An observational checklist was used at field level to guide assessments at camp level, for example, through "safety walks" including facility staff and the assessor.
3. **Community Consultation Questionnaire:** A questionnaire (Annex 1) was used for semi-structured community consultations through focus group discussions (FGDs) or key informant interviews (KIIs).
    a. **Focus Group Discussions** – A total of 35 FGDs were conducted through a tailored qualitative data collection tool in a small group interview format, separated by age and gender. The FGDs enabled an in-depth understanding of community members' concerns, experiences, points of views, perspectives, shared and diverging beliefs, norms and knowledge, and concrete information about issues at stake.
    b. **Key Informant Interviews** – A total of 9 KIIs were conducted with the key informants, who were eligible for providing candid and representative observations and assessment to the GBV and nutrition-related questions in the survey.
4. **Frequency Analysis** was employed, which is a statistical data analysis method that captures the number of occurrences of thematic content by categories across documents and reports assessed.

Data Collection Sources

The table below provides an overview of the data collection sources that have been used for the analysis.

Data Collection Sources	Number of FGDs/KIIs/reports	Camps Covered	Methodology
Safety Audits - FGD transcripts	35 FGDs	All 33 Rohingya refugee camps	Qualitative transcripts (FGDs)
Safety Audits - KIIs transcripts	9 KIIs	All 33 Rohingya refugee camps	Qualitative key informant interviews (KIIs)

Research Questions

The analysis was based on the following set of research questions:

1. **GBV risk assessment** (for the Nutrition Sector facilities)
    a. Safety and accessibility
        (1) What kind of services are they accessing?
        (2) Who are accessing or benefiting from these facilities?
        (3) How do the facility users find these - are these safe and unrestricted?
    b. Access to nutrition in the household
        (1) Gender, power and decision-making in accessing nutrition
        (2) Potential GBV risks associated with nutrition services
    c. Participation of communities
        (1) Nutrition volunteers in the community
        - What are their roles and relationship with the community?
        (2) Women's participation
        - Are there any cultural restrictions to women's involvement?

2. **Minimum standards for GBV risk mitigation** (in the Nutrition Sector facilities)

    a. To what extent are the nutrition facilities complying to minimum standards for GBV risk mitigation?
        (1) Facility standards
        (2) GBV referral pathways
        (3) Complaints and feedback mechanisms

3. **Recommended actions**
    What "recommended actions" can frontliners working in the Nutrition Sector facilities provide for enhancement of GBV risk mitigation?

Data Analysis Process

FGD and KII transcripts from 44 refugee camp sites were compiled for further qualitative thematic analysis using MAXQDA (a qualitative data analysis software). In the thematic analysis, a coding system was applied to capture reported thematic content by categories as developed by the GBV information management officer (IMO) from the GBV Sub-Sector. The GBV IMO coded relevant segments from the documents into respective thematic codes, and generated quote matrices by locations, gender and themes for further analysis. In addition, an inter-document analysis was conducted to compare thematic findings across different types of materials, locations, genders and age groups and coding distribution across documents and frequencies of themes were also analysed and put into graphs for content analysis.

The findings of the qualitative assessments were triangulated with multiple assessments, including protection monitoring reports, data from the complaint feedback mechanisms (CFM) and nutrition risk and needs assessment reports.

In the end, an overall appraisal of findings and strength of evidence was conducted by the Nutrition Sector and GBV Sub-Sector coordinators and the information management team in generating key results and recommended actions.

The thematic analysis of the report is based on graphs, tables and charts that illustrate findings from the frequency analysis as well as direct quotes from the affected community members, and does not intend to present data that is statistically representative of the whole of the Rohingya response coverage sites. Rather, it aims to provide a snapshot of the current key gaps in GBV risk mitigation and opportunities in the nutrition facilities and programming in Cox's Bazar from the perspective of frontliners and community members, including women, girls, men and boys.

Limitations

Although the analysed qualitative sources (reports, FGDs and KIIs) covered all major nutrition sites in Cox's Bazar Rohingya response with a timeframe ranging from January 2023 to September 2023, the compilation of these qualitative data applied no inclusion or exclusion criteria and took into consideration all materials submitted by the Nutrition Sector implementing partners. The study does not cover the Bangladeshi communities living in Cox's Bazar district.

Photo: NS/2022

In addition, the thematic analysis generated coded themes based on the qualitative data compiled from the 33 geographic locations, using data from 49 different sources (nutrition sites). However, sources from five nutrition sites were not considered during the analysis due to late submission. The code generation followed the qualitative data saturation rule and was thus to represent the most commonly discussed and referred to concepts and information pieces raised by the community and experts, who participated in the assessments.

However, the representativeness of such findings remains has certain limitations, and these should not be generalised to represent all population groups and types of humanitarian situations and needs.

Data Analysis and Major Findings

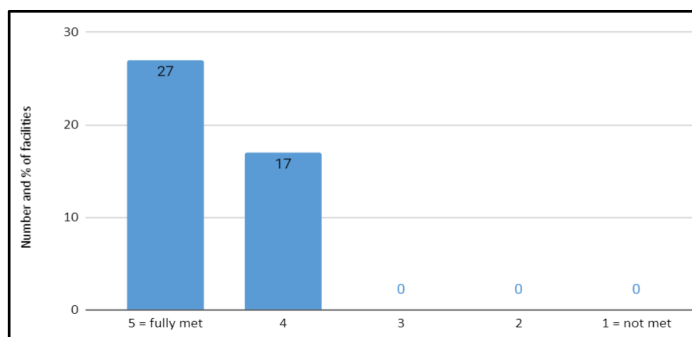
A. Reflection checklist

Below is an analysis of the "Reflection checklist" from a total of 44 facilities (42 integrated nutrition facilities and two stabilisation centres) across 33 sites (refugee camps and host communities), as filled out by respective facility staff.

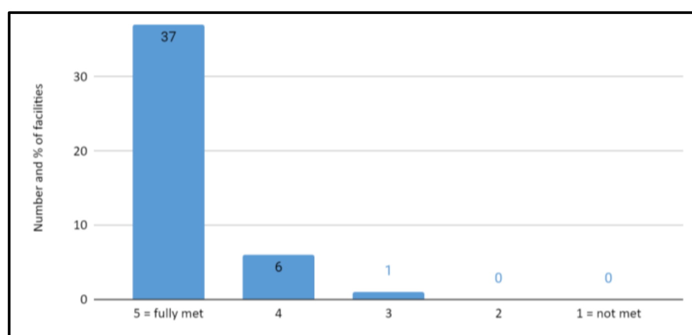
Standards to meet

Scores (5=fully met, 1= not met)

(1) Active participation of women, men, boys and girls of all backgrounds, including at-risk groups and/or with specific needs, is promoted in all nutrition assessment and planning processes.[7]

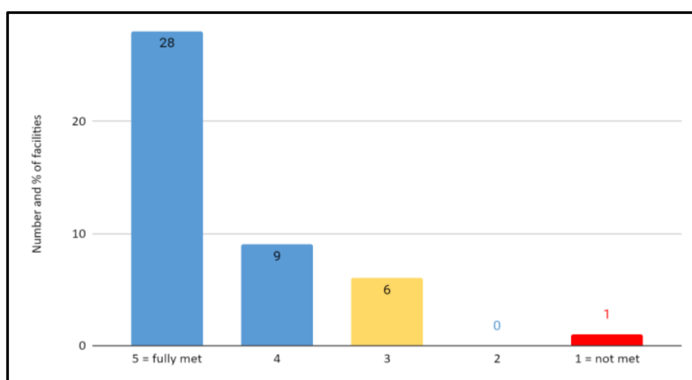


(2) Project description and monitoring framework include the ratio of male to female (1) nutrition staff; (2) community-based nutrition volunteers, taking also the nature of certain positions into consideration, seeking gender-preferred recruitment, where required.



(3) Project description includes:

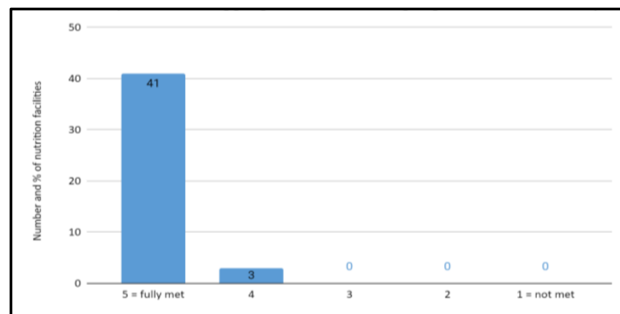
A. An analysis of how nutrition programming may increase GBV risks,[8]
B. An analysis of how nutrition programming may contribute to reduction of GBV risks,
C. Strategies and measures that mitigate GBV risks.



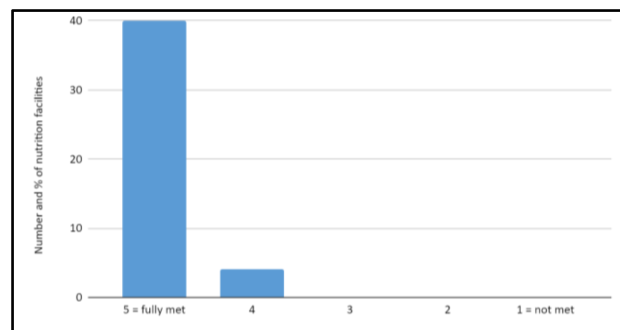
[7] including persons living with disabilities, with mental health issues, gender diverse populations, separated and unaccompanied children, orphans, persons living with HIV, or who are survivors of violence

[8] taking cultural harmful practices, negative masculine behaviours, discriminatory gender social norms, and environmental factors into consideration

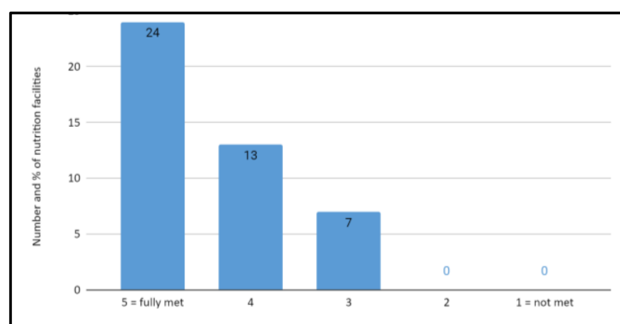
(4) Beneficiary data is disaggregated based on age, gender and diversity.



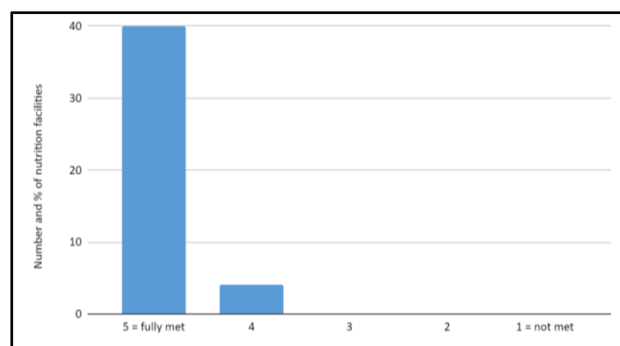
(5) All nutrition personnel and community volunteers are trained on the Code of Conduct, including on child safeguarding and protection from sexual exploitation and abuse (PSEA).



(6) All nutrition personnel and community volunteers are trained on basic issues related to gender, GBV, women's/human rights, and social exclusion.

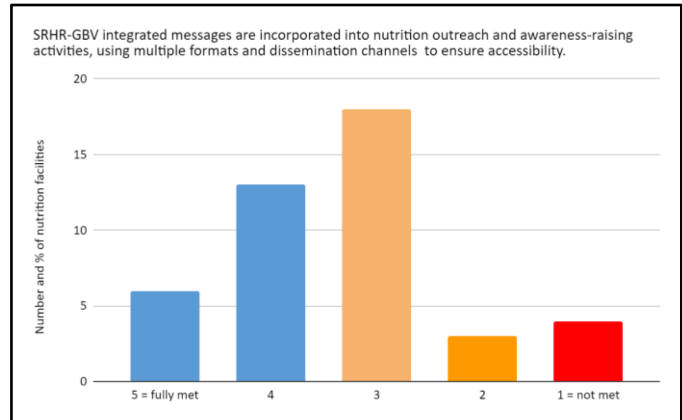


(7) All nutrition personnel and community volunteers are trained on how to handle disclosures of GBV incidents in a safe, confidential and dignified manner, including (camp-specific) referral pathways.[9]

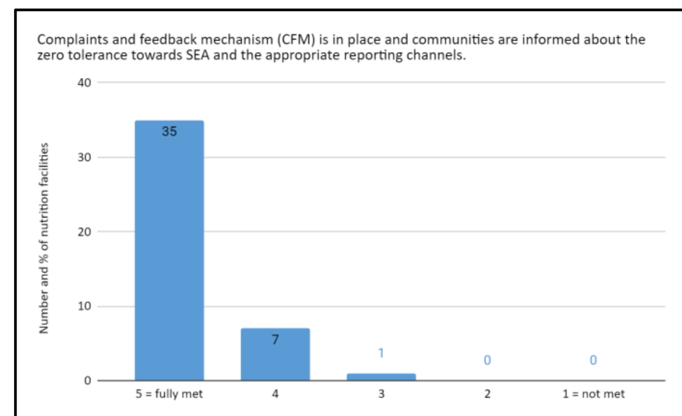


[9] GBV referral pathways per camp can be found here: https://rohingyaresponse.org/sectors/coxs-bazar/protection/gender-based-violence/referral-pathways.

(8) Sexual reproductive health and rights (SRHR)-GBV integrated messages, including on prevention, where to report risk and how to access GBV multisectoral services, are incorporated into nutrition outreach and awareness-raising activities, using multiple formats and dissemination channels to ensure accessibility.



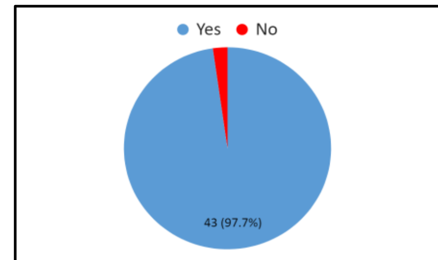
(9) Complaints and feedback mechanism (CFM) is in place and communities are informed about the zero tolerance towards SEA and the appropriate reporting channels.



B. Observation checklist

1. Safety and accessibility of **nutrition facilities**

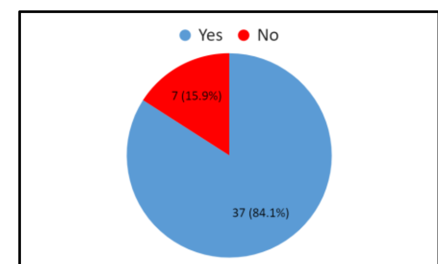
    (1) Are nutrition facilities in the areas that are **safe and equally accessible** for men, women, girls, boys and other at-risk groups?

    - 97.7 per cent of facilities are safe and equally accessible, except one with a partial “no”

    This observation was triangulated with the FGD findings, as quote below:
    “Some of the blocks are risky for PLW during the rainy season due to hills.”
    - FGD, Male 25-59 y/o, Eco-Social Development Organisation integrated nutrition facility in Camp 12

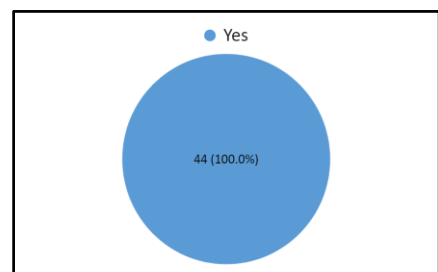
    (2) Do nutrition facilities ensure **accessibility for all persons, including those with disabilities** (e.g., physical disabilities, injuries, visual or other sensory impairments, etc.) and inclusiveness regardless of the age?

    - 15.9 per cent of facilities under observation (7 out of 44) returned a “no” for this standard.

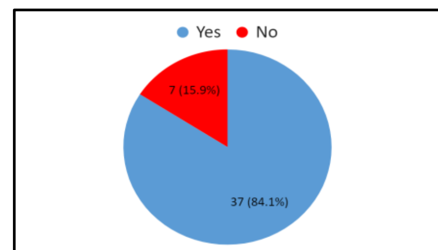
    "Due to the hilly area, the facility is not fully disability accessible."
    - Facility staff, INF in Camp 18

    (3) Are nutrition facilities free of potential **safety concerns** for women and children (either during the screening, nutrition education session or at the stage of consultation and supply distribution)?

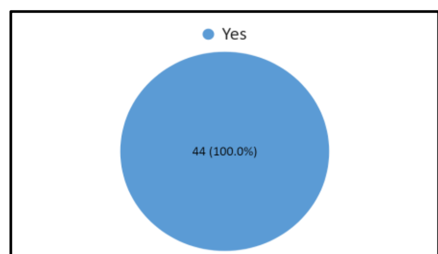
    - 100 per cent of facilities reported having no safety concerns.

    (4) Is there a **separate waiting area for women and men** in the nutrition facility with clear pictorial signage?

    - 15.9 per cent of facilities under observation returned a “no” to this question.

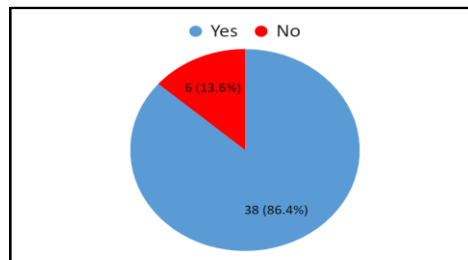
    (5) Is there a **private consultation/counselling room** in the facility?

    - 100 per cent of facilities reported having a private consultation/counselling room.

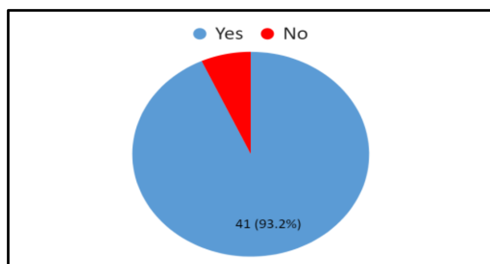
2. Safe and dignified **WASH** services in nutrition facilities:

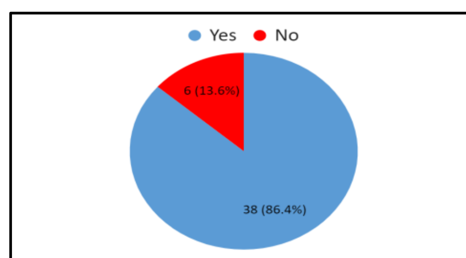
(1) Are toilets **accessible and safely located?** (2) Are toilets **adequate** in ><



number?

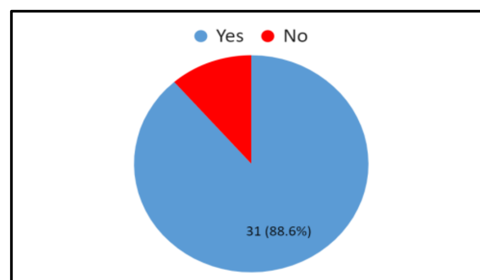
(3) Do they have **internal locks**? (4) Are **toilets separated by ><**
gender with clear pictorial signage?





(5) Are there any **GBV referral pathways/hotlines displayed** inside the nutrition facility?

- 11.4 per cent of facilities did not have any GBV referral pathways/hotlines displayed inside the nutrition facility.



3. **Ratio of male to female (M:F)** personnel:

Staff	M:F ratios vary from 13:7 to 4:15, but female staff consist of >50 per cent in all facilities.
Leadership	1. 22.7 per cent (10 out of 44 facilities) have only male in leadership/management roles. 2. For other 34 facilities, M:F ratios among leadership vary from 3:1 to 1:1

C. Community consultation

A total of 35 focus group discussions (FGDs) and 9 key informant interviews (KII) were conducted, reaching a total of 248 community members (female and male). For more detailed information, please refer to Annex 2.

Questions asked included the following thematic topics, as related to the nutrition facility accessed by the participants of these consultations:

1. Access to facility: safety and accessibility of the facility
2. Access to nutrition assistance: free and unrestricted access to nutrition assistance
3. Participation of communities
4. Complaints and feedback mechanisms

(1) Thematic analysis

The following sections provide an overview of key findings of the assessment with a focus on key quotes and graphics illustrating the results.

Access to nutrition facilities and services

1. Are the distances and routes to be travelled to the nutrition facility safe for all the beneficiaries?
    - Yes (97.7 per cent respondents)
        - "Routes are safe with no risks."
          - KII, female 25-59 y/o, Action Contre la Faim stabilisation centre in Camp 9
        - "It is safe for all the beneficiaries to access the nutrition centre."
          - KII, female 25-59 y/o, Concern World Wide INF in Camp 21
        - "Safe for all types of beneficiaries."
          - KII, female 18-25 y/o, Concern World Wide INF in Camp 24
    - Partially safe (2.3 per cent)
        - "Some of the blocks is risky for PLW during the rainy season due to hills."
          - FGD, male 25-59 y/o, Eco-Social Development Organisation *INF in Camp 12*
2. If you attend a nutrition facility, do you believe there are sufficient female staff in the nutrition facility that you go to?
    - 100 per cent respondents across all FGDs and KIIs conducted replied 'yes' to this question.
3. Do you or some groups of people need permission of somebody (e.g., authorities, *mahjis*) to get access to nutrition assistance?
    - Two reports of such incidents were captured across all FGDs and KIIs:
        - "Some PLW beneficiaries or mothers of U-5 children need their husband's permission."
          - FGD with women, Camp 20E, SARPV INF
        - "Some family members need to get consent from family influencers, like their husband, mother-in-law or father-in-law."
          - FGD with women, Camp 10, SARPV INF
4. Have you heard about requests for payment/favours (including sexual favours) to have access to nutrition assistance or food items?
    - 100 per cent respondents across all FGDs and KIIs conducted replied 'no' to this question.

Access to nutrition in household

1. Who buys food?
    - Husband/father (90 per cent of responses)
    - Other household leaders (10 per cent of responses)
2. Who decides what to eat?
    - Husband or male household leader (75 per cent of responses)
    - Female member, like wife, mother-in-law (25 per cent of responses)
3. Are there any food shortages in your family?
    - Yes (20 per cent of responses)
    - Sometimes (50 per cent of responses)
    - No (30 per cent of responses)
4. If there is not enough food in the house, who gets priority to eat?
    - Children and elderly (80 per cent of responses, other 20 per cent answered 'not applicable')
      "When there are shortages of family food and children gets priority"
      - Male, 25-59 y/o, FGD in SARPV INF, Camp 1E
    - Female members are reported to be least prioritised in some FGDs. "Child, then father-in-law, then husband, at last female member"
      - Female, 25-59 y/o, FGD in GK INF, Camp 4E
5. Breastfeeding challenges
    - None (all responses)

Service types accessed

1. Beneficiary composition:
   A miscellaneous composition of beneficiaries were interviewed in the FGDs and KIIs, conducted in the facilities (INF and SC). These include, for example, PLW and BSFP child caregiver, also have OTP and TSFP child caregiver; BSFP service for U5 child, among others.
2. Services/activities availed (select examples):
    - Health education, measurement, IYCF, sessions
    - Cooking demo, health education session, measurement, GMP, IYCF services, PLW points and ration.
    - Community volunteers visit: IFA to girls, nutrition session invitation
3. Mother-to-mother support groups
    - Have you discussed issues related to gender equality, sexual reproductive health and rights (SRHR)?
        - All respondents across FGDs and KIIs answered 'no' to this question.
        - Some participants were not familiar with the concept and said they are unaware of such programmes.
        - However, some indicated that they would love to learn more about it.
    - Is there anything that is related to gender equality and SRHR that you would like to receive more information on?
        - 50 per cent expressed interest, while 50 per cent did not indicate interest for such information
    - How can the mother-to-mother support groups be improved?

- ○ “Increase snacks.”
  - *- Female participant in FGD, SHED INF, Camp 2E*
- ○ "If the meeting is organised at the beneficiaries’ suitable time, rather than the volunteer's suitable time.”
  - *- Female KII, SHED INFP, Camp 18*

<u>Community participation</u>

1. How can community-based outreach on nutrition be improved?
   - The number of CNVs (community nutrition volunteers) could be increased.
   - Follow-ups could be more date-specific.

<u>(2) Key recommendations from the field</u>

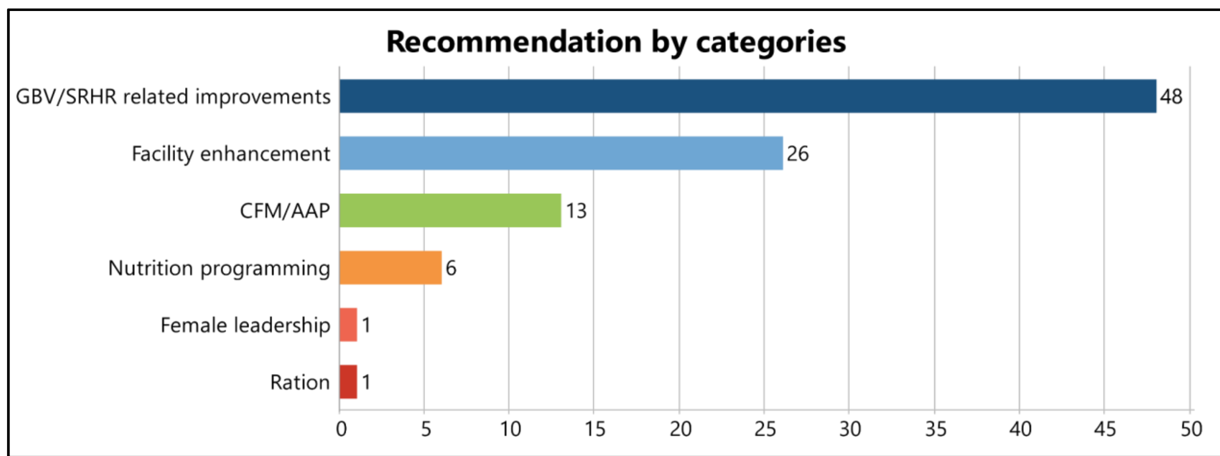


Fig 1. # of recommended actions proposed across all FGDs/KIIs, by thematic categories

GBV/SRHR-related improvements

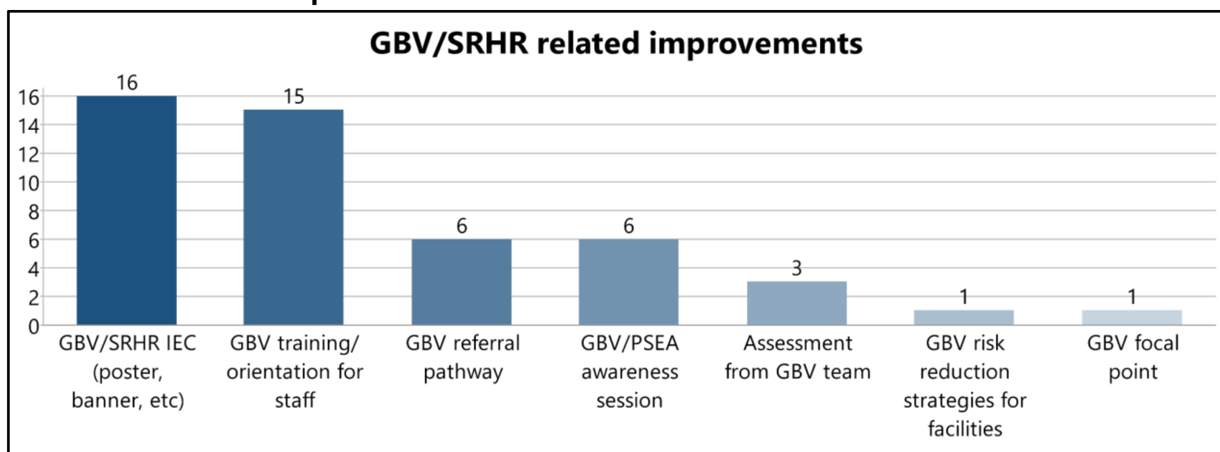


Fig 2. # of recommended actions proposed across all FGDs/KIIs under the category of “GBV/SRHR-related improvements”, by sub-categories

- "Around half of the beneficiaries of nutrition facilities expressed that they have seen a banner with a picture of "hand" (signage for safeguarding/PSEA/GBV). Another half did not observe."
  - FGD with men and women 25-59 y/o, Camp 3 INF by Gonoshasthaya Kendra
- Awareness building on GBV and PSEA of nutrition beneficiaries into continuous sessions; including SRHR and GBV awareness raising massages in outreach sessions.
  - Suggestion from staff, Camp 3 INF by Gonoshasthaya Kendra

Facility enhancements

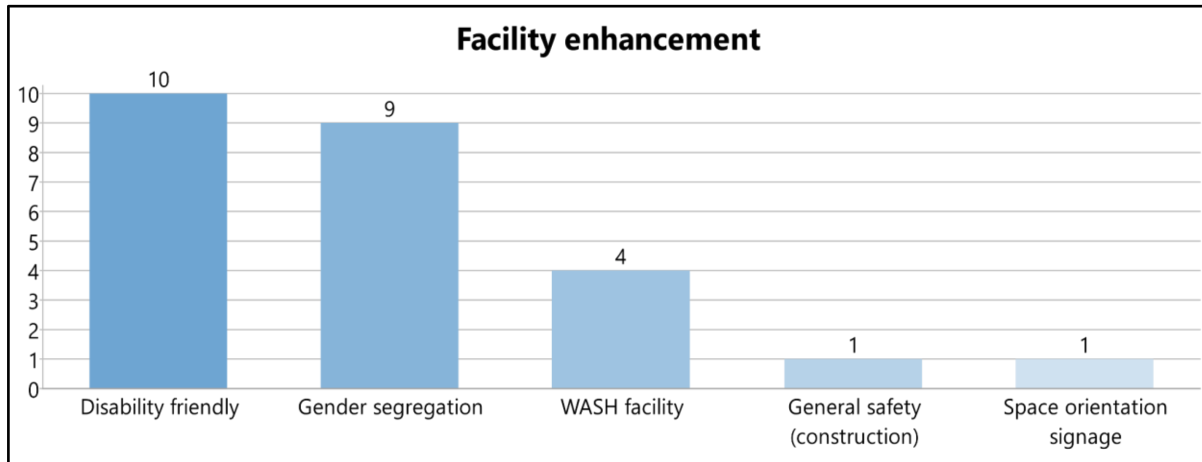


Fig 3. # of recommended actions proposed across all FGDs/KIIs under the category of "facility enhancement", by sub-categories

- Prominently displaying GBV referral pathways/hotlines, reinforcing awareness and support within nutrition facilities.
- Establishing separate waiting areas for women and men for enhanced comfort and equity.
- Some pictorial indication to separate waiting areas for women and men. (GK, Camp 3 Site 1)
- Disability-inclusion suggestions:
  - Ensuring disability-inclusive nutrition facilities - using ramps, handrails and pathway access to the facility.
  - Establishing disability-accessible toilet.

CFM/AAP

Under the category of "CFM/AAP", there were in total 13 recommended actions proposed across all FGDs/KIIs. These recommendations include:

- The CFM mechanism is established, and there is one CFM session per week. But there is a need for more sensitisation on CFM. Need to increase session participants as much as possible. (GK, Camp 3, Site 1)

Nutrition programming

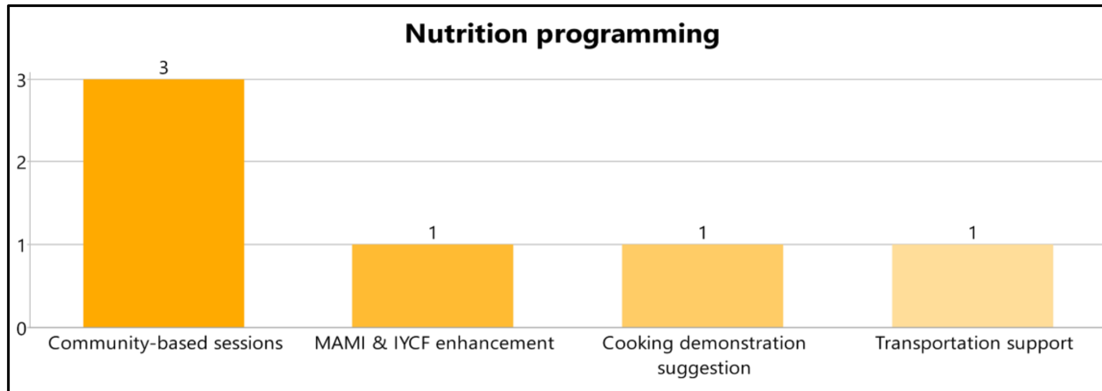


Fig 4. # of recommended actions proposed across all FGDs/KIIs under the category of "nutrition programming", by sub-categories

- Community dialogue (CD) and "*mukhe bhaat*" (MB) could be conducted in the block, INF space could be increased.
  - *Female key informant, 25-59 y/o, SHED INF, Camp 7*
- Increase food ration or e-voucher amount.
  - Female key informant, 25-59 y/o, Camp 9
- Transportation support while receiving monthly basis/bi-weekly supplementation due to the weight of ration.
  - Staff from ACF stabilisation centre, Camp 2E
- Beneficiary interviewed wants the 56 days ration at a time
  - Female key informant, 25-59 y/o, SHED INF, Camp 7

Female leadership and management

- Promote female leadership appointments for greater inclusivity and representation.
  - Medical doctor/facility staff, Camp 8E stabilisation centre, ACF

Ration

- Increase food ration or e-voucher amount
  - Female key informant, 25-59 y/o, Camp 9

Summary of findings

The paragraphs below summarise the safety audit findings corresponding to the categories of research questions (p.10) asked at the outset of the data collection. Among which, good practices (marked as ☑) and areas for improvement (marked as △) are labelled for easy reference.

GBV risks in nutrition facilities or services

1. Access to gender-friendly nutrition facilities and services

△ Certain population groups, for example, pregnant or lactating women (PLW) and mothers of under-5-year-old children, need their husband's permission to access nutrition facilities or services at times.

☑ 100 per cent respondents across all FGDs and KIIs think there were sufficient female staff at the nutrition facility. In addition, the survey found that female staff consist of >50 per cent in all facilities.

☑ No respondents reported encountering any requests for payment/favours (including sexual favours) to have access to nutrition assistance or food items.

2. Safe and dignified WASH services in nutrition facilities

☑ Toilets in the nutrition facilities are assessed to be accessible and safely located. △ Some 13.6 per cent of facilities assessed do not have adequate toilets and are not separated by gender.

3. Perceptions regarding gender equality and SRHR across mother-to-mother support groups:

△ All FGDs/KIIs respondents were unfamiliar with the concept/unaware of such programmes.

△ 50 per cent expressed interest in receiving more information about it; while 50 per cent were disinterested.

- Incentives (such as food and snack provision) and more conducive schedules for these activities in the mother-to-mother groups were suggested by participants.

Access to nutrition in household

1. Gender, power and decision-making in accessing nutrition

- Husbands/fathers (90 per cent of responses) and other household leaders (10 per cent) usually buy food.

- Husband or male household leader (75 per cent of responses), female family members like wife or mother-in-law (25 per cent of responses) usually decide what to eat.

- Food shortages in the family were reported by 20 per cent of respondents, while 50 per cent of them reported shortages happen sometimes, and 30 per cent reported no shortage.
If there is not enough food in the house, priority to eat is usually given to children and elderly (80 per cent of responses).

2. Potential GBV risks associated with nutrition services

△ Female members are reported to be least prioritised in some FGDs.

3. Challenges for specific groups:

☑ Overall, there are no breastfeeding challenges reported by respondents

Participation of communities

1. Roles and relationship with the community nutrition volunteers (CNVs) in the community.

☑ Overall, nutrition volunteers are perceived by the community to be very helpful and welcomed for the relevant and practical knowledge and skills they share with the community members.

- Some community members made suggestions for improvement to nutrition volunteers:

  - To increase the number of CNVs
  - Follow-ups for the nutrition visits could be more date specific

2. Cultural restrictions to women's participation

☑ Overall, women and girls in the community surveyed reported no particular cultural restrictions to women's involvement in nutrition-related service access

Minimum standards for GBV risk mitigation (in the Nutrition Sector facilities)

1. Facility standards

- Achievement

  ☑ Most of the assessed nutrition facilities promoted active participation of women, men, boys and girls of all backgrounds, including at-risk groups and/or with specific needs, in all nutrition assessment and planning processes.

  ☑ Beneficiary data is disaggregated by age, gender, diversity across all the nutrition facilities assessed.

  ☑ Majority of the facilities had project description and monitoring framework that include male-to-female ratio of nutrition staff and community-based nutrition volunteers, taking also into consideration the nature of certain positions while seeking gender-preferred recruitment, where required.

  ☑ Complaints and feedback mechanism (CFM) is in place and communities are informed about the zero tolerance towards SEA and the appropriate reporting channels, although many staff marked the importance of continuing community sensitisation.

- Areas for improvement

  △ Regarding project descriptions in the nutrition facilities with the standards below:

  1. An analysis of how nutrition programming may increase GBV risks;
  2. An analysis of how nutrition programming may reduce GBV risks;
  3. Strategies and measures that mitigate GBV risks;

Three per cent of the nutrition facilities did not meet this standard, *while 35 per cent of these partially fulfilled the requirements.*

△ While all nutrition personnel and community volunteers are trained on the Code of Conduct, including on child safeguarding and protection from sexual exploitation and abuse (PSEA) and handling disclosures of GBV, as high as 40 per cent of the facilities assessed have only partial staff (nutrition personnel and community volunteers) trained/oriented on basic issues related to gender, GBV, women's/human rights, and social exclusion.

△ From the reflection checklist analysis, in 80 per cent of the assessed facilities, staff did not perceive that sexual reproductive health and rights (SRHR)-GBV-integrated messages[10] are incorporated into the nutrition outreach and awareness-raising activities, using multiple formats and dissemination channels to ensure accessibility.

2. GBV referral pathways

△ Some 11.4 per cent of nutrition facilities did not have any GBV referral pathways/hotlines displayed inside the nutrition facility.

3. Complaints and feedback mechanisms

☑ Complaints and feedback mechanism (CFM) is in place and the communities are informed about zero tolerance towards SEA and the appropriate reporting channels.

Recommended actions from facility staff and the communities

1. GBV/SRHR-related improvements

- All across the board, staff have unanimously recommended to more systematically enhance the design and incorporation of awareness raising sessions for GBV/gender equality/SRHR information and services to the beneficiaries of nutrition facilities, through delivery of regular sessions.
- Community outreach sessions for SRHR and GBV awareness raising were also recommended by facility staff.

2. Facility enhancements

- Establish separate waiting areas for women and men for enhanced comfort and equity.
- Prominently displaying GBV referral pathways/hotlines, need for reinforcing awareness and support within the nutrition facilities.
- Some pictorial indications separate waiting areas for women and men.
    - Ensure disability-accessible nutrition facilities - using ramps, handrails and pathway access to the facility; establish a disability-accessible toilet

[10] including prevention, where to report risk and how to access GBV multisectoral services

3. CFM/AAP

- The CFM mechanism is established in most facilities, but increased sensitisation is needed.

4. Nutrition programming

- CD and MB could be conducted in the blocks, INF space could be increased
- Increase food ration or e-voucher amount.
- Increase transportation support while receiving monthly basis/bi-weekly supplementation due to the weight of ration.
- A few beneficiaries interviewed suggested distributing larger portion of ration at a time, rather than smaller portions in higher frequencies.

5. Female leadership and management

- Some 22.7 per cent facilities (10 out of 44) have only men in leadership/management roles. There is a need to promote women leadership appointments for greater inclusivity and representation.

Photo: NS/2022

Key recommended actions

Based on the analysis of the findings, the following overall recommendations are made:

To foster greater inclusivity and representation, the Nutrition Sector (NS) partners are expected to actively promote female leadership appointments within their organisations. Recognising the importance of diverse perspectives and experiences, empowering women in leadership roles will contribute to a more inclusive and equitable environment. Providing opportunities for women to take on leadership positions will inspire and empower others, creating a ripple effect that promotes gender equality and diversity within the NS partners and in the broader community.

To ensure safety and well-being of the beneficiaries, the NS partners are encouraged to increase awareness-raising sessions on gender-based violence (GBV) and protection from sexual exploitation and abuse (PSEA) in the nutrition sites and outreach programmes. To effectively communicate these important messages, it is recommended to use pictorial signage that convey safeguarding, PSEA, and GBV prevention information in a visual and easily understandable manner. This approach will help to overcome language barriers and ensure that all the beneficiaries, regardless of literacy levels, can access and comprehend the information, empowering them to protect themselves and seek support, if needed.

In order to provide enhanced comfort for caregivers, the NS partners will maintain and establish separate waiting areas for women and men within the nutrition sites, where possible. This is because some nutrition sites still have small land/space. Recognising that caregivers come from diverse backgrounds and may have different needs, it is critical to create a welcoming and inclusive environment where they can feel supported and are at ease. These waiting areas will prioritise women's and men's privacy and comfort, acknowledging the unique challenges and experiences faced by caregivers and providing a space where they can relax and seek respite.

To address GBV effectively, the NS members will display GBV referral pathways and information on hotlines within the nutrition facilities. By reinforcing awareness and support mechanisms, the beneficiaries will have an increased access to the information and resources they need to seek help and report incidents of GBV. These visible displays will serve as a reminder of the NS commitment to addressing GBV, and provide a clear roadmap for the beneficiaries to follow when faced with such challenges.

In dedication to inclusivity, the NS partners will maintain and strengthen disability-accessible and disability-inclusive nutrition facilities. This includes implementing infrastructure modifications, such as ramps, handrails, and improved pathway access to ensure that individuals with disabilities can access the facilities comfortably and independently. By removing physical barriers, an inclusive environment can be created to accommodate the needs of all individuals, promoting equal access to the nutrition services.

To improve the effectiveness of nutrition programming, it is recommended to conduct CD and MB at the block level within the camps. By engaging directly with the community through CD sessions and utilising MB as a mobile platform, it will be possible to increase community participation and gather valuable insights and feedback.

The NS will share the GBV safety audit report with all the NS partners once endorsed by the NS SAG and discuss on NS coordination meeting session, either in December 2023 or January 2024. The session will be conducted in collaboration with the GBVSS.

With the support of the GBVSS and its partners, the NS will conduct similar exercise (GBV safety audit) in July/August 2024 to monitor maintaining the good practices and achievements and fill the gaps.

Conclusion

The survey confirmed that the nutrition programmes' safety and accessibility are in an excellent standing. The participation of female staff and volunteers in the provision of nutrition services is outstanding as well. To encourage diversity and gender equality, however, there is a need to have greater representation of women in leadership positions. By implementing these measures, the sector can further solidify its dedication to providing not just nutritional support but also safe and dignified services for all the beneficiaries. Continuous monitoring and flexibility in adapting interventions will be vital in ensuring sustained progress and fostering an environment that prioritises inclusivity and mitigation of gender-based risks.

Photo: NS/2022

Annex 1. Safety audit tool

Click here to see the tool

Annex 2. Community consultation - population profile

Type	Location	Gender	Age group	Number of participants
KII	Camp 6	F	25-59 years	n/a
KII	Camp 1W, Site 1	F	18-25 years	n/a
KII	Camp 8W, Site 1	F	25-59 years	n/a
KII	Camp 10, Site 2	F	25-59 years	n/a
KII	Camp 19	F	18-25 years	n/a
KII	Camp 20 Ext	F	18-25 years	n/a
KII	Kutupalong RC	F	18-25 years	12
KII	Camp 8W, Site 2	F	25-59 years	8
KII	Camp 7, Site 1	F	25-59 years	n/a
KII	Camp 7, Site 2	F	25-59 years	n/a
KII	Camp 8E	F	25-59 years	10
KII	Camp 11	F	18-25 years	10
KII	Camp 14, Site 1	F	18-25 years	1
KII	Camp 14, Site 1	M	25-59 years	1
KII	Camp 21	F	25-59 years	1
KII	Camp 24	F	18-25 years	9
KII	Nayapara RC Site 1	F	18-25 years	8
KII	Nayapara RC Site 2	F	18-25 years	1
KII	Camp 2E	F	25-59 years	9
KII	Camp 8E	F	25-59 years	10
FGD	Camp 5	F, M	25-59 years	6
FGD	Camp 20	F	25-59 years	10
FGD	Camp 1E	F, M	18-25 years	n/a
FGD	Camp 2E	F, M	25-59 years	n/a
FGD	Camp 9, Site 1	F, M	12-17 years, 18-25 years, 25-59 years	9
FGD	Camp 9, Site 2	F	18-25 years	8
FGD	Camp 17	F	18-25 years	6
FGD	Camp 18	F	18-25 years	n/a
FGD	Camp 13, Site 1	F	18-25 years	20
FGD	Camp 13, Site 2	F	18-25 years	n/a
FGD	Camp 15, Site 1	F	18-25 years	n/a
FGD	Camp 15, Site 2	F	18-25 years	6
FGD	Camp 26	F	18-25 years	6
FGD	Camp 25	F		6
FGD	Camp 16	F, M	25-59 years	8

FGD	Camp 12	M	25-59 years	8
FGD	Camp 22	F	18-25 years	8
FGD	Camp 27	F, M	18-25 years	10
FGD	Camp 4 Ext	F	18-25 years	10
FGD	Camp 3, Site 1	F, M	25-59 years	10
FGD	Camp 4, Site 1	F	25-59 years	10
FGD	Camp 4, Site 2	F	25-59 years	8
FGD	Camp 2W	F	25-59 years	n/a
FGD	Camp 3, Site 2	F	25-59 years	n/a