

**PROGRAMME GUIDANCE TO
PROTECT THE NUTRITION OF
WOMEN AND ADOLESCENT GIRLS
IN HUMANITARIAN SETTINGS**

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Acronyms

ANC	Antenatal care
BEP	Balanced energy-protein (supplementation)
BMI	Body mass index
CCC	Core Commitments for Children in Humanitarian Action
ERP	Emergency response and preparedness
GBV	Gender-based violence
GNC	Global Nutrition Cluster
HB	Haemoglobin
HNO	Humanitarian Needs Overview
HRP	Humanitarian Response Plan
IFA	Iron and folic acid
IASC	Inter-Agency Standing Committee
IPC-AMN	Integrated Food Security Phase Classification Acute Malnutrition
MMS	Multiple micronutrient supplements
MUAC	Mid-upper arm circumference
SMART	Standardized Monitoring and Assessment of Relief and Transitions (Survey)
UNIMMAP	United Nations International Multiple Micronutrient Antenatal Preparation
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization

Introduction and purpose

This guidance has been created for nutrition cluster/sectors, programme staff of UNICEF and the World Food Programme (WFP), and other practitioners who are designing and/or implementing a nutrition response in humanitarian settings. These nutrition responses may include assessments and/or interventions for pregnant and breastfeeding women and adolescent girls in humanitarian settings.

This document is structured by five main questions that practitioners involved in designing a nutrition response will need to answer.

- 1. What is the nutrition situation** of pregnant and breastfeeding women and adolescent girls in this humanitarian context?
- 2. What nutrition interventions** protect the nutritional status of vulnerable women and adolescent girls in humanitarian contexts?
- 3. Which interventions to prioritize** for vulnerable women and adolescent girls based on the specific humanitarian context?
- 4. How to monitor nutrition interventions** for vulnerable pregnant and breastfeeding women and adolescent girls?
- 5. What are other important considerations** when programming for this population of vulnerable women and adolescent girls?

BOX 1



Defining pregnant and breastfeeding women and adolescent girls

Throughout the guidance, the term pregnant and breastfeeding women and adolescent girls will be used unless referring to all women/girls aged 15–49 years or only adolescent girls aged 15–19 years.

Pregnant and breastfeeding women and adolescent girls refers to women and adolescent girls between the period of pregnancy through to two years post-partum, regardless of their choice to breastfeed, mixed feed, or not breastfeed.

This guidance is grounded in three documents:

(1) the [UNICEF Core Commitments for Children in Humanitarian Action 2020](#),¹ which commits UNICEF to the prevention of all forms of undernutrition in pregnant and breastfeeding women and adolescent girls; (2) the [UNICEF Programming Guidance on Maternal Nutrition](#),² which outlines UNICEF's commitment to support a minimum package of preventive interventions for pregnant and breastfeeding women and adolescent girls in emergencies; and (3) the [WFP Food and Nutrition Handbook](#), which describes nutrition-specific and nutrition-sensitive interventions for this population.

This guidance document aligns to [WHO's guiding principle](#)³ that mothers/caregivers and their infants are interdependent. Evidence-informed care that meets the needs of both mothers/caregivers and their infants is therefore vital, as it is recognized that the health and well-being of one is intimately linked to the health and well-being of the other. It is critically important that all stakeholders recognize the value of both mother/caregiver and infant as individuals and as an interdependent pair.

This guidance is informed by current evidence on the nutrition of pregnant and breastfeeding women and adolescent girls in humanitarian contexts.^{4,5} While certain interventions impact a specific objective, such as anaemia reduction, this guidance presents recommendations of interventions for which evidence exists, and which contribute towards the **overall aim of protecting the nutritional status of pregnant and breastfeeding women and adolescent girls during humanitarian situations**. This guidance is intended to be a living document that will be periodically reviewed. With the scarcity of evidence currently available for 'what works' for this population in humanitarian settings, this guidance also advocates for 'best practices' that practitioners can adopt in the interim, until more evidence emerges.

Background

More than 1 billion adolescent girls and women suffer from undernutrition, the majority of which stems from deficiencies in essential micronutrients and anaemia,⁶ but also includes underweight and short height. Pregnant and breastfeeding women and adolescent girls are at heightened nutritional risk, compared to their non-pregnant and non-breastfeeding peers. In addition to the physical toll, the additional energy requirements of pregnancy during the second and third trimesters are around 300–390 kcal/day,^{7,8} and the additional energy costs of exclusively breastfeeding an infant under 6 months of age are estimated to be around 630–650 kcal/day.⁹ Micronutrient needs also increase during pregnancy and breastfeeding, which makes women and adolescent girls especially vulnerable to anaemia during this period. Anaemia during pregnancy may lead to greater blood loss during delivery, increased risk of post-partum haemorrhage, and maternal mortality.¹⁰

In humanitarian or emergency^a settings, this situation may deteriorate further. Women's existing nutritional vulnerabilities often reduce their resilience to shocks. Existing undernutrition can be further exacerbated by the contextual factors that drive – or result from – humanitarian crises, including exposure to violence, disruption of services, livelihoods and support, and increasing inequalities.¹¹ In the context of the current global food and nutrition crisis, UNICEF estimates that the number of malnourished pregnant and breastfeeding women and adolescent girls increased by 25 per cent between 2020 (5.5 million) and 2022 (6.9 million) in 12 crisis-hit countries.¹²

While some evidence exists for development settings, there is currently limited evidence on the nutritional status of pregnant and breastfeeding women and adolescent girls and effective programmatic responses in humanitarian contexts. Assessments and indicators of women's and adolescent girls' own nutritional status and well-being are often considered secondary to infant and child outcomes. Moreover, there is a lack of clear guidance linking the assessment of nutrition during pregnancy and breastfeeding to appropriate response packages for women and adolescent girls to address their own nutritional and health needs, in addition to those of their infants.

This guidance aims to bring together the key elements of existing guidance (Annex 1), which have relevance for the nutrition of pregnant and breastfeeding women and adolescent girls, and to strengthen this guidance, where possible, using the most recent evidence. The guidance is intended to be used in conjunction with existing documents, approaches and mechanisms, to assess a humanitarian context and plan an appropriate response.

It is focused on the specific elements that need to be integrated or added to address nutrition during pregnancy and breastfeeding. The guidance assumes that routine/standard crisis assessments and analyses are being undertaken to assess the food security situation and inform geographical targeting and household level approaches. It then describes the additional or focused approaches to be added for pregnant and breastfeeding women and adolescent girls.

While it is essential that research continues to inform tailored approaches, in the absence of clear evidence, pregnancy and breastfeeding are considered together in this guidance, except in places where there is evidence to separate interventions. There is also insufficient evidence to suggest specific approaches for pregnant and breastfeeding adolescents; however, advocacy and programming that seek to delay early marriage and the age of first pregnancy are critical interventions for adolescents in humanitarian settings.

In all cultures, a critical consideration for programming is acknowledging that women and adolescent girls live and work within family units and community systems. It is therefore essential that interventions are designed to be holistic, functioning at individual, family/household and community levels. The importance of gaining an understanding of what impact the crisis is having on these systems and how roles, relationships and support systems might have changed, cannot be underestimated. Any suggested interventions must also consider practical aspects for women, with an understanding of their multiple roles and responsibilities at home and in the workplace, including forms of unpaid labour.

^a The term 'emergency' is used interchangeably with the term 'humanitarian'. Emergency / humanitarian settings include the acute emergency phase, recovery and protracted situation with humanitarian needs.

1. Assess the nutrition situation for pregnant and breastfeeding women and adolescent girls in humanitarian settings

A primary objective of a nutrition response is to protect the nutritional status of women and adolescent girls during pregnancy and breastfeeding. To design a context-appropriate response, it is important to conduct a nutrition situation analysis. Inclusion of data for pregnant and breastfeeding women and adolescent girls will help to ensure that interventions are subsequently included in the costed nutrition response plan.

BOX 2.










Nutrition situation analysis

A robust nutrition situation analysis is fundamental to:

- Identify the problem, its scale and severity
- Establish the major causes of nutritional risk
- Identify the groups at highest risk
- Understand and prioritize local intervention needs
- Estimate the number of people needing assistance
- Understand the feasibility of implementation strategies
- Advocate for support and resources
- Act as a baseline to monitor the impact (and cost/cost-effectiveness) of interventions, and/or adapt the response to an improving, or worsening situation.

This section outlines the steps to strengthen a nutrition situation analysis for pregnant and breastfeeding women and adolescent girls in humanitarian settings to inform the nutrition response design. Steps are as follows:

-  **1.1** Identify any existing nutrition situation analyses and needs assessment processes and products.
-  **1.2** Review secondary data on pregnant and breastfeeding women and adolescent girls to assess risk
 -  **1.2.1** Individual indicators
 -  **1.2.2** Household and community indicators
-  **1.3** Analyse and summarize secondary data and decide if primary data are required
-  **1.4** Collect new primary data, if needed and feasible
-  **1.5** Finalize the nutrition situation analysis

STEP 1.1

Identify existing nutrition situation analysis and needs assessment processes

The first step is to identify what nutrition situation analysis and needs assessment processes already exist or are planned. This is because it is preferable to use existing processes as the entry point rather than undertaking a stand-alone situation analysis. Any existing situation analysis, from any source, should be considered and augmented with available data related to pregnant and breastfeeding women and adolescent girls.

In all contexts, governments should be supported pre-crisis to include data on this population in routine/annual planning processes for health and nutrition services, so that these services can be both planned for and resourced appropriately. The information will then be available to inform the most appropriate response when the crisis occurs. Emergency preparedness and contingency planning processes at the cluster/sector level generally include a nutrition situation analysis step.

In some humanitarian contexts there is an annual humanitarian planning cycle. In these countries, a **Humanitarian Needs Overview (HNO) and Humanitarian Response Plan (HRP)**¹³ are developed annually, which serve as the interagency response plan and usually include the various sectoral priorities, including nutrition. The HRP may be updated between annual cycles if there are major changes to the humanitarian situation.

The **Nutrition Humanitarian Needs Analysis Guidance**¹⁴ developed by the Global Nutrition Cluster (GNC) provides detailed guidance on conducting a nutrition situation analysis for nutrition clusters/sectors to inform the humanitarian planning process. This guidance is useful for developing a nutrition situation analysis, regardless of whether an HNO and HRP are being developed.

The **Integrated Phase Classification Acute Malnutrition (IPC-AMN)** is a nutrition situation analysis tool that is deployed in priority humanitarian contexts, where resources allow. It provides a common scale for classifying the severity and magnitude of acute malnutrition in a given population and supports caseload calculations for children and for pregnant and breastfeeding women and adolescent girls, along with recommended nutrition programmatic actions.

It is vitally important that pregnant and breastfeeding women and adolescent girls are carefully considered and that all relevant data are included in the cluster nutrition situation analysis that informs the HNO/HRP, or nutrition sector response plans.



Recommendation Assess the existing nutrition situation analysis processes in your context and identify opportunities to include and/or strengthen data and analysis for pregnant and breastfeeding women and adolescent girls.



STEP 1.2

Review secondary data to assess risk

In most contexts, it will be necessary to pursue more data sources to strengthen the nutrition situation analysis. Indicators and data sources that may be considered in the secondary data review are outlined below, and the most recent data should be included in the analysis.

1.2.1 Individual indicators

Quantitative individual nutrition indicators

The main individual nutrition indicators relating to nutritional status during pregnancy and breastfeeding that may already be collected in some form or by at least one system **are**:

TABLE 1. Indicators and thresholds

Indicator	Threshold information
Height, weight and body mass index (BMI)^a (kg/m²)	<p>Individual:</p> <ul style="list-style-type: none"> • <18.5 kg/m² is considered a low BMI for adult women • <-2 standard deviations (SDs) below the WHO growth reference median BMI-for-age^b for adolescent girls <p>Population:</p> <ul style="list-style-type: none"> • According to WHO, 20–39% is considered a high prevalence of underweight in women assessed by BMI; and 40% or higher is considered a very high prevalence¹⁵
Mid-upper arm circumference (MUAC) (cm)	<p>Individual:</p> <ul style="list-style-type: none"> • <23 cm threshold for risk of undernutrition^c <p>Population:</p> <ul style="list-style-type: none"> • <20% is considered indicative of low nutritional vulnerability, 20–39% is indicative of medium nutritional vulnerability, and >40% is indicative of high nutritional vulnerability (low MUAC <23 cm) in a population
Diet diversity/minimum dietary diversity for women	<p>Individual:</p> <ul style="list-style-type: none"> • 5 out of 10 food groups consumed is minimum dietary diversity <p>Population:</p> <ul style="list-style-type: none"> • Proportion of women 15–49 years of age who reach this minimum in a population can be used as a proxy indicator for higher micronutrient adequacy, one important dimension of diet quality
Anaemia; haemoglobin levels (Hb) (g/L)	<ul style="list-style-type: none"> • WHO defines anaemia in pregnant women as a haemoglobin concentration of <110 g/L and <120 g/L in non-pregnant women (at sea level) <p>Population:^d</p> <ul style="list-style-type: none"> • <5%: no public health problem; 5–19%: mild public health problem; 20–39%: moderate public health problem; ≥40%: severe public health problem

While there are no population thresholds established, other individual indicators to consider include:

- **Micronutrient intakes** (supplements – vitamin A, iron, folate, zinc, vitamin D, calcium, multiple micronutrient supplements (MMS), iodized salt)
- **Non-communicable disease risk** (including consumption of unhealthy foods, raised blood pressure, high salt intake, diabetes, obesity)
- **Infectious disease risk** (HIV, tuberculosis, parasitic or waterborne disease, etc.)

a BMI may not be a suitable measure of nutrition status in women or girls who are pregnant and/or breastfeeding an infant under 6 months of age.

b BMI-for-age <-2 SDs below the WHO Growth Reference median. Adolescence is defined by WHO as the period between the ages of 10 and 19 years. The Lancet Commission on Adolescents (2016) defined it as the period between the ages of 10 and 24 years. For the purpose of this review, the age range of interest was 15 to 19 years.

c Or as per national protocol.

d Prevalence cut-off values for public health significance WHO, 2008

↳ 1.2.2 Household and community indicators

To complement individual data or in situations where there are no up-to-date and/or reliable data that are specific to nutrition outcomes for women during pregnancy and breastfeeding (such as anthropometrics, micronutrient deficiencies or consumption/dietary diversity data), existing/secondary household and community level data can be used

to determine which at-risk women and adolescent girls need support. These kinds of data can serve as information for defining the context in which pregnant and breastfeeding women and adolescent girls live and can highlight the entry points through which nutrition programmes could be implemented.



The type of information needed for this deeper contextual analysis specific to the pregnancy and breastfeeding period, while not exhaustive, **includes:**

TABLE 2. Household and community information

Household	<ul style="list-style-type: none"> • Household structure (e.g., single women, women-headed households and socioeconomic status) • Household food insecurity using Food Consumption Score; Coping Strategies Index; Food Insecurity Experience Scale; information on the affordability of diets for the household; and information on intrahousehold food distribution and sharing • The health environment, including access to women’s health services more broadly and those specific to pregnancy and breastfeeding, such as antenatal care, postnatal care and nutrition counselling; access to safe water and sanitation; and access to sexual and reproductive health services • Access to nutrition services, social protection programmes and food assistance programmes • Access to and availability of affordable nutritious foods that meet the dietary needs of different household members (including market information, and trends or changes in cost of nutritious diets) • Women’s agency, empowerment and participation in decision-making; prevailing gender norms and roles; access to and control over resources; women’s time burden; and access to support networks
Community	<ul style="list-style-type: none"> • Women’s economic inclusion • Population displacement • Gender dynamics • Gender-based violence (GBV) related risks^a • Access to appropriate support for pregnant people of diverse sexual orientation, gender identity, gender expression and sex characteristics, and women and adolescent girls with disabilities • Community health and nutrition service mapping for pregnant and breastfeeding women and adolescent girls

When examining food security metrics, it is important to use more than one validated indicator to triangulate information, as each indicator assesses some but not all dimensions of food insecurity.¹⁶

^a Gender-based violence (GBV) takes many forms, including rape, sexual assault, intimate partner violence, child marriage, and early and forced marriage.

1. Assess the nutrition situation for pregnant and breastfeeding women and adolescent girls in humanitarian settings

Data sources for nutrition indicators (individual and/or household, community)

Table 3 describes the main sources of quantitative data on pregnant and breastfeeding women and adolescent girls that may already be available and may provide immediate entry points, if planned in the near future, as part of primary data collection per the recommendations below.

TABLE 3. Data and sources

Type of data	Source
Survey data	<ul style="list-style-type: none"> Large-scale nationally representative surveys (e.g., Demographic and Health Surveys, Multiple Indicator Cluster Surveys, national Standardized Monitoring and Assessment of Relief and Transitions (SMART) surveys, the Living Standards Measurement Study, as well as national micronutrient and national food consumption and dietary intake surveys) Subnational cross-sectional surveys (e.g., SMART, Rapid SMART, Standardized Expanded Nutrition Survey, Fill the Nutrient Gap analysis, Cost of the Diet, Comprehensive Food Security and Vulnerability Assessments)
Routine data	<ul style="list-style-type: none"> Health management information system (DHIS2 – formerly District Health Information System, clinical antenatal care visits)
Surveillance data ^a	<p>Surveillance data may come from:</p> <ul style="list-style-type: none"> Repeated cross-sectional representative surveys (e.g., National Surveillance System, Famine Early Warning Systems Network, National Risk and Vulnerability Assessment) Recurrent monitoring at selected locations (e.g., health facilities, schools and demographic surveillance sites, such as, the Global School-based Student Health Survey)

Generally, data collected in household surveys do not distinguish between adolescent girls and adult women, or by pregnancy and breastfeeding status. It may be possible to extract the data to allow this disaggregation if the indicators are within a larger dataset and where questions around pregnancy and breastfeeding have been asked, for example in assessments of minimum dietary diversity for women.

^a Surveillance is defined here as “the ongoing systematic collection, analysis, and interpretation of health data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those who need to know.” [Teutsch SM, Thacker SB. Planning a public health surveillance system. *Epidemiol. Bull.* 1995;16(1):1–6.].

Qualitative nutrition data

Quantitative data are rarely able to answer the important questions around ‘why’ the levels of malnutrition are as they are. Therefore, a combination of quantitative and qualitative data is recommended to give a fuller picture of any situation. Qualitative assessments gather the views of pregnant and breastfeeding women and adolescent girls themselves and those of household and community members, to tailor contextually-specific, culturally-responsive nutrition interventions to optimize their nutrition and health. This may be achieved, for example, by exploring women’s accounts and experiences of their own nutritional health and well-being through asking about their perceptions of risks and needs in their specific situation. Where possible, the views and perspectives of adolescent girls should be identified to inform their specific needs in the nutrition response.

These data may already be available from qualitative surveys, such as the Knowledge, Attitudes and Practices Survey, or other ethnographic studies carried out in the population, such as gender studies. However, in sudden onset humanitarian settings, the availability of such data may need to be rapidly assessed.



Recommendations Broadly scope what quantitative data

are already available for pregnant and breastfeeding women and adolescent girls in your context, looking at individual, household, and community levels.

Where possible, extract disaggregated data for adult women and adolescent girls, and for breastfeeding and pregnancy.

Complement quantitative data with any available sources of qualitative information about pregnant and breastfeeding women and adolescent girls that provides insights into their experiences and nutritional risks.

STEP 1.3

Analyse and summarize secondary data

The secondary data review should provide insights on the nutritional situation of women during pregnancy and breastfeeding and operational information about the humanitarian context. In addition to the nutrition-specific sources outlined above, consider how other humanitarian-specific information sources can help contextualize the analysis, for example flash appeals, humanitarian response plans, and organizational situation reports, commonly available on [ReliefWeb](#). Other sources of secondary data may be available in the specific context.

Once all available secondary quantitative and qualitative data have been collated, the information should be analysed and summarized. The framework for data analysis should be guided by what has been used for the broader nutrition situation analysis, where possible. Practitioners can then assess whether there are sufficient data on nutrition status during pregnancy and breastfeeding and programming related to these women, and determine what data and programmatic gaps exist. If analysis reveals that there are inadequate secondary data available, primary data should be collected.

The period of review for secondary data should be carefully considered against the context, especially in situations where there are no readily available or current data.



Recommendation A secondary data review synthesis should be undertaken to understand the nutrition situation for pregnant and breastfeeding women and adolescent girls and to clarify what critical data gaps exist.

STEP 1.4

Collect new primary data, if needed and feasible

1.4.1 Quantitative primary data

In any context, surveys and rapid assessments will likely be planned in which additional indicators on nutrition during pregnancy and breastfeeding could be included; as such, a stand-alone survey on this population is not recommended. Ideally, the inclusion of nutrition indicators within other surveys and assessments should be negotiated before a crisis – for example, when clusters/sectors are developing a rapid assessment tool as part of preparedness processes.

Where the situation is a rapid-onset crisis, or is highly fluid, practitioners will need to be opportunistic about where to include questions about pregnant and breastfeeding women and adolescent girls in other sectoral (i.e., health, food security) or multisector rapid assessments or surveys. An example of a multisector needs assessment is the [Basic Needs Assessment](#),¹⁷ which can be applied in both sudden onset and protracted emergencies. It can help to identify and prioritize the demand- and supply-side barriers to adequate nutrition, and how local communities think these barriers can be overcome.

Small-scale cross-sectional household surveys, such as [SMART surveys](#), are the main source of data for nutrition during humanitarian emergencies. To measure undernutrition during pregnancy and breastfeeding, it is therefore recommended to include routine MUAC measurement in all SMART surveys.

In some humanitarian settings, exhaustive MUAC screening for children aged 6–59 months will be conducted to detect and refer children for treatment of wasting. This presents an opportunity to also collect MUAC for pregnant and breastfeeding women and adolescent girls, and if the screening data are collected rigorously using the [MUAC collection tool](#),¹⁸ these data can also inform a proxy prevalence of undernutrition in this population.

In some contexts, it may be necessary to consider how monitoring processes can be leveraged. For example, inclusion of a single question about pregnant and breastfeeding women's dietary diversity, social assistance or other post-distribution monitoring can provide critical information about nutritional risk in an acute crisis, when other sources of data are not feasible to collect.

1.4.2 Primary qualitative data

Qualitative data collection must involve discussions (either key informant interviews or focus group discussions) with pregnant and breastfeeding women and adolescent girls themselves, as well as with other family and community members (i.e., husbands/partners, mothers/mothers-in-law, female community leaders and local women's organizations). Other routes for the collection of qualitative data may be through youth groups or civil society support groups, those who support people of diverse sexual orientation, gender identity and expression, and sex characteristics, as well as people with disabilities. This will help to illuminate and understand the different community and household dynamics and roles.

Knowing that it may not be possible to collect exhaustive data (either quantitative or qualitative) in fast moving or insecure contexts, rapid information to inform programming responses can be obtained through a minimal number of focused questions that target the most pressing needs in the given situation. Consider how one to two questions about women's needs during pregnancy and breastfeeding can be asked at transit or distribution points, at health facilities, and at other contact points, depending on what is feasible in the context.

Other assessment methodologies/resources to consider include:

- **Rapid Gender Analysis:** A tool to understand gender and cultural norms, women's agency,^a and the barriers and enablers to nutrition practices during pregnancy and breastfeeding, including the role of influential others in the community/household.^b
- **The Availability, Accessibility, Acceptability, Quality framework:** The framework helps to identify barriers faced by pregnant and breastfeeding women and adolescent girls in accessing humanitarian aid and services, including health and nutrition services.

- **The Cost of the Diet:** A mixed method assessment that determines how much a nutritious diet costs and whether people affected by a crisis can afford it. For vulnerable women and adolescent girls, it can help to identify gaps in basic needs and nutritional requirements (presuming local foods are available).
- **Knowledge, Attitudes and Practices survey:** A survey examining knowledge, attitudes and practices; it may focus on specific issues, such as water, sanitation and hygiene (WASH), or cultural norms, food preferences and/or taboos around care of infants and/or pregnancy and breastfeeding.
- The **GBV risk mitigation menu of measures** adapted to the nutrition sector. This menu of qualitative and quantitative questions can be used as a resource to identify specific questions about service availability, accessibility, acceptability, quality, coping strategies, and GBV risk mitigation to include in other surveys or assessments.



Recommendation Identify where focused questions on pregnant and breastfeeding women and adolescent girls can be included in other surveys, assessments and monitoring processes, rather than creating a stand-alone survey.

^a The capacity of women and adolescent girls to take purposeful action and pursue goals, free from the threat of violence or retribution. The three core expressions of agency are: decision-making, leadership, and collective action. These are not simply ingredients for agency; rather, they are ways that women and adolescent girls can exercise agency in their lives.

^b Bridging Research & Action in Conflict Settings for the Health of Women and Children (BRANCH) consortium's paper 'Investigating the delivery of health and nutrition interventions for women and children in conflict settings: a collection of case studies from the BRANCH Consortium' provides some examples of both quantitative and qualitative questions, as well as data sources.

STEP 1.5

✍ Finalize the nutrition situation analysis

The objective of the nutrition situation analysis is to inform a context specific nutrition response, including for women and adolescent girls who are pregnant or breastfeeding. By identifying secondary data (individual, household and community) and where necessary, collecting primary data, and including this in the situation analysis, a stronger rationale will be established for including interventions that protect the nutritional status of pregnant and breastfeeding women and adolescent girls in the nutrition response.

This guidance assumes that in most situations, there will be a nutrition situation analysis process that covers both the nutrition situation and the broader humanitarian context/

impact, and that this process can serve as an entry point for strengthening the analysis for pregnant and breastfeeding women and adolescent girls. Where this is not the case, a short summary of available data and interpretation of the different risks this group is facing should be developed to inform the rationale for including interventions for this population (section 2). This summary can also be useful for funding proposals and advocacy messages.

Section 3 of this guidance (page 29) describes how to use this situation analysis to determine the nutritional risk at population level and how to prioritize interventions for the pregnancy and breastfeeding period in a given context.



2. Nutrition interventions for pregnant and breastfeeding women and adolescent girls in humanitarian settings

This section provides an overview of evidence-informed **nutrition interventions** for pregnant and breastfeeding women and adolescent girls in humanitarian settings, and how the nutrition interventions are positioned within UNICEF’s systems approach to maternal and child nutrition. It describes the evidence for each nutrition intervention and outlines the recommendations for its use, based on current evidence. A comprehensive evidence review can be found [here](#).

The UNICEF Nutrition Strategy 2020–2030 recognizes the role of five systems – food, health, water and sanitation, education, and social protection – in securing positive nutrition outcomes for all women and adolescent girls. A systems approach is designed to ensure that stakeholders across these systems are more accountable for improving maternal nutrition in all contexts, including during humanitarian crises. Interventions should focus on utilizing a systems-strengthening approach in humanitarian contexts, wherever feasible.

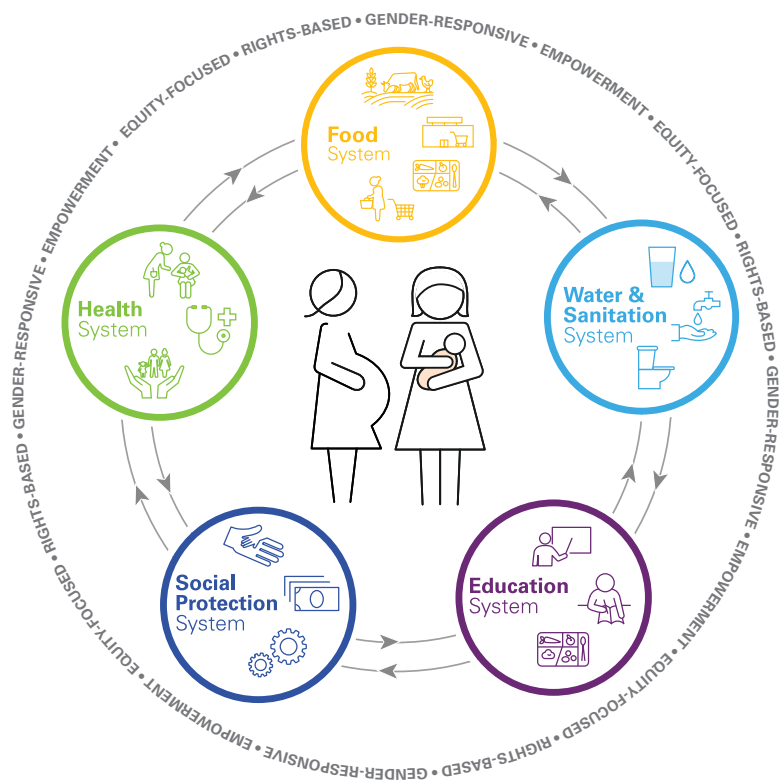


FIGURE 1. UNICEF’s Systems Approach to Maternal and Child Nutrition

The UNICEF Programming Guidance on Maternal Nutrition describes UNICEF’s commitment to support a minimum package of preventive nutrition interventions during pregnancy and breastfeeding in all contexts. WHO has placed substantial emphasis on nutrition assessment and provision of a set of integrated nutrition interventions in the [WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience](#).¹⁹ The interventions outlined in both of these documents are listed in Table 4 below.

Following the systems approach, governments and other actors doing programme delivery should seek to deliver these interventions by leveraging the food, health, water and sanitation, education and social protection systems (Figure 1). Using the water and sanitation system as an example, this would include efforts to improve the provision of, and access to, appropriate and safe water and sanitation facilities. See Table 4 below for priority interventions for women and adolescent girls in humanitarian contexts across the various systems.

TABLE 4. Sectoral interventions for pregnant and breastfeeding women and adolescent girls in humanitarian contexts

Sector	Priority interventions in humanitarian contexts
Health	<ul style="list-style-type: none"> • Scheduled quality antenatal care, including healthy weight gain monitoring, in line with the recommended coverage of four or more antenatal care visits • Support of quality skilled birth attendants • Early routine postnatal care within two days following birth • Routine vaccinations (per national protocols), including in hard-to-reach areas • Deworming and malaria control measures • Safe and uninterrupted access to quality health services through functional health facilities, household-, school- and community-based activities, including post-partum family planning • Quality, age- and gender-appropriate prevention, diagnosis and treatment for common causes of illness, access to HIV care and treatment services, and clinical care for sexual violence and intimate partner violence • Access to screening for mental health services and psychosocial support
Water and Sanitation	<ul style="list-style-type: none"> • Access to at least minimum standards of potable water and other water for washing, cooking, and access to soap • Access to latrines and appropriate menstrual hygiene items, including a collection and disposal mechanism • Access to social and behaviour change for hygiene knowledge, behaviour and practices
Food	<ul style="list-style-type: none"> • Access to adequate food assistance and/or social transfers that meet their increased nutrient requirements • Staple food fortification and home food fortification
Protection	<ul style="list-style-type: none"> • GBV case management and referral systems • Safe spaces for women and adolescent girls • Safety planning, including temporary accommodation options for survivors facing ongoing safety risks • Community engagement to provide information on available GBV response services and contribute to prevention • Protection from sexual exploitation and abuse • Mental health and psychosocial support
Social Protection	<ul style="list-style-type: none"> • Access to social transfers, with linkages to interventions for improved nutritious foods, practices and access to services • Linkages to other social protection interventions/programmes, including insurance, income generation etc.
Education	<ul style="list-style-type: none"> • Continued access to education for all adolescent girls, as well as pregnant and breastfeeding girls • Education for adolescent girls and boys to avoid early pregnancy • Access to school meal programmes • Gender, age-appropriate and inclusive mental health and psychosocial support programmes delivered in schools and learning environments

2. Nutrition interventions for pregnant and breastfeeding women and adolescent girls in humanitarian settings



It is recommended that sectoral interventions be packaged together to meet the needs of pregnant and breastfeeding women and adolescent girls according to the context, and targeted to the individual, household, and community levels simultaneously.

A critical consideration for programming is that in all cultures, women and adolescent girls are embedded within community systems and “family systems that determine roles, relationships, patterns of communication and power dynamics-thinking.”²⁰ Interventions therefore need to be holistic, acting at individual, family/household and community levels. It is also important to gain an understanding of what impact the crisis/humanitarian situation is having on these systems and how roles, relationships and support systems might have changed. Programming of interventions also needs to consider aspects of convenience for women, taking into consideration their multiple roles and responsibilities, both in the home and the workplace, combined with the care of children.

BOX 3.



The importance of being inclusive

The concept of ‘inclusion’ recognizes that some women and adolescent girls face additional risks and barriers to accessing nutrition interventions during pregnancy and breastfeeding due to the intersections between gender, age and other diversity factors, such as disability, ethnicity, migration status and others. An inclusive approach seeks to proactively understand these differing experiences, identify these barriers and address them, which may require adapting the way nutrition interventions are designed and delivered.

In terms of defining ‘family’, an inclusive definition encompasses any group of individuals forming a household based on mutual respect, love, and support for each other’s welfare. This definition acknowledges the complexity and richness of family, which can include single-parent households, households with both resident and non-resident family members, same-gender parents, as well as those with co-parents, foster parents, stepparents, and grandparents.

It is also important to recognize the diverse nature of parenthood and the varied ways in which individuals may fulfill these roles. Acknowledging and embracing the variety of experiences in parenthood and family structures is crucial for fostering inclusivity and understanding.

FIGURE 2. Response Framework

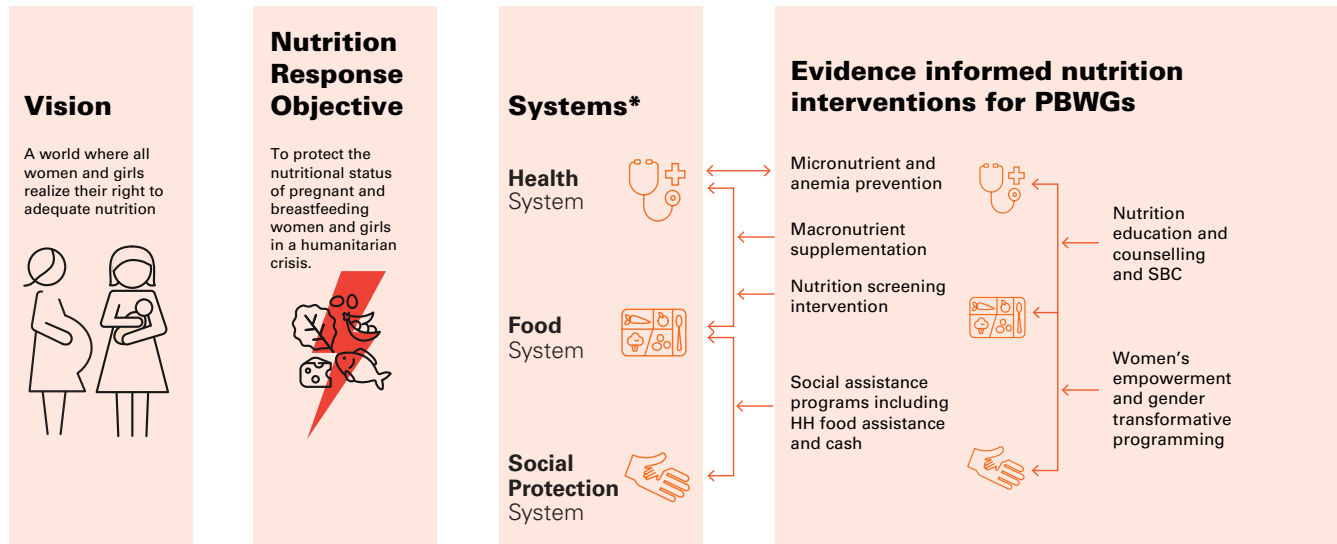


Figure 2 describes the link between the objectives of a nutrition response and the six main nutrition interventions for pregnant and breastfeeding women and adolescent girls in humanitarian settings.

1. Nutrition screening
2. Macronutrient supplementation: balanced energy-protein (BEP) supplements
3. Micronutrient supplementation: iron-containing supplements and other measures to prevent anaemia and micronutrient deficiencies
4. Nutrition education and counselling
5. Nutrition-responsive social protection
6. Empowerment and gender-transformative programming

INTERVENTION 2.1

Nutrition screening

Nutrition screening is the process that identifies women and adolescent girls at risk of undernutrition during pregnancy and breastfeeding so they can be referred and admitted to services or programmes for nutritional recovery.

In humanitarian contexts, nutrition screening can be conducted at health care facilities, or as part of outreach services and mass screenings, in conjunction with nutrition screening for children up to 5 years of age.

The anthropometry of women and adolescent girls (aged 15–49 years) has traditionally been assessed through BMI kg/m² and/or BMI-for-age.^a However, BMI may not be a suitable measure of nutrition status in women or girls who are pregnant and/or breastfeeding an infant under 6 months of age.^b Rather, **mid-upper arm circumference (MUAC)** is used in humanitarian settings, as it is a convenient, feasible and efficient way to assess nutritional status. MUAC is strongly correlated with BMI, both in non-pregnant and pregnant women, and regardless of gestational age.^{21,22}

While much of the research on MUAC to date has been operational rather than formative, and with relatively low sample sizes, evidence indicates that a low MUAC has been associated with anaemia in pregnant women,^{23,24} anaemia in newborns,²⁵ depression in women²⁶ and low birthweight in infants.^{27,28} Recent research from a variety of countries in Africa and Asia has led to a consensus that a MUAC of <23 cm in a pregnant woman is associated with increased risk of low birthweight in the newborn.

a BMI-for-age <-2 SDs below the WHO Growth Reference median. Adolescence is defined by the WHO as the period between the ages of 10 and 19 years. The *Lancet* Commission on Adolescents (2016) defined it as the period between the ages of 10 and 24 years. For the purpose of this review, the age range of interest was 15–19 years

b According to WHO, BMI can be used for breastfeeding women from 6 months post-partum onwards. Technical Report Series 854 p.110. World Health Organization (1995) Physical Status: The Use and Interpretation of Anthropometry. Report of a WHO Expert Committee, WHO Technical Report Series 854, World Health Organization, Geneva.

2. Nutrition interventions for pregnant and breastfeeding women and adolescent girls in humanitarian settings



Recommendations: The interim recommendation is to use a MUAC of <23 cm to identify all pregnant and breastfeeding women at risk of undernutrition and for referral/admission to nutritional recovery programmes.^{a,b}

All pregnant or breastfeeding adolescent girls (defined as <19 years of age) should be included in contextually-appropriate interventions, regardless of their MUAC measurement.

MUAC screening for pregnant and breastfeeding women and adolescent girls should be integrated into health services, community outreach, and any mass screening efforts conducted through health and nutrition services and/or by other actors/sectors, where feasible.

There is limited evidence on MUAC cut-offs beyond pregnancy in adult women; for example, for **breastfeeding women** and for **pregnant adolescents**. Noting the increased nutritional needs of pregnant and **breastfeeding adolescents** to cover their own growth at the same time as the growth of an infant, combined with their heightened vulnerability in most contexts, this guidance recommends that **all** pregnant and breastfeeding adolescents be considered for interventions to protect their nutritional status, regardless of their MUAC measurement.



BOX 4.



Gestational weight gain²⁹

To ensure healthy foetal growth during pregnancy, adequate weight gain is essential. The latest antenatal care guidelines from WHO (2016) reference the Institute of Medicine's recommendations for healthy gestational weight gain, as follows:

- Women who are underweight at the start of pregnancy: gain 12.5–18 kg
- Women who are normal weight at the start of pregnancy: gain 11.5–16 kg
- Women who are overweight at the start of pregnancy: gain 7–11.5 kg
- Women who are obese at the start of pregnancy: gain 5–9 kg

Of note, there is currently a Technical Advisory Group led by WHO examining whether these standards need to be updated.

Of critical importance during humanitarian contexts is regular monitoring for gestational weight gain at each antenatal care contact point throughout the pregnancy, and the provision of nutrition information and counselling.

a Note that some countries have developed national guidelines for MUAC cut-offs in various settings, and these should be consulted, where available.

b Until further robust evidence becomes available that can distinguish differentiated cut-offs for adolescents and breastfeeding women.

INTERVENTION 2.2

Macronutrient supplementation

For macronutrient supplementation, BEP supplements may be given to women and adolescent girls who are at risk of undernutrition during pregnancy and breastfeeding in food-insecure settings. BEP supplements are also recommended in the Lancet 2021 Maternal and Child Nutrition Series update,³⁰ and are included as a key intervention in the joint United Nations Global Action Plan on Child Wasting.³¹ Their objective is to supplement the diet with calories and micronutrients to protect nutritional status and/or to aid nutritional recovery (see Box 5).

BOX 5.



Balanced energy-protein supplements^{32,33}

BEP is a generic term for supplements that exist in various forms, including fortified cereals, biscuits, dairy products, beverages, or powdered supplements in sachets, or can be made using locally sourced ingredients.

- ❑ **Lipid-based nutrient supplements** provide >50% of energy from fat (including essential fatty acids). When these supplements are provided in medium- and large-quantity, they can be considered a BEP.
- ❑ **A lipid-based nutrient supplement** formulated to provide micronutrients in the same quantities as UNIMAPP MMS.
- ❑ **Fortified blended foods, including Corn/Wheat Soya Blend Plus**, which are commonly used in supplementary feeding programmes are also BEP.

The trials used to inform the WHO recommendation on the use of BEP in malnourished populations defined BEP supplements as those where the protein provides less than 25 per cent of the total energy content. BEP are typically (though not necessarily) fortified with micronutrients and/or administered along with iron and folic acid (IFA) or MMS^a.

The evidence of BEP impact on maternal outcomes, such as maternal anaemia and gestational weight gain, is mixed but promising. BEPs can, however, provide a valuable source of supplementation that can not only help to meet the additional nutritional requirements of pregnancy and breastfeeding, but also help to reduce the negative experiences of hunger and stress in extremely difficult situations.

In section 3, various scenarios to inform recommended interventions are outlined based on the existing level of nutritional vulnerability at population level. The below recommendation for BEP supplementation references these scenarios.



Recommendations:

- BEP should be provided to all pregnant and breastfeeding women and adolescent girls in contexts of high nutrition vulnerability.
- BEP should be targeted to women and adolescent girls with low MUAC (<23 cm) during pregnancy and breastfeeding to support nutritional recovery in contexts of medium nutrition vulnerability.
- All pregnant or breastfeeding adolescent girls (defined as <19 years of age) should be included in macronutrient supplementation interventions, regardless of their MUAC measurement, until further robust evidence becomes available.

^a MMS is formulated to contain the Recommended Daily Allowance of 15 micronutrients. The standardized formula that should be used is the United Nations International Multiple Micronutrient Antenatal Preparation (UNIMAPP). It contains the following doses of micronutrients: Iron 30 mg, Zinc 15 mg, Copper 2 mg, Selenium 65 µg, Iodine 150 µg; Vitamin A 800 µg retinol equivalent; Vitamin B1 1.4 mg, Vitamin B2 1.4 mg, Vitamin B3 (niacin) 18 mg, Vitamin B6 1.9 mg, Vitamin B9 (folic acid) 400 µg, Vitamin B12 2.6 µg, Vitamin C 70 mg, Vitamin D 200 IU, Vitamin E 10 mg.

INTERVENTION 2.3

Micronutrient supplementation: Iron-containing supplements and other measures to prevent anaemia

The provision of micronutrient supplements aims to fill the gap between the higher micronutrient requirements of pregnancy and breastfeeding and the low dietary intakes frequently observed in humanitarian settings, due to reduced access to healthy, diverse, and balanced diets.

A 2007 joint United Nations (WHO, WFP, UNICEF) statement advises that, *due to the increased risk of multiple micronutrient deficiencies in humanitarian emergencies, pregnant and breastfeeding women and adolescent girls should take a daily MMS to meet their recommended nutrient intakes.*³⁴ This supplement should be taken in addition to any fortified foods received.

Additional relevant WHO recommendations³⁵ for micronutrient supplementation during pregnancy and breastfeeding include:^a

- **Daily oral IFA supplementation** as part of antenatal care, containing 30–60 mg of elemental iron and 400 µg of folic acid to prevent maternal anaemia, puerperal sepsis, low birthweight, and preterm birth. (*Note: this recommendation is not applicable if MMS are provided instead.*)
- **Daily calcium supplementation** (1.5–2.0 g oral elemental calcium) to be given for pregnant women and adolescent girls in populations with low dietary intake, for the prevention of pre-eclampsia.³⁶
- In contexts where vitamin A is a severe public health problem, **vitamin A supplementation** is recommended for the prevention of night blindness in pregnant women and adolescent girls, according to WHO recommendations, to a maximum dosage of 10,000 IU per day or a weekly dose of up to 25 000 IU.^b Vitamin A has also been associated with a reduction in anaemia during pregnancy. Vitamin A supplementation is not recommended for post-partum women or adolescent girls, as the available evidence does not support a reduction in either maternal or infant morbidity or mortality.

^a In addition, WHO recommends weekly IFA supplementation as a public health intervention in menstruating women and adolescent girls living in settings where the prevalence of anaemia is 20 per cent or higher, to improve their haemoglobin concentrations and iron status and reduce their risk of anaemia. In settings where anaemia is highly prevalent (40 per cent or higher), daily iron supplementation is recommended. Weekly IFA supplementation can be implemented in malaria-endemic areas but should be conducted only in conjunction with measures to prevent, diagnose and treat malaria. Actors are encouraged to include it as part of nutrition in emergencies interventions, and while preparing HRP, to develop a procurement catalogue and facilitate the immediate response, including logistics of supplement provision.

^b A single dose of a vitamin A supplement greater than 25,000 IU is not recommended as its safety is uncertain.

WHO stresses that health educators need to understand micronutrient needs and metabolism as well as any potential adverse effects of supplementation such as toxicity. It is also important to understand regional and local variations in diet, different cultural practices, various methods of food processing and meal preparation, and economic constraints, when seeking to manage anaemia and implement micronutrient interventions.³⁷

It is also important to ensure good coverage, uptake and adherence to supplementation protocols. Poor coverage and compliance have been identified as major challenges in iron supplementation programmes.



Recommendations:

- **Iron-containing supplements should be given to all women and adolescent girls during pregnancy and breastfeeding.**
- **MMS are recommended for all pregnant and breastfeeding women and adolescent girls in humanitarian contexts.**
- **Where MMS are not available, IFA should be given. If IFA is already being successfully provided, it should be continued.**

INTERVENTION 2.4

Nutrition education and counselling

Nutrition ‘counselling’ is often used interchangeably with ‘information’ and ‘education’, but counselling should do more than inform and educate. Nutrition counselling during pregnancy and breastfeeding is an interactive process between a service provider and a woman and other key family members, during which information is exchanged and support is provided so that she can make decisions, with the support of her family, and take action to improve her nutrition.

WHO recommends that counselling on healthy eating should be integral to antenatal care.³⁸ One of UNICEF’s programmatic priorities is to improve the **coverage and quality of nutrition counselling** before and during pregnancy and while breastfeeding.³⁹

In humanitarian contexts, it can be particularly challenging to deliver nutrition counselling that has good coverage, quality and equity. However, as part of wider social and behaviour change interventions, the use of a set of approaches that strengthen nutrition counselling begins with an understanding of the context, including the barriers and enablers to nutrition counselling services and the adoption of optimal nutrition practices. Consideration must also be given to approaches that strengthen and improve the enabling environment for nutrition counselling, the design of counselling services, strategies for strengthening service delivery platforms, and the capacity of health workers and community health workers.

Designing behaviour change interventions requires consultative engagement with the target population, understanding their barriers and motivation to change, and adapting interventions to the contexts that facilitate change, including the environment and social networks. It is important to note that nutrition counselling must go beyond simply providing information; instead, it must give women the tools to make decisions, even in the face of challenges.

BOX 6.

Nutrition education, counselling and social and behaviour change^{40,41,42}

Nutrition education and counselling

Nutrition education presents general information related to health and nutrition, often to groups in clinic waiting rooms or community settings.

Nutrition counselling is a two-way interaction through which a client and a trained counsellor interpret the results of nutrition assessment, identify individual nutrition needs and goals, discuss ways to meet those goals, and agree on next steps.

Nutrition education and counselling are widely used strategies for improving the nutritional status of women during pregnancy. These strategies focus primarily on:

- Promoting a healthy diet by increasing the diversity and amount of foods consumed
- Promoting adequate weight gain through sufficient and balanced protein and energy intake
- Promoting consistent and continued use of micronutrient supplements, food supplements or fortified foods.

Social and behaviour change

Social and behaviour change is fundamentally centered on understanding people. It delves into the intricacies of how and why individuals make decisions and leverages this knowledge to positively transform social norms and change behaviors. By drawing on insights from the social and behavioural sciences, it plays a crucial role in shaping policies and programmes, making them more in tune with actual human behaviour and the functioning of societies, and ensuring they are contextualized and resonate with the communities they aim to serve.

2. Nutrition interventions for pregnant and breastfeeding women and adolescent girls in humanitarian settings

To design and implement effective nutrition counselling or wider social and behaviour change interventions, qualitative data should be collected during assessments to better understand women's lived realities during pregnancy and breastfeeding, given the constraints of humanitarian contexts. This includes considering the complex roots or underlying causes of their nutrition practices, the way people interact and make decisions, and how to engage and empower communities to co-create solutions for improving their health, well-being and food-related behaviours. It can help to focus on small doable actions that a woman and her family members can take, as well as concrete actions that other individuals (e.g., partners/husbands, grandmothers, etc.) can take to support the woman's actions.

Although there may be limited time and opportunity for nutrition education and counselling activities in humanitarian settings, counselling and support are even more critical in situations where normal services and support structures have been disrupted. Wherever possible, attempts should be made to offer safe spaces where pregnant and breastfeeding women can discuss their concerns and receive counselling and support to improve their nutrition and well-being. These spaces may be integrated spaces with multiple objectives; for example, supportive spaces for infant and young child feeding⁴³ (mother baby areas, infant and young child feeding corners, etc.) or multi-service hubs (i.e., Blue Dots), where counselling and other priority needs can be addressed. Nutrition counselling should be integrated with other supportive health services, including psychosocial care and GBV support, where they exist.



Recommendations:

- Include nutrition education and counselling during pregnancy and breastfeeding as a core nutrition intervention in every humanitarian response and ensure it is prioritized from the start.
- Ensure regular supervision to support community and facility based health workers in the delivery of quality nutrition education and counselling.
- Integrate social and behaviour change approaches that seek to improve the nutrition of pregnant and breastfeeding women and adolescent girls within community level action in humanitarian contexts.
- Consider alternative approaches to providing counselling and advice where restrictions on movement interrupt routine services.
- Provide safe spaces for women and adolescent girls to discuss concerns and receive nutrition counselling and well-being support during pregnancy and breastfeeding.

INTERVENTION 2.5

Nutrition-responsive social protection: Nutrition-sensitive social assistance programmes, including food assistance and/or transfers (cash or vouchers)

Women and adolescent girls are especially vulnerable to the negative impacts of food insecurity⁴⁴ due to their increased nutritional requirements during pregnancy⁴⁵ and for breastfeeding.⁴⁶ Food insecurity can be a risk factor for depression, anxiety, stress and poor-quality diets during pregnancy, as well as for breastfeeding interruption. It also increases the physical and psychosocial vulnerability of pregnant and post-partum women and adolescent girls during these periods.⁴⁷ Addressing household food insecurity is important to ensure the nutritional requirements of women are met; for example, in households with higher food security it is less likely there will be sharing of any supplementation given to pregnant and breastfeeding women and adolescent girls with other members of the household. Evidence shows that nutritional impact is greater when the cash transfer or other form of assistance is delivered in a predictable, regular, and timely manner.⁴⁸

There is clear evidence of the positive impacts of nutrition-sensitive social assistance programmes – such as food assistance and cash/voucher transfers – on maternal diet-related outcomes. However, the evidence on how they lead to improvements in maternal nutrition outcomes is not yet clear.

Social assistance programme interventions are more likely to improve maternal nutrition when they include a strong social and behaviour change component. Including pregnant and breastfeeding women and adolescent girls in humanitarian cash/voucher transfer interventions is likely to increase their access to services and improve the quality of their diets via enhanced purchasing power. It is important to foster linkages between social assistance programmes and other health and nutrition-specific programmes, such as the management of acute malnutrition and the provision of micronutrient supplements, to comprehensively protect nutritional status. The transfer provided through social assistance can increase the consumption of a more nutritious diet, but to ensure improvements in the access, affordability, availability and stability of nutritious foods, linkages must be forged with food system activities. For example, with agricultural programmes to improve nutritious food availability, or national efforts on food fortification.



Recommendations:

- Social assistance programmes must be deliberately designed to address maternal nutrition, with tailored activities to achieve this goal.
- Nutrition response design and implementation strategies should include linkages with contextually relevant and appropriate social assistance programmes, where available.
- Targeting of social assistance programmes should consider including pregnant and breastfeeding women and adolescent girls from vulnerable households (with ‘top-up’ support continuing until their child reaches 2 years of age).
- Transfers should be designed to promote access to a quality diet. This may include complementing the household transfer with individual supplementation specifically designed for pregnancy and breastfeeding, in the form of cash and/or in-kind assistance, including the provision of BEP, where appropriate.

2. Nutrition interventions for pregnant and breastfeeding women and adolescent girls in humanitarian settings

INTERVENTION 2.6

Women’s empowerment and gender-transformative programming

Promoting the empowerment of women, girls and people of diverse gender identities is a core aspect of gender-transformative programming. A useful definition of empowerment is “the expansion in people’s ability to make strategic life choices in a context where this ability was previously denied to them”.⁴⁹

Figure 3 illustrates how approaches that foster women’s empowerment can result in improved nutrition outcomes for women.⁵⁰ The first column, ‘elements of approach’, describes the ingredients required to achieve these outcomes. Nutrition interventions need to be designed to foster agency and to support opportunities for women, to ensure maximum benefit. If either of these are absent, improvements in nutrition outcomes are likely be limited. Cross-cutting contextual factors include the all-important

cultural, policy and legal environments that often restrict women’s empowerment in many contexts and that will need to be addressed simultaneously.

Although rapid-onset emergencies may not be the ideal time to engage in stand-alone empowerment activities, it is important to ensure that the multisectoral nutrition interventions described above (i.e., those related to water and sanitation, health, food) should be gender-responsive and inclusive in their design to meet the unique needs of women and adolescent girls and ensure they benefit equally from programme activities. Moreover, the disruption to systems, processes and conventions in humanitarian settings may present new opportunities for gender-transformative programming that address underlying gender norms and roles within the household. The decision to meaningfully engage women and adolescent girls in decision-making regarding programming, risk mitigation, and partnerships, can also help to promote women’s and adolescent girls’ leadership and resilience.

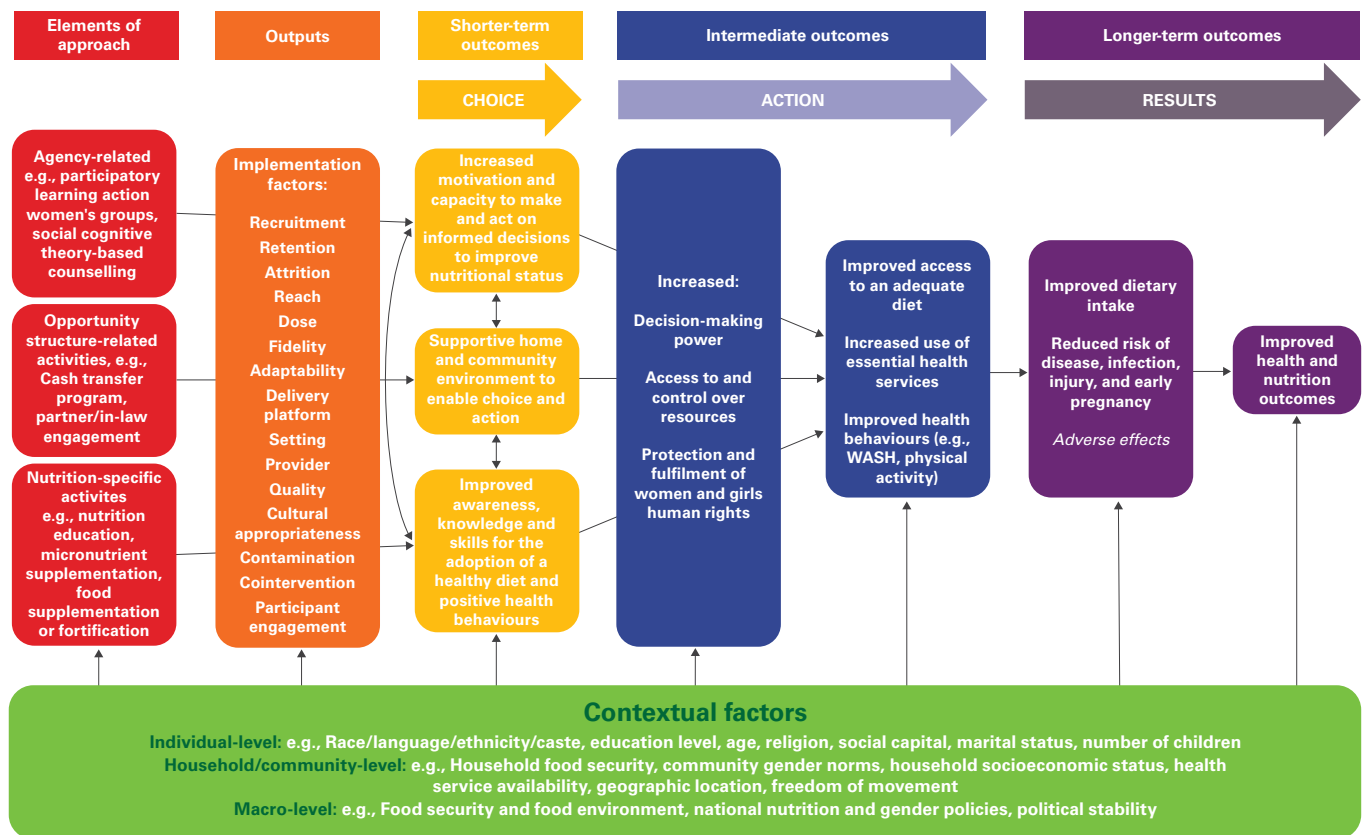


FIGURE 3. Logic model: Empowerment-based nutrition interventions to improve women’s nutritional status
 Source: Riddle, A. et al. (2021). PROTOCOL: The effects of empowerment-based nutrition interventions on the nutritional status of women of reproductive age in low- and middle-income countries. *Campbell Systematic Review*, 17(3).

There are several tools that have been developed to measure women’s empowerment, agency and inclusion, and identify barriers that need to be addressed. See section 3 in the [evidence review](#) for a list of these tools.

BOX 7.

Gender-transformative approaches

A gender transformative approach can help to promote gender equality by:

- Fostering critical examination of inequalities and gender roles, norms and power dynamics
- Recognizing and strengthening positive norms that support equality and an enabling environment
- Promoting the relative position of women, girls and marginalized groups
- Challenging and transforming the underlying social structures, policies, systems and broadly held social norms that perpetuate and legitimize gender inequalities.

More recently there has been greater acknowledgement that it is essential to advance gender-responsive humanitarian action, and that gender-transformative approaches in humanitarian settings should be considered, wherever possible (Figure 4). Within the nutrition community, there is a growing recognition that gender-based approaches do not focus only on women and adolescent girls; rather, they also seek to examine and shift norms, roles and responsibilities for boys and men and address the structural and social root causes of gender inequality.

The [Gender-Transformative Framework for Nutrition](#)⁵¹ is another reference tool that offers a framework for improved gender analysis, solutions design, and monitoring and evaluation of nutrition approaches, as well as interventions promoting women and adolescent girls’ empowerment. The [Inter-Agency Standing Committee \(IASC\) Gender with Age Marker](#)⁵² has a specific tip sheet for nutrition that provides examples of good gender equality programming in nutrition.

UNICEF applies the Gender Continuum diagnostic tool to evaluate the effectiveness of a development or humanitarian intervention in addressing gender inequalities in program design, implementation, monitoring or evaluation

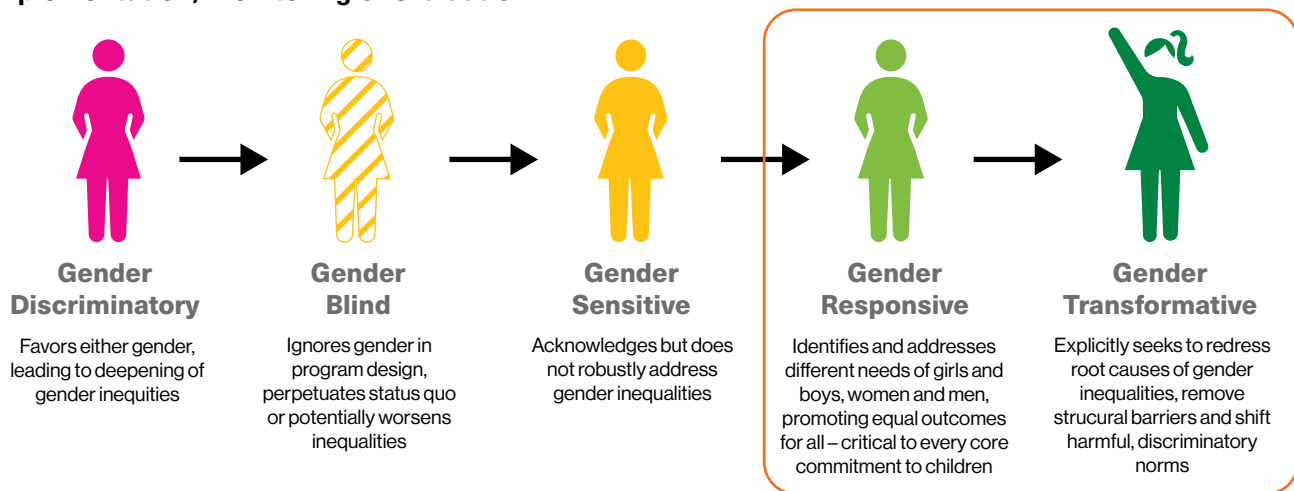


FIGURE 4. Gender continuum and humanitarian action



Recommendations:

- Nutrition interventions in humanitarian settings should aim to foster women’s agency, as well as support new and existing opportunities for women and adolescent girls, to ensure maximum benefit.
- Multisectoral interventions should be designed as gender-responsive, at a minimum. Where possible, gender-transformative interventions should be considered.
- Programme design should consider the concerns and suggestions of women and adolescent girls themselves.
- Gender approaches must consider the roles and responsibilities of men and boys, as well as women and adolescent girls.

BOX 8.



Overweight and obesity in pregnant and breastfeeding women and adolescent girls^{53,54,55}

The focus of this guidance is on protecting pregnant and breastfeeding women and adolescent girls from undernutrition and micronutrient deficiencies in humanitarian contexts. However, many low- and middle-income countries are now experiencing high levels of overweight and obesity that generally affect more women than men, due to unhealthy and unregulated food environments, low physical activity levels, constrained economic circumstances, and sociocultural factors, or a combination of these.

During pregnancy and breastfeeding in particular, the risk of associated morbidity and complications increase for women and adolescent girls, such as gestational diabetes, pre-eclampsia, pregnancy-related hypertension and caesarean deliveries, as well as postpartum weight retention, obesity and non-communicable diseases in later life.

Countries experiencing a humanitarian crisis may also have a high prevalence of overweight and obesity in women and adolescent girls who are pregnant or breastfeeding. This may necessitate different/altered responses to the crisis.

In these contexts, it is essential to ensure there are policies and regulations in place, such as those that:

1. Regulate food assistance to ensure the food and/or cash/voucher assistance programmes exclude ultraprocessed foods and beverages high in fat, sugar and salt.
2. Consider the existing food environment, including providing protection from the marketing of unhealthy foods and beverages and/or setting standards for what can be sold in and around areas where pregnant and breastfeeding women and adolescent girls are living, such as in camps for refugees or internally displaced persons.
3. Include social and behaviour change interventions that support policy and regulation to address overweight and obesity in a given setting.

3. Scenario-based response planning




This section describes the recommended nutrition interventions for pregnant and breastfeeding women and adolescent girls in humanitarian contexts (Figure 5).

Considering the wide range of humanitarian situations, Figure 5 guides practitioners by illustrating a variety of scenarios (based on existing levels of nutritional

vulnerability) and the level at which these interventions are being delivered within the population (i.e., individual, household and community).

The level of nutrition vulnerability is assessed by the prevalence of low MUAC (<23 cm) in pregnant and breastfeeding women and adolescent girls.^a Where these data are not available, other data sources should be considered, such as IPC Acute Malnutrition and IPC Acute

FIGURE 5. Summary of recommended interventions at individual, household and community levels, based on underlying nutrition context.

Population level of nutritional vulnerability	High (fulfilling 1 or more of these criteria)	Medium (fulfilling 1 or more of these criteria)	Low (fulfilling 1 or more of these criteria)
 Individual	<ul style="list-style-type: none"> PBWGs low MUAC \geq 40% BMI <18.5 kg/m² among women of reproductive age \geq40% IPC Acute Malnutrition 4-5 IPC Acute Food Insecurity (AFI) 4-5 GAM prevalence \geq15% in children 6-59 months 	<ul style="list-style-type: none"> PBWGs low MUAC \geq20-39% BMI <18.5 kg/m² among women of reproductive age \geq20-39% IPC Acute Malnutrition 2 or 3 IPC Acute Food Insecurity 3 GAM prevalence \geq10-15% in children 6-59 months 	<ul style="list-style-type: none"> PBWGs low MUAC <20% BMI <18.5 kg/m² among women of reproductive age <20% GAM prevalence 0-9% m² in children 6-59 months
 Household	MUAC screening Balanced energy protein supplementation for all PBWGs MMS/IFA Nutrition counselling	MUAC screening Targeted BEP (MUAC <23 cm and all PBGs <19 years) MMS/IFA Nutrition counselling	MMS/IFA Nutrition counselling
 Community	Social Behaviour Change Women's empowerment	Social Behaviour Change Women's empowerment	Social Behaviour Change Women's empowerment

BEP: Balanced energy protein; **BMI:** Body Mass Index; **GAM:** Global Accute Malnutrition; **IFA:** Iron and Folic Acid; **IPC:** Integrated Food Security Phase Classification; **MMS:** Multiple Micronutrient Supplementation; **MUAC:** Mid-upper Arm Circumference

^a When considering population level risk, according to WHO, for underweight in women assessed by low BMI (kg/ m²) a prevalence of 20-39% is considered high; and 40% or higher is considered a very high prevalence. While this guidance is addressing pregnant and breastfeeding women and adolescent girls rather than the wider population of women, these thresholds have been applied for MUAC as the recommended tool for screening and targeting for macronutrient supplementation in this population in humanitarian settings.

3. Scenario-based response planning

Food Insecurity severity classification, and/or prevalence of global acute malnutrition (Figure 5), along with other contextual considerations that impact nutrition, such as disease outbreaks and/or population displacement. Completion of the nutrition situation analysis, as described in section 1, will help practitioners piece together the various factors that may be contributing to nutrition vulnerability in pregnant and breastfeeding women and adolescent girls.

In most contexts, it is unlikely that the severity of the situation fits neatly into one single category of high, medium or low, so a 'best estimation' will be needed. As such, partners should come together to discuss the available evidence and determine the level of vulnerability of the population as best they can.

The differences in the recommended interventions between the three contexts of nutritional vulnerability are:

1. Whether BEP supplementation is recommended for all pregnant and breastfeeding women and adolescent girls (high); or targeted only to those with low MUAC (medium); or not given at all (low); and
2. Whether household food assistance and/or cash transfers are recommended (high and medium only).

All other interventions across the three different levels (individual, household and community) should be implemented, regardless of the existing nutritional vulnerability within the population.

This guidance acknowledges the wide variety of emergency contexts that practitioners face and offers some considerations for implementing interventions for pregnant and breastfeeding women and adolescent girls in four different response contexts: **complex, protracted, transit, and public health emergencies.**



<p>Complex context – where an acute humanitarian situation has occurred and multiple systems have been disrupted. There may be conflict, displacement, disruption to basic service availability and access. In this context, it is assumed that access to antenatal care and other maternal services are interrupted and/or very limited.</p>	<p>Considerations</p> <ul style="list-style-type: none"> • If antenatal care and access to basic health care at static sites is disrupted, alternative ways to reach women and adolescent girls will need to be explored, such as mobile health and nutrition teams. Consider how to strengthen mobile teams to deliver the package of interventions. • Scheduling of IFA/MMS should be adapted according to the context. In some complex contexts a three-month (or six-month) supply may be preferable to a one-month supply, to ensure that the population receives the recommended amounts. • General food assistance and other distributions may be organized to reach pregnant and breastfeeding women and adolescent girls, particularly with BEP, where indicated. • In the context of conflict and displacement, GBV and psychosocial support will be essential. Prioritize establishment of safe spaces and referrals to protection and other services, where available. • Nutrition education and counselling should be adapted to the specific context of food security and the level of stress that the population is facing. In some contexts, counselling will need to focus on supporting women and adolescent girls to meet their basic needs for safety and lifesaving support. • Routine data collection is likely very difficult, so where feasible, include pregnant and breastfeeding women and adolescent girls in MUAC screening when children’s MUAC is collected.
<p>Protracted context – where the humanitarian situation is no longer acute, and camps and settlements have been established. At least a minimal level of health and nutrition response services are in place.</p>	<p>Considerations</p> <ul style="list-style-type: none"> • This situation offers the best opportunity to implement the full package of interventions, including targeted BEP, if indicated. • Focus on linking with other sectoral responses (refer to Table 4, page 17) and ensuring effective coordination between the various services. • Consider how a systems-strengthening approach can be applied in the delivery of all services (see section 2). • Consider how support for pregnant and breastfeeding women and adolescent girls can be strengthened across services for child wasting and infant and young child nutrition, such as increasing access to counselling, referrals, GBV risk mitigation, etc. • Advocate for strong linkages with any social assistance programming, including cash transfers. • Advocate and coordinate across sectors for the inclusion of indicators for pregnant and breastfeeding women and adolescent girls in routine surveys and assessments and ensure that the population is reflected in any nutrition situation analysis updates.

Transit context in high- or middle-income country – usually an acute situation, where the population, including women and adolescent girls, is on the move. The particular feature of this response platform is the short contact time at the various transit points, and limited or no access to routine services. Transit contexts can be chaotic and highly challenging, especially at the onset and during the first weeks of a crisis.

Considerations

- The primary consideration is how to utilize the short contact time to provide the most essential support, especially considering that women are likely to be under considerable stress as they undertake a journey, particularly those who are pregnant and/or have children in their care.
- Where possible, integrate and position support for pregnant and breastfeeding women in girls in locations where they are seeking support and services for their children.
- Ask women and adolescent girls what they need most at this point in their journey. This can inform the package of support and may fall outside of the interventions outlined above. For example, a safe space might include hot tea, snacks, access to charging points, counselling, referrals and information about what services are available on their journey ahead.
- Transit sites can be crowded with different actors and volunteers providing services and assistance. Effective coordination is essential to maximize support and avoid duplication in the response.
- MUAC screening is not indicated in middle- and/or high-income settings, given that this is assumed to be a low nutrition vulnerability context. Any data collected should focus on qualitative information about women’s and adolescent girls’ needs.

Public health crisis – usually an acute situation involving a disease outbreak or epidemic, which severely constrains or even overwhelms existing health and nutrition services. Depending on the nature of the disease, the health and nutrition workforce may be affected, compromising their ability to respond. Different diseases will have varying effects on nutritional status. In high or medium nutritional vulnerability contexts, pregnant and breastfeeding women and adolescent girls may be rapidly affected and experience deteriorating nutrition status and outcomes.

Considerations

- There are likely to be significant operational constraints to effectively delivering an appropriate response to pregnant and breastfeeding women and adolescent girls, so careful assessment of delivery opportunities is required, tailored to the context.
- When pregnant and breastfeeding women and adolescent girls are admitted to a treatment facility, consider whether there is access to nutritious and adequate food and whether supplementation is needed to avoid weight loss and nutritional deterioration.
- In situations that require quarantine, consider how this affects a woman’s ability to care for herself, her family and meet her basic needs. Highly specific contextualization may be required in this instance.
- In public health crises, when a pregnant and breastfeeding woman or girl is sick, there is likely to be impact on her appetite and a marked increase in her nutritional vulnerability, particularly if the illness is prolonged.
- Mental health and psychosocial support should be linked to the nutrition response.
- Unless there is a specific clinical reason, infants and young children should not be separated from their mothers.
- Guidance for public health crisis response is generally focused on (1) infant outcomes of the pregnant woman; or (2) the infant feeding practices of the mother (i.e., continued breastfeeding support) and omits actions to support the needs of the mother herself. When applying other guidance, consider how the needs of pregnant and breastfeeding women and adolescent girls can be considered in a meaningful way.

4. Monitoring and learning

Monitoring and learning are critical aspects of programming. These processes can help to:

- Track progress towards objectives and determine whether aims and goals are being achieved as planned.
- Assess programme performance, identify obstacles and challenges, and help identify where adjustments are needed.
- Provide feedback to government and relevant partners.
- Understand the efficiency and effectiveness of interventions.
- Make decisions regarding when to close interventions.

Simple management and information systems can reduce the burden on programme staff, while offering sufficient and useful information to ensure programme effectiveness. It is therefore recommended that practitioners carefully consider what information they collect, and only collect information that will be used to report on and improve programme performance.

4.1 Monitoring

Table 5 below provides some examples of programme monitoring information that may be collected, for each of the five areas of intervention described above in this guidance. The GNC has compiled a comprehensive list of [indicators](#)⁵⁶ that may be a useful reference for additional indicators. Where possible disaggregation is advised between pregnant and breastfeeding, and women and adolescent girls.

TABLE 5. Interventions and example indicators for monitoring

Intervention area	Intervention	Example monitoring indicators
General		<input type="checkbox"/> Existence of a policy/guidance document for pregnant and breastfeeding women and adolescent girls in humanitarian settings (yes/no) Example indicators that could be included in national policy/guidelines <input type="checkbox"/> # pregnant and breastfeeding women and adolescent girls screened for underweight <input type="checkbox"/> Entry and exit criteria for eligible pregnant and breastfeeding women and adolescent girls established (yes/no) <input type="checkbox"/> Package of interventions for pregnant and breastfeeding women and adolescent girls defined (yes/no)
Macronutrient supplementation	BEP supplementation	<input type="checkbox"/> # of pregnant and breastfeeding women and adolescent girls receiving BEP supplementation <input type="checkbox"/> Proportion of pregnant and breastfeeding women and adolescent girls receiving BEP supplementation
Micronutrient supplementation	IFA/MMS programming	<input type="checkbox"/> # of pregnant and breastfeeding women and adolescent girls who receive IFA or MMS for 90+ days (disaggregated between IFA and MMS, where possible) <input type="checkbox"/> Proportion of pregnant and breastfeeding women and adolescent girls who receive IFA or MMS for 90+ days (disaggregated between IFA and MMS, where possible)
	Calcium supplementation	<input type="checkbox"/> # of pregnant and breastfeeding women and adolescent girls who received the recommended number of calcium supplements in their pregnancy <input type="checkbox"/> Proportion of pregnant and breastfeeding women and adolescent girls who received the recommended number of calcium supplements in their pregnancy

4. Monitoring and learning

Intervention area	Intervention	Example monitoring indicators
Micronutrient supplementation (cont.)	Vitamin A supplementation	<input type="checkbox"/> # of pregnant women and adolescent girls that received vitamin A supplementation <input type="checkbox"/> Proportion of pregnant women and adolescent girls that received vitamin A supplementation
	Deworming prophylaxis	<input type="checkbox"/> # of pregnant and breastfeeding women and adolescent girls who received deworming medication <input type="checkbox"/> Proportion of pregnant and breastfeeding women and adolescent girls who received deworming medication
Nutrition education and counselling	Nutrition counselling	<input type="checkbox"/> # of contacts where pregnant and breastfeeding women and adolescent girls received nutrition counselling on healthy eating, physical activity, rest, and appropriate weight gain during pregnancy <input type="checkbox"/> Proportion of ANC contacts in a facility during which pregnant women and adolescent girls received nutrition counselling on healthy eating, physical activity and appropriate weight gain during pregnancy <input type="checkbox"/> # of safe spaces established for pregnant and breastfeeding women and adolescent girls
Social protection	Social transfers for pregnant and breastfeeding women and adolescent girls (cash transfer, vouchers, food)	<input type="checkbox"/> # of targeted pregnant and breastfeeding women and adolescent girls receiving social transfers <input type="checkbox"/> Proportion of targeted pregnant and breastfeeding women and adolescent girls receiving social transfers
Empowerment and gender-responsive and transformative programming	All interventions	<input type="checkbox"/> # of interventions that considered gender-responsive actions in their design <input type="checkbox"/> # of interventions that considered gender-transformative actions in their design <input type="checkbox"/> # of interventions collecting sex and age disaggregated data

BOX 9.



Sphere minimum standards

The Sphere minimum standards are based on the Humanitarian Charter, which outlines the ethical and legal principles underpinning the Sphere project. Started in 1997, Sphere aims to improve the quality and accountability of humanitarian assistance across four main lifesaving areas: WASH; food security and nutrition; shelter and settlement; and health. Its minimum standards and indicators, which can be used to track progress, are outlined in the Sphere Handbook, which is regularly updated and reflects Sphere's commitment to a principled and rights-based humanitarian response. It is based on fundamental respect for people's right to be fully involved in decisions regarding their recovery.

The handbook can be found online in [English](#), [French](#), [Spanish](#) and [Arabic](#).

The specific recommendations relevant for women's nutrition are detailed in Annex 3.

4.2 Learning

As described above in each of the sections of this guidance, there are large gaps in our understanding of how to accurately assess and identify undernutrition in pregnant and breastfeeding women and adolescent girls. Without routine inclusion in nutritional situational analyses, the needs of this population will continue to be excluded from the planning, financing and appropriate programmatic response. It is therefore essential to not only include pregnant and breastfeeding women and adolescent girls in any nutritional assessments that will be conducted in your area, but also to invest in documenting the practice, to help with knowledge generation and learning. A summary of the key research gaps are outlined in Box 10.

BOX 10.



Research gaps for pregnant and breastfeeding women and adolescent girls, relevant to humanitarian programming

- Evidence on women's health and nutritional status as outcomes of interventions (as opposed to infant/child outcomes (e.g., low birthweight).
- Research examining intervention outcomes on women's nutritional status (e.g., MUAC, weight or BMI) and/or anaemia.
- Evidence coming from humanitarian contexts; a body of evidence around 'what works' in humanitarian situations.
- Studies that follow comparable/standard design and modality (including ration sizes where supplements are provided) so that intervention results can be compared and contrasted and studies can contribute to a body of evidence. At present, the heterogeneity between studies makes it difficult to draw compelling conclusions.
- Separate studies and/or analysis of pregnant adolescents versus pregnant women.
- Studies specific to breastfeeding women.
- Studies that examine how outcomes can be amplified by implementing a package of interventions that targets communities, at the same time as households and individuals.

5. Important considerations for programming

5.1 Preparedness

Preparedness is essential to promote a timely, effective and efficient nutrition response. Where there is a cluster/sector for nutrition at country level, there is also likely to be an emergency response preparedness (ERP) plan, developed in collaboration with the government and partners.

In countries with no cluster/sector, practitioners need to investigate where the emergency preparedness planning processes are supported. This may be the Ministry of Health, the National Disaster Management Authority or an equivalent body.

The GNC has developed a toolkit that outlines an [ERP process](#) to support nutrition clusters/sectors in developing an actionable ERP plan. This includes eight steps, from risk analysis and monitoring through to operational arrangements and preparedness actions.

It is important to consider and include pregnant and breastfeeding women and adolescent girls throughout this structured ERP process. Key steps where it is important to factor in these special needs include:

Scenario definition:

- Anticipate the plausible chain of events following a predictable shock that will negatively impact and/or affect pregnant and breastfeeding women and adolescent girls (e.g., population displacement during which decision-making power may shift, access to markets may change, or access to and demand for health and nutrition services may be affected).

Response analysis and response design:

- Map nutrition vulnerabilities with focus on pregnant and breastfeeding women and adolescent girls, layered with disaster risks, to identify areas of greatest vulnerability.
- Ensure needs of this population are taken into consideration (see section 1) through the review of

secondary information and triangulation of data from different sources.

- Ensure sex and age disaggregated data are available for mapping nutrition vulnerabilities, for people in need and calculations of target numbers, and any prioritization methodologies (as per HNO/HRP).
- Consult women and adolescent girls on preferred modalities of assistance (service-based, in-kind or cash/voucher).
- Consider evaluating risks associated with GBV and physical safety when accessing services and humanitarian assistance.
- Ensure nutrition practitioners and first responders are sensitized, as part of capacity building plans, on how to receive disclosures of GBV safely and supportively, and be able to provide up-to-date information on available GBV services (i.e., use referral pathways).

Plan for operational arrangements to coordinate and deliver response:

- Ensure necessary guidelines, protocol and training materials^a are available to guide a response to identified needs.
- Identify where there are capacity gaps in programming for pregnant and breastfeeding women and adolescent girls and inform a capacity strengthening plan.
- Ensure that assessment methodologies and tools include an evaluation of the needs of pregnant and breastfeeding women and adolescent girls, and that these needs are addressed in nutrition advocacy strategies and activities.
- Map the necessary supplies and stocks, and identify and accelerate procedures for procurement and delivery.
- Seek engagement with women-led/women's rights organizations in all steps of ERP planning. In the preparedness phase, identify and build partnerships with women-led civil society and organizations.

^a A short [training course on maternal nutrition](#) is available on Agora.

BOX 11.



How to access technical support from the GNC

If specific technical questions arise related to preparedness or at any phase of a nutrition response, the Global Nutrition Cluster can be contacted for technical support through the [GNC webpage](#).

5.2 Advocacy

Improving maternal nutrition status is foundational for healthy and strong families and communities. It also helps countries develop their human capital and become economically self-reliant. Historically, collective efforts within the global humanitarian and development sectors have been mostly directed towards child nutrition. However, in humanitarian settings, women and adolescent girls often bear the brunt of the crisis, with serious impacts for their own nutritional status as well as their ability to support healthy pregnancies and maintain optimal infant feeding practices and caregiving roles. Female-headed households are often especially vulnerable.

As mentioned throughout this guidance document, it is imperative that the needs of vulnerable women and adolescent girls, particularly those who are pregnant or breastfeeding, are properly assessed. Without a clear understanding of what their needs are, it is unlikely that they will subsequently be included in planning and service provision. Consistent advocacy messaging is essential, directed towards increasing investments and triggering policy change to adopt and scale maternal nutrition interventions so that pregnant and breastfeeding women and adolescent girls can be effectively targeted and reached with appropriate services, across multiple humanitarian contexts. Once a nutrition cluster is activated, an advocacy brief is usually developed to help bring attention to the needs. Annex 2 outlines some generic advocacy messages that may be adapted for inclusion in these advocacy briefs and advocacy opportunities, as well as funding proposals.

5.3 Disability inclusion

Fifteen per cent of the world's population – at least 1 billion people – have some form of disability, whether present at birth or acquired later in life. Inclusion starts with the understanding that disability is the result of interactions

between inaccessible environments and a person who has long-term impairments. Inclusion can be achieved when people work to break down physical barriers, when services are accessible to everyone, when policies equally benefit all individuals, and when communications reach every person, regardless of the disability that they are living with. Below are some specific actions to consider in designing a nutrition response for pregnant and breastfeeding women and adolescent girls:

- Ensure that needs assessments are inclusive of women and adolescent girls with disabilities, who commonly face barriers accessing nutrition interventions in emergencies. This includes disaggregating household survey data using the [Washington Group questions](#),^a and including women and adolescent girls with disabilities in any qualitative approaches (such as key informant interviews or focus group discussions). In some cases, this may require dedicated outreach to engage with more marginalized women and adolescent girls, such as those who have more severe physical or intellectual disabilities.
- Conduct accessibility audits of all nutrition programming for pregnant and breastfeeding women and adolescent girls to identify physical, communication and other barriers to access. These audits should ideally be done in a participatory way, engaging women and adolescent girls with disabilities in identifying barriers to access, and potential solutions. Routine monitoring of the accessibility of nutrition interventions, including through disaggregating indicators on access by disability, is also encouraged.
- Recognizing the potential barriers in humanitarian contexts, work towards nutrition education and counselling being delivered in accessible and inclusive formats, including for women and adolescent girls with hearing, visual and intellectual disabilities.
- Work towards nutrition interventions that address the specific nutrition needs of women and adolescent girls with disabilities. This may include addressing eating difficulties or specific dietary requirements.
- Engage with local organizations for persons with disabilities, particularly those led by women, in the planning, implementation and monitoring of nutrition interventions for pregnant and breastfeeding women and girls.

^a See: <https://www.washingtongroup-disability.com/question-sets/>



5.4 Accountability to affected populations

Accountability to affected populations is defined as an active commitment to use power responsibly by taking account of, giving account to, and being held to account by the people humanitarian organizations seek to assist.⁵⁷

It is strongly recommended that pregnant and breastfeeding women and adolescent girls be consulted, given their unique roles in family, household, and community structures. This ensures their knowledge and desires are reflected in programme design and that the nutrition response does not cause any unintentional harm.

The GNC has developed the [Operational Framework on Accountability to Affected Populations](#)⁵⁸ for nutrition clusters. The framework offers practical examples of what accountability looks like when applied in a nutrition response and ideas for performance indicators to measure progress. The framework outlines actions for the domains of transparency/information sharing, participation, and feedback and complaints.

5.5 GBV risk mitigation

IASC has clearly stated: “All humanitarian actors must be aware of the risks of GBV and – acting collectively to ensure a comprehensive response – prevent and mitigate these risks as quickly as possible within their areas of operation. Failure to take action against GBV represents a failure by humanitarian actors to meet their most basic responsibilities for promoting and protecting the rights of affected populations.”⁵⁹

In most settings, women and adolescent girls are the primary users of nutrition services, meaning that – based on global statistics – one in three individuals who come into contact with nutrition programming has experienced GBV at some point in their lifetime. Because nutrition services tend to be highly valued and trusted within communities, they are also a place where GBV survivors seek support to address the consequences of violence, particularly in locations where specialized GBV response services are not available. As such, proactively identifying and addressing GBV-related risks within nutrition programming is critical, both from a do no harm perspective, but also as a means of improving the efficiency and effectiveness of nutrition programmes. Some basic GBV risk mitigation actions that can be implemented by nutrition staff include:

- Utilizing safety audits (sample tool from South Sudan available [here](#)) to identify/implement necessary structural changes and/or service delivery adaptations.
- Increasing the proportion of female staff and community nutrition volunteers.
- Training frontline nutrition staff on how to safely and appropriately respond to GBV disclosures ([GBV Pocket Guide](#))
- Making [consultations with women and adolescent girls](#) a standard component of programmatic monitoring and evaluation.
- Other specific recommendations are available in the [IASC GBV Guidelines, Nutrition Thematic Area Guide](#).

Annex 1

Table of most useful guidance sources

Year	Author	Title	Link
2023	WHO	Guideline on the prevention and management of wasting and nutritional oedema (acute malnutrition) in infants and children under 5 years	WHO guideline on the prevention and management of wasting and nutritional oedema (acute malnutrition) in infants and children under 5 years
2022	WHO	Guideline for integration of perinatal mental health in maternal and child health services	WHO guide for integration of perinatal mental health in maternal and child health services
2022	UNICEF	UNICEF Programming Guidance: Prevention of malnutrition in women before and during pregnancy and while breastfeeding	Programme Guidance on Maternal Nutrition UNICEF
2022	WHO	WHO recommendations on maternal and newborn care for a positive postnatal experience	WHO recommendations on maternal and newborn care for a positive postnatal experience
2022	Interagency working group on reproductive health in crises	Success Depends on Collaboration Cross-Sector: Technical Brief on Maternal and Newborn Health and Nutrition in Humanitarian Settings	Success Depends on Collaboration: Cross-Sector Technical Brief on Maternal and Newborn Health and Nutrition in Humanitarian Settings Inter-Agency Working Group on Reproductive Health in Crises (iawg.net)
2018	Sphere Association	Sphere Handbook: Humanitarian charter and Minimum Standards in Humanitarian Response	The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response (Fourth Edition) (spherestandards.org)
2018	Interagency working group on reproductive health in crises	Field Manual on Reproductive Health in Humanitarian Settings	IAWG Inter-Agency Working Group on Reproduction Health in Crises (iawgfieldmanual.com)
2019	WHO	Essential Nutrition Actions	Essential nutrition actions: mainstreaming nutrition through the life-course (who.int)
2016	WHO	WHO recommendations on antenatal care for a positive pregnancy experience	WHO recommendations on antenatal care for a positive pregnancy experience
2011	United Nations High Commissioner for Refugees (UNHCR)/WFP	Guidelines for selective feeding: The management of malnutrition in emergencies	UNHCR Guidelines for Selective Feeding.pdf (inee.org)

Annex 2

Generic advocacy messages for pregnant and breastfeeding women and adolescent girls

- No women or girl should be denied their right to the highest possible standard of health and nutrition, especially during pregnancy and breastfeeding. For women and adolescent girls living in fragile settings the needs are compounded. Women and adolescent girls right to nutrition must be prioritized in humanitarian responses.
- To protect the rights of pregnant women and their children, there is an urgent need to scale up investment in adequate nutrition and quality antenatal services for women and adolescent girls, especially in fragile and vulnerable settings.
- Globally, nearly 1.2 billion women and adolescent girls suffer from deficiencies in vitamins and other essential nutrients such as iron, zinc, folate, and iodine. Malnutrition before and during pregnancy affects both the mother and child by increasing the mother's risk of life-threatening conditions such as high blood pressure, eclampsia, and severe anaemia as well as increasing the infant's risk of stillbirth or premature birth.
- Undernutrition weakens adolescent girls' and women's immunity to infections and other life-threatening complications. Poor nutrition also hinders girls' and women's ability to learn, earn, and thrive.
- At least 49 million adolescent girls (10 - 19 years) and 154 million women (20 - 49 years) are underweight due to the lack of access to nutritious and diverse diets required to maintain a healthy body weight. South Asia, West and Central Africa, and Eastern and Southern Africa are the three regions with the highest proportion of underweight and anaemia among adolescent girls and women.
- Passed down through generations from mother to child, malnutrition has lifelong consequences for women and their children. For girls that survive and go on to have children, they are more likely to give birth to infants more vulnerable to stunting and/or wasting, prolonging a vicious cycle of inter-generational poverty and undernutrition.
- Anaemia is the leading cause of maternal mortality and globally, the prevalence of anaemia in pregnant women has remained persistently high at 30 percent since 2000. Almost 1 in 3 adolescent girls and women (571 million) between the ages of 15 and 49 years suffer from anaemia, a preventable condition commonly caused by iron deficiency. No region is on track to meet the global targets to reduce anaemia by half, and low birth weight by 30 percent by 2030.
- Multiple micronutrient supplements (MMS) containing 15 essential vitamins and minerals in a single tablet - are a safe and cost-effective way to prevent anaemia and improve the nutritional status of pregnant women and should be accessible to all pregnant individuals as part of improved antenatal care services. MMS has been shown to reduce low birthweight by 14%, pre-term birth by 7%, and stillbirth by 8%.
- Prioritizing women and adolescent girls in humanitarian responses is not just a matter of equity, it is essential for the success of interventions. Women and adolescent girls often face disproportionate risks during crises, including increased violence, health risks, and economic instability. By focusing on women's and adolescent girls specific needs, the response addresses the vulnerabilities and barriers that prevent them from accessing essential services and resources.
- There is an urgent need to increase investments to scale up efforts for the reduction of malnutrition in women and adolescent girls, primarily in vulnerable settings marked by extreme poverty, humanitarian crises, and climate-related risks.
- Governments and partners must prioritize the collection of data to assess the nutritional needs of women and adolescent girls and mobilize funding for effective programming across multiple systems, including health and social protection.

Annex 3

Sphere Minimum Standards

– Specific recommendations for women and adolescent girls

Standard 2 on food security and nutrition:

- Developing an appropriate food response requires a full understanding of the unique nutritional needs of pregnant and breastfeeding women, infants and children, older people and persons with disabilities. Improving food security at the household level also requires an understanding of different roles. Women, for instance, often play a greater role in the planning and preparation of food for their households.
- Provide clear information on the importance of exclusive breastfeeding in children up to six months, and continued breastfeeding for children from 6 to 24 months, for both the physical and psychological health of mother and child.
- Admit breastfeeding mothers of acutely malnourished infants under six months to supplementary feeding programmes, independent of maternal nutrition status.
- Protect, promote and support exclusive breastfeeding in infants aged 0–5 months, and continued breastfeeding in children aged six months to two years.
- Provide access to skilled breastfeeding counselling for pregnant and breastfeeding mothers.
- Target mothers of all newborns with support for early initiation of exclusive breastfeeding.
- Provide simple guidance for exclusive breastfeeding in maternity services.
- Where mixed feeding is practised in infants aged 0–5 months, support transitioning to exclusive breastfeeding.
- Provide daily supplements to pregnant and breastfeeding women, including one daily requirement of multiple micronutrients to protect maternal stores and breastmilk content, whether the women receive fortified rations or not.
- If multiple micronutrient products containing iron are not available, provide daily iron and folic acid supplements to pregnant women and those who have given birth in the past 45 days. Continue iron and folic acid supplements when already provided.
- Prioritise pregnant and breastfeeding women for access to food, cash or voucher transfers and other supportive interventions.
- If the needs of pregnant and breastfeeding women are not met in food, or cash or voucher assistance programmes, target pregnant and breastfeeding women with fortified food. Give micronutrient supplements in accordance with WHO recommendations.
- Organise psychosocial support for distressed mothers, including referral to mental health services as necessary. Arrange appropriate support for mothers with disabilities. Create safe places in camp and other collective settings for women to breastfeed, such as baby friendly spaces with exclusive breastfeeding areas.
- Mothers living with HIV should be supported to breastfeed for at least 12 months and up to 24 months or longer while receiving anti-retroviral therapy. If anti-retroviral drugs are not available, choose the strategy that gives infants the greatest chance of HIV-free survival.
- Gender-based violence, gender inequality and nutrition are often inter-related. Domestic violence can pose a threat to the health and well-being of women and their children. Nutrition staff should provide supportive and confidential referral for caregivers or children exposed to gender-based violence or child abuse.
- Much other guidance for treatment of wasting and micronutrient deficiencies, as well as food distribution programmes, will be relevant for all the population.
- Use community-based risk assessments and other participatory monitoring to counter any patterns that endanger particular groups or individuals. For example, distributing fuel and/or fuel-efficient stoves may reduce the risks of physical and sexual assault for women and adolescent girls.
- Supplemental cash transfers, especially to vulnerable households or individuals, such as women- and child headed households or households with people with disabilities, can reduce the risk of sexual exploitation and child labour.

Food Assistance Standard 6.1

- Ensure that children aged 6-24 months have access to complementary foods and that pregnant and breastfeeding women have access to additional nutritional support.

Annex 3. Minimum Sphere Standards

- While nutritional value is the primary consideration in providing food assistance, the commodities should be familiar to the recipients. They should also be consistent with religious and cultural traditions, including any food taboos for pregnant or breastfeeding women.
- Children aged 6–59 months, pregnant and lactating women, people living with HIV and other vulnerable groups may be targeted for supplementary foods, or they may be linked to nutrition treatment and prevention strategies.
- Specific support may be needed to ensure that older people, pregnant and breastfeeding women, separated and unaccompanied children, and persons with disabilities can collect and retain their entitlements. Consider having other community members assist them, or provide them with more frequent, smaller rations.
- MUAC may be used as a screening tool for pregnant women, for example as a criterion for entry into a feeding programme. Given their additional nutritional needs, pregnant women may be at greater risk than other groups in the population. MUAC does not change significantly through pregnancy.
- Where there is high to moderate malaria transmission, provide LLINs to severely malnourished people and households, pregnant women, children under age five years, unaccompanied children and people living with HIV. Then prioritise people in supplementary feeding programmes, households with children under age five and households of pregnant women. Give pregnant women chemoprophylaxis according to national protocols and resistance patterns. In areas with high malnutrition and measles mortality, consider targeted seasonal malaria chemoprophylaxis.
- Provide all visibly pregnant women with clean delivery packages when access to skilled health providers and healthcare facilities cannot be guaranteed.
- Coordinate with the nutrition sector to ensure that pregnant and breastfeeding women are referred to nutrition services as appropriate, such as for targeted supplementary feeding.

Endnotes

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