NUTRITION INTERNATIONAL

Nourish Life

Sex- and Gender-Based Analysis

Maternal, newborn, adolescent health and nutrition programs in Pakistan

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Contents

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Acronyms

AHN	Adolescent Health and Nutrition
BCI	Behaviour Change Intervention
BHU	Basic Health Unit
CHWs	Community Midwives
CMWs	Community Health Workers
CSO	Civil Society Organization
DHO	District Health Officer
DHQ	District Headquarters (Hospital)
EPI	Expanded Program of Immunization
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-Based Violence
GCC	Gender Crime Cell
GoS	Government of Sindh
IFA	Iron and Folic Acid
KII	Key Informant Interview
KMC	Kangaroo Mother Care
KP	Khyber Pakhtunkhwa
LEA	Law Enforcement Agencies
LHS	Lady Health Supervisor
LHW	Lady Health Worker
LHV	Lady Health Visitor
MNAHN	Maternal, Newborn, Adolescent Health and Nutrition
MNHN	Maternal, Newborn Health and Nutrition
MoNHSR&C	Ministry of National Health Services Regulation and Coordination
NGO	Non-Governmental Organization
PDHS	Pakistan Demographic Health Survey
PPC	Pakistan Penal Code
RHC	Rural Health Centre
SGBA	Sex- and Gender-Based Analysis
THQ	Tehsil Headquarters (Hospital)
UC	Union Council
VAW	Voilence Against Women
WIFA	Weekly Iron and Folic Acid

Acknowledgments

We would like to acknowledge and thank the study participants, including district government officials, program personnel, staff at Nutrition International's partner organizations, service providers, teachers, and women and adolescent girls in the communities, for their time and enthusiastic participation in this study. We highly appreciate their candid discussions and valuable insights. We hope the insights from their input, discussions and suggestions will improve programing focused on fighting malnutrition among the most marginalized of population groups.

Executive summary

Pakistan is the fifth largest "young country" in the world with an estimated 63 percent of its population comprising of youth. Pakistan is home to about 40 million adolescents (between the ages of 10-19), equivalent to 23 percent of the total population. In Pakistan, girls are a neglected target group for health and nutrition interventions. They have a comparatively low social status, remain marginalized and are unable to avail opportunities restricting their socioeconomic empowerment. The two major adverse manifestations of the disempowerment of adolescent girls in Pakistan are early marriage and poor nutritional status. One in eight adolescent girls in Pakistan is underweight, with an alarming percentage (56.6 percent) being anaemic. Adolescent girls in rural areas are more likely (58.1 percent) to be anaemic than their counterparts in urban areas (54.2 percent). Early marriages, closely spaced pregnancies and maternal malnutrition lead to a vicious cycle of high morbidity and high mortality and, thus, adverse maternal and child health outcomes.

METHODOLOGY

Using a mixed methods approach, this study employed both qualitative and quantitative research methods as well as desk review of secondary data to gather data for Sex- and Gender-Based Analysis (SGBA) of Nutrition International's Maternal, Newborn Health and Nutrition (MNHN) and Adolescent Health and Nutrition (AHN) programs.

KEY FINDINGS

- Almost all the study participants across the three provinces underscored that male dominance and patriarchal value system was all-pervading. Across the province, it was common to see preference of sons over daughters and placing more importance on boys' health, nutrition and education over girls'. Discriminatory gender norms and practices, though in decline, were not uncommon.
- Community women highlighted the low status of young girls within households and lack of their involvement in decision-making in terms of financial, health or education matters. They also stressed that restrictions on female mobility, gender norms and cultural practices discouraged girls' education and employment, and encouraged early marriage.
- Almost all of the participants across the three provinces consistently pointed out the lack of financial autonomy and involvement in decision-making, particularly of younger and unmarried women and adolescent girls. Moreover, they discussed that restrictions on female mobility and the need for a husband's or guardian's approval hampered women and girls' ability to seek healthcare.
- The quantitative data corroborated the qualitative findings that men were more likely than women to enjoy greater social mobility and decision-making power.
- The study findings revealed changing food patterns and availability and use of unhealthy and processed foods and carbonated drinks. Many of the study

participants identified rising unhealthy dietary practices and lack of awareness regarding diversity of food and balanced diet.

- Majority of the study participants pointed out that socioeconomic factors – like large families, early marriages, illiteracy, unemployment, poverty and place of residence – influenced gender roles and access to education, health and nutrition for women and adolescent girls.
- Need for travel to health facilities and restricted social mobility for women hampered access to health services, including nutrition.
- COVID-19 pandemic and resulting lockdowns increased people's socioeconomic vulnerabilities and drastically affected their livelihoods, particularly the poorest segments of the population, and thus increased their food insecurity, health, and well-being.
- The data revealed that some communities were more vulnerable than others. For instance, ethnic minorities like Kohli, Baghri and Christians, and communities living in deserts, mountains, and flood prone areas lacked access to adequate health and information services.
- Barriers to women's health-seeking behaviour included travel to health facilities, restrictions on female mobility, financial constraints, lack of gender-sensitive service provision, lack of agency for independent decision-making and dependence on approval or permission from parents, husbands or in-laws.
- Barriers to adolescent health-seeking behaviour included poverty, lack of autonomy, gender discrimination and limited knowledge about healthy foods.
- Many of the study participants highlighted the important role of MNHN and AHN programs and the impact they were having in the intervention areas, particularly in terms of increased access to MNHN and AHN services and changing health related behaviours. The study also identified key programmatic challenges including the disruption and delays in MNHN and AHN activities and supplies.
- Many of the study participants emphasized the need to expand the AHN program to reach out-of-school adolescent girls as well as male involvement and greater community engagement.
- At programmatic level, many of the study participants suggested expanding the coverage of the MNHN and AHN programs to reach communities in remote areas, ethnic minorities, boys, out-of-school girls, and girls with disabilities.
- Most of the key informants had no clear understating of key gender concepts, as outlined in Nutrition International's Gender Strategy, such as sex and gender, gender equality, gender equity, women and girls' empowerment and gender mainstreaming. Most of them informed that they had not received comprehensive training on gender. The study findings highlighted that staff at Nutrition International's partner organizations required comprehensive training on gender as well as capacity building.

RECOMMENDATIONS

- Embed gender mainstreaming in the programs from design stage to its implementation and evaluation.
- In addition, the monitoring and evaluation (M&E) system should be strengthened to ensure that the programs collect disaggregated data on sex and gender.
- Organize comprehensive trainings for staff and partners on key concepts and values that underline Nutrition International's Gender Strategy and how gender equality and good nutrition are intertwined, as well as the crucial role everyone engaged in the MNHN and AHN can play in improving nutrition and empowering women and girls.
- Develop multidimensional interventions/activities that target not only in-school girls but also out-of-school adolescent girls, pregnant women, and other vulnerable population groups including minorities and people with disabilities.
- Ensure uninterrupted supply of nutritional supplements and MNHN/AHN supplies in the target service centres/communities.
- Develop social and behaviour change strategies to promote awareness about and consumption of a diverse range of foods to combat malnutrition and promote healthy eating practices.
- Develop behaviour change interventions and targeted messaging to address myths and misconceptions about Iron and Folic Acid (IFA) supplements, colostrum, exclusive breastfeeding and postpartum diet for the mother and child.
- Engage and train teachers on gender and nutrition and related health topics to raise awareness about healthy dietary practices and counter gender stereotypes.
- Increase outreach through CMWs/CHWs and door-to-door campaigns to raise awareness about the 1,000-day window and strengthen referral mechanism.
- Organize refresher trainings for service providers to enhance their capacity and keep them motivated.
- Engage males, social workers, community elders and religious leaders to sensitize communities about malnutrition, enhance acceptance of interventions and change behaviours.
- Utilize mainstream media channels as well as social media, local radio and cable TV networks to promote equal and positive gender norms and roles as social ideals and spread the information about the importance of nutrition, balanced diet, gender equality and women's and girls' empowerment.

Introduction and background

Malnutrition, either undernutrition or overnutrition, is a persistent global public health concern which causes different types of diet-related non-communicable diseases (Anik Al Rehman et.al. 2019). Malnutrition affects one out of three people on the planet in different forms and its impacts are particularly heavy on children, adolescent girls and women. The prevalence of stunting is declining too slowly while maternal overweight continues to rise globally (Hayashi Chika, 2017). In Pakistan and its neighbouring countries, child malnutrition is declining, although the prevalence remains high, while overweight and obesity have significantly increased among women (National Institute of Population Studies, ICF 2018). These countries are now facing a double burden of malnutrition, which means undernutrition and obesity coexist in the population.

The Pakistan Demographic Health Survey (PDHS) 2017-18 also reports high total fertility rate at 3.6 births per women, which may also have an effect on malnutrition among women and children. In addition, PDHS 2017-18 reports that 38 percent of children in Pakistan are stunted and 17 percent are severely stunted. Likewise, it reported that 23 percent of all children under five are underweight and eight percent are severely underweight. It is also revealing to note that children of women with no education and belonging to the poorest households are more likely to be stunted and underweight. For instance, 57 percent of children in the lowest wealth quintile are stunted as compared with 22 percent of children in the highest quintile. A higher percentage of children in rural areas (41 percent) than urban areas (31 percent) are stunted. Similarly, more children who are born to mothers with no education are underweight than their counterparts (32 percent versus eight percent); and children born women in the poorest households are underweight than their affluent counterparts (43 percent versus 11 percent). Likewise, more children in rural areas are underweight (25 percent) than children in urban areas (19 percent). At the same time, three percent of children under the age of five are overweight in Pakistan.

Pakistan is the fifth largest young country in the world with an estimated 63 percent of its population comprising of youth. Pakistan is home to about 40 million adolescents (between the ages of 10-19), equivalent to 23 percent of the total population (UNICEF, 2013). The prevalent culture of patriarchy and masculinity in Pakistan determines the power dynamics leading to the subjugation of women and control over their bodies, decision-making, mobility and relationships. In these social dynamics, girls have a comparatively low social status, remain marginalized and unable to avail opportunities restricting their socioeconomic empowerment, thus girls remain a neglected target group for health and nutrition interventions. The two major adverse manifestations of the disempowerment of adolescent girls in Pakistan are early marriage and poor nutritional status. The Gender Inequality Index (GII) data reports the adolescent birth rate (births per 1,000 women ages 15–19) at 38.8 percent in Pakistan (UNDP 2020). One in eight adolescent girls in Pakistan is underweight, with an alarming percentage of (56.6 percent) being anaemic, as per NNS, 2018 [6]. Adolescent girls in rural areas are more likely (58.1 percent) to be anaemic than their counterparts in urban areas (54.2 percent).

This shows the seriousness of the nutrition issues (National Nutrition Survey of Pakistan 2017-18).

The higher adolescent pregnancy rate puts adolescent mothers and their infants at risk of negative birth outcomes. Almost one in five adolescent girls are mothers. Factors such as early marriage and lower levels of education lead to high adolescent pregnancies, especially in rural areas. Nationally, 19 percent of adolescent girls became mothers by the age of 19. Early marriages, closely spaced pregnancies and maternal malnutrition lead to a vicious cycle of high morbidity and high mortality and, thus, adverse maternal and child health outcomes.

Rapid growth, menarche and malnutrition due to poor dietary intake among the adolescents are considered major causes of iron deficiency anaemia. Reducing anaemia for adolescent girls can contribute to 1) improved school performance; 2) increased productivity/energy and overall well-being for community and household activities; and 3) improved reproductive outcomes for adolescent girls who become pregnant. The opportunity to reduce anaemia with Weekly Iron and Folic Acid (WIFA) supplementation is a key intervention for improving health and well-being of adolescent girls.

In recognition of the different biological health needs of women and men, including the exposure of women to higher health risks related to pregnancy and childbirth, gender in the health sector has often been equated with "women's health". Other persistent disadvantages in education and economic opportunities also act as barriers to women's improved health and nutrition status. As a result, many public health interventions have mainly focused on improving women's health status, rather than addressing biological and non-biological gendered dimensions of health that is the socially constructed gender roles, norms and resulting behaviours that affect nutrition and health outcomes for women and girls, and men and boys. Pakistan ranked 151 out of 153 countries on the Global Gender Gap Index Report 2020 index, published by the World Economic Forum. The same report states that economic opportunities for women are extremely limited in Pakistan (32.7 percent). The gender gap in terms of health and survival, is reported at 94.6 percent, which means that millions of women in the country do not have the same access to healthcare as men. The country has unacceptably low sex ratios at birth in (92 girls for every 100 boys). These poor indicators are the result of gender differences at birth and gender-specific gaps on access to healthcare (WEF 2020). Access to education also reflects the beginning of gender inequality whereby 27.6 percent of females have some form of secondary education in contrast to 45.7 percent of males (Gender Inequality Index (GII), UNDP 2020). The rural areas in which our programs are being implemented have more male dominance, which affects girls' and women's decision-making power and their ability to access the health services. More than 50 percent of the girls are out-of-school, while others having lower attendance rates and higher dropout from primary to secondary schooling. There is growing awareness of women and adolescent girls' issues, and gender equality is becoming a priority in both public and private sectors. However, there are significant gaps from policy formulation to implementation.

Pakistan has made considerable progress in achieving Sustainable Development Goals (SDG), particularly in improving health. For instance, according to Voluntary National Review 2019, Pakistan reported a reduction in stunting and malnutrition between 2013-18 by six and nine percentage points, respectively. It also reported that skilled birth attendance had improved by 17 percentage points while neonatal mortality rate has fallen by 10 percentage points during the same period. However, Pakistan recognized persistent challenges and pledged greater focus and allocation of resources to achieve SDGs.

The PDHS showed that women's access to finance and assets was limited. Only six percent of women reported having access to either an individual or joint bank account. Although microfinance is estimated to reach at least two million citizens aged 15 years and older, the evidence base to support claims of the positive impact of microfinance on gender equality in Pakistan is weak. Only 13 percent of women reported owning any asset, compared with 69 percent of men. In addition, many households did not own household appliances that are time saving for women (e.g., refrigerators, electric or gas stoves, or washing machines), and women had limited access to markets, especially in rural areas. Bicycles and motorcycles were the most frequently owned household modes of transport; otherwise, women relied on extended family, neighbours, or public transport to travel any significant distance from their homes for education, employment or health services. The employment-population ratio for women doubled between 1995 and 2012. However, unemployment rates among young and women overall were higher than those for men and persisted even when analyzed by groups with different levels of educational attainment. Higher unemployment rates, along with lower average wages for females, indicate lower returns to education for girls and may affect parents' decisions regarding investment in a girl's education.

While the Pakistan Constitution provides a strong legal framework for many dimensions of women's equality, implementation of many provisions is weak. Since 2002, the proportion of seats in the national and provincial assemblies reserved for women has increased to about 20 percent and varies at local government levels from 10 percent to 33 percent. The presence and activity of female representatives have contributed to the passage of 10 new laws at the national level and 6 new laws at the provincial level, which promote or increase the protection of women's rights and empowerment. Within the executive branch, the passage of the eighteenth Amendment eliminated the Ministry of Women Development and devolved full responsibility for women's development to provincial governments. This occurred without prior strengthening of institutional capacity of provincial women development departments. Unlike the executive and legislative branches of government, Pakistan does not specifically reserve a percentage of seats for women in the Sharia Court, Supreme Court or other courts. None of the judges of the Supreme Court are women, and only three of 103 judges serving in the five high courts are women.

NUTRITIONAL STATUS OF WOMEN

The nutritional status of women was assessed with two anthropometric indices: height and Body Mass Index (BMI). The 2017-18 PDHS measured the height and weight of all

eligible women aged 15-49; excluded from analysis women who were pregnant and who had given birth in the two months preceding the survey. A total of 4,690 ever-married women were eligible for weight and height measurement, and the valid data, which accounted for 94 percent of the measurements. Overall, five percent of ever-married women are shorter than 145 cm. Nine percent of women are underweight, 39 percent have normal BMI, 30 percent are overweight, and 22 percent are obese. The mean BMI is 25.7 percent.

MICRONUTRIENT SUPPLEMENTATION AND DEWORMING DURING PREGNANCY

During pregnancy, women are at higher risk of anaemia due to an increase in blood volume. Severe anaemia can put both the mother and the baby in danger through increased risk of blood loss during labour, preterm delivery, low birth weight and perinatal mortality. To prevent anaemia, pregnant women are advised to take iron folate supplements, eat iron-rich foods and prevent intestinal worms. According to the 2017-18 PDHS, 41 percent of women with a child born in the last five years did not take any iron tablets during their most recent pregnancy. Only 29 percent of women took iron tablets for 90 days or more during their most recent pregnancy, while only two percent of women took deworming medication. Trends: The percentage of women taking iron supplementation for 90 days or more has improved from 22 percent in the 2012-13 PDHS to 29 percent in the 2017-18 PDHS. Deworming during pregnancy has not changed in the last five years. Patterns by background characteristics, intake of iron and deworming medication increase from younger to older women. For example, among women aged 15-19, twenty-two percent took iron for 90 days or more, and one percent took deworming medication during pregnancy. For women aged 40-49, the values for these interventions are 25 percent and four percent, respectively. More women residing in urban areas took iron tablets for 90 days or more during pregnancy (39 percent) than women living in rural areas (25 percent).

WOMEN'S CONTROL OVER THEIR OWN EARNINGS AND OWNERSHIP

Control over the cash earnings of both men and women varies according to the amount women earn relative to their husbands. Fifty-three percent of women who earn more than their husbands are the main decision-makers over their own earnings, and 21 percent make decisions about their husband's earnings. Sixty-eight percent of women who earn about the same as their husband jointly decide how to use their earnings, while 76 percent jointly decide on the use of their husband's earnings. In cases in which the husband has no cash earnings or does not work, 46 percent of women have independent control over their own incomes.

Women's individual ownership of assets provides economic empowerment and protection in the case of marital dissolution or abandonment. Ninety-seven percent of women did not inherit land or a house, while one percent inherited agricultural land and one percent inherited a house. Less than one percent of women inherited non-agricultural plots or residential plots. It is not common in Pakistan for women to inherit property. Gilgit Baltistan has the highest proportion of women inheriting agricultural land (3 percent). Thirty-one percent of men and 43 percent of women who own a house

have ownership of a title or deed. Age is a contributing factor in ownership of a title or deed for a house or land. Among both women and men, those in the 45-49 age group are most likely to have their name on a title or deed for a house (66 percent and 62 percent, respectively).

WOMEN'S PARTICIPATION IN DECISION-MAKING

The ability of women to make decisions that affect their personal circumstances is an essential element of their empowerment and serves as an important contributor to their overall development. To assess married women's decision-making autonomy, the 2017-18 PDHS collected information on their participation in three types of decisions: their own healthcare, major household purchases, and visits to family or relatives. To provide an understanding of gender differences in household decision-making, married women were asked about their participation in decisions about their own healthcare and major household purchases. Forty-one percent of women indicated that they make decisions regarding their own healthcare jointly with their husband, 37 percent reported that such decisions are made mainly by their husband, and 10 percent indicated that they mainly make these decisions on their own. Forty-six percent of men stated that they make decisions regarding their own healthcare jointly with their wife. A similar pattern is observed regarding major household purchases, with 38 percent of women making decisions jointly with their husband. The majority of women indicated that decisions regarding visits to their family or relatives are made jointly (39 percent) or mainly by their husband (34 percent).

More than four in 10 women decide by themselves or jointly with their husband on their own healthcare (51 percent), making major household purchases (44 percent) and visiting family or relatives (49 percent). Thirty-six percent of women participate in all three decisions, and 39 percent participate in none of the decisions. Men are more likely than women to report that they decide alone or jointly on their own healthcare (89 percent) and making major household purchases (83 percent). Seventy-nine percent of men participate in both decisions, and only eight percent participate in neither decision.

GENDER-BASED VIOLENCE IN PAKISTAN

Multifaceted manifestation of violence exists in Pakistani society and negatively influences the well-being of various groups – particularly women and girls. The prevalence data on different forms of violence against women shows that in their lifetime, 24.5 percent of women will experience physical and/or sexual intimate partner violence. Similarly, 14.5 percent of women reported experiencing physical and/or sexual intimate partner violence in the last 12 months. Twenty-one percent of all marriages in Pakistan are child marriages. In 2016, the UN Development Program's Human Development Report ranked Pakistan 130th (out of 159 countries) for gender inequality, and the 2021 Global Gender Gap Report published by the World Economic Forum (WEF) ranked it 153rd (out of 156 countries) on the gender parity index. The 2017-18 PDHS found that 28 percent of women ages 15-49 have experienced physical violence since age 15. Eight percent of married and divorced women report that their husbands display three or more specific types of controlling behaviours. Thirty-four percent of

married and divorced women have experienced physical, sexual or emotional spousal violence (Tariq and Bilber, 2020).

Pakistan ranks as the sixth most dangerous country in the world for women, with cases of sexual crimes and domestic violence rising rapidly. Activists blame the society's patriarchal attitudes for the problem. According to media reports, more than 51,241 cases of violence against women were reported between January 2011 and June 2017. Conviction rates, meanwhile, remain low, with the accused in just 2.5 percent of all reported cases being convicted by the courts. In November 2018, Zohra Yusuf, the former chairperson of the Human Rights Commission of Pakistan (HRCP), told German broadcaster Deutsche Welle that "'Feudal orthodoxy and conservative norms have deep roots in Pakistan. Men want to control women and they treat them as their 'property'. They don't allow any freedom to women." Verbal abuse, controlling behaviour by the husband, conflict with in-laws, overburdening domestic work, and threatening to leave or remarry were also considered VAW. The HRCP 2018 report noted, "The outlook for women showed little signs of improvement from that reported in previous years, and the issues that confront women were illustrated in stark terms in the news throughout the year – most notably in the cases of domestic and sexual violence that prevail in such a patriarchal society. When other factors come into play – so-called 'honour' killings, acid attacks, extended family dynamics, social restrictions on movement and jobs, inequality, and abject poverty, forced and arranged marriages – a grim picture emerges." (DW, 2021)

During COVID-19, Pakistani government officials reported a 25 percent increase in domestic violence incidents during the lockdown across the eastern Punjab province, with authorities registering 3,217 cases between March and May of 2020 (Home Office, 2020). The Digital Rights Foundation in Pakistan reported an increase in complaints from January and February of 2020 to March and April of 189 percent with their Cyber Harassment Helpline. Of these complaints, 74 percent were made by women (UN ESCAP, 2020).

WOMEN RELATED LEGISLATION IN PAKISTAN

This section presents a comprehensive brief of the available legislative framework regarding protection of women in Pakistan. Article 3 of the Constitution adopted in 1973, and amended in 2015, includes the provisions: The State shall ensure the elimination of all forms of exploitation and the gradual fulfilment of the fundamental principle, from each according to his ability, to each according to his work.

On February 2, 2012, the Pakistan Senate unanimously approved the National Commission on the Status of Women Bill 2012 to protect women's rights against discrimination. The new bill replaces the National Commission on the Status of Women Ordinance from 2000 and strengthens the Commission by giving it financial and administrative autonomy through an independent secretariat. The Commission has a mandate to gather information, investigate, monitor and advise on issues regarding women's rights violations. As well, the Commission has increased responsibilities to oversee the international commitments by the government on all women's issues.

PAKISTAN PENAL CODE, 1860

The Pakistan Penal Code (PPC) is a penal code for offences charged in Pakistan. Whereas the PPC covers the majority of criminal offences, recent pro-women laws have focused on making amendments in the PPC to address any shortfalls. Offences covered in the PPC include (but are not limited to):

The Protection Against Harassment of Women at the Workplace Act, 2010

This law *introduces the definition of harassment at the workplace as an offence*. It provides for wide descriptions of the workplace to include premises out of the place of work, where any official work or work activity is being carried out. Harassment is defined within the concept of work. A number of penalties are identified for those found guilty of harassment, varying upon the degree and extent of harassment. It also spells out the procedures where cases of harassment come forward.

Criminal Law Amendment Act, 2010

The law creates *an amendment to Section 509 of the PPC*. It replaces the original section with the offence of sexual harassment. As a result, a wide definition of sexual harassment has been included in the law, effectively criminalizing it.

Criminal Law (Second Amendment) Act, 2011

This law includes provisions within the PPC to *specifically deal with the offence of hurt being caused by acid*. The overwhelming majority of acid attack victims are women. The law makes amendments in the section of hurt to include the effects of acid (i.e., disfigurement or defacing).

The Prevention of Anti Women Practices - Criminal Law (Third Amendment) Act, 2011

This law makes amendments to the PPC, including a number of offences within the PPC that are considered to be customary practices. It expands the existing clause on prohibition on exchange of women for purposes of resolution of a dispute to include prohibition of customs such as *Wanni*, *Swara* or any other such customs. New sections added include prohibition of depriving women from inheriting their property, creating an offence for forced marriages of women and marriage of a woman to the Holy Quran.

Domestic Violence (Prevention and Protection) Act, 2012

The Domestic Violence Bill makes violence against women and children an offence punishable by time in jail and imposition of fines. The Bill also stipulates that cases involving domestic violence be dealt with expeditiously and provides timelines for these cases. Besides children and women, the Bill also provides protection to the adopted, employed and domestic associates in a household.

THE GENDER CRIME CELL

The Gender Crime Cell (GCC) was established in April 2006 in the National Police Bureau, Ministry of the Interior. The GCC gathers, collates, and analyzes data on violence against women, especially cases of gang rape, rape, abduction, kidnapping, and "honour killings." This central repository of data assists policymakers to develop comprehensive and effective measures to control violence.

NATIONAL GENDER REFORM ACTION PLAN

Under the National Gender Reform Action Plan, funds have been allocated for the Federal Bureau of Statistics to design and implement surveys to collect data on violence against women, including data disaggregated by gender and socioeconomic indicators. The Ministry of National Health Services, Regulations and Coordination (MoNHSR&C), in collaboration with partners, is also working on evidence generation, policy planning, and guidelines as well as developing a monitoring framework for adolescent nutrition. The MoNHSR&C, in collaboration with the World Health Organization (WHO), developed national guidelines on adolescent nutrition and supplementation in 2018 with Weekly Iron Folic Acid Supplementation (WIFAS) as one of the recommended strategies to reduce anaemia among this vulnerable group. Other strategies discussed include national adolescent nutrition strategy and Iron Folic Acid Supplementation (IFAS), including WIFAS for anaemia prevention in adolescent girls. To date, there has been a series of technical consultations in which Nutrition International has provided technical inputs. A national technical advisory group has been established and Nutrition International has been nominated as a member.

The above section demonstrates that Pakistan has introduced legislation to protect the women and uplift their status. However, implementing this legislation remains a significant challenge. The lack of strong political will, the low priority of women's empowerment on the political agenda and patriarchal social norms remains major hurdles in effective implementation of these progressive laws.

NUTRITION INTERNATIONAL PROGRAMS

In implementing its Country Strategic Plan (2020-25), Nutrition International – in collaboration with the MoNHSR&C and provincial departments of health – aims to provide technical and managerial support in implementing MNHN and AHN programs.

The MNHN program aims to scale up high impact, low cost maternal and newborn interventions, including delivering IFA package (including comprehensive antenatal care attendance during pregnancy); birth packages (skilled birth attendance, optimal cord care and Kangaroo Mother Care) for low birth weight babies; and postnatal care packages (optimal breastfeeding and good nutrition). All these packages will have a Behaviour Change Intervention (BCI) component at facility and community levels.

Under AHN program, there will be integrated health and nutrition interventions to deliver WIFA supplementation and nutrition education to adolescents aiming at improving iron and anaemia status.

With the intention of contributing to gender equality, Nutrition International launched its global Program Gender Strategy in 2018 to mainstream gender equality systematically into nutrition programs. To ensure a deeper integration of gender into all aspects of programming, Nutrition International conducted a SGBA of these two programs to better promote gender equality and respond to gender barriers and any potential enablers, considering this a critical step to design gender sensitive or responsive programming. SGBA is intentional in Nutrition International programming

and learnings will be captured throughout the programming cycle of these interventions, particularly to inform program implementation and designing of BCI, monitoring (including gender sensitive indicators and sex disaggregated data) and evaluation.

Contextualizing this from global to local and considering country's poor sociocultural norms with respect to gender, the MNHN and AHN programs also aim to mainstream gender as one of the key cross-cutting themes throughout the life cycle from design to evaluation. This will ensure better health and nutrition outcomes that are also aligned with Nutrition International's global priority of gender equality.

KEY OBJECTIVES

The key objectives of the study included:

- Assess the gender equality issues relevant to MNHN and AHN in selected geographic areas to learn about local context for women and girls including socioeconomic status (gender roles and their status within households, income levels, control over assets), participation and decision-making, access to nutrition information and services, and other vulnerabilities (including gender-based violence).
- Assess outcomes and outputs indicators for MNHN and AHN program design and suggest opportunities and interventions to make this more gender sensitive and responsive, as applicable.
- Identify and explain gender barriers, lessons and key entry points that were found to be effective in previous MNHN and AHN programs
- Identify potential opportunities, barriers and enablers and provide recommendations for developing short- and long-term strategies that will promote gender equality and empowerment of girls and women through the programs.

Methodology

STUDY DESIGN

Using a mixed methods approach, this study employed both qualitative and quantitative research methods, as well as desk review of secondary data to gather data for SGBA of Nutrition International's MNHN and AHN programs. This reports largely presents the key findings of the qualitative data in order to provide in-depth and contextualized insights to inform Nutrition International's short-term and long-term strategies for promoting gender equality and implementing gender responsive programs.

STUDY AREA AND POPULATION

The study was conducted in four districts where Nutrition International had implemented MNHN and AHN programs. These included Lodhran in Punjab, Jamshoro and Khairpur in Sindh, and Swabi in Khyber Pakhtunkhwa (KP). The study population included staff of implementing partners, district health officials, community members and direct beneficiaries of the programs.

DATA COLLECTION TOOLS

The data collection tools included Focus Group Discussions (FGD), Key Informant Interviews (KII), and semi-structured interviews. The tools were pre-tested and translated into Sindh and Urdu, and pre-tested again before administration in the field. KIIs were utilized to collect data from Nutrition International and partners' staff as well as community elders; FGDs were conducted to collate data from women and in-school adolescent girls, while semi-structured interviews were administered to community members.

SAMPLING

Based on purposive sampling technique and as per objectives of the study the following target populations will be covered:

- Nutrition International staff
- Staff of implementing partners
- District government officials from health, education, and social welfare departments and CSOs
- Teachers and healthcare providers
- Community elders from Punjab, Sindh and KP
- Women and adolescent girls from Punjab, Sindh and KP (One group of women from each target district between 18-45 years; and one group of in-school adolescent girls from one school in each target district between 10-18 years)
- Community members from Punjab, Sindh and KP

The following table provides the actual/achieved breakdown of the sample size:

Target Group	Key Informant Interviews	Focus Group Discussions	Semi-structured Interviews	Total (for 4 districts)
Nutrition International staff	03			03
Implementing partners' staff	02			08
District government officials from health, education, and social welfare departments and local CSOs (1 each)	04			16
Teachers and healthcare providers	04			16
Community Elders	02			08
Women & adolescent girls (1 for each)		02 (6-10 Participants/ FGD)		08
Interviews with community members			30	120

DATA COLLECTION

The data collection was carried out in all four target districts by a team of qualified and experienced researchers in January and February 2021. In addition, KIIs and FGDs were conducted in local languages using FGD and KII guides and lasted approximately 45-60 minutes. All of the KIIs and FGDs were audio-recorded with the consent of the study participants. Similarly, semi-structured interviews were administered, and verbal consent was received from the participants. The majority of the interviews were conducted face-to-face, but where necessary, some interviews were conducted by telephone and were recorded with the consent of the respondents.

DATA ANALYSIS

The quantitative facility assessment data were entered into an Excel spreadsheet for data management and analysis. Simple analysis of each variable was performed, and descriptive summary tables and charts based on frequencies from the database were prepared. In addition, audio recorded KIIs and FGDs were transcribed verbatim and translated into English. The qualitative data analysis was conducted manually, and the analysis was guided by thematic content analysis approach using an iterative process in order to identify themes and patterns.

ETHICAL CONSIDERATIONS

Following the client's approval, all study documents and tools were submitted to the Institutional Review Board (IRB) of Research and Development Solutions (RADS) Islamabad which provided the ethical approval for the study. Moreover, to ensure the dignity, rights and safety of participants and their voluntary participation, verbal informed consent was received from all study participants. The consent form included details regarding study purpose, rights of the study participants, possible risks and benefits, confidentiality and anonymity. Study participants were also informed about their right to decline participation or withdraw from the interview/discussion at any point or refuse to answer any question. Moreover, the KIIs and FGDs were audio-recorded with the verbal consent of the interviewee/participants.

Findings

The data was collected through interviews with 51 key informants, eight FGDs with community women and adolescent girls, and a structured questionnaire administered to 120 men in the community. The key findings of the study are thematically presented below. Figure 1 provides a summary of the key findings.

FIGURE 1: SGBA in Brief

Sex- and Gender-Based Analysis of Nutrition Programs in Pakistan	
i) Maternal and Newborn Health Nutrition	**ii) Adolescent Health Nutrition**
Context/Issues	• Overall malnutrition and poor dietary intake as well as gender biased food patterns at home • High fertility rates (Repeated pregnancies, Son preference etc.) • Child marriages and teenage pregnancies • Restricted mobility of women especially young girls • Limited access of women to economic resources • Limited access to health and other services • Decision-making by men with limited or no involvement of women • High prevalence of domestic violence and gender-based violence • Lack of appropriate knowledge on importance of healthy food • Overall low socio-economic status of the majority population
Program Gender Responsiveness Issues	• Low capacity of staff around key gender concepts including gender equity & responsiveness • Higher coverage through public sector health department especially Lady Health Workers Program but the uncovered areas of outskirts and marginalized groups at higher risk of being overlooked • Lack of sex segregated and marginalized groups (disabled people, minorities, out-of-school girls etc.) data collection in regular monitoring and reporting process • No pre-assessment of target districts with regards to vulnerable and marginalized groups • Women and girls only interventions but the issue is equally serious for boys and men • Limited direct contact with communities causing low visibility of intervention • Centralized program designing with no or minimal involvement of field level stakeholders • Bureaucratic procedures causing delays in provision of services
Recommendations/ Way Forward	• A comprehensive capacity building plan around key gender concepts for staff, partners and district level stakeholders • Focused community mobilization and community level awareness raising at least in start • Engagement of men and boys in awareness/Behaviour Change Communication (BCC) campaigns as many issues relate to them • Involvement of boys in adolescent nutrition programs as direct beneficiaries • Use of mass media and social media needs to be increased for community campaigns • Special initiative may be taken by engaging volunteers to increase the outreach to uncovered areas (as per past experience of CMWs) • Out-of-school adolescent girls need to be covered by outreach mechanism of reaching at their doorsteps • Assessment of most vulnerable and marginalized groups may be done in the target areas

GENDER ISSUES/NORMS AND BARRIERS

Almost all the study participants across the three provinces agreed that male dominance and the patriarchal value system was all-pervading. Son preference and giving more importance to boys over girls was a recurrent theme in the discussions across the provinces. Simultaneously, respondents argued that harmful gender norms and practices were on the decline largely due to increasing education and urbanization. Despite the decreasing prevalence of these harmful gender norms and practices, respondents concurred that they were not uncommon.

"The parents want a boy. They do not want a girl. She is unwanted, unwelcomed. After the birth of a baby, they do not celebrate her Chatti (a ritual to celebrate the birth of a child). When a boy is born, parents joyously celebrate his Chatti and distribute sweets in their community. Right from the birth, she is on the road to discrimination, neglect and malnutrition." (Female Service Provider, Sindh)

The issue of gender discrimination starts even before the birth of a child. The prevalence of abortion and its trends also show sex selective practices. It was reported that in some cases, women are forced to abort their baby if they are pregnant with a girl.

"Sometimes, the pregnant woman is forced to abort her pregnancy if it is a girl". (Female Teacher, Punjab)

According to traditional gender stereotypes, boys are given precedence over girls because they are expected to become the breadwinners, while girls are expected to marry and leave their parents' house after the marriage. For example, parents want their boys to be strong because they have to work and earn a living; therefore, they prioritize boys over girls when nutritious food like meat and milk is available at home.

"Where there is poverty, more attention is paid to boys because they will provide income and support. In case of a well-off family, there is no difference between a boy and a girl." (Female District Health Official, Punjab)

Similarly, in the patriarchal social structure, men are considered heads of the household and typically control financial resources while women are financially dependent on the men in their households. Likewise, men take priority when food is served, and women typically eat last. The key informants and community women emphasized that these cultural norms affect women's health and well-being. For instance, the practice of men eating first leaves little food for girls and women, especially those who are pregnant, which leads to them becoming undernourished. Lack of financial autonomy may also restrict women's ability to avail much needed healthcare.

"We are living in male dominant society. We also observe that a woman who prepares food for her family, often eats leftovers. This is wrong." (Male District Health Official, Sindh)

"It is a male-dominant society in which males are preferred over female members of the family. Definitely, this sort of preference and orientation would have its effects on

society. For instance, male members of the family are served with food first and then leftovers are eaten by the females. It is a patriarchal society." (Male Nutrition International Staff, KP)

"An adult woman, even if she is pregnant, will try to feed her children and her husband first even though she may need more because she is pregnant." (Male Nutrition International Partner Staff, Sindh)

Unlike Punjab, community women and elders from Sindh and KP reported that discrimination between girls and boys was not universal. They said that some families discriminated between girls and boys, while others did not. According to them, depends more on the levels of education and awareness of the parents. It was highlighted that with the passage of time and increased awareness the situation is changing and now many families do not observe such discriminatory practices.

"There are some families in which it is said that boys should eat first, and girls should eat later. Also, there are some families who eat together." (Community Woman, Sindh)

"There was gender disparity in our society but now this discrimination between men and women is on the decline. There were such issues when we were kids and there were no schools for girls in our village. The girls used to go to the nearby village for schooling. Now, we have a middle and higher secondary school for girls in our village. There was a lack of interest and mistakes at the government level that girls were denied proper education facilities. There were also certain cultural values to that restrict female education. Now by the grace of Allah, the girls of our village are going to public and private schools. They are going to professional medical and engineering colleges." (Male Community Elder, KP)

In contrast to Sindh, adolescent girls – especially in Punjab – pointed out that discriminatory gender norms favouring boys over girls were all-pervasive. This may be because of deep rooted gender norms and the conservative social milieu in Punjab or that girls in Punjab felt more confident in voicing their opinions. The in-school adolescent girls participating in this study, particularly from the Lodhran district in Punjab, enthusiastically discussed the gender norms and roles, how pervasive they are in their communities and how they negatively affected their lives in terms of their health, nutrition, education and future. Particularly, they highlighted discriminatory gender behaviours favouring boys over girls.

"What happens is that whatever is cooked at home, mother says that you have to give it to your younger brother. If he refuses to go to school, then she says make him ready for school first, you can do it later." (In-School Adolescent Girl, Punjab)

"In our society, boys are sent to private schools while girls are sent to government schools. And even in hostels, girls are not allowed to stay but boys can." (In-School Adolescent Girl, Punjab)

Community women from KP and Punjab also highlighted the low status of young girls within households and lack of their involvement in decision-making with respect to financial, health or education matters. Mostly, they said that parents – and more specifically, male members of the family – made the decisions. They also talked about gender norms favouring mobility of boys over girls for access to education, health, and food. Some cultural practices discouraging girls' education and employment, while encouraging early marriage are also common

"In our society the women have a very inferior position. Our men do not give importance to women." (Female Teacher, KP)

"Generally, in our society, daughter-in-law is not given much respect which she as a human being deserves. Particularly, if her first born is a girl, she becomes like a pariah in the eyes of the mother-in-law." (Female District Health Official, Punjab)

Some of the participants, particularly from Sindh and Punjab provinces, reported that there is a perception in the community that the girls grow faster than boys and therefore, they require less food or that, to keep their growth slow, they should be given less food. Besides, they discussed, the boys were given preference because they were going to stay with the family and become breadwinners while the girls had to leave the house after marriage.

"Some people think that girls must be given less food than boys because they grow up fast and they have to go to the next house (get married)." (Community Woman, Punjab)

Moreover, social expectations and pressure force young or newly married couple to have babies right after the marriage, notwithstanding their desire to space out their children or have a smaller family.

"As soon as a girl is 12-13 years of age, parents only think to marry that child. This culture is still followed. That's the reason girls are unable to get proper medication and face shortage of food. Because of this attitude, both mother and child suffer from iron deficiency." (Community Woman, Punjab)

Barriers to women health-seeking behaviour include large distances to travel, restrictions on female mobility, financial constraints, lack of gender-sensitive service provision (e.g., women avoiding going to the clinic if the doctor is male), lack of agency for independent decision-making and dependence on approval or permission from parents, husbands or in-laws. Based on these major findings of the study, interventions should consider the issues of mobility, gender of the service provider and provision of livelihood opportunities.

"In some places, women cannot access health facilities because if there is no man in the house, she cannot go out. If a child is sick, the mother cannot go to the hospital until the child's father returns home." (Male NI Partner Staff, Sindh)

Barriers to adolescent health-seeking behaviour include poverty, lack of autonomy and gender discrimination whereby boys are taken to hospitals and clinics in case of any illness while girls' health is neglected or they receive care at home.

> *"Financial pressure is the major hurdle in adolescent nutrition. If a family is rich, they can have better food for both boys and girls but if a family is poor, they are bound to have less food and so they neglect the girls to some extent". (Female Teacher, Punjab)*

> *"Sometimes, some parents get so careless that they take boys to hospitals in case of sickness but do not do the same in case of girls and try to cure them at home. Similarly, in some households, boys are sent to private schools while girls are sent to government ones. This is mainly due to lack of awareness. People do not realize that boys and girls are equal and should be treated equal." (Female Teacher, Punjab)*

The quantitative data collected from community members corroborated the qualitative findings. The results, as shown in Figure 2 below, inform that the majority of the respondents strongly agreed that men and boys, could easily move at their will. In contrast women and girls were less likely to freely move even when they need to. These results complement the qualitative findings that female mobility was highly restricted.

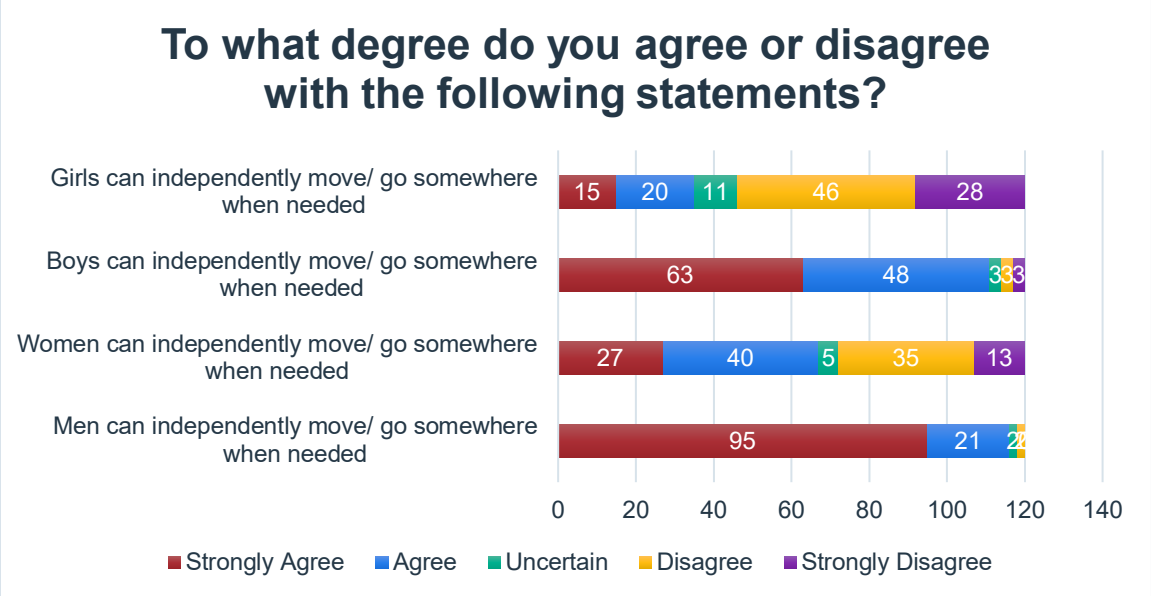

FIGURE 2: Male and Female Mobility

PARTICIPATION AND DECISION-MAKING

Almost all of the participants across the three provinces consistently pointed out the lack of women's financial autonomy and involvement in decision-making. Moreover, they reported that, due to culture of male dominance, restrictions on female mobility and the need for husband or guardian's approval hampered the ability of women and girls to seek healthcare. This highlights the need to engage men and sensitize them on the issues surrounding women's health, especially the maternal reproductive health. Without the

support of men, the community women will not be able to access the otherwise available service in their area. In this context, the engagement of men as a facilitating and supporting figures can increase the chances to counteract the prevalence of malnutrition.

"Most of the time men make the decisions and if a man gives his wife or daughter permission to go out then they go out." (Male Nutrition International Partner Staff, Sindh)

"Women do have a role in decision-making. However, it depends upon the status of women. For example, I am a working woman, so I have the resources to meet my needs without any hurdle. Furthermore, the mobility of woman is a matter of trust. In our family we usually inform our males before visiting a place and they never forbid us. Mobility of women is both a matter of trust and compulsion. No female goes out of her house without any inevitability." (Female Teacher, KP)

Most of the key informants and women and adolescent girls across the study areas reported that older and married women had relatively more involvement in decision-making. In contrast, the younger and unmarried women had no or very limited role in decision-making. They shared that only married women could exercise some form of freedom of movement like going to a hospital. The participants stressed that, in most cases, women could not even go to a hospital if not accompanied by a family member. Likewise, they pointed out that older women – in contrast to young girls – had more power in the household and were also involved in decision-making. Moreover, working women or women with an independent source of income were more likely to play an important role in decision-making.

"Older women ones have this right in our family, younger ones can't make decisions own their own." (In-School Adolescent Girl, Punjab)

"Married women can easily go to hospitals as compared to unmarried women. In our society, there are a lot of restrictions on female mobility." (Male District Health Official, Sindh)

"Women have a very limited role in decision-making. They also face the issue of mobility. They are not allowed to go outside their houses, especially in rural areas." (Female Teacher, KP)

The quantitative data collected from community members substantiated the qualitative findings. The results, as shown in Figure 3 below, demonstrate that the majority of the respondents strongly agreed that men were the key decision-makers at the community and household levels. However, 50 out of 120 respondents concurred that women had decision-making authority at household level.

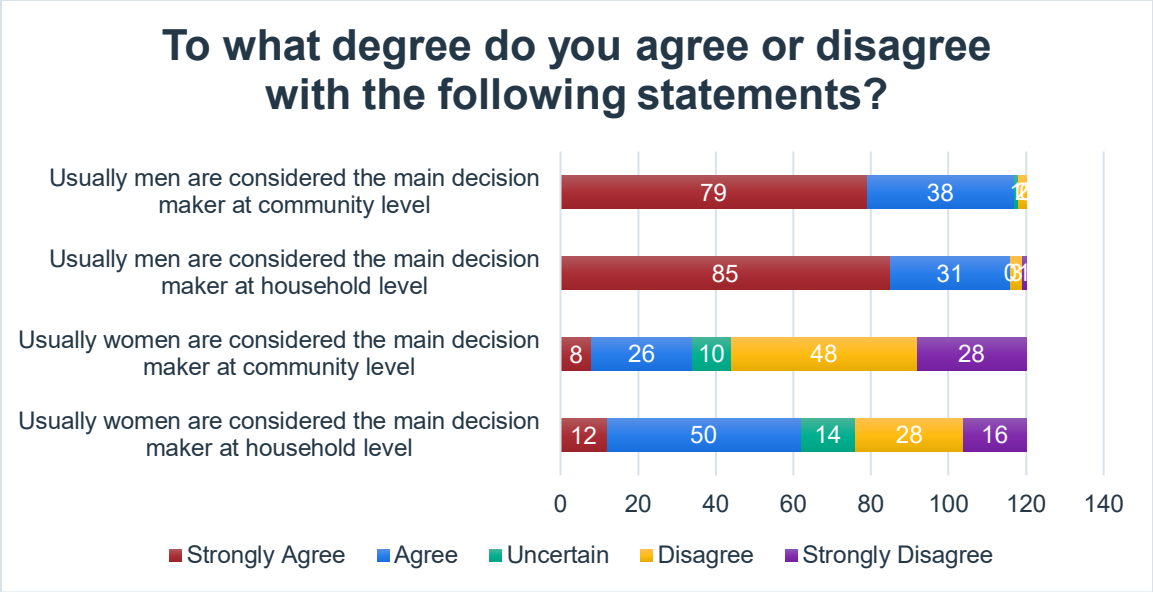

FIGURE 3: Decision-Making at Household and Community Level

ACCESS TO NUTRITION INFORMATION AND SERVICES

Many of the study participants stressed that unhealthy dietary practices were on the rise and led to malnutrition. The majority of participants identified other important causes of malnutrition in women and adolescent girls, including lack of awareness regarding diversity of food and balanced diet and that malnutrition can also be managed with available resources at home.

> *"Our general concept is that we have to eat till our abdomen is filled and we don't know the proper diet. Educated as well as illiterate lack awareness and do not know what a balanced diet is and how to avail it." (Male Nutrition International Partner Staff, Sindh)*

> *"Due to a lack of awareness, females are facing such (nutrition related) issues. And lack of education and poverty further exacerbates the situation." (Male Community Elder, KP)*

> *"Mostly, people do not have much awareness about nutrition and the important role of food diversity in nutrition." (Female Nutrition International Staff)*

Many of the key informants and women from the communities also highlighted some myths and misconceptions with respect to food consumption, particularly what a pregnant woman or recently delivered mother should and should not eat. Similarly, there are traditional practices with respect to colostrum whereby it is wasted instead of giving it to the child.

> *"When a woman gives birth to a child, it is traditionally said that she should not be given vegetables or anything that causes pain in her child's stomach. If you feed her bread without curry, she will be fine. This is a misconception because if a woman gives birth to a child, she should be given good food which will be beneficial for both mother*

and child. They should protect the mother from diseases. Instead, they themselves are push her towards diseases." (Community Woman, Sindh)

"When we went into the field, we found out that people did not know the importance of mother's first yellow, thick milk. They said that we shouldn't feed it to our babies instead, we should waste it. They have strong myths about it and said that our elders have taught us to waste it." (Male Nutrition International Partner Staff, Punjab)

The findings show that many people, especially the community elders, do not acknowledge malnutrition or consider it a problem.

"If we talk about laymen, they are completely in denial mode. They don't even recognize malnutrition as an issue. The poor don't give much thought to their health. For them, it's rich a man's issue." (Female Nutrition International Staff)

"Community elders were totally blind about the nutritional issues; however, they usually think that boys and girls should be treated equally". (Nutrition International Partner Staff)

The findings also reveal that dietary patterns are changing in rural areas and urban areas with increased consumption of processed and junk foods. Consumption of vegetables and fruits was low especially among adolescents. Similarly, drinking habits were also changing with increased consumption of soft drinks and tea in combination with sugar. The study also found that socioeconomic status plays an important role in these practices.

"According to the current trend, children eat snacks and junk food all the time so when a girl gets to adulthood, especially during menstruation, she gets weak and faces deficiencies." (Community Woman, Punjab)

"Some wealthy families consume meat most of the time and seldom take vegetables. They think that a good diet means eating meat a lot. Some people would prefer pulses over potatoes. The doctors should be hired to spread awareness using different means like mass media and taking sessions at the community level. The people having awareness are taking care of their diets. Those who are not aware are suffering from malnutrition." (Male Community Elder, KP)

Some study participants highlighted the lack of access to information and services for women and adolescent health and nutrition. It highlights the need for a more aggressive and comprehensive awareness campaign for not only provision of knowledge but also to change attitudes within the communities.

"When it comes to adolescence, we have no such awareness program at private or public level to tell people that how important adolescent's nutrition is, especially for girls." (Male Nutrition International Partner Staff, Sindh)

"There is no access to information. For instance, in my village there is a civil dispensary in which there is no MNCH facility available. Although, government has initiated different programs but still there is need of proper follow up to ensure quality services are available." (Male District Government Official, KP)

SOCIOCULTURAL VULNERABILITIES

The majority of study participants underscored how socioeconomic factors, like large families, early marriage, illiteracy, unemployment, poverty, price hikes, and place of residence (e.g., remote rural areas compared to urban areas) influenced gender roles and access to education, health and nutrition for women and adolescent girls. Moreover, travel to health facilities and restricted social mobility for women hampered access to health services including nutrition. The notion of restricted mobility of the young women and adolescent girls is multifaceted and directly linked to the sociocultural practices of the specific geographical areas, ethnicity, caste, and socioeconomic status of the families.

Additionally, unexpected situations, like the COVID-19 pandemic, increased people's socioeconomic vulnerabilities and drastically affected their livelihoods, particularly the poorest segments of the population, and thus increased their food insecurity, health and well-being.

"Poor people do not get good food as compared to wealthy people. The poor do not have the resources. Only the wealthy people have the resources. It is a matter of economy." (Female Teacher, KP)

"If I have money, there are no obstacles. If I do not have money, there are obstacles all around. If I earn five rupees, then I would be able to eat as much. These barriers occur because people do not earn much." (Community Woman, Sindh)

"During the lock down, the rich got things but the poor got affected so much that they didn't even have anything to eat. This is one of the reasons for food deficiency in girls." (In-School Adolescent Girl, Punjab)

The primary data, collected from the field, also revealed that some communities were more vulnerable than others. For instance, ethnic minorities like Kohli, Bagri and Christians, and communities living in deserts, mountains and flood prone areas in Sindh lacked access to adequate health and information services. Nutrition International's AWHN & MNHN interventions relies primarily on public sector infrastructure and in above mentioned areas, access to the public system is limited. This situation makes it challenging to reach these demographic segments to provide services.

"Here we have communities like Kohli, Baghri and Christians who marry their girls at an early age. When these girls get pregnant, many of them either die themselves giving birth or their babies die. These issues are common with them." (Female Service Provider, Sindh)

"Gender norms favouring boys over girls are slowly changing but in many areas like Kacha area, hilly areas like in Khairpur, or desert areas like Thar, where there is not

much awareness, boys are given priority. The main reason is that people think that a girl has to get married and go to her home, so what is the need for her to get a job or what is the benefit of educating her? The boy gets good nutrition because either he would help his father in his work or get an education and get a job and support his family. There are socioeconomic factors behind different attitudes towards boys and girls." (Male Nutrition International Partner Staff, Sindh)

GENDER SENSITIVITY AND RESPONSIVENESS WITHIN NUTRITION PROGRAMS

Most of the key informants, including Nutrition International staff, staff at Nutrition International's partners and government officials had no clear understating of key gender concepts, as outlined in Nutrition International's Gender Strategy – including sex and gender, gender equality, gender equity, women's and girls' empowerment and gender mainstreaming. They also lacked a clear understanding about the role of people engaged in nutrition programs with respect to gender transformation and gender equality. This may be because – as the study findings revealed – while staff at Nutrition International and partner organizations were provided orientation on the nutrition programs, they had not received comprehensive training on gender. Many of the key informants from Sindh, Punjab and KP reported that they had not received any comprehensive training on gender after joining the program. However, they shared that they had trained the district government officials on the basis of their past experience of working in development sector.

"We have not been given any training in this program. We are learning from district health authority, doctors, and our health team guides us. But we have not received training on gender or malnutrition. I have been working here for three years and they have not provided any training." (Male Nutrition International Partner Staff, Punjab)

"If there is proper policy orientation, it is going to help a lot." (Male Nutrition International Staff, KP)

"The trainings under the Nutrition International's Right Start program are not substantial. Even if a new staff is hired, they do not receive many trainings on capacity building or gender equality." (Male Nutrition International Partner Staff, Sindh)

Most staff at Nutrition International and partner organizations reported that they had a strong monitoring system. However, some of them said that they did not collect adequate gender disaggregated data, while others said that they did. However, many respondents claimed that since the services as primarily for women and girls, the data on beneficiaries do not require sex disaggregation. It was further mentioned that since there are so few community-based activities for awareness raising and mobilization, the data is just collected in numbers with no mention of age or sex.

In addition, Nutrition International programs primarily focus on women and girls as the main beneficiaries, but the issue of malnutrition is equally serious for boys. The exclusion of men and boys – especially where adolescent girls are targeted but boys are

not – is difficult to justify at the community level. On the other hand, there are a lot of misconceptions/myths related to the initiatives of non-governmental organizations (NGO) in Pakistan especially with regards to a supposed hidden agenda of population control by affecting the fertility of young people. The exclusion of boys and men in community mobilization activities might strengthen these myths.

Additionally, Nutrition International's monitoring system is very well structured and information is being collected and analyzed on a regular basis. The country office collects all the data and records the progress on monthly basis. However, the data is being collected without any mention or assessment of the geographically segregated and vulnerable populations being covered. The program coverage is mainly based on the public sector outreach through Lady Health Workers (LHW). The LHWs generally cover most of the areas in any district however sparsely populated areas and areas on the outskirts are usually not covered at all or receive insufficient coverage. In Lodhran, Nutrition International made a special effort to cover these areas and EPI campaign volunteers were retained for the outreach and access to all the segments. However, the current programs do not have such activities in place to cover the populations that are otherwise missed by the public sector health structure, including the LHW program.

Another major finding was the very limited community level campaigns to raise awareness among the general population about malnutrition and Nutrition International programs. The majority of the general public was unaware of the importance of healthy food, and they were unaware of any service delivery initiative by Nutrition International. It was felt that a well-structured community campaign that involved all segments of society –targeting both men and women – will not only increase the awareness of the issue and the initiatives, but also will improve the eating habits and regularity of taking supplements.

"The Nutrition International has strong monitoring system in place. We receive monthly data from the field. However, we do not receive male and female segregated data, particularly the data about trainings, community engagement activities or indirect beneficiaries." (Female Nutrition International Staff, Islamabad

"In various events that we do, we monitor how many females there are and how many males there are among the participants." (Male Nutrition International Partner's Staff, Sindh)

"I think that the programs are gender responsive to an extent as these promote gender equality. But the problem is that the programs are solely focused on women and girls and completely exclude boys." (Nutrition International Partner's Staff, Punjab)

OUTCOME INDICATORS OF MNHN AND AHN PROGRAMS

Many of the study participants highlighted the important role of MNHN and AHN programs and the impact they had in the intervention areas – particularly in terms of increased access to MNHN and AHN services and changing health-related behaviours.

"Nutrition International with Right Start established KMC ward in Liquat Medical University Jamshoro. Before this nobody visited for nutrition. Now people are visiting KMC for the services. We are receiving many patients from the surrounding communities which shows that their field work and efforts are paying off." (Male District Health Official, Sindh)

"The biggest achievement of the program is that counselling skills of our providers have improved. Second, in our community, people also realize why and how to keep a baby in KMC because our LHW went door-to-door and told them about KMC." (Female District Health Official, Punjab)

The majority of the key informants highlighted the important role of Lady Health Visitors (LHV) and LHWs in community mobilization and awareness raising. This was mostly highlighted as a strength that the involvement of health workers makes it possible to reach most of the areas with very minimal additional economic resources required. They mentioned that the LHWs are an already available trained human resource with prior knowledge of the area and the subject. Engaging government stakeholders and these trained women is the most convenient and efficient way of implementing the program. However, it was also found that the system makes it almost impossible to reach the areas excluded from the LHW program especially areas on the uncovered and in sparsely populated areas.

"We see an improvement in the services. It is because our LHVs and LHWs are going door-to-door. In addition to the ambulance service that has been provided, many patients come to us who otherwise may not have come here. These are very good services ambulance and LHW. LHWs also provide iron tablets. Patients who come to us from LHW are well manageable. They have been getting iron and folic acid since early pregnancy." (Female District Health Official, Punjab)

"Many people know about the Right Start program. The LHWs have not only distributed folic acid supplements but also given awareness to people. Now they know how much nutrition should be given at what age. They know about vaccination of children and how much nutrition a pregnant woman needs. People did not know this before. If they know now, it is only because of LHWs." (Female Service Provider, Sindh)

Some of the key informants reported resistance in the communities with regards to IFA supplements and use of colostrum. They reported that, at the start of the program, women looked at IFA supplements with suspicion. However, they said the trend seems to be changing for the better with increased acceptance of nutrition supplements. Similarly, people in communities used to avoid giving colostrum to newborns and considered it a taboo. Community health workers are slowly but effectively countering the myths and misconceptions about colostrum in their fight to improve women and children's health.

"Majority of pregnant women in our country are suffering from malnutrition. However, they do not know the benefits of the IFA supplements we are giving them. In the beginning, we used to hear that the IFA supplements we gave through LHWs were not being used by those women, maybe because they were provided free of cost. But now

the trend has changed, and women are using it. I think there have been some changes, women have started using it, and LHWs have told me about adolescents are also using it, and they demand IFA from LHWs." (Male Nutrition International Partner Staff, Sindh)

"The LHWs told that initially they faced challenges as women declined to take IFA supplements as they believed that they were causing dryness in their throats and caused acidity. They worked hard to overcome these misconceptions." (Male Nutrition International Partner Staff, Sindh)

"Due to extensive community mobilization by LHWs, people have started taking IFA supplements. That is also one of our successes. If this community is moving towards early breastfeeding (colostrum) then this is also one of our successes. In other words, in order to save mother and child, we have been following the Thousand Days approach and creating acceptance in the community in which birth spacing is also a part of maintaining the health of mother and child. Now people are also paying attention to birth spacing that we have to do this. So, I think this is our success." (Male Nutrition International Partner Staff, Sindh)

The in-school adolescent girls participating in this study – particularly from Lodhran district in Punjab – reported that they knew about the Nutrition International and the nutrition program for adolescent girls from their teachers. They said their teachers had conducted the awareness raising sessions at their schools and talked about the importance of an adequate and balanced diet. The teachers had also informed them that as part of the nutrition program, they will receive WIFA supplementation. However, they reported that they had not received any WIFA supplements yet because the program had not started. They hoped to receive the supplements and suggested that the WIFA supplements should also be distributed at the community level so out-of-school adolescent girls could also benefit from the program.

"We know about Nutrition International as our teachers got training and they told us about the WIFA pills we have to take every week. Our teachers told us about the supplement and that our nutritional deficiency will be cured by it." (In-School Adolescent Girl, Punjab)

"We were only told about it (WIFA). Our teachers told us. We have not got any supplements yet." (In-School Adolescent Girl, Punjab)

"We need to cater to adolescent boys as well as girls. In addition, the problem with the program focusing on adolescent girls in schools is that not all adolescent girls go to school." (Female Nutrition International Staff, Islamabad)

Regarding program sustainability, study participants emphasized that continuity of the programs is a must for sustainable impact. In addition, they underscored the role of government/public sector to ensure continuity and sustainability of the programs.

"NGOs come with short term projects and they definitely create a dent, and they do their job which makes some impact. However, the achievement of the major goal

remains incomplete. Therefore, government can play a major role here in terms of resource allocation, facilitation and community engagement." (Male Nutrition International Partner Staff, Sindh)

"LHWs are doing great work and will gradually change behaviour. That is why we are emphasizing on their capacity building. Our goal is to make this government resource so strong that they can go ahead and serve their communities after the Nutrition International leaves." (Male Nutrition International Partner Staff, Sindh)

Some of the staff of implementing partners appreciated that Nutrition International involved them in the program design while few others mentioned that Nutrition International should engage the partners more often. It was reported that the program designing, and decision-making is usually done at central level with some involvement from field staff, but their involvement is more related to planning for implementation.

"During the annual planning, we have a joint meeting with the Nutrition International to discuss what we are going to do, how we are going to do it and the challenges in that regard. And Nutrition International provides its input." (Male Nutrition International Partner Staff, Sindh)

Many key informants from KP reported that they were not part of the AHN program as the program had not yet started there. However, they mentioned that the government departments were highly cooperative and they had not faced any challenges working with them during their previous professional engagements. In addition, they said that the communities in their respective areas were very cooperative and supportive whenever approached. The teachers involved in this study also reported that parents were cooperative and supportive.

Similarly, participants from Sindh reported that the AHN program has not yet started there, but they said they expect it will start soon. In contrast, few key informants from Punjab shared that they expected some potential challenges with respect to the implementation of AHN program, particularly when they would start distribution of WIFA in schools.

"We urge NGOs and other welfare organizations to launch interventions for adolescent girls. We have not faced any hurdles from the parents of children. In case of any issues, we approach government departments to solve such problems and they are supportive." (Female Teacher, KP)

"We should target unmarried girls so that they do not face nutrition related problems at a later stage of life. This is our mistake that we take care of male's nutrition but not female. It's better to take care of girls before marriage."
(Male District Health Official, Sindh)

"We expect to face some challenges when we will start WIFA supplementations as the parents may be reluctant towards it. But for that we have prepared our field teams. We

have taken the teachers and health workers on board to adequately manage those potential challenges." (Male Nutrition International Partner Staff, Punjab)

The teachers engaged in the WIFA intervention in Punjab highly appreciated the initiative focused on health and nutrition of adolescent girls in schools. Particularly, they appreciated the informative trainings imparted to the teachers and reported that they conducted the sessions with the adolescent girls in their schools. However, teachers also shared some challenges, including shortage of training materials and delays in getting the training material.

"Teachers have received the training. Parents have not been involved yet. Teachers have shown great interest in the WIFA intervention training. They really liked the training. We all got to know about many informative facts that we didn't know before like what diet is important for girls and which age is better for the growth. Now when we implement hopefully, we will have good outcomes." (Female Teacher, Punjab)

"The main thing is that this intervention created a lot of awareness. We told all this to the schoolgirls too and asked them to share the knowledge with their parents. We specifically asked them to convey about the WIFA program to their parents and tell them about the advantages. The girls too took a lot of interest in this and they asked almost daily about when the iron folic acid pills will arrive, and they will start taking them." (Female Teacher, Punjab)

"We faced problems from the management as there was very limited training material and we had to conduct five activities on a single chart. Then we called project coordinator and he told us about someone to get in touch with and then we got it. However, we think, the training material should be provided to us in schools." (Female Teacher, Punjab)

Implementing partners, (Shifa Foundation for all of the intervention areas and Change Consulting for Punjab) and the Nutrition International staff shared that they had the capacity to implement the project within their limited geographical reach. In addition, they stressed the need to improve the Nutrition International's compliance system. The study revealed that partners were trained on the technical areas related to the programs but there was little the focus on community mobilization and reaching the most marginalized people –especially women and girls

"We are not the implementers. We work with partners. So far, we can say that they have the capacity to implement. However, the scope of their geographical reach is quite limited." (Female Nutrition International Staff, Islamabad)

"Our compliance system to ensure quality and efficient delivery of care and services is very poor." (Female Nutrition International Staff, Islamabad)

CHALLENGES/BARRIERS AND FACILITATING FACTORS

The study participants shared challenges as well as facilitating factors in the implementation of the MNHN and AHN programs. The key challenges included lack of

infrastructure to establish Kangaroo Mother Care (KMC) centres, unavailability of trained staff, delays in program implementation, resistance from communities and disruption in supplies.

"When you implement a project, there are a lot of things that happen unexpectedly. For example, we had planned to conduct Infection Prevention and Control (IPC) training in May 2020. But the government had so many activities of its own ongoing like polio, immunization, Eid, Muharram etc. So, we conducted the IPC training in November 2020. And for that too we sat down with the District Health Department and organized about eight parallel events." (Male Nutrition International Partner Staff, Sindh)

"There are so many challenges that should be addressed. For instance, the CMW program in which we were supposed to receive supplies from the government so that we can send them to the uncovered areas, we did not receive those supplies. IFA supplies also stopped due to COVID-19."
(Male Nutrition International Partner Staff, Punjab)

Moreover, with respect to challenges faced during program implementation, Nutrition International staff underlined frequent transfers of government officials, dealing with Law Enforcement Agencies, timely and quality data from implementing partners and the challenge of working with LHWs due to their perceived association with family planning.

"The biggest challenge of working with public sector is attitude of bureaucracy and frequent transfers in public sector due to that you have to keep continuous liaising and orienting new officials. Other challenge is delays in approvals and letters and reluctance of public officials or offices to share data. With regards to partners, important challenges we face are that they work on a different pace and issues with regards to sharing of timely and quality data. At community level, we face challenges on account of security issues mostly. For instance, sometimes LEAs do not allow community level activities or trainings. At program level, one of the challenges is that that engaging LHWs is problematic at times because they are largely perceived to be associated with family planning and in some areas, it becomes quite a sensitive issue."
(Female Nutrition International Staff, Islamabad)

A district health official in Sindh also highlighted the issue of refusals due to financial constraints faced by women and desire to give birth at home.

"In our KMC program we face a lot of refusal cases. This may be because people have to travel for services and follow up. However, rate of refusal in our covered areas is low because our female staff motivate them. In uncovered areas, refusal rate is higher. I think if we engage CMWs in uncovered areas then refusal rate will be lower."
(Male District Health Official, Sindh)

Discussing the facilitating factors, many of the key informants reported that district administration and health and education departments were very cooperative and highly supportive. They shared that they did not face any major challenges working with them.

"Whatever activity we were planning and whatever work we were doing, we used to have a meeting with the DHO RHMC or LHS and they supported us in every possible way. Personal help was also given in this work by officials because they believed that everyone would benefit from this program." (Male Nutrition International Partner Staff, Sindh)

"Right Start is providing good trainings. Coordination with departments and officers is very strong. They are also conveying the message to the community which is a good thing." (Male District Health Official, Sindh)

SUGGESTIONS TO IMPROVE THE PROGRAMS

The majority of the study participants from Sindh, KP and Punjab suggested engaging males, influential community members, community elders, and religious leaders in programs focused on women and adolescent nutrition.

"We need to work on attitudinal change, and it can be achieved through the help of religious leaders to bring this change. We need to give due status to the girls and women in our society." (Male District Government Official, KP)

"We should engage males, especially husbands. If he has knowledge, he would support his wife to take healthy diet." (Male Nutrition International Partner Staff, Sindh)

Moreover, they suggested to utilize mainstream media and social media to raise awareness about positive gender norms and importance of diversified nutrition for pregnant and lactating women and adolescent girls.

"I think that media plays a major role in raising awareness. For example, videos, radio, and television can play an important role." (Male Nutrition International Partner Staff, Sindh)

"We can use social media to spread it in backward areas. We can also use religious scholars in this regard." (In-School Adolescent Girl, Punjab)

Furthermore, government officials and partners both in Sindh and Punjab suggested to restart the CMW initiative and door-to-door campaigns to maximize community outreach, especially in uncovered areas.

"Involving local people in the programs will ensure the success of the programs. For instance, with the help of local women councilors or other influential women in the community like teachers, out of schoolgirls can be reached" (Female Teacher, KP)

"I think we can spread the word by going door-to-door just like the polio campaign as it proved really effective. We can visit every house and tell them how to end the nutritional deficiency in young girls." (In-School Adolescent Girl, Punjab)

At the programmatic level, many study participants suggested expanding coverage of the MNHN and AHN programs to reach communities in remote areas, as well as ethnic minorities, boys, out-of-school girls, and people with disabilities.

> *"WIFA initiative should be launched at provincial and district. Don't limit it to health workers and covered areas. Expand it to the uncovered and backward areas as well. Also don't limit it to schools but launch it on the community level as well so that better results of this program can be attained." (Female Service Provider, Punjab)*

> *"To further improve the interventions in future, I would suggest strengthening the KMC wards through the referral mechanism, as there are many premature or low birth weight babies. They die because of these causes and if they take advantage of this intervention then we need to strengthen it. Plus, we need continuous mobilization so that the message, especially of thousand-day approach may reach far and wide in the community in order to improve maternal and child health." (Male Nutrition International Partner Staff, Sindh)*

One key finding that emerged through the analysis of program design and that many stakeholders mentioned was that boys should be included as beneficiaries of the AHN program, because their nutrition status is as bad as girls' nutrition status. Furthermore, including both genders in the program will increase acceptance at the community level, and it will help to reduce community misconceptions around such initiatives. This is supported by the national evidence on malnutrition, which stresses that the pattern of distribution of malnutrition among boys and girls remains the same, with boys being more affected than girls by all forms of malnutrition. For example, the National Nutrition Survey (NNS) of Pakistan 2017-18 reported stunting among children under five at 40.2 percent, and the sex segregated data shows it is 40.9 percent in boys and 39.4 percent in girls. Likewise, more than half (53.7 percent) of Pakistani children are anaemic and 5.7 percent are severely anaemic. The prevalence of anaemia is slightly higher (54.2 percent) amongst boys than girls (53.1 percent). Similarly, NNS 2018 shows that among adolescents (10-19 years), 21.1 percent of boys and 11.8 percent of girls are underweight.

Finally, it was found that all levels of programming need a comprehensive capacity building plan on gender related concepts from the management to field level – including implementing partners and government stakeholders – for better understanding and to ensure the outreach of services to more marginalized groups of women and girls.

Discussion and conclusion

The study findings inform that male dominance and a patriarchal value system was all-pervading across Sindh, Punjab and KP provinces. Gender discrimination that favoured boys over girls in areas of children's nutrition and health was widespread across the provinces. This is largely because boys are perceived to be future breadwinners. However, the study findings demonstrate that while early marriage and gender discrimination (two major causes of malnutrition in adolescent girls) are still pervasive, they are on the decline. These findings confirm the imbalanced gender power relations, low social status of women and adolescent girls and persistent gender inequality in Pakistan, which were identified in previous research studies (UNICEF 2011).

The study findings also underscored socioeconomic factors, like unemployment, poverty, place of residence (e.g., remote rural areas or urban areas) and ethnic identity (e.g., Kohli, Bagri or Christian people) contributed to malnutrition among women and adolescent girls. Moreover, unexpected situations – like the current COVID-19 pandemic – increased people's socioeconomic vulnerabilities and drastically affected their livelihoods, particularly the poorest segments of the population, and thus increased their food insecurity, health and well-being.

Both quantitative and qualitative findings showed that women, particularly young and unmarried women, had little role in decision-making at the household level and depended financially on their husbands or parents even for health services. Moreover, restrictions on female mobility and the need for approval from a husband or guardian hampered the ability of women and girls to seek healthcare. However, working women or women with an independent source of income were more likely to exercise an important role in decision-making. Critical barriers to women's health-seeking behaviour included long distances to travel, restrictions on female mobility, financial constraints, lack of gender sensitive service provision, lack of agency for independent decision-making and dependence on approval or permission from parents/guardians, husbands or in-laws. Likewise, barriers to adolescent health-seeking behaviour included poverty, lack of autonomy, gender discrimination and limited knowledge about healthy foods. The previous research evidence from developing countries shows that improving women's empowerment, increasing their role in decision-making and giving them financial control will significantly enhance the quality of healthcare and nutrition for women and their children. In the same vein, intervention design is a way to improve women's mobility to access services, specifically for nutrition, which can also improve overall health status of young children and adolescents.

In addition, the study findings revealed changing food patterns and availability and use of unhealthy and processed foods and carbonated drinks that may increase the burden of nutrition related diseases. Other important causes of malnutrition in women and adolescent girls, as identified by the majority of the participants, included lack of awareness regarding diversity of food and balanced diet. Therefore, promoting positive health and nutrition behaviour from an early age can have a significant impact on the adult health of today's adolescents, as well as on the health of their children.

Most of the key informants had no clear understating of key gender concepts, as outlined in Nutrition International's Gender Strategy – like sex and gender, gender quality, gender equity, women and girls' empowerment and gender mainstreaming – and how they can play an effective role in gender transformation. The study findings revealed that this may be because staff at Nutrition International and partner organizations were provided orientation on the nutrition programs, but they did not receive comprehensive training on gender. The findings also highlighted the need to embed gender policies and strategies at every stage of the program implementation. In line with Nutrition International's Gender Strategy, the programs need to emphasize that "good nutrition and gender equality are mutually reinforcing" and the crucial role everyone engaged in the (MNHN & AWHN) programs can play in improving the nutritional status and social status of women and girls. Moreover, the findings underscored the need for a robust M&E system to ensure that sex and gender disaggregated data was collected and utilized when making programmatic decisions.

Many of the key informants highlighted the important role of MNHN and AHN programs and the impact they were having in the intervention areas particularly in terms of increased access to MNHN and AHN services and changing health related behaviours. They also noted the enabling factors with respect to the programs included the committed and well-respected service providers – local LHWs and CMWs – with extensive outreach and established trust within the communities, as well as cooperative and responsive government officials.

The study findings suggested the need to expand the AHN program to engage in-school and out-of-school girls, and to distribute WIFA supplements at the community level so that out-of-school adolescent girls also benefit from the program. Furthermore, the findings underlined the importance of targeting boys as well as girls in nutrition programs. Teachers can play a part in raising students' awareness about health and nutrition, as well as engaging and influencing parents as they are highly respected and considered reliable sources of information. The teachers can also help reach out-of-school adolescent girls.

The study showed that mass media and social media are perceived to be important agents of change for empowerment of women and girls. The findings also highlighted the need to engage males, community influencers and religious leaders in the programs focused on health and nutrition of women and adolescents. Furthermore, they suggested using door-to-door campaigns through CHWs to raise awareness about the healthy gender norms and importance of diversified nutrition for pregnant and lactating women and adolescent girls.

Recommendations

- Gender mainstreaming needs to be embedded in the programs from the design stage to its implementation and evaluation. In addition, strengthen the M&E system to ensure that the programs collect disaggregated data on sex and gender. More specifically, the gender lens should be used for regular nutrition situation analysis, analyzing nutrition related needs of communities, sociocultural practices that influence food patterns, and roles of men and women in the communities. Organize comprehensive trainings for staff and partners on key concepts and values that underline Nutrition International's Gender Strategy and how gender equality and good nutrition are intertwined, and explore the crucial role everyone engaged in the MNHN and AWHN can play in improving nutrition and empowering women and girls.
- It is important to recognize that there is more to gender then just targeting women in the intervention design, its implementation, or the intervention itself. Hence women should be targeted However, it is imperative to reach out men as well to help address their needs, particularly by targeting men via youth groups and boys via adolescent group as is done with women and girls. This can significantly influence nutrition status in early life – which can improve overall health status. Engaging of adolescent and youth can also challenge harmful normative practices that promote gender inequality around accessing resources and food.
- Specifically in the context of engagement of women and men, the designed program related to nutrition must promote "balanced distribution" of the household tasks between women and men, if any is related to the nutrition intervention. In this case, mainly women are responsible for providing care. Therefore, the program should encourage men to acknowledge women's roles and support them by contributing to childcare.
- In relation to recognizing vulnerabilities of women, programs should include multidimensional interventions/activities that target not only in-school girls but also out-of-school adolescent girls, as well as pregnant women and other vulnerable population groups including minorities and people with disabilities. Specifically for adolescents and young girls who share the burden of household chores – and in certain situation have increased household chores because they are responsible for caring for younger siblings, which can ultimately affect their education because they have to quit school. Therefore, interventions may question such gender specific roles at the household level and may consider engaging boys in caring for the young at the household level. The purpose should be to challenge the privilege boys have over girls. The same privilege is reflected within the medical care seeking behaviour and gender-centric food distribution and uptake at household level.
- Ensure uninterrupted supply of nutritional supplements and MNHN/AHN supplies in the target service centers/ communities.

- Develop social and behaviour change strategies to promote awareness about, and consumption of, a diverse range of foods to combat malnutrition and promote healthy eating practices at the household and community levels. Hence, women should be centre of attention because they can influence good nutrition practices, health supporting behavior, good hygiene practices, as well as understand the dynamics of malnutrition in children and be empowered to get essential support. Such practice at the household level can inspire to other women and families within the communities.
- Parents at the household level may be targeted to achieve desired results of the intervention. Through awareness creation and behaviour change communication strategies, emphasis should be given that the parents may realize and understand the importance of nutrition at the various stages of children development. They should also be included as a part of the intervention design where emphasis is given about health seeking behaviour and transformation in normative practices. Possible entry points include: awareness creation through radio programs, community engagement through mobilization, organization of seminars, engagement of village nutrition/health committees, engagement and training of nutrition volunteers, and healthy competition/events related to healthy children.
- Mobility related barriers should be addressed by making nutrition related issues a health priority into the local context. This can be achieved through creating awareness and behaviour change communication, and engagement of local stakeholders
- Behaviour change interventions and targeted messaging to address myths and misconceptions about IFA supplements, colostrum, exclusive breastfeeding and postpartum diet for the mother and child at household and community level.
- Community level change should be part of intended outcome of the designed intervention. Behaviour change communication strategies and awareness should promote a culture of demand generation at community level. This occurs when community members demand services that may improve nutrition status or counter malnutrition in the community. These demands could be related to water supply, sanitation, hygiene, quality of service delivery for childcare at health facilities, availability of financial resources for childcare and child development via credit or other schemes.
- A culture of local ownership and management of the initiatives should be promoted. A community driven accountability mechanism should be developed to engage public and private stakeholders to improve of nutrition status of children, as per community needs. Community ownership can be enhanced and intervention can be sustained when the financial needs required for the nutrition uptake are either institutionalized through community fund or linked with public sector initiatives. However, such initiatives should consider gender dynamics as well where women and girls should be given due roles in relation to men and boys within the community driven initiatives.

- Engage and train teachers on gender and nutrition and related health topics to raise awareness about healthy dietary practices and counter gender stereotypes.
- Increase outreach through CMWs/CHWs and door-to-door campaigns to raise awareness about the 1,000-day window and strengthen referral mechanism.
- Organize refresher trainings for the service providers to enhance their capacity and keep them motivated.
- Engage males, social workers, community elders and religious leaders to sensitize communities about malnutrition, enhance acceptance of interventions and change behaviour.
- Mass media, social media in particular, is perceived to be an important agent of change. Therefore, utilize mainstream media channels as well as social media, local radio and cable TV networks to promote equal and positive gender norms and roles as social ideals, and spread the information about the importance of nutrition, balanced diet, gender equality and empowerment of women and girls.

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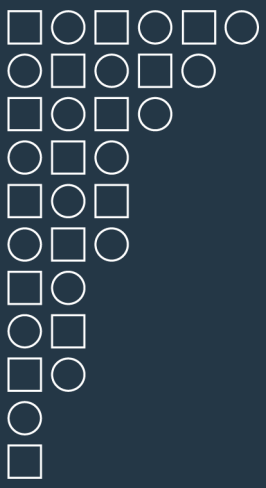

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