POLICY BRIEF | BANGLADESH

Integrating Gender Equality in Nutrition Policies and Practices

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NUTRITION INTERNATIONAL

Nourish Life

INTRODUCTION

Despite strides in poverty reduction and improved life indicators, Bangladesh faces a significant nutrition challenge. Bangladesh has the highest prevalence of low birthweight children in the world at 28%, and 28.9% of girls and women between the ages of 15–49 suffer from anaemia.[1] Approximately 24% of children under five are stunted, 22% are underweight, and 11% suffer from wasting. Additionally, almost half of the pregnant women in the population suffer from anaemia, which is a key indicator for maternal health and nutrition.[2] Thirty-one percent of adolescent girls between the ages of 15–19 are undernourished. Limited access to nutritious food and health care affects pregnant women who require increased nutrients including higher iron intake during pregnancy due to physiological factors. Limited access also affects adolescents and young children who require higher nutrition intake during their growing years.

Achieving equitable and sustainable nutrition demands recognition of the inextricable link between gender equality and good health. While access to nutritious food is a fundamental human right, women and girls disproportionately suffer from malnutrition due to entrenched inequalities in access to, and control over, resources needed for accessing nutritious food and health and nutrition services.

Further exacerbating the issue is the lack of decision-making power women and girls have to implement positive health and nutrition practices. Conversely, women who are equipped with healthcare knowledge and empowered to participate in community and household decision-making may actively break the nutritional barriers and drive positive change.

To improve the country's nutrition status, the Government of Bangladesh is integrating nutrition into public health and family planning services, with support from development partners and civil society organizations. The government developed the National Nutrition Policy 2015 and the Second National Plan of Action for Nutrition 2016–2025 (NPAN-2) to improve the nutritional status of the population, especially those with high nutrition needs including mothers, pregnant women, women, adolescent girls, and children. However, discriminatory social and religious norms such as food taboos, early marriage, early pregnancy, limited decision-making opportunities afforded to women, and limited access to education for girls (in certain districts) affect their health and nutrition. Nutrition programs need to acknowledge these gender barriers, and address them wherever possible. Therefore, investing in gender-responsive nutrition policies is not just a moral imperative but strategically vital to unleash the full potential of all individuals and build stronger communities.

1 National Micronutrient Survey 2019–2020
2 Bangladesh Demographic and Health Survey 2022

OBJECTIVE

Since 2014, Nutrition International has been working in Bangladesh as a key ally of the government to strengthen the maternal health program by improving the delivery of antenatal care services for pregnant women and iron and folic acid (IFA) supplementation. In March 2022, Nutrition International extended its support to implement the government's adolescent nutrition program in 10 districts, reaching over 870,000 adolescents through 2,800 schools. Additionally, Nutrition International works on food fortification through the government's social security programs i.e Vulnerable Women Benefit (VWB) and Food Friendly Program (FFP) where 3.6 million women and adolescents receive fortified rice.

To gain a deeper knowledge of how perceptions and social norms related to gender affect individual health and nutrition, Nutrition International conducted two studies:

1. **Gender and human rights analysis of barriers to uptake of positive nutrition practices:** This qualitative study was undertaken to assess gender equality issues relevant to adolescent and maternal nutrition programs in Cox's Bazar. The study was conducted as part of Nutrition International's Adopting a Multisectoral Approach for Nutrition (AMAN) project to inform the design of gender-responsive interventions that meet the needs of women, adolescent girls, and children. A total of 298 people (148 males, 148 females, two gender diverse) participated in this study through focus group discussions (FGD), in-depth interviews, key informant interviews, and observation tools in eight sub-districts of Cox's Bazar.
2. **Sex- and gender-based analysis of adolescent nutrition and maternal nutrition programs:** Conducted in Jamalpur, Sherpur, and Habiganj this study analyzed the impact of gender barriers on adolescent and maternal nutrition programs, and informed short- and long-term strategies to better integrate gender into Nutrition International's programming in Bangladesh. The study gathered data through a quantitative survey with 666 adolescent girls, pregnant women, and lactating mothers. In-depth interviews and FGDs were conducted with adolescent girls and boys, pregnant and lactating women and adolescents, mothers-in-law, husbands, parents of lactating and pregnant adolescents, along with key informant interviews with stakeholders from Nutrition International, government and community leaders.

This policy brief outlines the study findings and has been developed with the following objectives:

1. Uncover links between gender and malnutrition, illustrating how inequalities affect women and girls.
2. Highlight the importance of prioritizing gender equality in empowering individuals, families, and communities, ultimately improving nutrition for everyone.
3. Offer recommendations to embed gender equality within nutrition programming—including policy recommendations, funding commitments, and strategic partnerships.

KEY FINDINGS

Gender equality perception, norms and behaviour

Studies showed that 60% of adolescent girls perceived they receive equal treatment to boys with respect to education, food, decision-making, etc. A further 16.7% of adolescent girls reported that boys get higher preference in families because they would earn for the families, whereas the girls will be married off and leave the family. Though both girls and boys reported no discrimination with respect to food distribution at home, there were some reports of men getting preference when being served food. It should also be noted that boys and girls have different nutritional needs, with girls requiring more micronutrients like iron, while boys require more energy.

Participants in individual interviews did not report any discrimination during pregnancy. Most said that they eat together with the men. However, in certain areas, reports of superstitions such as keeping pregnant women confined to homes and giving them less food were reported. These practices can have adverse effects on the overall health of pregnant women. Other taboos and social norms may influence diet quality during pregnancy.

Pregnant women and lactating women have among the highest nutritional needs. Only 25% of pregnant women and 23% of lactating women reported getting special preference with respect to food. Ensuring equity in nutrition is about ensuring needs are met, especially for those with the greatest nutritional needs and potential consequences.

Religious norms such as purdah restrict women's mobility. Most women had not undergone formal education and thus have few employment opportunities and income sources to support themselves, compounding their lack of agency and access to resources.

Adolescent boys reported that they were shy to discuss puberty-related issues or their physical and sexual changes with parents or adults. There was a perception among men that their needs are neglected as most government services related to health and nutrition are tailored to meet the needs of women and children.

Women, adolescent girl survivors of gender-based violence (GBV) tend to not disclose incidents of violence fearing further shaming by the community, which deprives them of care when they need it the most. Even with formal grievance redressal measures established at district and upazila health complexes to report reproductive health and GBV issues, people prefer contacting NGOs, due to the fear of public shaming, humiliation and nepotism.

Access to health and nutrition services for women

Persons with increased needs—such as pregnant women and individuals living in marginalized or minority communities—do not get equitable and responsive treatment at health facilities. For example, gender diverse persons do not have separate lines or special counters at government health facilities, which causes fear of psychological and physical abuse among them. However, lactating women receive health services from community clinics and government hospitals, and while responding to study questions they shared that they did not face any discrimination based on gender. Though many pregnant women reported receiving IFA supplements, a few did not consume them due to prevailing misconceptions about consuming food and supplements together.

Though there are social security programs (SSPs) in Bangladesh, like the Vulnerable Women Benefit and Mother and Child Benefit programs, which are exclusively designed for vulnerable women and children, some beneficiaries still find the health and nutrition services insufficient. Furthermore, SSPs do not place enough focus on fulfilling the nutrition gap and its associated challenges. Lack of adequate staff and alleged misappropriation of resources hamper equitable distribution of services.

Many local healthcare facilities are poorly maintained and provide only basic services. For major illnesses, people need to travel to upazila health complexes where they encounter long waiting hours, variable conduct by staff, and inadequate infrastructure and human resources.

Decision-making

While most women are aware of health and nutrition services, barriers such as geographical distance, lack of transportation, domestic responsibilities, socio-economic pressures, and cultural and religious practices prevent them from accessing these services. In most households, women are not allowed the decision-making power to seek medical or nutrition-related assistance for themselves or their children, and the men make those decisions. In some households, decisions on visiting health facilities are made jointly by men and women.

Pregnant women, especially newly married women, reported the need to obtain permission from their husband or mother-in-law to avail antenatal and postnatal care. Many pregnant women reported that their mothers-in-law decide if they can consume IFA supplements.

While women make decisions about some household routine chores such as cooking and what kind of foods to eat, it is the men of the household who make decisions on food purchases and who buys the food items. Men make most of a family's major decisions, such as having children, purchasing assets, etc., though some women reported making such important decisions jointly with their husbands.

Gendered division of labour

It was reported that after 10 years of age, girls experience more restrictions on mobility as compared to boys. They are engaged in indoor household responsibilities while boys are engaged in helping with tasks outside the home and helping the father in earning for the family. Girls tend to drop out of school due to early marriage and participation in household responsibilities, whereas boys tend to drop out due to engagement in livelihood activities and lack of interest in studies. The gendered division of labour continues throughout the lifecycle with women assuming the role of primary caregivers in families. Most women have accepted this role and do not see the need for any change.

Respondents reported some degree of participation by men with household chores. Of the types of household work done by men, 30% helped their wives, 40% helped in household work and 10% engaged in teaching their children. Only 10% reported that they did no household work. Among pregnant women, 38% reported that their husbands helped with household chores such as cooking, fetching water, childcare and cleaning, whereas 20% reported that no one helped them.

Sixty percent of adolescent girls reported that household responsibilities never interfered with their school or leisure time. Eighty-two percent of them said that gender responsibilities never caused any obstacles.

Access to adolescent health and nutrition services

Eighty-nine percent of adolescent girls were aware of health and nutrition services, 94% availed of health services and 92% received micronutrient services. While girls receive information from their mothers and through nutrition education during weekly IFA supplementation in schools, adolescent boys feel deprived of adequate services and information on health and nutrition. Some adolescent girls face obstacles in accessing health services due to restricted mobility. The lack of female health providers in healthcare facilities poses barriers for adolescent girls seeking health services. Conversely, when health providers are female, adolescent boys hesitate to seek healthcare.

Autonomy and control over resources

Many women stated that they enjoy control over household resources. However, men still control household finances, and women often need their permission for major economic decisions including decisions for spending on health and nutrition. Even in the ethnic Garo community where inheritance is matrilineal, management of resources are controlled by the men.

CHALLENGES TO INTEGRATING GENDER INTO NUTRITION SERVICES

Lack of gender disaggregated data

Government reporting and recording systems are not always developed to capture sex and gender disaggregated data. As a result, gender integration into nutrition services sometimes becomes challenging.

Discriminatory gender norms and practices

Gender discriminatory norms and gender-defined roles are deeply entrenched in communities. Patriarchal norms that give preference to boys lead to disadvantages for girls, with prevents girls from accessing education and consequently impacts their future employment opportunities. When it comes to food and dietary practices, though women decide what food to cook and eat, they are often eat least and last. Males or family elders often govern decision-making for accessing healthcare. Women cannot easily access nutrition services due to lack of economic opportunities and mobility, as well as limited decision-making powers and control over resources. Certain maternal health and nutrition services also use gender-biassed messaging, targeting only women with nurturing, caregiving education.

Social bias and norms also make facilities hostile for victims of GBV. Hence, women are afraid to seek help from such facilities for fear of being shamed and stigmatized.

Lack of dedicated human and financial resources

Health facilities often lack inclusive and gender-friendly physical infrastructure (like a separate corner/space for breastfeeding to maintain safety and privacy) and adequate gender sensitivity among staff to provide good quality, gender-responsive services to people—especially those with special needs and vulnerabilities. There is a lack of healthcare facilities that provide special care and support to women who are victims of GBV.

OPPORTUNITIES FOR PROMOTING GENDER-RESPONSIVE NUTRITION SERVICES

Gender mainstreaming in government policies

The government's NPAN2 envisages coordinated multisectoral efforts to deliver nutrition services across the country. Realizing that gender equality is essential to the successful operationalization of NPAN2, it is vital to mainstream gender in the assessment of health and nutrition programs. The National Nutrition Policy (NNP) is also being reviewed and updated, and there is scope to revise it with a gender lens.

Awareness among women of their rights and needs

Though many respondents had accepted existing gender roles that deny opportunities to women, many still felt the need to exercise their rights and wished for greater access to resources and equal rights as men.

Balancing gender roles

In a positive deviation from traditional norms, some men have started engaging in household responsibilities and helping their pregnant wives, and who feel it is their duty to support their spouses in household tasks. This indicates the possibility of balancing gender roles. This positive deviance could be showcased to create greater awareness on the need for balancing gender roles to prioritize health of all family members.

KEY RECOMMENDATIONS

KEY PRINCIPLE	RECOMMENDED ACTIONS
Policy	• Ministry of Health needs to assess key gaps in terms of addressing the need for equitable measures that promote gender equality within the existing NNP and NPAN-2. Additionally, they could prioritize incorporating gender-responsive plans into these documents with more focus on promoting women's leadership in decision-making as it is the key to tackling malnutrition. • Ministry of Health / Bangladesh National Nutrition Council (BNNC) must uphold the gender mainstreaming approach into the Multisectoral Nutrition Action Plan to ensure nutrition services are gender responsive through proper planning, budgeting, implementation, and monitoring. This also requires coordinated efforts of various concerned ministries and departments. • Ensure creation of option for and regular collection of sex-disaggregated data and that it is reflected in the dashboard managed through nutrition programs by Ministry of Health/BNNC, Ministry of Education. • Allocate adequate resources within government nutrition programs under Ministry of Health for gender-related activities such as gender training, awareness creation and inclusive infrastructure.
Programs	• Integrate gender analysis in every stage of nutrition programming—from planning to monitoring and impact assessment. • Establish accountability among service providers to ensure that they plan, monitor, and evaluate their interventions with a gender equity lens so that they can incorporate the relevant indicators into their monitoring systems. • Conduct regular gender audits of nutrition programs and budgets to assess effectiveness in gender equity and identify areas for improvement. • Undertake research into the interplay between gender dynamics and nutrition, including gender norms, and power relations within households and communities.
Inclusivity	• Design and implement nutrition interventions that consider the specific needs of women, men, children, adolescent girls and boys, other gender diverse groups, and marginalized populations. • Engage men and boys in nutrition and health education, and build their understanding of gender differences in needs and the potential benefits of addressing these differences. • Ensure access to information on sexual and reproductive health information and services for adolescents, and recognize the unique needs of adolescent girls and boys. • Create awareness on not just the health of men/boys, but also on the role of men in caregiving/household tasks. • Organize family- and community-level discussions on entrenched patriarchal notions regarding gender-based roles and household/caregiving responsibilities. • Identify role models among men and boys who have defied gender roles and engage them as champions of gender equality.
Accelerate access and participation of women and adolescent girls	• Enhance women's voice, leadership, and decision-making related to nutrition at the family and community level through community-based awareness sessions where all genders are involved. • Provide opportunities for extracurricular activities and sports for adolescent girls, including engaging out-of-school adolescent girls in health and nutrition activities. • Address barriers related to women's mobility and GBV-related issues to ensure that adolescent girls and women have equitable and secure access to health and nutrition services.
Capacity building	• Provide gender-related training and sensitization to healthcare and service providers, civil society organizations and other agencies working in the nutrition sector. • Organize dialogues among families and communities to challenge harmful gender norms, and to promote equitable food distribution and access to health and nutrition services.
Mass awareness	• Build awareness on the rights of women, as well as special nutrition and health needs through public discourses on equality versus equity. • Conduct mass awareness campaigns through radio/TV programs and social media; engage the community by organizing seminars/courtyard sessions to disseminate health and nutrition information and messages on gender equity, preventing early pregnancy and early marriage, and how this relates to nutrition.

ABOUT NUTRITION INTERNATIONAL

Founded in 1992, Nutrition International is a global organization dedicated to delivering proven nutrition interventions to those who need them most. Working in partnership with countries, donors and implementers, our experts conduct cutting-edge nutrition research, support critical policy formulation, and integrate nutrition into broader development programs. In more than 60 countries, primarily in Asia and Africa, Nutrition International nourishes people to nourish life.

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