**Collective for Social Science Research**
**Maximising the impact of cash transfers on undernutrition in Pakistan**

**Qualitative Research Findings and Pilot Recommendations**

## A. Introduction

### 1. Research objectives

The design of proposed pilot interventions builds on existing knowledge about barriers to nutritional improvement and the possibility of leveraging the cash transfer programme summarized by the desk review. Primary fieldwork was carried out to supplement findings of the desk review with an understanding of realities at the level of the BISP beneficiary.

An in-depth qualitative survey was carried out at the community level to address three sets of questions:

- How does the cash transfer programme actually interface with the beneficiaries and the wider community?
- What are the norms, perceptions, behaviour and constraints which might influence nutrition outcomes, and how might these change for positive impacts on nutrition?
- What are promising models of pilot interventions and why?

To understand the current and future nutrition policy and programming landscape, key informant interviews were conducted with nutrition focal persons of each provincial government. The objective of the interview was to gain insight into the process of policy and the level of involvement of various stakeholders in formulation of policy and implementation of programmes.

This note summarises the findings of the qualitative fieldwork and key informant interviews. Before doing so, however, we outline the nutrition policy context which exists in Pakistan and the opportunities provided by the Benazir Income Support Programme (BISP) which can be leveraged for nutrition programming. In light of this, and with the findings from our fieldwork, we conclude the note with recommendations for design of pro-nutrition pilots which can be implemented alongside the BISP.

### 2. Nutrition policy and programming

Nutrition as a policy priority was recognised in 2002 with the establishment of a separate nutrition wing within the Ministry of Health. Two main programmes were pioneered by the nutrition wing in the 2000s:

(1) The Improvement of Nutrition through Primary Health Care and Nutrition Education/Public Awareness – this initiative was delivered through the Lady Health Worker (LHW) programme and aimed to improve nutrition by building awareness about nutrition at the community level, growth monitoring and Vitamin A supplementation. While there has been no evaluation done on the programme, an evaluation of the LHW programme shows child growth monitoring coverage was low and there was a negative impact on breastfeeding (Oxford Policy Management, 2009).

(2) National Plan of Action for Control of Micronutrient Malnutrition. This included a salt iodisation programme, wheat flour fortification, fortification of *ghee* (cooking fat) and provision of micronutrient supplementation sachets.

Other nutrition-sensitive programmes that were run in the past were the Infant and Young Children feeding (IYCF) programme in which the training curriculum of the LHW was revised to include IYCF

education and the Community Based Management of Acute Malnutrition (CMAM) during emergencies and disasters (Balagamwala and Gazdar, 2012).

During the Indus floods of 2010, rapid assessments of nutrition were conducted by organisations working on recovery in flood-affected. It was brought to attention that nutrition problems among children were not restricted to acute malnutrition (which might have arisen due to the emergency) but there were high levels of chronic malnutrition as well. Multilateral organisations and NGOs which had coordinated the development and relief activities by forming clusters built upon their relationships to work together to form the Pakistan Integrated Nutrition Strategy (PINS) (Balagamwala and Gazdar, 2012).

However, following the eighteenth constitutional amendment, health has been made a provincial subject and each provincial government is now responsible for formulating its own policies. As mentioned, earlier, interviews were conducted with nutrition focal persons in each province to find out more about the policy process in place and plans for future nutrition programmes and interventions. In the last year, there has been a much needed shift towards developing a nutrition policy across the four provinces mainly due to the importance given to the subject by multilateral and bilateral institutions. All provinces are currently developing inter-sectoral nutrition policies for the next four to five years. The overarching policy and the nutrition interventions lined up are similar across provinces possibly because they are based on almost identical policy guidance notes developed by the World Bank.

Proposed nutrition interventions place stress on the identification of nutrition issues at the community level and builds upon the CMAM programme implemented in emergency and disaster affected areas. However, the programme will not be restricted to treating malnutrition as the CMAM was, but will also include a Behaviour Change Component focusing on infant and young child feeding practices and health education and counselling. At the community level the LHW will place a key role in areas to promote health behaviour and to screen children in need of treatment for malnutrition in those areas where there is coverage of the LHW programme and in those areas where there are no LHWs present, local NGOs will be contracted. Capacity building of the health department and staff, LHWs and NGOs is also an important part of the programme. In Punjab, within the health department, the programme is being led by National Programme for Family Planning and Primary Health Care (which consists of the LHW programme and BHUs) while in Sindh and Balochistan the health department's programme is spearheaded by the Nutrition Cell.

*mHealth pilot:* There is a programme being piloted in Layyah in Punjab which provides Android smart phones to LHWs (in partnership with World Bank). The objective is to increase frequency of reporting and move towards an e-reporting system.

**3. Opportunities provided by the Benazir Income Support Programme (BISP)**

The BISP represents a qualitative shift in social protection programming in Pakistan (Gazdar 2011). It is the first large-scale cash transfer programme in the country with a significant fiscal outlay, a comprehensive system of targeting, and with a primary focus on women beneficiaries. Moreover, the programme has not only sustained through a period of fiscal constraints since its inception in 2008, it has grown and has made important institutional transitions towards greater effectiveness.

*Women beneficiaries*

The BISP is the first cash transfer programme whose primary beneficiary is individual women from poor households. Given the importance of women's agency in mediating nutritional outcomes – partly through greater regard for their own health and nutritional status – the long term effects of

simply bringing women in a predominantly patriarchal society into direct contact with social programming are likely to be positive. Other programmes which have a direct outreach to individual women and children are in the closely connected areas of preventive and maternal and child health (such as the Expanded Programme for Immunisation (EPI) and LHW programme)

*Database and universe*

In 2010, a nationwide poverty scorecard census was undertaken by the BISP through survey organisations who conducted a door-to-door survey. While the primary purpose of the poverty scorecard and the BISP database is to target the poor using state-of-the-art methods, in the process the programme has created a database of virtually all households and individuals based on the poverty scorecard census. This database represents a significant institutional innovation on several accounts. It is one of the few social policy interventions which is based on a clear idea of a universe – in this case all residents of Pakistan. Nutrition interventions like most other forms of social services, particularly those relating to children and women, are based on the presumption of universal outreach. Such interventions do not simply wait for demand from potential beneficiaries but actively seek out their potential beneficiaries. The idea of universal outreach, or even targeting or sampling from a well-defined universe, has been relatively weak in Pakistan. If programmes only reach those who are more able or willing to access them they are likely to exclude the most needy and vulnerable. The BISP database not only allows for programme design to be based on a well-defined universe, it may have initiated a wider change in programming culture in Pakistan.

*Case management system*

A case management system has been constructed based on interactive processing of the BISP database. The database includes all census entries covering all fields of the census questionnaire. Additional linked information is provided by NADRA verification of individual identities and addresses. The case management system, which is supposed to be accessible at all BISP offices, can be regarded as the backbone of the programme. Events such as payments as well as any complaints are recorded in the system.

*Organisational outreach*

The BISP has established a presence down at the tehsil/taluka level. These local offices are linked, in principle, through the case management system, with district, regional and provincial offices, and ultimately with the national headquarters. Local offices are staffed with case officers who are trained in the use of the case management system. While the tehsil/taluka level outreach is a major advance on the initial reliance entirely on subcontracted personnel, it still falls far short of any notion of community level outreach. The programme's approach thus far has been to subcontract field activities as well as beneficiary interface to partner organizations, and to focus its own staff's activities on the case management system.

BISP institutional innovations can be leveraged for pro-nutrition interventions more effectively if the main strategic advantages due to these innovations are recognized. To recap, the main strategic advantages are:

- Idea of universe-based programming established
- National database of beneficiaries and non-beneficiaries
- Direct government outreach to women
- Possible interaction with existing universe/listing based programmes in health (EPI, LHW)
- Possible extension of these in nutrition

However, it is important to place on the record a number of limitations with respect to beneficiary or citizen interaction:

- Use of partner organizations for outreach
- Direct interaction with residual complaint cases
- Social intermediation in use of payment modalities

**4. Methodology and site selection**

An in-depth qualitative survey was conducted in eight sites. For the purposes of fieldwork, the following strategy was used to select sites (see Table 1 for selected field sites):

i. Pakistan was broadly divided into five regions with each region representing a province and due to its large population and socio-economic regional variation Punjab was divided into two regions - North Punjab and South Punjab.

ii. In each region (except for Khyber Pakhtunkhwa) districts with the worst nutritional indicators (or proxies of nutrition indicators) were short-listed and from within the short-listed districts, the district with the highest proportion of BISP beneficiaries in total population was chosen.[1] In Khyber Pakhtunkhwa, Malakand was selected as the Waseela-e-Taleem programme (a cash transfer conditional on education) is being run by the BISP which includes a community mobilization component.

iii. In the districts selected, Union Councils (UCs) with a high percentage of BISP beneficiaries were selected since the lowest aggregation at which data on number of BISP beneficiaries is available is the UC.

iv. The problem of undernutrition is not an exclusively urban or rural phenomenon and neither is the BISP. To take into accounts differences in access to services and behaviour that could exist between rural and urban areas, in three districts (Jhang, Rajanpur and Thatta), one urban UC and one rural UC were selected. It was ensured that the two both were within the same *tehsil/taluka.*

v. A UC is too large a unit to be covered for qualitative fieldwork. For purposes of this study, a site was defined as a *mauza* or *deh* (the lowest administrative unit) in rural areas and a *mohalla* (neighbourhood) in urban areas. In order to select a fieldwork site within a UC, two main criteria were used: (1) presence of an active LHW since the LHW has played an integral role in past nutrition programmes and continues to do so in future interventions as well and (2) sizeable number of BISP beneficiaries. As far as it was possible, it was ensured that there was heterogeneity in terms of kinship and occupational groups present in the selected site.

[1] Nutrition indicators used for each province were different since no one source has nutrition data at district level. For Punjab, the Multiple Indicators Survey 2007-8 (MICS) was used, for Sindh district level data from National Nutrition Survey 2011 as presented by the Aga Khan University were used, for Balochistan mortality rate for children under five was used from MICS 2010 and in KP data from MICS 2001-2002 were utilized. Data on BISP beneficiaries are district level were from May 2012 and population data from the 1998 census were used. It is acknowledged that population has since then changed but since the purpose was to rank districts, all districts will have an underestimated population.

Table 1: Sites selected for fieldwork

| | Region | District | Tehsil | Union Council | Rural/Urban |
|---|---|---|---|---|---|
| 1 | Balochistan | Lasbela | Uthal | Kahinwari | Rural |
| 2 | Khyber Pakhtunkhwa | Malakand | Bat Khela | Palai | Rural |
| 3 | North Punjab | Jhang | Jhang | Chak No. 268 | Rural |
| 4 | North Punjab | Jhang | Jhang | Gulab Wala | Urban |
| 5 | South Punjab | Rajanpur | Rajanpur | Sakhani Wala | Rural |
| 6 | South Punjab | Rajanpur | Rajanpur | Rajanpur Sharki | Urban |
| 7 | Sindh | Thatta | Thatta | Chatu Chand | Rural |
| 8 | Sindh | Thatta | Thatta | Thatta - 1 | Urban |

Within each field site the following research instruments were used to collect qualitative data:

i. Community profile of *mazua/deh/mohalla* – This provided basic facts about the community such as demographics, social structures, livelihoods and infrastructure.
ii. Focus group discussions (FGD) – Three FGDs were carried out with (1) female BISP beneficiaries (2) female non-BISP beneficiaries and (3) males belonging to BISP beneficiary households. The purpose of the FGDs was to gauge perceptions about nutrition and nourishment and its determinants within the community, to understand interactions with the BISP and to discuss feasibility and desirability of potential pilots.
iii. Key informant interviews – Interviews of five key informants per site were done with individuals with familiarity about the community such as local leaders, teachers and social activists. Care was taken to include at least one woman and one representative from a marginalised or low income group.
iv. Key informant interview with a LHW – The LHW has played an important role in nutrition interventions and other community-based health programmes. The interview with the LHW focused on the responsibilities of the LHW, the challenges faced and the processes involved.
v. The lowest administrative presence of the BISP is at the *tehsil/taluka* level and the purpose of this office is mainly to deal with complaints received from beneficiaries. An interview was conducted with a representative for the BISP tehsil office to gain insight into the BISP operational systems and capacity at the local level.

## B. Findings

### 1. BISP cash transfer programme

All survey sites had sizeable numbers of BISP beneficiaries. There were differences between sites, however, in the length of exposure of communities to the programme. While some sites had had BISP beneficiaries in Phase 1 (beneficiary identification through elected representatives) there were also sites where the programme actually arrived in Phase 2 –after the Poverty Scorecard Census. It was relatively easy to identify programme beneficiaries through rapid survey methods and key informant interviews because knowledge about who was a beneficiary was widely known.

*Modalities*

Pakistan Post was initially used to deliver cash installments to beneficiaries. However, in all of our field sites, Benazir Debit Cards have been issued which can be used to withdraw money from an ATM or a bank franchise. The main challenge that beneficiaries face with the new modality is the lack of financial services available in their village or neighbourhood. There is a cost implication as beneficiaries have to arrange transport to get to the nearest large town or to the city centre. The scale of the challenge is less in urban sites where financial services are closer and there is better transport. Other problems with the modality include the large queues as the same cash withdrawal

point services a large population and a general sense of unfamiliarity with operating ATMs making beneficiaries dependent on an intermediary to help them out.

However, some prefer the BDC to the Pakistan Post modality since money comes directly to the account and they do not have to run after the Pakistan Post representative and Rs 200 is not deducted as it previously used to. For some, the Rs 200 is not a deal-breaker since they end up spending as much on transport. Some also end up paying agents who help them withdraw the money from the ATM. In some areas, women said they had to be present to receive the money from the bank (or the franchise) while in one site, Lasbela, some women said their husbands would withdraw the money and at times not hand it over.

*Use of BISP money*

Money received from the BISP is usually spent on "essential household items" which includes both food items as well as non-food items. In areas such as rural Thatta, where there is widespread food insecurity, money is spent on purchasing food. Across sites, the money is also spent on clothes especially those of children and in households where a family member is ill, health care becomes one of the main areas where the money is spent. For widows, who do not have a source of income, the money becomes very important as it is used to run the household. In most sites, the beneficiaries said they had control over the money and spent it on their own will except for Rajanpur urban and Lasbela where the money was handed over the head of the household as they bear the responsibility of providing for the family.

*BISP Tehsil Office*

The BISP tehsil office generally has an Assistant Director, and Assistant Complaints officer (AC) and in some cases (Malakand and Lasbela) field supervisors. The main role of the office is to register grievance of beneficiaries and complaints of those who have been left out by the programme. They are also responsible for monitoring other programmes of the BISP such as the Waseela-e-Rozgar scheme. In 3 out of 5 tehsil offices that we interviewed, the staff do not travel to the field but in the other 2 (Malakand and Lasbela) there are field supervisors who go out in the field to collect complaints and to resolve them.

The only communication the *tehsil* office has with the head office in Islamabad is via the Case Manangement System (CMS), which is the interface used to register complaints. The office works in coordination with the National Database Registration Authority (NADRA) and banks to rectify complaints and if the Waseela-e-Rozgar programme is running in the area with vocational training institutes and if the Waseela-e-Taleem programming in present then the department of education. Main complaints of beneficiaries include loss of card or pin codes, problems with the card and fraud by intermediaries who help them with cash withdrawal.

**2. Lady Health Worker**

As mentioned above, one of the selection criteria for field sites was the presence of a Lady Health Worker. In some areas, the LHW is the only health service provider and plays an important role in guiding residents, especially women about health issues.

*Caseload and duties*

The core responsibilities of the LHW include the following (OPM, 2009):

- Provide hygiene education on drinking water and sanitation
- Provide nutritional advice and growth monitoring

- Monitor and advise women on their health, and that of their babies, after birth
- Supply and refer women for family planning
- Motivate and educate women on family planning
- Promote and facilitate vaccination.

Apart from these duties, the LHW is officially involved in other community based health programmes such as National Immunisation Days (or polio eradication drives) and Vitamin A supplementation programmes.

In our fieldwork sites, the list of duties she performed varied across sites. Polio eradication campaigns were an integral role of the LHW and in some areas such as urban Rajanpur, the role of the LHW was restricted to administering polio drops. A LHW in our sites spends three to five days in a month on the polio campaign. Other activities include giving vitamin A capsules to children, vitamins to women, distribution of de-worming medicines (Thatta and Rajanpur), other immunisations such as measles (Rajanpur), spreading awareness about dengue (Jhang), family planning advice including distribution of condoms and administering birth control injections, advice to pregnant women, advice about infant and young child feeding and general advice about health and hygiene. However, the level of services provided by the LHW was not constant across sites. In some sites her role was viewed only as a supplier of medicines and polio drops while in sites such as Jhang she was considered an important source of advice and counselling especially for pregnant women and mothers.

The prescribed caseload of the LHW is serving a population of 1000 individuals which is approximately 200 households and the standard practice it to visit each household at once in a month (OPM, 2009). In our field sties the caseload of the LHW ranged from 7 households in rural Jhang to covering a population of 1000 in Malakand. These figures were obtained from the LHW herself as community respondents were not aware of the caseload of their local LHW. There were no reports of a LHW skipping a household in a village or community except for in Lasbela, where the LHW was reported to gather women together instead of going from house to house. LHWs visited each household at least once a month and the frequency of visit increased if a woman or her child is ill or if someone is pregnant. In Lasbela, however, according to community members, the LHW visited their village once in 2 or 3 months.

*Reporting and records*

The LHWs work in close contact with other LHWs in their area. Each LHW has a supervisor who the LHW has to report to at a monthly meeting held at the local BHU or health centre. The LHW has several record keeping notebooks. She has a list of all households in her catchment area with details such as the name of the woman, the address, a household roster and in some areas, like urban Thatta, CNIC number of the household head. She has a separate record of all pregnant women with details about their month of pregnancy, expected date of delivery and where the birth took place. There is one list of children under five with details about their immunisations. The LHWs marks the date of visit against each household after a visit. In Jhang, she has a diary with notes from the meeting of a Health Committee which has been set-up by the LHW consisting of four to five local residents (however, there was no mention of this committee from other respondents).

*Challenges faced*

One of the biggest problems faced by the LHW, across all sites, was transport, as official transport is not provided. Many LHWs live outside their catchment area.

In areas such as rural Thatta the LHW said that due to a lack of education, some women do not take her advice on health and hygiene. In Lasebla, she faced opposition from low income households who taunt her for merely giving advice but not providing resources which they can use to put the advice in practice. In Thatta and Lasbela, women were reluctant to take vitamins given to them as in the former they believed they would have no impact on health and in the latter they were afraid they might be contraceptives. In Malakand, religious groups oppose the LHW and blame her for spreading Western ideas.

**3. Norms, perceptions, behaviours and constraints which might affect nutrition**

A general question was asked to respondents regarding which women and children they viewed as well-nourished and why. The range of answers received showed a good understanding amongst community members about factors affecting nutrition outcomes. A child who is fat and active was considered well-nourished. The difference between a well-nourished child and an under-nourished child was attributed mostly to diet (adequacy and diversity) but also to health, hygiene, feeding practices and mother's nutritional status. Factors such as diet and access to healthcare depend upon economic status of the household. A woman's role is to ensure her child is well-fed, clean and healthy while it's a man's role to ensure he earns enough to provide for his child.

Women from economically better off households were considered to have better nutrition due to a better diet and lower workload. However, in many sites, a woman was considered to be generally undernourished and weak irrespective of economic status. High rates of fertility and poor maternal health were cited as an important factor in determining the health of women and children alike. For women, indicators of good health and nourishment were considered to be consumption of an adequate diet and nutritious foods, good health and life free of stress.

**a) Food acquisition and security**

*Food acquisition*

Most households purchase food items from local shops or markets in a nearby town. Prices in local shops are considered to be slightly higher than those in larger towns. Households involved in farming (either through land ownership, tenancy or agricultural labour) rely on grains and at time vegetables which they harvest. Households that own livestock and poultry use domestically produced milk and eggs

Utility stores are not the preferred store to shop for rations from in all sites as (i) they do not offer credit like local shopkeepers (ii) they typically do not sell small quantities thus necessitating bulk purchasing, (iii) quality of goods is sometimes low and (iv) utility stores are not open every day.

Across the sites, iodized salt is not consumed because it is either unavailable in local markets or was much costlier compared to regular salt. There was, however, in most sites, awareness about iodised salt.

*Food security*

In some sites (Rajanpur Urban and Rural, Thatta Rural, Jhang Rural, Malakand) there are households which go hungry but in the rest of the sites, all households manage to eat at least one meal a day (Lasbela, Thatta Urban, Jhang Urban). Households that are food insecure are those which depend on daily wage labour or are affected by seasonal shocks e.g. fishermen in Thatta who catch less fish during the rains and in winter. Foods that are considered nutritious (milk, fruits, meat, fish) are not widely consumed as they are expensive and most households cannot afford them.

**b) Health**

*Facilities*

In most of the sites (see Table 2) there was no health facility available and residents travel to the nearest town to seek medical treatment. Usually transport has to be arranged for and the cost of travel ranges from site to site depending on the distance. Apart from transport cost, in some sites, residents have to pay doctor's fee, if they choose private treatment and for medicines. In areas such as Malakand where the nearest health facility is far, if there is not enough money and the health issue not serious enough, then home remedies are used.

Table 2: Health facilities

| Site name | Health facilities in site | Nearest hospital |
|---|---|---|
| Jhang (Rural) | *Hakeem* and dispensary | 7 km |
| Jhang (Urban) | Private hospital, mother and child health center | 4 km |
| Rajanpur (Rural) | Medical stores | BHU 2 km, hospital 7 km |
| Rajanpur (Urban) | Medical store | 1.5 km |
| Thatta (Rural) | BHU and private clinics | Not available |
| Thatta (Urban) | Private clinics | 3 km |
| Lasbela | None | 7 km |
| Malakand | None | 25 km |

*Antenatal care*

When a woman is pregnant there is no major change in her diet and women from poor households do not cut their level of activity. Women from higher income households are able to afford to eat better food and reduce physical activity and thus able to take care of themselves better. They get routine checkups done while pregnant whereas other women do not necessarily get antenatal checkups and those who do go once or twice. In sites where the LHW is active, she provides advice and assistance to pregnant women.

*Child birth*

In six out of eight sites (Lasbela, Thatta Rural, Thatta Ubrban, Jhang Urban, Malakand, Rajanpur rural) majority of women give birth at home with the help of a local midwife or *dai*, who is not necessarily trained. In the rural site in Rajanpur, for example, women choose to give birth at home since the cost of a home birth is much less than that of a hospital birth and the midwife also accepts credit. Only if there is an emergency are women taken to the nearest hospital. In places like Palai in Malakand where the nearest hospital is 25 kilometers away there is a high incidence of maternal mortality. In rural Jhang there was a trained Community Midwife (CMW) (appointed by the MNCH programme) but most women choose not to go to her after she mishandled some childbirth cases. Husbands and mothers-in-law usually make decisions regarding maternal care and in some places the woman and her husband make a joint decision.

*Family planning*

Family planning decisions are mainly made by men and in some cases the decision is mutual between the husband and wife. In most areas, contraceptives are not used as children are considered a blessing from God. In some sites (e.g. the one in Lasbela) we were told that religious leaders forbid the use of contraceptives. Women in many areas said they would want to have fewer

children since they are the ones who have to go through child birth. In some sites, women do not use take contraceptive pills or injections as they experience side effects. In some sites, the LHW only provided condoms and for pills or injections the woman had to go to a doctor. An operation was also preferred rather than contraceptives as it does not have side effects and eliminates to possibility of an accidental pregnancy.

**c) Water, sanitation and hygiene**

*Facilities*

Drainage systems did not exist or did not function properly across the eight sites. As a result there was stagnant water in the streets and clogged drains which gives rise to mosquitoes and diseases. This problem was particularly acute during the rainy season. There was general awareness about the deleterious effects of poor sanitation on the health and nutritional status of children.
Drinking water is obtained from a variety of sources across sites but water was considered clean only in three out of eight sites (Rajanpur rural and urban and lasbela). In rural Jhang, for example, drinking water was contaminated due to a poor sewerage system. Those who can afford it, install hand pumps or filters to ensure access to clean drinking water.

There were no garbage collection systems and garbage was often thrown on the streets outside houses and after a pile was accumulated it was burnt. In urban Thatta, garbage was sometimes collected by the Town Municipal Authority but only when community residents lodged a complaint. In some sites such as Lasbela, urban Thatta and rural Rajanpur all households have toilets inside their homes but in areas such as Malakand, rural Thatta and rural Jhang most households resorted to open defecation.

*Practice*

In many areas soap is not used while washing hands as households cannot afford soap. However, the awareness of the importance to using soap does exist. In rural Thatta, respondents said that focus on cleanliness and hygiene has increased after NGOs ran programmes on hygiene after the floods and in rural Jhang where people used to traditionally clean their hands by rubbing mud, the use of soap had increased.

**d) Childcare and feeding practices**

Across sites there are many similarities in infant feeding practices. It is common practice to breastfeed a child till at least the age of six months. Most women breastfeed their baby either till they are pregnant again or till the child is two years of age. However, some women stop breastfeeding as they perceive they are not producing enough breast milk due to themselves being malnourished. Breastfeeding is not exclusive as boiled water is given to babies in most sites. In all sites, except for Lasbela, complementary foods are introduced at the age of six months which are usually soft foods such as mashed banana, potatoes, boiled rice or sometime Cerelac if it can be afforded. Most women want to give Cerelac to their children as they have been advised by a health professional to do so. In Lasbela, women are reluctant to give food to their babies at six month since they feel it causes stomach aches.

What does differ across sites is when the woman first starts breastfeeding her baby. In Rajanpur (rural and urban), Thatta urban and Malakand, breast milk is given after 3 days of birth since it is thought that women do not have enough breast milk till then. In the meanwhile goat's milk is given. In some areas, boiled water or water with coal is given to cleanse the baby's stomach. There has been a change in infant feeding practices in some areas such as Malakand or urban Jhang where

traditionally mother's milk was not the first thing given to babies but now new mothers are increasingly breastfeeding their child soon after its born. The opinion of elder women in the community still holds important in matters of childcare and feeding.

**e) Decision making and opinions**

"Big" decisions such as marriages of children, large household purchases, community level matters are all made by men whereas decisions of lesser importance such as small household purchases and decisions such as what food to cook are made by women. In some areas, men make all decisions regarding to healthcare as well. It is considered a man's right to make such decisions as there are heads of households and more knowledgeable. Educated woman are sometimes consulted but the final decision rests with the men.

The *wadera* (village leader) plays an integral role in decision making and behavior change in some sites (rural Thatta, Lasbela), the local religious leader in some areas (Malakand and Lasbela) and elders of the community. The opinion of the LHW and NGOs, if any, were also considered important.

**4. Pilot interventions**

**a) Nutrition agent**

A strong preference was expressed across survey sites for a nutrition programme where there is regular face-to-face interaction with a nutrition agent or a team. This would give women the opportunity to openly discuss their problems with someone especially women from poorer households who might not have access to doctors or other health facilities. Women would be keen to receive information and training from the nutrition agent as they do seek advice on health issues, childcare, health and hygiene and according to most respondents, the advice would be practiced as well. In many sites, there has been a change in behaviour and attitude towards health, hygiene and child feeding programmes with women changing their practices and viewing LHWs or other NGO programmes as an important source of advice and groups who were traditionally opposed to programmes (for example religious leaders against polio vaccinations) have also started accepting them.

Visits should be frequent (some respondents said weekly, some said monthly) to ensure there is constant interaction and trust is developed between women and the nutrition agent. Some respondents preferred the agent to be an educated person from within the community so that there is already established trust and understanding of local issues, while some said it should be an outsider since they would be taken more seriously. Some respondents said the LHW should be the nutrition agent as she has already developed trust within the community and women take her advice. In areas such as Lasbela, it was considered essential for there to be one local person in the team. Support of local leaders for the programme was considered essential in more than one site. The question of whether the programme should be run by the government or a NGO varied – in Lasbela, people are suspicious of NGOs while in Thatta the government is looked at unfavorably since it has not done much to bring about improvements in the community.

The nutrition agent's role should not be limited to giving advice but she should also distribute items such as nutritious foods since advice without resources will not be practiced since in many areas households lack access to resources', the agent will be trusted more if she provides something and more attention will be paid to the advice. At the same time, providing commodities without advice on their correct use and importance is also considered ineffective.

**b) Mobile phones**

Mobile phone ownership is common in all sites but is restricted to male members of the households. All households, except the one or two poorest, were reported to have at least one mobile phone. Women generally did not own mobile phones except for (i) women who were from the most well off families in the area, (ii) women who were educated and (iii) women whose husbands worked outside the village or community. A woman was more likely to own a mobile phone in an urban site.

Mobile phones are used mainly for making or receiving calls. Women, use their male family members phones and are limited to receiving calls and at time making calls. Often, they are dependent on others to dial a number. Very few people used text message services due to illiteracy. Easy paisa mobile banking services were used in some, but not all, sites. Not all sites had easy paisa facilities in the vicinity.

In many sites, men did not think a woman should own a mobile phone because:

i. Women are "illiterate" and do not know how to use a mobile phone
ii. Women stay at home and do not need their own mobile phone
iii. It is considered indecent and socially unacceptable for women to own mobile phones
iv. It cannot be afforded

Some women said they would like to own a mobile phone, there were also reports of women secretly owning (Thatta Rural) while some said they would not know how to use one or they do not need one.

The use of mobile phones to deliver nutrition-related information was not considered effective since women did not have personal mobile phones and even if they did, would not be able to understand the message given to them. Women also do not pick up phone calls from unknown numbers. A few respondents in some of the sites said targeting men through mobile phones could work but others said men would not deem the messages or calls important and would not share it with women in the household.

In almost all sites, the LHW had a personal mobile phone but only in a few sites did her clients have her number. In areas which women were in contact with the LHW through mobile phones would call her in case of a health-related problem. However, for example in Lasbela, the LHW said she would prefer to see the women in-person as they would not understand her advice or message over the phone. The LHWs did, however, use their mobile phones to remain in contact with their supervisor and other LHWs in their team.

**c) Vouchers**

With regards to vouchers, in most areas people were receptive to the idea of vouchers and many women said they would use them as intended. Respondents suggested that the vouchers should be for items that households currently do not have access to because they cannot afford them or such items are not easily available in their community. These items include nutritious foods such as fruits, milk and juices, food for infants such as Cerelac and other items such as soap or medicines. Vouchers were preferred over cash since the latter can be spent on non-nutrition related purchases and secondly the organisation providing vouchers would know better than the beneficiaries about which items are health- or nutrition-improving.

However, there was a concern about fungibility and distribution of vouchers. Many respondents suggested there be monitoring to ensure the vouchers are used properly and not sold off, that vouchers should be given directly to women and not to the men who might sell them and that the vouchers should be delivered by the organization itself rather than being distributed by local leaders

who might sell the vouchers or the items redeemed. As a result, some respondents preferred that food items and other commodities be directly provided to beneficiaries rather than through vouchers.

## C. Analysis

*Similarities and differences across sites*

An important result of the qualitative fieldwork was that there existed many similarities across all eight sites. A priori it was expected that there may be differences resulting from socio-economic, geographical and cultural variation across sites which might warrant design of multiple nutrition pilots to adapt to local variations. However, here were not any major differences in terms of behaviour, attitudes and practices between regions or between rural and urban areas. For instance, the use of mobile phones was highly gendered everywhere, there was awareness about iodised salt but was not used, lack of functioning sanitation systems were an important issue, foods that were considered nutritious were mainly milk, fruits and meat/chicken/fish, the practice of not giving a child breast milk for the first three days were found in many sites and many other similarities in behaviour were observed as outlined in earlier sections.

Apart from nutrition, even the interaction of beneficiaries with the BISP was comparable across sites. The changes in modality of cash transfer from Pakistan Post to Debit Cards lead to similar problems for beneficiaries as access to and understanding of financial services were the main difficulties faced. Moreover, the money was used in a similar way and the woman's control over money was also prevalent across all sites.

However, there were differences with regards to infrastructure and level of service provision between sites. For example, the LHW in Lasbela was fairly irregular but not in Jhang and was only part of the polio team in urban Rajanpur but active in rural Rajanpur. Similarly, health facilities were better in some areas while in places like Malakand and Lasbela there were no health facility within the village. Compared to rural sites, urban areas were better off with regards to transport which made access to health facilities and financial services (to withdraw BISP money from) easier.
There was a fairly correct understanding of what leads to better nutrition and this, too, was similar across all field sites. Good nutrition was understood to be more than food consumption alone. The quality of diet eaten, mother's nutrition status, health, hygiene, sanitation and the importance given by a mother to childcare were all understood to be essential for improved nutrition.

*Behaviour change versus resources*

The success of "behaviour change communication" was evident in many areas. For example, the importance of soap was understood in many areas and there were reports of improvements in hygiene practices due to programmes run by NGOs or the LHW. Similarly, there was knowledge about iodised salt, possibly due to a successful awareness campaign run in the past. There was also a change in breastfeeding and infant feeding practices according to respondents. While behaviour change had been achieved in certain aspects, the success was limited in sectors such as family planning despite family planning being an essential objective of the lady health worker programme. Birth control and birth spacing are opposed by men in most areas as their use is viewed as denying God's blessings. That said, the success of the programme cannot be completely discounted as family planning advice might not be practiced but is not out rightly opposed and women are open to receiving information about it.

However, there are two main constraints faced in implementation of behaviour change communication. There is a lack of resources to actually practice the advice being disseminated. For example, while the importance of the use of soap to wash hands is widely understood, the actual use of soap is not as widespread as many households cannot afford to purchase soap or maybe do not consider the expense on soap as necessary. Similarly, iodised salt is not consumed since it is much more expensive that the alternative available in the market or is not available for purchase in local markets. The importance of diversity of diet is well understood but only basic food can be afforded and a child can sometimes not be breastfed as prescribed because the mother is too malnourished to produce milk. Therefore, even if an individual is aware the current practice they follow is wrong they do not have the means to change and for a nutrition intervention to be effective it has to move beyond behaviour change communication.

Secondly, water and sanitation infrastructure is poor and there is an absence of health facilities and as a result, behaviour change at the individual level can only have a limited impact. Across all sites, there was a repeated preference for there to be improvements in public goods and service delivery. According to be respondents, there should be a health centre or a hospital in the village/neighbourhood, garbage should be collected by municipal authorities instead of being throw out in the streets and burnt, drains should be covered, the sewerage system should be improved and drinking water should be clean. The lack of such facilities was viewed as a hurdle to improvements in health and nutrition of children. While economically better off households were able to overcome such problems through private expenditure, even they were not completely unaffected by problems at the public level.

*Face-to-face versus remote interaction*

For a nutrition programme to be effective, face-to-face interaction is preferred over remote means of communication such the media or mobile phone. If there is a health worker physically present, the advice is understood better, there is an opportunity for women to ask question and is taken more seriously. With advice communicated through other means, there is a chance that the message is not comprehended due to a general lack of education and there is greater possibility of the advice being discarded. Moreover, intervention is not targeted to everyone but those with access to the medium of communication and the chances of exclusion are greater. Similarly, if vouchers are provided without them being accompanied by a meeting or training session, the provision of commodities will not be effective as beneficiaries will not understand the importance of those items nor their correct use.

With face-to-face interaction, especially that which is repeated there is an opportunity for trust to be built. In our interviews, the importance of trusting the advice giver came up often. Receiving similar information via a television programme or through a mobile phone does not allow beneficiary-advisor trust to be created.

## D. Recommendations

This note started out with outlining the policy context within the nutrition sector and the opportunities provided by the BISP and the limitations of the programme with regards to nutrition programming. The qualitative fieldwork provided an opportunity to gain insight into how the BISP programme and community based initiatives such as the LHW programme interface with beneficiaries and the community and the feasibility of different models of pilot interventions. We were also able to develop a sense of the level of knowledge about nutrition and behaviours that influence nutrition outcomes (such as food diversity, water, sanitation and hygiene, health, maternal care and childcare), existing practices and constraints which might prevent improvements in

nutrition. Based on this we are now able to outline factors that need to be considered in the design of a pilot intervention that can be implemented alongside the BISP.

Before proceeding with our recommended template and pilot design, it is important to note and explain the variation between these ideas and early discussion about proposed pilots. To recall, the review process concluded by OPM proposed three alternate pilots: (a) vouchers for pro-nutrition goods and services; (b) mHealth based initiatives for behaviour change communication; (c) community-based services. Stakeholder consultation led to the clarification that these three proposals need not be seen as mutually exclusive alternatives. An intervention could be a combination of one or more of these pilot ideas.

Our recommendations focus on possible combinations of (a) and (c) along with BISP-specific processes for improved effectiveness, management and beneficiary utilisation. We rule out (b) as a result of strong and unequivocal findings from our primary fieldwork which suggest the inappropriateness of behaviour change communication through mobile telephony in the Pakistani context. This finding, alongside a strongly expressed preference for personal interaction, implies that we place the entire weight of behaviour change communication on (c). Our survey findings found strong support for the idea of dedicated vouchers for pro-nutrition products but raise concerns about leakage in delivery mechanisms and the fungibility of vouchers/products if not robustly monitored. Across fieldwork sites we were told that a community-based nutrition agent was the appropriate vehicle for the delivery of vouchers and/or pro-nutrition products.

**a) Pilot components**

We propose a template for a nutrition intervention complementary to the main cash transfer component of the BISP which allows for several alternative modules which can be tested at the pilot stage. The template consists of 5 distinct components which we derive from the preliminary review of the evidence (Inception Report and its review of literature), key informant interviews (at the provincial and programme levels), and primary qualitative fieldwork. After describing the 5 components we lay out combinations/variations of these as possible pilots.

*Component 1: Community-based nutrition agent (CBNA)*

The core component is the idea of a community-based nutrition agent (CBNA) which emerges from our fieldwork findings that there is a strong preference among potential beneficiaries for face-to-face interaction with a knowledgeable professional who is familiar with the local community. This idea is very similar to the existing LHW programme, and it is possible that community-level respondents base their preferences on positive experiences with that programme. In practice, the proposed CBNA might leverage on the LHW programme, or it may be autonomous from it, at least at the pilot stage. In either case, the experience of the LHW programme is a source of operational information for CBNA design.

*Component 2: Caseload management*

The LHW programme prescribes a caseload of 200 households per LHW with specified requirements for home visits and record-keeping. Actual practice can vary greatly from this prescription. There is little evidence thus far that LHW records are integrated into a database or used for tracking the progress of an individual case. There are existing pilots, however, for equipping and training LHWs in the use of smart phone technology for updating case records. The use of BISP for caseload management on the part of the CBNA will be a qualitative shift in tracking individual cases of women and children through an integrated system. The case management system of the BISP is already used for the implementation of CCTs, implying the versatility of this system. Caseload management

may also be made interactive, with the CBNA inputting case information and receiving real-time prompts about follow-up actions.

The cash transfer component of BISP targets beneficiaries on the basis of their poverty scores. Given that the relationship between income and nutritional status is mediated by a range of other variables, including community fixed effects, we recommend that the nutrition intervention should be targeted to ALL households within the pilot community regardless of income or poverty score. The BISP poverty score can be an effective instrument for the calibrated selection of target communities.

Within the pilot communities there may be further criteria for the selection of the CBNA caseload. Even of income or poverty score targeting is not used, there may be an argument for targeting the nutrition intervention to households or mothers who are within the 1,000-day nutrition window (from conception till the child reaches the age of two years).

*Component 3: Behaviour change communication*

Our fieldwork findings confirm the need as well as acceptance, at the community level, of behaviour change communication with respect to improving nutrition. As reported above, the preferred channel of communication is a nutrition professional (CBNA) with regular and frequent contact with her caseload. Behaviour change communication, therefore, will be one important component of the activities of the CBNA, and the main focus of her interaction with her caseload.

*Component 4: Pro-nutrition resources*

The need for the supply of a range of pro-nutrition resources – including nutritious and fortified foods and supplements, and hygiene and sanitation products – was articulated widely in our fieldwork sites. There was also a concern that the delivery of these resources was vulnerable to leakage, and that even when delivered they may be exchanged for cash or other goods. It was further noted that behaviour change communication may be most effective if combined with the delivery of substantive items. We also found severe limitations in the capacity of existing formal and informal retail systems in the efficient delivery to the poor of pro-nutrition resources through vouchers or other mechanisms. The provision of pro-nutrition resources, therefore, is another key task of the CBNA.

*Component 5: Beneficiary incentives - demand side*

While components 1-4 above deal with the supply side of the nutrition intervention, BISP offers the opportunity of also eliciting a demand side response. Beneficiary participation in nutrition counselling sessions and/or utilising the inputs provided can be incentivised through the provision of a top-up on the existing cash transfer for the CBNA caseload conditional on interaction with the CBNA. Existing BISP cash delivery systems are well-positioned for this task.

**b) Pilot**

We propose 4 possible pilot interventions based on different combinations of the 5 Components identified above. The basic unit of intervention in all these cases is a well-defined geographical boundary whose entire population will be taken as the treatment group, subject to the 1,000-day window criterion. The basic pilot (Pilot 1) consists of Components 1, 2 and 3 and is administered in all intervention communities, with Components 4 and 5 added as alternatives (see Table 3).

Table 3: Pilots

| | Components 1, 2, 3 | Component 4 | Component 5 |
|---|---|---|---|
| **Pilot 1** | X | | |
| **Pilot 2** | X | X | |
| **Pilot 3** | X | | X |
| **Pilot 4** | X | X | X |

Pilot 2 will measure the impact of the provision of pro-nutrition resources complementing regular and frequent contact with the CBNA and behaviour change communication. Pilot 3 will measure the additional impact of demand-side incentives complementary to Pilot 1. In Pilot 4 we propose the combination of all 5 Components, as a way of comparison with Pilots 2 and 3.