

Exploring Adolescent Girls' Nutrition-related Behaviours in Pakistan

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Contents

01 Introduction

02 Adolescent Girls: A Day in the Life

03 Before SOPRAN

04 The WIFA Journey

05 Adoption of Fortified Wheat Flour

06 Learning about Food: Nutrition Education

07 Changes at Home

08 Implication for Sustaining and Scaling Up the Program

09 Annex A: Methodology



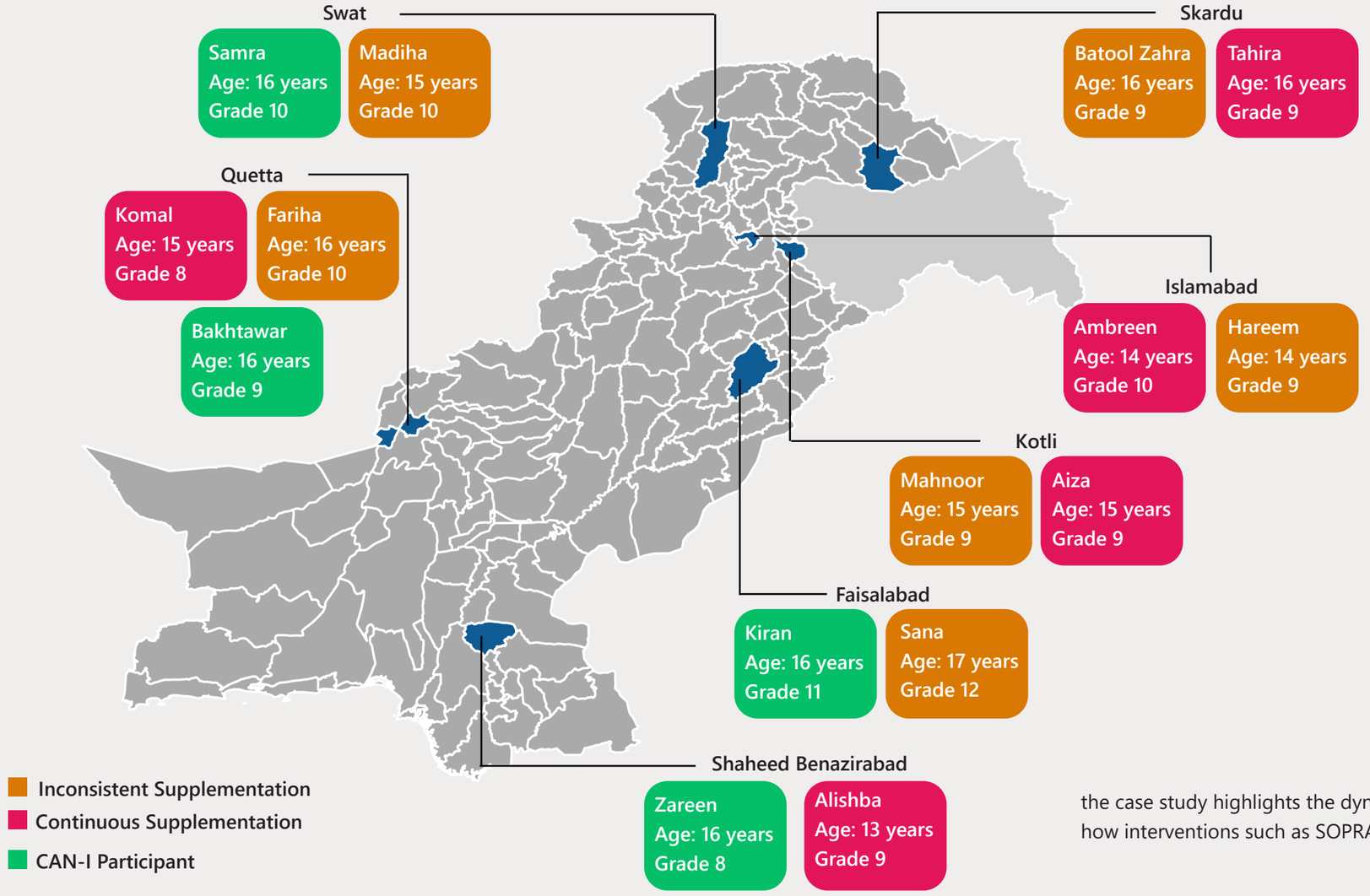
01 Introduction

According to the Global Nutrition Report (2022), 41.3% of women aged upwards of reproductive age are suffering from anaemia[1] with the highest prevalence among the adolescent age group, i.e. 14 to 18 years.[2] The consequences are multifold, ranging from stunted growth and poor academic performance to increased risks during pregnancy and long-term health complications. This is evident in Pakistan's Maternal Mortality Rate, where poor nutrition contributes to 186 deaths per 100,000 live births.[3] While these conditions are well documented, adolescent girls' nutrition occupies limited space within policy and programming.[4] Interventions tend to reach girls indirectly, folded into broader maternal or household health efforts, with little focus on how girls themselves experience nutrition-related guidance within their daily lives.

The Leveraging Pakistan's Social Protection Programmes for Adolescent Girls' Nutrition (SOPRAN) project was introduced into this context, with the strategic goal to demonstrate that small and targeted interventions can produce significant change. By embedding nutrition knowledge into the local context to encourage positive behavioral changes among adolescent girls, and providing Weekly Iron-Folic Acid (WIFA) supplementation to prevent anaemia, SOPRAN aims to create lasting impacts on adolescent nutrition. Implemented through government schools participating in BISP's Taleemi Wazaif programme, the project combines nutrition education with WIFA supplementation while engaging key stakeholders i.e. parents, teachers, Lady Health Workers, and community and

[1] Global Nutrition Report, "Pakistan Nutrition Profile," 2024, https://globalnutritionreport.org/resources/nutrition-profiles/asia/southern-asia/pakistan/.
[2] Ashraf et al. (2024). Prevalence and factors influencing anemia in women of reproductive age in Karachi. Women's Health, 20.
[3] Ikram Junaidi, "Over 41 pc Pakistani women suffer from anaemia: report," Dawn, August 28, 2024.
[4] Government of Pakistan and UNICEF, Pakistan Adolescent Nutrition Strategy and Operational Plan 2020–2025 (Islamabad: Ministry of National Health Services, Regulations and Coordination and UNICEF Pakistan, October 2020). https://www.unicef.org/pakistan/reports/pakistan-adolescent-nutrition-strategy-and-operational-plan

religious leaders to create an enabling environment where these actors become active participants in supporting adolescent girls' nutritional well-being. The project spans seven districts; Islamabad, Faisalabad, Shaheed Benazirabad, Quetta, Skardu, Kotli, and Swat; each shaped by distinct social, cultural, and economic conditions. This case study forms part of SOPRAN's broader learning and evaluation framework, which includes baseline, midline, and endline qualitative assessments. While these evaluations document changes in knowledge, attitudes, and practices over time, the case study is designed to complement them by focusing on experience. Its purpose is to examine how the intervention was encountered: how girls made sense of nutrition information and WIFA supplementation, navigated hesitation and rumours, negotiated support within their households, and sustained or changed nutrition practices over time.



As such, the inquiry draws on in-depth, semi-structured interviews with fifteen adolescent girls in grades nine and ten across the project districts. The interviews explored daily routines, food practices, household dynamics, experience with the program's interventions and perceived changes over time. Participants were purposively selected using school supplementation records to reflect varied experiences of SOPRAN engagement.

A deductive thematic analysis was conducted on these interviews, through the systematic coding and categorization of recurring patterns and insights by the adolescent girls. This analysis is presented as a narrative case study of the adolescent girls' experiences of SOPRAN's interventions, presented under assumed names.

These accounts are situated in everyday spaces: classrooms where fatigue had long been normalised and attention waned by midday; households where meals were negotiated within tight budgets and pre-established routines; social settings where conversations about nutritional supplements and health were largely absent and, when they did occur, were mediated through elders who enabled or resisted such discussions. By centering the girls' own accounts, the case study highlights the dynamics that shape their social reality, exercise of agency and, by extension, how interventions such as SOPRAN are experienced and sustained over time.



02 Adolescent Girls: A Day in the Life

Moments after sunrise, a world awakens. In some homes, Fajr prayers and recitations of the Quran are in order. A nap shortly after, if time permits. Mornings work against the clock, as the girls and their siblings get ready to make it in time for school.

Next, the kitchen comes alive. Mothers swiftly line stove-tops with a *tawa*, pot or kettle, and perhaps a frying pan - ready to prepare a hot breakfast for their spouse and children. Paratha and egg is a winning combination, often accompanied by chai - or, in the case of Swat, a glass of milk with turmeric.

> "It's like, 'Get up quickly, it's time for school.' My sisters wake me up early to pray Fajr at 5...In the morning, it's just chaos. Getting ready and hurrying to school and class."
> **-Mahnoor, Kotli**

> "Everyone is in a rush, everyone has to get to work."
> **-Komal, Quetta**



Although breakfast is prepared in most homes, it is met by varying levels of enthusiasm from adolescent girls. Some have it as a rule, others on the insistence of their parents. In some cases, the routine frenzy to get to school, feeling nauseous and unavailability of cooking gas in the morning are reasons that some girls choose to skip breakfast.

These everyday routines are shaped by varied household dynamics, structures and resources. What is prepared, eaten or skipped is tied closely to how families are organized and responsibilities are distributed.

Life at Home

Household contexts are equally varied. Some girls live in nuclear families with two or three siblings, while others are part of large extended households where multiple generations share the same compound. Sana from Faisalabad is the youngest among five sisters, living in a household shaped by her mother's limited mobility due to paralysis and her father's work as a driver. In contrast, Kiran, also from Faisalabad, comes from a family where her uncle regularly helps with transportation, illustrating how support networks often extend beyond immediate parents.

WIFA Days as Breakfast Motivators

In Quetta, Fariha knows to take a good breakfast seriously when the WIFA tablet has to be taken. So, once a week, she has a heavier breakfast than usual.

Mahnoor from Kotli feels nauseous in the morning. She skips breakfast on most days, except when she has to take the WIFA tablet.

While making breakfast a regular habit in their daily routines is still a work in progress for the adolescent girls, the weekly requirement of a proper breakfast day for WIFA supplementation establishes a foundation for this practice.



Getting to School

The morning commute serves as a daily negotiation over how, and with whom, girls are allowed to move. In some homes, fathers or uncles drop their daughters off on their way to work. In others, girls walk; alone, with siblings, or alongside friends from the neighbourhood.

Ambreen in Islamabad walks a single street to school. Zareen in Shaheed Benazirabad walks ten minutes each morning with her younger sister. In Quetta, Bakhtawar walks nearly twenty minutes and speaks of the distance as something her body has learned to manage, even value.

For Kiran in Faisalabad and Aiza in Kotli, the journey depends on who is available that morning. When their fathers can take them by rickshaw, they do. When no one is free, walking becomes the only option. The choice is practical, shaped by time, safety, and permission rather than preference.

For Komal, physical capacity matters. The daily walk to her school in Quetta left her exhausted. So, for a time, she was dropped by car instead.

These journeys are ordinary and rarely discussed, yet they quietly reflect how girls navigate energy, mobility, and household boundaries in their everyday lives.

In Swat, household arrangements are shaped by labour migration. Maliha lives in a compound shared with uncles and cousins while her father works abroad, whereas Samra lives in a smaller household where her father works locally as an electrician. These differences affect not only household income, but also who is present to make decisions and enforce norms.

Extended family living is especially prominent in Quetta. Fariha lives in a joint household of eighteen members where space, resources, and authority are shared among uncles, aunts, and elder siblings. Bakhtawar also lives in a large household, but one where her father is the sole her mother's ill health. With many dependents and limited income, affordability becomes a daily consideration. As Bakhtawar explains, this can lead to nutritional compromises:

> "In the market, there are two types of things: cheap and expensive. The expensive ones are very good, but due to poverty, our family sometimes eats the cheaper things. Consequently, iron is low in that."
> **- Bakhtawar, Quetta**

Aiza's household in Kotli reflects a similar instability. Both of her parents are daily wage earners, and income shifts from month to month. Her father works as a tailor and also owns a rickshaw, relying on the number of customers he finds and the rides he is able to take. Her mother works as a househelp in different homes, but only on days when her health allows it. When work is steady, the household manages better. When it is not, spending tightens quickly. Aiza describes this fluctuation without drama. When resources are available, her parents try to provide more. When they are not, the family adjusts without much complaint. For her, food is shaped by uncertainty as much as by preference.

Across households like Aiza's and Bakhtawar's, financial constraint is only part of the picture. Their accounts also point to quieter gaps in how nutrition is understood. Iron-rich foods such as lentils and pulses are often available at lower prices but their nutritional value goes unrecognized. Girls tend to gravitate toward tastier, more familiar foods, even when healthier options are within their reach.

> "If the food doesn't taste good, people won't eat it, even if it's nutritious."
> **- Haya, Islamabad**

Therefore, providing knowledge about how healthier foods can be made more appealing, and thus, incorporated into daily diets, is equally important.

In Kotli, Mahnoor learnt through nutritional awareness in school that including more vegetables is healthier and more affordable. However, as someone who did not particularly prefer eating vegetables, she found a way to make them more appealing: "I asked my mother to make *bhindi* (ladyfinger) with meat...I told her that if she makes it this way, it will turn out very tasty...so we can enjoy eating it." By adopting this simple food combination, she made eating vegetables more enjoyable for herself. Her example shows that with the right knowledge about what is nutritious, girls can work within their available resources to make healthier food choices a regular part of their daily routines.

Across these settings, girls occupy different positions within sibling hierarchies. Some are the eldest, carrying responsibility for younger siblings; others are the youngest, more closely monitored by parents and elders. These roles quietly shape how much freedom girls have to influence decisions about food, health and nutrition, as well as how responsibilities are distributed. Nutrition is deeply embedded in household structure, income stability, and everyday negotiations over what is perceived as being possible. Yet, with systematic nutrition knowledge, and the willingness to adopt healthier food choices, making the best of available resources to achieve a more nutritious diet is possible.

Kitchen Gardening

Nutritious food is not always sourced from the market. Vegetables grow in some adolescent girls' courtyards, fruit trees planted and gently tended to by their fathers or grandfathers over time, or grains that are cultivated in a field not far from home. In Swat, Maliha speaks with pride about trees her father planted when she was much younger. Orange, guava, and fig trees now provide seasonal fruit for the household, and caring for them has become her responsibility. While other groceries are purchased from the market once a month, these trees remain part of the family's food routine. Samra, also in Swat, describes a similar arrangement. Her grandfather looks after lemon and chilli plants at home, while flour and rice come from the family's fields. Market food fills in the gaps.

In Quetta, Bakhtawar's financially constrained household has some vegetables and protein at hand. Onions and tomatoes come from their own land, cared for by her father, who she says is "very fond" of growing these things. Livestock provides desi eggs, reducing reliance on market food. Other items that the family buys depend on what they can afford that month. Homegrown produce softens those fluctuations. For Bakhtawar, the value of growing food at home is also about trust. Vegetables grown at home are "fully natural," without chemicals, and therefore better for health.

Girls often link homegrown food to better nutrition. They express unease about vegetables from outside, worrying about chemicals or hygiene. Komal from Quetta explains that her mother prefers growing tomatoes at home for this reason. In Faisalabad, even where families do not grow food themselves, proximity to farmers matters. Sana explains that people in her village grow their own crops, and vegetables are often bought fresh from nearby households rather than distant markets.

However, not all girls have access to this option. In Quetta, Fariha recalls trying to grow okra and tomatoes, only for the plants to dry up due to lack of water. In Skardu, Tahira explains that space is the limiting factor. Their house is too small for gardening, leaving the family dependent on market food. Even in Swat, Samra notes that limited space can make growing food "messy" and difficult.

These accounts show that girls do see growing food at home as a way to manage access, affordability, and quality. But they also show its limits. Kitchen gardening exists where land, water, skill and household willingness supports it. As the adolescent girls' interest in nutrition builds, these everyday practices offer insight into how nutrition interventions can intersect with what families are already able to grow, maintain, and sustain.



03 Before SOPRAN

Aiza can list off the snacks available near her home in Kotli with ease. Samosas, burgers, *papad*, pizzas — all within reach. All she and her siblings need to do is convince their mother, or pool their pocket money and send a younger brother to fetch what they want. Food, for them, is accessible, tasty, and chosen quickly.

Aiza admits she does not think much about nutritional value. She eats what she likes, even when her mother scolds her for it. She also names the contradiction without embarrassment: she knows junk food is unhealthy, but "what can I do? It's tasty!"

Similarly, Hareem and Ambreen from Islamabad regularly consume samosas, *chaats, gol gappas* or chocolates from their canteen during their breaktime. When asked what more they would like to be added onto their canteen menu, Ambreen expressed her fondness of noodles, pasta, and macaroni. Junk foods still seem to be a regular part of their diet, as Hareem said, "I find samosas and rolls enjoyable, so I eat them twice a week." It is only on days when Hareem has run out of canteen money or is sick that her mother packs homemade lunch for her, such as anda paratha, chapati and curry, or sandwiches.

Alishba and Zareen from Shaheed Benazirabad who, while admitting that they ate biscuits, chips, or *nimko* from their canteens, expressed the need for healthier options like fruits. "Eating *samosas* and *biryani* is not good at all…it can cause harm and make you sick. The canteen items are a bit unhealthy." - Their cases indicate the lack of healthy food options at these girls' school canteens, a place they eat from almost everyday, demonstrating that while these girls are aware of their unhealthy diet, the option to buy healthier snacks is often unavailable.

For Mahnoor, also from Kotli, the struggle is different. She has eaten little since childhood, speaks of being ill as a child, and is often persuaded to eat adequately by her family. She describes how quickly she feels full. This lowered appetite shapes her relationship with food. No matter how enticing the food options offered to her may be, once she feels full, Mahnoor is unable to eat beyond that. Similarly, Hareem in Islamabad expresses a lack of appetite in the morning, leading her to skip breakfast often, as she does not "feel like having breakfast in the morning."

Several girls echo this experience. They describe eating very little since childhood, feeling full quickly, or needing encouragement or pressure from family members to eat more. Weakness and fatigue appear in their accounts, but largely as long-standing conditions shaped since childhood rather than sudden changes in their health. Such symptoms are noticed, managed, and addressed only when they translate into illness.

For some girls, meals are shaped as much by circumstance as by appetite. Aiza, for example, describes days when she skipped lunch simply because there was no money to buy food from the school canteen. "Sometimes I make my money last for a whole week," she explains. "[Other days] I don't have [school lunch] for three, four days." Morning routines also played a role. Tahira from Skardu notes, "Sometimes I don't have breakfast; sometimes I wake up late," echoing the experiences of other girls who skipped breakfast entirely on days when time ran short before school.

The adolescent girls broadly understood nutritional health but rarely maintained it with intention. Girls spoke of home-cooked food as cleaner, safer, and better for the body, while junk food remained appealing because it was quick, filling, and familiar. In everyday practice, what they ate, when they ate, and how much they consumed followed habit, taste, affordability, and convenience more than nutritional value. In this sense, adolescent girls were largely recipients of their food environments, surrounding support systems, and peer influences, where nutrition was acknowledged but rarely centered. Decisions about food were mostly shaped around them rather than by them.

Maliha's account from Swat introduces a contrast. Her relationship with food has always been more deliberate. Even when she eats little, she describes trying to ensure that what she eats is healthy. She is involved in where the ingredients are sourced from, how the food is prepared at home. Her personal willingness to prioritize hygienic and organic food has ensured that she maintains a more nutritious diet, often at the annoyance of her family members or peers, who consider her *vehmi* (superstitious) for being so cautious of what she eats. Maliha's attentiveness to nutrition, in this case, is a personal goal.

Taken together, these stories describe the environment in which SOPRAN was introduced. Nutrition was not unknown, nor entirely ignored. However, it existed unevenly; as information without urgency, as concern without follow-through, as individual effort without collective reinforcement. Food choices were shaped first by routine, appetite, cost, and environment. Nutrition adjusted to these realities rather than directing them.





04 The WIFA Journey

Across seven districts, what started with a tablet wrapped up in rumours and resistance, ended up paving the way for improved health outcomes for many adolescent girls. The WIFA supplementation journey illustrates how the simple practice of providing and normalizing Iron and Folic Acid tablets was met with misconceptions, family dynamics, and diverse physical responses to the tablets, eventually reshaping many girls' relationships with their health and dietary choices.. Even those who stopped their intake of the weekly supplementation found reasons compelling enough to resume.

First Encounters



The girls recalled standing in lines after their morning assembly, outside their classrooms or teachers' staffrooms. Some remembered getting excited as they realized that the test they had in the next class would probably get postponed.

The girls recalled standing in lines after their morning assembly, outside their classrooms or teachers' staffrooms. Some remembered getting excited as they realized that the test they had in the next class would probably get postponed. Others remembered being curious about what exactly was going on, as they waited for their turn to pick up a paper cup from the table filled with water, and swallow the tablet being handed to the girls ahead of them.

In Islamabad, Hareem stood in line, clenching her water bottle in her hands, waiting for her turn to take the WIFA tablet. The day before, a flurry of messages in the WhatsApp group on her mother's phone had informed them about the upcoming first dose, and Hareem had already discussed her wish to take the supplement with her parents.

While she managed to convince her mother by sharing with her what her teachers had taught her about the supplements and the importance of Iron in her Biology class, getting her father's approval had proved to be a bit more challenging. Determined to get her father on board, she took a tablet home after taking her first dose in school, and showed it to her parents with all the research she could gather about the supplement, managing to finally convince him to support her supplementation journey. In this moment, Hareem, with the help of nutrition education and research, demonstrated the potential that girls her age have in persuading those around them of the benefits of a healthy diet.

> "When I took [the first] dose, a lot of glasses were kept there, and girls were standing in lines."
>
> "We were told to eat breakfast, bring our water bottle, and not to lie about eating breakfast. If we hadn't eaten, we were told to take it after lunch or at home."
>
> **- Aiza and Haya, Kotli and Islamabad**

Nutrition education is a key component of the interventions in SOPRAN in empowering girls to be agents of change. As highlighted by Hareem's experience of her first dose, it was her research and the nutrition education she received at school that enabled her to convince her family to let her continue her WIFA doses.

For Mahnoor, however, her first experience of the WIFA dose started with hesitation. She saw a big pill and immediately worried it would be too difficult to swallow. Her teachers were wearing gloves, handing the tablet to her peers after making sure that they had breakfast that day. When it was her turn, Mahnoor expressed reluctance in taking the tablet: "It might get stuck." Her teacher responded by explaining the benefits of the supplement to her, attempting to convince her to take the first dose. But when Mahnoor informed her teacher that she had not had breakfast, she was told to rush to the canteen and get some biscuits, after which she was finally given her first dose of WIFA.

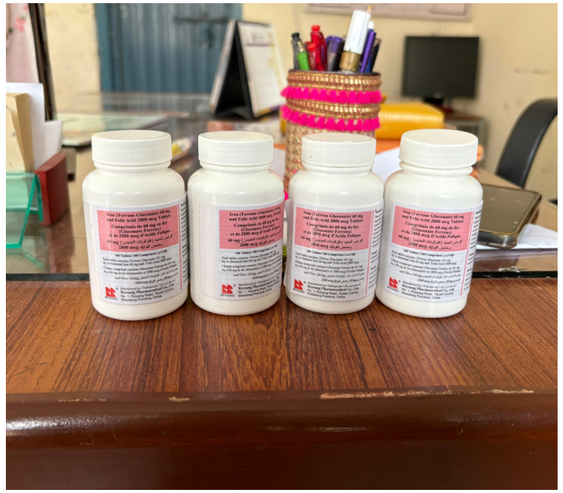
Like Mahnoor, Alishba and Zareen's teachers in Shaheed Benazirabad had emphasized the importance of a healthy breakfast on the morning of the first dose. Having eaten a hearty breakfast of eggs and parathas, both Alishba and Zareen were set to have their first dose of WIFA.

On the other hand, in Swat, Tahira remembered feeling nauseous after taking her first dose. She was reluctant to take another dose, worried that the nausea would return again. Yet, it was her teacher who encouraged her to take a leap of faith, and try the second dose. She recalled, "I took it, said 'Bismillah' and it was fine, nothing happened." She described how the teacher encouraged her to continue the supplementation, explaining to her how the tablet could cure her iron deficiency, and would not let her get sick.

These experiences show how Mahnoor's resistance to what she described as the "big pill" shifted from hesitation to her willingness to take the dose through her teacher's intervention, ensuring she had eaten well before the supplement. Similarly, Alishba and Zareen's teachers emphasized the importance of a healthy breakfast, setting a positive tone for their first dose. Although Tahira's first dose may have not gone well, the teacher's reassurance led her to take the second dose. These moments capture how the WIFA program's success depended on teachers' ability to navigate students' fears while maintaining necessary health protocols.

In those initial days, the role of teachers was crucial in convincing adolescent girls to take WIFA supplements: They watched closely on WIFA days, reminded girls to eat beforehand and held back tablets from those who had not until they ate something. These nuanced supervisions shaped how the girls learned to accept the tablet, turning an unfamiliar, even daunting, practice into something unintimidating and manageable.

In Quetta, Bakhtawar's experience further illustrates the careful steps taken to ensure that protocols were implemented properly. Bakhtawar, along with her peers, was instructed to get permission letters signed from her parents as a precautionary measure taken to ensure consent. Moreover, teachers in each district ensured that students were well-informed regarding the benefits of the tablet they were about to take. In Quetta, Bakhtawar, who had taken permission from her parents to take the WIFA tablet, Sana from Faisalabad, and Samra from Swat sat in the sessions organized by their teachers after the assembly, learning about the dietary advantages of the WIFA supplement. Both girls had positive experiences: Bakhtawar, having had a heavy breakfast that morning, and Samra, being well-informed regarding the benefits of WIFA, described their first experiences of the dosage as having gone well.



The Continuous Journey: Girls Who Persisted

The girls who took supplementation doses continuously were able to do so because of the support systems around them, including family, friends, and teachers. By dismissing rumours, along with the visible improvements in their health, they were motivated to continue their intake.

In Swat, Samra represents an example of someone who remained unaffected by the rumours circulating around her. Her friends and neighbors would come up to her and try to convince her to stop taking the supplement: "they damage the uterus," "they could lead to negative changes in your body."

However, Samra remained determined to continue her WIFA doses, stemming mostly from her father's support and encouragement: "I did not face any difficulties, and I was completely satisfied with them because my father had already informed me of their benefits." Her motivation was further reinforced by the improvements she noticed in her health. From being inactive in sports, she became someone who would participate regularly.

Meanwhile in Quetta, Bakhtawar's journey of continuous supplementation looked slightly different, but was similarly sustained by her physical improvements. While Bakhtawar's father, like Samra's, supported her intake of the WIFA supplements, she faced some trouble navigating her family's backlash, which took root from the rumours circulating around them. Her mother displayed some hesitation, which her father was able to counter. However, her brothers showed resistance, warning her, "don't eat it." Yet, her father's support reassured her mother, and eventually proved decisive. According to her, there was a list of reasons for her to continue the supplementation: "I have become very active, strong, and I don't feel sleepy much… Now there is no dizziness. I am fully active, fresh, and whatever I study… it stays in my mind."

Ambreen's WIFA journey in Islamabad also showcases her family's support, along with early positive effects as motivators in her decision to start and continue the supplementation. Ambreen remembered feeling hesitant when the tablets were initially introduced to her school. Her friends told her their experience of feeling dizzy and even vomiting after taking their first dose. Her fear of going through the same experience led her to skip the first dose. "Friends said that they experienced side effects, which influenced me," she explained.

WIFA Intake Linked to Better Academic Performance

In Kotli, Aiza continued her regular supplementation as she noticed that she was able to concentrate better on her studies, as opposed to earlier, when she would feel sleepy.

Fariha from Quetta felt more active and fresh in the morning and while studying: "I did not have any difficulty in memorizing tests."

Tahira from Skardu expressed that she would feel tired and dizzy in school, but now she doesn't feel tired at all.



However, her sister - a doctor - reassured her, explaining how, while the tablets may have mild side effects in the first few doses, can help with iron deficiency. Upon her sister's advice, she set out to begin her WIFA journey, and since then, continued her supplementation as she noticed herself feeling more active, and her laziness fading away.

Male family members can either hinder or support girls' WIFA supplementation. Including them in awareness sessions is crucial to building the support system that adolescent girls need to continue their supplementation journeys.

Taken together, these accounts show that continued supplementation was rarely an individual decision. Girls persisted when resistance at home was addressed, whether through reassurance from a trusted family member, prior knowledge, or observed health benefits of the tablet. Support did not always mean unconditional agreement within the household; in some cases, it meant a parent's endorsement carrying enough weight to counter hesitation or doubt from others. Where such mediation was present, the girls were able to continue, gradually building confidence in the tablet through their own experience of feeling stronger, more alert, and better able to engage in school and daily life.



The Inconsistent Journey: Navigating Interruptions

For girls whose supplementation was interrupted, rumours, side effects, and other hesitations momentarily overweighed their motivations. The concern that WIFA might affect fertility indicates the cultural importance of childbearing, as the nuclear family is highly valued. However, these girls eventually chose to resume their doses due to observed health improvements while they were consuming the supplement.

In Faisalabad, even though Sana's sister encouraged her intake of the supplements, the tension between family support and peer pressure eventually led her to stop her dosage. Misconceptions being spread on social media reached Sana as her phone pinged with the links her friends sent her to videos explaining how, because these supplements were only for girls, they are used "to control the population." Similarly, Batool Zahra in Skardu expressed reluctance in continuing the supplement due to its "strange smell," and due to her family and friends' advice, who framed it as a "conspiracy." "They said that it was a conspiracy by non-Muslims... to reduce the population of Muslims," she said.

However, the health benefits that Sana and Batool Zahra felt from the WIFA doses motivated them to restart their doses. Both described feeling more active while taking WIFA, interpreting the changes they experienced as effects of the supplementation. In Sana's words, "my back used to hurt a lot when I used to sit down. Now, while I'm sitting down, it doesn't hurt that much...Now I also enjoy studying." Similarly, Batool Zahra said, "In the last two periods, I used to feel very lazy... now, I don't feel that way; I am active."

On the other hand, in Kotli, while Mahnoor was able to overcome her initial hesitation about the WIFA tablet with the teacher's support, other medical issues led to her personal decision to stop the supplement. As she shared the almost animated story of how a childhood monkey bite left her with chronic leg pain, requiring regular treatment, she explained that she stopped taking WIFA because she was already taking too many medicines. As someone who found big tablets hard to swallow, adding another one felt overwhelming. However, she soon realized that this was a mistake. She recalled noticing how she was getting better when she was taking the supplement, whereas before she would get breathless while climbing the stairs. This was a change that she believed came as a result of the supplementation, convincing her to start taking WIFA again.

In Swat, Maliha faced a combination of family resistance and medical reasons when a diagnosis of kidney ulcers led her to pause supplementation.

The elders of her family, including her father and grandmother further discouraged her based on the rumours regarding the disability to bear children due to the tablet's intake. However, she decided to restart her doses as she shared how, according to her, the WIFA tablet had decreased her levels of lethargy, along with perceived improvements to her skin, as noted by her: "The tablets have ended the dryness of my skin."

Furthermore, initial side effects also caused some reluctance in continuing the dosage, as was the case in point with Fariha in Quetta. Fariha recalled feeling side effects like stomach pain, headaches, and heaviness. However, perceived bodily improvements, such as healthier hair and skin, once again, proved to be significant enough to motivate her toward resumption. Additionally, she was further encouraged by the fact that the supplements, which she could not afford otherwise, were being provided at school for free. Her mother encouraged her to resume the doses and take advantage of the free school supplementation, as they could not afford buying the tablets themselves.

WIFA linked to Better Moods

Mahnoor described quite cheerfully that her health improvements even affected her mood: "I laugh a lot now. Everybody says that I'm always laughing."

Similarly, Maliha, who would feel "nervous," according to her, due to a lack of energy, now "mingles, sits, and jokes with everyone."



These WIFA journeys illustrate that adoption of new interventions is never straightforward. For those who maintained continuous supplementation, and those who maintained inconsistent doses, observed improvements in their health and experiences ended up determining their journeys. Such experiences are stories of how girls learned to trust their instincts and, with the support of their teachers and elders, overcame rumours, peer pressure, and social resistance.

The WIFA supplementation journey represents stories of agency: girls who, guided by their own observations of improved health and supported by teachers and elders, learned to trust their instincts over rumours, peer pressure, and family resistance.





05 Adoption of Fortified Wheat Flour

Wheat flour enters the adolescent girls' kitchens through familiar and well-established routes. Decisions about where it is sourced are rarely made by adolescent girls themselves, and are shaped instead by household habit and convenience. In Swat, Maliha explains that the wheat flour used in her home comes from their own land. It is ground locally, brought home as part of the household's regular food supply, and used without question. The source is known, reliable, and requires no additional effort. In Kotli, Aiza's household purchases packaged wheat flour from a large grocery store nearby, buying it monthly alongside oil and rice. Here too, flour is part of a settled routine, folded into the household's broader method of food procurement.

It is within these existing systems that some girls recall first hearing about fortified wheat flour. A small number remember learning about it during school-based nutrition education sessions. In Islamabad, Hareem recalls receiving a pamphlet and a brief explanation about fortified flour, including where it could be purchased.

In Faisalabad, the information was more specific: Girls were told that fortified flour contained added nutrients, much like WIFA supplements, and that it was available at designated chakkis in nearby areas.

Sana, from Faisalabad, took this information home. One of the identified chakkis was close enough to be accessible, and her family decided to try the flour. What stood out to her was not a visible difference, but a perceived one. According to her, the rotis made from the fortified flour were softer, easier to chew, and more filling than what the household had used before. Over time, these small, practical improvements mattered. Sana's family continued to use fortified flour because it fit into established household routines and was well-received. For Sana, fortified flour's nutritional value became part of a broader set of changes she associated with feeling better, alongside taking WIFA regularly.

> “It is better than the flour we used to get before. The roti of that (other) flour was a little hard and difficult to chew...and it was not filling.”
> **- Sana, Faisalabad**

Hareem’s experience in Islamabad bought fortified flour once after learning about it in the school session. They recognised it as a healthier option and noticed no major difference in the taste or method of preparing rotis. But the mill was far from their home, and returning there required an additional trip outside their usual shopping routes. Hareem’s family did not purchase fortified flour again.

Kiran’s experience, also in Faisalabad, unfolded along similar lines. She remembers the same information being shared at school and recalls that her teachers identified specific chakkis where fortified flour was available. Her father went once but forgot to bring it back. The mill was far, and the purchase was not repeated. As Kiran explains, it was not a deliberate refusal. “It is a new thing,” she says. “Sometimes, it is not [easily] remembered.” In her household, where wheat flour could be sourced more easily through existing channels, fortified wheat flour remained an idea rather than a practice.

Taken together, these accounts suggest that awareness alone cannot reshape staple food practices. Where fortified flour is accessible within existing purchasing patterns, households try, and then decide to adopt it; where it demands extra effort, they return to purchasing flour from their usual sources. Lasting uptake, then, rests on aligning easy accessibility with awareness, and reinforcing messages to parents, who anchor household food decisions.

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06 Learning about Food: Nutrition Education

Across districts, adolescent girls encountered nutrition education as structured exposure to ideas about food, health, and caring for their own bodies. These sessions introduced SOPRAN, healthy eating practices, the importance of a balanced and iron-rich diet, and weekly iron-folic acid supplementation. For many girls, this was the first time nutrition was addressed directly and intentionally within their school lives.

The girls recall these sessions differently. Most describe an initial event where parents were invited, adolescent health was discussed, students performed speeches or role plays, and parental consent was sought for their daughter's participation in WIFA supplementation at school. For others, nutrition education arrived in smaller ways: during morning assemblies led by schoolteachers, or inside classrooms when a teacher set aside ten or fifteen minutes during a regular school day to talk about anaemia, iron deficiency, or the idea of a balanced diet. These moments were brief and often informal. For some girls, they happened once. For others, they resurfaced during WIFA cycles.

Seeing Food Differently

On one side: a basket of snacks they already know by taste. On the other: a bowl of fruits and vegetables. Tahira remembers the scene clearly; "There were *papads* in the junk food… there was healthy food on the other side, bananas and other vegetables." In Faisalabad, Sana recalls a similar demonstration. A tray held everyday snacks alongside healthier options, and students were told which foods strengthened the body and which weakened it.

In Kotli, Aiza watched her schoolmates perform a drama depicting two households. In one, junk food was eaten frequently. In the other, meals were home-cooked and balanced. Over time, the child from the first home became ill and had to visit the doctor, while the child from the second family remained active and healthy.

The message, Aiza recalls, was simple: "If you eat healthy, you stay healthy and do not fall ill."

In Skardu, Batool Zahra participated in a similar drama, but one that centered on family. She played the role of an only brother whose sisters pleaded with him to stop eating junk food. "You are our only brother," they told him. "If something happens to you, what will happen to us?"

In Islamabad, Haya's school used more hands-on approaches. Nutrition education took place through speech and poster competitions, and a dish-making contest. Haya chose to participate by preparing a nutritious dish at home. "We were asked to prepare something containing iron and other nutrients and bring it to school," she explains. She researched recipes, settled on spinach because of its iron content, and won first prize.

These activities took place over the course of many months and remain some of the adolescent girls' most vivid recollections. Their experience showcases that incorporating dialogue and practical learning can root nutrition within the adolescent girls' daily contexts. It gives them the opportunity to visualize how certain food patterns can be harmful for their health and to strategize on improving them by using research, exchanging ideas and new-found knowledge with their school fellows.

Learning Outside School: CAN-I Workshop

In select districts, a small group of adolescent girls attended nutrition workshops held outside their schools. Shortlisted by their teachers, they travelled to larger venues; a hotel, a restaurant, a city hall, and joined girls from other institutions. These workshops were interactive, designed around a show-and-tell format that encouraged participation. Using papers, pencils, and drawing materials, girls were asked to reflect on what they had learned about nutrition and build on it through activities.

> "Then the teachers gave us some papers. Pencils and sheets were already there…They made us do [this] activity, where shapes were made. What things do you like? A certain shape was cut out to look like a school building. What do you like about school? You had to cut and paste, apply glue, and put together what you liked. We enjoyed doing activities a lot."
> **- Kiran, Faisalabad**

In Shaheed Benazirabad, Zareen recalls playing a version of Snakes and Ladders next. The game was repurposed for the participants to "address food shortages, what should be done to ensure healthy food availability, and what measures should be taken for people who are sick." The girls were asked to discuss strategies to combat these issues.

For Bakhtawar in Quetta and Samra in Swat, the change in setting mattered. The workshop felt deliberate and focused. They recall interactive exercises, prepared materials, and facilitators who explained nutrition in simple, direct language. Unlike classroom sessions that competed with the pressures of a school day, the workshop created a space where learning felt intentional, designed specifically for adolescent girls rather than fitted in around other lessons.





07 Changes at Home

SOPRAN's activities entered the adolescent girls' lives as structured sessions at school, as tablets handed out on specific days, as information imparted by teachers and facilitators. However, once carried home, this information met dynamic spaces where parents, siblings, grandparents, all weighed in. Meals followed habit and affordability. Mothers prepared what the household was used to eating. Fathers brought home what was available. Elders offered opinions on the new activities in school, sometimes gently, sometimes firmly.

So, when the adolescent girls introduced their newly acquired nutrition knowledge at home, they did so by way of observation, gentle suggestion, quiet support and personal example.

Negotiating within the Household

In Skardu, Tahira remembers opening the fridge and seeing spinach. Before, it would have stayed there, untouched. This time, she asked her mother to cook it. When lentils were planned for dinner, she asked if spinach could be added instead. She "used to hate it" but now eats it willingly.

In Faisalabad, Sana began observing what her younger sister ate. She noticed how often junk food appeared between meals and started commenting on it, quietly at first. Over time, her sister began eating less of it. Nothing, the snacks did not disappear entirely. But they became less frequent, and Sana considers this a win.

Not every household responded the same way. In Swat, Maliha learned quickly that her advice regarding shifting to healthier food at home was not always welcomed by her family. Over time, however, this led to many conversations with her mother and phone calls with her father. Gradually, separate meals were prepared for her, consisting of vegetables and proteins. When possible, her father would also arrange olive oil for her food to be

cooked in.This change emerged from personal determination and managing existing resources. While the rest of her household preferred their usual food, Maliha was able to negotiate these changes for herself with the gradual support of her parents.

Elsewhere, resistance came from the family elders. In Kotli, Aiza describes how her maternal grandmother objected to her taking WIFA supplements. Rather than arguing, she chose silence. She placated her grandmother by telling her that she was not taking them, even when she was. The decision was deliberate, a way of protecting both her own health and her mother from conflict.

"It Is Up to Us": When Fathers Block Community Pressure

Kiran recalls people calling her home in Faisalabad specifically to discourage her participation in WIFA supplementation at school. They framed the tablet as something a girl should not be taking. Her father's response did not focus on explaining iron deficiency or debating the myths. He simply replied; "It is up to us. She is our daughter."

In Quetta, extended family members and neighbors voiced concerns openly as well. WIFA tablets were described as harmful for women's fertility. Some girls stopped sharing their WIFA experience altogether. Others limited their discussions to parents and siblings, who were more receptive.

Early confusion and suspicion towards WIFA supplements led to widespread initial refusal as well. People asked whether the tablet was "about pregnancy?", highlighting mistrust in the purpose of mass, free supplementation.

> "When a doctor gives you a tablet that you pay for, people believe it's good. But when something is given for free, even if it's very good for you, people say, "No, this is a scam; it can't be good." ... people believe that if something is free, then there must be something wrong with it."
> **- Hareem, Islamabad**

The adolescent girls navigated this resistance primarily through the support of parents and teachers.

Small Wins

For many girls, the most lasting changes are not about new additions, but more so about adjusting previous practice. Simple measures with lasting results.

Bakhtawar notices the amount of oil used in everyday cooking. Meals that were once prepared unquestioned, the same potatoes, the same levels of salt. But now, everything is different. She explains what she learned: How excess oil contributes to weakness over time. How sugar, salt, and oil affect the body negatively. Her mother listens. The meals do not change overnight, but gradually, less oil is used. Levels of sugar and salt in food are reduced. Drinking water is boiled instead of poured directly from the tap. The food remains recognizable, but its composition shifts.

In Kotli, the negotiation takes a different form. Aiza's mother brings home beetroot after hearing it is good for health. She cuts it daily and asks her daughter to eat it. The girl tries a little but it is not tasty. Yet, she does not refuse it outright. At times, she takes the occasional nibble. Sometimes, when her mother is distracted with other household work, she quietly sets it aside. The effort is imperfect, but it is intentional. The shared nutrition knowledge between mother and daughter has entered the household. A visual that may stick.

In contrast, Mahnoor has learnt to frame her requests in ways that invite agreement. Where once she would join her siblings in ordering fast-food, she now asks her mother to cook vegetables with meat, explaining that it improves both taste and nutrition. The trial dish is *bhindi gosht* (okra with red meat). It turns out well and becomes part of the household menu.

Many girls have taken iron absorption tips to heart, and they time their tea and breakfast separately. A simple strategy which does not require a household change, applying what they learned about food combinations at school.

These negotiations are small and rarely dramatic. They do not challenge norms. Through explanation, suggestion, and persistence, girls begin to impact what is cooked and how. The change is not absolute, but it is real; translating in less oil, fewer outside meals, and a growing confidence that what they learned at school belongs at home too.



Comfort, Hesitation and Social Boundaries

"When was the last time you asked for your parents' permission?"

In Kotli, Aiza describes asking permission to leave the house one evening. A fair was being held at the local ground. She wanted to go. Her father refused. The reason: There had been a fight there before, involving some boys. The decision was final.

Aiza does not argue. She goes to her room, closes the door, and sits quietly. A knock moments later, her father explains again why he does not allow it. Boys are outside in the evenings, he says. It is not safe.

Aiza listens. She does not insist. She does not escalate. Instead, she concludes; "May God throw these boys in the river." Then, simply: "Then, I was fine."

These same boundaries shape who girls speak to about nutrition. Aiza is clear that she does not talk to boys or men. This is not framed as fear, but as propriety. Certain conversations, like certain spaces, are simply not available to her.

Bakhtawar explains that speaking in front of elders in Quetta feels risky. Elders, she says, believe young people should "not talk like this". Similarly, Maliha from Swat describes herself as confident, yet still hesitant around one uncle she calls "serious-minded." The detail is small, but portrays how adolescent girls' navigate age, gender and social cues when holding conversations. This also extends to nutritional messaging.

Adolescent girls are careful about who they speak to and what they say, specifically when it comes to talking about nutrition. Speaking to elders can feel risky, while talking to boys or men is often not allowed. These boundaries shape how they share information about nutrition.



Leading by Example

Over time, some girls begin to notice that what they do is being watched. Not in dramatic ways. Not announced. But quietly, in kitchens, in shared meals, in who eats what and when. The change begins not when a girl explains nutrition, but when she alters her own habits and sees others respond.

In Quetta, Bakhtawar notices that when she stops eating outside food, her younger brothers follow without being told. When she avoids the canteen, they do too. When she brings home what she learned from school and applies it herself, meals begin to shift. Influence here is not delivered through instruction. It is modeled. Her authority comes from consistency, not insistence.

In Faisalabad, Sana understands influence differently. She describes persuasion through proof. If she were to convince another girl, she would talk about how her body felt before and after taking WIFA. Weakness, fatigue, and then improvement. Rather than giving advice, she focuses on persuading others through her personal experience.

In Skardu, Tahira's idea of persuasion includes an honest and straightforward account of her experience. If she were to convince someone to take iron supplements, she would explain how WIFAs helped with headaches and blood deficiency, and note how the first dose may cause some nausea - as she felt it too - but that it goes away with the next few doses, as hers did too.

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These moments offer small windows into influencing change at home. Through practice, through personal example and through imparting learnt knowledge, adolescent girls are confident in impacting individual action.

Adolescent girls, at present, influence change through incremental practice and advocacy. Their own habits and personal experiences become their tools of persuasion, equipping them with the confidence to impact others around them.

Imagining Change Beyond Home

In Faisalabad, Kiran imagines herself moving through her community the way the nutrition workshop facilitators moved through hers. She talks about going door-to-door, asking families what they eat, stopping junk food because "this is what has ruined the younger generation." The structure of the intervention has stayed with her, reworked into personal aspiration.

In Quetta, Bakhtawar frames nutrition education as an obligation. "It is the duty of a person to inform other people," she says. She believes people follow behavior more readily than words. When she changes, others follow.

In Skardu, Tahira imagines change through restriction rather than persuasion. She talks about banning unhealthy foods altogether, convinced that children's health would improve if access were removed. Her version of change involves challenging habits and cutting the source of unhealthy foods.

What these accounts make clear is that nutrition interventions like SOPRAN are not sustained through targeting the adolescent girls alone. They move through families, through codes of conduct, through gendered expectations about who may speak and who must listen. Their impact depends not only on what girls learn, but on who stands behind them when they act. If girls are expected to carry change into their households and communities, then credibility, protection, and endorsement must travel with them.



Implications for Sustaining and Scaling up the Program

The stories captured in this case study point to the following considerations for strengthening future school-based nutrition interventions:

1. **View the household as an active site of change.** The girls' ability to continue WIFA supplementation and apply nutrition knowledge depended greatly on parental and elder support, particularly their fathers' endorsement and the broader household's willingness to accommodate small adjustments. **Engaging parents through recurrent awareness programming is crucial to lasting behavioral change.**

2. **Strengthen teachers' role in managing queries and misconceptions.** Teachers were central to normalising WIFA intake, enforcing practical protocols (such as eating breakfast before the WIFA dose), addressing fears and rumours, and motivating adolescent girls to continue supplementation. **Therefore, periodic training programs can prepare teachers to actively engage with students and parents, and advocate for better nutrition.**

3. **Encourage peer-learning activities.** Adolescent girls were motivated to obtain parental permission and begin WIFA consumption after witnessing observable improvements in the health of their peers. **Student testimonials and intentional sharing of "visible gains" between peers is key to validating and creating acceptance for nutrition initiatives.**

4. **Program implementation should include a risk mitigation strategy stemming from social dynamics.** Pre-existing social beliefs, misconceptions and initial hesitation among parents led to inconsistent supplementation patterns among some students. **Project communication should anticipate these narratives, share evidence-based messaging with recipients of the program and engage government officials through formal steering structures.**

5. **Recognise and value incremental change.** Meaningful shifts often occurred through small, everyday practices, such as girls persuading their households to reduce oil use, adopting more consistent meal timings and reducing junk food consumption. **School-based nutrition interventions should recognize and reward self-led initiatives by recognizing these efforts as formal measures of success.**

6. **Use activity-based learning to encourage the application of nutrition knowledge.** Girls were able to retain and relay messages better when delivered through participatory learning such as games, debate and poster-making competitions, and physical demonstrations (e.g. role plays). Hence, **nutrition education should include practical activities paired with modules on confidence-building, communication and decision-making skills to ensure sustained behavior change.**

7. **Explicitly increase fortified flour awareness sessions for adolescent girls and engagement with household decision-makers.** School-based awareness and education aligned with local availability and ease of access ensured regular uptake of fortified flour. Hence, **repeat purchase of fortified flour requires consistent and organized messaging and availability at accessible locations and moderate price points.**

8. **Promote kitchen gardening to combat food affordability and accessibility.** Adolescent girls shared subsistence food growing practices that ensured certain fruit and vegetables were available to their households. **Building capacity for kitchen gardening can empower families and improve their access to nutritious foods.**



Annex A: Methodology

This case study was conducted as part of SOPRAN's multisite learning and monitoring efforts to understand how Weekly Iron and Folic Acid (WIFA) supplementation, nutrition education, and flour fortification interventions have influenced the adolescent girls' nutrition-related knowledge, behaviors, and lived experiences across diverse contexts.

The study aims to generate in-depth insights into how adolescent girls experience and respond to nutrition interventions in everyday life, and how these experiences are shaped by household dynamics, school environments, and social contexts. Particular attention was given to understanding adolescent girls' agency as change agents and the pathways through which nutrition-related learning translated into practice.

To guide this inquiry, the case study sought to address the following questions:

1. How have adolescent girls' nutrition-related knowledge, attitudes, and practices changed following exposure to WIFA supplementation, nutrition education sessions, and any SBCC materials?
2. Which aspects of SOPRAN's interventions were most salient and influential in supporting learning and behavior change?
3. What household, school, and community factors contributed to observed changes in nutrition, health, and academic participation?
4. How do adolescent girls act as change agents within their households and schools, and what conditions enable or constrain this role?

Study Design and Approach

The case study applied a narrative case study approach complemented focused on the detailed program experience of each case study participant. This approach was selected to surface nuanced experiences, contextual influences, and unanticipated outcomes. By focusing on individual narratives and lived experiences, the study aimed to illuminate how and why change occurred, rather than merely whether it occurred.

Sampling Strategy

Purposive sampling was used to identify information-rich cases that could offer meaningful insights into program implementation and outcomes. A total of fifteen girls were interviewed across districts, with two interviews per project district and one additional interview conducted with a continuous supplementation participant in Quetta.[5]

In districts where CAN-I Workshops had been conducted, workshop participation lists were used to identify eligible schools. In districts without CAN-I Workshops, district officials identified schools with relatively high and low WIFA uptake, from which one school was randomly selected.

Within selected schools, two adolescent girls were identified using school-level supplementation records.

Eligible participants included:

- Adolescent girls who had received continuous WIFA supplementation (defined as consuming 80 percent or more of doses) and participated in CAN-I Workshops, where applicable;
- Adolescent girls who had received continuous supplementation in districts without CAN-I Workshops;
- Adolescent girls who had initiated supplementation, discontinued, and later resumed (consuming at least 30 percent of doses).

In all cases, the first eligible adolescent girl to provide informed consent was selected for an interview.

Data Collection

Primary data was collected through in-depth, semi-structured interviews with the selected adolescent girls. The interviews explored experiences with supplementation, nutrition learning, changes in household food practices, school participation, and the participants' own perceptions of health and well-being. In addition, these interviews also focused on the adolescent girls' social experiences, family setups, household environments, gender roles, financial dynamics and the adolescent girls' opinions on these existing setups.

[5] The school administration had incorrectly identified an adolescent girl who was taking consistent supplementation as a CAN-I workshop participant. This became clear while the interview was in session.

Most importantly, the interviews were designed to allow participants to narrate change in their own terms, while ensuring consistency across core thematic areas.

Data Analysis

Qualitative data were analyzed thematically using a structured coding framework aligned with the study objectives and focus areas. Codes captured changes in knowledge, behavior, agency, as well as social support systems and barriers. Code summarizations helped identify recurring patterns, enabling factors, and any contextual differences across districts or between participants.

The analysis was presented in the form of a narrative case study, supported by individual vignettes to capture and interconnect individual stories.[6] The narrative style is maintained throughout the case study to best portray the adolescent girls' own stories and experiences built chronologically from their baseline, to intervention experience, and then tied to changes and impact.[7]

Ethical Considerations

Participation in the study was voluntary, and informed consent was obtained from all participants prior to data collection. Confidentiality was maintained throughout the research process, and no personally identifiable information is included in reporting. The names are assumed and photographs do not feature any of the case study participants.








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