Gender and Nutrition Learning Paper

Breaking down barriers for better nutrition: Main lessons learned from Concern Worldwide's experience in Burundi

Context

Burundi is one of the poorest countries in the world, with over 65% of the population living below the poverty line. The prevalence of stunting is one of the highest in the world, far exceeding the thresholds set by the WHO. According to the national survey on nutrition and mortality using the SMART methodology conducted in 2024, 52.8% of children aged 6 to 59 months are affected by chronic malnutrition, 8% by acute malnutrition and 28.3% by underweight at the national level. This high rate of chronic malnutrition hinders human capital development, compromising children's immune function, psychomotor and cognitive development, and long-term educational and economic outcomes.

Underlying causes include extreme poverty, lack of dietary diversity, inadequate hygiene conditions and limited access to health services and micronutrient-rich foods. Nationwide, only 28% of children aged 6 to 23 months have a diverse diet, and only 18% meet the minimum acceptable threshold. These nutritional deficits lead to significant micronutrient deficiencies, as evidenced by the high prevalence of anaemia, which affects 59% of children aged 6 to 59 months and 40% of women of reproductive age.

How to gender barriers impact malnutrition?

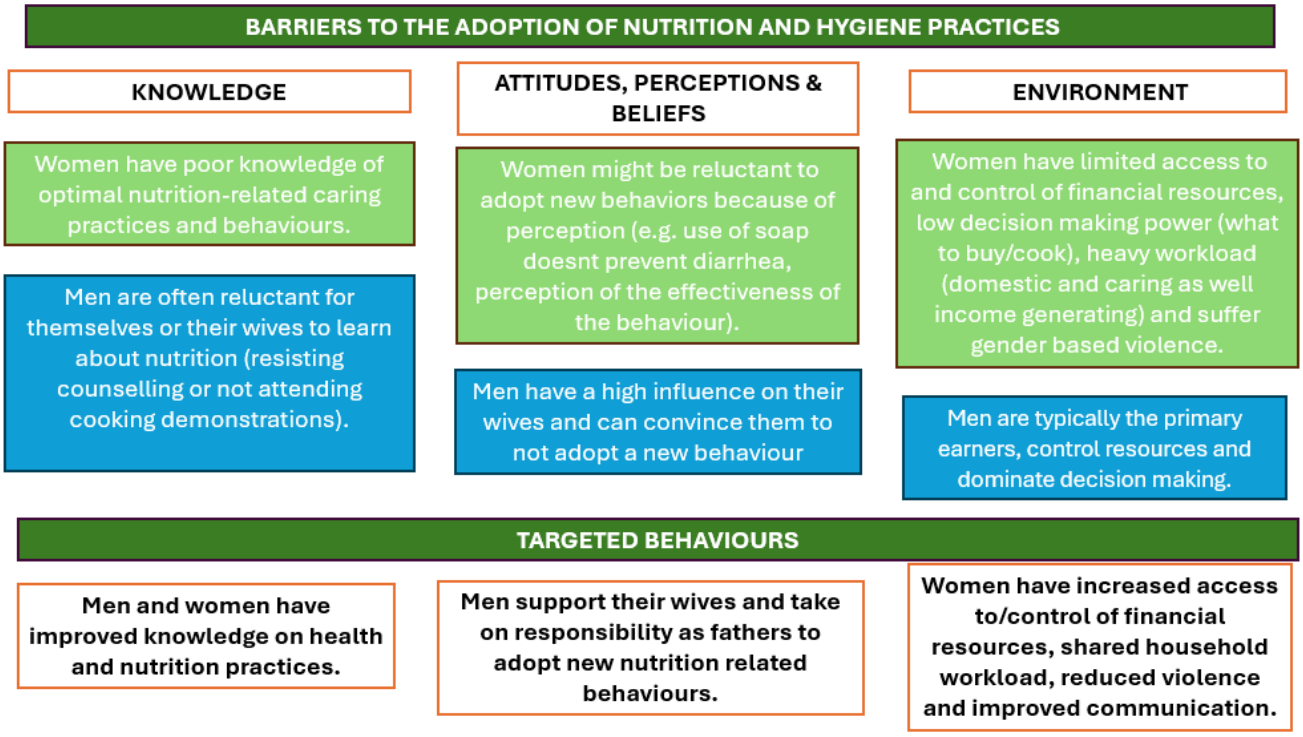
Women play a crucial role in Burundi's food production, frequently managing market gardening groups, farming and vegetable sales. However, they encounter systemic discrimination and restricted access to resources, limiting their involvement in decisions such as seed selection and produce allocation, while men typically decide what food is being sold and what is being consumed.

Care Group Volunteer providing nutrition counselling during a home visit, Kirundi, October 2024. Photo: Diane Moyer

Even when income-generating programmes (IGA) target women, this may only lead to limited control over assets gained. Patriarchal structures continue to shape social norms and practices, typically positioning men as primary decision-makers regarding household finances and market transactions.

Additionally, women carry the main responsibility for childcare and domestic work (including yard maintenance), water and firewood collection, resulting in considerable workloads. These can adversely affect their health, especially during pregnancy, as well as their capacity to provide optimal care for their children (including early childhood development, meal preparation, participation in cooking demonstrations, and use of health facilities for immunisations and preventive and curative services).

Analysis of the barriers to nutrition practices in Burundi (based on focus groups and interviews).



The Burundi gender-nutrition approach for improved nutrition outcomes

The Burundi approach builds on two existing and well-known approaches in the field of behaviour change communication: Care Groups (CG) and Husband schools.

The **Care Group model** promotes social and behaviour change on improved infant nutrition and hygiene through supported peer-to-peer (predominantly mother-to-mother) knowledge sharing.

Each Care Group composes of 15 lead mothers, selected based on their model behaviour regarding to nutrition and health practices. Following training, these mothers, carry out 12-16 monthly home visits to pregnant and lactating women and young children to share health and nutrition messages.

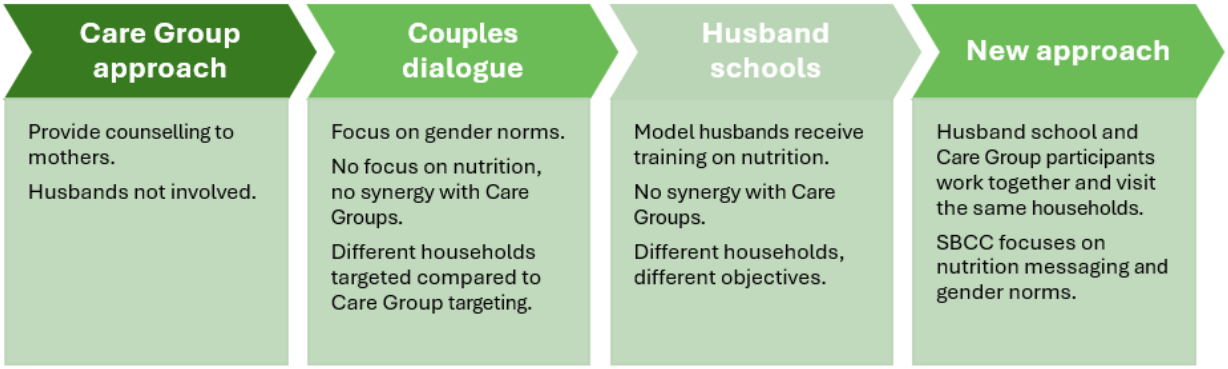
Care Group Volunteer providing nutrition counselling during a home visit, Kirundi, October 2024. Photo: Diane Moyer

The **Husband School** approach was initially developed in Niger by UNICEF and adapted by Concern to promote the use of reproductive health services for women by identifying the husbands of the women attending those services and using them as actors of change in the community. In Burundi, the approach functions the same as the Care Group, including the identification of 'model husbands' through a series of criteria (e.g. healthy children, clean house, no conflict in the house), and train them on identifying and breaking down gender barriers (through home visits and community sensitisation).

Members of a Husband School, Kirundi, April 2025. Photo: Diane Moyer

Evolution of the integration of gender into Nutrition Social Behaviour Change (SBC) approaches

The development of the approach currently being used in Burundi has evolved from the team's previous experiences in nutrition and gender approaches. The diagram below highlights this evolution.



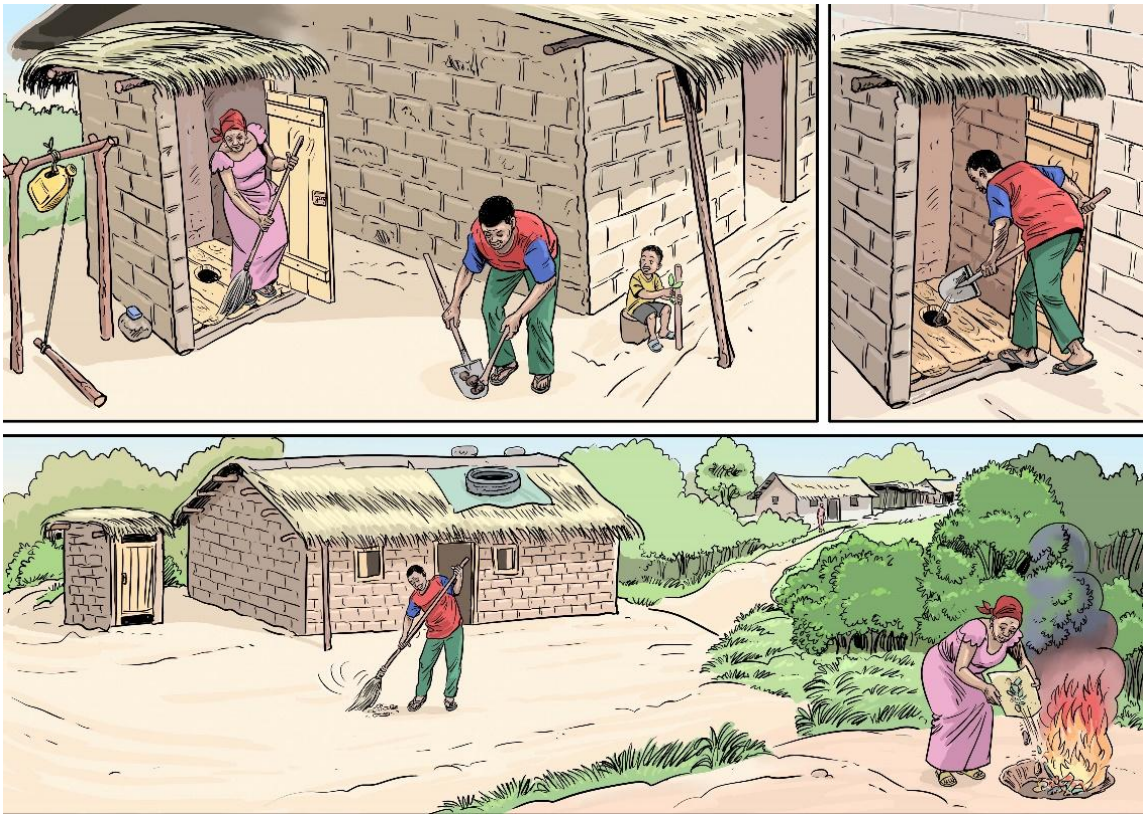
Traditionally, each approach was implemented independently, with little collaboration between volunteers; Care Group volunteers and model husbands did not interact, nor did they target the same households or coordinate their messages. Barriers related to gender and nutrition led to a revision of this approach to better support nutrition outcomes.

Behaviour change strategies typically focus on mothers and rarely involve fathers, therefore mothers often face resistance and lack of support from husbands and encounter gender-related barriers that limit their uptake of new behaviours and ultimately the effectiveness of the Care Group model.

Revised components of the approach

Concern's approach works on three levels:

1. Stronger synergy between gender and nutrition	Model Husbands are sensitised on the importance of nutrition for children and the impact of gender norms on nutrition. Lead Mothers are trained to identify gender barriers and how these could impact nutrition outcomes. Care Groups and Husband Schools meet regularly to learn and share experiences of gender barriers and nutrition. Gender transformative Information, Education Communication (IEC) materials for nutrition are developed.



Example of gender transformative nutrition IEC materials used by Concern Worldwide Burundi.

Joint Husband School/Care Group meeting to discuss gender barriers to nutrition, October 2024.

Whilst Care Group volunteers receive a more extensive training on nutrition (breastfeeding, complementary feeding, hygiene, use of health services etc.), men receive training[1] on nutrition followed by a more extensive gender training in the following areas (not exhaustive):

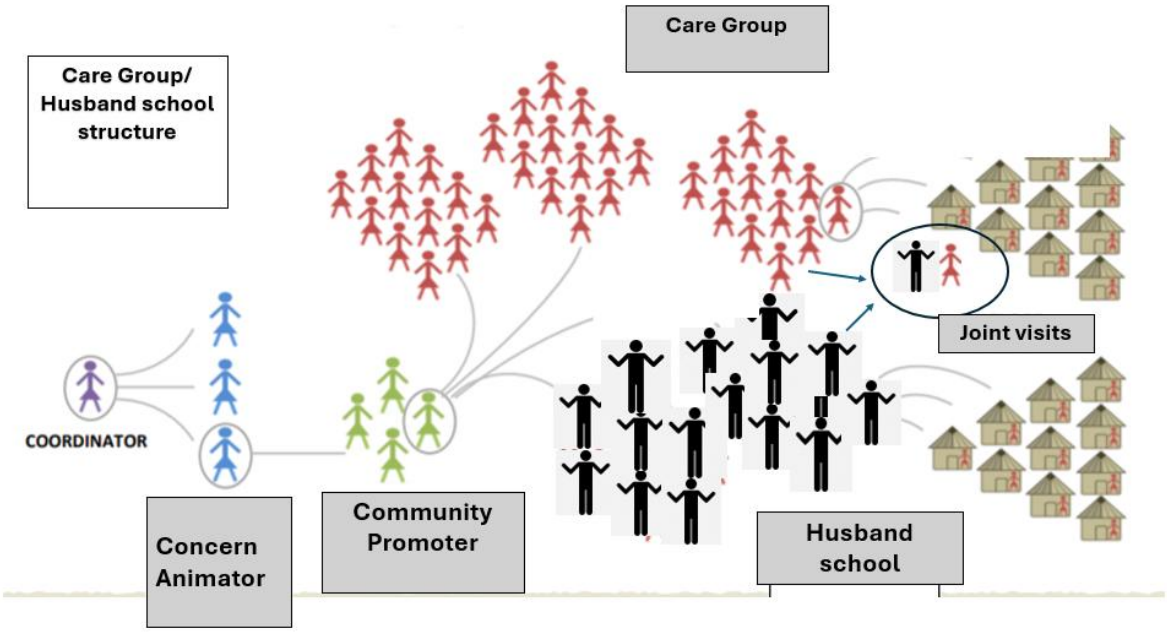
- Effective communication.
- Sex and gender.
- Violence prevention.
- Equality and household task distribution.
- Asset and income management.
- Decision-making (related to people and assets).
- Family planning.
- Intimate relationships.

2. One household and one strategy

Lead Mothers and Model Husbands are paired and follow the same households.

Lead Mothers are encouraged to provide nutrition counselling to the husbands, and reach out their male counterpart for support.

They meet regularly to discuss their observations and recommendations.



The Husband School structure comprises of groups with 10 members, each receiving monthly training on relevant themes before conducting awareness sessions with 10 households, visiting each household once per month. Each husband is paired with a Care Group volunteer to visit their 10 allocated households.

[1] Training content was inspired by Concern Worldwide guidelines on the Husband school.

3. SBCC includes targeting both households and community	Home-visits aim to identify and address individual issues through individual nutrition counselling. Community sensitization aims to create a supportive environment for the adoption of behaviour change.

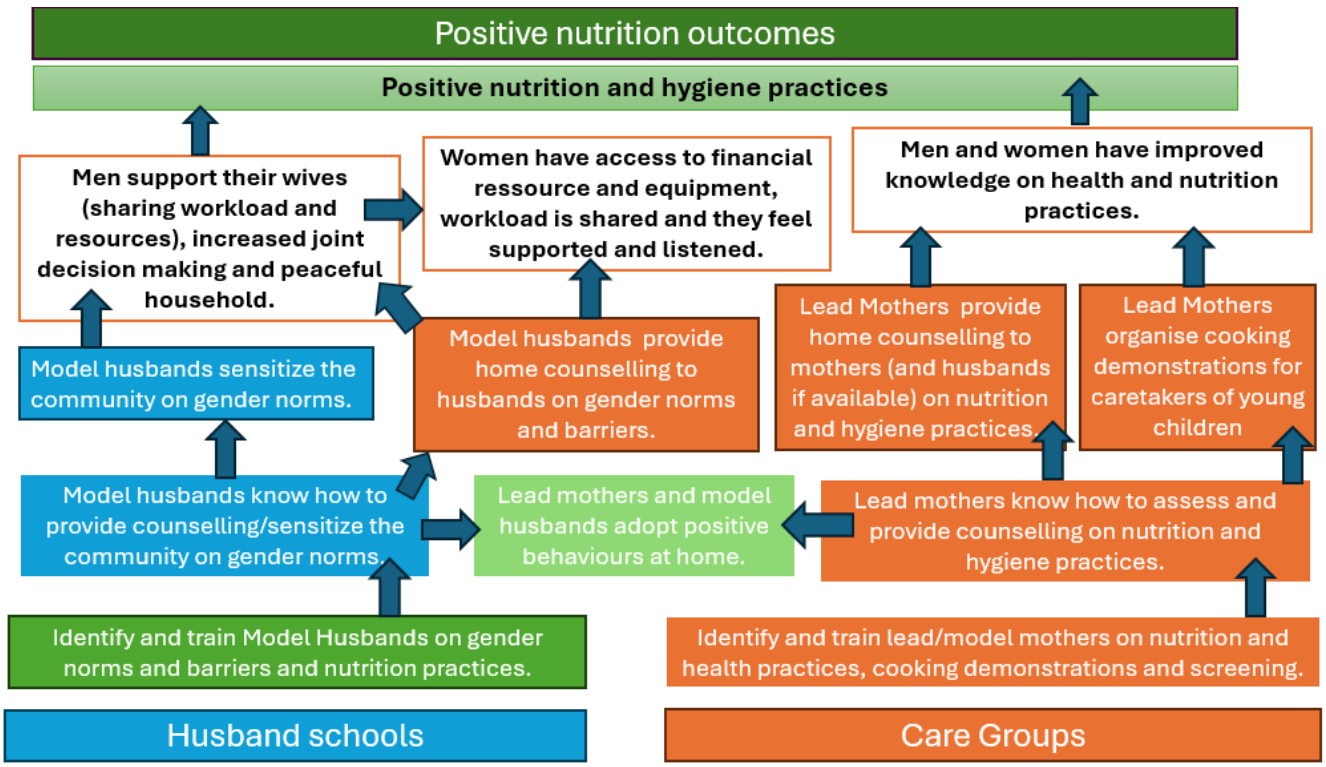
Men may encounter social barriers when participating in traditionally 'feminine' tasks such as childcare and domestic tasks.

To improve husbands' nutrition awareness and promote gender transformation, it is recommended that efforts should target both individuals and communities.

At home, Model Husbands - assisted by Lead Mothers - coach men and offer advice on gender issues affecting nutrition, for example the refusal to buy nutritious food or soap.

In the community, Model Husbands exhibit motivation, recognise the significance of their role, and take pride in their responsibilities. They share how adopting new gender and nutrition practices has benefited them and their families, encouraging others to do the same; "*Previously, I did not value my home and often misused finances. Now, I prioritise providing for my family.*"

Theory of Change



What impact?

The Care Groups and Husband Schools have recognised that change is most effective when initiated within their own households. Women report feeling greater inclusion, and men are more involved in the well-being of household members.

- **Awareness and attitude changes**: Reports indicate that men previously distanced themselves from domestic tasks or communication but now participate more actively, believing this benefits household functioning. There is an expressed consensus that leadership responsibilities begin at home, and men are increasingly applying newly acquired knowledge. Respondents observe changes in husbands' attitudes, including increased interest in childcare and household activities. Some women mention that their husbands now take initiative in seeking balanced nutrition for children and share feedback following programme sessions. Men report adapting their roles, such as caring for children during their spouses' absence. Spouses express approval of these changes and new roles within the community.

- **Task sharing**: Division of household tasks has reportedly shifted, with men participating in domestic chores such as fetching water, working in fields, or cooking when required. One respondent summarises this transition as increased cooperation. While women usually continue to manage domestic work, men now assist when needed; for instance, taking over cooking or fetching water if their partner is unwell or unavailable. Programme participants expressed their thoughts:

  "*Before, men didn't want to help women or do tasks perceived as feminine, but now they realise that if they help, the household thrives*."

  "Before, *men didn't help* at *home and women did everything. Now my husband fetches water and helps me clean the yard*."

  "Before, *men refused to work in the fields and preferred to look for money, but now they help us in the fields."*

  "My husband has learned to cook and now he cooks when I'm sick."

- Men's behavioural changes are specific but do not reflect a truly egalitarian shift, rather, they signal early shifts in what is considered acceptable by local standards. While encouraging, these changes remain limited. Many men only help with tasks like cooking when vital and avoid taking on more domestic responsibilities to prevent further expectations.

  "*We cook when the woman is not there or when she is ill. Otherwise, we don't cook. We can barely put the sticks in the fire if she goes to fetch water in the meantime, for example, and that's it."*

- **Household conflict:** Several accounts point to reduced household conflict and quicker intervention in cases of disagreement. Men acknowledge that lower conflict levels correlate with improved child health. Some narratives detail previous practices of confrontation or violence, which participants attribute to evolving through programme involvement.

  "We have seen a real decrease in conflicts within households, and if there are conflicts, we intervene immediately."

  "Men realise that a household without conflict is a household where children are healthy."

- **Decision-making in food and healthcare**: We have seen examples of inclusive financial and nutritional decision-making, with increased consultation between partners. Communication around resource allocation appears to have improved, with both men and women reporting joint planning and dialogue.

  "Before, I couldn't use the household money to buy food for the children, but now my husband lets me do it."

- **Childcare and support for women:** Reports describe increased participation by men in childcare and in supporting women during pregnancy or illness, and in accompanying them to health facilities. Greater male involvement in market purchases is also mentioned. The approach appears to have contributed to outcomes such as improved sanitation, family planning uptake, and reduction in malnutrition.

  "More households are practising family planning. Among the households I follow, there is one that does not space births. The child is one year old. The husband says that they need to space out births and practise family planning now. The women appreciate this."

  Male help remains generally conditional on a woman's absence or inability to complete certain tasks; otherwise, traditional roles persist.

- **Influence on the wider community:** Involving model husbands to encourage behavioural change among men is generally viewed as constructive. Community members have noted reductions in behaviours such as vagrancy, public alcohol consumption, and domestic disputes. Some men report benefiting from guidance provided by model husbands and observing subsequent changes.

Changes observed in Husband Schools and Care Group households have influenced other sensitised households as well. For example, some individuals share nutritional knowledge with neighbours, reporting that others are beginning to apply the advice, such as mixing foods for improved nutrition. One male participant explained: "*I talk to my neighbour about what I have learned about good practices. I have seen the change; he now knows that you have to mix foods.*" A female participant added: "*Before, if a child fell ill, it was difficult to know how to treat them. Some neighbours may not be happy, but others are starting to apply the advice. It is no longer just the woman who cares for the sick child."*

Whilst there are positive outcomes, resistance to change has been encountered among both men and women. In some instances, rumours and misconceptions, such as the suggestion that women were being given medication to influence men as a form of witchcraft (a belief commonly engrained in communities), have arisen.

What are the limitations of the approach?

Husband Schools and Care Groups demonstrate increased confidence addressing this resistance, though they admit that promoting gender equality, especially around task distribution, is difficult due to insufficient training and persistent reluctance. They also face scepticism, such as rumours of being paid volunteers.

The Care Groups support awareness efforts, conducting home visits and cooking demonstrations, primarily attended by women. Care Group volunteers wish their husbands would attend and learn these skills so they could share responsibilities when needed.

Challenges identified include limited knowledge sharing, insufficient resources for cooking demonstrations, inadequate water and hygiene supplies, lack of arable land or funds to acquire it, and awareness activities mainly reaching programme graduates instead of entire communities. For example, participants noted some positive impacts but felt changes were less significant than hoped, partly due to high expectations. Initial resistance from men towards women's involvement in behaviour change was reported, but acceptance has since improved.

Recommendations for Husband Schools to have an increased impact on nutrition

- Establish a list of topics that will be covered by both Care Groups and Husband Schools and ensure that all IEC materials used are harmonised and gender transformative. Care Groups volunteers could benefit

from additional IEC materials for specific topics (e.*g. how to increase breastfeeding frequency or how to manage breast pain).*

- Both mothers and husbands should receive the same hands-on training (e.g., preparing fortified flour, cooking nutritious meals, constructing latrines or tippy taps) to promote equal knowledge and break traditional roles.

- In countries where Husband Schools lack government recognition, develop an advocacy strategy for integration, supported by data collection and analysis to build local authority support.

- Compare activity packages, tools, and implementation strategies across different programmes (NGO-led versus direct implementation by Concern).

Conclusion

The programme's approach to involving men in health and nutrition practices seems to facilitate the adoption of recommended behaviours, yet challenges remain regarding shifts in power dynamics. Men typically retain authority over key decisions, particularly those concerning reproductive health and family planning. While joint decision-making is increasingly reported, ultimate authority often remains with men. The engagement strategy has resulted in some gender-sensitive changes, though transformative impacts on established power structures are less evident. Impact on nutrition outcomes were reported by practitioners but have yet to be formally assessed using traditional indicators.

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