

Nutrition for National Development

Pakistan's Integrated Nutrition Strategy

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1.0 Background and Rationale

1.1. Situation of Nutrition in Pakistan

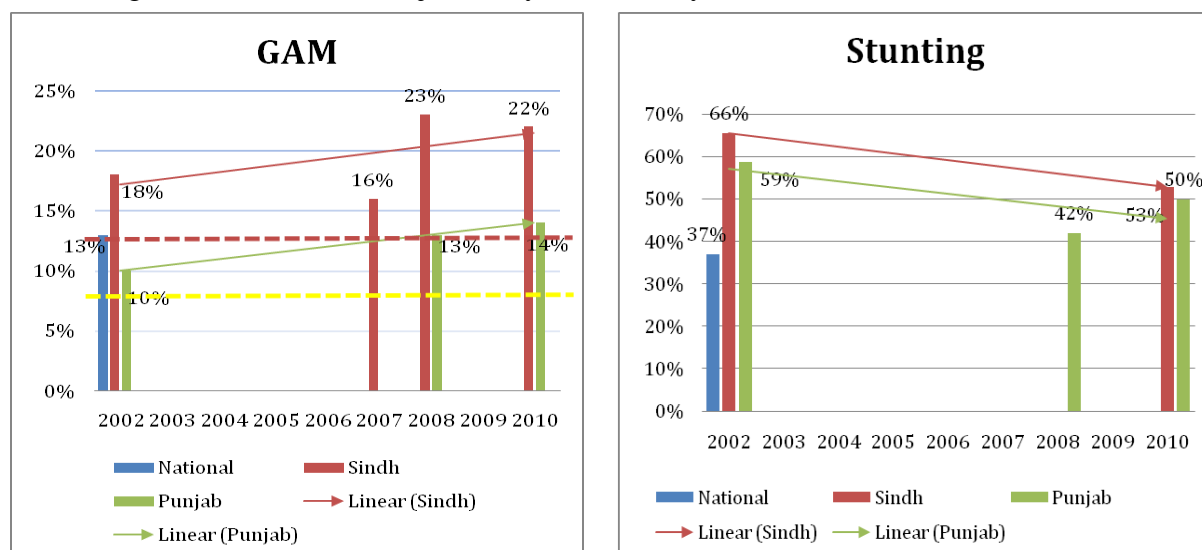
A high prevalence of undernutrition has existed throughout Pakistan well before the most recent floods brought the problem to national and international attention. The table below shows the levels of acute and chronic undernutrition drawn from different studies done in the country over the past decade. Though each study was done using different methodologies and sampling, the data is still unmistakable in demonstrating the long-standing nature of this problem. Acute malnutrition levels have been consistently above the cut-off for a serious public health problem.

Indicators	Pakistan	KPK	FATA	Balochistan	AJK
Stunting (NNS, 2001)	37%	43%	-	39%	34%
(MICS, 2008)			42%		
Wasting (NNS, 2001)	13%	11%	-	14%	-
(MICS, 2008)			13%		
Severe wasting (MICS, 2008)			7%		
Iron Deficiency anaemia (Children) (NNS, 2001)	67%	56%	-	36%	66%
Iron Deficiency anaemia (Mothers) (NNS, 2001)	45%	44%	-	55%	30%
Low birth weight (weight less than average (NDHS 2006)	31.1%	34%	-	43%	-
Exclusive breastfeeding (NDHS 2006)	37%				
(MICS, 2008)		45%	39%		
Poor food consumption score (WFP, 2009)	15.7%	29%	27%	27%	
Population with food insecurity (WFP 2009)	48.6%	56.2%	67.7%	61.2%	-

A situation of serious malnutrition (severe acute malnutrition of 6-9%) was recorded in Khyber Pakhtunkhwa (KPK) after the 2009 and 2010 floods (Nutrition Survey Reports 2009-2010) after which nutrition responses were established by the government. Moreover, iron deficiency anemia in women and children was detected at levels of severe public health significance in Pakistan with Azad Jammu Kashmir (AJK) and KPK recording among the highest levels (66% and 56% respectively) among children, and Baluchistan (55%) and KPK (44%) recording the highest among mothers as per the National Nutrition Survey (NNS). All measures were from before the most recent floods. National measures of low birth weight have remained high at 22.1% from 1980 to 1991 before further deterioration to 26% in 2006 (PDHS 2001/2006). In 2006-7, nearly 43% and 34% of infants reported to have been born less than average in

Balochistan and KPK respectively. Studies have shown that low birth weight is strongly associated with maternal malnutrition before and during pregnancy.

The figures below were graphically compare global acute malnutrition (GAM) and stunting between two major provinces: Sindh and Punjab. Again, the data come from different sources and, though not continuous, are joined by lines merely intended to demonstrate the overall trends



in each Province. In the slide of GAM, the yellow line indicates the cut-off for a serious public health problem; the red indicates a severe problem. When the most recent National Nutrition Survey is completed, another national measure on the graph will be available for trend analysis.

The problem with severe malnutrition is not confined to Pakistan.

Neighboring India also has indicators of serious nutrition problems, and although both are better in U5 mortality rates than

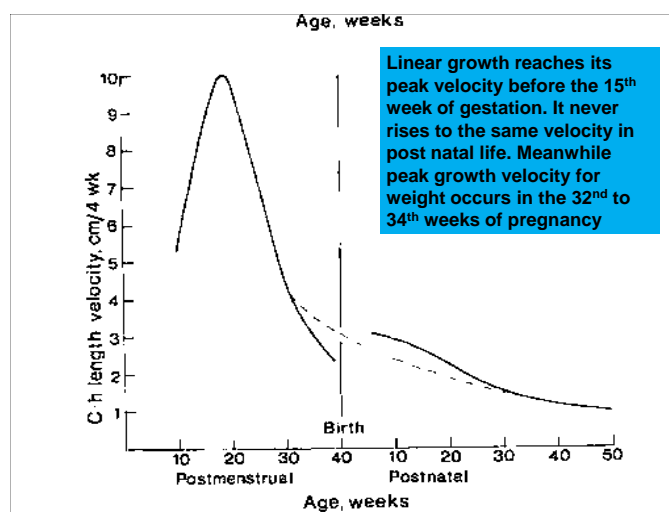
Country	U5 mortality rank (worst is ranked #1)	Low birth weight (%)	Stunting (%)	Wasting (%)
Pakistan	42	32	42	14
India	49	28	38	19
Ethiopia	27	20	51	12
Thailand	125	9	16	5

an African country like Ethiopia, in terms of wasting and low birth weight they are similar if not worse. When compared to a country in south East Asia like Thailand, all indicators are significantly worse in Pakistan.

1.2 Causal analysis of stunting and anaemia

Vulnerable periods and the ‘Window of 1000 Days’

Recent publications (Shrimpton,R., Victora,C, 2010) indicate that not only low weight, but stunting and young child anaemia are measureable at birth and thus have their origins during pregnancy. Additional analysis of intrauterine linear growth (Winick 1968) suggests that the critical time period is in the first trimester reaching a peak around 16 weeks. This adds further evidence to the importance of women’s nutritional status entering pregnancy. (Further work by Dobbing indicates that the growth in neural cells in the central nervous system is reaching its peak velocity in the same period.)¹



Province / National	BMI <18.5	MUAC <23	Anemia
Sindh		17-25 % (2010)	29.0 % (2002)
Punjab		35.2 % (2010)	
Pakistan	12.4 % (2002)		29.4% (2002)

The status of women’s nutrition and anaemia found in Pakistan is shown in the adjoining table². A recent Johns Hopkins Study in Pakistan (2004-8) noted that ‘Pakistan...may harbor the highest prevalence of severe anaemia in South Asia’ with as high as 15% reported for pregnant women. The study

also detected similar rates (11-12%) in young children. Severe anaemia is not only the result of poor intake of often expensive protein and iron rich foods, but is usually accompanied by intercurrent infections (e.g., urinary tract infections, malaria, tuberculosis) that are easily treated if there is access to health services. In Pakistan, it is estimated that in some areas one in five women suffer from malaria in pregnancy – many of whom do not receive treatment. This figure is highest in rural areas (22%), and relates to socioeconomic status as well: 29% prevalence in the lowest quintile, and 23% in the second lowest quintile – the near poor.

¹ Dobbing, J., Pediatrics, 1974:53.

² Note that very little data on women’s nutrition is available; more complete data will be provided by the most recent National Nutrition Survey

These indicators of nutritional status with origins in pregnancy are also affected by the age of the woman when she becomes pregnant. While age at first pregnancy is difficult to measure (legal consequences for adolescent pregnancies prevent direct answers in some surveys), the age of marriage is a standard question in the Demographic Health Survey. The accompanying table is taken from the PDHS 2006-7 and shows the remarkable number of children married before the age of 15 (13.9%) and before age 18 (50.1%). One cannot directly link these numbers with

Age at first marriage or union for 20-24 year old females (percent)		
Region	Married by age 15	Married by age 18
Punjab	11.6	44.8
Sindh	15.5	57.8
NWFP	19.4	56.4
Balochistan	14.0	45.4
Urban	12.6	40.9
Rural	14.5	54.1
National	13.9	50.1

Read the first column of data as "Percent of 20-24 year old females married by age 15."

adolescent pregnancies. However, in the same DHS it was found that only 12-22% of 15-24 year olds reported ever using contraception. With the exception of some young girls who are kept from their husband's home until they are over the age of 18, the implication of a high number of adolescent pregnancies is significant.

Adolescent girls who are still growing (estimated as an average period of five years after menarche in an undernourished population) tend to use calories for their own growth, rather than for the growth of the foetus. At the same time, because of the

outpouring of hormones during pregnancy, their long bone growth plates (the areas at either end of the long bones where new growth occurs in length) fuse leading to a cessation in linear growth. Any calories taken in therefore tend to add weight not height to the adolescent mother and her tendency is to become short and overweight with pregnancy. The tendency for the newborn is to be low birthweight.³ In addition, the iron needed for her growth and for her growing foetus is insufficient so she becomes anemic as well.

This easily measured marker (Hgb or Hematocrit) becomes an indicator of women's status in society and of gender inequity. It means that a woman is not getting the proper nutrition she needs, does not have access to basic health care, and is of a generally low status in the family where she is either a young woman about to be married into another family, or the youngest in her new family where she usually eats last. When anaemia is present to such a degree, the seriousness of the problem and its significant implications cannot be underestimated: anaemia is a factor in 20% of maternal deaths, and known to affect growth and development in children. The long term problem of undernutrition in children cannot be solved without addressing the

³ Alternatively, undernourished girls, if they do not become pregnant and are free from basic diseases, tend not to have the characteristic adolescent growth spurt around 12 years of age as their well-nourished sisters have, but will continue to grow into their late teens and early twenties, achieving low but within the range of normal height.

nutrition and health of women throughout the nine months of pregnancy, which means reaching them in adolescence and young adulthood with adequate nutrition and access to health services.

The importance of pregnancy in setting the trajectory of growth for the young child after birth is represented in the accompanying graph that shows stunting (height for age - blue), wasting (weight for length - red), and underweight (weight for age - green) as they exist at birth up to 59 months of age. The figures in these graphs are the aggregate of data from DHS done in 54 countries in Europe and Central Asia; Latin America and the Caribbean; North Africa and Middle East; South Asia; and sub-Saharan Africa. As stated, the presence of stunting at birth indicates that the potential for normal linear growth is established in pregnancy. However, whether the child lives up to that potential comes from adequate health and nutrition after birth, during the first 24 months of life. If the bar is set low in pregnancy, no matter how good the conditions of health and nutrition are in the first two years, that child will tend to be stunted. As seen in the graph, the problem of stunting increases until 24 months of age. After that, stunting is essentially irreversible despite post-infancy conditions of health and nutrition. The child who is stunted at 24 months of age will become a stunted adult.

This vulnerable period from -9 months to 24 months offers a **‘window of 1000 days’** when

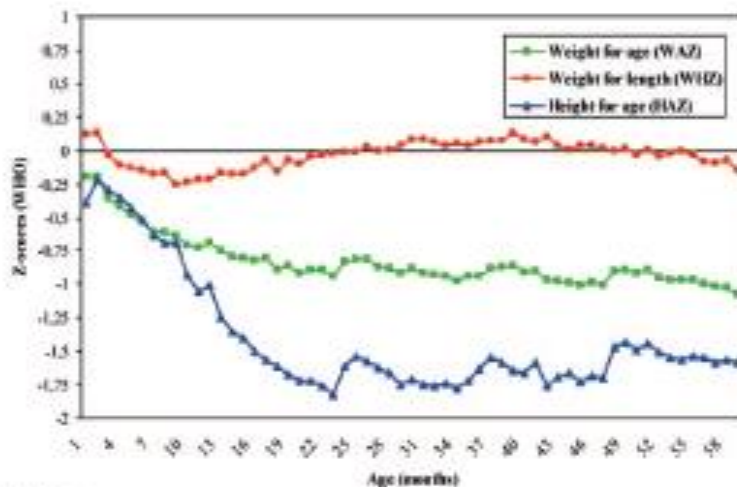


FIGURE 1
Mean anthropometric z scores according to age for all 54 studies, relative to the WHO standard (1 to 59 months).

interventions targeted at reducing malnutrition in women and children will have their greatest impact. These interventions, if successful during pregnancy, have far-reaching consequences. It is now known that malnutrition *in utero* predisposes children to adult-onset diseases like coronary artery disease, diabetes, and obesity.

The implications are not nutritional alone. In addition,

recent research has shown that “...exposure to nutritious supplement during pregnancy and early childhood...led to greater adult height, schooling (for women), improved scores on tests of intelligence and reading, greater income, and better growth of the next generation.” (Victora, Lancet 2008). Other researchers have confirmed this association between intrauterine growth, cognitive development, and later economic development.

'Productivity gains come from linking impact on schooling and cognitive development and knowledge of how these affect wages' (Alderman, H. 2011)

Alderman's and Victora's assertions are based on an extensive review of the literature. Assuming they are correct, that growth in utero affects schooling, then the importance of the finding that "...one additional year of schooling is associated with 12-14% increased lifetime earnings" (Psacharopoulos, G. 2004) has profound implications for not only household but national economic development.

Infant and Young Child Feeding

Poor infant and young child feeding practices are a major contributor to childhood malnutrition. In Pakistan, the 2006/07 PDHS showed that despite an increase in exclusive breastfeeding rate over a period of 15 years, (25% in 1991 to 37% in 2006-7), levels in many areas of the country remained disappointingly low. During the same period, there was only a 4% increase in the timely introduction of complementary foods. Other studies in 2008 indicated that exclusive breastfeeding rates from 0-6 months were 45% in KPK. Forty percent of young children had timely introduction of complementary feeding (MICS 2008). **The timing of breastfeeding initiation is also important:** 16% of neonatal deaths could be saved if all infants were breastfed from day one and 22% if breastfeeding started within the first hour (Edmond, KM et al, 2006). In Pakistan, only 28.8% initiate breastfeeding in the first hour, a number that rises, however, to 69.5% in the first day. This figure is not related to exclusive breastfeeding as 65% of women report giving something other than breastmilk to their babies in the first three days (PDHS 2006-7). Further data from the Complementary Feeding Practices Survey report (Z. Bhutta et al, 2007) show similarly low rates of early initiation of breastfeeding within the first hour after birth in KPK (57%), Sindh (30%), Baluchistan (20%), and Punjab (15%).

Food insecurity

These problems of poor nutrition are compounded by food insecurity and poor food intake, particularly by women and girls. The food consumption score (FCS) is a composite indicator of adequate caloric intake. Intake less than 1750 Kcal/day for adults is considered inadequate and a proxy indicator for subjective hunger. According to the 2009 study, KPK has the highest percentage (29%) of people with a poor food consumption score, followed by Balochistan (27%). These figures indicate a poor food security situation in the provinces [Food insecurity in Pakistan, 2009: Balochistan (61.2%), and KPK (56.2%)]. In addition, Balochistan has the highest number of districts with the worst conditions of food insecurity. The 20 districts of Pakistan with worst conditions for food insecurity include 10 districts from Balochistan and three from KPK.

Food security is worsened by increases in food prices, as these impact on the socio-economic access to food. Rising food prices affect nutritional outcomes by reducing food availability and

limiting food choices. The impact is greatest on vulnerable and poor rural households, but is particularly severe on the poorest urban and peri-urban households who depend on food bought from markets rather than from their own production. Food purchases pre-flood accounted for 47.6% of total household consumption in Pakistan in general, a figure that rises to 70% in the poorest households (HPN, 2009⁴). In addition, it is estimated that these proportions, calculated before the recent floods, will show an increase of up to 10% as food prices rise. As a result, poor households are forced to opt for cheaper but less nutritious foods, and women, who generally are the last to eat, suffer the most. As a consequence, protein, vitamin and mineral deficiency rates may increase, leading to an increase in stunting and low birth weight for young children, and increased morbidity and mortality and reduced work output and learning performance for older children and young adults.

The stress from the resulting diminished household purchasing power poses a major barrier to access to health care for the poor due to the high cost of health services. Seventy percent of the total expenditure on health in the country is private, of which 82% is out-of-pocket (NHA, 2007). This lack of a safety net with regard to health pushes families to self-treatment, or to treatment by unregulated and often unqualified private practitioners. To cope with these increased costs, poor families withdraw children from school not only because of their inability to meet the cost of schooling but because of the need to enlist children in income-generating activities (the opportunity cost of school attendance) and to care for younger siblings; the latter adds an additional compromise to the quality of care given to younger children.

Natural hazards and emergencies

To add to this discouraging picture, an almost continuous state of emergency (both natural and complex) over the past five years has added to the stress of the population, especially the most vulnerable (pregnant and lactating women and young children). Since the earthquake of 2005, Pakistan has faced seasonal flooding, cyclones, earthquake (Baluchistan) and finally the devastating flood affecting and impacting on all the provinces, regions and almost 12% of the total population directly. A disaster results when a natural hazard impacts on a vulnerable population. The severity and scope of the nutritional impact on women and children in the Provinces indicate an extraordinarily large vulnerable population, and has resulted in the high rates of moderate (MAM) and severe acute malnutrition (SAM) following the recent floods. The already fragile resources and existing health infrastructure is not robust enough to cater to the needs or respond adequately. As a consequence, despite the government's best efforts, a large number of the population has been adversely affected, adding tremendously to the already large numbers of those malnourished.

⁴ Humanitarian Practice Network, on <http://www.odihpn.org/report.asp?id=2988>, accessed 3 Feb 2011.

2.0 The Pakistan Integrated Nutrition Strategy (PINS)

2.1 Integration and synergy ⁵

For integration and synergy to occur between partners working to improve nutrition, three elements must be in place to maximise the effectiveness and efficiency in dealing with such an enormous acute as well as chronic problem:

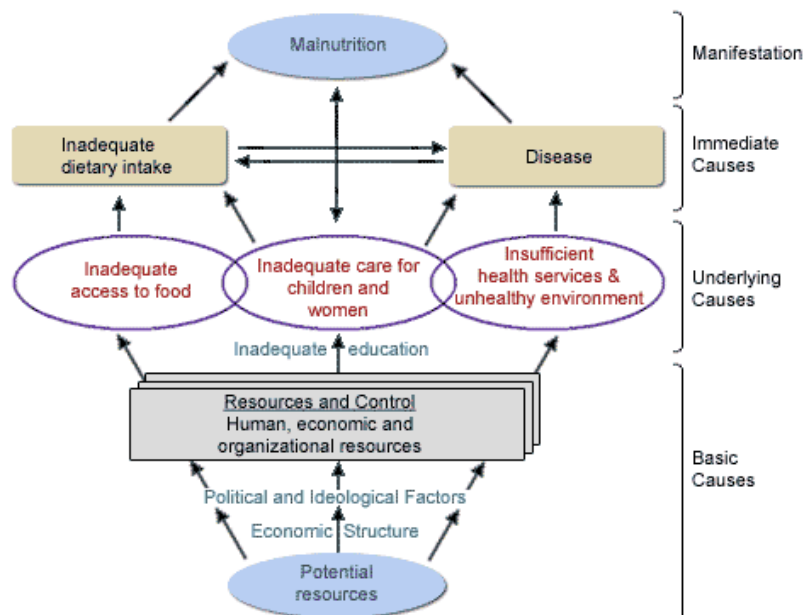
- Conceptual integration: the agreement by all parties on the causes of the problem, and on the components of the package that will be necessary to solve the problem.
- Programmatic complementarity: an understanding that each development partner does not have to do the same thing nor adopt the same approaches; however, the approach of each partner must contribute to solving or addressing a consensually recognized component of the problem in a coordinated way, so that the sum of interventions – like the pieces of a puzzle – will come together to comprise a complete approach to every aspect of the problem of malnutrition in Pakistan.
- Geographic convergence: unless partners are working in the same place at the same time, complementarity will not succeed, and synergy will be lost.

2.2 Conceptual framework and a comprehensive approach

The Nutrition Conceptual Framework presented below offers a causal analysis of malnutrition at various levels – immediate, underlying, and basic.

Efforts to date to combat acute malnutrition in children and women have largely targeted the immediate and only some of the underlying causes of malnutrition.

In the flood-affected Provinces of Pakistan, the urgent and immediate priority, given the severity of the recent floods, has been to care for those children who are moderately or severely acutely undernourished by correcting their inadequate dietary intake and taking steps to reduce the incidence of new diseases. This has been done through community management of acute malnutrition (CMAM) programs that provide therapeutic and



⁵ Synergy: the ability of the group to outperform even its best individual member.

supplementary foods and micronutrients and that aim to improve infant and young child feeding practices.

Programs and approaches that target immediate causes clearly save lives (e.g., introduction of ORS for acute diarrhea, use of antibiotics like Cotrimoxazole or Amoxacillin for acute lower respiratory infections, and so on). But sadly, though millions of lives may have been saved, the problems remain. Diarrhea and pneumonia remain the top causes of child hood deaths in most developing countries, including Pakistan. Delving into underlying and basic causes is infrequently done, because the agencies that address these problems are usually acting independently and are not always equipped with the wide range of knowledge, skills, or other resources to go into these profoundly complex issues. Nor is the donor community able to fully invest in the exercise since the tasks are long term and the results seen over a 5-10 year horizon, rather than the 1-3 year span of most development grants. Their constituencies, particularly in the present global economic environment, are demanding quick returns on their investment, i.e., lives saved.

However, in the present context of Pakistan post-floods, where so many different agencies are converged with different human resource capacities, with substantive funding, and a variety of interventions to offer, the possibility exists of a comprehensive approach that, through synergy and coordination not only attempts to answer the immediate problems but can begin to address those basic problems that have placed the country in its present precarious position. In addition, because of the international attention that the floods brought to the alarming status of malnutrition in the country, there is considerable political will channeled into improving the situation.

2.3 Guiding Policies and Principles: Child Rights and National Development

The approach offered in the Pakistan Integrated Nutrition Strategy (PINS) links five on-going measures presently being implemented (i.e., the response to the acute flood situation; the transition of nutrition service delivery in the post 18th amendment devolution to the provincial level; the protection of child rights guaranteed in the Convention of the Rights of the Child⁶; and the country's obligation to achieve the Millennium Development Goals) with further investment in nutrition as a major factor in national development.⁷ PINS is developed within a human rights framework that commits the nation to guarantying the rights of every child – boys and girls – to adequate nutrition, primary health care, and basic education.

It has been increasingly clear that targets for the reduction of extreme poverty and hunger (MGD1) will not be achieved without new approaches and with decisive, integrated efforts by

⁶ Pakistan ratified the Convention of the Rights of the Child on 12 December 1990.

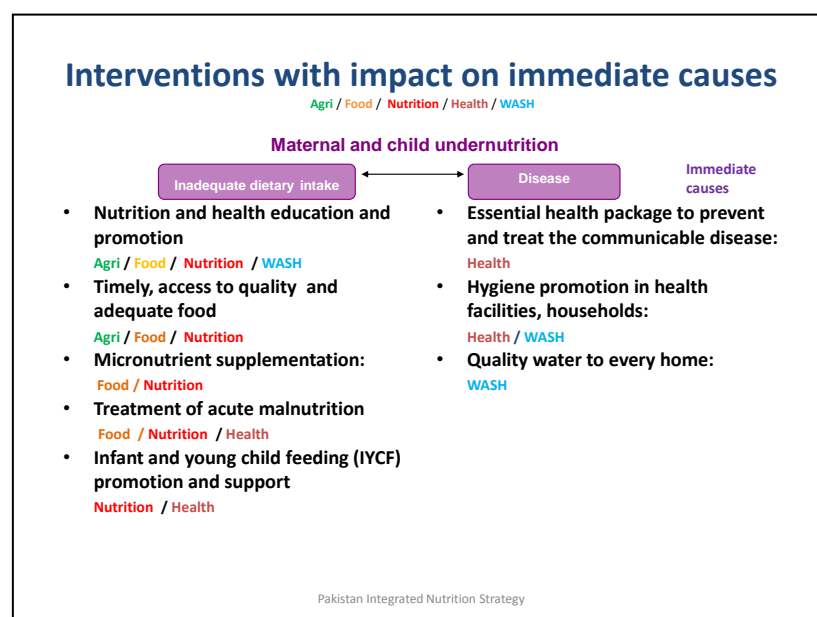
⁷ In this regard, it is also necessary to factor in the process of adoption of the Nutrition PC1 being developed in each province (with assistance from the World Bank.)

partners. In addition, most people now recognize that MDGs 4 (Child Survival) and 5 (Improve maternal health) cannot be achieved without improvements in Nutrition. The causes of child under-nutrition reflected in the nutritional causal framework above are known; some are predictable and preventable, others will require more long-term solutions. Bringing on-going interventions to scale will offer some impact, but the urgent need is to add new interventions and target the new population of young women for long-term reduction in the nutritional vulnerability that has made the recent crisis so devastating.

2.4 Using the conceptual framework to define the focus of interventions

Interventions with impact on immediate causes

Each level of the conceptual framework offers the structure for integrated and coordinated inputs from the development agencies both inside and outside of the government. The diagram below of the interventions with impact on immediate causes essentially describes what is happening at present in the flood-hit parts of the country. The colour-coded notations beneath each example of an intervention indicate which of the five sectors most directly involved with nutrition are



leading the intervention. In presenting these sectors, it must be recognized that future plans should include others: education, child protection, family planning, health policy, and economics. Each sector includes participation from Government and Non-government organizations, bilateral donors, and multilateral entities like the UN.

The problem of poor dietary intake was delineated by

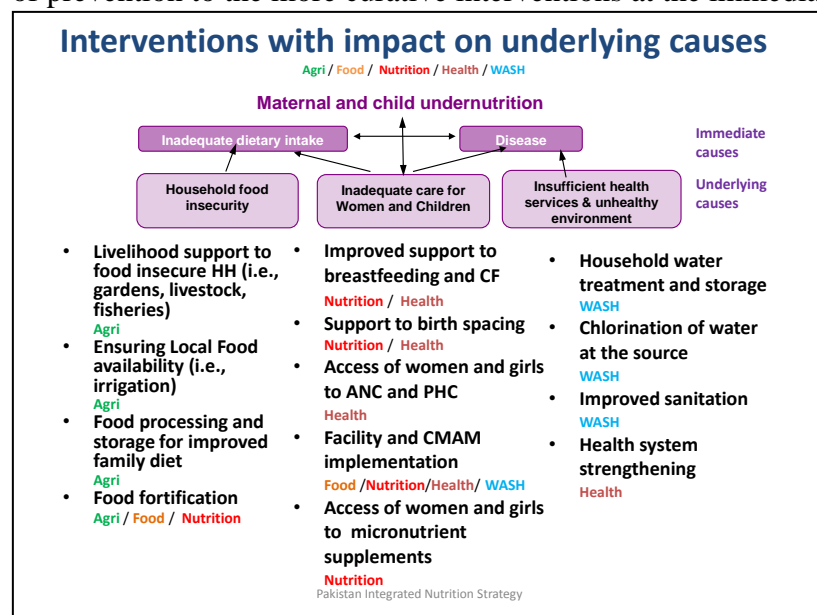
surveys done in Sindh and the Punjab: in Sindh, 28.5% of infants were eating only two meals a day; in Punjab, about 50% of adults reported taking less than three meals a day, mainly consisting of wheat, sugar, oil and some dairy product. Not only is their diet low in quantity, but with this lack of dietary diversity, low in quality as well. The floods, of course have exacerbated the situation and many people report that they will be depending on food aid from camps until the next harvest. The interventions involve promotion and community education, access to enough food of sufficient quality, supplements with micronutrients to treat the deficiencies that arise from lack of dietary diversity, and the two cornerstones of the flood response: facility and

community management of acute malnutrition and promotion and support of breastfeeding and timely introduction of complementary foods.

Those interventions directed at diseases are aimed at prevention or treatment of a high prevalence of diseases: in North Sindh, 54.2% of respondents reported sickness in the two weeks prior to the survey; in Punjab the prevalence was 67.2%. The common diseases affecting the population were fever, diarrhoea, and acute respiratory infections. This segment of the diagram is therefore understandably dominated by the health sector and the WASH sector, which is most often associated with childhood illnesses.⁸

Interventions with impact on underlying causes

Implementation of the interventions with impact on underlying causes adds a stronger element of prevention to the more curative interventions at the immediate level: household food



insecurity, inadequate care for women and children, and insufficient health services along with an unhealthy environment comprise some of the most important elements for primary prevention.

The framework shows nicely the key importance of household food security as an integral element in establishing nutrition security. Since nutrition security includes all of the elements in the conceptual

framework, not just those on the left side of this diagram, one can see that all of these interventions need to be put in place if the child and mother are to remain well-nourished.

These interventions were developed in response to the data for Pakistan. Those on the left side of the diagram are needed particularly for displaced people, or those who are moving back into homesteads and land that has been ravaged by floods or droughts. They speak to the need for people to develop local food sovereignty (i.e., local production and storage of food to meet their daily needs) as well as to improve the quality of food in response to poor dietary diversity through initiatives like food fortification. Food supplements offer another alternative.

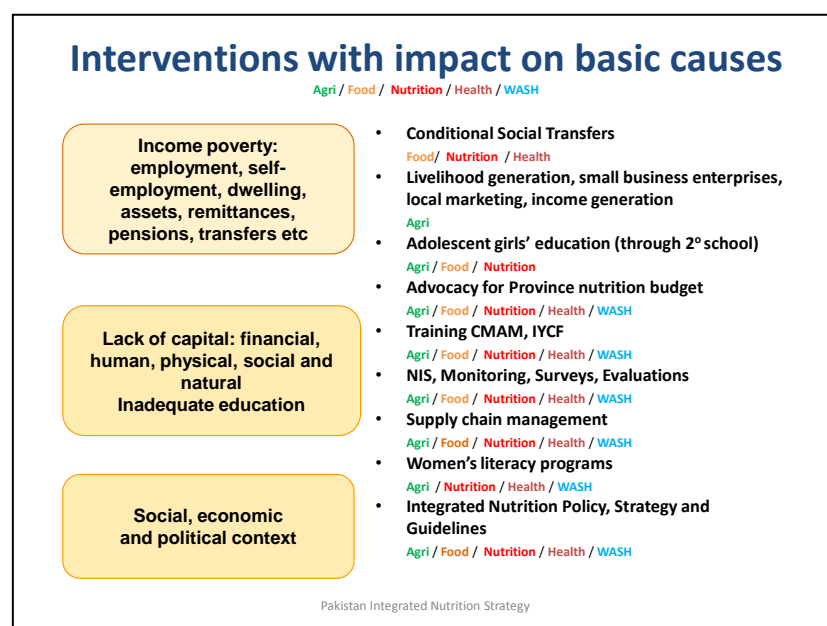
⁸ Studies have shown that hand washing with soap alone can prevent up to half of all cases of diarrhea and pneumonia. [Luby, S.P., et al, *Lancet*. Vol 366 July 16, 2005]

The interventions addressed to improve inadequate care are in response to the poor nutrition indicators in the country mentioned above: only 25-28% of mothers breastfeed their infants within the first hour of birth, and only 37% exclusively breastfeed for the first six months of life; adolescent pregnancies and short birth spacing with development of maternal deprivation syndrome requires better birth spacing and family planning; both women and girls are known to be anaemic, and iron deficiency is usually not found in isolation from other micronutrient deficiencies.

The interventions on the right of the diagram are aimed at improving the environment in which the child lives, and the caring environment that constitutes the health system. Data indicates that the health system has dropped some of its most important interventions: in Sindh vitamin A supplementation only reached 26 %, and only 59% in Punjab; measles coverage was 56.3% and 60% in South and North Sindh respectively, and 35% in Punjab; in that Province, only 32% of children had received deworming tablets. These are symptoms of an unhealthy health system that must be strengthened if health *and* nutrition are to be improved.

Interventions with impact on basic causes

While many of the interventions in the previous two sections may already be implemented in some areas, the interventions with impact on basic causes offer a final list of those that could be, but may not yet be in place. Through discussion with partners, there is agreement that all are certainly within the realm of responsibility for the sectors listed. Bringing them together in time and space and finding the resources to support them in a sustainable way are major challenges.



Missing from the list are important interventions that require input from other sectors not listed. For example, while all sectors can advocate for a larger piece of the provincial budget to go to Nutrition, it will take the input from financial institutions, Ministries and Departments of Finance and Planning to make those decisions. Similarly, while the agriculture sector can point the way for livelihood generation,

development of small business enterprises, and other forms of income generation, it will take the enlistment of other agencies involved in micro-finance on a broader scale to extend these interventions outside of nutrition and health as poverty alleviation strategies.

Perhaps the most important underlying factor of all is gender equity and women's empowerment. This is alluded to in the two entries of adolescent girls' education through secondary school (known to delay marriage and early pregnancy) and women's literacy programs that are aimed at giving women the opportunity to have more knowledge and control over their surroundings. Each of these activities is also aimed at bringing women out of their homes and into the public space; to give them a voice in the forum of ideas.

This will require interventions not found on this conceptual framework: legislation for social protection and human rights, (and enforcement of laws already passed)⁹, education of the community and education of women about their importance for the growth and development of future generations and the future of the country. These can begin with the education of adolescent girls and boys, but to carry it forward will take a national effort supported by progressively minded religious leaders¹⁰ and backed by strong political will at the highest levels of government.

2.5 Using the conceptual framework as a structure for planning

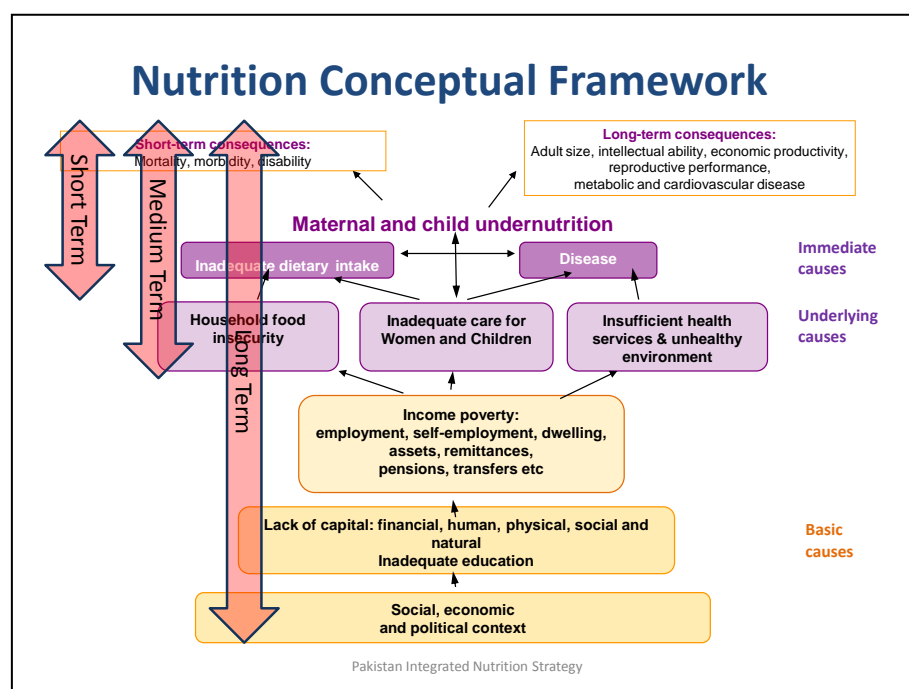
As long as there is conceptual integration by all partners on the place of interventions within the framework, and agreement to try to coordinate programs in the same place at the same time, making short, medium and long term plans can be defined through application of the causal levels of the framework. In this way, the framework can be used to identify the time horizons of each intervention. The key, however, is remembering that although interventions may have three, five or 10 year horizons, they must all be started at the same time – long term goals do not mean starting something after a long time!

The most important partners in this process are the government and the donors whose pressure from constituents to show immediate results from precious funds, and whose relatively frequent turnover of leadership often makes medium and long term commitments of funds difficult. Leadership changes, reluctance to turn over a long term project to the opposition (should

⁹ Decentralization In the post 18th Constitutional Amendment scenario – the following legislative initiatives have been posted: the National Commission on the Rights of Children Bill (2009), the (Child Protection) Criminal Law Amendment Bill (2009) [to be introduced by the Federal Government], the Charter of Child Rights Bill (2009), the Prohibition of Corporal Punishment Bill (2010), and the Child Marriages Restraint (Amendment) Bill (2009) [pending before the National Assembly].

¹⁰ The provisions of Article 12 of the Convention of the Rights of the Child (having to do with the right of the child to express his or her views freely in all matters affecting the child, or to participate in any judicial and administrative proceedings affecting the child) do not have specific comparable provisions in Pakistani law. Pakistan is a federative republic in addition to being an Islamic republic. As a result, religious interpretations have a great deal of influence on these legal areas of state

government change), and sometimes a lack of vision prevents decisions that will install programs with such a long shelf-life. However, as donors like DfID have suggested, this could be a defining moment for the government, a chance to establish its legacy as the government that turned malnutrition around in Pakistan.



Donor coordination is no less important than coordination among other development partners. To serve this function, donors could consider forming a **Donor Coordinating Body** among nutrition-oriented Donors. Applications for funding would be submitted by development agencies to a **donor pool** where proposals would be considered by

interested donors in a coordinated way. This would avoid the possibility (which occurs occasionally) that similar projects by different development agencies would be submitted to different donors for funding. If submitted to the pool, donors could choose to consider those proposals that were closest to their priorities and philosophy. Fragmentation of funding and redundancies would be avoided.

3.0 Moving forward: Recommendations for an Integrated Cluster Approach

Recommendation 1: Develop a coordinated monitoring system based on commonly defined indicators. For this strategy to work, it must be monitored carefully and in a coordinated manner. Monitoring itself is a way of strengthening partner coordination and integration. To do this, concerned government ministries at Central (Planning Commission) and Provincial level must work alongside of all development agencies and partners in each cluster (i.e., Agriculture, Food, Health, Nutrition and WASH plus others as possible) in order to identify a core list of sectoral input and process indicators suitable for monitoring short-term, mid-term, and long-term progress.

Recommendation 2: Keep monitoring and evaluation separate, plan joint evaluation of programs. Partners should identify a core list of joint outcome / impact indicators suitable for evaluating outcomes that require multi-sectoral input to be accomplished. Integrated and convergent programmes will not be sustainable if goals and objectives are set independently by partners and defined in a way that does not require synergy.

Recommendation 3: Identify trends in malnutrition using a combination of sites; train local staff in using data for decision making. By using a combination of sentinel sites, local OTP, SFP, and SC reporting data, plus local and periodic national surveys, a broad and relatively inexpensive system of monitoring can be developed. However, in order to improve the quality of data, it will be important to train local resource people in how to use data for decision making, and allowing them to participate in identification of indicators and development of data collection methods.

Recommendation 4: Develop a joint integrated workplan. Using the integrated cluster approach outlined above, develop a joint integrated workplan with a timeline for each stage: short, medium, and long term.

The model for this integration is found in the “Three Ones” strategy developed by UNAIDS for the fight against HIV: (1) One agreed framework that provides the basis for coordinating the work of all partners, (2) One national coordinating authority with a broad multi-sectoral mandate, and (3) one agreed national monitoring and evaluation system. To apply the model, the following recommendations are proposed:

Recommendation 5: Develop one national coordinating authority. Maintain a National and Provincial Multi-sectoral **Nutrition Board**, that reports to the Provincial Chief / Health Minister and/or the Prime Minister.

Recommendation 6: Develop one agreed national monitoring and evaluation system. Simplify the **Nutrition Information System** by reducing the reporting forms; develop good models for evaluation.

Recommendation 7: Develop one agreed framework. **Maintain an intersectoral working group** made up of the 5-6 nutrition-related sectors that provides a coordinating framework and technical input to the Nutrition Board, and that mainstreams nutrition into all development and humanitarian projects.

4.0 A Provincial Integrated Nutrition Strategy (PrINS)

During the course of the work on PINS, there was an opportunity to explore the application of these and other recommendations with officials in the Provincial Government of Sindh. It was felt that at least initially, a Provincial Integrated Nutrition Strategy (PrINS) could be the umbrella under which the Provincial CMAM strategy and Response Plans fit – both largely at the immediate causal level.

To approach problems beyond the immediate, committees would be formed representing two different levels of governance: the bureaucratic and the political. Both of these would be in harmony with the PC1 Nutrition (Province) being developed. A draft PrINS would be presented to the Federal Planning Commission for review, comment and approval (i.e., to support moving forward with implementation in one model Province). This proposal would include the establishment of a National Nutrition Board.

Following approval by the Federal Planning Commission, a Provincial Nutrition Coordinating Committee (PrNCC) would be formed at the political level, i.e., chaired by the Chief Minister with members from related Ministries (e.g., Health, Nutrition, WASH, Food and Agriculture, Environment, Child Protection, etc.) plus representatives from the Province Intersectoral Nutrition Working Group (INWG).

The INWG would be formed in the Province at the bureaucratic level, i.e., chaired by the Chief Secretary with members from related Ministries plus representatives from the UN, International and National NGOs and Civil Society Organizations, Donors, Academia, etc. This group would provide technical support and monitoring to the PrNCC.

Finally, as part of their preliminary actions, the INWG would edit and simplify the monitoring forms to make them more ‘user friendly’ for decision makers at all administrative levels in the Province.

An acknowledged weakness in the Province is the lack of human resources with the capability of responding to the nutritional problems in the country. An integral part of PrINS would be the development of a Human Resource Capacity Plan. This capacity plan would improve the numbers and quality of human resources dedicated to public health nutrition through the following three interventions:

- Recruitment: through an extended search process and suitable incentives, identify qualified individuals from public and private sector, in-country or expatriated, who could serve as District-level Public Health Nutrition Specialists, to oversee the training and the work of the re-tooled staff.
- Re-tooling of existing staff: train and re-train the workforce (e.g., LHWs) through in-service and pre-service training on public health nutrition. To the extent possible, existing institutions within the country would become training centers for these staff members, who would be supervised and supported by the District-level Public Health Nutrition Specialist. Because the need is so great, and the problem urgent, out-sourcing to regional training institutions may be necessary supported by donors and the UN.

- Reallocation: develop a roster of Public Health Nutrition Specialists in all the Provinces who could be put on retainer for call-up during emergencies or for critical periods in the implementation of the PINS/PrINS.

5.0 Conclusions

The concept of developing conceptual integration, program complementarity, and geographic convergence among all partners involved in health and nutrition is at the heart of this Pakistan Integrated Nutrition Strategy. Without these three elements in place, integration and coordination will not occur, and both efficiency and effectiveness will fail. This will require sustaining a new way of working together that has been initiated in the coordinating mechanisms surrounding the flood response. The challenge will be to keep that coordination and focus even after the floods have receded. With climate change a reality and the number of natural disasters increasing in the world today, there can be no question that Pakistan will be challenged by more disasters in the future. The success of its response will depend on the size of its vulnerable population. All measure must be taken today to initiate short, mid, and long term interventions to address the immediate, underlying and basic causes of its malnutrition problem.

To address the full scope of nutritional problems – acute and chronic – intersectoral input is needed at all levels of the causal framework. At present, the UN agencies working most closely together are WHO, UNICEF, FAO and WFP (with the latter performing a significant role in the provision of supplementary food at the community level.) However, for true synergy to occur in addressing this long-standing problem the intersectorality must include the leadership as well as participation of agencies outside of the UN – international and national non-government and civil society organizations, academia, and donors – working at all levels of causality. Success will be more likely if individual agencies look to ways to internally integrate all of their programs with a mandate to include interventions in each that target some aspect of nutritional improvement. Partners are not intended to lose their identities in this integrated approach, but to merge their strengths with the strengths of other organizations in order to achieve the goals.

By now, it must be clear to all involved – government, development agencies, and the donor community – that the future of the country is hanging in the balance. Without a response to the devastating situation of malnutrition with its roots in the poor status of women in the country, the economic, intellectual and social development of the nation is at risk.