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NUTRITION POLITICAL ECONOMY, PAKISTAN



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SINDH PROVINCE REPORT

NUTRITION POLITICAL ECONOMY, PAKISTAN

PROVINCE REPORT: SINDH

Report from the Maximising the Quality of Scaling up Nutrition Programmes (MQSUN)

About Maximising the Quality of Scaling up Nutrition Programmes (MQSUN)

MQSUN aims to provide the Department for International Development (DFID) with technical services to improve the quality of nutrition-specific and nutrition-sensitive programmes. The project is resourced by a consortium of eight leading non-state organisations working on nutrition. The consortium is led by PATH. The group is committed to:

- Expanding the evidence base on the causes of under-nutrition.
- Enhancing skills and capacity to support scaling up of nutrition-specific and nutrition sensitive programmes.
- Providing the best guidance available to support programme design, implementation, monitoring and evaluation.
- Increasing innovation in nutrition programmes.
- Knowledge-sharing to ensure lessons are learnt across DFID and beyond.

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About this publication

This report was produced by Shehla Zaidi, Zulfiqar Bhutta, Rozina Mistry, Gul Nawaz, and Noorya Hayat of the Division of Women & Child Health, Aga Khan University; and by Shandana Mohmand and A. Mejia Acosta of the Institute of Development Studies, through the Department for International Development (DFID)-funded Maximising the Quality of Scaling up Nutrition Programmes (MQSUN) project.

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ACRONYMS

ACS	Additional Chief Secretary
AusAID	Australian Government's Overseas Aid Program
BISP	Benazir Income Support Programme
CMAM	Community Based Management of Acute Malnutrition
CPI	Consumer Price Index
CSOs	Community support organizations
DFID	United Kingdom Department for International Development
DoE	Department of Education (provincial)
DoH	Department of Health (provincial)
DRGO	Distribution of Revenues and Grants-in-Aid Order
EPI	Expanded Programme on Immunization (World Health Organization)
FAO	Food and Agriculture Organization
GDP	Gross domestic product
INGO	International non-governmental organisation
KPK	Khyber Pakhtunkhwa Province
LHW	Lady Health Worker programme
MDG	Millennium Development Goal(s)
MI	Micronutrient Initiative
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, Neonatal, and Child Health programme
MoH	Ministry of Health
MPI	Multidimensional poverty index
NDMA	National Disaster Management Authority
NFC	National Finance Commission
NNS	National Nutrition Survey
NPC	National Planning Commission
P&DD	Planning and Development Department (provincial)
PC-1	Project Cycle 1
PDHS	Pakistan Demographic Health Survey
PDMA	Provincial Disaster Management Authority
PHE	Public Health Engineering (sector)
PML-N	Pakistan Muslim League (Nawaz)
PPHI	President Primary Health Care Initiative
PPP	Pakistan Peoples Party
PSDP	Public Sector Development Program
Rs.	Pakistani Rupees
UN	United Nations
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHO	World Health Organization

1. INTRODUCTION

Despite promising improvement, Pakistan has one of the highest rates of under-five mortality in South Asia. Data from 1990 to 2010 show that in the 1990s, Pakistan, India, and Myanmar had the same under-five mortality rate; rates in Bangladesh and Nepal were higher. All of these countries improved their rates in the following decade. By 2010, all had drastically lowered their under-five mortality rates and are now on track to achieve their Millennium Development Goals (MDGs).

In the Sindh Province of Pakistan, under-nutrition remains a recognized health problem and plays a substantial role in the region's elevated maternal and child morbidity and mortality rates. The devastating burden of under-nutrition has lifelong negative consequences, including stunted growth and impaired cognitive development. These can permanently disable a child's potential to become a productive adult.

In April 2010 the parliament of Pakistan passed the 18th Amendment, which devolved 17 ministries, including the Ministries of Agriculture, Education, Food, and Health, from the centre to the provinces. This was the first time that such power was given to the provinces. Past decentralization reforms had generally bypassed the provincial tier by decentralizing administrative responsibility for most social services directly to the sub-provincial district level.

At the same time, there were significant changes in funding modalities. Although the 2010 devolution shifted financing responsibility for devolved ministries to provincial governments, provincial funding allocations also increased substantially as a result of the seventh National Finance Commission (NFC) Award of 2010. In Pakistan, the financial status of provincial governments is dependent on federal transfers of tax revenues to the provinces through NFC Awards. The 2010 NFC Award was significant because it increased the provincial share of resources to 56%. It also introduced a more equitable distribution formula, which benefitted smaller provinces by changing the calculation of the award from a population-based model to a new model that also factored in economic backwardness, inverse population density, and revenue collection and generation (Social Policy and Development Centre [SPDC], 2011).

In this report we take a look at strategic opportunities and barriers for action on under-nutrition, particularly for women and children in Sindh Province in the post-devolution context. We will assess underlying contextual challenges pertaining to nutrition, horizontal coordination for nutrition across sectors, vertical integration of existing and past nutrition initiatives, funding, and monitoring and evaluation, and identify several emerging strategic opportunities. Finally, we will summarize salient findings and provide broad recommendations for further action in the province.

2. METHODOLOGY

We applied a nutrition governance framework (Acosta & Fanzo, 2012) to research and analyse the provincial experience with nutrition policy in Pakistan, looking both at chronic and acute malnutrition. This framework is focused on the capabilities of relevant stakeholders and the broad parameters of the existing institutions and policy frameworks in which they operate. It focuses in particular on (a) cooperation between different stakeholders in the design, formulation, and implementation of nutrition policy; (b) the extent of integration between policy formulation and implementation at different levels of government; and (c) the extent to which this cooperation and integration is held together by adequate funding mechanisms. It is supplemented by a policy analysis model which cyclically links the process, actors, context, and content of nutrition initiatives at the design and implementation levels (Walt & Gilson, 1994).

We applied qualitative research methods that combined 31 in-depth interviews with stakeholders from the provincial departments of Agriculture, Education, Food, Health, Planning and Development, and Public Health Engineering (PHE); nutrition experts; media; politicians; and development partners involved in Sindh. Three focus group discussions were held with civil society organizations and private food processors. We supplemented these interviews with a document review of published and grey literature. Consultative provincial roundtables were held to validate and supplement the findings of the document review and interviews. These roundtables were attended by 26 participants from different sectors and chaired by the Pakistan Peoples Party (PPP) representative and the Planning & Development Department (P&DD). The number of interviews representative of the nutrition community and triangulation with other methods was sufficient to make valid inferences.

Nutrition Status in Sindh: Under-nutrition levels in Sindh are marginally higher than national averages (Table 1). Around 40% of children in Sindh are underweight. Nearly two thirds of mothers and children in Sindh are anaemic, and nearly half the mothers and children in the province have vitamin A deficiency. These numbers also reflect long-standing under-nutrition in the region, as evidenced by the fact that in 2011, 49% of the population had stunted development, or ‘stunting’.

Table 1: Under-nutrition status in Sindh, 2011 (% of population surveyed)

Under-Nutrition Status	Sindh	Pakistan
Child malnutrition		
Underweight (severe + moderate)	40.5	31.5
Stunted (severe + moderate)	49.8	43.7
Wasted (severe + moderate)	17.5	15.1
Child micronutrient deficiencies		
Vitamin A deficiency*	53.3	54.0
Anaemia	73.0	62.0
Zinc deficiency**	38.6	39.2
Maternal micronutrient deficiencies		
Vitamin A deficiency – Pregnant mothers	46.7	46.0
Anaemia – Pregnant mothers	62.0	51.0
Zinc deficiency – Pregnant mothers	44.5	47.6

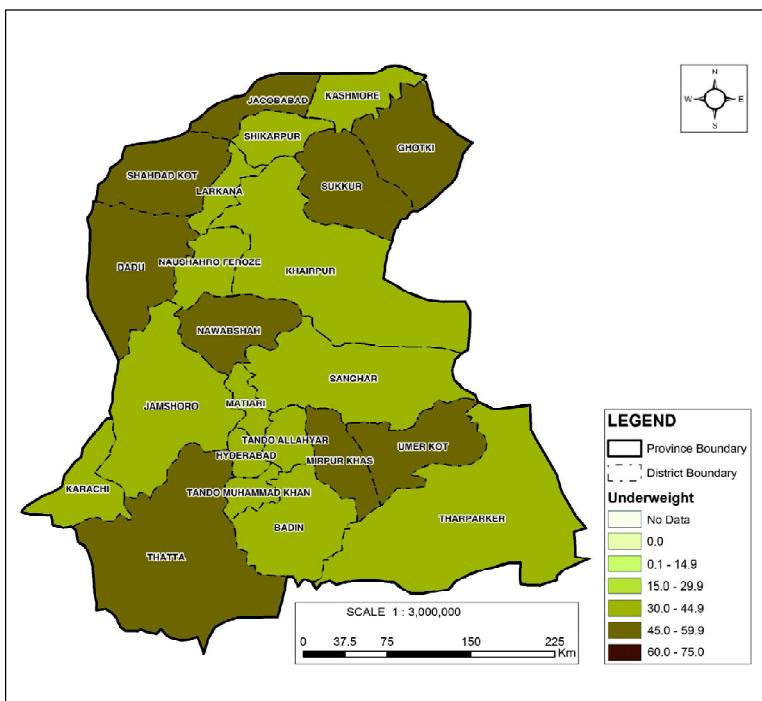
Source: NNS, 2011

* Biomarker used: Serum retinol levels

** Serum zinc levels

Sindh shows marginally higher figures for under-nutrition in comparison to other provinces, and this is evident at a regional level as well: western Sindh shows the districts with the highest prevalence of under-nutrition (Figure 1). Child under-nutrition levels go up to 75% (National Nutrition Survey [NNS], 2011) in districts within the province as compared to a provincial total of 40.5%.

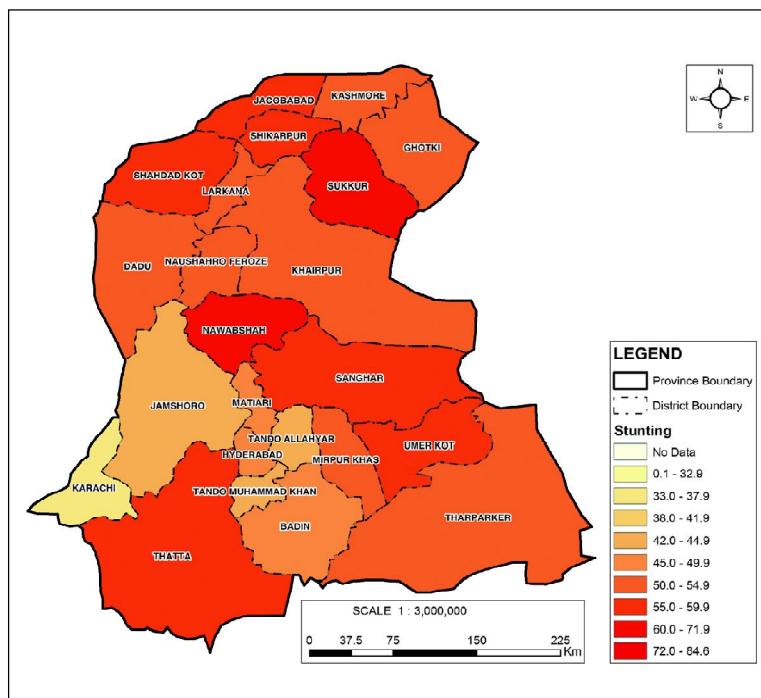
Figure 1: Underweight differentials in Sindh, 2011



Source: NNS, 2011 (Unadjusted)

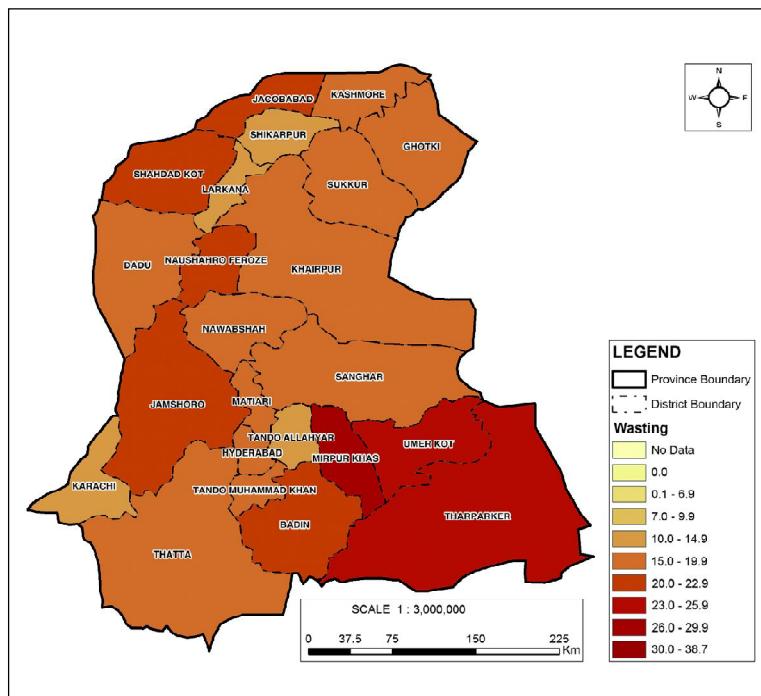
Broadly comparable trends are also seen with prevalence of stunting and wasting in southern areas of the province (Figures 2 and 3).

Figure 2: Stunting differentials in Sindh, 2011



Source: NNS, 2011 (Unadjusted)

Figure 3: Wasting differentials in Sindh, 2011

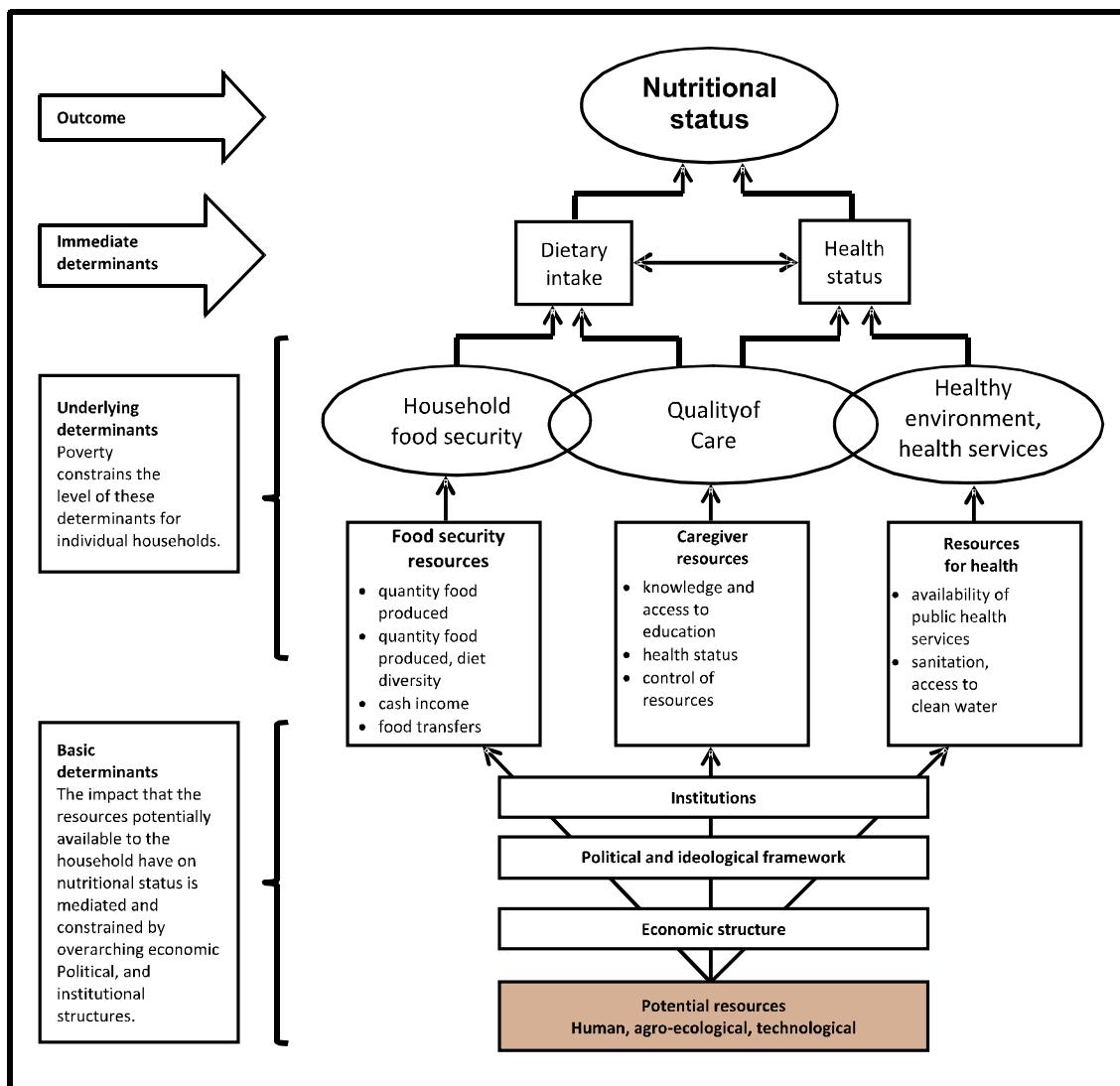


Source: NNS, 2011 (Unadjusted)

3. UNDERLYING FACTORS CONTRIBUTING TO NUTRITION STATUS

It is important to understand the causal pathway for nutrition in order to identify provincial resources, or lack of resources, for control of under-nutrition (Figure 4). Nutrition is linked to household food security, a healthy environment, health status, and care giver resources. Persistent poverty and natural disasters constrain access to all of these factors. Overarching institutional, political, and economic structures also facilitate or constrain access. Underlying factors that contribute to under-nutrition in Sindh are dealt with in detail below.

Figure 4: Causal pathway of under-nutrition



Sources: UNICEF, 1990; Benson & Shekar, 2006

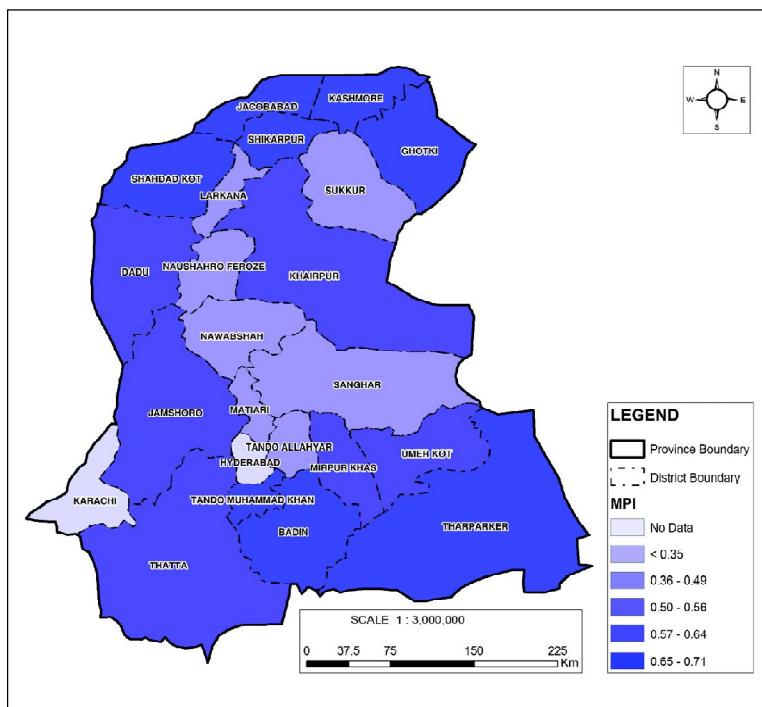
4. PROVINCIAL CONTEXT FOR UNDER-NUTRITION

Poverty and Its Various Dimensions: Pakistan's economic productivity has been decreasing since the 1980s in a spiral that has been particularly marked since 2005. Gross domestic product (GDP) has averaged around 3% each year since 2005; the national GDP in 2012 was 3.7% (PES, 2011–2012). Even in times of better productivity, trickle-down of GDP benefits to the poor is questionable, and recession further compounds poverty. In parallel to national poverty at 33%, Sindh shows a similar poverty rate at 31% province-wide and 23% in cities, although the rate is disproportionately high in small towns (40%) followed by rural areas (38%) (SPDC, 2004). Poverty in Sindh is highest in the population lacking land ownership (58.6%) and drops by 16.9% with land ownership (41.7%) (PIDE, 2001). The district gap in poverty is reflected through the percentage of the population in possession of at least three major household items, which ranges from 16% to 90% in the urban centre of Karachi (MICS, 2003–2004). Similarly, access to basic utilities like electricity and gas and adequate housing is lowest in rural areas and highest in urban cities.

We estimated the multidimensional poverty index (MPI)* for various districts of Sindh based on input variables reflecting an array of health, social sector, and environmental indicators. This included education, schooling, child deaths in the last three years, and underweight children (less than -2 SD). We also used standard of living measures, such as the availability of electricity, clean drinking water, sanitation, cooking fuel, flooring, and household assets. Figure 5 displays the MPI for various districts in Sindh and highlights the significant differences that exist.

* MPI is calculated by multiplying the percentage of people who are MPI poor (incidence of poverty) with the average intensity of MPI poverty across the poor (%).

Figure 5: Multidimensional poverty index by district in Sindh, 2011



Source: NNS, 2011

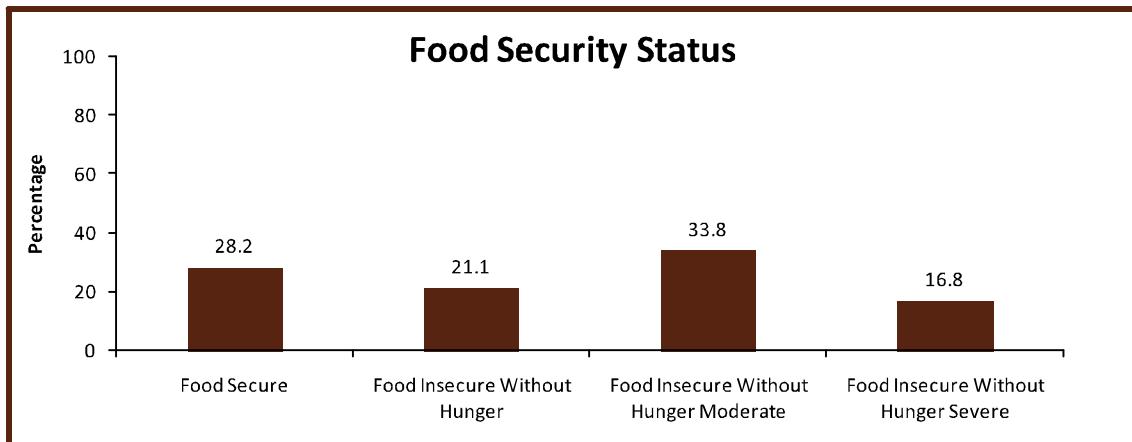
These issues of poverty have clear links to gender and place a disproportionate burden on women, as discussed further below.

Food Security and Resources: The term ‘food security’ originated in international development literature in the 1960s and 1970s, and came into more prominent use after global oil and food crises between 1972 and 1974. African famines, and the subsequent growth of food supplementation programmes to displaced and conflict-affected populations, have also led to a rapid increase in the literature on food security. Our literature review revealed that currently there are more than 200 definitions and 450 indicators of food security. The concept of food security has emerged and expanded over time to integrate a wide range of food-related issues and to more completely reflect the complexity of the role of food in human society (Cook, 2006). The Rome declaration on World Food Security in 1996 defined food security as a situation where ‘All people at all times have physical and economic access to sufficient, safe, and nutritious foods to meet their dietary needs and food preferences for an active healthy life’ (World Food Summit, 1996). It is recognized that the converse, the experience of household food insecurity, can have several dimensions. Notably:

- Quantitative (not having enough food).
- Qualitative (reliance on inexpensive non-nutritious foods).
- Psychological (anxiety about food supply or stress associated with trying to meet daily food needs).
- Social (having to acquire food through socially unacceptable means such as charitable assistance, buying food on credit, and in some cases, stealing) (Cook, 2006).

Current screening systems for food security and insecurity at the household level are based on an assessment of the availability of food and its stable supply in relation to the basic human instinct of hunger. Although this ought to ideally reflect observed food resources and consumption patterns over time, this is not practical, and standardized instruments are used to assess household-level perceptions of food security. The NNS 2011 survey also estimated household-level food security using a standard questionnaire approved by the World Food Programme (WFP). At the national level, almost 30% of households reported experiencing a period of moderate to severe hunger. The comparable figure for Sindh was higher than other provinces and is reflected in Figure 6.

Figure 6: Food security perceptions in Sindh, 2011 (% respondents)



Source: NNS, 2011

Sindh has the second most agriculturally productive land in the country, but at the same time 50% of households are food insecure with moderate to severe hunger (NNS, 2011). The major income source in Sindh is through wages and salaries, especially in the urban areas. Agriculture is another key sector of the provincial economy with 27.3% of the land being agriculturally productive (FBS, 2009–2010). Of the rural population, 30.6% are employed in agriculture (HIES, 2010–2011). This is related to inequitable land distribution and high levels of poverty, especially in rural Sindh (Table 2), as well as vulnerability to disasters and political instability.

Table 2: Food security resources and poverty in Pakistani provinces, 2009–2011 (% population)

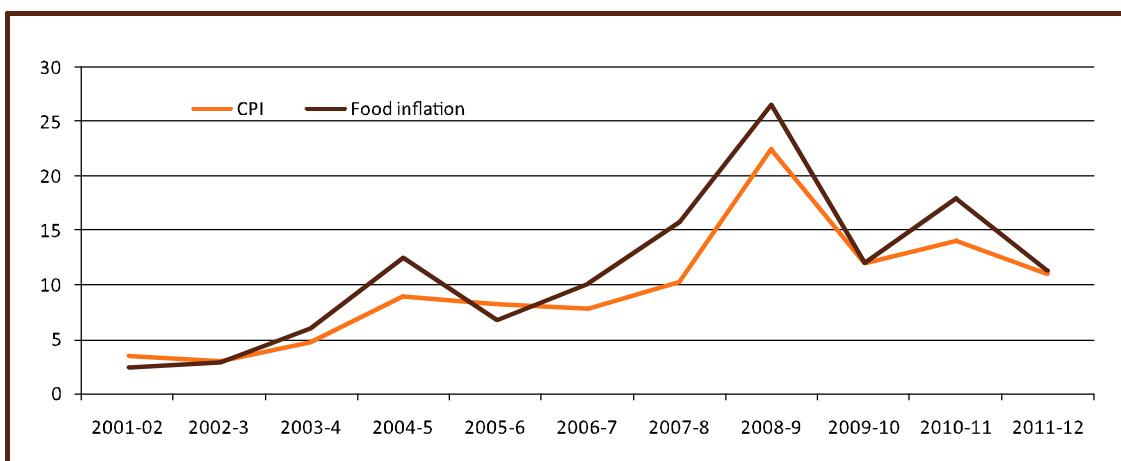
	Sindh	Punjab	KPK*	Baluchistan	Pakistan
Food secure ¹	28.2	40.5	68.5	36.5	42.0
Food insecure ¹					
- Without hunger	21.1	32.2	21.0	33.9	28.4
- With moderate hunger	33.8	18.5	6.0	18.0	19.8
- With severe hunger	16.8	8.8	4.5	11.5	9.8
Agriculturally productive land ²	27.3	83.0	16.5	3.0	30.0
Poverty incidence ³	31.0	26.0	29.0	48.0	33.0
	Rural areas (38.0)	Rural areas (24.0)	Rural areas (27.0)	Rural areas (51.0)	Rural areas (35.0)
	Small towns (40.0)	Small towns (43.0)	Small towns (41.0)	Small towns (44.0)	Urban areas (30.0)
Poverty incidence ³					
- No land ownership	41.3	26.0	32.0	52.5	31.8
- Land ownership	20.9	12.3	19.5	42.6	17.9

* Khyber Pakhtunkhwa

Sources: (1) NNS, 2011. (2) FBS, 2009–2010. (3) SPDC, 2011.

Between 2001 and 2012, the slowdown and stagnation of Pakistan's economy, a fall in GDP, and severe price hikes on essential food items (from 32% to 74%) after 2008 (National Planning Commission [NPC], 2009) placed an increased burden on already-stretched household food budgets. Figure 7 displays changes in annual inflation and the consumer price index in Sindh during roughly the last decade.

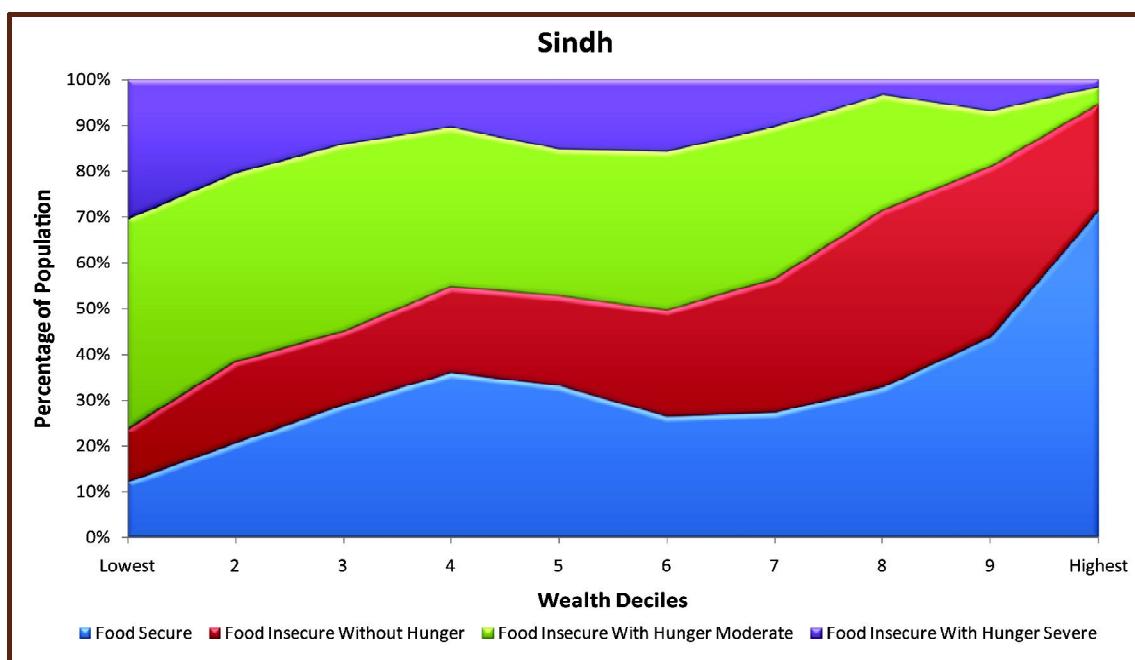
Figure 7: Annual inflation and consumer price index (CPI) changes in Sindh, 2001–2012



Source: Pakistan Economic Surveys, 2001–2012

In addition, and as indicated above, social factors and gender inequities can influence intra-household food distribution and maternal nutrition status. The association of food insecurity with poverty as assessed by wealth indices also shows a close correlation between the two measures for Sindh (Figure 8). Data suggest that both poverty and food insecurity operate in Sindh and that a significant proportion of the poorest quintiles of the population experience food insecurity.

Figure 8: Association between food insecurity and poverty in Sindh, 2011



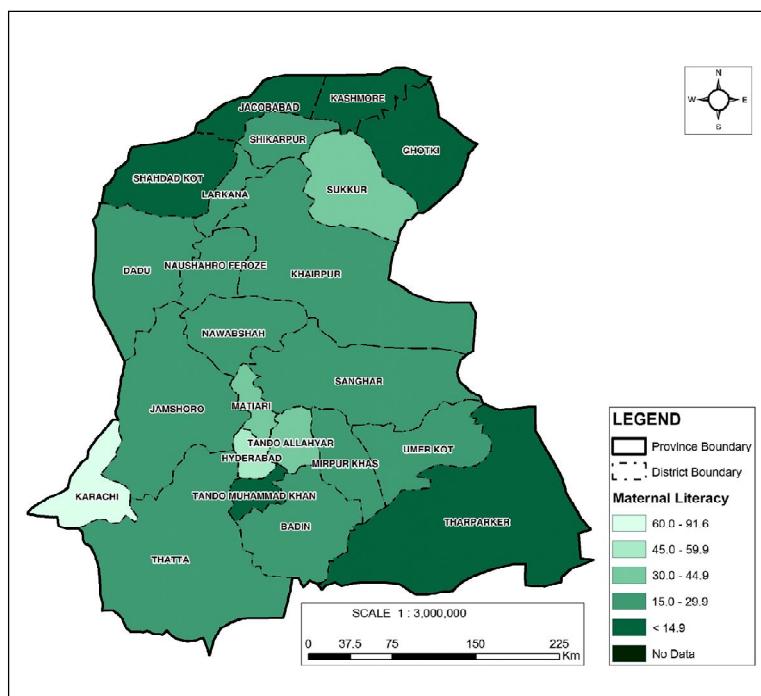
Source: NNS, 2011

Care Giver Resources: Maternal and child under-nutrition is driven by a number of development-related factors, including household food security and underlying poverty; the female care giver's education, awareness, and autonomy; and access to key social sector services. Maternal education is an important covariate of under-nutrition: There is evidence that child severe and moderate stunting rates fall drastically when a mother's education is above matriculation level (NNS, 2011). Gender disparities in education, economic independence, and decision-making power affect nutrition levels. This is especially true of care giver mothers and the female children within their households. The literacy rate for females in Sindh is 46% compared to 71% for males, and the district disparities in female literacy range from 16% to 69% across the province (NNS, 2011). In short, only half of the women in Sindh are literate; this translates directly into the number of educated mothers. Without being able to read, they have little access to educational materials and are not aware of dietary and feeding practices to improve health and nutrition for themselves and their children.

Women's autonomy is weak in Sindh, as in the rest of the country, with unemployment rates for females (6.8%) higher than males (4.7%) (FBS, 2010–2011). Sindh has one of the lowest levels of female economic autonomy in the country with only 5–6% of women having bank accounts and 40–41% of women allowed to work for a livelihood (United States Agency for International Development, 2012). Gender inequality is particularly apparent in the traditional intra-household set-up, as men have the decision-making power within households and are also served first during meals (NNS, 2011). It can be further inferred that men have more access to food, and especially nutritious food like dairy products, meat, and high quality wheat, compared to the women in the household. Intra-household and gender division of food and labour is often masked in overall food-secure households as well.

For maternal education, the differentials (Figure 9) are clearly seen to be similar to in the principal components of MPI (Figure 5), with striking district variation.

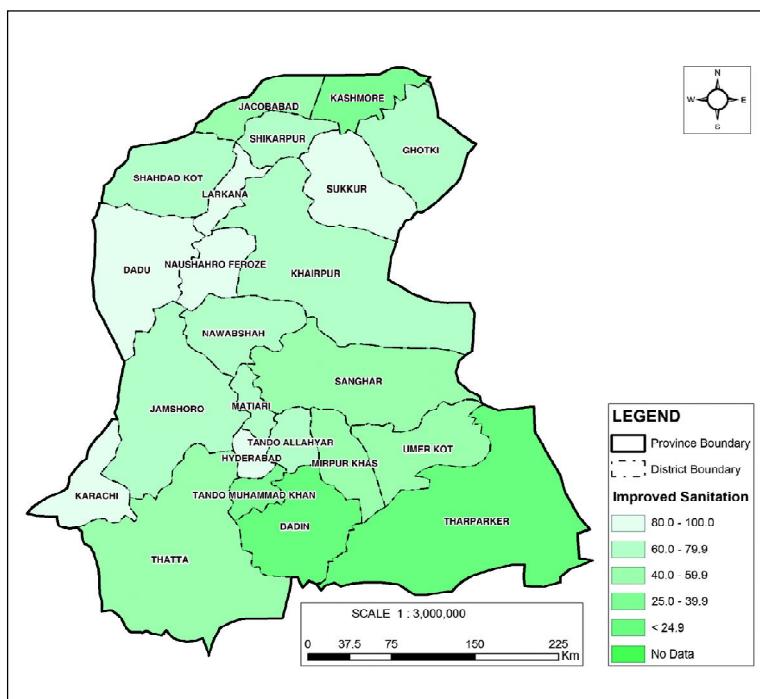
Figure 9: Maternal education differentials in Sindh, 2011



Source: NNS, 2011

Healthy Environment: A lack of safe water, and poor sanitation, are key contributors to under-nutrition. Both lead to a chronic cycle of illness and under-nutrition, and infants and young children are particularly susceptible. Sindh has slightly better levels of safe water usage by household (89%) as compared to the national level (87%), while in contrast, use of hygienic sanitation facilities is slightly lower (62%) than national use (66%) (FBS, 2010–2011). However these figures mask significant inter-district variation in access to safe water and sanitation as illustrated in Figure 10.

Figure 10: Improved sanitation differentials in Sindh, 2011



Source: NNS, 2011

Access to Key Health and Social Sector Services: Sindh is the second largest province by population with a high population density of 216 people per square kilometre compared to a national average of 166 people per square kilometre (Sindh HSS Report, 2011). As of mid-2011, the province's population was estimated at 43 million and the urbanization rate at 44%, although there were district disparities, with sparse population in the districts of Sukkur, Larkana, Hyderabad, and Karachi.

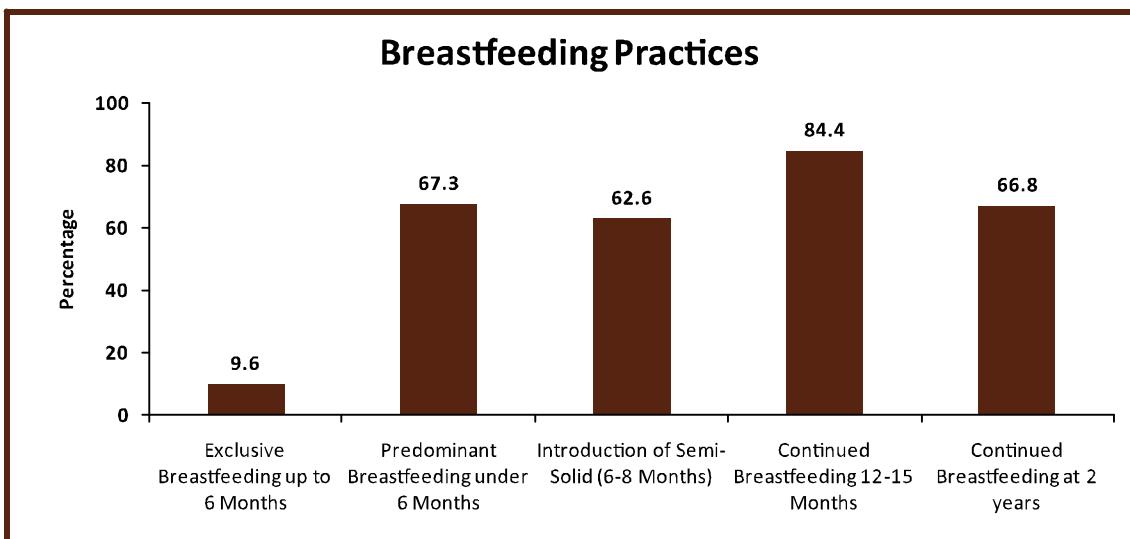
Coverage and access to essential preventive and curative medical services is not equal between groups and geographic regions. This lack of uniform access presents a major barrier to safe health and nutrition in the province. Table 3 indicates the median coverage for various interventions with coverage rates for various districts of Sindh.

Table 3: Coverage of health interventions across districts in Sindh, 2011 (% population)

Indicator	Prevalence	Range Across Districts
Improved sanitation	74.7	18.4–99.5
Maternal literacy (%)	37.8	6.3–70.1
Antenatal care by skilled attendant	56.6	20.4–89.3
Nutrition during last pregnancy		
Iron supplement intake	26.1	3.3–42
Folic acid intake	31.3	6.5–54.1
Child growth		
Stunting (< -2 SD)	49.8	37.3–66.1
Wasting (< -2 SD)	17.5	12.6–26.4
Underweight (< -2 SD)	40.5	31.3–54.0
Supplement intake (children under five years of age)		
Vitamin A	67.4	43.2–79.7
Zinc	2.8	0–7.3
Immunization status (children under five years of age, verified from vaccination card)		
BCG	19.0	0–48.2
Pentavalent	16.7	0–40.7
OPV	15.6	0–45.1
Measles	14.3	0–38.1
Initiation of breastfeeding (< 1 hour)	50.5	24–73.2
Colostrum given at birth	86.2	67.3–95.1

A key intervention to reduce child under-nutrition is continued breastfeeding. Low rates of exclusive breastfeeding in Sindh (Figure 11) reflect inadequate attention to community education and a lack of supportive strategies to facilitate exclusive breastfeeding.

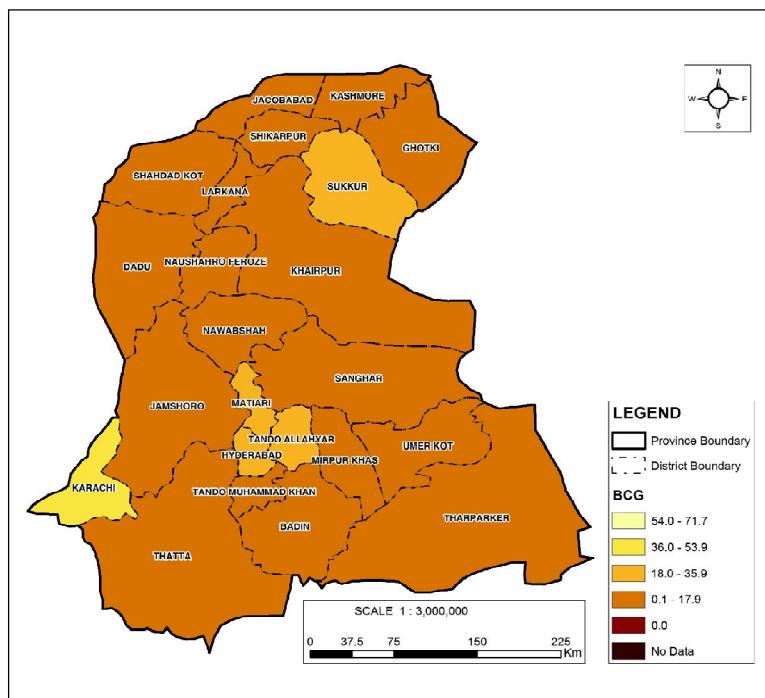
Figure 11: Breastfeeding practices in Sindh, 2011



Source: NNS, 2011

Childhood immunizations are a measure of promotive and preventive strategies in health systems. Figures 12 and 13 reflect the sub-provincial coverage of two vaccines, BCG and measles, based on verified data from the NNS 2011 survey.

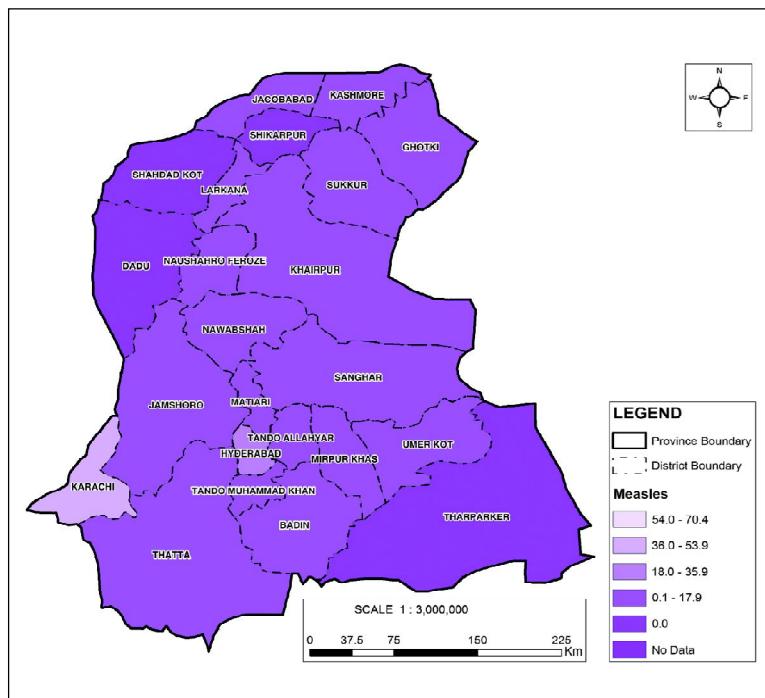
Figure 12: BCG vaccination at birth in Sindh, 2011



Note: Verified from immunization card.

Source: NNS, 2011

Figure 13: Measles vaccination (children under five years of age) in Sindh, 2011



Note: Verified from immunization card.

Source: NNS, 2011

Figure 14: Rates of maternal iron intake during last pregnancy in Sindh, 2011

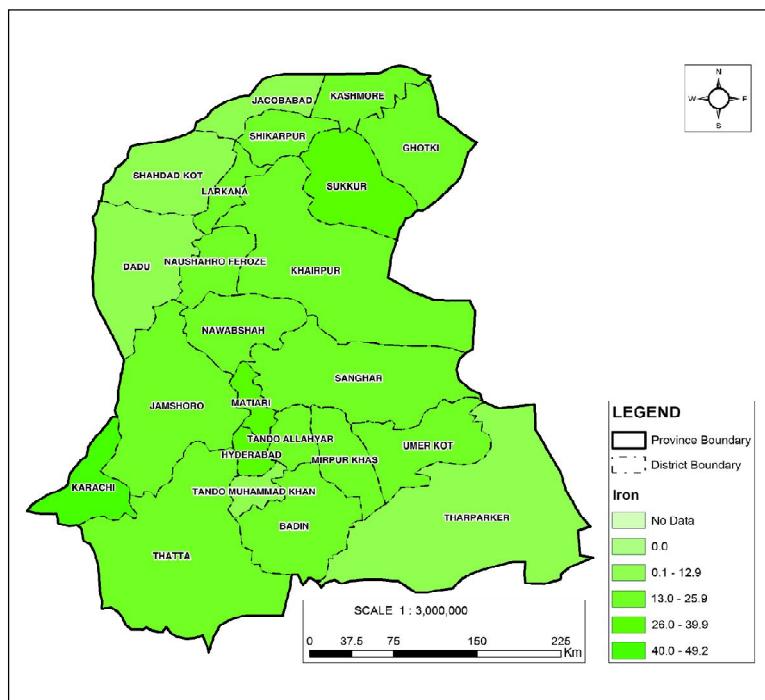
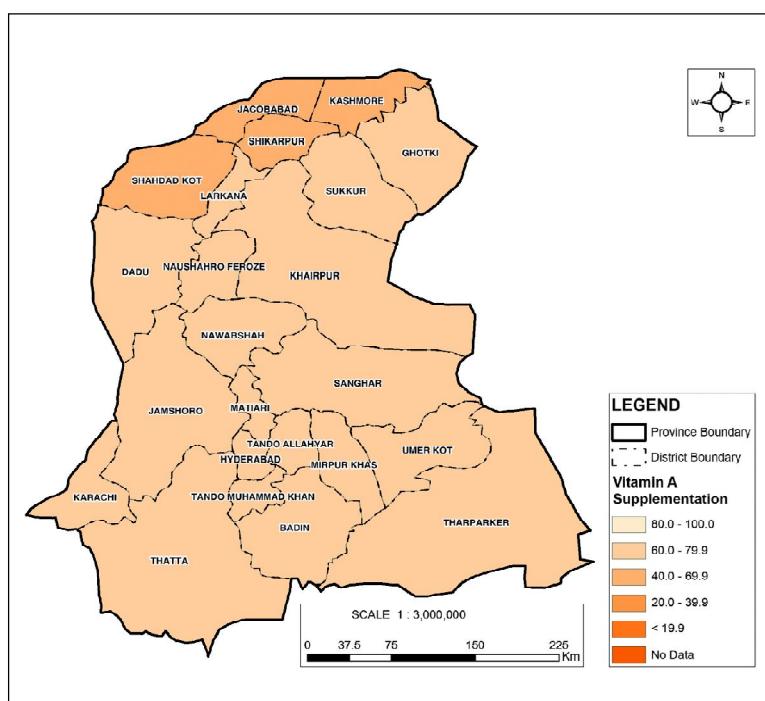


Figure 15: Child vitamin A supplementation (coverage) in Sindh, 2011



The issue of inequity in access and care in Sindh is notable, with differentials in health- and nutrition-related interventions across wealth quintiles (Table 4).

Table 4: Health and nutritional intervention coverage by wealth quintile in Sindh, 2011

Intervention	Wealth Quintile (% population covered)					Overall
	Poorest	Poor	Middle	Rich	Richest	
Antenatal care by skilled health worker (during last delivery)	35.0	53.1	72.1	86.2	96.3	56.6
Maternal iron folate supplements	11.2	20.4	29.3	39.3	45.5	26.1
Exclusive breastfeeding up to 4 months	27.9	20.2	23.7	18.5	20.9	23.5
Exclusive breastfeeding up to 6 months	12.4	9.0	4.8	6.2	9.6	9.4
BCG vaccination (card)	2.9	8.1	21.7	35.3	51.2	19.0
Measles vaccination (card)	2.1	5.1	15.5	26.7	41.0	14.3
Vitamin A supplementation	62.7	71.6	72.2	68.1	71.7	67.4

Source: NNS, 2011

Disaster: Sindh experienced the worst form of flash and monsoon floods over 2010 and 2011, and this has resulted in extensive damage to crops, services, and infrastructure together with slowing down of developmental and economic activity. The 2010 floods affected close to 7.2 million people in the province, and the 2011 floods affected 9.2 million people with the most damage to the sectors of Agriculture, Housing, and Infrastructure (PDMA website). These floods have resulted in food insecurity and disease outbreaks in affected districts, increasing vulnerability to under-nutrition.

5. POLICY STREAM FOR NUTRITION, UNDERSTANDING, OWNERSHIP, AND FUNDING

Mandate for Nutrition: In Pakistan, nutrition was institutionalized as a subject, rather than a sector, in the National Planning Commission (NPC) in 1970. This meant that nutrition efforts had to rely on multi-sectoral ownership and close linkages between sectors such as Agriculture, Education, Health, Social Protection, Water and Sanitation, and Women's Development. There was little movement towards nutrition until the 2000s. Although the NPC had a mandate to mainstream nutrition across different sectors, operationalization was based in the nutrition wing of the Ministry of Health in 2005. This meant that nutrition projects and operational plans were conceived as a subset of health, and remained confined to the Health sector.

Dominance of Food over Nutrition: Food distribution as a response to the issue of hunger is more visible across provinces than health-based interventions. Politicians at both the federal and provincial level have tended to pay more attention to food distribution than to nutrition, and food distribution continues to be a political priority at the federal and provincial level.

Emphasis from economists and policy planners, and strong support by politicians, has resulted in a number of federally led initiatives. The topic of hunger has been included in the slogan and manifesto of the federal ruling Pakistan Peoples Party since the 1970s, and food distribution schemes remain popular as a politically visible agenda item amongst politicians of different political parties. Federally driven food distribution schemes have included a card-based rationing system for the urban poor, which was later replaced by a wheat subsidy and distribution system designed to ensure that flour would be available at controlled prices to both the urban and rural poor. In the wake of the recent floods, distribution of food rations to flood victims through the Provincial Disaster Management Authority (PDMA) has been under way in Sindh, and it has continued beyond the flood recovery period with popular support from elected representatives. The PDMA assisted flood-affected districts for provision of food packs of 37kg each in the districts of Ghotki, Jacobabad, Kashmoor, Khairpur, Sukkur, Shehdadkot, Shikarpur and Qambar.

Another related initiative, part of the Benazir Income Support Programme (BISP), transfers cash to low-income women. It is being implemented in Sindh and has an extensive field outreach and database. A flagship programme of the PPP government, BISP is housed in the federal Cabinet Division, is financed entirely by federal funds, and has strong administrative and political support at both federal and provincial levels. A clear connection between cash transfers and improved nutrition has yet to be made, and because BISP is a federally led programme, discussion and design for such an evaluation are out of the purview of the province. Such a review or study has yet to be undertaken. Although there is openness amongst departments for cross-sectoral linkages with BISP, there are apprehensions about low support for conditionalities (introduction of linking cash transfers with nutrition intervention) with politicians.

Nutrition Initiatives – Content, Funding, and Stakeholders: In contrast to the state's leadership on hunger and food security, nutrition efforts have been implemented through fragmented initiatives, mostly in the form of short-term projects funded by United Nations (UN) agencies and bilateral funding through international non-governmental organisations (INGOs). This history shows a lack of strategic ownership by the state at all levels, as evidenced by the fact that projects are halted as soon as donor funds have dried up. These short-term projects also underline a lack of cohesive framework on under-nutrition. Under-nutrition has generally been a subset of health-related activities, and health activities themselves have often lacked a cohesive strategy, with emphasis over the years shifting from one set of activities to the other.

In Sindh, interventions have traditionally been led by UN agencies and positioned at the provincial Department of Health (DoH) and public sector teaching hospitals. A cursory outline of several key nutrition-related activities follows; Table 5 provides an additional overview.

- Baby Friendly Hospitals have been established to promote newborn breastfeeding in public sector hospitals, and ‘nutrition corners’ have been established at hospitals to provide nutrition related advice. Both of these initiatives were developed and executed with medical professors serving in public sector hospitals.
- There has also been a Safe Motherhood Initiative, supported by the WFP, involving edible oil distribution linked with pregnancy check-ups.
- More lately, in the wake of the floods, UN-supported nutrition initiatives have involved CMAM (Community Based Management of Acute Malnutrition) in the disaster-affected areas through health facilities managed both by district government and President Primary Health Care Initiative (PPhi). PPhi manages the contracted Basic Health Units PPhi, supplemented simultaneously by community-based nutrition screening and referrals through community support organizations (CSOs). INGOs such as Merlin and Save the Children have also been active in nutrition in the disaster areas.
- The DoH-supported main interventions are provided as part of the Lady Health Worker programme, the World Health Organization’s Expanded Programme on Immunization, and the Maternal, Neonatal, and Child Health Programme, and include vitamin A supplementation to children, de-worming in children, iron and folate provision to pregnant and lactating mothers, and breastfeeding counselling, but have had uneven performance due to reasons explored in later sections of this report.
- Salt iodization, though not focused specifically on pregnant and lactating women and children, was implemented in all districts of Sindh with training, equipment, and commodities provided by Micronutrient Initiative (MI), an INGO. The initiative was directed towards food processors in the private sector (MI, 2011).
- Due to low recognition for under-nutrition, government support for operational commodity costs has not been forthcoming, and this has led to supply breaks on tapering off of international agency funding. Wheat flour fortification has as yet not been implemented in Sindh.
- In Sindh there has also been interest in girl child school feeding, but there is debate over the type of commodity that should be used. Varying models of school feeding programs targeted at girls 6–11 years of age have been implemented in focal districts. These include the TAWANA Project, led by the Women’s Development Department and funded by Bait-ul-Mal, which was specifically targeted at nutrition through provision of locally prepared meals at girls schools managed by parent committees. The program also included dietary awareness education for mothers, and growth monitoring of students (TAWANA Report, 2006).

- After the Bait-ul-Mal programme was discontinued midway through implementation, operational pilot feeding programs funded by the WFP were implemented through the Education Department. These programs provided edible oil and high-energy biscuits to female schoolchildren. The Department used different food commodities including the milk and cookies pilot by USAID and edible oil and high-energy biscuits pilot by the WFP. These have been redesigned and funded by the Education Department for up-scaling with provision of edible oil and milk powder to girl school children in 500 schools in five districts. However, the initiative is mainly positioned to increase school enrolment with lesser value for under-nutrition control, as discussed in later sections. Table 5 further outlines key nutrition-related activities in Sindh.

Table 5: Nutrition interventions in Sindh

Activity (On-going and Completed) and Responsible Organisations	Planned
Breastfeeding <i>DoH</i>	Infant and child feeding practices
Vitamin A (with polio campaign) <i>DoH</i>	Vitamin A (with polio)
Iron and folate to pregnant mothers <i>DoH</i>	Zinc supplementation LHWs
Sprinkles: Pilot district <i>MI/DoH</i>	CMAM
Community Based Management of Acute Malnutrition : Disaster districts <i>UNICEF, WHO, WFP, INGOs, DoH, PPHI</i>	Micronutrient powders/Sprinkles
Salt iodization <i>MI/Private sector/DoH</i>	Iron and folate to adolescent girls: 6 districts
School feeding <i>WFP/DoE</i>	De-worming pilot for adolescent girls
	Awareness and communication

Source: PC-1 Sindh, 2012–2015

6. FOCUSING EVENTS FOR NUTRITION

A number of recent events have highlighted the nutrition policy agenda. The flash floods of 2010 and 2011 instigated a coordinated development partner response in affected areas of all four provinces. Mother and child under-nutrition in affected areas was visibly highlighted to stakeholders during the course of recovery efforts, and a Pakistan Integrated Nutrition Strategy was formed at the federal level, spearheaded by UNICEF (Pakistan Integrated Nutrition Survey, 2011). The release of the National Nutrition Survey data in early 2012, backed with unusual media publicity, further shot under-nutrition into policy prominence. It sparked a call for action backed by researchers, media, and development partners. Media activism in Pakistan has seen unprecedented growth over the last decade, and the provision of statistics that showed little progress (and in some cases even decline) was important in capturing media attention. Lastly, the provincial devolution of 2011 provided development partners an easier direct engagement process with implementers, sidestepping the centralized and slower planning processes.

Nutrition hence became a new public policy agenda, spearheaded by development partners in all provinces. However, uptake and ownership by government is slow and questionable, as will be discussed below.

Recent Profiling of Nutrition: The recent move towards nutrition, led by international donors, is positioned towards cross-sectoral action on nutrition in contrast to past initiatives mainly operationalized within the Health sector. This nascent move has gained momentum in the post-devolution period and involves the provincial Planning & Development Department (P&DD) as the focal point for coordinated action. Pressure by development partners has also resulted in the establishment of provincial Inter-Sectoral Nutrition Committees headed by the P&DD.

Within the provincial departments, the Department of Health has been the most visible in defining a five-year strategy for nutrition, particularly targeted at women and children, to be implemented at an approximate cost of Rs.5 billion. It will be supported mainly by development partners (led by the World Bank) with lesser share from the provincial DoH. However, this is a recent move instigated with development partner support and funding, and its sustainability is as yet uncertain. The section below discusses some of the events behind this instigation of cross-sectoral nutrition planning.

7. HORIZONTAL COORDINATION FOR CROSS-SECTORAL ACTION

Structural Challenges of Devolution – Housing of Nutrition and Executive Leadership:

Before devolution, the National Planning Commission was mandated to provide the lead for nutrition policy and strategy. Although the NPC had made little movement on nutrition over the years, this structure had the advantage of vertical leverage across the provinces.

In 2011, nutrition as a subject was not devolved; however, many of the sectors required for mainstreaming nutrition have been devolved, including the Ministry of Health, which has been the focal point for nutrition-related projects over the years. Other devolved sectors include Agriculture, Education, Food, Social Protection, Water, and Women's Development.

Sindh, like the other provinces, is the lead driver of its social sector policy, and nutrition must now follow a ‘bottom up’ province-driven process of strategy formation. Feedback from provincial stakeholders shows that although devolution has increased the workload in Sindh, it has also provided space for strategic work tailored to the province’s specific needs. At the same time, devolution creates the need for a new ‘home’ for nutrition. Post-devolution, there is lack of a central authority for nutrition in Sindh to serve as the counterpart of the NPC.

This central authority is needed for two reasons. First, given that improving nutrition is an ambitious goal, a convening agent is needed to mainstream nutrition across different provincial sectors. Sindh’s provincial government departments maintain separate planning, management, and accountability functions. People from many of these sectors have pointed out that an inter-departmental gulf exists, created by a lack of time, by the fact that there is no mandate for coordination, and by the poor circulation of documents. The Health sector continues to be the principal active sector for nutrition projects. Basing database and monitoring for nutrition within the Health sector provides further traction towards the sector. There is apprehension; however, that concentrating inter-sectoral authority in one specific sector will make other sectors less keen to buy in to nutrition efforts. Hence, there is popular demand from sectors in Sindh for the P&DD to have a central role, with nutrition placed under the Additional Chief Secretary.

Second, although several sectors have been devolved to the provinces, others are retained at the federal level, raising challenges for horizontal coordination. These include important vertical structures such as the BISP, the National Disaster Management Authority (NDMA), and the recently created Ministry of Food Security and Research. This means that the provinces, including Sindh, have to not only coordinate nutrition policy within their own departments but also negotiate and coordinate with federal counterparts. A strong structural home and accompanying leadership capacity is required for wider coordination and to work out administrative implications.

With the exception of the provincial Health sector, no focal person (or role) for nutrition or a nutrition unit has been identified or created within key provincial departments. There is acceptance for loose coalition towards inter-sectoral action under the P&DD’s leadership, which would rely on sector-specific strategies and independent budgetary lines. There is low buy-in by government departments for joint funding; this is driven by ‘turf’ issues over funding control. At the P&DD Sindh there is similar reluctance towards centralized initiatives given past experience of collective failure in Social Action Programme, apprehensions of increasingly poor governance within sectors, and reluctance to take the blame for non-performance or for the lack of clear direction from political leadership – direction which will be necessary given the complexity of the agenda.

Hence existing momentum in Sindh is towards a loose coalition of sectors, which impedes the construction of a strong central structure for nutrition. A P&DD notification dated November 2012 has constituted a provincial Multi-Sectoral Committee for Nutrition headed by the Additional Chief Secretary. It includes representatives from the Agriculture, Education, Food, Health, Industries, Local Government & Rural Development, Public Health Engineering, Social Welfare & Women's Development sectors, as well as a co-opted member from UN donors. This committee is supported by a Technical Working Group on nutrition comprising focal persons from relevant sectors.

Discourse on Nutrition: In Sindh there is consensus within the key sectors that under-nutrition has suffered from low priority attention and needs more concerted action. The need for connections between sectors for tackling under-nutrition is recognized by provincial stakeholders, but there is a relative disconnect in terms of the main thrust of responses. Unemployment, poverty, rising food prices, and uncontrolled population growth emerge as dominant issues in the discourse around nutrition and are commonly recognized by all stakeholders, including the public sector, media, NGOs, and philanthropic foundations. The DoH, the main provincial entity that has focused on nutrition projects in the past, emphasizes insufficient funding and low priority for preventive health programs as major constraints. Within the DoH there is less buy-in for expensive imported commodities for malnutrition management. Additionally, health NGOs and experts highlight patriarchy and lack of community development as constraints on uptake of interventions by mothers and young children. Another sub-set of actors involving Agriculture, Food, CSOs involved with farmers, philanthropic interventions around food, and poverty alleviation schemes highlight poverty reduction, food security, and food safety as the main interventions to be targeted.

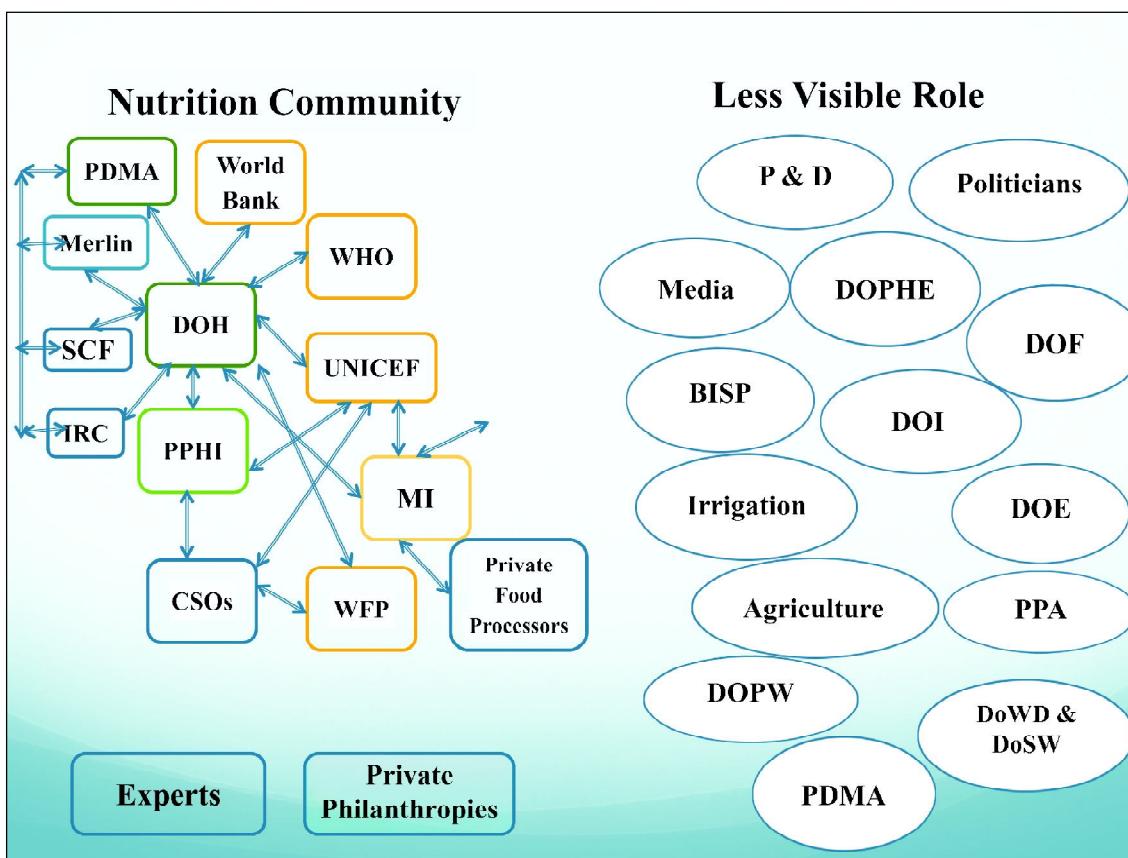
There is a consensus that there has been lack of delivery on mandates by respective provincial sectors. There is also common recognition that nutrition, due to its reliance on multiple sectors, will be extremely challenging to implement in Sindh due to overall weak provincial governance. Lack of a development vision for MDGs, frequent transfer of department secretaries, placement of political appointees in key development posts, and weak coordination between province and districts on implementation of development schemes are some of the main governance-related impediments. Political championing is felt to be necessary for mainstreaming nutrition across sectors, but under-nutrition has yet to be well advocated to politicians. Law and order issues in Sindh will continue to occupy the attention of the provincial media and politicians, resulting in less policy space for development issues.

Nutrition Coalition for Cross-Sectoral Action: The nutrition community at present comprises a loose coalition of stakeholders; some have made visible connections with nutrition, others have an important potential role that needs to be defined. Within the provincial departments, Health has most visibly defined its role around nutrition, which is focused on employing preventive health strategies targeted towards women and children. However, this is a recent move, instigated with support and funding from development partners, and its sustainability is uncertain. Other sectors have only recently been drawn into the loose nutrition coalition, and role definitions are still emerging under the dialogue started by the P&DD. In the post-devolution scenario, donors have emerged as a harmonized community that closely coordinates respective inputs for under-nutrition but stops short of pooled funding. Development partners providing technical support in Sindh include long-standing partners such as UNICEF, WFP, WHO, and MI as well as new entrants such as the World Bank, which is providing a soft loan for province-wide activities.

Sindh's non-state sector is the most active amongst all provinces. A handful of nutrition experts in the medical community, from Sindh's public and private sector both have successfully promoted recognition of nutrition within the Sindh Paediatric Association and have mainstreamed nutrition within the work of local health-focused NGOs. A number of national NGOs based in Sindh have nutrition as part of their agenda; however there has been a lack of connection to mainstream government programs. In addition, a service provision mindset has detracted from provision of CSOs as watchdogs for monitoring. CSO experts have been the focal point of past UN-led nutrition projects and surveys in Sindh.

Another feature seen in Sindh is the emergence of private philanthropic foundations for feeding the poor, particularly in urban low-income areas. These foundations have emerged over the last four to five years in response to increasing poverty and hunger and demonstrate the growth of local coalitions around food, although children are not the explicitly targeted beneficiaries. Recent activity in flood-affected areas of the INGO sub-sector for nutrition provides additional experienced resources. And the province's government circles show greater acceptance of academia than in other provinces with the inclusion of professors in the Technical Working Group for Sindh's Multi-Sectoral Committee for Nutrition. However there is lesser acceptance of NGOs in Sindh, with apprehensions in both the public sector and the media about NGO accountability. Figure 16 shows a net map of actors involved in nutrition activities in Sindh.

Figure 16: Nutrition activities in Sindh



Source: PC-1 Sindh, 2012-2015; Sindh Stakeholder interviews

Past Experiences and Recent Opportunities: The history of food fortification demonstrates the way that nutrition schemes are dependent on horizontal coordination between different sectors. The addition of iodine to food (iodization), for example, included private food processors, the provincial Food and Health sectors, and development partners. However, iodization was operationalized within the Health sector, and the Food sector was more focused on wheat management, which led to the Food sector having a negligible role in field-monitoring processors and providing market quality assurance.

Another scheme, the TAWANA Project, had more successful horizontal cooperation but consequently faced challenges. The project, funded by Bait-ul-Mal, provided freshly prepared food and dietary education in girls' schools. Because it was housed in the Women's Development Department, it involved multiple sectors. The programmes ability to improve nutrition was lessened by turf-setting and low ownership at the district level, where the Education Department, rather than Women's Development, had a visible presence. This struggle was further compounded by slow financial releases (TAWANA Report, 2006). Subsequent school feeding schemes have been operationalized through the Education Department and have had better district ownership, but horizontal coordination with relevant sectors has been weak. These schemes have also lacked potentially useful connections with the Health sector (such as connections to child preventive health interventions) and with poverty alleviation schemes such as BISP (for targeting poor households).

While dealing with the floods in Sindh over the last three years, many stakeholders have had positive experiences with the 'integrated cluster approach' to inter-sectoral coordination. The preference within sectors is for a mechanism that allows for operational plans to be aligned whilst keeping budget lines independent.

8. VERTICAL INTEGRATION OF EXISTING NUTRITION INITIATIVES: GAPS BETWEEN DESIGN AND IMPLEMENTATION

In Sindh the full range of nutrition-related health measures are as yet not in place due to lack of sufficient recognition and commitment and inadequacy of funding, as discussed in previous sections. Amongst the main interventions are salt iodization, some preventive health measures through the LHW and frontline government health facilities, and provision of food commodities to girl children in schools. These interventions target different age groups and are not restricted to pregnant women and children under two years of age; hence they broaden the opportunity for cross-sectoral action.

Challenges: Sindh faces organizational challenges of insufficient access to services in focal areas and low accountability to province of both district government and private sector at all levels. Outreach is poor in certain disadvantaged districts, reflected in an LHW coverage rate of only 50% (Oxford Policy Management, 2009), and consequently low levels of preventive measures for under-nutrition (such as exclusive breastfeeding, hand washing, and birth spacing) are low (Table 6). Harder districts also face inadequate funding for travel and staff incentives for nutrition screening, awareness, and monitoring, as district budgeting follows an even-sized approach across all districts. In addition, all three nutrition interventions in place, including preventive health measures, food fortification, and school feeding, are constrained by lack of local community networks at the union council level. This has resulted from unequal power structures and low investment in community mobilization.

Table 6: Micronutrient supplementation, feeding practices, and malnutrition management in Sindh Province and Pakistan, 2006–2007 and 2011

Evidence-Based Intervention	Sindh (% population)	Pakistan (% population)
Exclusive breastfeeding up to 6 months ¹	10.0	13.0
Complementary feeding at 6–8 months ¹	63.2	51.8
Hand-washing with soap ¹	56.2	57.6
Contraceptive prevalence rate (modern method) ²	22.0	21.7
Vitamin A supplementation ³	83.7	79.1 (78 - 92)
De-worming ¹	71.6	77.0

Sources: (1) NNS, 2011. (2) NIPS, 2006–2007. (3) VAS Survey, 2011.

Effective health delivery in Sindh is impeded by silos created by vertical programming within the Health Department for the Expanded Programme on Immunization, MNCH, nutrition, and LHW. Despite the policy space provided by devolution, the province has made little progress in integration due to internal turf issues and lack of consensus. Meanwhile the lack of standardized nutrition services in the province's private health sector goes largely unregulated despite 78% of the population utilizing government health facilities (FBS, 2010–2011). Last, there are issues of district accountability and ownership for nutrition initiatives. The Local Government Ordinance of 2001 decreased districts' accountability to provincial departments, reducing vertical coordination between province and district for nutrition initiatives. Given the traditional emphasis on training district government officers in administration and security maintenance, district ownership of development services such as nutrition is variable and dependent on the individual.

Sindh also faces issues of low technical priority and capacity. Nutrition is dealt with by a single nutrition focal person at the provincial Health Directorate, unsupported by technical and administrative staff for effective planning and monitoring at either the provincial and district level. Moreover staff capacity at all tiers of the health care system is low for under-nutrition screening, management, and counselling. Nutrition training has not been integrated in medical and allied health sciences curriculum, nor are there funds for in-service trainings. Similarly, although a school feeding programme is under way, there is a lack of training and tools for under-nutrition monitoring in schools.

Political appointments within the public sector, such as LHW staff, health facility staff, and teachers, are pervasive in Sindh. There is a work culture of patronage and favours instigated by elected representatives, which are seen to improve chances of re-election. These result in low accountability and performance as well as demotivation of better performing staff at the district and sub-district level. There is also an ingrained practice of political appointments at the higher managerial level for control of resources, which increases the vulnerability of nutrition funding.

Opportunities: Post-devolution, the DoH, with development partner support, has expanded into a number of cost-effective nutrition interventions including infant and young child feeding, vitamin supplementation, management of acute malnutrition, food fortification, and household awareness-building. An Education Department initiative on food support to girl children is also under way but is less well positioned for nutrition due to design issues discussed below.

Examples of Some Successes and of Underperformance: The vitamin A supplementation effort has achieved some of the best results, providing 83% coverage (Table 6). This is due largely to effective horizontal coordination with the federally supported polio immunization programme and strong vertical coordination with provincial and local governments (VAS Survey, 2011). Salt iodization has performed less well in Sindh despite success stories in some of the other provinces, and only 52% of salt available in the province is iodized as compared to 69% nationally (NNS, 2011). Lack of subsidy support for food fortification has resulted in lapses by private processors, particularly when there are low checks by the state. Sindh is supported by the presence of supportive district legislation, and draft provincial legislation has been prepared. However, weak vertical coordination between province and district governments for enforcement in the more remote districts has undermined iodization. Market quality assurance of fortification is also weak due to low emphasis and rent seeking nexus. Similar issues are likely to affect the wheat flour fortification planned in the 2013/14 ADP for Sindh.

Folic acid and iron supplements to pregnant and lactating women have been affected by supply breaks as a result of inadequate funding. Community-based nutrition screening, an awareness and referrals child has not had sufficient focus and also faces outreach constraints in few districts. School feeding has relatively strong ownership and funding by Sindh Education Department but is constrained by design issues related to beneficiary age group, the focus on nutrition monitoring as opposed to school enrolment, and uncertainty regarding whether the commodities are consumed by the children themselves.

9. FUNDING: TYPE, ADEQUACY, AND MODALITIES

Traditional Funding Landscape: Nutrition-related initiatives have historically been dependent on development partner funding. Such initiatives require support for commodities, awareness-building, and monitoring. Donor funding in Sindh has traditionally involved support from UNICEF, WFP, and WHO to specific facilities and districts for CMAM, Infant and Young Child Feeding, Baby Friendly Hospitals, and school feeding, as well as small grant disbursement to CSOs for nutrition awareness and screening in the community. Bilaterals have supported INGOs in Sindh for nutrition-related initiatives in flood districts as well as for implementation of district-based pilots for food fortification. This funding has been small scale and involved overlapping initiatives. Funding for field activities is provided by WFP, UNICEF, and WHO to the Sindh DoH, while commodities are directly purchased by development partners. Within the PSDP (Public Sector Development Programme) there has been no funding separately earmarked for nutrition. However, staff and infrastructure for preventive health measures are provided federally through the LHW programme for community outreach, and are supported provincially for health facilities. Provincial budgetary provision has been extremely inadequate, supporting only a small unit for nutrition at the provincial level and no matching staff at the district level. Commodity support has been restricted to folic acid and iron to pregnant and lactating women, but has suffered from supply breaks, as in other provinces.

Recent Shifts in Donor Funding: Recent movement towards scoping nutrition within development planning in Sindh has been accompanied by some positive changes in donor funding. A faster and more efficient process of donor engagement in the Sindh provincial government post-devolution has paved the way for inflow of funds. Sindh also is the province with the least investment by development partners due to apprehensions over corruption and poor governance. Support for nutrition in Sindh is confined to a loan by the World Bank, with some support from UN agencies but lack of commitment from bilateral. Another visible departure is that substantive funds will now flow to the provincial government rather than being directly managed by international agencies as in the past.

Recent Shifts in Government Funding: There is less visible change in state funding despite increased fiscal space in Sindh. In the post-devolution scenario, funding for the social sector is not provided at the federal level. Rather, provinces are the main drivers and financiers of social sector initiatives. The financial status of provincial governments in Pakistan is dependent on federal transfers of tax revenues to the provinces, which are constituted through National Finance Commission Awards. The financial status of the four provinces has improved since the seventh NFC Award of 2010. The seventh NFC is historic for a number of reasons: (1) a consensus-based award was arrived at despite several inconclusive attempts in the past; (2) the provincial share of resources increased to 56%, which is a departure from the 1990s and 2000s, when the Federation had the major share of resources; and (3) the distribution formula has shifted from being population-based to taking into account both population and other factors, such as economic backwardness, inverse population density, and revenue collection and generation (SPDC, 2011). Sindh has benefited with Rs.207 billion in the budget of 2010–2011, involving an increase of Rs.45.9 billion over the previous 2006 Award as a result of the new distribution formula (Table 7).

Table 7: 2010 National Finance Commission (NFC) Awards and 2006 Distribution of Revenues and Grants-in-Aid Order (DRGO) amounts distributed to each province

	2010 NFC Award (Rs. millions)	2006 DGRO Award (Rs. millions)	Difference (Rs. millions)
Punjab	488,401	405,607	82,794
Sindh	233,445	187,502	45,943
Khyber Pukhtunkhwa	151,199	95,599	55,600
Baluchistan	89,060	38,410	50,650
Total	962,105	727,118	234,987

Source: SPDC, 2011

Translation into Nutrition Funding: Sindh as yet has not defined a development strategy for the post-devolution period, and in most sectors there is little change from previous policies. Nutrition spending continues to be low despite increased fiscal space as a result of the seventh NFC Award, mainly due to weak government priority. Health, the main sector in which nutrition has been operationalized, continues to receive a low proportionate share of Sindh's overall provincial expenditure (Table 8). Even within the Health sector, priorities are tilted towards more visible projects, and infrastructure dominates with hospital construction, upgrading, and running comprising more than two thirds of consolidated development and operational funding. The majority of operational expenditures are spent on staff salaries, leaving little room for the commodities and outreach activities required for nutrition programs

Table 8: Consolidated provincial and district health expenditure and overall expenditure in Sindh, 2008–2011

Financial Year	Health Expenditures (Rs. millions)	Total Provincial Expenditures (Rs. millions)	Health Expenditures as % of Total Provincial Expenditures
2008–09	10,864	235,987	5%
2009–10	14,556	288,398	5%
2010–11	16,877	383,267	4%
Provincial and district expenditures on health increased (+70%) from Rs.10.7b to Rs.18.2b over the last three years – the increase was mainly in employee-related costs.			
Provincial and district development expenditures on health remained static (+2%) from Rs.3.9b to Rs.4b over the last three years – taking inflation into account, there is a decline.			
77% of total consolidated health expenditures supported ‘General Hospital Services’ and 11% supported ‘Administration’.			

Source: TRF, 2012.

There is a planned increase in expenditures to support nutrition activities over three years in focal disadvantaged districts. This planned increase for nutrition is predominantly being funded through a World Bank–provided soft loan, with a matching contribution of only 20% by Sindh. Funding, as previously, is confined to development funds with a low chance of being taken up in the operational budget. There is already low support for financing the expensive imported commodities for malnutrition treatment. The establishment of a siloed project-funded Nutrition Programme in Sindh, as opposed to the integrated programs in KPK and Punjab, increases the fragility of the programme and the uncertainty of it continuing after withdrawal of donor funding.

There has been little move towards nutrition in sectors other than Health with the exception of food commodity distribution in Education. One reason is the lack of donors to support nutrition in other sectors, whereas in Health the process was sped along and incentivized due to donor support and advocacy. There is also uneven level of interest in nutrition within the different provincial departments, but a strong stewardship role of P&DD has not been seen. Public sector development funding priorities in Sindh, as in other provinces, are primarily shaped by the perspective of political representatives, and the low political visibility of nutrition compared to infrastructure-led projects hampers funding commitment by the state.

Funding Flow Preferences: Despite the flood responses of joint funding lines used by government departments and pooled funding placed by donors, in the case of nutrition both donors and government prefer a risk-neutral approach that allows for carefully coordinated operations but separated funds. Hence the financing landscape in Sindh, as in other provinces, supports loose coalitions rather than tight structural coordination. Within sectors there is generally lack of conclusive support for tying fund releases to performance targets as a means to ensure vertical coordination. A contributing reason is inexperience with these mechanisms and inadequate technical capacity for roll out.

10. MONITORING AND COMMUNICATION

For monitoring, regulation, and evaluation of nutrition interventions, and to better assess the status of the country, consistent and reliable information is needed on baseline indicators for measurement. Sindh, like other provinces, has credible and comprehensive household baseline data on acute and chronic malnutrition, micronutrient deficiency, and food consumption from the two successive rounds of National Nutrition Surveys conducted in 2001 and 2011. The surveys' prime utility lies in rigorous evaluation of progress; accordingly, they are conducted at decade intervals. The gap lies in the fact that there is no system for monitoring progress in the interim.

Inadequate Priority across Sectors: Low emphasis on nutrition in Sindh, as in other provinces, has led to insufficient provision for nutrition in routine sectoral monitoring. The existing nutrition information system is confined to Health. Even within Health, nutrition monitoring is inadequate, because it is confined to village-based reporting and is not integrated into health facility reporting. The placement of nutrition monitoring within Health, rather than a central body, also provides traction away from horizontal coordination across sectors. So far, there has been no attempt to arrive at a common basket of nutrition-sensitive indicators that can be applied across relevant sectors (Education, Food, Health, Sanitation, Social Protection, Water, etc.) in the province. Monitoring within Education, Food, and the PDMA is mainly confined to input measurement and doesn't translate into nutrition. The Food Security Index, developed by the National Food Security Task Force, is a positive development for a nutrition basket of indicators, but measurement at the provincial level must still be operationalized (NPC, 2009).

Fragmented Systems: Central coordination between existing fragmented systems is still needed due to domain issues between different stakeholders. There is siloed management of information within Health and disconnects between villages, PPHI-managed Basic Health Units, and the rest of the system. Salt iodization, an important nutrition-related activity, is separately monitored by field monitoring teams supported by MI and district health officers, with no connection to other programs. There has also been a proliferation of multiple information systems for nutrition-specific projects in flood-affected areas with vertical reporting to UN agencies and INGOs. Food distribution is carried out in parallel by the Education and Food sectors, the PDMA, and other groups, but with little sharing of data. Monitoring of food quality parameters has a split responsibility. Wheat market surveillance is carried out by the Food Department, while quality assurance of other items is reported to Health.

Information on poor female beneficiaries can be provided by BISP, but due to its siloed federal management programme there has been little sharing of data with other sectors, thus little progress towards reaching out to the poor for work on under-nutrition.

Implementation Issues: Two types of information are required for nutrition – monitoring of nutrition and pro-nutrition indicators, and monitoring of targeting of interventions. Although Sindh has adequate technical capacity and a number of locally based experts for assistance with nutrition monitoring, efforts for effective implementation of nutrition field surveillance are likely to be undermined by weak accountability of districts. Targeting information can be provided by BISP. Sindh, having a PPP-led government, has extensive BISP outreach and positive support for BISP; however validation of transparency needs to be ascertained as in other provinces.

Advocacy Coalitions: Sindh has a more active non-state sector for advocacy and social accountability than do the other provinces. The academic sector has been responsible for data production and raising the agenda for nutrition in Sindh. Academics' backgrounds have influenced the type of research produced with attention to health and medical aspects, and there is need to move beyond the traditional Health aspects of nutrition. CSOs and local change agents for Sindh such as union council leaders, politicians, teachers, Community Midwives (CMWs), and LHWs need to be more effectively tapped for awareness-building. Media, an increasingly important player for mobilizing change agents, has not been tapped due to lack of people with skills in media management and propagation. There has recently been inclusion of the non-state representatives from Health in the Nutrition Technical Working Group, and such forums need to be expanded to include non-state representation from other sectors.

11. OPPORTUNITIES AND BOTTLENECKS: SUMMARY

Sindh has one of the highest under-nutrition levels in Pakistan, comprising chronic malnutrition and micronutrient deficiencies. Sindh is faced with contextual challenges as well as low emphasis to under-nutrition across all sectors. Contextually, despite better visibility of agriculture compared to KPK and Baluchistan, Sindh has the highest level of food insecurity amongst all four provinces and has several underdeveloped districts with higher prevalence of under-nutrition. Although schemes such as cash transfers to poor, school feeding, and food distribution to disaster affectees are in place, there is a lack of connections between relevant sectors and also lack of effective capture by the at-risk group of low-income pregnant women and children under three years of age.

Post-devolution Sindh has the policy space to design and implement province-specific strategies, and has benefitted from closer interaction with development partners. Sindh has yet to come up with a development strategy defining its own vision for the social sector and more specifically a nutrition strategy that links up with development priorities of relevant sectors. Weak governance in Sindh, an uneasy coalition government, and law and order issues in the provincial capital lead to lack of a cohesive development vision in Sindh.

One of the main issues confronting nutrition is of understanding and ownership. Nutrition is a complex, multifaceted subject and there is lack of a cohesive understanding of under-nutrition across sectors. There is commonly a weak priority for nutrition across all sectors due to nutrition's low visibility as well as it being an ambitious subject that relies on shared action. Sindh has better activism in the non-state sector compared to other provinces, with instigation on nutrition amongst experts, NGOs, and paediatric associations. These parties have instigated nutrition initiatives, which then failed to be sustained due to lack of champions among politicians and the bureaucracy. Political commitment is important for leveraging nutrition across sectors, but federal support has been towards the more politically visible agenda of hunger, with less connection with nutrition, while provincially the emphasis has been on infrastructure-dominated projects. Hence nutrition has lacked a comprehensive strategy and state funding, relying instead on fragmented donor-supported projects.

There are also structural and coordination issues in Sindh, as in other provinces, for mainstreaming nutrition across sectors. There is no formal structure to serve as the provincial counterpart of the National Planning Commission, and the province lacks strong executive leadership. Such leadership is necessary given that provincial departments have a vertical accountability structure and lack a mandate for coordination. Hence there are lack of connections between programs, beneficiaries, and targeting of different sectors such as BISP, Education, Food, and Health. Nutrition tends to be narrowly operationalized within the Health sector in terms of both projects and monitoring databases, thereby limiting inter-sectoral responses to nutrition. The cluster approach that followed the floods provided positive experiences for horizontal coordination, and there is willingness for functional coordination given that budget lines are kept separate. Although there is recent movement towards horizontal coordination for nutrition, this is based on a loose coalition comprising an inter-sectoral committee and does not provide structural home for nutrition.

Amongst the nutrition strategies implemented so far in Sindh, vitamin A supplementation has had the best coverage, as in other provinces. It has benefitted from the political and administrative support given to polio immunization, on which it was piggybacked. Sindh has had lesser coverage of nutrition-related preventive health strategies and food fortification due to weak vertical coordination between the district and provincial governments. This is compounded by low emphasis on and funding for outreach services and lack of ‘topping up’ of funding for disadvantaged districts. Overall weak governance in Sindh constrains local-level implementation of nutrition and other social sector services. Technical capacity for nutrition planning, implementation, and monitoring also remains weak across all sectors.

Funding for nutrition has traditionally been led by development partners and is likely to remain so. Although the provincial government is negotiating with development partners for an enhanced nutrition project based in Health, the government’s matching contribution will be a lesser share of the total compared to development partner allocations. A stand-alone siloed programme in nutrition is also less likely to be sustained after wrap-up of donor funding.

Sindh, like other provinces, has a credible database of nutrition measurements, however the emphasis remains on large surveys of nutritional outcomes, and insufficient attention has been given to process measurement. There is lack of a common basket of nutrition indicators across all sectors as well as of a supporting monitoring and evaluation framework.

12. STRATEGIC RECOMMENDATIONS

In Sindh, despite the development of a nutrition PC-1 within the Department of Health, broader multi-sectoral planning for nutrition and functional integration of concerned departments and programs have lagged. The Chief Secretary of Sindh has, however, recently notified a steering committee to oversee the development of a multi-sectoral nutrition policy guidance document, an integrated nutrition strategy and operational plan for Sindh. These are promising steps. The following recommendations, based on various consultations in Sindh and with other national stakeholders may help define the tasks ahead.

Key Findings:

- Technical support needs to be provided to Sindh to cohesively define nutrition priorities across sectors and across urban and rural Sindh. There is need for higher development partner investment in Sindh to incentivize nutrition as a priority.
- Political championing at the highest level is required to leverage nutrition into development priorities across party lines. Sindh, due to its Pakistan Peoples Party prop-rural poor electoral base, is well positioned to support the nutrition agenda, but nutrition needs to be well advocated to politicians across party lines to develop a bipartisan and broad support base. The women's caucus and pro-active female parliamentarians who have championed social issues in Sindh present important trigger points for the nutrition agenda.
- Attention is needed to overcome weak governance including induction of political appointees, corruption, weak writ of government, and low accountability between province and district, as this is likely to undermine any social sector initiative including nutrition. Supportive measures for nutrition would require common buy-in by political parties, high level of executive leadership at the Additional Chief Secretary level, clear administrative lines, result-based funding, third-party monitors, and social accountability.
- A fundamental shift in funding needs to be made from small-scale project-based allocations for nutrition by the provincial government to integrating nutrition within the operational work of key sectors. Within Health, nutrition projects will have better chances of continuity if integrated with the Lady Health Worker; Maternal, Neonatal, and Child Health; and other similar programmes through a common pool of resources rather than continuing as siloed, donor-supported projects.
- Incentives need to be provided to make central convening structures effective. These can include central housing of monitoring databases, joint funding lines, approval of sectoral plans, undertaking of joint sectoral initiatives, and provision of technical capacity.
- There is popular support within sectors for working closely together yet with independent budgetary lines. This willingness can be tapped for joint initiatives that have well-defined interventions, common beneficiaries and geographical targets, and soft conditionalities.
- Sindh has weak vertical coordination, and beyond expansion of effective intervention within sectors needs to give fundamental priority to strong vertical accountability within sectors.
- Inequities in food insecurity and poverty in Sindh merits significant policy attention. Adequate steps towards equitable land holdings, with subsidies for kitchen farming/livestock and irrigation support for marginalized rural groups, are needed. Pricing control needs to be improved to benefit both the rural and urban poor and will need to be expanded from wheat to an expanded range of essential food commodities. This will require proper multi-stakeholder enforcement.

- Current poverty alleviation strategies such as Bait-ul-Mal, Zakat systems, and the Benazir Income Support Programme need strong connections with targeted beneficiaries of nutrition. In addition, interventions to maximize nutrition outreach to the poorest groups and particularly women care givers, and improvements in development value provided by social safety nets will be important. Systems need to be in place to ensure that implementation of such programs is bipartisan and above political considerations.
- Sindh has become increasingly vulnerable to disasters, which heightens the nutrition crisis. While there is effective management of acute emergency priorities, attention to disaster mitigation and recovery is needed. Disaster recovery must make a shift from short-term interventions such as food distribution to links with Agriculture, Health, Public Health Engineering, Social Protection, and other sectors for effective rehabilitation.
- The impact of food insecurity and poverty alleviation needs to be strengthened through awareness of basic nutrition concepts, environmental hygiene, and disease prevention. Public Health Engineering needs a greater level of policy priority and planning with extension to urban slums, while preventive health needs effective management and stewardship.
- The current mix of preventive and promotive nutrition strategies within existing health programmes – such as the Lady Health Worker and Maternal, Neonatal, and Child Health programmes as well as other primary care health programs – needs expansion. Better implementation is needed to support exclusive breastfeeding through ordinance and awareness, an optimal mix of complementary feeding strategies, nutrition rehabilitation services for severe acute malnutrition at the district level, and strengthening of the vitamin A supplementation programme and the iron and multiple micronutrient fortification of wheat flour and other staples. This will require concerted monitoring and implementation.
- Affordable funding options need to be explored and will require development of local, low cost home rehabilitation diets and foods and appropriate nutrition rehabilitation services for severe acute malnutrition. This will require building economies of scale through maximizing use of all contact points such as immunization services, school services, and targeting opportunities such as those provided by the Benazir Income Support Programme.
- Sindh has a well-resourced private food sector, but its contribution to nutrition needs to be made more effective through placement of both incentives, in the form of state support for commodities, and effective enforcement of fortification legislation through market surveillance. Multi-stakeholder involvement in Food, Health, and local government is needed, with clear administrative roles and technical capacity-building support.
- District and local governments need to be recognized as distinct sets of stakeholders with investments in nutrition awareness and capacity-building at these levels.
- Central coordination of nutrition monitoring is needed. It should be housed in a central convening body and comprise a common basket of pro-nutrition indicators across Education, Food, Health, Poverty and Disaster, Public Health Engineering, and water, sanitation, and hygiene in order to effectively monitor interim progress.
- Sindh has an active and well-resourced non-state sector, involving experts, media, and non governmental organizations. Mainstream linkages with the state are required for partnerships around data production, awareness, advocacy, and monitoring, which will require forums for the state-non-state interactions.

ANNEX 1: REFERENCES

- Acosta, M. & Fanzo, J (2012). *Fighting Maternal and Child Malnutrition: Analysing the political and institutional determinants of delivering a national multi-sectoral response in six countries*. Brighton, UK: Institute of Development Studies.
- Benson, T. & Shekar, M. (2006). Trends and Issues in Child Undernutrition. In: Jamison, D.T., Feachem, R.G., Malegapurun, W. et al., eds. *Disease and Mortality in Sub-Saharan Africa*. Washington DC: World Bank.
- Cook, B. (2006). *Food Security, Implications for the Early Years*. Background Paper. Toronto, Ontario: Toronto Public Health.
- Federal Bureau of Statistics (FBS). (2009–2010). *Labour Force Survey*. Pakistan Bureau of Statistics, Government of Pakistan. Accessed November, 2012, Available at <http://www.pbs.gov.pk/content/labour-force-survey> 2009–2010.
- Federal Bureau of Statistics (FBS). (2010–2011). *Pakistan Social and Living Measurement Survey*. Pakistan Bureau of Statistics, Government of Pakistan. Accessed on November, 2012, Available at <http://www.pbs.gov.pk/content/pakistan-social-and-living-standards-measurement>.
- Household Integrated Economic Survey (HEIS). (2010–2011). Household Integrated Economic Survey, Federal Bureau of Statistics, Government of Pakistan.
- Micronutrient Initiative (MI). (2011). *Micronutrient Initiative Assessment of Iodized Salt Production in Pakistan. Research and Development Solutions for the Micronutrient Initiative*. Pakistan: Pakistan Ministry of Health, Government of Pakistan.
- Multiple Indicator Cluster Survey (MICS). (2003–2004). Sindh Multiple Indicator Cluster Survey.
- National Institute of Population Studies (NIPS). (2006–2007). *Pakistan Demographic and Health Survey 2006-2007*. Pakistan: National Institute of Population Studies.
- National Nutrition Survey (NNS). (2011). Aga Khan University; Pakistan Medical Research Council, Nutrition Wing Cabinet Division; Government of Pakistan; United Nations Children's Fund Pakistan. (2011). *Pakistan National Nutrition Survey; 2011*. Pakistan: Aga Khan University.
- Oxford Policy Management. (2009). *Lady Health Worker Programme: External evaluation of the national programme for family planning & primary health care*. Oxford: Oxford Policy Management.
- Pakistan Economic Surveys (PES). (2001–2012). Federal Bureau of Statistics & Ministry of Health, Government of Pakistan.
- Pakistan Integrated Nutrition Survey (PINS). (2011). Nutrition for National Development Report: Pakistan's Integrated Nutrition Strategy.

PC-1 Sindh (draft). Nutrition Programme for Sindh, Department of Health, Government of Sindh.

PDMA website: <http://flood2010.pdma.gos.pk/>.

Pakistan Institute of Development Economics (PIDE). (2001). The determinants of food prices: a case study of Pakistan. *Pakistan Institute of Development Economics*, Working papers 2011:76.

National Planning Commission (NPC), Government of Pakistan. (2009). *Task Force on Food Security Report, 2009*. Pakistan: Government of Pakistan.

Sindh HSS Report (2011). Situation analysis for post devolution health sector strategy of Sindh Province.

Social Policy and Development Centre (SPDC). (2004). Combating poverty; is growth sufficient? *Social Policy and Development Centre Annual Review, 2004*. Karachi, Pakistan: SPDC.

Social Policy and Development Centre (SPDC). (2011). Financial Implications of 7th NFC Award and Its Impact on Social Services. *Meeting of the Pakistan Society of Development Economists*.

TAWANA Report. (2006). The Aga Khan University, Department of Community Health Sciences. *TAWANA Pakistan Project Report*. Karachi: Aga Khan University.

Technical Resource Facility (TRF). (2012). Health Budget and Expenditure. Technical Resource Facility.

United Nations Children's Fund (UNICEF). (1990). *Strategy for Improved Nutrition of Children and Women in Developing Countries*. New York: UNICEF.

United States Agency for International Development (USAID). (2012). *Gender differences: understanding perceptions, National Baseline Survey*. Washington, DC: USAID.

VAS Survey. (2011). Aga Khan University (AKU) and Micronutrient Initiative (MI), Pakistan. (2011). *Vitamin A Supplementation Coverage Validation Survey*. Karachi, Pakistan: Aga Khan University.

Walt, G. & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning*. 1994; 9(4), 353–370.

World Food Summit. (1996). *Rome declaration on world food security*. Retrieved January 2013 from: <http://www.fao.org/docrep/003/w3613e/w3613e00.htm>.

ANNEX 2: STAKEHOLDERS

Serial #	Name of Stakeholder
1.	Representative, Pakistan People's Party
2.	Planning and Development Department, Government of Sindh
3.	Health Department, Government of Sindh
4.	Education Department, Government of Sindh
5.	Food Department, Government of Sindh
6.	Agriculture Department, Government of Sindh
7.	Women's Development Department, Government of Sindh
8.	PDMA, Sindh
9.	Benazir Income Support Program, Sindh
10.	UNICEF, Sindh
11.	UNFPA, Sindh
12.	WHO, Sindh
13.	WFP, Sindh
14.	Save the Children, Sindh
15.	Merlin, Sindh
16.	Micronutrient Initiative, Sindh
17.	Aga Khan University, Karachi
18.	Collective for Social Sciences Research, Karachi
19.	Technical Resource Facility, Sindh
20.	Paediatrician (retired), Civil Hospital Karachi
21.	Health and Nutrition Development Society (HANDS)
22.	Sindh Agricultural and Forest Workers Coordinating Organisation (SAFWCO)
23.	Sindh Rural Support Organisation (SRSO)
24.	Sindh Rural Support Programme (SRSP)
25.	ShirkatGah, Karachi
26.	Sailani Welfare Trust
27.	Shan Foods
28.	Pak National Salt Refinery
29.	National Foods
30.	DAWN

