Punjab Province Report: Nutrition Political Economy, Pakistan

MQSUN REPORT

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

About 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 six 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, Akhtar Rasheed, Gul and Nawaz, 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

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 organisations
DFID	United Kingdom Department for International Development
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 Goals
MI	Micronutrient Initiative
MICS	Multiple Indicators Cluster Survey
MNCH	Maternal, Neonatal, and Child Health programme
MoH	Ministry of Health (national)
MPI	Multidimensional poverty index
NDMA	National Disaster Management Authority
NFC	National Finance Commission
NGO	Non-governmental organisation
NNS	National Nutrition Survey
NPC	National Planning Commission
P&DD	Planning and Development Department (provincial)
PDMA	Provincial Disaster Management Authority
PHE	Public Health Engineering
PML-N	Pakistan Muslim League N
PPHI	President Primary Health Care Initiative
PPP	Pakistan Peoples Party
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 rate of under-five mortality; rates in Bangladesh and Nepal were higher. All of these countries saw improvement in the following decade. By 2010, they had drastically lowered their under-five mortality rates and are now on track to achieve their Millennium Development Goals (MDGs).

In the Punjab 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 from the centre to the provinces, including the Ministries of Agriculture, Education, Food, and Health. 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 2009. In Pakistan, the financial status of provincial governments is dependent on federal transfers of tax revenues to the provinces through NFC Awards. The 2009 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 Punjab 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 21 in-depth interviews with stakeholders from the state, donor agencies, and civil society organisations, and nutrition experts. 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 provincial 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 Punjab: Under-nutrition levels in Punjab are marginally lower than national averages (Table 1). One-third of the children in Punjab are underweight and nearly half of the mothers and children in the province have vitamin A deficiency and anaemia. These numbers also reflect long-standing under-nutrition in the region, as evidenced by the fact that in 2011, 39% of the population had stunted development, or 'stunting'.

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

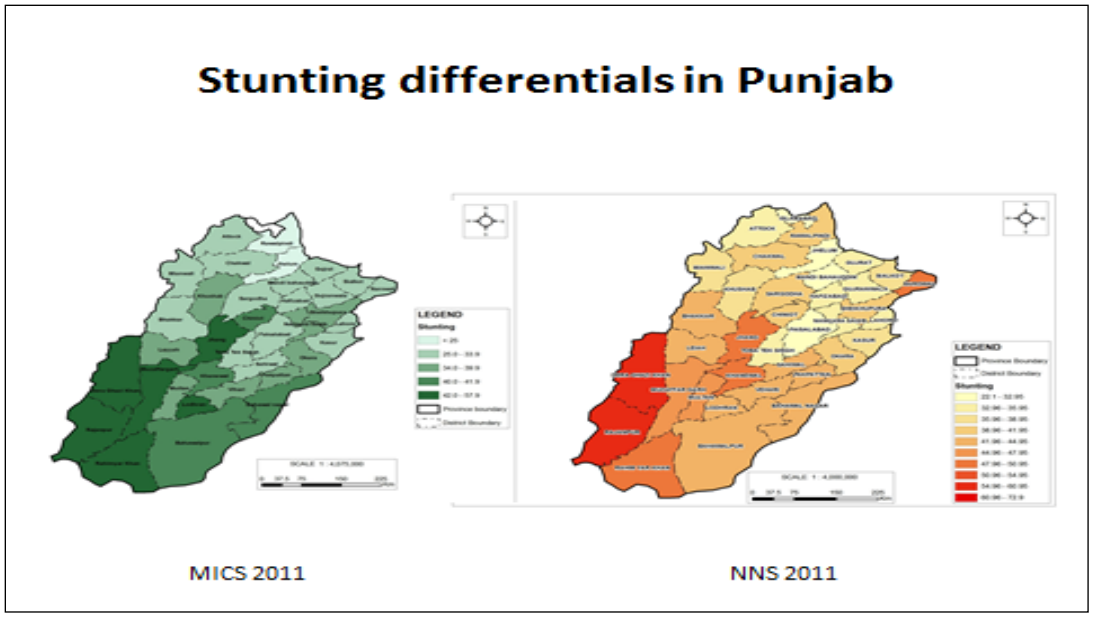
Under-Nutrition Status	Punjab	Pakistan
Child malnutrition		
Underweight (severe + moderate)	29.8	31.5
Stunted (severe + moderate)	39.2	43.7
Wasted (severe + moderate)	13.7	15.1
Child micronutrient deficiencies		
Vitamin A deficiency*	51.0	54.0
Anaemia	60.3	62.0
Zinc deficiency**	38.4	39.2
Maternal micronutrient deficiencies		
Vitamin A deficiency – Pregnant mothers	43.7	46.0
Anaemia – Pregnant mothers	49.3	51.0
Zinc deficiency – Pregnant mothers	47.3	47.6

Source: NNS, 2011
* Biomarker used: Serum retinol levels
** Serum zinc levels

Although Punjab as a whole has marginally less under-nutrition than other provinces, there are large disparities within the province. Districts with the highest prevalence of under-nutrition are in Southern Punjab. In this region, child under-nutrition levels are 52.9% (Multiple Indicator Cluster Survey [MICS], 2011) as compared with a provincial level of 29.8%. Findings from the MICS are quite comparable to those seen in the 2011 National Nutrition Survey (NNS). Both show huge differentials in stunting rates in various districts of Punjab and preponderance in the south (Figure 1). Please note that although the NNS 2011 was not powered for district-level

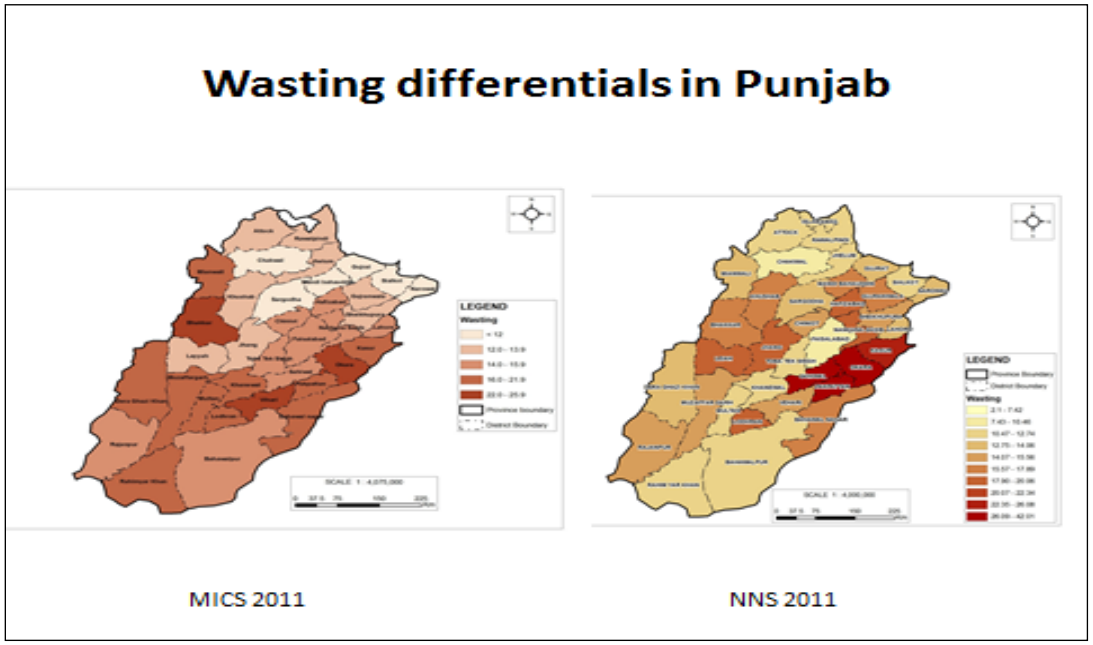
specificity, in this instance weighted multivariate analysis for district level anthropometry was undertaken using a Bayesian model adjusted for wealth index, rural residence, maternal illiteracy, and food security scores. Broadly comparable trends were also seen in the prevalence of wasting in southern areas of the province (Figure 2).

Figure 1: Stunting differentials in Punjab, 2011



Source: NNS, 2011

Figure 2: Wasting differentials in Punjab, 2011

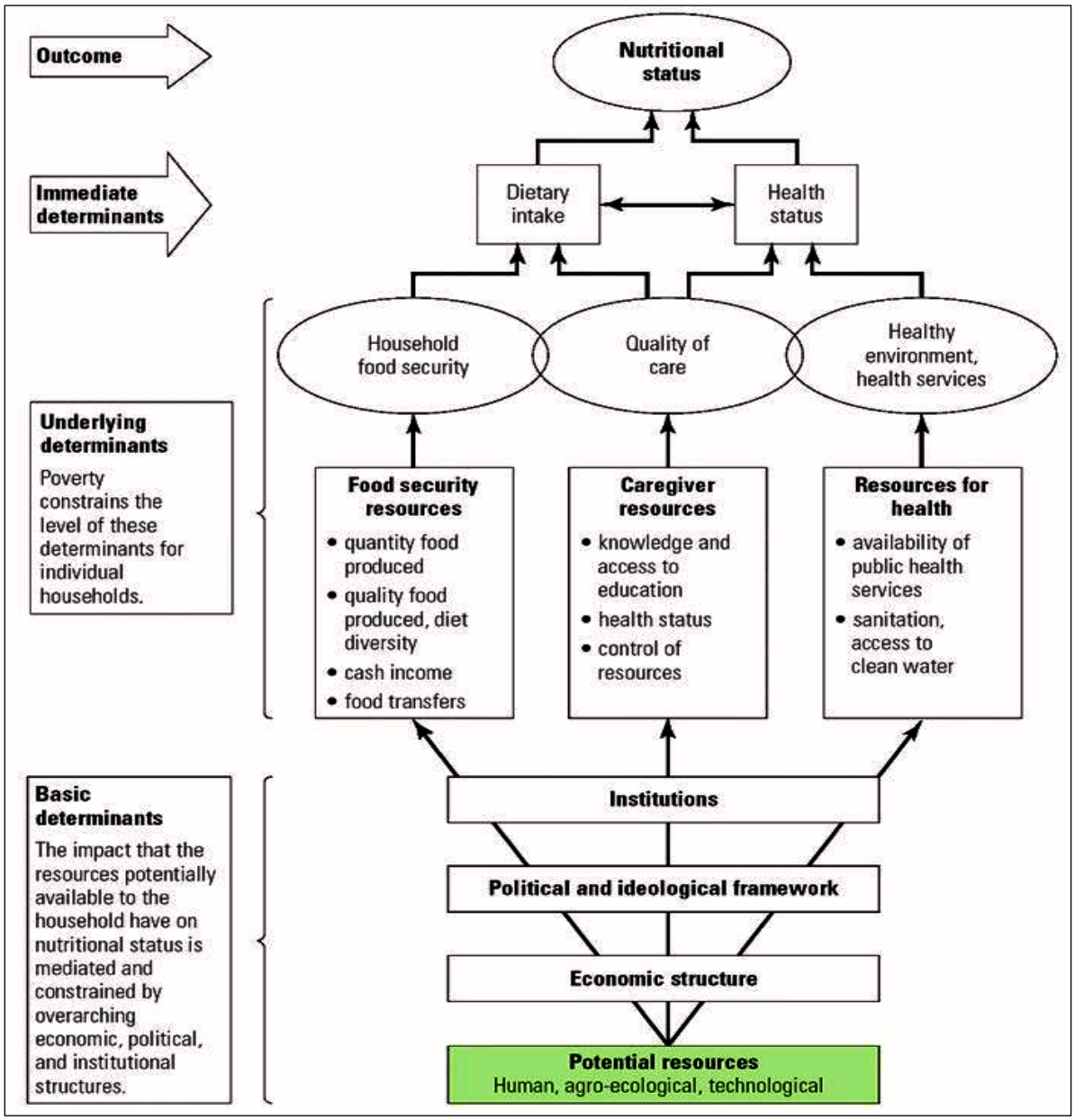


Source: MICS, 2011; NNS, 2011

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 3). 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. Over-arching institutional, political, and economic structures also facilitate or constrain access. Underlying factors that contribute to under-nutrition in Punjab are dealt with in detail below.

Figure 3: Causal pathway of under-nutrition



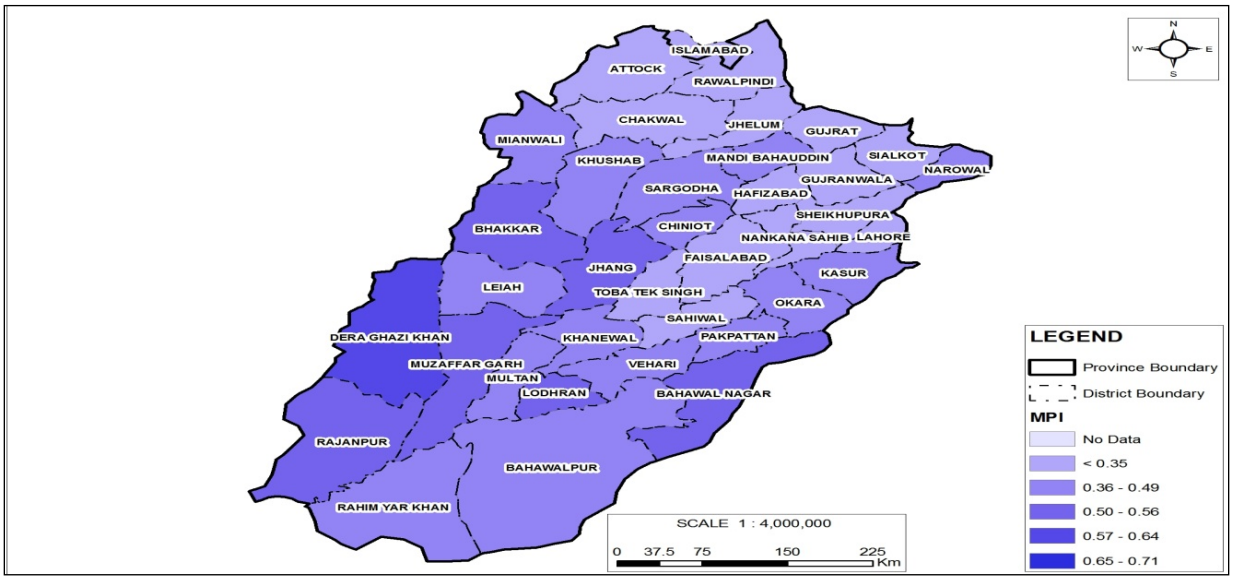
Sources: UNICEF, 1990; Benson & Shekar, 2006

4. Provincial Context for Under-Nutrition

Poverty and Its Various Dimensions: Pakistan's economic productivity has been decreasing since the 1980s, a spiral that has been particularly marked since 2005. Gross domestic product (GDP) has averaged around 3% each year; the national GDP in 2012 was 3.7% (Pakistan Economic Survey [PES], 2011–2012). Even in times of better productivity, trickle-down of GDP benefits to the poor is questionable, and recession further compounds poverty. Punjab is the wealthiest of Pakistan's provinces; in 2004, it had a lower poverty incidence (26%) than the nation as a whole (33%) (SPDC, 2004). Punjab's relative wealth is largely due to its position as the 'food basket' of the country. Agriculture is a key sector of the provincial economy; 83% of the land is agriculturally productive, and 44% of the rural population work in agriculture (FBS, 2009–2010).

We estimated the multidimensional poverty index (MPI)* for various districts of Punjab 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 4 displays the MPI for various districts in Punjab and highlights the significant differences that exist.

Figure 4: Multidimensional poverty index by district in Punjab, 2011



Source: NNS, 2011

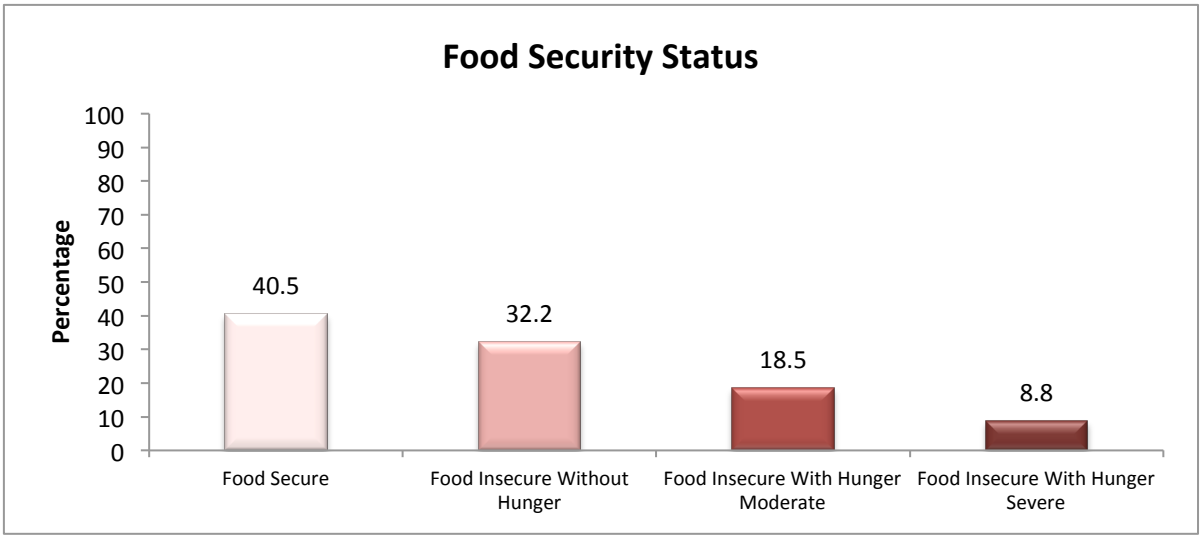
* MPI is calculated by multiplying the percentage of people who are MPI poor (incidence of poverty) with the average intensity of MPI poverty across the poor (%).

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 programs 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 2011 figure for Punjab was lower and is reflected in Figure 5, along with other responses from the region.

Figure 5: Food security perceptions in Punjab, 2011 (% respondents)



Source: NNS, 2011

As discussed above, agriculture is a key sector of the provincial economy. Punjab produces 75% of the country's output of wheat. Nevertheless, 27.3% of its households are food insecure. Table 2 displays detailed relationships between food security resources (agriculturally productive land and/or land ownership) and poverty in the Sindh, Punjab, Khyber Pakhtunkhwa (KP), and Baluchistan provinces, and in Pakistan as a whole.

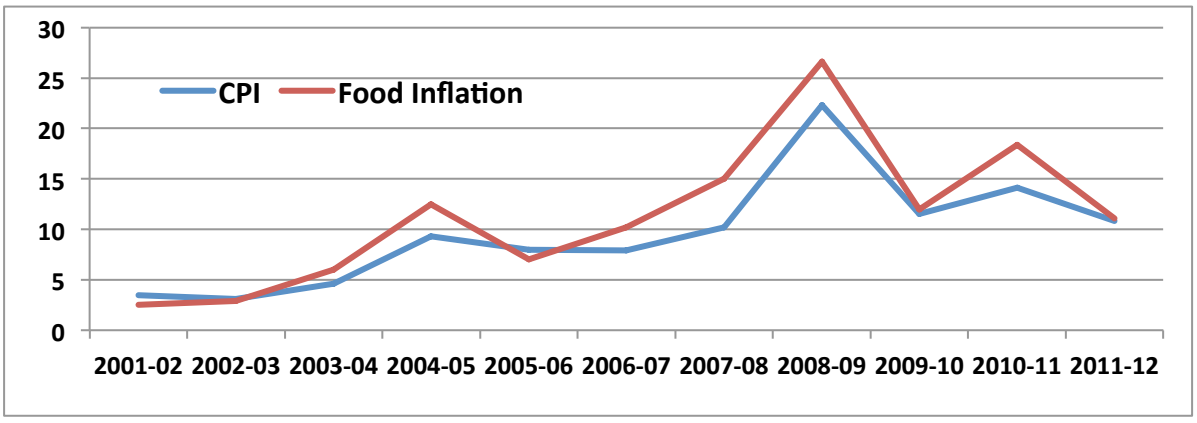
Table 2: Food security resources and poverty in Pakistani provinces, 2009–2011 (% population)

Food security resource or poverty	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 with[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

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

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) have placed an increased the burden on already-stretched household food budgets. Figure 6 displays changes in annual inflation in Punjab during roughly the last decade.

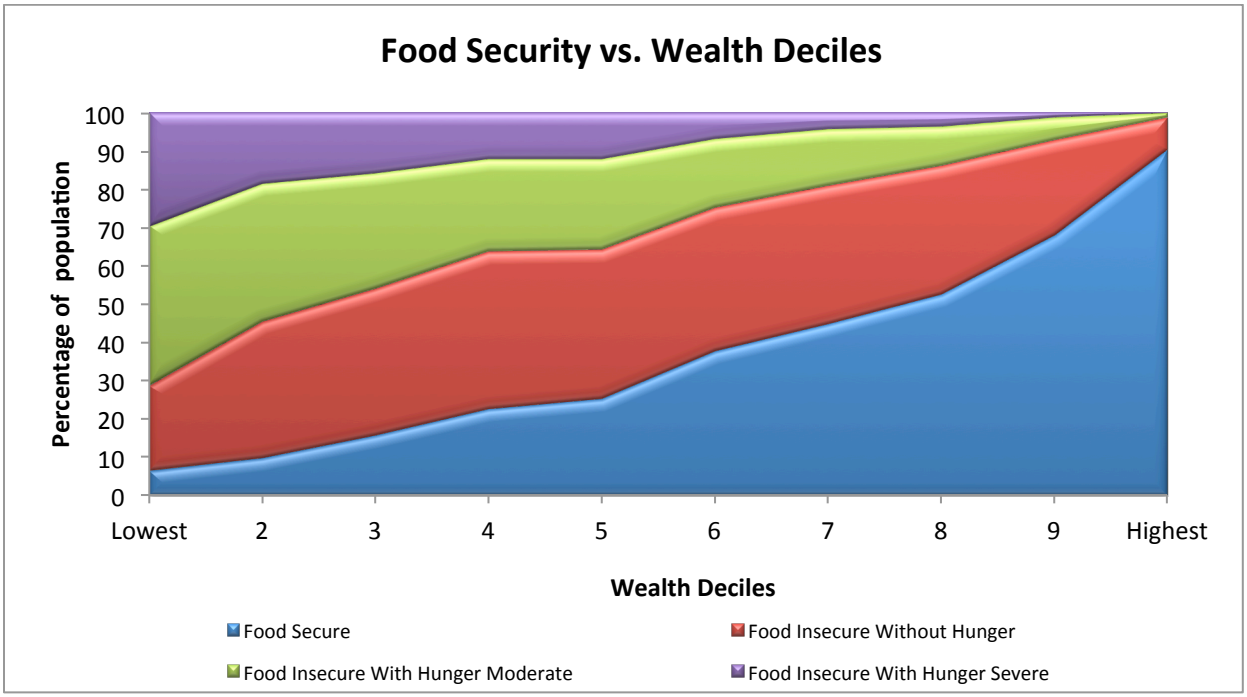
Figure 6: Annual inflation and Consumer Price Index changes in Punjab, 2001–2012 (% change)



Sources: PES 2006–2007; PES 2011–2012

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 Punjab (Figure 7). Data suggest that both poverty and food insecurity operate in Punjab and that a significant proportion of the poorest quintiles experience food insecurity.

Figure 7: Association between food insecurity and poverty in Punjab, 2011



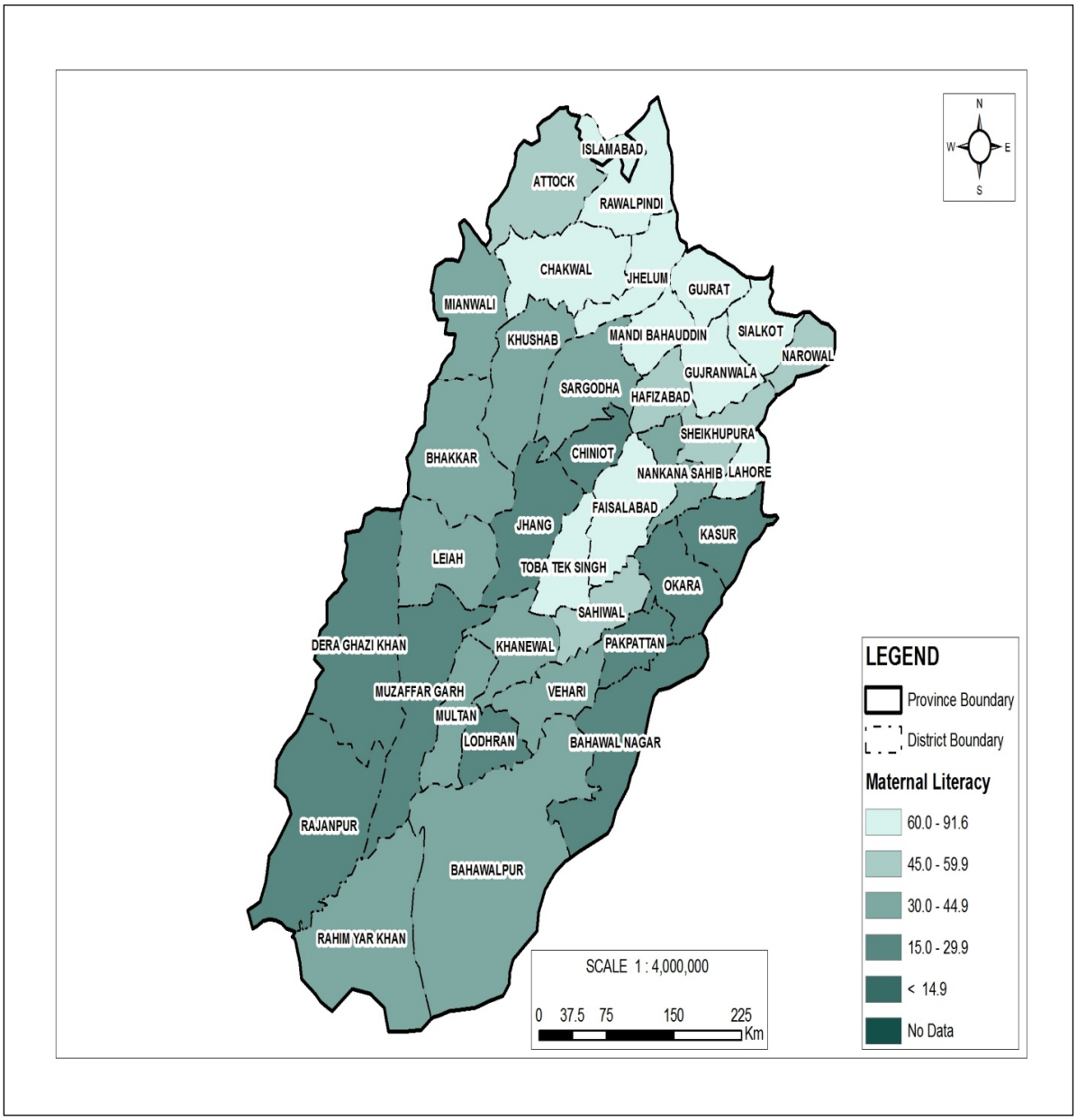
Source: NNS, 2011

Care Giver Resources: Maternal and child under-nutrition is driven by a number of development-related factors, including household food security and underlying poverty and the female care giver's education, awareness and autonomy, and access to key social sector services.

Clearly, the same differentials are seen in the principal components of MPI reflecting maternal education and environmental conditions. 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 household. The literacy rate for females in Punjab is 50.7% compared to 68.2% for males, and the district disparities in female literacy range from 27.8% to 70.4% across the province (MICS, 2011). This gap is further widened in the rural population, where 42.5% females are literate compared to 63.3% of males (NNS, 2011) and is reflected in sub-provincial differentials. In short, only half of the women in Punjab 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.

Figure 8 displays differentials in maternal education for Punjab and illuminates very large north/south differentials.

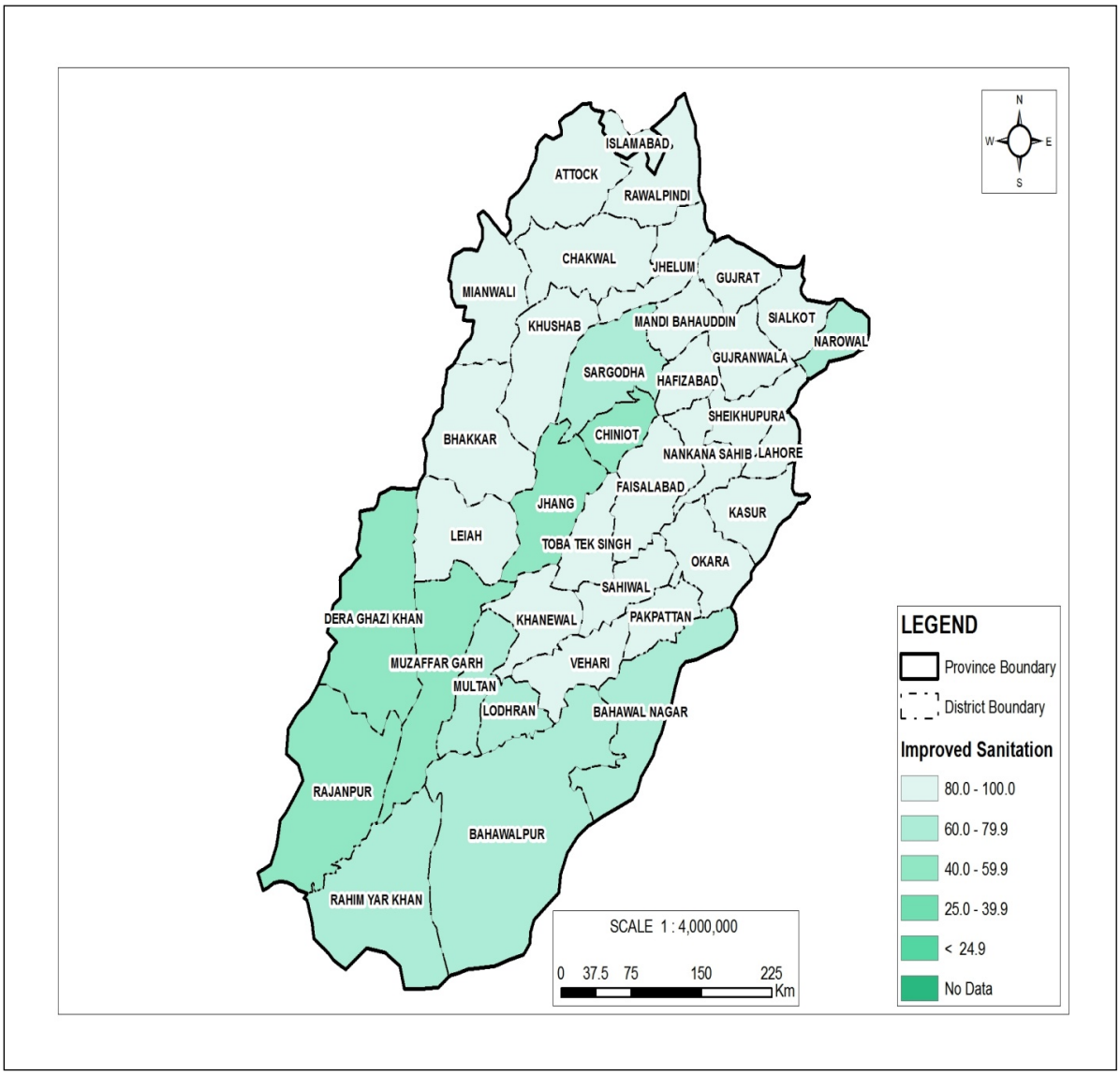
Figure 8: Maternal education differentials in Punjab, 2011



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, with infants and young children being particularly susceptible. Punjab has better levels of safe water usage by household (93%) as compared with the national level (87%). Use of hygienic sanitation facilities is also higher in the province (72%) compared with national use (66%) (FBS, 2010–2011a). However, these figures mask significant inter-district variation in access to safe water and sanitation, as illustrated in Figure 9.

Figure 9: Improved sanitation differentials in Punjab, 2011



Source: NNS, 2011

Access to Key Health and Social Sector Services: Punjab is the largest province by population. It has a high population density of 490 people per square kilometre compared with a national average of 166 people per square kilometre (United Nations Development Programme [UNDP], 2011). As of mid-2011, its population was estimated to be 94.4 million people. The urbanization rate is 31.3% per year, although there are district disparities. Southern areas, such as Bahawalpur and DG Khan, are sparsely populated, whereas the areas of Faisalabad, Gujranwala, Lahore, and Sialkot are more densely populated (UNDP, 2011). 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 displays the median coverage for various interventions with coverage rates among various districts of Punjab.

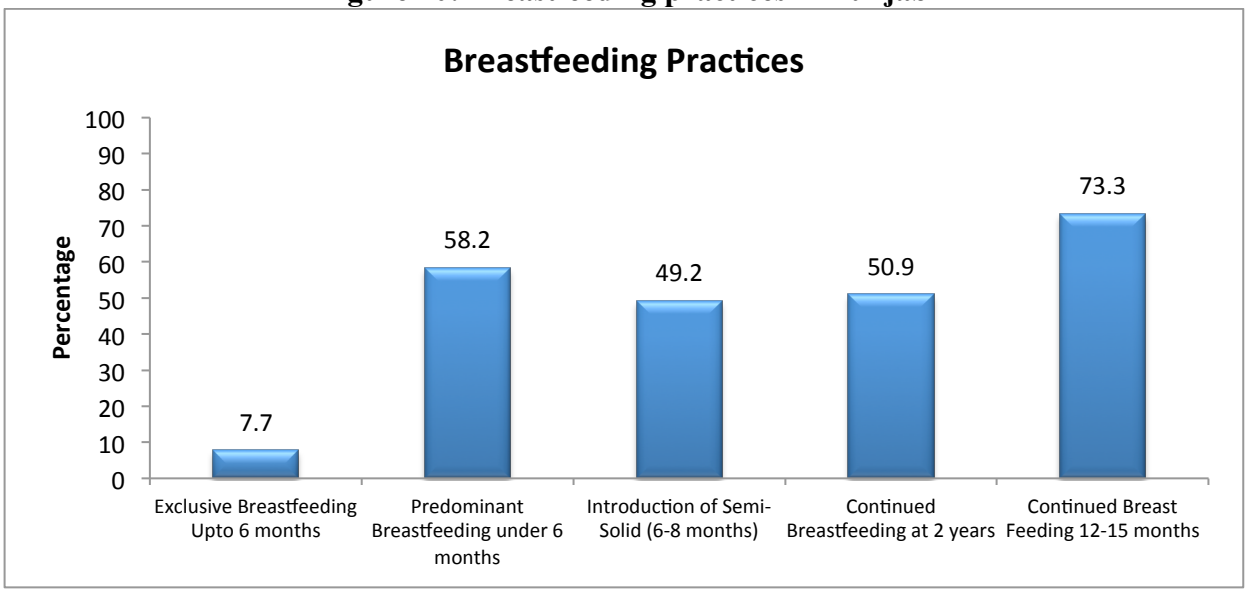
Table 3: Coverage of health interventions across districts in Punjab, 2011 (% population)

Indicator	Prevalence	Range Across Districts
Improved sanitation	83.5	43.5–100
Maternal literacy	47.4	16.8–75.2
Antenatal care by skilled attendant	56.9	25.8–74.9
Interventions during last pregnancy		
Iron supplement intake	26.3	11.7–39.8
Folic acid intake	22.5	7.4–36.6
Interventions in children under five years of age		
Initiation of breastfeeding (<1 hour)	28.1	7.5–75.8
Colostrum given at birth	78.8	59.2–99.3
Vitamin A	80.4	66.6–97
Zinc	3.4	0–13.1
Immunization status (under five years of age) Verified from vaccination card		
BCG	38.2	9.6–65.4
Pentavalent	36.8	9.2–64.8
OPV (oral polio vaccine)	34.2	9.5–62.3
Measles	27.0	4.7–53.4

Source: UNDP, 2011

A key intervention to reduce child under-nutrition is continued breastfeeding. Low rates of exclusive breastfeeding in Punjab (Figure 10) reflect inadequate attention to community education and a lack of supportive strategies to facilitate exclusive breastfeeding.

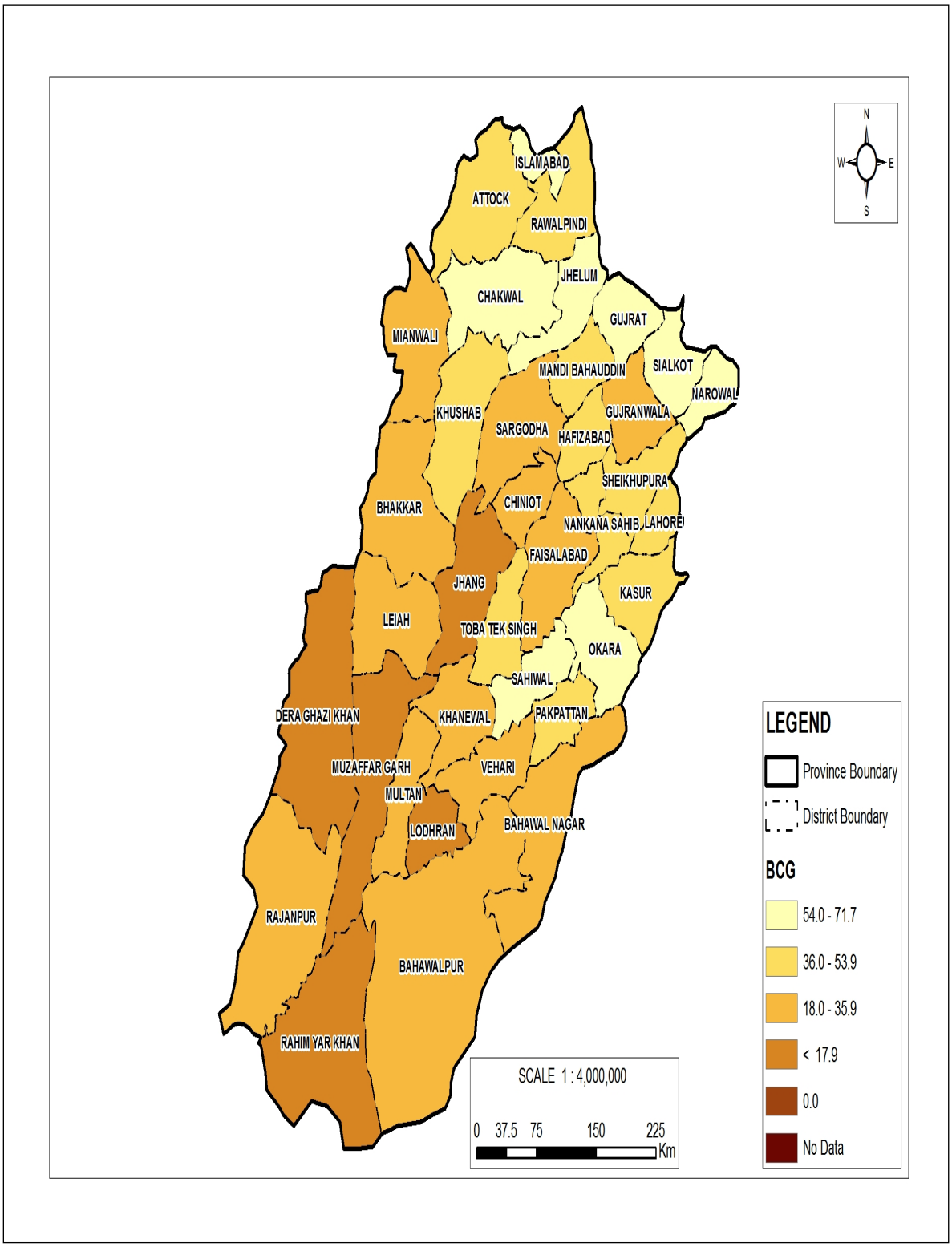
Figure 10: Breastfeeding practices in Punjab



Source: NNS, 2011

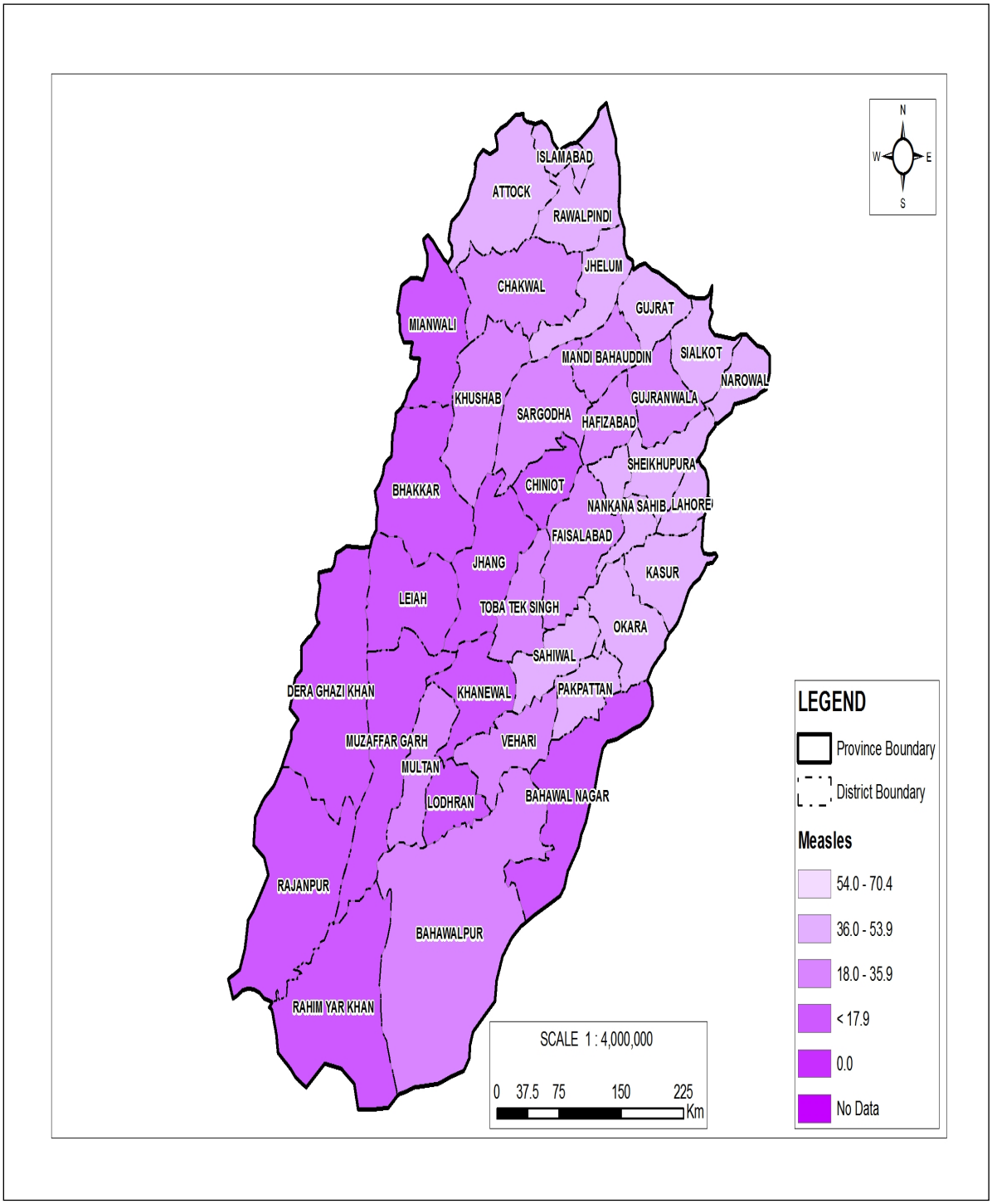
Childhood immunizations are a measure of promotive and preventive strategies in health systems. Figures 11 and 12 reflect the sub-provincial coverage of two vaccines, BCG and measles, based on verified data from the MICS 2011 survey.

Figure 11: BCG vaccination at birth in Punjab, 2011



Note: Verified from immunization card.
Source: MICS, 2011

Figure 12: Measles vaccination in Punjab, 2011

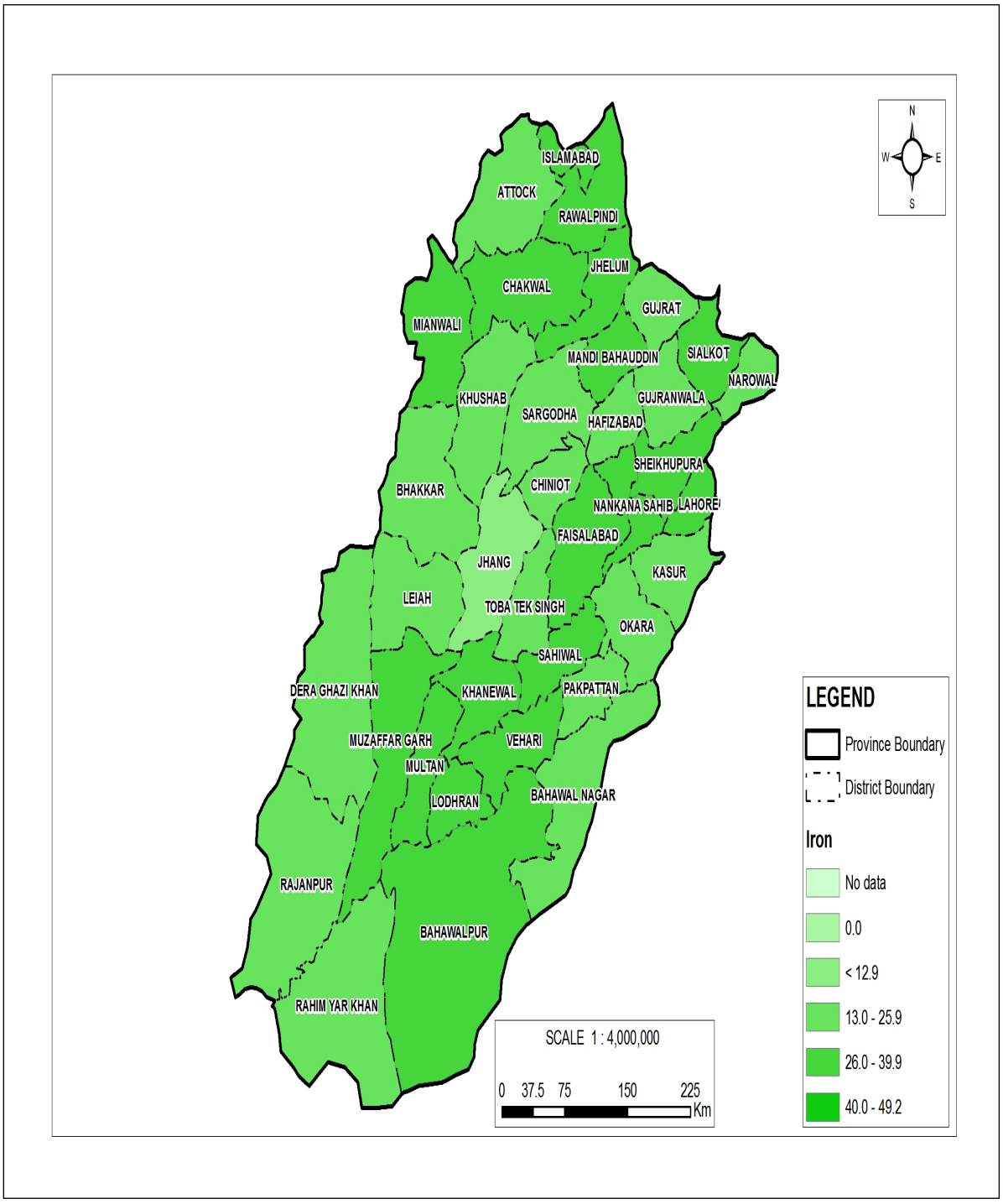


Note: Verified from immunization card.
Source: MICS, 2011

Public sector programs addressing micronutrient deficits and malnutrition have a limited range, but include iron-folic acid supplements during pregnancy, and vitamin A supplementation for children older than six months of age. The overall rates of coverage for these basic interventions

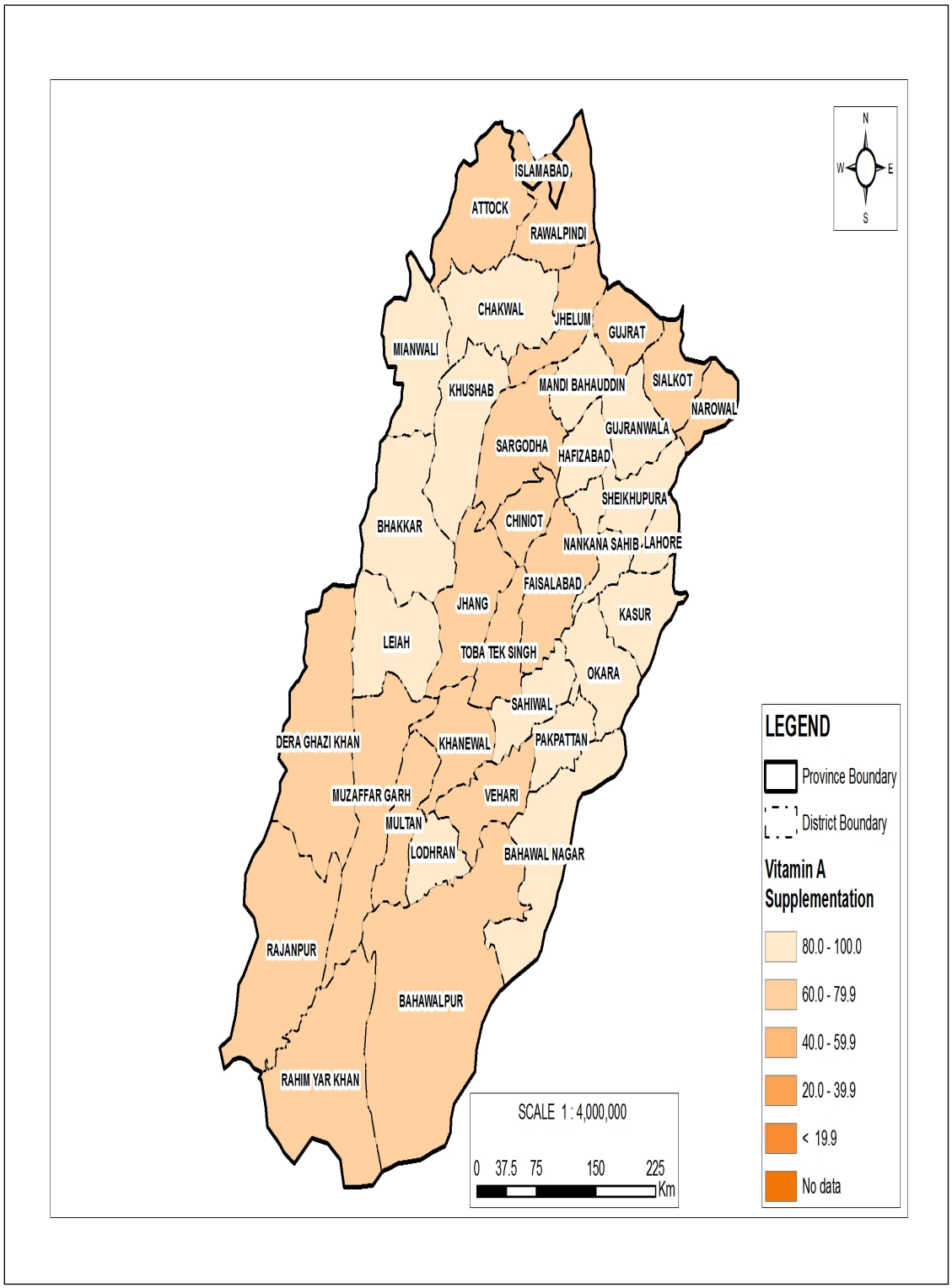
are 26% and 80% respectively, with major differentials between districts. This is illustrated in Figures 13 and 14.

Figure 13: Rates of maternal iron intake during last pregnancy in Punjab, 2011



Source: MICS, 2011

Figure 14: Vitamin A supplementation (coverage) in Punjab, 2011



Source: NNS, 2011

The issue of inequity in access and care in Punjab is notable. Differentials in health- and nutrition-related interventions across wealth quintiles are displayed in Table 4.

Table 4: Health and nutrition intervention coverage by wealth quintile in Punjab, 2011

Intervention	Wealth Quintile (% population covered)					Overall
	Poorest	Poor	Middle	Rich	Richest	
Antenatal care by skilled health worker (during last delivery)	44.6	54.8	65.8	75.9	88.2	56.9
Maternal iron folate supplements	16.8	19.3	23.5	30.1	39.1	26.3
Exclusive breastfeeding up to 4 months	3.8	9.3	13.2	16.9	19.5	12.9
Exclusive breastfeeding up to 6 months	2.3	5.2	7.2	10.4	12.2	7.6
BCG vaccination (card)	19.4	30.2	41.9	45.8	49.6	38.2
Measles vaccination (card)	12.4	19.8	29.8	33.2	37.1	27.0
Vitamin A supplementation	76.4	80.1	81.8	81.9	80.8	80.4

Source: NNS, 2011

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, as it was in many countries. 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 sub-set 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's 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 recent floods, food rations were distributed to flood victims in Punjab through the Provincial Disaster Management Authority (Punjab PDMA), and were continued beyond the flood recovery period with popular support from elected representatives. The National Disaster Management Authority (NDMA) assisted flood-affected districts through provision of food packs of 37 kg each in districts Rahimyar Khan (1,000 packets), Rajhanpur (7,900 packets), Dera Ghazi Khan (12,000 packets) and Muzaffargarh (1,500 packets) (NDMA, 2012). Another related initiative, part of the Benazir Income Support Programme (BISP), transfers cash to low-income women. It is being implemented in Punjab and has an extensive field outreach and database. A flagship program 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 program, 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 though 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. Interventions have traditionally been led by UN agencies and positioned at the provincial Departments 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, along with the establishment of nutrition corners at hospitals to provide nutrition-related advice.
- The Safe Motherhood Program provided edible oil to pregnant mothers at government health facilities during and after pregnancy.
- More lately in the wake of floods, nutrition initiatives have involved CMAM (Community Based Management of Acute Malnutrition) in disaster-affected areas. This effort has operated through health facilities managed both by district government and by the President Primary Health Care Initiative (PPHI), which manages the contracted Basic Health Units PPHI.
- Efforts are also supplemented with community-based nutrition screening and referrals through community support organisations (CSOs).
- DoH-supported interventions have been provided through the Lady Health Worker program (LHW), the World Health Organization Expanded Programme on Immunization (EPI), and the Maternal, Neonatal, and Child Health Programme (MNCH), and are dependent upon the outreach and function of these programmes. Key nutrition-related interventions include providing children with vitamin A supplements, de-worming children, providing iron and folate to pregnant and lactating mothers, and providing breastfeeding counselling. These have had varying success, for reasons that will be discussed later in this report.
- Beginning in 2010, UNICEF and the World Food Programme also launched nutrition initiatives. These were primarily collaborations with the DoH through LHW and other non-governmental organisations.
- Through EPI, children are provided with vitamin A twice-yearly.
- Children may also be de-wormed during 'mother and child health weeks' sponsored by LHW with the support of UNICEF (PC-1 Punjab, 2012–2015).
- Salt iodization was implemented in all districts of Punjab by Micronutrient Initiative (MI), an INGO, which provided training, equipment and commodities. The initiative was directed

towards food processors in the private sector. Because there is low recognition for under-nutrition activities, government support for operational commodity costs has not been forthcoming, leading to breaks in supply and a tapering off of international agency funding.

- Wheat flour fortification has as yet not been implemented in Punjab (MI, 2011).
- Varying models of school feeding programs targeted at girls from 6 to 11 years of age have been implemented in focal districts. These include the TAWANA Programme, led by Women's Development and Bait-ul-Mal, which specifically targeted nutrition. Bait-ul-Mal provided locally prepared meals at girls schools managed by parent committees, dietary awareness to mothers, and growth monitoring of students (TAWANA Report, 2006).
- After the Bait-ul-Mal program was discontinued midway through implementation, operational pilot programmes funded by the WFP were implemented through the Education Department. These programmes provided edible oil and high-energy biscuits to female school children. They are now being redesigned and funded by the Education Department and up-scaled to provide edible oil and milk powder to girls. However, as we will discuss later in this report, the initiative serves mainly to increase school enrolment. It actually has less value for controlling under-nutrition.

Table 5: Health cluster interventions in Punjab

Activity (On-going and Completed) and Responsible Organisations	**Planned**
Iodized salt *Micronutrient Initiative (MI)/private sector/Department of Health (DoH)*	Wheat flour fortification *Department of Food, DoH, private sector*
Vitamin A (with polio campaign) *DoH*	Supplementation to severely acute malnourished children and moderately acute malnourished pregnant and lactating women *DoH*
Iron and folate to pregnant mothers *DoH*	Infant and child feeding practices:
Sprinkles: Pilot district *MI/DoH*	De-worming to children and mothers *DoH*
Community Based Management of Acute Malnutrition: flood districts *DoH*	Zinc supplementation to children *DoH*
Breastfeeding *DoH*	Vitamin D to children and mothers
Awareness and communication *DoH*	Women-focused approach: 1,000 days + Model: Iron and folate to mothers before pregnancy
School feeding using commodities *World Food Programme/Department of Education*	Awareness and communication *DoH*
School feeding using local foods *Social welfare/Bait-ul-Mal*	Micronutrient sprinkles pilot *Donors/MoH*
	Promoting kitchen gardening
	Access to safe drinking water

Source: PC-1 Punjab, 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 NNS 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 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.

Amongst the Punjab provincial departments, the Department of Health (DoH) has been the most visible in defining a five-year strategy for nutrition, particularly targeted at women and children, to be implemented at a cost of Rs.1.5 billion. It will be supported mainly by development partners (led by the World Bank) with lesser share from the provincial DoH. The full strategy will be implemented in 12 districts, and awareness and communication activities will target all districts. Other provincial departments are in varying stages of identifying pro-nutrition measures. 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 Development.

Punjab, like the other provinces, is the lead driver of its own 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 Punjab it has also provided space for strategic work tailored to the province's specific needs. At the same time, devolution creates a need for a new 'home' for nutrition. Post-devolution, there is lack of a central authority in Punjab for nutrition to take on the work of the National Planning Commission.

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. Punjab'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. Health 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 Punjab 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, National Disaster Management Authority (NDMA) and the recently created Ministry of Food Security and Research. This means that the provinces, including Punjab, 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 P&DD 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. The P&DD Punjab has traditionally provided stronger stewardship than that seen in other provinces, and provides positive support for nutrition. P&DD Punjab understands nutrition as a component of the health sector that requires multi-sectoral linkages and is likely to blunt strong cross-sectoral coordination.

Punjab was the first province to establish a provincial Multi-Sectoral Committee for Nutrition headed by the Additional Chief Secretary. It includes representatives from the Health, Food, Agriculture, Education, Local Government & Rural Development, Public Health Engineering, Social Welfare & Women's Development sectors, industries, and co-opted members from the United Nations/donors. This is supported by a technical working group on nutrition comprising focal people from relevant sectors.

Overall, existing momentum is towards a loose coalition of sectors and inter-sectoral action on nutrition. There is also resistance within sectors to joint funding lines, and a lack of championing for nutrition by political and bureaucratic elites. Together, these factors impede the construction of a strong central structure for nutrition.

Discourse on Nutrition: In Punjab there is a general consensus within the key sectors that under-nutrition has suffered from low priority attention and needs more concerted action. Provincial stakeholders recognize that it is necessary to connect sectors to tackle under-nutrition, but there is a relative disconnect in terms of the main thrust of responses. In recent discourse on nutrition, poverty comes across as the single most dominant theme for concerted action. Stakeholders emphasize the connection between poverty, food, preventive health and awareness, and are sharpening efforts to provide targeted resources in poorer districts.

There is a general consensus that there has been lack of delivery on mandates by respective sectors. Stakeholders recognize that because progress on nutrition relies on multiple sectors, efforts are challenging to implement. However, there is optimism that with political championing nutrition might get due recognition in development.

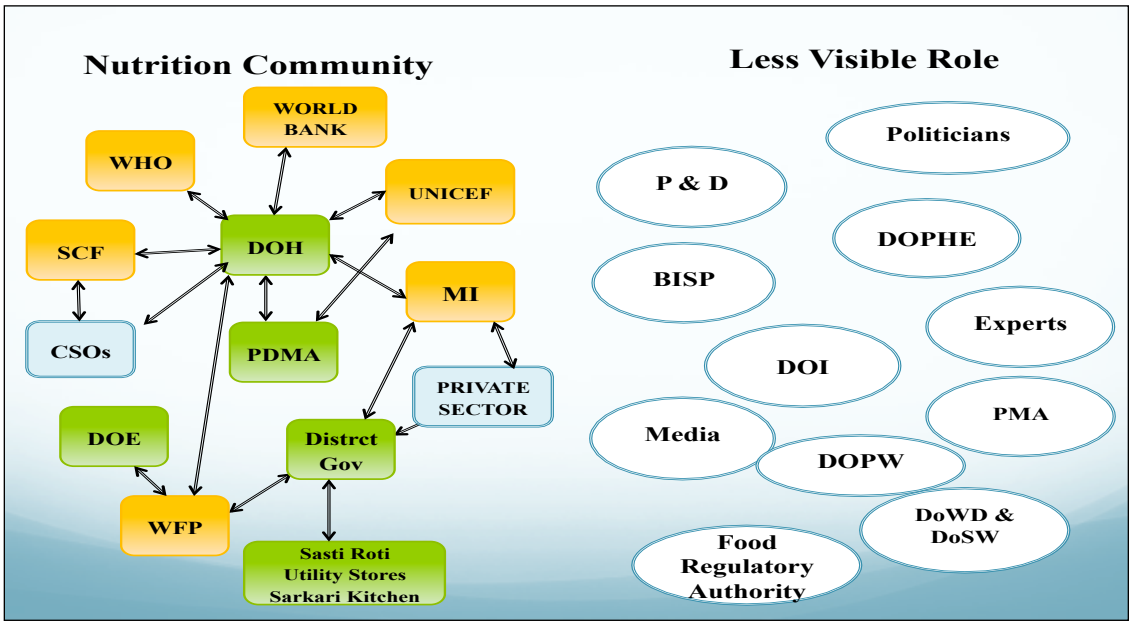
Nutrition Coalition for Cross-Sectoral Action: As we have discussed, the nutrition community at present comprises a loose coalition of stakeholders. Some have made visible connections with nutrition and others have an important potential role that still needs to be defined.

- Within the provincial departments, the Health sector has been the most visible in defining its role around nutrition, and has employed preventive health strategies targeted at women and children. However this is a recent move instigated with development partner support and funding, and its sustainability is uncertain.
- Other sectors, such as Agriculture, Food, Education, and Public Health Engineering, have only recently been drawn into nutrition coalitions. The definition of their role is still emerging under the dialogue started by the P&DD. Punjab P&DD has a supportive stance towards nutrition, but views nutrition as a technical subject related to health, and its own role with respect to nutrition is still being defined.
- A Food Regulatory Authority, initiated in 2012, is an important development in Punjab. Its mandate is to enhance food safety by horizontally coordinating the Food and Health sectors to achieve market quality assurance for food commodities. It will also regulate the enforcement of fortification (Punjab Disaster Management Authority website).
- After devolution, donors have emerged as a harmonized community, closely coordinating inputs for under-nutrition while keeping short of pooled funding. Development partners providing technical support in Punjab include old partners, such as the United Nations Children's Fund (UNICEF), WFP, the World Health Organization (WHO) and MI. There have also been new entrants. The World Bank is providing a soft loan, while the United Kingdom Department for International Development (DFID) is supplementing work through grant support (PC-1 Punjab, 2012–2015).
- The non-state sector in Punjab, beginning with agriculture, has also made a promising start towards improving nutrition. Punjab has recently implemented a graduate and post-graduate programme in nutrition, the first of its kind in any province. This programme is based within the Agriculture and Veterinary sector but emphasizes both community-based nutrition and

food safety. Despite an active private sector, mainstreaming within Punjab's medical community has been weak. Nutrition has lacked visible advocates in the private health sector and professional medical associations. Community support organisations so far have not internalized nutrition as their agenda and involvement has been confined to short term activities as contractees of UN agencies. There has been recent emergence of private philanthropic foundations, which have focused on feeding the poor in public sector hospitals in major urban cities in response to increasing poverty and hunger. Although children are not the only beneficiaries of hunger programmes, these show growing local coalitions around food as the emergence of hunger is focused by philanthropic foundations.

Visible connections between non-state and state sector efforts are missing, partly because there are no state-sponsored forums for dialogue. As we have discussed, unlike other provinces, provincially based politicians in Punjab have shown a strong leaning towards action on hunger and food security. Low visibility and lack of advocacy for nutrition are the main bottlenecks to political championing, and an effective coalition involving politicians and media has yet to be to be built. Figure 15 shows a net map of actors involved in nutrition activities in Punjab.

Figure 15: Nutrition activities in Punjab



Source: PC-1 Punjab, 2012–2015; Punjab Stakeholder interviews

Past Experiences and Recent Opportunities: 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 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 programme's ability to improve

nutrition was lessened by turf-setting and low ownership at the district level, where the Education Department, rather than the Women's Development Department, 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).

Whilst dealing with the floods in Punjab 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 Punjab, as in other provinces, a full range of nutrition-related health measures is not in place due to a lack of sufficient recognition, commitment, and funding. Main nutrition-related interventions include salt iodization, some preventive health measures through LHWs and frontline government health facilities, and the 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, which broadens the opportunity for cross-sectoral action.

Challenges: Punjab has comparatively fewer issues around outreach access, security, and female mobilization than Pakistan's other provinces. Consequently, hand washing, introduction of complementary feeding at six months of age, and birth spacing are equal or higher than national figures (Table 6). The province also faces fewer challenges to district cooperation and accountability because it has a strong administrative culture of vertical command and implementation.

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

Evidence-Based Intervention	Punjab (% population)	Pakistan (% population)
Exclusive breastfeeding up to 6 months[1]	22.0	13.0
Complementary feeding, 6–8 months[1]	49.6	51.8
Hand-washing with soap[1]	57.8	57.6
Contraceptive prevalence rate (modern method)[2]	29.0	21.7
Vitamin A supplementation[3]	81.0–91.0	79.1 (78 - 92)
De-worming[1]	78.0	77.0

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

The main challenge for Punjab in implementing existing nutrition initiatives has been lack of an understanding and focus on nutrition, and consequently weak technical capacity for nutrition. Nutrition is dealt with by a single nutrition focal person at the provincial DoH. This person is not supported (by technical and administrative staff at either the provincial or district level) to effectively monitor nutrition and plan improvement efforts. Moreover, health care provider capacity at all tiers of the health care system is low for under-nutrition screening, management, and counselling. Nutrition topics have not been integrated with medical and allied health sciences training curricula (to reach new cohorts), and there has not been funding for in-service trainings (to educate practicing health providers).

Organizational challenges, although less pronounced than in other provinces, have also impeded the effective delivery of under-nutrition management and prevention. First, planning management and monitoring of nutrition services has been impeded by the presence of separate vertical programmes within the DoH (i.e., EPI, MNCH, Nutrition, LHWs). Second, standardized nutrition services are not widely provided in the private health sector. This is a gap that goes largely unregulated, even though the 73% of the population, including the poor, use the private sector in Punjab (FBS, 2010–2011b). Third, there is lower outreach in focal areas of Punjab with LHW coverage of 52% (Oxford Policy Management, 2009) due to under- coverage levels in Southern Punjab districts. At the same time these districts face inadequate funding to cover travel costs and provide staff incentives to increase nutrition screening, awareness and monitoring, because district budgeting follows an even-sized approach across all districts.

Opportunities: Post-devolution, Punjab has made important strides in terms of organization and re-structuring. The Health Department, 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, fortification, and household awareness-building.

Punjab has also overcome the siloed management of vertical programmes by integrating proposed cost-effective programmes into a single programme for provincial MNCH, nutrition, and LHWs. Even though the nutrition component relies heavily on donor support, this integration offers nutrition efforts a better chance of sustainability through shared operational planning, management, staff, infrastructure, and field-related costs. Punjab is also the first province to have instituted a provincial Food Regulatory Authority. Amongst other tasks, the Authority should provide coordinated efforts to monitor food fortification.

Examples of Some Successes and Underperformance: The vitamin A supplementation effort has achieved some of the best results, providing between 81% and 91% coverage (Table 6). This is largely due to effective horizontal coordination with the federally supported polio immunization programme and strong vertical coordination with provincial and local governments. Punjab also has the highest rate of iodized salt availability (78.8%) in Pakistan, compared with a 69% national availability (NNS, 2011). This is due to a strong administrative culture of cooperation between provincial and district governments, and good presence of private salt processors in all districts, and has been achieved despite a lack of supportive legislation. New provincial legislation, when it passes, is expected to fill the remaining gap in salt iodization.

Quality assurance of salt available on the market remains weak in Punjab, as in all provinces. Market quality assurance of fortification is also weak due to low emphasis and rent seeking nexus. Similar issues are likely to affect wheat flour fortification planned in the 2013/2014 ADP for Punjab.

Other nutrition initiatives have been less successful. Programmes to supply folic acid and iron supplements to pregnant and lactating women have suffered from supply breaks resulting from inadequate funding. Community-based nutrition screening, awareness, and child referral efforts do not face outreach constraints as seen in other provinces, but still have not been given sufficient priority. School feeding programmes, despite strong ownership and funding support from the provincial government, have been constrained by technical and design issues related to beneficiary age group. They are also limited by the fact that more focus is placed on school enrolment than on nutrition monitoring, and continued uncertainty as to whether the commodities are actually consumed by the children.

9. Funding: Type, Adequacy, and Modalities

Traditional Funding Landscape: Nutrition-related initiatives have historically been dependent on development partner funding and involve support for commodities, awareness-building, and monitoring. Donor funding in Punjab in the past has involved support from UNICEF, WFP, and WHO to specific facilities and districts for CMAM, infant and young child feeding programmes, and school feeding, as well as small grant disbursement to CSOs for nutrition awareness and screening in the community. Bilaterals have supported INGOs in Punjab for nutrition-related initiatives in flood districts as well as implementation of district-based pilots for food fortification. All of this funding has been small-scale, and it has lacked coordination amongst donors. Within public sector development programmes there has been no funding separately earmarked for nutrition. Provincial budgetary support has been extremely inadequate, supporting only a small unit for nutrition at the provincial level and no matching staff in the districts. Commodity support has been restricted to the provision of folic acid and iron to pregnant and lactating women, and has suffered from supply breaks.

Recent Shifts in Donor Funding: Recent post-devolution movement toward nutrition profiling in Punjab has been accompanied by positive changes in donor funding. Punjab has been pledged with better investment for nutrition from development partners as compared to the other three provinces. This can be seen in the wide range of partners that have been engaged, including AusAID (the Australian Government's Overseas Aid Program), DFID, and the World Bank, in addition to technical support from UN agencies and INGOs. Good governance and planning, and easy access from the federal capital are important factors attracting aid to Punjab; this is also the case with KP (Khyber Pakhtunkhwa) Province. Experience with the faster and more efficient process for donor/government engagement in Punjab in the post-devolution scenario has also paved the way for a substantial new inflow of funds. At the same time, this is making it more complex to strategize donor investment at the federal level. Donor funding has been up-scaled, involves coordinated contributions from different donors, and has shifted from short-term projects towards five-year medium term funding. 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 Punjab. In the post-devolution scenario, funding support for the social sector is not provided from 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 after the seventh NFC Award of 2010. The seventh NFC is historic for a number of reasons: (1) a consensus-based award has been arrived at despite several inconclusive attempts in the past; (2) the provincial share of resources increased to 56%, which is a departure from the1990s 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). Punjab has benefited with Rs. 437 billion in the 2010–2011 budget, involving an increase of Rs. 83 billion as result of the new distribution formula. Table 7 compares the funding amounts received by each of the provinces from the National Finance Commission Awards, in 2010, and through DRGO (Distribution of Revenues and Grants-in-Aid Order) Awards in 2006.

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 DRGO Award (Rs. millions)	Difference (Rs. millions)
Punjab	488,401	405,607	82,794
Sindh	233,445	187,502	45,943
Khyber Pakhtunkhwa	151,199	95,599	55,600
Baluchistan	89,060	38,410	50,650
Total	962,105	727,118	234,988

Source: SPDC, 2011

Translation Into Nutrition Funding: Punjab has yet to come up with a development strategy vision in the post-devolution period. Despite this lack of a formal vision, however, it has started making deliberative reforms in key nutrition-relevant sectors, such as Health and Food. Health, the main sector in which nutrition has been operationalized, has had a steady increase in funding, with proportionate spending by Punjab higher than other provinces (Table 8). However, within Health there has until recently been little meaningful translation into nutrition. The majority of funding, including development and operational funding, is spent on hospitals. Development expenditure has remained stagnant, without allocations for nutrition, and the majority of operational expenditure is for staff salaries, leaving little room for the commodities and outreach activities required to support nutrition.

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

Financial Year	Health Expenditures (Rs.)	Total Provincial Expenditures (Rs.)	Health Expenditures as % of Total Provincial Expenditures
2008–2009	22,947	417,000	6%
2009–2010	34,572	489,873	7%
2010–2011	47,581	580,287	8%
Provincial and district expenditures on health increased 33%, from Rs. 29.3b to Rs. 39b over the last three years, mainly to support employee-related costs.			
Provincial and district development expenditures on health remained static, adding only 1%, from Rs. 8.6b to Rs. 8.7b over last three years. Taking inflation into account, there is a decline.			
77% of total consolidated health expenditures supported 'General Hospital Services' and 8% supported 'Construction and Transport'.			

Source: TRF, 2012

Recent donor-provided funding to the Health sector to support nutrition is estimated at around Rs. 1,500 million from the World Bank. This, together with commodity support from WFP, UNICEF, and WHO, has catalyzed matching contributions from the Punjab government. This is, however, merely 20% of the total amount, and it is funded from the Development budget. Both factors raise serious sustainability issues. A positive development for the sustainability of committed funds is that funding in Punjab, compared to other provinces, will be allotted within an integrated PC-1 for Reproductive Health, Child Health, and Nutrition. This is expected to improve financial sustainability through shared resources (as compared with a standalone Nutrition PC-1).

Funding for nutrition in other sectors has involved planning around school feeding, the creation of a Food Regulation Authority, and kitchen gardening. However, except for school feeding, there has not been commitment of substantial funding in other sectors. One reason is the lack of donors to support nutrition efforts in other sectors, whereas in the Health sector, the process was speeded along and incentivized due to donor support and advocacy. There is also a lack of consensus on what funding to provide for nutrition. Sectors other than health disfavor heavy investment in supplement provision as an unsustainable response, and there is better support for poverty and food security determinants. A substantial funding commitment for nutrition that encompasses all sectors will depend upon political championing by parliamentarians, as public-sector development funding priorities in Punjab, as in other provinces, are primarily shaped by the perspective of political representatives. The 'case for nutrition' has yet to be properly presented and advocated to the political elites to pursue meaningful funding commitment.

Funding Flow Preferences: Amongst government sectors, the preferred funding modality is separate, rather than joint funding lines, supplemented with funding support for the Intersectoral Technical Working Group on Nutrition. Despite both the joint funding lines used by government departments during the flood response, and the pooled funding placed by donors during the response, in the case of nutrition both donors and government prefer a risk-neutral approach that allows for carefully coordinated operations but separated funds. Hence, as we have discussed, the financing landscape in Punjab supports loose coalitions rather than tight structural coordination. Within sectors, there is generally low demand for tying fund releases to performance targets as a way to improve vertical coordination. This is due less to apprehensions (as seen in other

provinces) as it is to the fact that in Punjab, compliance between administrative tiers is felt by stakeholders to be less of an issue as compared to other provinces.

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. Punjab, like other provinces, has credible and comprehensive household-level 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. As in other provinces, cross-sectoral initiatives to plan future efforts to reduce under-nutrition in Punjab would benefit from a rigorous baseline. 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 Punjab, 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 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 programmes. 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 by parallel sectors including Education, Food, and PDMA, but with little sharing of data. Monitoring of food quality parameters has a split responsibility. Wheat market surveillance is carried out by Food Department, while quality assurance of other items is reported to Health.

Implementation Issues: To implement nutrition efforts, it is necessary to monitor two types of information: nutrition and pro-nutrition indicators, and targeting of interventions. Punjab has a strong level of vertical coordination between the province and the districts. This may ensure effective implementation of nutrition monitoring, but as in other provinces, success will require technical support to design a comprehensive monitoring system. Targeted information on poor female beneficiaries can be provided by BISP. Due to turf issues between the federal Pakistan People's Party-led government and the provincial government, led by the Pakistan Muslim

League N (PML-N), BISP has less coverage in Punjab than would otherwise be expected, and a parallel cash transfer scheme involving Bait-ul-Mal has been started by the PML-N. Both present opportunities for nutrition linking but there must be strong coherence across social safety net initiatives.

Advocacy Coalitions: Punjab has a better-developed non-state sector for advocacy, as compared with KP and Baluchistan. So far, however, advocacy has been limited, has had low trickle-down to the community, and has been confined to the Health sector. It still needs to make a visible connection, particularly with the Agricultural sector given Punjab's context. As in other provinces, there are no forums between the state and non-state sectors, an issue that is compounded by fragmented data collection. In Punjab, teachers, LHWs, district governments and politicians have been identified as important potential proponents who need to be effectively captured through timely and relevant information sharing. Media, an increasingly important player for mobilizing change agents, has not been tapped. This is due both to a lack of communication channels between the state and the non-state sectors and to an absence of skill in media management and propagation.

11. Opportunities and Bottlenecks: Summary

Punjab's nutritional puzzle is that it has high levels of chronic malnutrition and micro-nutrient deficiencies despite a surplus production of food and a low poverty level. Under-nutrition is mainly linked to insufficient attention to preventive health strategies and to a lack of connection between relevant sectors such as Education, Health, Poverty, Safe Water and Sanitation, and Food.

Punjab has a strong governance culture at both the provincial and district levels. The province has initiated a number of food distribution schemes, and has made important strides post-devolution by integrating siloed pro-nutrition vertical preventive health programmes and establishing a Food Regulatory Authority.

One of the main issues confronting nutrition is a lack of adequate understanding and ownership. Nutrition is a complex, multifaceted subject, and a cohesive understanding of under-nutrition is lacking across sectors. There is commonly weak recognition due to low visibility and to the fact that improvement is an ambitious goal that relies on shared action. Low civil society and media activism on nutrition, as well as lack of championing by politicians, further weaken nutrition's place on the list of provincial priorities. Political commitment, which is important for leveraging nutrition across sectors, is dominated by more politically visible schemes such as food distribution and hunger. Hence, nutrition has lacked a comprehensive strategy and state funding, relying instead on fragmented donor-supported projects.

As we have discussed, structural and coordination issues also affect efforts to mainstream nutrition across sectors. No formal structure exists in Punjab to serve as the provincial counterpart of the National Planning Commission, and the province lacks strong executive leadership on nutrition. This is necessary because provincial departments have a vertical accountability structure and lack a mandate for coordination. Hence there are insufficient connections between programmes, beneficiaries, and targeting of different sectors. Nutrition tends to be narrowly operationalized within Health both in terms of projects and the monitoring

database, which limits inter-sectoral response. The closed departmental coordination used both for the flood response and to respond to outbreak of dengue fever provided positive experience with horizontal coordination, and there is openness across sectors for coordination. The P&DD has also taken a positive stance towards nutrition support, but with a construct that sees nutrition as a technical subject of health. Although there is recent positive movement towards horizontal coordination across sectors for nutrition, and Punjab is the first province to institute an inter-sectoral committee under the P&DD, this effectively puts together a loose coalition without providing a structural 'home' for nutrition.

Implementation of past nutrition initiatives, such as salt iodization and vitamin A supplementation, have had some of the best results in Punjab. This is the result of a strong level of vertical cooperation at all administrative tiers, and political priority. Progress in other areas is constrained by insufficient awareness of other preventive health measures, lack of connections between poverty, school feeding, safe water and food, and insufficient capture by lesser-developed districts and the at-risk group of low income pregnant women and children under three years of age. Technical capacity for nutrition planning, implementation, and monitoring is also weak across all sectors, and requires sustained support.

Funding for nutrition has been led by development partners in the past, but is showing signs of a positive shift towards government sustainability. This may be achieved by integrating nutrition within the larger government-sponsored integrated financing of preventive programmes related to mother and child health. Although Punjab will have significantly increased its funding support from the government compared with some of the other provinces, it will still be reliant on substantial development partner funding.

Punjab has a credible database of nutrition measurement. However, the emphasis remains on nutritional outcomes through large surveys. Insufficient attention has been given to process measurement. There is lack of a common basket of nutrition indicators across all sectors, and there is no monitoring and evaluation framework to support these activities.

12. Strategic Recommendations

There is much awareness at the policy level in Punjab that issues related to maternal and child nutrition must receive much greater attention and concerted action. Some of this stems from a new recognition of acute malnutrition in the wake of the recent floods which affected southern Punjab. There is also some recognition, albeit fragmented, that addressing under-nutrition would require multi-sectoral action and functional integration of various departments and programmes.

Key Findings:

- Universal concurrence is needed across party lines for political support and ownership for nutrition, with steering by executive leadership.
- Punjab has effective stewardship from the Planning and Development Department and strong interest shown by the Health sector. However, the construct of nutrition needs to be broadened as a cross-sectoral agenda. This may occur by building awareness and by providing the same kinds of funding and technical support incentives to other sectors that have previously been provided to the Health sector.
- Creation of a central convening structure is needed for effective cross-sectoral coordination. A convening structure should approve sectoral plans, house the monitoring database, provide joint funding lines, and coordinate joint sectoral initiatives. It should also be the central point for procuring and providing technical capacity for nutrition.
- There is popular support within sectors for independent budgetary lines but close functional working. This can be constructively tapped for joint initiatives that have well-defined interventions, common beneficiaries and geographical targets, and soft conditionalities.
- Sustainable funding is needed for nutrition, moving efforts beyond the Health sector to other sectors. A shift from the development to the operational budget is also necessary.
- Affordable funding options should be explored. Efforts will also require the development of local, low-cost home rehabilitation diets and foods, and appropriate nutrition rehabilitation services for severe acute malnutrition. It will also be necessary to build economies of scale by maximizing the use of all contact points, including immunization and school services, and by targeting opportunities such as those provided by the Benazir Income Support Programme.
- Punjab has made advances in salt iodization and vitamin A coverage due to strong vertical coordination between the province and local implementers. Punjab has an advantage over other provinces because it has more effective implementation and interventions. These strengths now need to be broadened to improve other nutrition activities.
- Focal and coordinated interventions in Punjab need to be directed toward Southern Punjab districts. They should focus on food security, poverty, patriarchy, HPE and health. This should be supported by a disaster recovery and mitigation plan.
- Current poverty alleviation strategies, such as the Benazir Income Support programme and Bait-ul-Mal, need a stronger connection with nutrition targets. They also need interventions that will help them maximize their nutrition outreach to Punjab's poorest groups and to women care providers, and improve the development value provided by social safety nets. Systems should be put into place to ensure that the implementation of such programmes is bipartisan and independent of political considerations.
- The current mix of preventive and promotive nutrition strategies within existing health programmes, such as the Lady Health Worker programme and maternal, neonatal, and child

health programmes, as well as other primary care health programmes, needs expansion and better implementation. Expanded efforts may include increasing exclusive breastfeeding through ordinance and awareness; an optimal mix of complementary feeding strategies; nutrition rehabilitation services at the district level for severe acute malnutrition; strengthening of the vitamin A supplementation programme; and iron and multiple micronutrient fortification of wheat flour and other staples. This will require concerted monitoring and implementation.

- 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 not only the Health but also the Disaster, Education, Food, Poverty, Public Health Engineering; and Water, Sanitation, and Hygiene sectors to effectively monitor interim progress.
- Punjab has a well-developed local non-state sector but needs effective partnerships around data production, awareness, advocacy, and monitoring. These can be incentivized with development of nutrition forums linking the state and non-state sector, harmonization of activities, and earmarked funding with the non-state sector. Linkages with local change agents, such as tribal elders, lady health workers, teachers, members of the media, and others need to be made to build an effective mobilization base at the local level. Nutrition advocacy needs to be enhanced in the Health sector and extended to activism in the large Agriculture and Food sectors of Punjab.

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Annex 2: List of Stakeholders

Serial #	Name of Stakeholder
1.	Anjumen-e-Sheharyan-Lahore
2.	Benazir Income Support Programme, Punjab
3.	CMAM & Nutrition Project, Lady Health Worker Programme
4.	DAWN Newspaper
5.	Department of Health, Government of Punjab
6.	DGHS, Department of Health Government of Punjab
7.	Focal Person, World Food Programme
8.	Food & Nutrition Department Government of Punjab
9.	Government of Punjab, PMLN
10.	Health Department, Punjab
11.	Health System Reform Unit
12.	Jahandad Society for Community Development
13.	King Edward Medical University
14.	Micronutrient Initiative , Punjab
15.	Micronutrient Initiative, Punjab
16.	MNCH Programme, Punjab
17.	Representative, Pakistan Muslim League (PML-N)
18.	National Programme for Family Planning and Primary Health Care (NP FP & PHC), Punjab
19.	Pakistan Medical Association, Punjab
20.	Representative, Pakistan-Tehreek-e-Insaaf
21.	Planning & Development Department, Government of Punjab
22.	Representative, PMLQ
23.	Representative, PTI, Punjab
24.	Punjab Food Authority Lahore
25.	Save the Children, Punjab
26.	School Education Department, Punjab
27.	School Education Department, Punjab
28.	SPHERE, Punjab
29.	UNICEF, Punjab
30.	University of Veterinary & Animal Sciences
31.	United Nations World Food Programme, Punjab
32.	WHO, Punjab
33.	World Food Programme, Punjab
34.	Department of Food Sciences and Human Nutrition, University of Veterinary & Animal Sciences, Lahore