August 2013

Nutrition political economy, Pakistan. Province Report: Khyber Pakhtunkhwa

Shehla Zaidi
Aga Khan University, shehla.zaidi@aku.edu

Zulfiqar Ahmed Bhutta
Aga Khan University, zulfiqar.bhutta@aku.edu

Abdul Wajid
Aga Khan University

Gul Nawaz
Aga Khan University

Kashif Nazeer
Aga Khan University

See next page for additional authors

Authors
Shehla Zaidi, Zulfiqar Ahmed Bhutta, Abdul Wajid, Gul Nawaz, Kashif Nazeer, Shandana Khan Mohmand, and Andres Mejia Acosta

AUGUST 2013

Institute of Development Studies

THE AGA KHAN UNIVERSITY

NUTRITION POLITICAL ECONOMY, PAKISTAN

Shehla Zaidi, Zulfiqar Bhutta,
Abdul Wajid, Gul Nawaz and Kashif Nazeer
Division of Women & Child Health
Aga Khan University

Shandana Khan Mohmand and Andres Mejia Acosta
Institute of Development Studies
University of Sussex

KHYBER PAKHTUNKHWA PROVINCE REPORT

NUTRITION POLITICAL ECONOMY, PAKISTAN

PROVINCE REPORT: KHYBER PAKHTUNKHWA

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.

MQSUN partners

Aga Khan University
Agribusiness Systems International
ICF International
Institute for Development Studies
International Food Policy Research Institute
Health Partners International, Inc.
PATH
Save the Children UK

About this publication

This report was produced by Shehla Zaidi, Zulfiqar Bhutta, Abdul Wajid, Gul Nawaz and Kashif Nazeer 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.

This document was produced through support provided by UKaid from the Department for International Development. The opinions herein are those of the author(s) and do not necessarily reflect the views of the Department for International Development.

TABLE OF CONTENTS

ACKNOWLEDGEMENT

This work was led by the Women and Child Health Division of Aga Khan University in collaboration with the Institute of Development Studies Sussex. Funding was provided by the United Kingdom Department for International Development and is gratefully acknowledged. Facilitation and support were also provided by the Program for Appropriate Technology in Health (PATH) as part of the Maximizing Quality of Scaling Up Nutrition project (MQSUN).

The team is grateful for fieldwork support and insights provided by the Khyber Pakhtunkhwa (KP) Province Agriculture Department, Education Department, Health Department, Food Department, Planning and Development Department, and Public Health Engineering Department, as well as the Provincial Disaster Management Authority, Benazir Income Support Programme, experts, United Nations Children's Fund, World Food Programme, Food and Agriculture Organization, and private sector stakeholders. The report also draws upon contributions and suggestions made at the KP Nutrition Note Workshop and the subsequent National Roundtable.

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
KP	Khyber Pakhtunkhwa
LHW	Lady Health Worker programme
MDG	Millennium Development Goals
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
PDMA	KP 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 Programme
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 Khyber Pakhtunkhwa (KP) 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 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 KP 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 20 in-depth interviews and two focal group discussions with stakeholders from the state, donor agencies, and civil society organizations, along with nutrition experts. We supplemented these discussions 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 KP: Under-nutrition levels in KP are marginally higher than national averages (Table 1). One fourth of the children in KP 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, which was evidenced by high levels of stunting in 2011 (48%) and the fact that stunting rates in the province have marginally increased over the years.

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

Under-Nutrition Status	KP	Pakistan
Child malnutrition		
Underweight (severe + moderate)	24.1	31.5
Stunted (severe + moderate)	47.8	43.7
Wasted (severe + moderate)	17.3	15.1
Child micronutrient deficiencies		
Vitamin A deficiency*	68.5	54.0
Anaemia	49.0	62.0
Zinc deficiency**	45.4	39.2
Maternal micronutrient deficiencies		
Vitamin A deficiency– Pregnant mothers	76.2	46.0
Anaemia– Pregnant mothers	30.0	51.0
Zinc deficiency– Pregnant mothers	52.6	47.6

Source: NNS, 2011

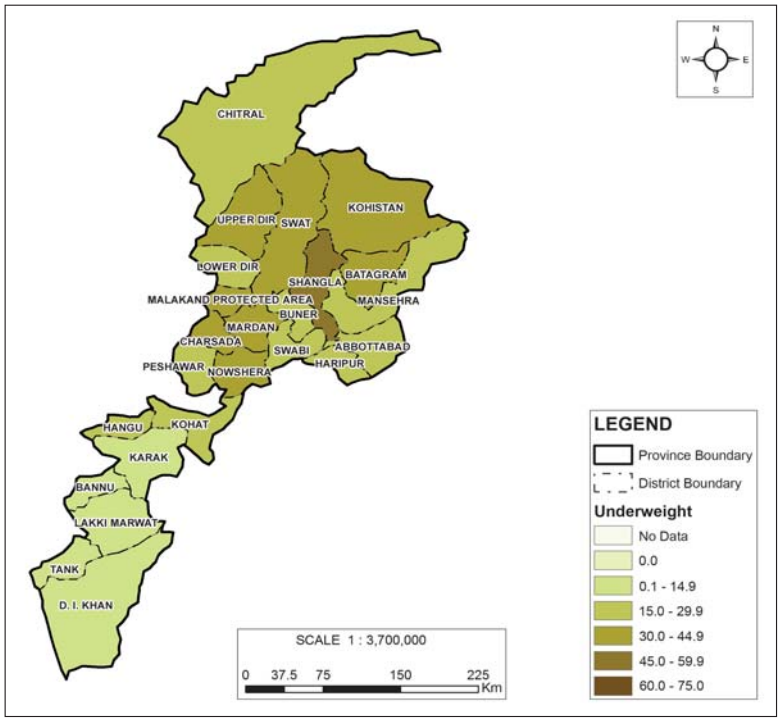
* Biomarker used: Serum retinol levels

** Serum zinc levels

KP as a whole has more under-nutrition than other provinces. There are also great regional disparities within the province; districts in southern KP have the greatest prevalence of under-nutrition. Results of the 2011 National Nutrition Survey (NNS 2011) show lower levels of underweight children as compared to national levels, although the proportion of children suffering from stunting and wasting is higher than national figures.

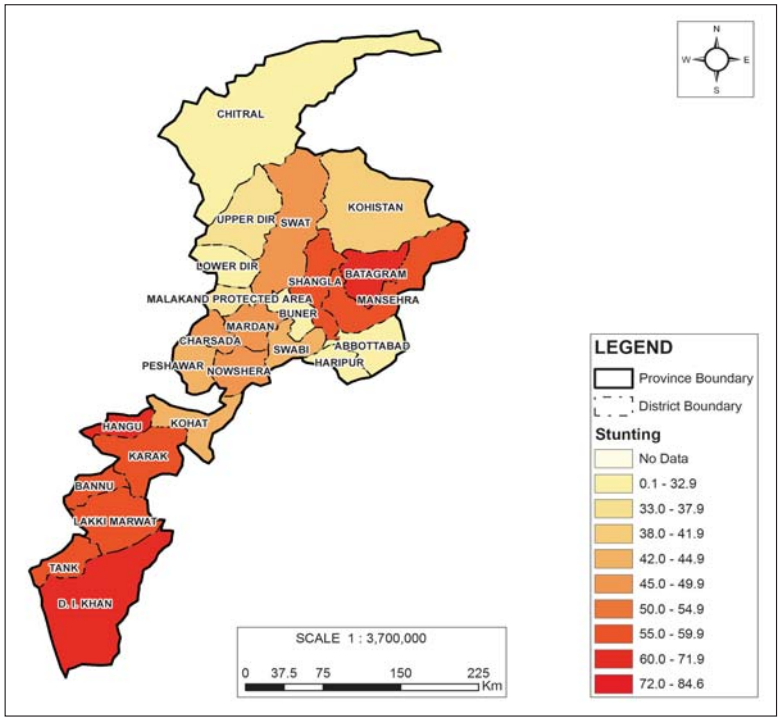
Broadly comparable trends were also seen with prevalence of wasting in central areas of the province. Figures 1, 2, and 3 show regional variations in underweight, stunting, and wasting in KP.

Figure 1: Underweight differentials in KP, 2011 (<2 *SD*)



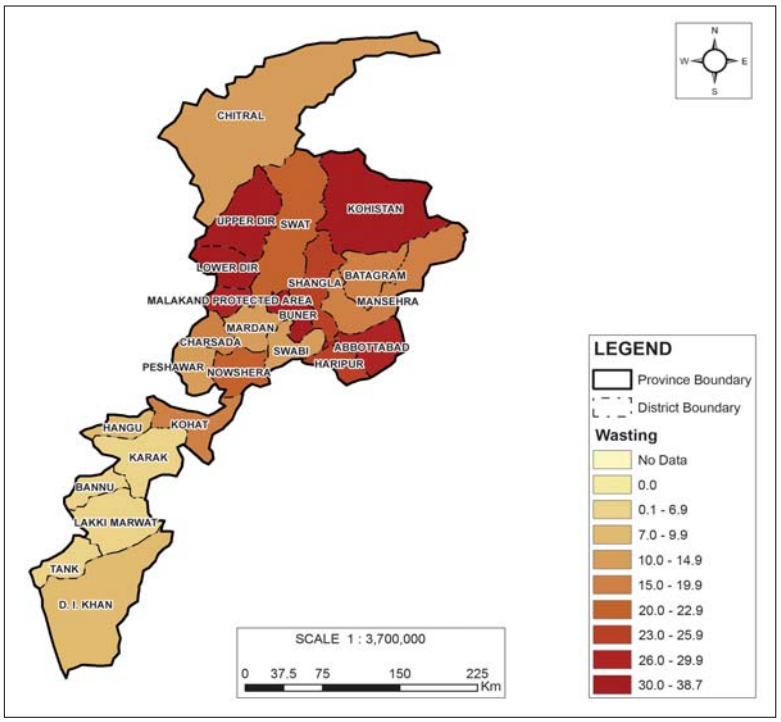
Source: NNS 2011

Figure 2: Stunting differentials in KP, 2011 (<2 *SD*)



Source: NNS, 2011

Figure 3: Wasting differentials in KP, 2011 (<2 *SD*)

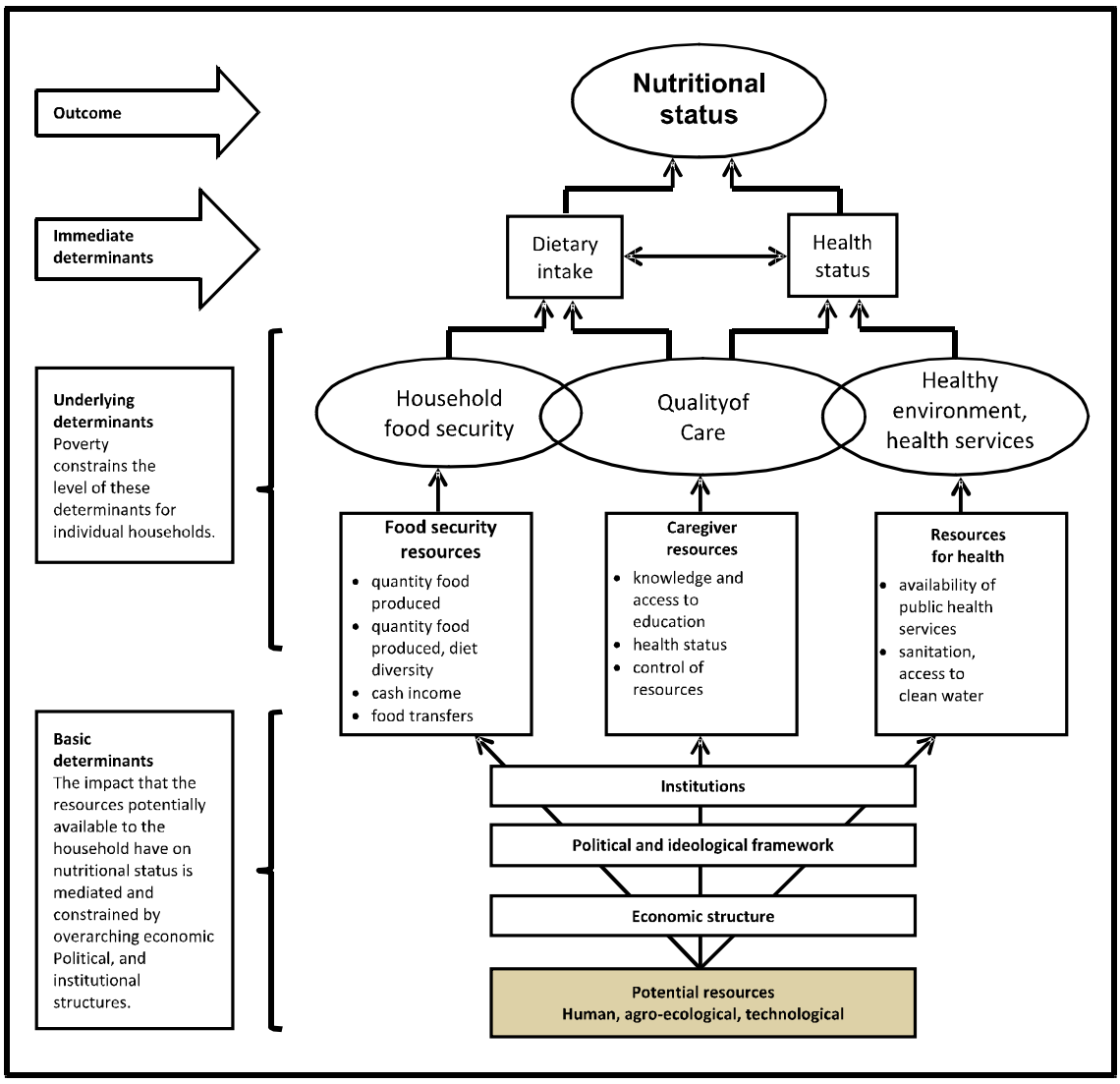


Source: NNS, 2011

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

Figure 4: Causal pathway of under-nutrition



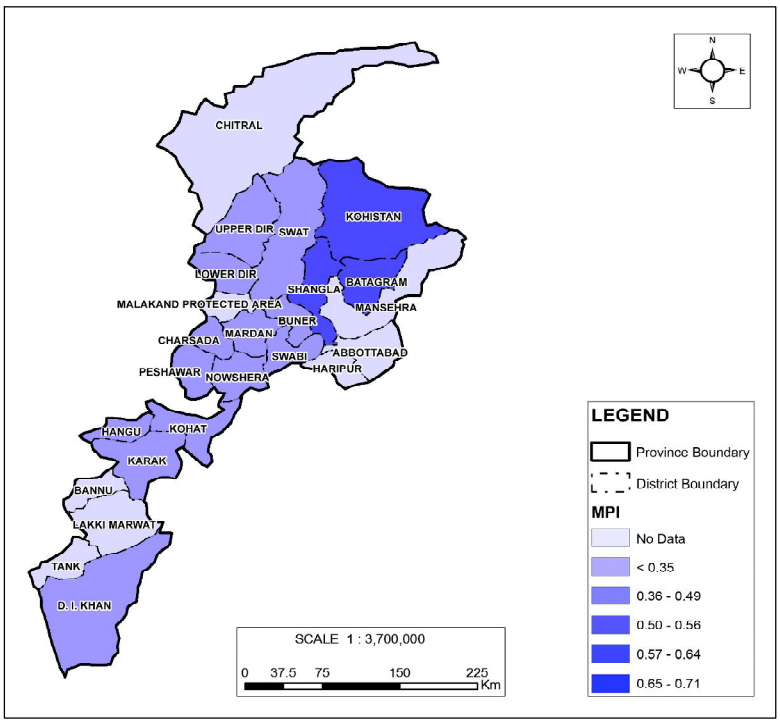
Sources: UNICEF, 1990; Benson & Shekar, 2006

4. PROVINCIAL CONTEXT FOR UNDER-NUTRITION

Poverty and Its Various Dimensions: Pakistan's economic productivity has been decreasing since the 1980s, 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. KP has a lower poverty incidence (29%) than Pakistan as a whole (33%) (United Nations Development Programme [UNDP], 2011; SPDC, 2004). KP is less agricultural than Sindh and Punjab provinces. Only 16.5% of the land in the province is agriculturally productive (FBS, 2009–2010; KP CDS 2010–2017). The province is largely mountainous; only about 30% of the land is cultivable or arable (FBS, 2010–2011b).

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

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



Source: NNS, 2011

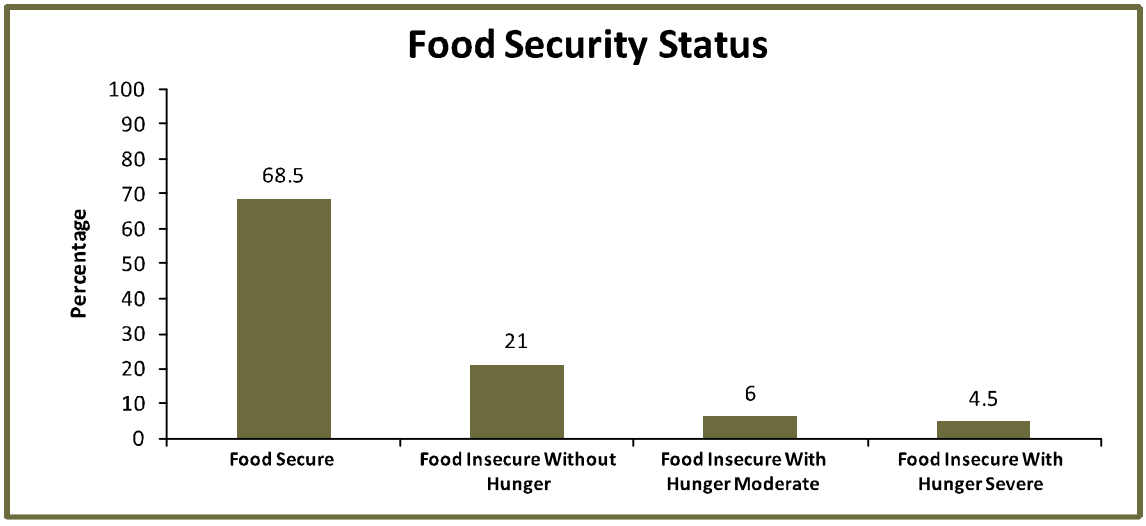
* MPI is calculated by multiplying the percentage of people who are MPI poor (incidence of poverty) with the average intensity of MPI poverty across the poor (%)

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 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 KP was much lower and is reflected in Figure 6.

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



Source: NNS, 2011

KP depends on other provinces for food, and 31.5% of the households in the province are food insecure. Explanations for this food insecurity include a high population growth rate; inequitable wealth distribution; district variations in poverty (primarily in rural districts); and inflation in food prices across the province. Table 2 displays detailed relationships between food security resources (agriculturally productive land and/or land ownership) and poverty in the Sindh, Punjab, KP, and Balochistan provinces, and in Pakistan as a whole.

Table 2: Food security resources and poverty in Pakistani provinces, 2009–2001 (% population)

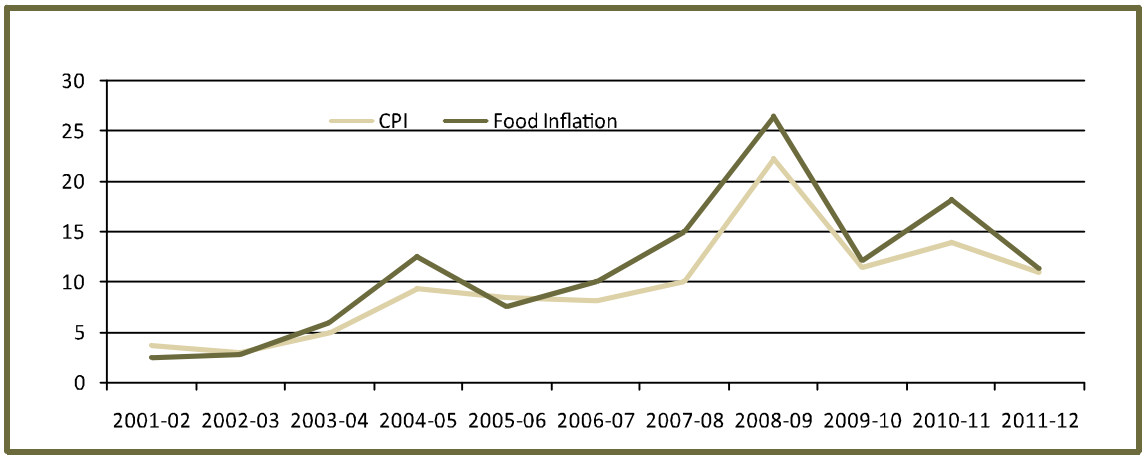
Food Security or Poverty Status	Sindh	Punjab	KP*	Balochistan	Pakistan
Food secure[1]	28.2	40.5	68.5	36.5	42.0
Food insure[1]					
- Without hunger	21.1	32.2	21.0	33.9	28.4
- With moderate hunger	33.8	18.5	6.0	18.0	19.8
- With severe hunger	16.8	8.8	4.5	11.5	9.8
Agriculturally productive land[2]	27.3	83.0	16.5	3.0	30.0
Poverty incidence[3]	31.0	26.0	29	48	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) have placed an increased the burden on already-stretched household food budgets. Figure 7 displays changes in annual inflation in KP during roughly the last decade.

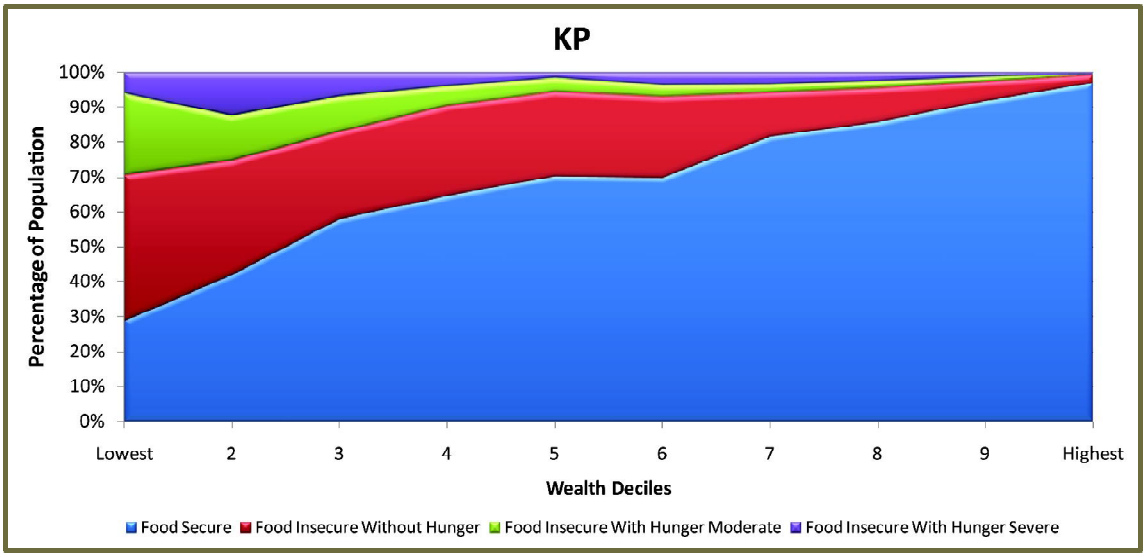
Figure 7: Annual inflation and consumer price index (CPI) changes in KP, 2001–2012



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 close correlation between the two measures for KP (Figure 8). Data suggest that both poverty and food insecurity operate in KP and that a significant proportion of the poorest quintiles of the population experience food insecurity.

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

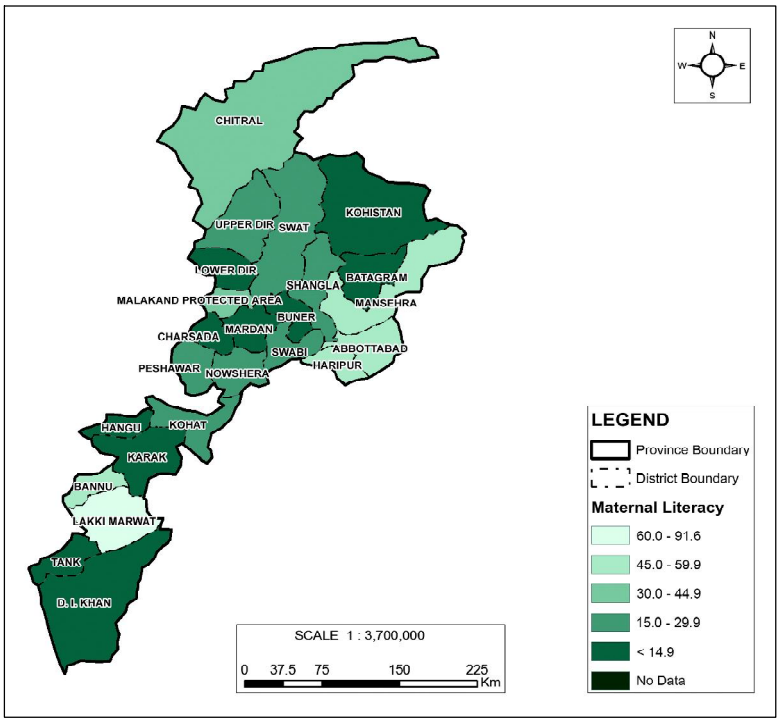


Source: NNS, 2011

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.

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 women in KP is 33% compared to 68% for men and the district disparities in female literacy range from 6% to 59% across the province (FBS, 2010–2011a). Recent NNS data show that 72.2% of mothers in KP are illiterate. 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 9 displays the wide differentials in maternal education in KP.

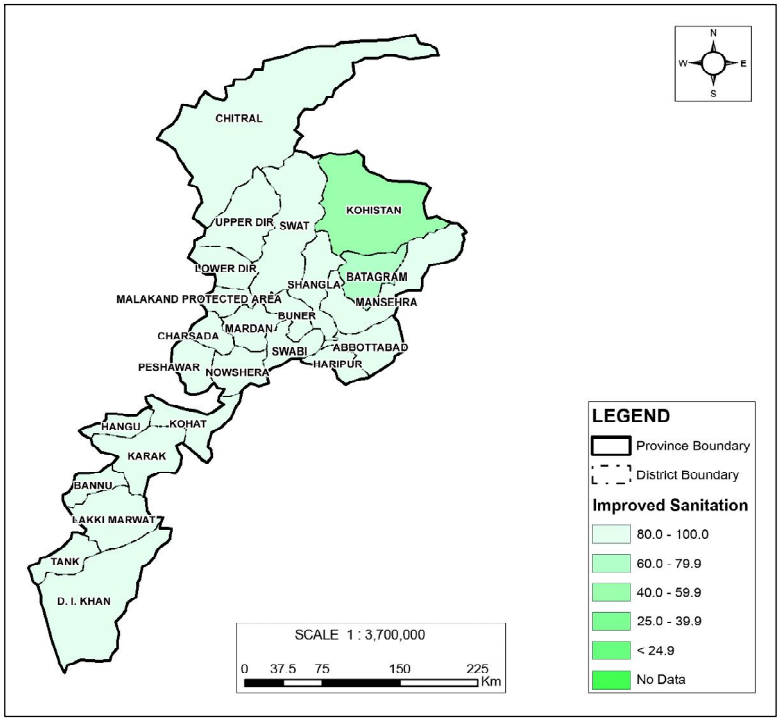
Figure 9: Maternal education differentials in KP, 2011



Source: NNS, 2011

Healthy Environment: Lack of access to 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. KP has marginally lower levels of safe water usage by household (70%) as compared to the national level (87%).Use of hygienic sanitation facilities is also slightly lower (62%) than the national level (66%) (FBS, 2010–2011a). 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 KP, 2011



Source: NNS, 2011

Access to Key Health and Social Sector Services: KP is the second smallest province by population. It has a high population density of 332 people per square kilometre compared with a national average of 166 people per square kilometre (UNDP, 2011). As of mid-2011, its population is estimated to be 24.7 million people. The urbanization rate is 17% per year, although there are district disparities. The population is primarily concentrated in three cities: Peshawar, Mardan, and Mingora (UNDP, 2011; Census, 1998).

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 across various districts in KP.

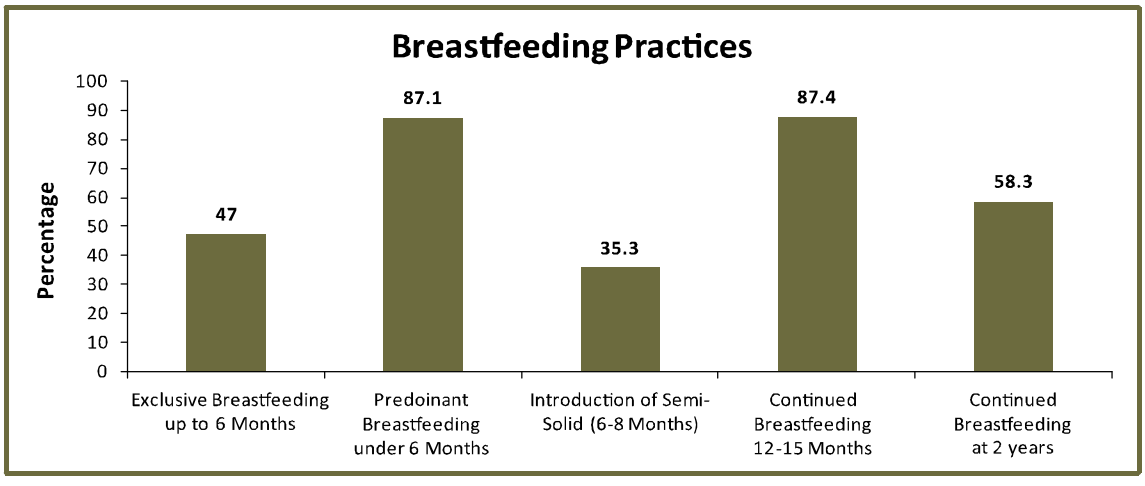
Table 3: Coverage of health interventions across districts in KP, 2011 (% population)

Indicator	Prevalence	Range Across Districts
Improved sanitation	93.9	49.0–100
Maternal literacy (%)	27.8	2.0–64.5
Antenatal care by skilled attendant	47.7	0.6–75.4
Nutrition during last pregnancy		
Iron supplement intake	19.3	1.3–44.1
Folic acid intake	28.0	0.0–54.0
Child growth		
Stunting (<-2*SD*)	47.8	33.3–65.7
Wasting (<-2*SD*)	17.2	4.4–42
Underweight (<-2*SD*)	24.1	6.0–44.4
Supplement intake (children under five years of age)		
Vitamin A	75.2	(29.7–100)
Zinc	1.3	(0.0–9.5)
Immunization status (children under five years of age, verified from vaccination card)		
BCG	35.4	(0.0–70.2)
Pentavalent	36.6	(0.0–72.3)
OPV	28.4	(0.0–50.5)
Measles	31.2	(0.0–70.5)
Initiation of breastfeeding (<1 hour)	74.3	(17.1–100)
Colostrum given at birth	96.3	(77.1–100)

Source: UNDP, 2011

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

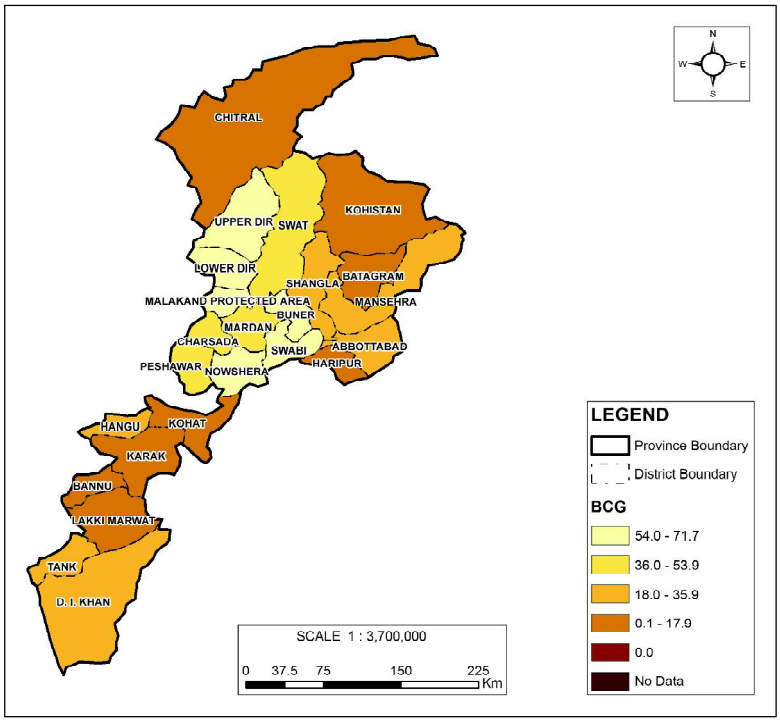
Figure 11: Breastfeeding practices in KP



Source: NNS, 2011

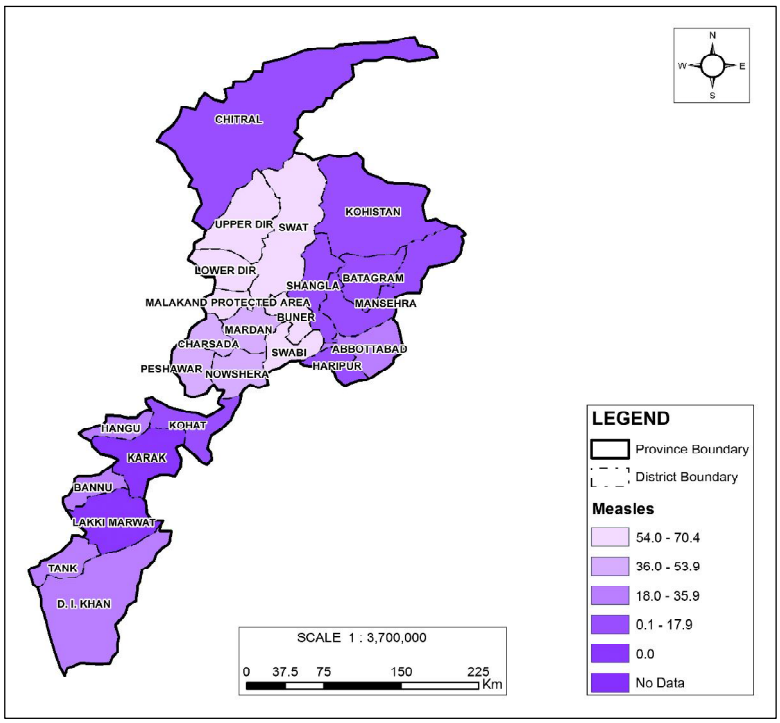
Childhood immunizations are a measure of promotive and preventive strategies in health systems. Figures 12 and 13 reflect the inter-district coverage of two vaccines, BCG and measles, based on verified data from the NNS2011 Survey.

Figure 12: BCG vaccination at birth in KP, 2011



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

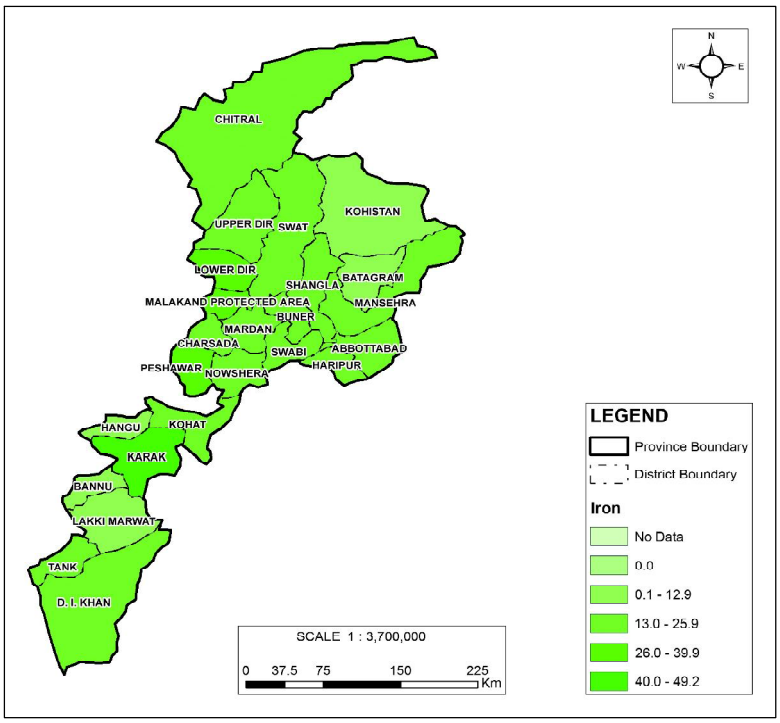
Figure 13: Measles vaccination in KP (children less than five years of age), 2011



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

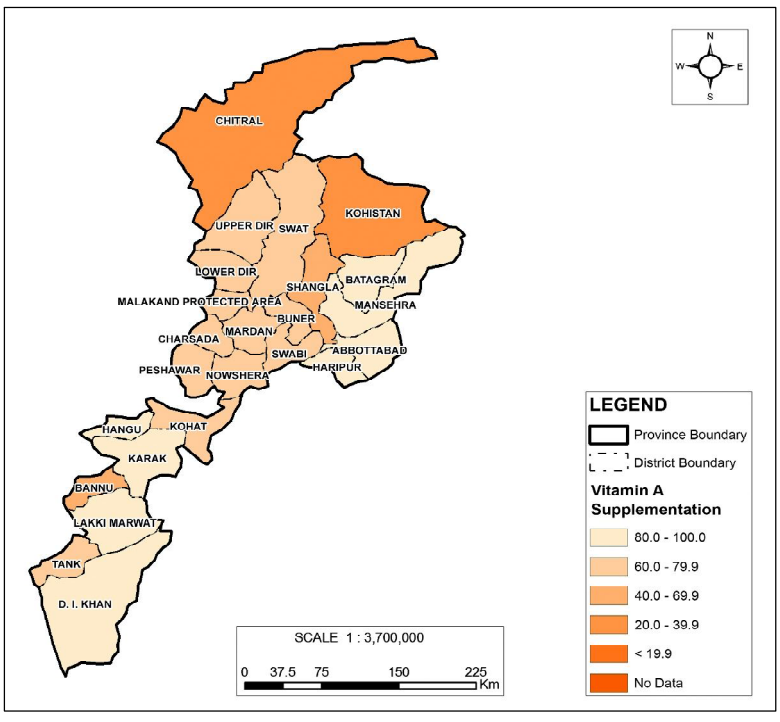
Public sector programmes addressing micronutrient deficiencies and malnutrition have a limited range, but include iron-folic acid supplements during pregnancy, and vitamin A supplementation for children older than six months of age. The overall rates of coverage within the province for these basic interventions are 19% and 75% respectively, with major differentials between districts. This is illustrated in Figures 14 and 15.

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



Source: MICS, 2011

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



Source: MICS, 2011

The issue of inequity in access and care in KP is notable. Differentials in health- and nutrition-related interventions among people in various wealth quintiles are displayed in Table 4.

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

Intervention	Wealth Quintile (% population covered)					Overall
	Poorest	Poor	Middle	Rich	Richest	
Antenatal care by skilled health worker (during last delivery)	31.2	41.0	59.6	73.5	87.6	47.7
Maternal iron folate supplements	7.7	14.9	17.4	26.0	35.8	19.3
Exclusive breastfeeding up to 4 months	46.1	49.5	59.8	58.6	59.8	55.5
Exclusive breastfeeding up to 6 months	40.2	42.3	52.7	47.0	49.6	47.1
BCG vaccination (card)	26.1	29.8	34.4	45.0	50.8	35.4
Measles vaccination(card)	28.8	29.4	28.5	35.7	39.6	31.2
Vitamin A supplementation	55.9	75.0	80.0	81.8	78.0	75.2

Source: NNS, 2011

Disaster: Disasters have a profound effect on nutrition. They have the potential to destroy crops and health and social services infrastructure, and reverse development resources. KP has recently been plagued with conflicts, leading to internally displaced people and militancy in several districts. In 2005, an earthquake affected four districts, and floods affected nearly all districts in 2010 and seven districts in 2012.

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 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 (MoH) 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 (PPP) 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, food rations were distributed to flood victims in KP through the Provincial Disaster Management Authority (KPPDMA), and were continued beyond the flood recovery period with popular support from elected representatives.

Another related initiative, part of the Benazir Income Support Programme (BISP), transfers cash to low-income women. It is being implemented in KP and has extensive field outreach and a large 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 not yet been 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. In KP, 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.

- In KP and federally administered tribal areas, nutrition-related projects have been implemented to support people internally displaced as a result of conflict.

- More lately, after flooding, 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 organizations (CSOs).

- INGOs such as the Centre of Excellence for Rural Development, Mercy Corps, and the International Rescue Committee have been active in nutrition in the disaster areas.

- DoH-supported interventions have been provided through the Lady Health Worker Programme (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.

- The earliest and most concerted attempts at food fortification have been in KP. Salt iodization was implemented in all districts of KP 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). 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.

- KP is the only province where iron fortification of wheat flour has been piloted. It has been introduced in two districts, but further scale-up was stalled due to lack of government support for fortification commodities (WFP, 2007; MI/WFP, 2010).

- 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 Program, led by the Women's Development Department 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 programs funded by the WFP were implemented through the Department of Education Department. However, the initiative serves mainly to increase school enrolment and has less value for controlling under-nutrition.

Table 5: Health cluster interventions in KP

Activity (Ongoing and Completed) and Responsible Organisations	Planned
Breastfeeding *Department of Health (DoH)*	Infant and child feeding practices *DoH/ President Primary Health Care Initiative / Non-governmental organizations*
Vitamin A (with polio campaign) *DoH, Micronutrient Initiative (MI)//UNICEF*	Community based malnutrition management *DoH*
Iron and folate to pregnant mothers *DoH*	*Zinc supplementation to children* *DoH*
Community based management of acute malnutrition *Nutrition Cell/World Food Programme (WFP)/United Nations Children's Fund (UNICEF)*	De-worming pilot for adolescent girls as a pilot *DoH*
Infant and child feeding practices	Awareness and communication *DOH*
Salt iodization *MI/Private sector/ DoH*	Wheat flour fortification *DOF under discussion*
Wheat flour fortification *MI, Department of Education (DoE)/Private sector*	Scale-up of salt iodization *Department of Food (DoF), under discussion*
School feeding *WFP/DoE, Women Development, Bait-ul-Mal*	Micronutrient powders/sprinkles *DOF, under discussion*

Source: PC-1 KP, 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 NNS2011 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 also seen unprecedented growth over the last decade, and the provision of statistics that showed little progress on nutrition (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 Health. 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 resulted in the establishment of provincial Inter-Sectoral Nutrition Committees headed by P&DD.

Within the KP provincial departments, the DoH has been the most visible in defining a four-year strategy for nutrition which will be implemented through an integrated Minimum Service Delivery Package particularly targeted at women and children across all frontline public sector facilities. Fortification of food, in contrast to past projects, will be led through the Department of Food but is expected to involve linkages with other sectors including the Health and private sectors. Other departments are in varying stages of identifying pro-nutrition measures.

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.

KP, 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 KP 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 KP for nutrition to take on the work 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. KP'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 KP 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 KP, 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. At the P&DD there is similar reluctance towards centralized initiatives given past experience of collective failure in Social Action Programme and a lack of clear direction from the political leadership, which is

necessary given the complexity of the agenda. A P&DD notification dated November 2012 established a provincial Multi-Sectoral Committee for nutrition headed by the Additional Chief Secretary. It includes representation from the Agriculture, Education, Food, Health, Local Government & Rural Development, Public Health Engineering, Social Welfare & Women's Development sectors, industries, and a recommended member from the United Nations or 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: Despite the recent donor-supported momentum for cross-sectoral action on under-nutrition, there is lack of a common understanding of under-nutrition in KP across sectors. There is a general consensus within the key sectors that under-nutrition has suffered from low priority attention and needs more concerted action. Most stakeholders believe that it is necessary to connect sectors to tackle under-nutrition, but there is a disconnect concerning which approach is best. For example, private health providers see lack of dietary awareness, false cultural beliefs, and an emphasis on the quantity rather than the quality of food as contributing factors for under-nutrition. Conversely, provincial DoH counterparts view the weak priority given to integrated management of nutrition and childhood illness and the LHW programme (as opposed to more prioritized infrastructure schemes), as the main impediment to tackling under-nutrition. Other stakeholders, including members of the Agriculture, Education, Food, and PHE sectors, perceive under-nutrition as linked to food pricing control, hygienic food preparation, and safety standards for seeds and agricultural products. Private food processors, for their part, tend to see demand creation for nutrition amongst the community as the area most in need of attention.

Stakeholders agree that there has been lack of delivery on mandates by different sectors and weak communication on nutrition across sectors due to siloed work. Lack of championing by politicians is also perceived to be a major bottleneck to action and funding on under-nutrition. Under-nutrition has not been well advocated to politicians. This is necessary to leverage nutrition across the bureaucracy, but there is mixed opinion on potential support. There is some optimism related to young parliamentarians from KP looking for social policy agendas, and there is an active women's caucus in national parliament that often works across party lines to support pro-women issues. However, there is also entrenched cynicism within and outside bureaucracy concerning politicians' traction towards infrastructure-heavy projects that allow corruption and rent-seeking.

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:

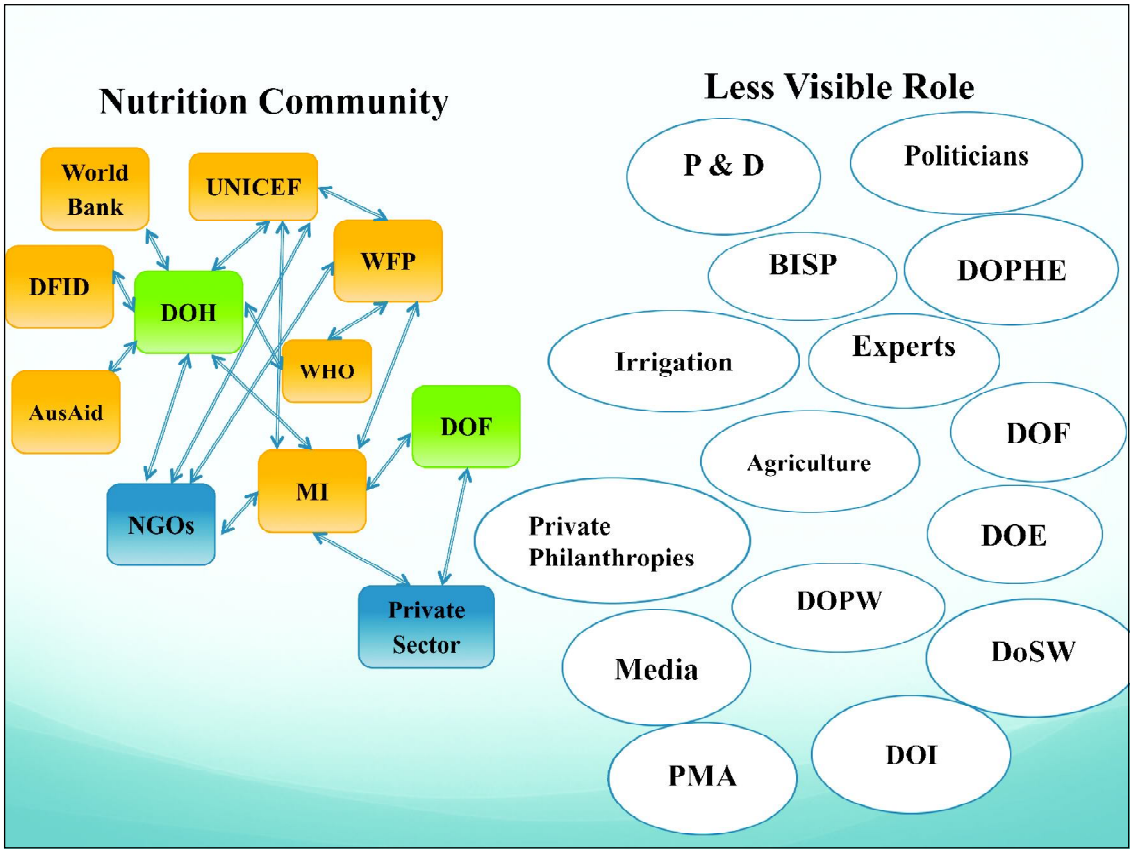
- Within the provincial departments, the DoH has been the most visible in defining its role around nutrition. It has implemented preventive health strategies targeted at women and children. However, this is a recent move instigated with development partner support and funding, and its sustainability is uncertain.

- Other sectors have only recently been drawn into nutrition coalitions, and the definition of their role is still emerging under the dialogue started by the P&DD. Within KP, there is a general consensus that the local government should be brought in for water, sanitation, and food pricing initiatives, with which it is often directly involved.

- After devolution, donors have emerged as a harmonized community, closely coordinating inputs for under-nutrition while keeping short of pooled funding. 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 for province-wide activities, and the Australian Government's Overseas Aid Program (AusAID) is supporting efforts through a grant in five districts.

- The non-state sector in KP comprises a relatively strong INGO sub-sector and a weaker presence of local CSOs and experts in nutrition. INGOs have traditionally been active in KP, where they have addressed nutrition and health and built field linkages and capacity for implementation. CSOs so far have not internalized nutrition as their agenda, and their involvement has been confined to short-term activities as contractees of UN agencies. Nutrition has lacked visible advocates in the private health sector and professional medical associations. Within government circles, there is mixed buy-in of the non-state sector for nutrition activities. Some acknowledge their usefulness; while others worry that the work is for monetary incentives. Figure 16 shows a net map of actors involved in nutrition activities in KP.

Figure 16: Nutrition activities in KP, 2011



Source: PC-1 Khyber Pakhtunkhwa, 2012-2015; Khyber Pakhtunkhwa 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 programme's 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).

There has been recent positive movement towards horizontal coordination. KP was the first province post-devolution to come up with a development strategy defining its own vision for the social sector. The strategy coordinated efforts horizontally across sectors under the leadership of the P&DD (KP CDS 2010–2017). On the implementation side, many stakeholders have had positive experiences with the 'integrated cluster approach' to inter-sectoral coordination while dealing with the floods in KP over the last three years. 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 KP, 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: KP faces serious organizational challenges to a roll out of nutrition interventions. One of these is outreach. Although the overall population density of the province is higher than the national density, most of the population is concentrated in Peshawar, Mardan, and Mingora. LHW coverage is 54% (Oxford Policy Management, 2009), and the programme faces tough contextual constraints to expanding its outreach efforts. Consequently, provincial levels of hand washing, introduction of complementary feeding for babies at six months of age, and birth spacing are all lower than national levels (Table 6).

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

Evidence -Based Intervention	KP (% population)	Pakistan (% population)
Exclusive breastfeeding up to 6 months[1]	47.0	13.0
Complementary feeding 6–8 months[1]	36.0	51.8
Hand-washing with soap[1]	62.0	57.6
Contraceptive prevalence rate (modern method)[2]	18.7	21.7
Vitamin A supplementation [3]	77.8	79.1(78 - 92)
De-worming[1]	88.0	77.0

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

Because district budgeting follows an even-sized approach across all districts, the areas that are hardest to reach also face inadequate funding(in terms of travel cost and staff incentives for nutrition screening), awareness, and monitoring. Difficult outreach is compounded by security concerns and low female mobility in conflict districts. In addition, existing nutrition interventions, including preventive health measures, food fortification (e.g., wheat), and school feeding are constrained by a lack of local community networks at the union-council level. This is due to low investment in community mobilization. Effective nutrition service delivery has also been impeded by siloed management of EPI; Maternal, Neonatal, and Child Health (MNCH); nutrition; and LHW programmes within the DoH. Finally, standardized nutrition services are not available in the private health sector. Although nearly half of the population of KP, including the poor, use this sector, it is largely unregulated (FBS, 2010–2011a).

In addition, there are issues of low technical priority and capacity. 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). Similarly, although a school feeding programme is underway, there are few trainings or tools to support nutrition monitoring in schools.

Opportunities: KP has a relatively strong governance culture at both the provincial and district levels. There is good vertical coordination between province and district around development initiatives. This is despite the Local Government Ordinance of 2001, which decreased the accountability of the districts to the province. Post-devolution, KP has made important strides in terms of organization and re-structuring, which will support the mainstreaming of nutrition interventions across the public and private health sectors. 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. A minimum service delivery package has been developed, which may cut across siloed management within the Health sector. There has also been an attempt to increase the use of government health facilities through a number of recent management contracts with NGOs and the creation of a Health Regulatory Authority to standardize private sector services.

Examples of Some Successes and Underperformance: Vitamin A supplementation has achieved a reasonably high coverage of 77.8% (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. KP was the first province to begin salt iodization, and the programme has successfully reduced iodine deficiency and served as a model for the rest of the country. In KP, 73.6% of salt available in the province is iodized, compared with 69% nationally. This is due to provincial legislation, strong cooperation from several district governments, and, with NGO and INGO support, growing community demand.

Market quality assurance of fortified foods is weak due to low emphasis and rent-seeking. Similar issues affected pilots of wheat flour fortification programmes. Moreover, because wheat fortification has expensive commodity costs, it requires a commitment from the government for subsidy provision.

Folic acid and iron supplements to pregnant and lactating women have suffered from supply breaks as a result of inadequate funding. Community-based nutrition screening, awareness, and child-referral efforts have not been given sufficient priority, and face considerable outreach constraints.

School feeding programmes 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. There is also inadequate buy-in from the government for up-scaling beyond donor supported pilots.

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 KP in the past has involved contributions from UNICEF, WFP, and WHO to specific facilities and districts for CMAM, Infant and Young Child Feeding and school feeding, as well as small grant disbursement to CSOs for nutrition awareness and screening in the community. Bi-laterals have supported INGOs in KP 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. However, staff and infrastructure for preventive health measures are supported federally through the LHW programme (for community outreach), and provincially (for health facilities). 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 supplies for folic acid and iron to pregnant and lactating women.

Recent Shifts in Donor Funding: Recent movement towards scoping nutrition within development planning in KP has led to positive changes in donor funding. Compared with other provinces, KP has had the best investment for nutrition efforts from development partners. This can be seen in the wide range of partners working in KP. This includes AusAID, the United Kingdom Department for International Development (DFID), and the World Bank, in addition to technical support from UN agencies and INGOs. Moreover, it is the only province that will benefit from grant support that has been earmarked for nutrition in Health, as opposed to soft loans in other provinces. Good governance and planning, and easy access from the federal capital, are important factors attracting aid to KP (this is also the case in Punjab Province).

Experience with the faster and more efficient process for donor/government engagement in KP 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. However, a substantial portion of funding is a soft loan provided by the World Bank rather than a grant.

Recent Shifts in State Funding: Changes in state funding that will make use of increased provincial fiscal space in KP are also under finalization. In the post-devolution scenario, funding support 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 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).

Economically backward provinces have gained the most from this change. As a result of the new distribution formula, KP's award amount increased by roughly 50% between 2006 and 2010. 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. In terms of per cent change, Balochistan has gained the most, with an increase of more than 100%, followed by KP.

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 Pakhtunkhwa	151,199	95,599	55,600
Balochistan	89,060	38,410	50,650
Total	962,105	727,118	234,987

Source: SPDC, 2011

Translation of Funding into Nutrition: KP is the only province to have come up with a cohesive development strategy in the post-devolution period and is undertaking deliberative reforms within sectors to support this effort. However, work to improve nutrition has yet to be mainstreamed across the development priorities of individual sectors. Despite increased fiscal space providing by the seventh NFC, nutrition spending is low because of weak priority from the government. Compared to other provinces, KP's Health sector (in which nutrition activities have been operationalized), has a better proportionate share of overall provincial expenditure. However, spending within Health does not favour nutrition (Table 8). The majority of funding, including development and operational funding is spent on hospitals and medical colleges. Development expenditure has increased, but has not included allocation for nutrition. The majority of operational expenditure goes towards staff salaries, leaving little room for the commodities and outreach activities required to support nutrition programs.

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

Financial Year	Health Expenditures (Rs. millions)	Total Provincial Expenditures (Rs. millions)	Health Expenditures as % of Total Provincial Expenditures
2008–2009	7,495	113,322	7%
2009–2010	8,359	134,424	6%
2010–2011	12,512	208,274	6%
Provincial and district expenditures on health increased 75%, from Rs. 7b to Rs. 12.3b over the last three years, mainly to support employee-related costs.			
Provincial and district development expenditures on health increased 24%, from Rs 3.7b to Rs 4.6billion over last three years.			
71% of total consolidated health expenditure supported 'General Hospital Services' and 10% supported 'Professional Teaching/Colleges'.			

Source: TRF, 2012

The recent integration of nutrition into development funding for mother and child health and immunization services demonstrates new commitment to nutrition goals. This change may improve financial sustainability through shared resources (as compared with standalone Nutrition Project Cycle-1 [PC-1], such as those underway in Sindh and Balochistan Provinces). However, as in other provinces, funding is confined to the development budget and is a smaller proportion of the required amount. In addition, the majority of this funding is provided by donors; meaningful sustainability will require up-scaling and a shift onto the operational budget.

In KP, as in other provinces, funding for nutrition has not been marked in other sectors. One reason is the lack of donors to support nutrition. In the Health sector, the process was speeded along and incentivized due to donor support and advocacy, but this is not the case for other sectors. Another reason for this delay is that KP is in the process of aligning nutrition content between different sectors. This is in line with the provincial development priorities, and although it is a slow and deliberative process, it is expected to result in better sustainability. A substantial funding commitment for nutrition that encompasses all sectors will depend upon political championing by parliamentarians. Public-sector development funding priorities in KP, 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: 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 the financing landscape in KP, as in other provinces, supports loose coalitions rather than tight structural coordination. There is general recognition in KP (also seen in Balochistan), for the value of distribution of sectoral funds based on the needs of the individual provinces. This would allocate greater support for greater financial needs of harder-to-reach districts. Preference remains for input-based funding, rather than tying fund releases to performance targets. Apprehensions are due to inexperience with these mechanisms and to the fact that there is not a work culture of following crisp targets.

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. KP, 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 KP 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 KP, as in other provinces, has led to insufficient provision for nutrition in routine sectoral monitoring. The existing nutrition information system is confined to the Health sector. 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 the Education and Food sectors and the KP 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 by parallel sectors including Education and Food, and by the PDMA, but with little sharing of data. Monitoring of food quality parameters has a split responsibility with wheat market surveillance 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, and could potentially help other sectors reach out to the poor with efforts to target under-nutrition. However, due to BISP's siloed federal management program, there has been little sharing of this database.

Implementation Issues: To implement nutrition efforts, it is necessary to monitor two types of information: nutrition and pro-nutrition indicators, and targeting of interventions. Implementation of a comprehensive nutrition effort will require technical support and separate coordination with districts for ownership in implementation. Targeting information can be provided by BISP.KP, like Sindh, has a reasonable BISP infrastructure at the community level and good acceptance amongst stakeholders.

Advocacy Coalitions: Unlike Sindh, KP does not have a well-developed non-state sector for advocacy; it has been reliant on INGOs for nutrition work. There are 'pockets' where communities have a reasonable level of awareness around salt iodization as a result of INGO-led work, but further expansion is needed. In KP, teachers, tribal elders, religious politicians, and LHW shave been pointed out as important potential proponents. These groups 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 non-state sectors, and to the absence of experts with skill in media management and propagation. As in other provinces, there are no formal or informal forums to link the State and Non-State sectors. This is compounded by fragmented data collection and the confinement of nutrition to its 'health' aspects.

11. OPPORTUNITIES AND BOTTLENECKS: SUMMARY

In KP, under-nutrition is a hidden and silent issue comprising chronic malnutrition and micronutrient deficiencies. Although KP has less agriculture than other provinces and is dependent on them for food, it has lower levels of food insecurity than other provinces. Under-nutrition is mainly linked to insufficient attention to preventive health strategies; lack of connections between relevant sectors, such as Education, Food, Health, Poverty, and Safe Water and Sanitation; and a lack of effective access to food by at-risk low-income pregnant women and children under the age of three.

KP was the first province post-devolution to come up with a development strategy defining its own vision for the social sector. It has also made important strides in the health sector by integrating siloed vertical preventive programs and taking steps towards regulation of the private health sector. KP has a relatively strong governance culture at both provincial and district levels. However, nutrition has not yet been sufficiently mainstreamed in KP.

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. There is no formal structure to serve as the provincial counterpart of the NPC, 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 few connections between programs, beneficiaries, the goals of different sectors, such as Food, Health, and Education; and BISP goals. Nutrition tends to be narrowly operationalized within the Health sector, both in terms of projects and the monitoring database. This limits inter-sectoral responses. The cluster approach used during the response to recent floods gave many stakeholders a positive experience with horizontal coordination, and there is openness across sectors for coordination. Although there is positive movement towards horizontal coordination across sectors for nutrition, this is based on a loose coalition (an inter-sectoral committee) and does not provide a true structural 'home' for nutrition.

In KP, implementation of past nutrition initiatives, such as salt iodization and vitamin A supplementation, have had some of the best results. The high priority given to polio at all levels, the strong district support given to salt iodization, and a generally stronger culture of governance than some of the other provinces have also contributed to successes. Further progress is constrained by the challenge of providing people in harder-to-reach districts access to services. Funding for outreach services has historically been low and there is no 'topping up' of funding for more disadvantaged districts. INGO, NGO, and private sector involvement is important for coverage expansion, but is has not yet been strategized and coordinated by the government.

Technical capacity for nutrition planning, implementation, and monitoring is also weak across both the public and private sectors. Recent work for internally displaced people has helped build capacity for nutrition in the health sector, but further progress will require sustained support for these efforts within this and other sectors.

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 minimum service development package for health. However, KP will still be dependent upon development partners for commodity support for malnutrition treatment.

KP 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 no common basket of nutrition indicators across all sectors, and no monitoring and evaluation framework to support measurement.

12. STRATEGIC RECOMMENDATIONS

In Khyber Pakhtunkhwa (KP), post-devolution energy and planning for health and development have shown marked advances compared with other provinces. Despite limited resources, KP has moved quickly to develop a strategy for an integrated health plan focused on addressing under-nutrition and micronutrient deficiencies. There is nevertheless a need for wider cross-sectoral action.

Key Findings:

- Political championing at the highest level is required to make nutrition a development priority across party lines. KP existing ruling coalition is supportive of social development schemes. The nutrition agenda must be well-advocated to politicians across party lines to develop a broad bipartisan support base. KP, like Sindh, has proactive female parliamentarians participating in a women's caucus in Parliament, which may be an important trigger point for the nutrition agenda.

- Post-devolution, KP has delineated a vision for development. However, nutrition should be mainstreamed into sectoral development priorities. This should be accompanied by a shift that moves funding for nutrition from the Development to the Operational budget. Donor funding can be used to incentivize nutrition in other sectors, as has been done within the Health sector.

- Incentives need to be provided to make central convening structures effective for cross-sectoral coordination. This may include housing the monitoring database centrally, working out joint funding lines, approving sectoral plans, undertaking joint-sectoral initiatives, and providing technical support to improve capacity.

- There is popular support within sectors for independent budgetary lines but close functional work. This can be constructively tapped for joint initiatives that have well-defined interventions, common beneficiaries and geographical targets, and soft conditionalities.

- There is uneven vertical coordination in KP. Although districts generally have effective management, there should be stronger vertical accountability within sectors to enhance implementation.

- Parts of KP that are largely dependent upon imports for staple food sources (and are therefore sensitive to food price shocks) highlight food security as an important issue. It is critical to ensure adequate food supplies, pricing support, and provision of subsidies to the agricultural sector. KP tackled severe acute malnutrition in the wake of the floods in 2010, and the province still has pocket areas with wasting. The province must provide adequate rehabilitation programs that also tackle food security at the household level.

- KP, like other provinces, has become vulnerable to disasters. This has heightened the nutrition crisis. Although there is effective management of acute emergencies, more attention should also be placed on disaster mitigation and recovery. Disaster recovery must make a shift from short-term interventions, such as food distribution, towards creating linkages between sectors, which will support effective rehabilitation.

- The impact of efforts to address food insecurity and alleviate poverty can be strengthened by an increased awareness of basic nutrition concepts, environmental hygiene, and disease prevention. For example, the Public Health Engineering sector needs a greater level of policy priority and planning, and will need to extend its focus to urban slums, and Preventive Health work needs effective management and stewardship.

- Current poverty alleviation strategies, such as the Benazir Income Support Programme (BISP), need a stronger connection with nutrition targets. They also need interventions that maximize their nutrition outreach to KP's poorest groups, particularly women care givers, and improve the development value provided by social safety nets. Systems should be put into place to ensure that implementation of such programs is bipartisan and independent of political considerations.

- The current mix of preventive and promotive nutrition strategies within existing health programmes needs expansion and better implementation. This includes the Lady Health Worker programme; the Maternal, Neonatal, And Child Nutrition programme; and other primary care programmes. Expansion should include efforts 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 work to strengthen the vitamin A supplementation programme and the fortification of wheat flour and other staples with iron and multiple micronutrients. This will require concerted monitoring and implementation.

- To provide appropriate nutrition rehabilitation services for severe acute malnutrition, it is necessary to explore affordable funding options and to develop local, low-cost home rehabilitation diets and foods. It will also be necessary to build in economies of scale by utilizing all contact points, including immunization services, school services, and opportunities such as those provided by BISP.

- KP has made advances in food fortification compared to other provinces. Continued expansion requires multi-stakeholder involvement by the Food and Health sectors and the local government. This should be supported by efforts to build technical capacity.

- District and local governments need to be recognized as a distinct set of stakeholders, investment should be made in building nutrition awareness and capacity at these levels.

- Central coordination of nutrition monitoring is needed. It should be housed in a central convening body. There is also a need for a standard basket of pro-nutrition indicators that extend across the Education; Health; Food; Water, Hygiene, and Sanitation; Poverty; and Disaster sectors to effectively monitor interim progress.

- KP does not have a well-developed local non-state sector compared to the larger provinces. International non-governmental organizations and national non-governmental organizations need to have a greater role in partnerships around data production, awareness, advocacy, and monitoring. They should be supported by forums that link the state and non-state sector. Linkages with local change agents such as tribal elders, lady health workers, teachers, members of the media, are necessary to build an effective mobilization base at the local level.

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; 2006.

Census. (1998). Population Census Organization, Pakistan. Accessed on November, 2012, Available at http://www.census.gov.pk/datacensus.php.

Cook, B. (2006). *Food Security, Implications for the Early Years.* Background Paper. Toronto, Ontario: Toronto Public Health; 2006.

Federal Bureau of Statistics (FBS). (2009–2010). *Labour Force Statistics 2008–2009 and 2010-2011*. Pakistan: Government of Pakistan. Accessed on November, 2012, Available at http://www.pbs.gov.pk/content/labour-force-survey 2009-10.

Federal Bureau of Statistics (FBS). (2010–2011a). Pakistan Social and Living Measurement Survey. Pakistan: Government of Pakistan. Accessed on November, 2012, Available at http://www.pbs.gov.pk/content/pakistan-social-and-living-standards-measurement-survey-pslm-2010-11-provincial-district.

Federal Bureau of Statistics (FBS). (2010–2011b). *Agricultural land utilization statistics 2010-2011*. Pakistan: Government of Pakistan.

Khyber Pakhtunkhwa Health Sector Strategy (KP CDS), 2010–2017. Pakistan: Government of Khyber Pakhtunkhwa (KP).

Micronutrient Initiative (MI) and the World Food Programme. (2010).*Final Technical Report on Wheat Flour Fortification project in Earthquake affected Districts of KP & AJK.*

Micronutrient Initiative (MI). (2011). *Assessment of Iodized Salt Production in Pakistan. Research and Development Solutions for the Micronutrient Initiative*. Pakistan: Pakistan Ministry of Health, Government of Pakistan.

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.

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

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 Integrated Nutrition Survey. (2011). Nutrition for National Development Report: Pakistan's Integrated Nutrition Strategy.

Pakistan Economic Surveys (PES). (2001–2012).Federal Bureau of Statistics& Ministry of Health, Government of Pakistan.

Pakistan Economic Survey (PES). (2006–2007).Federal Bureau of Statistics, Government of Pakistan.

Pakistan Economic Survey (PES). (2011–2012).Federal Bureau of Statistics, Government of Pakistan.

PC-1 KP. Nutrition Programme for KP, Department of Health, Government of KP.

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 Nations Development Programme (UNDP) and the Government of KP. (2011). KP *Millennium Development Goals Report, (2011).*

VAS Survey. (2011). Aga Khan University and Micronutrient Initiative, 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 Programme (WFP). Assisted Commercial Wheat Flour Fortification Project for Earthquake Affected Areas of NWFP, Pakistan. (2007). Project *Completion Report (January 2007–December 2007).*

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: LIST OF STAKEHOLDERS

Serial #	Name of Stakeholders
1.	Hayatabad Medical Complex
2.	North West Hospital
3.	Khyber Teaching Hospital
4.	Flour Mills Association, KP
5.	Salt Processors Association KP
6.	Health Reform Unit, KP
7.	MNCH Program
8.	Representative, ANP, KP
9.	National Program for FP and PHC (LHW Program)
10.	Planning Commission, Government of KP
11.	Nutrition Cell
12.	Health System Reform Unit
13.	DGHS KP
14.	Planning and Development Department, KP
15.	UNICEF, KP
16.	World Bank, KP
17.	Finance Department, Government of KP
18.	WFP, KP
19.	Health Department, Government of KP
20.	Department of Food Khyber Pakhtunkhwa
21.	Micronutrient Initiative, KP
22.	UNHCR
23.	FOA
24.	Department of Social Welfare
25.	CERD
26.	Merlin, KP
27.	Public Health Engineering Department
28.	Agriculture Department, Government of KP
29.	Food Department, Government of KP
30.	Representative, Pakistan People's Party
31.	Representative, Awami National Party