

# FRAMEWORK FOR ACTION POLICIES AND PROGRAMMES

**A Policy Paper on Adolescent Nutrition in Pakistan**

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## ACRONYMS

|         |   |
|---------|---|
| AA-HA   | Accelerated Action for the Health of Adolescents                |
| AAP     | Accelerated Action Plan   |
| BMI     | Body Mass Index   |
| CSO     | Civil Society Organization                                      |
| DHS     | Demographic + Health Survey                                     |
| FAO     | Food + Agriculture Organization                                 |
| GAIN    | Global Alliance for Improved Nutrition                          |
| GDP     | Gross Domestic Product  |
| GNR     | Global Nutrition Report   |
| HIES    | Household Integrated Economic Survey                            |
| IFA     | Iron + Folic acid   |
| LLMICs  | Low + Lower Middle Income Countries                             |
| MSAN    | Multi-Sectoral Action for Nutrition                             |
| MoNHSRC | Ministry of National Health Services, Regulation + Coordination |
| NCD     | Non-communicable disease  |
| NGO     | Non-governmental organization                                   |
| NNS     | National Nutrition Survey                                       |
| ODF     | Open defecation free  |
| P&D     | Planning + Development  |
| PDHS    | Pakistan Demographic and Health Survey                          |
| PSLM    | Pakistan Social & Living Standards Measurement                  |
| SAFANSI | South Asia Food & Nutrition Security Initiative                 |
| SDG     | Sustainable Development Goal                                    |
| SHR     | Sexual and reproductive health                                  |
| SUN     | Scaling Up for Nutrition  |
| UN      | United Nations  |
| UNICEF  | United Nations Children's Fund                                  |
| WASH    | Water Sanitation and Hygiene                                    |
| WB      | World Bank  |
| WFP     | World Food Programme  |
| WHO     | World Health Organization                                       |

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## EXECUTIVE SUMMARY

### Why invest in Adolescents?

The adolescent period presents an opportunity to build behaviours and practices that will support good nutrition, health and family well-being well into adulthood. Malnourished boys and girls will not have the capacity to develop to full potential, acquire an education, bear healthy infants, and participate fully in the labour market and economy. Investment in the human capital of adolescents is thus essential for economic growth because better nutrition shapes the life course and yields a *triple dividend*, for adolescents currently, as future adults and for the next generation<sup>1</sup>.

### Why this document?

Pakistan signed up to the Sustainable Development Goals (SDGs) and, in 2013, to the Global Scaling-Up Nutrition (SUN) Movement. Multi-sectoral nutrition strategies and stunting-reduction programmes are now in place. These efforts have created a climate that is moving resources into nutrition. However, the government's focus is on the 1000-days window, with adolescent nutrition issues only partially addressed in policies and programmes.

It is generally recognised that Pakistan's adolescents suffer from malnutrition. However, piecemeal and small-scale interventions have been implemented by different partners over time. The Global Alliance for Improved Nutrition (GAIN), in collaboration with Aga Khan University, described the situation of adolescent malnutrition in girls in "Embodying the Future: How to Improve the Nutritional Status of Adolescent Girls in Pakistan" in 2017<sup>2</sup>. This piece recommended further in-depth evidence review, including analysis of existing policy and programme gaps to guide future actions to address adolescent malnutrition in Pakistan. In response to increased government interest, GAIN, with support from the World Bank SAFANSI, conducted an "Evidence Review on Nutritional Status of Adolescent Boys and Girls in Pakistan"<sup>3</sup> in 2018. This set out data gaps in existing large data sets and recommended a priority research agenda to understand the scope and magnitude of problems and explore solutions.

This document is the third critical analytical piece in the same series. It includes global and regional best practice to improve adolescent nutrition, while providing direction in the form of a "Framework for Action" for future policies and programming in Pakistan.

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<sup>1</sup> WHO (2017). *Global accelerated action for the health of adolescents (AA-HA)*. Geneva: WHO.

<sup>2</sup> van Liere, M., Bhutta, Z. A., Hartvig-Blomberg, J., & Mahmood, S. (2017). *Embodying the future: how to improve the nutrition status of adolescent girls in Pakistan*

<sup>3</sup> Beal, Vossenaar, Tumilowicz et al (2018) *Review of evidence on the nutritional status of adolescent girls and boys in Pakistan*. Islamabad: GAIN.

## The global/regional picture

There is as yet no regular global reporting on adolescent nutrition. From 1975 to 2016 body mass index (BMI), overweight and obesity increased globally and in most regions, while thinness has only modestly declined among children 5-19 years. Globally, adolescent thinness is increasingly concentrated in South Asia, where the highest prevalence has been found for several decades. Iron deficiency anemia and other micronutrient deficiencies are widespread. South Asia has the highest burden of anaemia in children and women in the world.

## Situation in Pakistan

Pakistan has a high burden of malnutrition, costing US\$ 7.6 billion or 3% of GDP annually. Girls experience a higher burden of stunting (11-23%), depending on the population, and overweight/obesity (8%) than boys (5% for both). Overweight and obesity increase substantially in adulthood. Boys have a slightly higher prevalence of thinness (12%) than girls (10%). Thinness is more common in rural areas and overweight/obesity in urban areas. Anaemia is prevalent among adolescent girls 15-19 years (54%) as well as deficiencies in folic acid (49%), zinc (42%), and vitamin A (40%). Deficiencies likely also exist in iodine, calcium, and vitamin D. Trends from 2001 to 2011 in women of reproductive age suggest iodine deficiency and iron deficiency anaemia have decreased, while anaemia, vitamin A deficiency, and night blindness have increased. No micronutrient deficiency data is available for adolescent boys. However, the upcoming 2018 National Nutrition Survey will measure nutrition indicators for adolescent boys and girls 10-19 years for the first time, including anthropometry, biomarkers, and diet quality.

## Programming in Pakistan

There has been increasing attention in the last five years to the “1000-day window” approach federally and provincially, and most provincial multi-sectoral nutrition strategies emphasize this. Multi-sectoral strategies for Sindh and Punjab provinces include some aspects aimed at addressing malnutrition in adolescent girls – through education, WASH, social protection for example. However, as yet, few programmes currently target nutritional status of adolescent girls and no programmes target adolescent boys.

## Framework for Action

In light of widespread adolescent malnutrition in Pakistan and the predominance of nutrition programming efforts aimed at reducing stunting in young children via the “1000-day window” approach, the Government of Pakistan will need to launch a focused *national* response to improve nutrition of adolescents built around the following seven areas<sup>4</sup>:

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<sup>4</sup> This Framework for Action uses, as a point of reference, the World Health Organization’s 2018 publication *Guideline: Implementing effective actions for improving adolescent nutrition*.



- Evidence based advocacy and sensitizing government officials
- Raising awareness on adolescent nutrition
- Setting policy priorities for adolescent nutrition
- Designing nutrition-specific interventions in the health sector
- Designing nutrition-sensitive interventions in the non-health sector
- Scaling up effective interventions for impact
- Monitoring and evaluation, learning and accountability

## Leadership & Roles

The health sector and a number of non-health sectors (agriculture and food, social protection, WASH, for example) will play key roles in rolling out identified priority interventions. However, this Framework takes the perspective that the Department of Health should play the leadership role for adolescent nutrition going forward in Pakistan. Roles are designated in this *Framework* for federal and provincial government agencies and departments, as well as communities, CSOs, academia and development partners.

## Concluding Statement

Pakistan is poised to make significant strides towards improving adolescent nutrition. Important programming work is underway at provincial level to address child stunting; a revision exercise is getting underway to update the series of multi-sectoral nutrition strategies that guide this work; and the 2018 National Nutrition Survey report will be published very shortly with information, for the first time, on nutrition indicators of adolescent boys and girls aged 10-19 years. Implementing the 21 priority actions presented in this *Framework for Action* will help make important gains in improving adolescent nutrition in Pakistan.





# INTRODUCTION

## Understanding why to invest in adolescent nutrition

The period 10-19 years of age is one of accelerated growth both physically and psychosocially. Boys and girls during this rapid growth phase have increased nutritional requirements of both macronutrients (carbohydrate, protein, and fat) and micronutrients. This is due to rapid physical growth and the onset of menses in girls and accelerated muscle and bone mass development in boys<sup>1</sup>. At the same time, adolescents often experience poor access to adequate, safe and healthy food. They also experience challenges completing their education and finding economic opportunities. Some of these constraints are due to low income, poverty and neglect, often coupled with prevailing cultural norms which exacerbate their situations. The adolescent period, however, presents a window of opportunity to build behaviours and practices that will support good nutrition, health and family well-being well into adulthood. Investment of US\$4.6 per capita annually through 2030 in interventions to improve adolescents' physical, sexual and mental health would yield ten times the benefits<sup>2</sup>.

Malnutrition is common among adolescents in all regions, South Asia in particular, and impacts have been extensively reviewed<sup>3</sup>. Malnutrition in adolescents has immense implications for families, communities and nations. Malnourished boys and girls will not have the capacity to develop to full potential, acquire an education, bear healthy infants, and participate fully in the labour market and economy. Under-nutrition in girls 10-19 years has inter-generational effects. It contributes to low birth weight and child stunting which, in turn, leads to poor survival, growth and development, and poorer livelihoods. This contributes to significant losses in human capital and productivity<sup>4</sup>. Malnutrition in boys 10-19 years negatively affects educational outcomes and future income. It also reduces their potential to become young men who are fully informed about optimal health behaviours and family care. Investing in adolescent nutrition should be moved to the forefront of national policy, programming, advocacy and research agendas. Investing in adolescent nutrition means investing in human capital and thus in economic growth.

Investment in the human capital of adolescents is thus essential for economic growth because better nutrition "shapes the life course" and yields a *triple dividenda*, i.e., for adolescents currently, as future adults and for the next generation<sup>5</sup>. Put another way,

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<sup>1</sup> WHO (2018). *Guideline: Implementing effective actions for improving adolescent nutrition*. Geneva: WHO.

<sup>2</sup> Sheehan, Sweeny, Rasmussen et al (2017). Building the foundations for sustainable development: a case for global investment in the capabilities of adolescents. *Lancet*, 390(10104), p. 1792.

<sup>3</sup> Bundy, de Silva, Horton et al (2018). Investment in child and adolescent health and development: key messages from *Disease Control Priorities*, 3<sup>rd</sup> Edition. *Lancet*, 391(10121), p 687.

<sup>4</sup> Madjdian, Azupogo, Osendarp et al (2018). Socio-cultural and economic determinants and consequences of adolescent undernutrition and micronutrient deficiencies in LLMICs: a systematic narrative review. *Annals of the New York Academy of Sciences*, 1416: 117.

<sup>5</sup> Stephenson, Heslehurst, Hall et al (2018). Before the beginning: nutrition and lifestyle in the preconception period and its importance for future health. *Lancet* 391(10132), p 1830.

investing in adolescents has a multiplier effect. Nutrition benefits can accrue to several cohorts of children. Also, these investments are critical to curbing the nutrition transition and the increase in overweight and obesity and related non-communicable disease (NCDs) which arise in adulthood and even in young adults.

## Why this document?

Pakistan signed up to the Sustainable Development Goals (SDGs) and, in 2013, to the Global Scaling-Up Nutrition (SUN) Movement. The multi-sectoral approach to nutrition appears to have been embraced at the provincial level as evidenced by the series of multi-sectoral nutrition strategies and stunting-reduction strategies now in place. There is also a national Multi-Sectoral Nutrition Strategy spanning the years 2018-2025. These efforts have created a climate that is moving resources into nutrition; stunting reduction in particular. Meanwhile, the government's focus is on the 1000 days window, while adolescent nutrition issues are partially addressed in policies and programmes.

It is generally recognised that adolescents in Pakistan suffer from malnutrition. However, piecemeal and small scale interventions have been implemented by different partners over time. In tandem with this, specific and aggregated evidence on adolescent malnutrition has been a limiting factor. GAIN, in collaboration with the Aga Khan University, captured the situation of adolescent malnutrition in girls "Embodying the Future: How to Improve the Nutritional Status of Adolescent Girls in Pakistan" in 2017<sup>6</sup>. The document recommends more in-depth evidence review; analysis of existing policy and programme gaps to provide future direction for addressing adolescent malnutrition in the country. Considering increased interest of the government, GAIN with support from the World Bank SAFANSI funding conducted "Evidence Review on Nutritional Status of Adolescent Boys and Girls in Pakistan"<sup>7</sup> in 2018. The document looks at the data gaps in the existing large data sets and recommends priority research agenda to understand the scope and magnitude of problems and explore solutions.

This document is the third critical analytical piece of work in the row. It includes global and regional best practice to improve adolescent nutrition and provides direction in the form of a "Framework for Action" for future policies and programming in the country.

The *Framework for Action, Policies and Programmes* builds on government's current initiatives and aims to guide government and partners towards developing policies and programmes and selecting proven interventions to address the adolescent malnutrition. A dedicated platform for adolescent nutrition, "The National Technical Advisory and Advocacy Platform for Improved Adolescent Nutrition" was established by the MoNHSRC in August 2018 as part of the WB SAFANSI support. This has not

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<sup>6</sup> van Liere, M., Bhutta, Z. A., Hartvig-Blomberg, J., & Mahmood, S. (2017). *Embodying the future: how to improve the nutrition status of adolescent girls in Pakistan*. GAIN Report

<sup>7</sup> Beal, Vossenaar, Tumilowicz et al (2018) *Review of evidence on the nutritional status of adolescent girls and boys in Pakistan*. Islamabad: GAIN.

only served to bring together key partners in the adolescent nutrition space but will also anchor and drive further action in line with, “the Framework for Action”.

## Methodology

For this document, the Terms of Reference were developed by GAIN and a Consultant was engaged in mid-July 2018. During August 2018, a literature review was undertaken encompassing the global picture and regional trends in adolescent nutrition, and globally recommended policies and programmes to identify global best practices. Key published papers that helped to ground the work included the *Lancet* Commission on Adolescent Health<sup>8</sup>, the WHO’s Global Accelerated Action Strategy for Adolescent Health<sup>9</sup>, and the recently published Guideline for Adolescent Nutrition published this year by WHO<sup>10</sup>. A detailed review of national documents was also conducted to apprehend the current policies and programmes for the adolescents if any. It includes, the federal government’s National Health Vision 2016-2015<sup>11</sup>, the national Pakistan Multi-Sectoral Nutrition Strategy 2018-2015<sup>12</sup>, five multi-sectoral (termed inter-sectoral in several instances) nutrition strategies drawn up by the provinces<sup>13</sup>, “PC1” documents from health departments of Khyber Pakhtunkhwa<sup>14</sup> and Sindh<sup>15</sup>, two examples of legislation concerning child marriage<sup>16</sup>. The key informant interviews with federal-level partners were also conducted during August. To complement this, during the month of September, a GAIN senior staff undertook on-site interviews with key government policy and programming staff in four provinces. Seven priority areas of work which form the core of this *Framework for Action* emerged from this process. A limited number of high-impact Priority Actions were then identified under each of the seven main areas. The limited number of Priority Actions reflects an expressed desire for focused, practical work that cuts across sectors, departments and the partnership landscape.

The initial draft of the *Framework for Action* was shared with government and development partners for comment, and a consultative workshop under the “National Technical Advisory and Advocacy Platform for Improved Adolescent Nutrition” was convened in mid-October 2018 to obtain feedback from partners. The seven areas and 21 priority action areas were reviewed and finalized in the group works. Four key nutrition partners (WB, WHO, SUN secretariat and MoNHSRC) provided detailed peer review of the first draft. A full revision was prepared in Islamabad by the third week of

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<sup>8</sup> Patton, Sawyer, Santelli et al (2016). Our Future: A *Lancet* Commission on Adolescent Health and Wellbeing. *Lancet* 387(10036), p 2423.

<sup>9</sup> WHO (2017). *Global accelerated action for the health of adolescents (AA-HA)*. Geneva: WHO.

<sup>10</sup> WHO (2018). *Implementing effective actions for improving adolescent nutrition*. Geneva: WHO.

<sup>11</sup> Government of Pakistan (2015). *National Health Vision on Pakistan 2016-2015*. Islamabad: Ministry of National Health Services, Regulation and Coordination.

<sup>12</sup> Ministry of Planning, Development + Reform and World Food Program (2018). *Pakistan Multi-sectoral Nutrition Strategy 2018-2015*. Islamabad: Ministry of Planning, Develop + Reform.

<sup>13</sup> These are: Baluchistan (2013), Khyber Pakhtunkhwa (2014), Azad Jammu + Kashmir (2015), Punjab (2015), Sindh (2015), also for Sindh the Accelerated Action Plan Booklet for Reduction of Stunting and Malnutrition (2017).

<sup>14</sup> Government of Khyber Pakhtunkhwa (2011). *Revised Integrated PC-1*. Peshawar: Provincial Health Department.

<sup>15</sup> Government of Sindh (2016). *PC1 Nutrition Support Program for Sindh*. Karachi: Provincial Health Department.

<sup>16</sup> Provincial Assembly of Sindh (2014). *Sindh Child Marriages Restraint Act (2013)*. Karachi: Sindh Government Gazette, and, *Punjab Marriage Restraint Amendment Act (2015)*. Mimeo.

October. Subsequent revision was undertaken in November 2018 and shared with the World Bank. Relevant content from the Global Nutrition Report 2018 (GNR)<sup>17</sup> which was released in late November 2018 was also reviewed with a view to aligning the Priority Actions proposed in this Framework.

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<sup>17</sup> Global Nutrition Report (2018). *Shining a light to spur action on nutrition*. London, UK: Portland Communications.

## BACKGROUND AND CONTEXT

### The global picture for adolescent nutrition

Malnutrition during the adolescent period includes under-nutrition, micronutrient deficiency, and overweight and obesity which increases the risk of diet-related NCDs such as heart disease, diabetes, stroke and some cancers. Under-nutrition can present as thinness, underweight, and stunting also referred to as short stature for age<sup>18</sup>. The so-called double burden of malnutrition is characterized by the presence of under-nutrition with overweight or obesity and diet-related NCDs in the same community or country. There is as yet no regular global reporting on adolescent nutrition. From 1975 to 2016, trends in BMI, underweight and overweight and obesity in youth 5-19 years in 200 countries showed that average BMI and the prevalence of overweight and obesity are increasing in most regions<sup>19</sup>. While BMI may have plateaued in high-income countries, the rate of increase in BMI in middle-income countries continues to accelerate, especially in South Asia. Despite this trend, underweight is more common in this age group than obesity. Globally, adolescent underweight is increasingly concentrated in South Asia, including Pakistan, as well as east and central Africa.

### Regional trends in adolescent nutrition indicators

Under-nutrition – stunting, wasting, micronutrient deficiencies, especially anaemia – is widespread in adolescents across South Asia. Analysis of data from Demographic Health Surveys (DHS) conducted in 53 countries, together with national surveys in five countries, shows that South Asia has the highest prevalence of thinness, nearly double that of East Asia or East and Central African countries<sup>20</sup>. About one-half of girls 15-19 years old in South and South East Asia have anaemia which is associated with poor cognitive and educational performance<sup>21</sup>. It has been estimated that 90% of adolescent girls in 16 districts in India are iron deficient<sup>22</sup>. Diet alone does not appear to be the sole driver of anaemia in adolescent girls in South Asia. Religious practice is a household-level factor that correlates with anemia in adolescent girls in Bangladesh, Nepal and India<sup>23</sup>.

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<sup>18</sup> Underweight or thinness is defined as BMI-for-age Z-score below -2 SDs, severe thinness as BMI-for-age Z-score below -3 SDs, overweight as BMI-for-age Z-score above 1, and obesity as a Z-score greater than 2 of the WHO growth reference standard. Adolescents aged 10-14 years who have a mid-upper arm circumference of less than 160 mm and have signs of severe visible wasting or bilateral pitting oedema are diagnosed as having severe acute malnutrition.

<sup>19</sup> NCD Risk Factor Collaboration (2017). Trends in adult body-mass index in 200 countries from 1975 to 2016: a pooled analysis of 2416 population-based measurement studies with 19.2 million participants. *Lancet* 387(10026), p 1377.

<sup>20</sup> Jaacks, Slining, Popkin (2015). Recent trends in the prevalence of under- and overweight among adolescent girls in low- and middle-income countries. *Pediatric Obesity* 10 (6), p 428.

<sup>21</sup> WHO Regional Office for South East Asia (2011). *Prevention of Iron Deficiency Anaemia in Adolescents. Role of Weekly Iron and Folic Acid Supplementation*. New Delhi: WHO.

<sup>22</sup> Akhtar (2013). Zinc status in South Asian populations, an update. *J Health Pop Nutrition* 31 (2), p 139.

<sup>23</sup> UNICEF et al (2018). *Child stunting, hidden hunger and human capital in South Asia*. Katmandu: UNICEF.

The 2017 Global Nutrition Report (GNR)<sup>24</sup> called attention to the “outstanding need” for data on nutrition status of adolescents. The 10-19-year-old is rarely surveyed. Adolescent girls 15-19 years are considered women of reproductive age but most often data for this large group (15-49 years) is not disaggregated into smaller age groupings. The 10-14 year old is virtually neglected. Adolescent girls and boys are at a critical stage in development, not yet adults but possibly soon-to-be mothers and fathers. The GNR points out that the lack of data for countries in the region is an obstacle to coherent planning and policy making for adolescent nutrition, where thinness is coupled with early marriage and child birth amongst young girls, and poor diets and other exposures (smoking for example) amongst young boys.

## Adolescent nutrition in Pakistan

The landscape analysis conducted by van Liere et al<sup>25</sup> in 2017 for GAIN provided insight into nutritional status of adolescent girls. This report draws attention to the “alarming” prevalence of micronutrient deficiencies, with more than half of girls 15-19 years suffering from anemia, 21% are iron deficient, 49% folic acid deficient, 42% zinc deficient and 40% vitamin A deficient<sup>26</sup>. This report also points to high levels of stunting (22%) and overweight (16%)<sup>27</sup> among adolescent girls 15-19 years. An analysis of the underlying determinants of malnutrition in adolescent girls by the DHS (2013) points to poor education achievement, illiteracy, as well as early marriage and pregnancy. The 2014-15 National Food Consumption Survey highlighted that only 15% of adolescent girls 10-19 years old consumed any green leafy vegetables on the previous day<sup>28</sup>. It is noteworthy that the 2018 Global Nutrition Report in its review of global progress against nutrition targets categorizes Pakistan as making “no progress or worsening” for adult obesity and diabetes.

Building on this, the Evidence Review by Beal et al<sup>29</sup> (second analytical piece by GAIN) provides a literature survey of key nutrition indicators for 10-19-year-old boys and girls in Pakistan. Importantly, the study reveals a high burden of stunting, thinness and overweight amongst adolescents. Girls experience a higher burden of stunting and overweight than boys but whether this is generalizable across the country is an open question. Thinness is more common in rural towns and villages, while overweight is more prevalent in cities. There are no clear trends in adolescent anthropometry over time. Anemia, zinc and vitamin A deficiencies are common in girls, and other micronutrient deficiencies are likely. The study emphasizes that there are no micronutrient deficiency data available for adolescent boys.

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<sup>24</sup> Development Initiatives (2017). *Global Nutrition Report 2017: Nourishing the SDGs*. Bristol, UK: Development Initiatives.

<sup>25</sup> van Liere, Bhutta, Hartvig-Blomberg et al (2017). *Embodying the future: how to improve the nutrition status of adolescent girls in Pakistan?* Islamabad: GAIN.

<sup>26</sup> These data are from the National Nutrition Survey (NNS) of 2011.

<sup>27</sup> It is noteworthy that Beal et al, in a re-analysis of the data that excluded outliers, arrived at prevalence of 8%.

<sup>28</sup> Food Consumption Survey (2014-15) as summarized by van Liere et al (2017).

<sup>29</sup> Beal, Vossenaar, Tumilowicz et al (2018). *Technical Report: Review of evidence on the nutrition status of adolescent girls and boys in Pakistan*. Geneva: GAIN.



Data on adolescent nutrition will be available in the upcoming 2018 National Nutrition Survey (NNS) report which will include data on height, weight and mid-upper arm circumference, anaemia and iodine status. Biological specimens have been collected from girls 10-19 years. As well, information on minimum dietary diversity will be available from women 15-19 years. Focus group discussions were being conducted with boys and girls. The NNS 2018 is an important step towards filling information gaps related to the adolescent.

Updated fertility and health-related information is found in the recently released 2018 DHS<sup>30</sup>. This report documents declining total fertility (although the trend is slowing in recent years), and increased age at first birth, including amongst 15-19 year olds. Contraceptive use is very low (7.4%) and unmet need is relatively high in this group, at 18%. Although 85% of teenage mothers have skilled care at delivery, only 43% attend the recommended four antenatal visits. Differences between urban and rural residence, and across income and education bands all point to higher rates of fertility and malnutrition amongst poor uneducated rural women.

Taken together, these evidence pieces paint a picture of generalized nutritional deprivation amongst Pakistan's adolescents which reaches across provinces and geographic areas of the country. Household food insecurity is a main reason why diets are poor, especially in rural areas where more than half of households are food-insecure for most of the year<sup>31</sup>. The Beal et al report identifies seven main determinants of adolescent malnutrition as follows: food insecurity, poor diet, insufficient control over dietary intakes, low school attendance and literacy, child marriage and early pregnancy, poor access to comprehensive reproductive health information (both boys and girls), and low levels of physical activity especially in towns and cities.

## Current programming in Pakistan

There is no national adolescent nutrition policy in Pakistan although several policy and strategy documents do refer to the nutrition needs of adolescents. The national vision for reproductive health<sup>32</sup> provides some focus on the adolescent girl in the context of their reproductive health needs and argues for increased attention to this group. The national health vision<sup>33</sup> addresses the health of adolescents but does not provide explicit policy guidance. Similarly, the recently released national nutrition strategy<sup>34</sup> refers to the adolescent in the context of specific issues (micronutrient malnutrition and thus IFA, gender equity) but does not provide coherent policy guidance for adolescent nutrition. These gaps, together with the pattern of double

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<sup>30</sup> National Institute of Population Studies (NIPS) and ICF (2018). *Pakistan Demographic and Health Survey 2017-2018*. Islamabad Pakistan and Rockville Maryland: NIPS and ICF.

<sup>31</sup> Akseer, Al-Gashm, Mehta et al (2017). Global and regional trends in nutritional status of young people: a critical and neglected group. *Annals of the NY Academy of Sciences* 1393 (1), p 3.

<sup>32</sup> Ministry of National Health Services, Regulation + Coordination (2015). *National Vision for RMNCAH 2016-25*. Islamabad: MoNHSR&C

<sup>33</sup> Ministry of Health Services, Regulation + Coordination (2015). *National Health Vision 2016-2025*. Islamabad.

<sup>34</sup> Ministry of Planning, Development + Reform (MPDR) and World Food Program (2018). *Pakistan Multi-sectoral Nutrition Strategy (2018-2015)*. Islamabad: MPDR.

malnutrition burden, i.e., under- and over-nutrition in the same communities, pose challenges to developing effective programmes, with appropriate entry points, that would have adequate coverage and impacts.

During the course of preparing this *Framework for Action*, interviews were conducted by GAIN with government officials and development partners in four provinces<sup>35</sup>. The aim was to determine the extent of recent or new nutrition programming efforts in the provinces. This provided useful insights into the growth of nutrition work across sectors since publication of the GAIN report<sup>36</sup> two years ago. In each province, there are large-scale nutrition programmes that incorporate both nutrition-specific and nutrition-sensitive interventions, and which include some elements for the adolescent, although the focus is mostly on reducing stunting. Each province has a flagship nutrition programme (described below) with varying degrees of government and partner financing. These provincial-level programmes are important because lessons learned from these experiences will inform design of other programmes going forward. These programmes are also important because they will help to establish the “soft infrastructure” such as professional nutrition networks, steering committee structure, technical advisory working groups, management teams, and cross-disciplinary collaboration.

- In Punjab, the Chief Minister’s 3-year Stunting Reduction program, started in 11 districts and plans are in place to scale up to 36 districts. This program is based on the “1000+ days” concept and incorporates iron and folic acid (IFA) for adolescent girls and nutrition awareness for girls and boys via the Health and Nutrition Supervisor cadre. This program is managed out of the health department while emphasizing collaboration with WASH and education departments.
- In Sindh, the Accelerated Action Plan (AAP) for Nutrition focuses on stunting reduction and provides nutrition counselling and IFA for adolescent girls as future mothers. Updates and strengthening of the school nutrition curricula, which emphasize healthy eating and appropriate WASH-related behaviours, is intended to reach adolescent girls and boys. Cross-sectoral collaboration involves health, WASH, education and agriculture.
- In Balochistan, the Nutrition Program for Mothers and Children is currently rolled out in seven districts. Anchored in the Provincial Nutrition Cell, it provides IFA supplements to young married adolescent girls as well as behaviour change communication and strengthening governance and monitoring and learning.
- In Khyber Pakhtunkhwa, in an advanced stage of planning is the Stunting Prevention & Rehabilitation Integrated Nutrition Gains program. This is a multi-sectoral platform that will bring together

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<sup>35</sup> These interviews were conducted by Dr. Asma Badar in Punjab, Sindh, Baluchistan and Khyber Pakhtunkhwa provinces during August 2018. Dr. Badar’s findings were used in drafting the Priority Actions.

<sup>36</sup> van Liere, M., Bhutta, Z. A., Hartvig-Blomberg, J., & Mahmood, S. (2017). *Embodying the future: how to improve the nutrition status of adolescent girls in Pakistan*

IFA supplementation, nutrition awareness raising to diversify the diet and de-worming for adolescents. Schools may provide the main entry point for the WASH component.

The interviews indicated that most nutrition-specific programmes in Pakistan, including those described above, target the first 1000 days with interventions for pregnant and lactating women and children under two. There has been increasing attention in the last five years to the 1000-day focus, federally and provincially, and the series of provincial multi-sectoral nutrition strategies emphasize this approach. Multi-sectoral strategies for Sindh and Punjab provinces include aspects aimed at addressing malnutrition in adolescent girls – through education, WASH, social protection, for example. However, as yet, few programmes target nutritional status of adolescent girls *specifically*. Other authors find virtually no programmes addressing nutrition of boys. Also, programmes that reach adolescent girls –sexual and reproductive health (SRH) and family planning for example – are generally not “adolescent friendly” and do not make explicit effort to support the pregnant teen nor monitor results. While IFA supplementation during pregnancy is available across the country, this reaches 15-19 year olds only *as part of* the larger group of women of reproductive age. The WHO-initiated anemia reduction plans at national and provincial level are a notable step forward to address iron status of adolescents. While fortified food staples are available in the market, these reach adolescents only as part of the family unit.

In summary, a comprehensive review of programmes in the provinces conducted during preparation of this *Framework for Action* through interviews and document review indicates that the main gaps in current nutrition programming to be addressed by a *Framework for Action* are the following:

- very few programmes target the adolescent specifically despite inclusion, and explicit mention, in the multi-sectoral strategies,
- poor geographic coverage of adolescents by existing programmes (limited to selected districts),
- opportunities to deepen and expand design of current programmes to enrich content for adolescents as yet unexploited,
- virtually no programming for the adolescent boy.

### **Globally recommended policies and interventions for adolescent nutrition**

The importance of adolescent health is given needed global attention in the WHO publication *Global Accelerated Action for the Health of Adolescents (AA-HA!)*. The perspectives of this global guidance lend support to treating adolescents as central to countries’ development efforts. In this vision, nutrition takes a prominent place amongst policy directions and specific interventions.

Building on this, WHO more recently published an updated conceptual framework<sup>37</sup> which encapsulates a comprehensive set of policies and interventions to address nutrition of adolescent boys and girls. The framework addresses the underlying causes of under-nutrition – food insecurity, inadequate feeding and care, environmental factors and health services – as well as three *capacities*. These are ability to access a nutritious diet, ability to contribute to health through positive behaviours and ability to access essential health services. Eight evidence-based policies and interventions have been identified as global guidance for their role in adolescent nutrition. Because the 10-19-year-old group overlaps with both childhood and adulthood, adolescents can and will be reached by interventions aimed at these two groups, i.e., children (5-17 years) and adults (18 onwards). However, if the intervention is not offered in a manner of interest and relevance to the adolescent, effectiveness and impacts will be compromised. This is a critical point for programme design in Pakistan.

The following globally recommended actions<sup>38</sup> are based on accumulated best practice and would provide the basis for a menu of policies and interventions to improve nutrition of adolescents across Pakistan. More detailed guidance and information is available in the WHO publication cited above. The point here is to provide some basis for checking the breadth and depth of current efforts in Pakistan and to adjust, expand and invigorate actions to address adolescent nutrition *nationally*. The Government of Pakistan will need to launch a focused *national* response to improve nutrition of adolescents built around the following:

- *Promoting healthy diets in adolescents* – Healthy diets have a critical role in preventing all forms of malnutrition and reducing the risk of diet-related illness. In Pakistan, promotion of healthy diets can be implemented in conjunction with national food-based dietary guidelines. This will entail messages that are tailored to the particular groups, rural/urban for example.
  - Example: Several countries in the region – Thailand, Malaysia, Sri Lanka for example – have initiated youth programmes to increase fruit and vegetable consumption to at least 400 grams/day, reduce free sugar consumption to less than 10% of total energy intake and reduce sodium intake to below 2 grams/day<sup>39</sup>.
- *Providing additional micronutrients through mass fortification of staples and targeted supplementation* – Consuming fortified foods and supplements can help meet the nutrient needs of adolescents while a diverse and nutrient-dense diet with bioavailable iron would be the base. There is a long tradition in Pakistan of mass fortification, as well as providing IFA supplements to pregnant women 15-49 years. The needs of younger and non-pregnant

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<sup>37</sup> WHO (2018). *Guideline for implementing effective actions for improving adolescent nutrition*. Geneva: WHO.

<sup>38</sup> The term *action* in this context refers to a policy, a statement of intent or vision. An *intervention* denotes a process of providing a service or commodity.

<sup>39</sup> Global Panel on Agriculture and Food Systems for Nutrition (2016). *Food Systems and Diets: Facing the Challenges of the 21<sup>st</sup> Century*. London, UK.

adolescents who have reached menarche needs to be addressed explicitly and protocols updated.

- Example: Daily oral iron supplementation at 30-60 mg/day for 3 consecutive months, as a preventive strategy at population level for non-pregnant adolescent girls 10-19 who have reached menarche is recommended, however, experience is limited. Bangladesh's experience<sup>40</sup> with reaching the non-pregnant adolescent (12-17 years) is relevant here.
- *Managing acute malnutrition in adolescents* – This refers to a coherent approach to identifying, assessing and managing the recovery of acute malnutrition in adolescents. All adolescents presenting with acute weight loss should be assessed for underlying causes and offered nutritional support and counselling. Referral to appropriate programmes and astute follow-up to tackle causes will be critical.
  - Example: In Nepal, as an extension of the national tuberculosis control effort, adolescents with weight loss, or who fail to gain weight appropriately, are assessed for co-morbidities and provided with counselling, locally available nutrient-rich foods and, in some regions, fortified supplementary foods<sup>41</sup>.
- *Preventing adolescent pregnancy and poor reproductive outcomes* – Policy actions needed here will include age-appropriate and comprehensive sexual education for all adolescents as well as removal of social and non-medical restrictions on the provision of contraceptives to married adolescents. Delivery mechanisms for contraceptives will need to be acceptable to adolescents, i.e., not exclusively through health services.
  - Example: Ethiopia, Uganda and Tanzania, through sensitizing political leaders to the perils of early marriage and enacting legal reforms, have experienced significant declines in child marriage in recent years<sup>42</sup>. This is helping to remove societal pressure on under-age girls to bear children as evidenced by delayed first pregnancies.
- *Promoting preconception and antenatal nutrition in adolescents* – Availability of antenatal, childbirth and postnatal care needs to be expanded to reach all adolescents, while ensuring these services are adolescent-friendly and appropriate. Nutrition support during pregnancy needs to be tailored to the pregnant teen who will not have achieved full growth potential yet herself.

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<sup>40</sup> WHO Regional Office of South East Asia (2011). *Prevention of Iron Deficiency Anemia in Adolescents – Role of Weekly Iron and Folic Acid Supplementation*. Delhi India: WHO.

<sup>41</sup> WHO (2013). *Guideline: Nutritional care and support of patients with tuberculosis*. Geneva: WHO

<sup>42</sup> Svanemyr, Scolaro, Blondeel et al (2013). *The contribution of laws to change practice of child marriage in Africa*. Geneva: Inter-Parliamentary Union (IPU).

- Example: In Viet Nam, the Ministry of Health, in 2009, initiated an antenatal nutrition support programme for pregnant teens which included one-on-one counselling on healthy eating, birth preparedness, and comprehensive maternal and newborn care. “Little Sun” nurseries have been credited with improving reproductive health outcomes for adolescents who participate<sup>43</sup>.
- *Providing access to a safe environment and hygiene* – Dramatically improved access to safe, separate and private sanitation facilities will be crucial for personal hygiene management, comfort and health of adolescent girls. Reliable facilities at home, school and in the community should become the norm across Pakistan. This will help to sustain school attendance and reduce drop-out which, in turn, renders teens more vulnerable to early marriage and childbearing.
  - Example: India has made rapid progress in increasing access to sanitation facilities in middle schools<sup>44</sup>. This has contributed to improved school attendance and reduced drop-out and serves as a platform for awareness raising, hygiene education and behaviour change.

*Promoting physical activity in adolescents* – Especially in urban areas, physical activity may decline and sedentary behaviours increase during adolescents – exacerbating the effects of poor diet – unless concerted actions are taken. These would include, at a policy level, reconsidering social norms that may keep adolescent girls indoors and fostering organized sports for both boys and girls.

- Example: Based on a target of 60 (accumulated) minutes of moderate to intensive physical activity daily, a multi-pronged programme was launched in Mauritius in 2012 initially aimed at the growing problem of adolescent obesity. The programme achieved measurable changes in food-related behaviours.<sup>45</sup>

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<sup>43</sup> Alive + Thrive (2016, August 1). *Breastfeeding against the odds in Viet Nam*. Retrieved from URL: <https://www.aliveandthrive.org/resources/breastfeeding-against-the-odds-in-viet-nam/>

<sup>44</sup> WHO/UNICEF Joint Monitoring Program for Water Supply, Sanitation and Hygiene (2018). *Drinking water, sanitation and hygiene in schools. Global Baseline Report*. New York: UNICEF.

<sup>45</sup> Bhurosy, Jeewan (2014). Overweight and obesity in developing countries: A problem with diet, physical activity or social status? *Scientific World Journal* PMC 4212551.

## FRAMEWORK FOR ACTION, POLICIES AND PROGRAMMES

Previous sections of this document dealt with the justification for addressing adolescent nutrition and long-term socioeconomic benefits of investment and took us through the efforts undertaken by GAIN and World Bank in collaboration with Government and partners to position adolescent nutrition in Pakistan. The current global picture and regional trends, and the situation in Pakistan were summarized with some analysis of key indicators and their determinants. Global guidance on policies and interventions known to be effective in most settings and relevant to Pakistan has also been presented. This section identifies high-level Priority Actions that government needs to commit to so that sustained achievement is possible in years to come. Three Priority Actions are identified in each of seven separate areas. The point here is to set out Actions that are critical to a national response to adolescent malnutrition (in all its forms) and where resources should be applied without delay. The WHO Guidelines (referred to above) will be useful in determining content for 3.0 Setting Policy Priorities and 4.0 Nutrition-specific interventions in the health sector, below.

### 1.0 Evidence based policy advocacy and sensitizing government officials

Why is this important? Despite growing awareness amongst stakeholders and development actors in Pakistan that the adolescent experiences a crucial stage of the life cycle, both physically and socially, adolescent nutrition is neglected. The Data is limited and health and nutrition services and interventions targeting the adolescent are often of poor quality and insignificant coverage<sup>46</sup>. Adolescent nutrition needs to be placed higher on the agenda of government. The non-government sector, academia and development partners can play an important role in supporting delivery, but government has the mandate to deliver services to the Pakistani population. Concerted, organized and fully resourced action by government is needed. Political commitment, strong government leadership and engagement of capable institutions will be critical. The actions outlined below aim to inform and sensitize senior government officials to the nutrition issues and concerns of adolescents and to build an understanding of the value of investing in adolescents.

**Priority Action 1.1** – Evidence based advocacy with relevant political and government entities and forums through targeted events using knowledge products prepared as part of the WB SAFANSI project and by other partners

**Priority Action 1.2** – Convene national and provincial dialogues on how the “1000 days” approach can be supplemented by focusing on adolescent nutrition to improve maternal and child nutrition outcomes.

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<sup>46</sup> Countdown to 2030 (2018, June 28). *Country Profile Pakistan*. Retrieved from URL: <http://countdown2030.org/wp-content/uploads/2018/01/Pakistan-CD2030.pdf>



**Priority Action 1.3** – Advocate for revision, enactment and enforcement of “Child Marriages Restraint” act at National and Provincial level

## 2.0 Raising awareness on adolescent nutrition

Why is this important? Families, communities and adolescents will play an important role, bringing attention to adolescent nutrition, in a number of ways.

Adolescents and families need to understand the peculiar nutritional requirement for this age group and adopt healthy behaviours and practices. Moreover, an informed public will participate more meaningfully in decisions that politicians and government officials make. They will also generate demand for programs and services and support their implementation. They will be a voice in the public debates and the news media when issues of interest to them arise (for example, a change to program entry criteria that directly affects their family). Their role in supporting positive changes in social norms and attitudes that impede progress will be critical. An informed public can also advocate for adolescent health and nutrition and hold their governments accountable for appropriate resource allocation, sensible policies and effective implementation strategies.

**Priority Action 2.1** – Develop Communication Strategy for adolescents, design and launch campaigns to inform the public about the *long-term benefits* of good nutrition for adolescents and the value for families and communities. Messages should be tailored to age, culture and local circumstances. Community health workers<sup>47</sup>, play an important role in reaching families with adolescents.

**Priority Action 2.2** – Develop and implement innovative *low-cost approaches including the use of mobile technology and social media* to influence behaviours related to adolescent nutrition

**Priority Action 2.3** – Develop and implement interventions utilizing existing community-based structures and schools as *platforms* for catalyzing broader participation by families and communities in improving the nutritional well-being of adolescent boys and girls, including those out of school.

## 3.0 Setting policy priorities for adolescent nutrition

Why is this important? Economic growth alone will not address adolescent malnutrition adequately. Greater attention needs to be paid to the social, economic and political drivers, with targeted efforts towards populations at higher risk. There is growing consensus that economic growth will only be effective in addressing adolescent malnutrition if increases in national income are directed at improving the diets of adolescents, improving the status of adolescent girls, addressing inequities and reducing poverty. A focus on an economic growth model that does not address intermediary policies that affect the most vulnerable will not be effective. Intermediary policies are needed in three key areas as described below. These are

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<sup>47</sup> The curriculum of LHWs has been revised incorporating adolescent nutrition

policies around better diet quality for all adolescents, specific policy actions that address the 10-19-year-old girl and a national policy that sets out a vision. These policies would need to be implemented against a backdrop of policies in other realms which address the persistent and, in some areas, worsening socio-economic inequities across Pakistan.

**Priority Action 3.1** – Building on the Framework for Action, develop a *national adolescent nutrition policy/strategy* that sets out a vision for adolescent health and nutrition for Pakistan and guides current and future program design in relevant sectors.

**Priority Action 3.2** – Review and refine existing policies *related to the food environment so as to ensure better diet quality and* improved access to nutritious foods (adequate energy, protein, and micronutrients) and discourage consumption of low-value foods by adolescents

#### 4.0 Nutrition-specific interventions in the health sector

Why is this important? Measures to address child stunting have taken root in Pakistan as evidenced by signing-up to the SUN Movement, development of multi-sectoral stunting-reduction implementation plans in several provinces, a national nutrition policy and nutrition being incorporated into several key platform agreements such as the National Health Vision 2016-25. It is broadly accepted that mother’s short stature, underweight, lack of education, early marriage and low household income are significant drivers of child stunting across Pakistan. Nutrition-specific interventions pertain to the direct causes of malnutrition and, for child stunting, these include promotion of exclusive breastfeeding, appropriate complementary feeding, hygiene and sanitation practices and infrastructure, prevention and treatment of infectious illness and severe malnutrition. The important work underway aimed packaging these nutrition-specific interventions for children needs now to be replicated for the adolescent. Adolescence needs to be seen as the second “window of opportunity” to address malnutrition, and, along with this recognition would be a core set of effective nutrition-specific interventions that explicitly address the adolescent as set out below.

**Priority Action 4.1** – Develop a *core package of nutrition-specific interventions* and promote provision to all adolescents across Pakistan in four areas: healthy eating, nutrient supplementation<sup>48</sup>, behaviour change for health and avoiding risk; and hygiene and sanitation.

**Priority Action 4.2** – Develop training package/s to build capacity of healthcare providers in the public and private sector to enhance the quality and reach of healthcare care services for adolescent girls<sup>49</sup> and boys.

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<sup>48</sup> With regards to micronutrient supplementation, a nutrient-by-nutrient approach will not suffice in Pakistan and neither will a focus on some but not all micronutrient deficiencies deliver high gains. Supplementation has a place in the core package but needs to be aligned with other direct interventions.

<sup>49</sup> Including Adolescent friendly antenatal, maternity and newborn services

**Priority Action 4.3** – Develop costed plans (national and provincial) in line with the Adolescent Nutrition Strategy to address the issue of *poor geographic coverage and access to nutrition-specific interventions targeting adolescent boys and girls.*

## 5.0 Nutrition-sensitive interventions in the non-health sectors

Why is this important? The nutrition-specific interventions which tackle the direct causes of malnutrition (section above) will need to be combined with nutrition-sensitive programs that address basic and underlying socio-economic and other determinants of adolescent malnutrition. Neither on its own will be enough to sustainably improve adolescent nutrition outcomes. Nutrition-sensitive interventions are normally implemented by and through the non-health sectors, such as agriculture, education and social protection. Clearly some nutrition-specific interventions – sexual and reproductive health services for example – would be implemented through the non-health sector (education in this case) and this overlap will help to build understanding and synergies, as well as reduce program costs and extend reach. The point here is to *universalize* evidence-based nutrition-sensitive policies and programs designed to improve nutrition of adolescents and to support rapid expansion of direct nutrition services. In other words, tackle adolescent malnutrition from multiple directions at once. Developing food systems and marketing will be important in view of the strong role that food insecurity and diet play in adolescent malnutrition.

**Priority Action 5.1** – Develop *core package of nutrition sensitive interventions* in line with global practice *for integration into relevant programs in non-health sectors (including education, water/sanitation, food safety, agriculture& livelihood, social protection, gender empowerment, skill building etc.) that targets the adolescent explicitly.*

**Priority Action 5.2** – Develop training package/s to build capacity of relevant departments and their staff to implement the *core package of nutrition sensitive interventions.*

**Priority Action 5.3** – Work with the provincial Planning and Development Departments to develop costed plans for incorporation of the core package into existing and upcoming programs.

## 6.0 Scaling up for impact

Why is this important? Scaling up refers to a process aimed at *maximizing the effectiveness of a range of nutrition-relevant actions* leading to sustained impact on nutrition outcomes<sup>50</sup>. Once a package of core interventions is identified and the “right mix” is understood and accepted by stakeholders, careful consideration will need to be given to operationalizing equitable coverage in different settings. It won’t just happen on its own. Each province will have its own pace and challenges, and

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<sup>50</sup> Gillespie, Menon, Kennedy (2015). Scaling up impact on nutrition: what will it take? *Advances in Nutrition* 6, p 440.

these will be worked out locally. Going to scale will involve establishing measurable outcomes for adolescent nutrition. Examples are reducing anemia, improving food consumption quality and quantity, enhancing sanitation infrastructure and usage. Stakeholders will need to be clear on what exactly is to be scaled up to achieve large-scale impact. Lessons learned from trials at the district level will be helpful here. Further, implementation contexts will be important because they will shape the ability to scale up interventions and their impact. For example, if an intervention calls for dedicated nutrition workers, or not, raises different challenges for implementation. Household and community contexts will need to be factored in because they too shape the ability of interventions to have impact. For example, food insecurity would constrain a behaviour-change intervention.

**Priority Action 6.1** – Ensure substantially increased *domestic resources* for adolescent nutrition to build national ownership of programs and related capacity and to support a sustained policy and programming thrust moving forward. (Note: highly relevant to 1.0 Advocacy as well).

**Priority Action 6.2** –Regular convening of the “National Technical Advisory and Advocacy Platform for Improved Adolescent Nutrition” and establishment of similar provincial platforms to guide and implement the scale-up.

**Priority Action 6.3** – Continue to innovate and try new *integrated approaches* and delivery platforms so that scale-up approaches continue to proliferate and mature; innovation is key here given the widely diverse programming settings across the provinces.

## 7.0 Monitoring and evaluation, learning and accountability

Why is this important? Monitoring and evaluation are important to learning throughout the scale-up process and in generating evidence of impact. Investments in monitoring, evaluation and accountability are critical to identifying needed changes to the design of programs. Data and information from monitoring and evaluation systems are also crucial for accountability and effective governance. This, in turn, requires an orderly committee structure that reaches across sectors and from national to community levels. There is significant experience in Pakistan with different approaches to measuring intervention coverage (surveys and other methodologies); however, deeper investments will need to be made in strengthening implementation research to support both health and non-health systems as interventions that target adolescents are scaled up. Implementation research to improve program delivery, use, cost effectiveness and scale, would also explore alternate platforms when feasible. The aim is to develop a flexible and responsive system that captures and disseminates learning.

**Priority Action 7.1** – Develop a monitoring and evaluation framework as part of the National Adolescent Nutrition Strategy.

**Priority Action 7.2** – Integrate the adolescent age group, 10-19 years, into routine nutrition surveillance<sup>51</sup>, appropriately sampled in population surveys<sup>52</sup> and disaggregated in program evaluation, and continue to document determinants of poor nutrition in 10-19-year-olds using standardized indicators.

**Priority Action 7.3** – Strengthen and ensure appropriate *skills and capacity* of mid-level and senior government officials in program implementation research so that they can fully support the pace and quality of learning in relation to scaling-up impact on adolescent nutrition.

**Priority Action 7.4** – Ensure *participation of adolescents* in the interpretation of evaluation findings, as well as the design and implementation of policies, programs and guidelines.

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<sup>51</sup> District Health Information System and LHW MIS in particular

<sup>52</sup> NNS and PDHS, MICS, PSLM, PHIES

## ROLES AND RESPONSIBILITIES: TOWARDS A COORDINATED NATIONAL RESPONSE

Implementation of this *Framework for Action* to improve adolescent nutrition in Pakistan is the responsibility of authorities at the three levels of government: federal, provincial and district. Supportive collaborations with partners outside government such as civil society, NGOs, professional bodies, faith-based organizations and development partners will be of benefit. The following highlights the roles and responsibilities of stakeholders.

| At the federal level   |  |
|--|--|
| Ministry of Planning , Development and Reform                      | <ul style="list-style-type: none"> <li>▪ Ensure adequate resources for full implementation of this <i>Framework for Action</i></li> <li>▪ Provide a bridge that joins up ministries and departments that have nutrition-related mandates and work plan, and a responsibility for, especially, nutrition-sensitive actions</li> <li>▪ Review institutional arrangements for adolescent nutrition and nutrition policy delivery and identify creative solutions when corrective action is required</li> <li>▪ Raise awareness of the costs and benefits – economic, developmental and societal – of preventing malnutrition</li> </ul> |
| Scaling Up for Nutrition (SUN) Movement Secretariat                | <ul style="list-style-type: none"> <li>▪ Ensure informed public dialogue on the importance and feasibility of preventing malnutrition in adolescents and advocate for continued political visibility of adolescent nutrition</li> <li>▪ Revisit SUN guidance currently in use by the full range of SUN alliances – Civil Society, Academia, Business Network to name just three – and incorporate priority actions of relevance to adolescent nutrition.</li> <li>▪ Make public annual reports on progress made in <i>Framework</i> implementation and achievement of results</li> </ul>   |
| Ministry of National Health Services, Regulations and Coordination | <ul style="list-style-type: none"> <li>▪ Articulate a vision for adolescent nutrition in Pakistan and take leadership role in providing overall technical policy direction and monitor quality and coverage of core packages</li> <li>▪ Mobilize domestic financial resources for adolescent nutrition and the goals and aims of the Framework</li> <li>▪ Provide supportive supervision for implementation of this Framework through the recently established Technical Advisory and Advocacy Working Group for Improved Adolescent Nutrition</li> </ul>  |

| At the provincial level                               |   |
|---|---|
| Provincial Department of Planning and Development     | <ul style="list-style-type: none"> <li>▪ Ensure adequate budgets for adolescent nutrition and timely release of funds</li> <li>▪ Coordinate contributions from non-health sectors to <i>Framework</i> implementation – this task could be usefully assigned to the SUN Focal Point in this Department</li> <li>▪ Liaise with provincial line departments via technical committees on nutrition to oversee the quality and coverage of adolescent nutrition core packages</li> </ul>   |
| Provincial Department of Health                       | <ul style="list-style-type: none"> <li>▪ Through existing primary health care revitalization initiatives currently underway, ensure that adolescent nutrition programming is adequately staffed</li> <li>▪ Ensure that adolescent nutrition is reflected in guidelines for minimum standards and that this is periodically reviewed and updated</li> <li>▪ Keep under review results of relevant formative research which points the way to innovations in delivery of adolescent nutrition services in the primary care setting</li> </ul>   |
| Provincial Department of Education                    | <ul style="list-style-type: none"> <li>▪ Take a proactive role for adolescent nutrition in Pakistan and the implementation of this <i>Framework for Action</i> starting by collaboration with health, WASH and other sectors (social welfare, youth affairs and sports) in schools</li> <li>▪ Revitalize and update nutrition and life skills curricula with a view to addressing the needs of adolescent boys and girls, including those out of school</li> <li>▪ Place renewed emphasis on using schools to engage communities in improving adolescent nutrition knowledge and practice, and to address out-of-school teens.</li> <li>▪ Re-emphasize the critical importance of school enrollment and retention in helping to prevent child marriage and early pregnancy; extend all efforts to support implementation of child marriage restraint legislation</li> </ul> |
| Provincial Department of WASH or Rural Infrastructure | <ul style="list-style-type: none"> <li>▪ Achieve and sustain universal coverage of open defecation free (ODF) which means all districts and communities based on mapping and participatory appraisals.</li> <li>▪ Intensify behaviour-change communication around the use of toilets and latrines, and hand-washing after use of the facility, and before food preparation or consumption and other critical times.</li> <li>▪ Drive up coverage rates of improved water source and safe drinking water</li> </ul>  |
| Provincial Department of Agriculture                  | <ul style="list-style-type: none"> <li>▪ With agriculture and food production being the backbone of diets and nutrition, policies should emphasize that eating better helps to ensure sustainable systems</li> <li>▪ Keep under review the extent to which predominant food systems contribute to adverse nutrition outcomes for the adolescent</li> <li>▪ In the long run, ensure that food systems and markets are sensitive to the needs of adolescents</li> <li>▪ Engage adolescents in finding less resource-intensive ways to produce safe, nutritious, healthy diets and help to build their capacities to build a sustainable food supply</li> </ul>  |



Provincial  
Department of  
Social Protection

- Take initiative, as opportunities arise, to re-shaping the large national cash-transfer program<sup>53</sup> for low-income women to deliver benefits specifically to adolescent girls
- Sensitize social and community workers to the value of social protection program benefits for low-income adolescents, and potential nutrition impacts
- Collaborate with the nutrition community to track Social Protection's contribution towards overall nutrition-sensitive spending, and spending on adolescents in particular

#### At the district level

- District-level coordination amongst line departments
- Collaborate with communities and provincial departments of health to identify core adolescent priority interventions
- Collaborate with communities to strengthen community adolescent and youth nutrition work, learn lessons and keep track of resources and results
- Identify new stakeholders in the overall Framework effort and encourage their participation and contribution

#### At the community level

- Bring forward adolescents' concerns, priorities and needs of the community to community outreach workers, managers of the health and other facilities, including schools.
- Help to ensure consistent implementation of the Framework at (for the health sector) facility and community levels, explain concepts of malnutrition prevention to communities
- Spearhead community mobilization and establishment of functioning community groups

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<sup>53</sup> Benazir Income Support Program

### NGOs and CSOs

- Support government in shifting to a focus on malnutrition prevention and communicate with the public on status of structural and other barriers to improved adolescent nutrition behaviors
- Demonstrate leadership by publically endorsing this Framework and implementing it through all relevant programs
- Work with the federal and provincial ministries to explain to families and communities that adolescent malnutrition is preventable

### Development partners

- Fund and support innovation in adolescent nutrition program delivery at all levels, and help to identify approaches that are ready for scale up and can deliver results
- Assist in developing an agenda for formative research which prioritizes examination of key barriers to scale up, measurement and effective advocacy
- Bring experiences from other countries to bear on implementation strategies in Pakistan
- Provide technical support to government

## NEXT STEPS

This *Framework* is intended to serve as a guidance document for government and partners to develop policies and strategies in reaching a vision of ensuring that all adolescents are adequately nourished and participate fully in family and community life. Delivering on this agenda will require proactive leadership and effective partnerships. The government should maintain its leading role, but also collaborate with stakeholders across sectors to build an enabling environment for adolescent nutrition. Some of the gaps identified during preparation of this *Framework* include: a lack of evidence, a national level Adolescent Nutrition Strategy that also encompasses provincial contexts and action plans, and limited interventions and experience or practice working across sectors for this age group. The following Next Steps are offered for consideration by government to take this *Framework for Action* forward over the next year.

- 1.** National dissemination of the “Evidence Review on Nutritional Status of Adolescent Boys and Girls in Pakistan” and “A policy Paper on Adolescent Nutrition in Pakistan: Framework for Action Policies and Programs” to share findings and sensitize key stakeholders in government, donors, UN agencies and implementing partners.
- 2.** The Ministry of National Health Services Regulation and Coordination should take a leadership role. The “National Technical Advisory and Advocacy platform for Improved Nutrition” has been established under the ministry. It has a diverse membership base from the government, UN and the development community including the SUN secretariat and provides an excellent opportunity to take forward the agenda chalked out in the Framework for Action. The MoNHSRC needs to ensure regular convening of this platform.
- 3.** To ensure alignment across government levels, the MoNHSRC should approach the provincial governments to establish a multi-stakeholder platform similar to The National Adolescent Nutrition platform. The provincial Departments of Health should take a leadership role similar to MoNHSRC at the federal level. There is already extensive committee infrastructure in place at provincial levels working on health and nutrition, so it will be important to clearly explain the aim of Provincial Adolescent Nutrition chapters and build linkages, synergies, credibility and the work portfolio.

- 4.** Develop a national strategy for improving adolescent nutrition in Pakistan. Based on the work conducted by GAIN through the WB SAFANSI Program and WHO's support for implementation of the AA-HA framework for Pakistan, it has recently been decided in a meeting of the National Adolescent Nutrition Platform that a dedicated National Strategy for Improving Adolescent Nutrition should be developed. UNICEF, WHO and GAIN will be the key technical partners supporting the development of the strategy. It should be developed through a broader consultative process at the national and provincial levels. The strategy document should be informed by the existing multi-sectoral strategies at national and provincial levels, and the recently developed National Nutrition and Supplementation Guidelines and Pakistan Dietary Guidelines.
- 5.** To facilitate the strategy development process and development of sector specific action plans, the MoNHSRC should consider formation of a "working group/s" at the federal and provincial levels. This working group should be constituted from the members of the core group of the national platform and relevant stakeholders from the provincial governments. The working groups would ensure that the strategy development process takes into account and redresses the priority areas and actions identified in the framework for action. Sub-groups at the federal and provincial level may also be constituted to provide a focus to sector specific inputs.
- 6.** In the wake of high level political interest and commitment to tackle malnutrition in the country, the MoNHSRC should work with the provincial governments and key partners to undertake targeted advocacy at the federal and provincial level to further heighten interest in adolescent nutrition as a means to improving health and nutrition outcomes as well as key contributors to enhanced productivity and economic growth. This advocacy effort should also ensure adequate domestic resourcing as the strategy development and preparation of downstream action plans move forward.
- 7.** Use the Nutrition Partners forum convened by the WB to solicit resources from donors and development partners to support the strategy development process, capacity building initiatives, piloting innovative interventions and scale up.

**Global Alliance for Improved Nutrition**