**SINDH COSTING FOR OPTIMA NUTRITION**

**REPORT**

**September 2019**

**Author: Davide De Beni**

Contents

[I. OBJECTIVE AND SCOPE OF THE ANALYSIS 2](#_Toc19545345)

[II. OVERALL APPROACH AND CLASSIFICATION OF COSTS 3](#_Toc19545346)

[III. SUMMARY RESULTS 5](#_Toc19545347)

[IV. COSTING ASSUMPTIONS PER INTERVENTION 7](#_Toc19545348)

[*Treatment of Severe Acute Malnutrition (SAM)* 7](#_Toc19545349)

[*Infant and Young Child Feeding programme (IYCF)* 11](#_Toc19545350)

[*Iron and folic acid supplementation* 12](#_Toc19545351)

[*Vitamin A supplementation* 14](#_Toc19545352)

[*Micronutrients powders (children)* 16](#_Toc19545353)

[*Zinc for treatment +* *oral rehydration solution (ORS)* 17](#_Toc19545354)

[*Lipid-based nutrition supplements (LNS)* 18](#_Toc19545355)

[*Fortification of staples* 19](#_Toc19545356)

[*Water, Sanitation, and Hygiene Interventions (WASH)* 20](#_Toc19545357)

[*Family planning* 21](#_Toc19545358)

[V. Annex: Methodology and Data Collection Strategy 23](#_Toc19545359)

[Methodology and Data Collection Strategy 23](#_Toc19545360)

[Background 23](#_Toc19545361)

[Objective 24](#_Toc19545362)

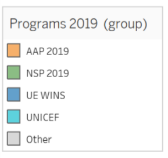
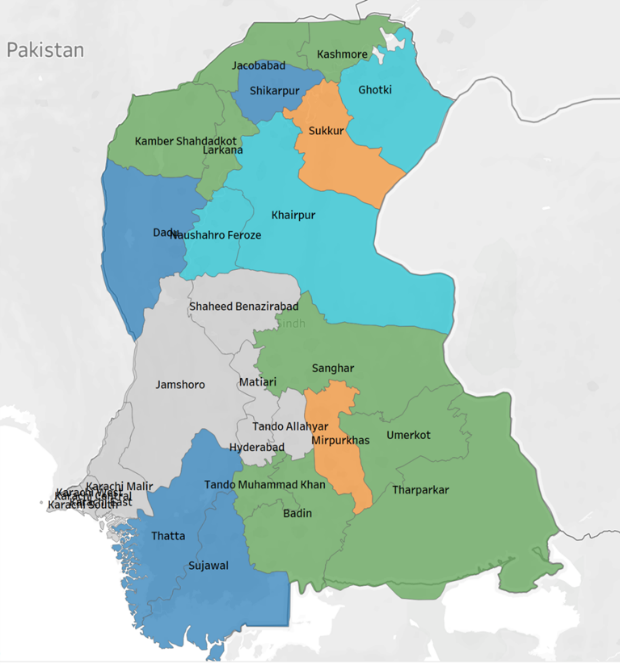
[Scope of the analysis 25](#_Toc19545363)

[Process of undertaking costing exercise 25](#_Toc19545364)

1. OBJECTIVE AND SCOPE OF THE ANALYSIS
2. **The scope of the analysis**. The objective of this analysis is to estimate unit cost (annual cost per beneficiary) and coverage of the key high-impact, evidence-based nutrition interventions in Sindh, Pakistan, to inform an application of the Optima nutrition tool and conduct allocative efficiency analyses of nutrition investments. The nutrition interventions included in the Optima analysis for Sindh are listed in the table below:

|  |  |
| --- | --- |
| Optima Nutrition Interventions | Description |
| Treatment of SAM | Treatment of Severe Acute Malnutrition (SAM) |
| IYCF1 (Community) | Infant and Young Child Feeding (IYCF) education programs; Delivered at health facility and community level, and through mass-media campaigns. |
| IYCF2 (Health Facility) |
| IYCF3 (Mass Media) |
| IFAS for pregnant women (Community) | 90 days Iron and Folic Acid Supplementation (IFAS) for pregnant women implemented at health facility and community level |
| IFAS for pregnant women (Health Facility) |
| Vitamin A supplementation | Delivered mainly through mass campaigns |
| Micronutrients powders (children) | Provision of micronutrients powders added to children 6-23 months for improving iron status and reducing anaemia |
| Zinc + ORS for treatment of diarrhoea | Provision of oral zinc tablets and ORS in the treatment of diarrhoea in children 0-59 months of age |
| Lipid-based nutrition supplements | Implemented at small-scale programme in 2 districts only |
| Fortification of wheat flour | Fortification of wheat flour with iron/folate, B12 and zinc |
| Fortification of vegetable oil with vitamin A | Fortification of cooking oil with Vitamin A |
| Iodine fortification of salt | Provincial salt iodization programme |
| Water, Sanitation, and Hygiene Interventions (WASH) | Handwashing with soap, Hygienic disposal of children stools, Improved sanitation, Improved water sources |
| Family planning | Provision of family planning services to women in reproductive age |

1. OVERALL APPROACH AND CLASSIFICATION OF COSTS
2. **The main source of data used for calculating the unit costs was the Nutrition Support Programme of Sindh (NSP).** The NSP is a regional programme for scaling-up high impact nutrition interventions for the period 2015-2019 in 9 districts of Sindh: Badin, Jacoabad, Kambar, Kashmor, Larkana, Sanghar, Tando.M.Khan, Tharparkar, and Umerkot. The NSP is delivered through three main modalities and delivery channels across the province: through the health facilities of the People Primary Health Initiative (PPHI); community level for the uncovered areas (NGOs as implementing partners); and via mass media messages (for IYCF behaviour change communication programmes).



1. Other sources for costing and coverage were the **Accelerated Action Plan (AAP)** for reduction of stunting and malnutrition supported by the Health Department of the Government of Sindh (GoS) in Mirpurkhas and Sukkur; and the nutrition programmes supported by **UNICEF** in Ghotki, Khairpur and Naushero Feroze. Additionally, some interventions coverage information was collected for the European Union funded programme known as **WINS (Women & Children Improved Nutrition in Sindh)** implemented by Save the Children and Action Against Hunger in the districts of Dadu, Shikarpur, Thatta and Sujawal.
2. Where possible**, costs were classified and divided into ‘direct costs’ and ‘programme costs’**. Direct costs are costs for inputs per beneficiaries incurred at the point of delivering the intervention, such as drugs and medical supplies (including transportation and distribution). Programme costs refer to costs that operate across several different service delivery points at a level other than the delivery point of an intervention to beneficiaries, like training, coordination, monitoring and evaluation (staff costs were also included in this category).
3. Average unit costs estimations were constructed from actual financial reports obtained from the NSP for the period 2015 to 2019 for the **treatment of SAM, infant and young child feeding (IYCF) programmes, iron and folic acid supplementation (IFAS) for pregnant women, micronutrients powders for children**. For the other interventions, costing information were obtained from the Health Department, the Planning and Development Department of GoS, and UNICEF.
4. The so-called ‘ingredient approach’ was adopted for estimating direct costs for the **treatment of SAM, IFAS, and vitamin A supplementation**. For these interventions, programme costs were added as a percentage of direct costs, based on actual financial costs incurred implementing existing programme, mainly the NSP. For all other interventions, we used the ‘programme approach’: unit costs were calculated by dividing total programme costs by the number of beneficiaries who benefited from the intervention.
5. Unit costs and coverages information for the **food fortification programme in Sindh** were provided by Nutrition International. **Lipid-based nutrition supplements (LNS)** information were obtained from a WFP-lead stunting prevention operational research project in the districts of Thatta and Sajjawal. **Family planning and Water, Sanitation, and Hygiene Interventions (WASH) interventions** information were provided by the Planning and Development Department of the GoS.
6. **Exchange rate.** Prices were considered in transaction originating currency Pakistani Rupee (PKR) or US Dollar (US$). The currency conversion rate used was 110 PKR to 1 US$ as indicated by NSP.
7. **Baseline coverage data** was assumed for the year 2019. For each intervention, the coverage was calculated through a mapping exercise conducted by key focal points for each stakeholder. Intervention coverage refers to how many people, out of the target population, were receiving the intervention in each district of Sindh in 2019.
8. SUMMARY RESULTS

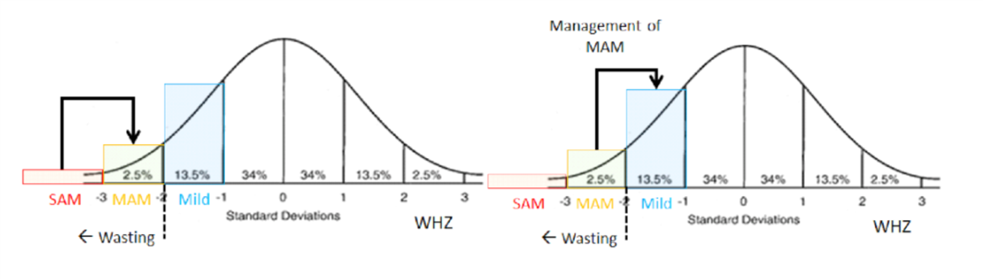
The table below contains average unit costs and coverage for the interventions included in this analysis for the province of Sindh. District specific cost and coverage information is discussed in the following sections for each specific intervention.

|  |  |  |  |
| --- | --- | --- | --- |
| Intervention | Target Population | Unit cost (US$) | Baseline coverage (2019) |
| Treatment of SAM | Children 6-59 months  (UNICEF treats children 6-23 months) | Average for NSP districts: US$ 129 (assumed 15% inpatient @ US$ 73 and 85% outpatient @ US$ 139) | 13% |
| IYCF1 (Community) | Pregnant and lactating women | US$ 1.43 | 23% |
| IYCF2 (Health Facility) | Pregnant and lactating women | US$ 0.63 | 23% |
| IYCF3 (Mass Media) | Pregnant and lactating women | US$ 0.57 | 23% |
| IFAS for pregnant women (Community) | Pregnant women | US$ 1.65 | 13% |
| IFAS for pregnant women (Health Facility) | Pregnant women | US$ 0.97 | 10% |
| Vitamin A supplementation | Children 6-59 months | US$ 0.05 | 87% |
| Micronutrients powders (children) | Children 6-23 months | US$ 1.37 | 6% |
| Zinc + ORS for treatment of diarrhoea | Children 0-59 months | US$ 1.38 | Not available |
| Lipid-based nutrition supplements | Children 6-23 months  Pregnant and lactating women | US$ 140 (children)  US$ 187 (PLW) | 44% (only in two piloted districts, Thatta and Sajjawal) |
| IFA fortification of wheat flour (with iron and folic acid) | General population | US$ 0.2 | 5% |
| Cooking oil fortification | General population | US$ 0.1 | 80% |
| Iodine fortification of salt | General population | US$ 0.012 | 100% |
| WASH:  Handwashing | General population | US$ 16.25 | 2% |
| WASH: Hygienic disposal | US$ 0.36 | 22% |
| WASH: Improved sanitation | US$ 0.82 | 34% |
| WASH: Improved water source | US$ 0.28 | 22% |
| Family planning | Women in reproductive age | US$ 0.08 | 42% |

1. COSTING ASSUMPTIONS PER INTERVENTION

## Treatment of Severe Acute Malnutrition (SAM)

1. **The treatment of Severe Acute Malnutrition (SAM)** is implemented as per WHO/UNICEF’s protocols of Community Based Management of Malnutrition (CMAM), through outpatient therapeutic programmes and stabilisation centres, and inpatient care for cases with complications. As June 2019, in the province of Sindh, the treatment of SAM was delivered through the NSP in the 9 districts supported by this programme. UNICEF leads the implementation of this intervention in Ghotki, Khairpur and Naushahro Feroze. The Health department of the GoS, trough the Accelerated Action Plan (AAP) for tackling stunting and malnutrition in the district of Mirpurkhas and Sukkur. The EU WINS programme has also supported the treatment of SAM in Dadu.
2. **There is no treatment of Moderate Acute Malnutrition (MAM) currently integrated in the province of Sindh**. This is important to note as, for Optima Nutrition, scaling up treatment of SAM does not directly reduce the prevalence of wasting, since wasting is a combination of SAM and MAM and children recover from SAM to MAM (which is still considered wasting). In the model the treatment of SAM intervention has an option to include management of MAM. If selected, the treatment intervention will also shift children from MAM to mild acute malnutrition (Figure 2). Only the combined action of the treatment of SAM and MAM will reduce the prevalence of wasting in the model.



Treatment of MAM

Treatment of SAM

1. **The analysis of unit costs for the treatment of SAM was conducted dividing the intervention between inpatient and outpatient treatment**. Children who are diagnosed with SAM and have no medical complications are admitted in Outpatient Therapeutic Programs (OTP) and are managed with Ready to Use Therapeutic Food (RUTF). Those present with complications are first admitted in for inpatient care in a hospital or a stabilization centre where they are managed with F75, then F100 and are then discharged into OTP. In OTP, these children are then managed with RUTF until they attain the recommended weight for height. Other drugs like antibiotics and deworming may be included in management of SAM.
2. **Treatment of SAM with medical complications (SAM Inpatient).** A child admitted in the inpatient care is first managed with F75 until is fully stabilized. This normally takes 2-3 days. Children who are stable take slightly increased calories and nutrients, are then managed with F100. A child weighing 7kgs and stays in transition for 2 days utilizes a total of 4 sachets of F100 (F-100 therapeutic milk, sachet, 114g for 500ml water). Medication provided in inpatient care may include: Amoxicillin, Gentamycin, Mebendazole, Ceftriaxone, ReSoMal (for rehydration).
3. **The estimated cost per average case for the drugs and supplies required for treatment for SAM impatient is around US$ 41 per child (PKR 4,514).** This amount includes a 20% mark-up for transportation and distribution costs. It must be said, however, that these estimates are to be considered a broad approximation as direct costs for medication depends on the level of complication affecting the child admitted to the programme.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Management of severe acute malnutrition (SAM) - Inpatient** | | | | | | | | | *Input Currency* | *Display Currency* |
| Drug/Supply | Percent receiving this aspect of the treatment | Number of units | Times per day | Days per case | Units per case | Unit cost FOB | Cost per average case FOB | Transp + Distrib. (%) | Cost per average case | Cost per average case |
|
|  |  |  |  |  |  | PKR | PKR |  | PKR | USD |
| Ready-to-use Therapeutic Food (RUTF) | 100 | 1 | 1 | 1 | 1 | 33.0000 | 33.0000 | 20% | 39.60 | 0.36 |
| F-75 therapeutic milk, CAN, 400g per can | 100 | 0.25625 | 2 | 3 | 1.5375 | 280.5000 | 431.2688 | 20% | 517.52 | 4.70 |
| F-100 therapeutic milk,sachet, CAN, 400g per can 114g for 500ml water | 100 | 0.285 | 2 | 2 | 1.14 | 324.5000 | 369.9300 | 20% | 443.92 | 4.04 |
| Amoxicillin, pdr/oral susp 125mg/5ml/BOT 100ml | 100 | 1 | 1 | 1 | 1 | 60.0000 | 60.0000 | 20% | 72.00 | 0.65 |
| Gentamycin, injection, 40 mg/ml in 2ml vial | 100 | 1 | 2 | 7 | 14 | 26.1800 | 366.5200 | 20% | 439.82 | 4.00 |
| Ceftriaxone, injection, 1g | 100 | 1 | 1 | 5 | 5 | 500.0000 | 2,500.0000 | 20% | 3,000.00 | 27.27 |
| ReSoMal (for rehydration) (42g/satchet/1ltr water) | 20 | 0.025 | 6 | 1 | 0.15 | 19.6790 | 0.5904 | 20% | 0.71 | 0.01 |
|  |  |  |  |  |  | **Total cost per average case** | | | **4,513.57** | **41.03** |

1. **Treatment of SAM without complications (SAM Outpatient).** Children without complications and those discharged from inpatient care are managed with RUTF. Prescription is dependent on weight of the child. A child weighing 7-8.4kgs consumes 3 sachets of RUTF daily. Taking into account an average length of stay to be 60 days, this child will consume a total of 180 sachets to recovery. Children who previously were not in the inpatient are prescribed amoxicillin and one dosage of Albendazole.
2. **The estimate average unit cost for the treatment and management of SAM Outpatient is approximately US$ 65 (PKR 7,203)**. RUTF accounts for the majority of this cost and includes 20% mark-up for transportation and distribution.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Management of severe acute malnutrition (SAM) - Outpatient** | | | | | | | | | *Input Currency* | *Display Currency* |
| Drug/Supply | Percent receiving this aspect of the treatment | Number of units | Times per day | Days per case | Units per case | Unit cost FOB | Cost per average case FOB | Transp + Distrib. (%) | Cost per average case | Cost per average case |
|
|  |  |  |  |  |  | PKR | PKR |  | PKR | USD |
| Amoxicillin, pdr/oral susp 125mg/5ml/BOT 100ml | 100 | 1 | 1 | 1 | 1 | 60.0 | 60.0 | 20% | 72.00 | 0.65 |
| Mebendazole, tablet, 500mg - PAC 100 | 91 | 1 | 1 | 1 | 1 | 3.1 | 2.8 | 20% | 3.33 | 0.03 |
| Ready-to-use Therapeutic Food (RUTF) | 100 | 1 | 3 | 60 | 180 | 33.0 | 5,940.0 | 20% | 7,128.00 | 64.80 |
|  |  |  |  |  |  | **Total cost per average case** | | | **7,203.33** | **65.48** |

1. **Programme costs for the treatment of SAM were computed from actual financial reports obtained from the NSP for the period 2015 to 2019.** Programme costs includes direct salaries, training costs, and other allocations of shared programme activities such as personnel not directly implementing the intervention, supervision, monitoring and evaluation, communication, advocacy and general programme management. From the NSP financial reports, the percentage of programme costs over the costs for drug and medical supplies was calculated for each of the nine districts. The average was used to estimate the total unit costs per average case for the treatment of SAM: **US$ 73 (PKR 8,062) for SAM inpatient and US$ 139 (PKR 15,314) for SAM outpatient)**.
2. The estimated total unit cost for the treatment of SAM in the province of Sindh was then calculated as an average on the assumption that 15% of the children required inpatient treatment. **Based on these assumptions, the total unit cost per average case of SAM in Sindh is estimated approximately US$ 129 (PKR 14,226).**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Unit cost  (PKR per beneficiary per year)** | | | | | | |
|  | **Treatment of SAM  (Inpatient)** | | | **Treatment of SAM  (Outpatient)** | | | **Treatment of SAM** |
| Province/District | Unit cost for drug/medical supplies | % of programme costs | Total unit cost per average case | Unit cost for drug/supply | % of programme costs | Total unit cost per average case | Total unit cost per average case (assumed 15% inpatient and 85% outpatient) |
| **Sindh** | **4,514** | **79%** | **8,062** | **7,203.33** | **113%** | **15,314.28** | **14,226.39** |
| Tahrparkar | 4,514 | 70% | 7,673 | 7,203.33 | 73% | 12,461.76 | 11,743.46 |
| Umerkot | 4,514 | 77% | 7,989 | 7,203.33 | 87% | 13,470.23 | 12,648.05 |
| Sanghar | 4,514 | 75% | 7,899 | 7,203.33 | 198% | 21,465.93 | 19,430.85 |
| Jacobabad | 4,514 | 71% | 7,718 | 7,203.33 | 136% | 16,999.86 | 15,607.61 |
| Larkana | 4,514 | 101% | 9,072 | 7,203.33 | 96% | 14,118.53 | 13,361.59 |
| TMK | 4,514 | 75% | 7,899 | 7,203.33 | 115% | 15,487.16 | 14,348.90 |
| Badin | 4,514 | 68% | 7,583 | 7,203.33 | 145% | 17,648.16 | 16,138.36 |
| Kambar Shahdadkot | 4,514 | 84% | 8,305 | 7,203.33 | 94% | 13,974.46 | 13,124.04 |
| Kashmore | 4,514 | 85% | 8,350 | 7,203.33 | 70% | 12,245.66 | 11,661.33 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Unit cost  (US$ per beneficiary per year)** | | | | | | |
|  | **Treatment of SAM  (Inpatient)** | | | **Treatment of SAM  (Outpatient)** | | | **Treatment of SAM** |
| Province/District | Unit cost for drug/medical supplies | % of programme costs | Total unit cost per average case | Unit cost for drug/supply | % of programme costs | Total unit cost per average case | Total unit cost per average case (assumed 15% inpatient and 85% outpatient) |
| **Sindh** | **41.03** | **79%** | **73.29** | **65.48** | **113%** | **139.22** | **129.33** |
| Tahrparkar | 41.03 | 70% | 69.76 | 65.48 | 73% | 113.29 | 106.76 |
| Umerkot | 41.03 | 77% | 72.63 | 65.48 | 87% | 122.46 | 114.98 |
| Sanghar | 41.03 | 75% | 71.81 | 65.48 | 198% | 195.14 | 176.64 |
| Jacobabad | 41.03 | 71% | 70.17 | 65.48 | 136% | 154.54 | 141.89 |
| Larkana | 41.03 | 101% | 82.48 | 65.48 | 96% | 128.35 | 121.47 |
| TMK | 41.03 | 75% | 71.81 | 65.48 | 115% | 140.79 | 130.44 |
| Badin | 41.03 | 68% | 68.93 | 65.48 | 145% | 160.44 | 146.71 |
| Kambar Shahdadkot | 41.03 | 84% | 75.50 | 65.48 | 94% | 127.04 | 119.31 |
| Kashmore | 41.03 | 85% | 75.91 | 65.48 | 70% | 111.32 | 106.01 |

1. The baseline coverage for each district was calculated as the percentage of children 6-59 months of age who were treated for SAM in 2019. The average coverage for Sindh was estimated as 13%. For each of the districts were this intervention was delivered in 2019, the relative coverage rates are showed in the table below.

|  |  |  |
| --- | --- | --- |
| **Baseline coverage (2019)** | | |
| **Programme** | **Province/District** | **Treatment of SAM** |
|  | **Sindh** | **13%** |
| **NSP** | Tahrparkar | 25% |
| Umerkot | 18% |
| Sanghar | 11% |
| Jacobabad | 10% |
| Larkana | 7% |
| TMK | 15% |
| Badin | 17% |
| Kambar Shahdadkot | 10% |
| Kashmore | 13% |
| **UNICEF** | Ghotki | 28% |
| Khairpur | 56% |
| Naushero Feroze | 43% |
| **EU WINS** | Dadu | 60% |
| **AAP** | Mirpurkhas | 12% |
| Sukkur | 21% |

## Infant and Young Child Feeding programme (IYCF)

1. **In Sindh, the promotion of breastfeeding and complementary feeding is provided within the Infant and Young Child Feeding programme (IYCF).** The programme was delivered in 15 districts supported by the NSP (9 districts), UNICEF (Ghotki, Khairpur and Naushahro Feroze), AAP (Mirpurkhas and Sukkur) and EU WINS (Dadu). These programmes support the district health and community departments in building the skills of health services providers and communities helping families to learn essential skills and basic knowledge in the nutrition care of young children. Mothers are educated on the benefits of breastfeeding (BF), how to breastfeed, exclusive breast feeding (EBF) for the first six months and continue breastfeeding for two years and beyond; Complementary feeding counselling and support involves educating mothers on appropriate complementary feeding practices and the appropriate timing of introducing the same.
2. **IYCF is delivered through three different modalities and delivery channels across the districts: community level (IYCF1); through health facilities (IYCF2) and via mass media messages (IYCF3).** The beneficiaries of IYCF programmes are pregnant and lactating women, mothers, caregivers and peers of children under two years who attend the training and counselling sessions.
3. **Unit costs for IYCF programmes were estimated from the financial reports provided by the NSP for the period 2015-2019.** Unit costs were calculated by dividing total programme costs by the number of beneficiaries who benefited from the intervention. The average unit costs for delivering IYCF at community level (IYCF1) in Sindh is US$ 1.43 (PKR 158), at health facility level (IYCF2) is US$ 0.63 (PKR 69) and via mass media US$ 0.57 (PKR 63).

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Unit cost  (PKR per beneficiary per year)** | | | | | | | | |
|  | **IYCF1 (Community)** | | | **IYCF2 (Health Facility)** | | | **IYCF3 (Mass Media)** | | |
| Province/District | Total programme costs | # beneficiaries | Total unit cost per average case | Total programme costs | # beneficiaries | Total unit cost per average case | Total programme costs | # beneficiaries | Total unit cost per average case |
| **Sindh** | **534,439,711** | **4,456,926** | **158** | **43,981,469** | **2,352,643** | **69** | **283,742,155** | **4,521,378** | **63** |
| Tahrparkar | 64,683,683 | 1,303,158 | 50 | 5,662,727 | 371,884 | 15 | 38,296,429 |  | 63 |
| Umerkot | 94,835,719 | 381,575 | 249 | 4,928,187 | 521,214 | 9 | 24,912,791 |  | 63 |
| Sanghar | 91,528,717 | 850,030 | 108 | 5,207,366 | 713,382 | 7 | 47,754,015 |  | 63 |
| Jacobabad | 79,423,969 | 575,573 | 138 | 4,598,517 | 55,220 | 83 | 23,360,909 |  | 63 |
| Larkana | 50,795,567 | 349,950 | 145 | 4,867,115 | 167,457 | 29 | 35,388,320 |  | 63 |
| TMK | 30,278,200 | 114,142 | 265 | 4,245,246 | 76,103 | 56 | 15,721,663 |  | 63 |
| Badin | 26,561,571 | 434,694 | 61 | 5,213,547 | 382,553 | 14 | 41,891,345 |  | 63 |
| Kambar Shahdadkot | 23,864,156 | 143,280 | 167 | 4,670,394 | 50,285 | 93 | 31,131,923 |  | 63 |
| Kashmore | 72,468,129 | 304,524 | 238 | 4,588,370 | 14,545 | 315 | 25,284,760 |  | 63 |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Unit cost  (US$ per beneficiary per year)** | | | | | | | | |
|  | **IYCF1 (Community)** | | | **IYCF2 (Health Facility)** | | | **IYCF3 (Mass Media)** | | |
| Province/District | Total programme costs | # beneficiaries | Total unit cost per average case | Total programme costs | # beneficiaries | Total unit cost per average case | Total programme costs | # beneficiaries | Total unit cost per average case |
| **Sindh** | **4,858,543** | **4,456,926** | **1.43** | **399,832** | **2,352,643** | **0.63** | **2,579,474** | **4,521,378** | **0.57** |
| Tahrparkar | 588,033 | 1,303,158 | 0.45 | 51,479 | 371,884 | 0.14 | 348,149 | - | 0.57 |
| Umerkot | 862,143 | 381,575 | 2.26 | 44,802 | 521,214 | 0.09 | 226,480 | - | 0.57 |
| Sanghar | 832,079 | 850,030 | 0.98 | 47,340 | 713,382 | 0.07 | 434,127 | - | 0.57 |
| Jacobabad | 722,036 | 575,573 | 1.25 | 41,805 | 55,220 | 0.76 | 212,372 | - | 0.57 |
| Larkana | 461,778 | 349,950 | 1.32 | 44,246 | 167,457 | 0.26 | 321,712 | - | 0.57 |
| TMK | 275,256 | 114,142 | 2.41 | 38,593 | 76,103 | 0.51 | 142,924 | - | 0.57 |
| Badin | 241,469 | 434,694 | 0.56 | 47,396 | 382,553 | 0.12 | 380,830 | - | 0.57 |
| Kambar Shahdadkot | 216,947 | 143,280 | 1.51 | 42,458 | 50,285 | 0.84 | 283,017 | - | 0.57 |
| Kashmore | 658,801 | 304,524 | 2.16 | 41,712 | 14,545 | 2.87 | 229,861 | - | 0.57 |

1. The baseline coverage for this intervention was estimated as percentage of PLWs who received counselling on IYCF in 2019. The average for Sindh was estimated at around 23%, with the highest coverage rates reported in the districts covered by the NSP.

|  |  |  |
| --- | --- | --- |
| **Baseline coverage (2019)** | | |
| **Programme** | **Province/District** | **IYCF** |
|  | **Sindh** | **23%** |
| **NSP** | Tahrparkar | 59% |
| Umerkot | 62% |
| Sanghar | 65% |
| Jacobabad | 25% |
| Larkana | 47% |
| TMK | 44% |
| Badin | 82% |
| Kambar Shahdadkot | 68% |
| Kashmore | 82% |
| **UNICEF** | Ghotki | 6% |
| Khairpur | 58% |
| Naushero Feroze | 41% |
| **EU WINS** | Dadu | 66% |
| Shikarpur | 0% |
| Sujawal District | 0% |
| Thatta District | 0% |
| **AAP** | Mirpurkhas | 6% |
| Sukkur | 9% |

## Iron and folic acid supplementation

1. Pregnant women, especially with limited pre-pregnancy stores, have an increased micronutrient needs among them iron folic acid. Iron deficiency put a mother at risk of death from severe bleeding. It also predisposes the neonate to poor iron stores. The NSP in Sindh supplements with iron and folic acid at health facility level trough the PPHI during the antenatal care visits or during campaigns run by implementing partners.
2. The unit cost per average for the suppliesis based on the supplementation of 90 combined Ferrous Salt and Folic Acid tablets per pregnant woman over a period of three months. **The estimated unit cost for the full course of supplementation is** **US$ 0.39 per beneficiary (PKR 42.69).** This amount includes a 20% mark-up for transportation and distribution costs.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Iron and folic acid supplementation** | | | | | | | | | | *Input Currency* | *Display Currency* |
| Drug/Supply | Percent receiving this aspect of the treatment | Note | Number of units | Times per day | Days per case | Units per case | Unit cost FOB | Cost per average case FOB | Transp + Distrib. (%) | Cost per average case | Cost per average case |
|
|  |  |  |  |  |  |  | PKR | PKR |  | PKR | USD |
| Iron60mg + Folic ac. 400mcg tab / PAC (10x10) | 80 | 3 months suppl. | 1 | 1 | 90 | 90 | 0.494059 | 35.572248 | 20% | 42.69 | 0.39 |
|  |  |  |  |  |  |  | **Total cost per average case** | | | **42.69** | **0.39** |

1. Programme costs for IFAS were computed from the NSP financial reports (2015 to 2019) as the percentage of programme costs over the costs for medical supplies for each of the nine districts. **As an average of the nine NSP’s districts, the total unit cost per average case of IFAS supplementation is estimated approximately US$ 1.65 (PKR 181) delivered at community level, and US$ 0.97 (PKR 125) if delivered at the health facility level.** The table below shows the breakdown of the calculation by district.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Unit cost  (PKR per beneficiary per year)** | | | | | | **Unit cost  (US$ per beneficiary per year)** | | | | | |
|  | **IFAS (Community)** | | | **IFAS (Health Facility)** | | | **IFAS (Community)** | | | **IFAS (Health Facility)** | | |
| Province/District | Unit cost for supplies | % of programme costs | Total unit cost per average case | Unit cost for supplies | % of programme costs | Total unit cost per average case | Unit cost for supplies | % of programme costs | Total unit cost per average case | Unit cost for supplies | % of programme costs | Total unit cost per average case |
| **Sindh** | **43** | **324%** | **181** | **43** | **192%** | **125** | **0.39** | **324%** | **1.65** | **0.39** | **192%** | **0.97** |
| Tahrparkar | 43 | 148% | 106 | 43 | 239% | 145 | 0.39 | 148% | 0.96 | 0.39 | 239% | 1.31 |
| Umerkot | 43 | 225% | 139 | 43 | 258% | 153 | 0.39 | 225% | 1.26 | 0.39 | 258% | 1.39 |
| Sanghar | 43 | 122% | 95 | 43 | 69% | 72 | 0.39 | 122% | 0.86 | 0.39 | 69% | 0.66 |
| Jacobabad | 43 | 247% | 148 | 43 |  | 43 | 0.39 | 247% | 1.35 | 0.39 |  | 0.39 |
| Larkana | 43 | 215% | 135 | 43 | 188% | 123 | 0.39 | 215% | 1.22 | 0.39 | 188% | 1.12 |
| TMK | 43 | 510% | 260 | 43 | 310% | 175 | 0.39 | 510% | 2.37 | 0.39 | 310% | 1.59 |
| Badin | 43 | 378% | 204 | 43 | 138% | 102 | 0.39 | 378% | 1.86 | 0.39 | 138% | 0.92 |
| Kambar Shahdadkot | 43 | 581% | 291 | 43 | 144% | 104 | 0.39 | 581% | 2.64 | 0.39 | 144% | 0.95 |
| Kashmore | 43 | 492% | 253 | 43 |  | 43 | 0.39 | 492% | 2.30 | 0.39 |  | 0.39 |

1. The proportion of pregnant women who received any iron folic acid as for the mapping exercise undertaken by each programme’s focal point is contained in the table below. **The average coverage of IFAS in 2019 for Sindh was estimated 13% delivered at community level and 10% delivered through health facilities.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Baseline coverage (2019)** | | | |
| **Programme** | **Province/District** | **IFAS  (Community)** | **IFAS  (Health Facility)** |
|  | **Sindh** | **13%** | **10%** |
| **NSP** | Tahrparkar | 20% | 21% |
| Umerkot | 14% | 27% |
| Sanghar | 58% | 22% |
| Jacobabad | 20% | 21% |
| Larkana | 50% | 14% |
| TMK | 40% | 35% |
| Badin | 19% | 23% |
| Kambar Shahdadkot | 29% | 21% |
| Kashmore | 22% | 6% |
| **UNICEF** | Ghotki | 20% | 0% |
| Khairpur | 21% | 0% |
| Naushero Feroze | 15% | 0% |
| **EU WINS** | Dadu | 0% | 0% |
| Shikarpur | 0% | 0% |
| Sujawal District | 0% | 0% |
| Thatta District | 0% | 0% |
| **AAP** | Mirpurkhas | 16% | 62% |
| Sukkur | 23% | 35% |

Vitamin A supplementation

1. The supplementation of vitamin A to children in Sindh is done mainly through mass campaigns alongside other health mobilization events (i.e. polio campaigns). Routine delivery through health facilities is also taking place, especially in urban areas. Children 6-59 months are supplemented with vitamin A capsules bi-annually. At 6 months, children are given 100,000IU capsule and thereafter 200,000IU.
2. **Drugs and supplies required**: Each case per year requires: 1 x vitamin A (100,000 IU) for infants 6-11 months (one dose) and 2 x vitamin A (200,000 IU) for children 12-59 months per year. In this analysis is included the procurement of vitamin A supplies, plus cost for transport and distribution (20%). The cost per bottle (500 capsule) is US$ 10.66 for 200,000IU and US$ 2.53 for 100,000IU. **Therefore, the average unit cost for supplies of the bi-annual supplementation of vitamin A per child is approximately US$ 0.05 (PKR 5.20)**.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Vitamin A Supplementation** | | | | | | | | | | *Input Currency* | *Display Currency* |
| Drug/Supply | Percent receiving this aspect of the treatment | Note | Number of units | Times per day | Days per case | Units per case | Unit cost FOB | Cost per average case FOB | Transp + Distrib. (%) | Cost per average case | Cost per average case |
|
|  |  |  |  |  |  |  | PKR | PKR |  | PKR | USD |
| Vitamin A, caplet, 100,000 IU | 10 | 6-11 Months | 1 | 1 | 2 | 2 | 0.5566 | 0.1113 | 20% | 0.13 | 0.00 |
| Vitamin A, caplet, 200,000 IU | 90 | 12-59 Months | 1 | 1 | 2 | 2 | 2.3452 | 4.2214 | 20% | 5.07 | 0.05 |
|  |  |  |  |  |  |  | **Total cost per average case** | | | **5.20** | **0.05** |

1. **When adding the estimated percentage of programme costs required to deliver this intervention (+200%), the total unit cost per average case for vitamin A is around US$ 0.14 (PKR 16) per child.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Unit cost  (PKR per beneficiary per year)** | | | **Unit cost  (US$ per beneficiary per year)** | | |
|  | **Vitamin A Supplementation** | | | **Vitamin A Supplementation** | | |
| Province/District | Unit cost for supplies | % of programme costs | Total unit cost per average case | Unit cost for supplies | % of programme costs | Total unit cost per average case |
| **Sindh** | **5.2** | **200%** | **16** | **0.05** | **200%** | **0.14** |
| Tahrparkar | 5.2 | 200% | 16 | 0.05 | 200% | 0.15 |
| Umerkot | 5.2 | 200% | 16 | 0.05 | 200% | 0.14 |
| Sanghar | 5.2 | 200% | 16 | 0.05 | 200% | 0.14 |
| Jacobabad | 5.2 | 200% | 16 | 0.05 | 200% | 0.14 |
| Larkana | 5.2 | 200% | 16 | 0.05 | 200% | 0.14 |
| TMK | 5.2 | 200% | 16 | 0.05 | 200% | 0.14 |
| Badin | 5.2 | 200% | 16 | 0.05 | 200% | 0.14 |
| Kambar Shahdadkot | 5.2 | 200% | 16 | 0.05 | 200% | 0.14 |
| Kashmore | 5.2 | 200% | 16 | 0.05 | 200% | 0.14 |

1. **The estimated programme coverage for the supplementation of vitamin A in Sindh for 2019 among children 6-59 months is 87%.** Almost full coverage level was reported for the majority of districts with the exception of Tahrparkar, Karachi west and Korangi.

|  |  |  |
| --- | --- | --- |
| **Baseline coverage (2019)** | | |
| **Programme** | **Province/District** | **Vitamin A Supplementation** |
|  | **Sindh** | **87%** |
| **NSP** | Tahrparkar | 42% |
| Umerkot | 95% |
| Sanghar | 95% |
| Jacobabad | 95% |
| Larkana | 95% |
| TMK | 95% |
| Badin | 95% |
| Kambar Shahdadkot | 95% |
| Kashmore | 95% |
| **UNICEF** | Ghotki | 95% |
| Khairpur | 95% |
| Naushero Feroze | 95% |
| **EU WINS** | Dadu | 95% |
| Shikarpur | 95% |
| Sujawal District | 95% |
| Thatta District | 95% |
| **AAP** | Mirpurkhas | 95% |
| Sukkur | 95% |
| **Others** | Hyderabad | 77% |
| Jamshoro | 95% |
| Karachi Central | 78% |
| Karachi East | 70% |
| Karachi South | 95% |
| Karachi west | 43% |
| Korangi | 41% |
| Malir | 95% |
| Matari | 95% |
| Shaheed Benazirabad | 95% |
| Tando Allah Yar | 95% |

Micronutrients powders (children)

1. Multiple micronutrient powders are powders of various vitamins and minerals (at least iron, vitamin A and zinc) added to or sprinkled on a child’s complementary food for improving iron status and reducing anaemia of children 6-23 months of age. The NSP in Sindh is responsible for scaling up this intervention in 9 districts targeting non-SAM children 6-59 months of age.
2. Unit costsinclude the procurement of micronutrient sachets, training, advocacy and other indirect programme costs. The average unit cost was calculated by dividing total NSP costs by the number of beneficiaries of the intervention. **The estimated average unit cost for delivering the intervention (assumed 55% implemented at community and 45% at health facilities) was around US$ 1.37 (PKR 151) per child.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Unit cost  (PKR per beneficiary per year)** | | | | | | |
|  | **Micronutrients powders  (Community)** | | | **Micronutrients powders  (Health Facility)** | | | **Micronutrients powders** |
| Province/District | Total programme costs | # beneficiaries | Total unit cost per average case | Total programme costs | # beneficiaries | Total unit cost per average case | Total unit cost per average case (assumed 55% community and 45% health facilities) |
| **Sindh** | **174,901,782** | **2,313,703** | **90** | **110,899,132** | **833,547** | **226** | **151.10** |
| Tahrparkar | 26,531,434 | 545,515 | 49 | 9,292,157 | 104,414 | 89 | 66.80 |
| Umerkot | 18,353,764 | 302,858 | 61 | 8,166,419 | 89,908 | 91 | 74.20 |
| Sanghar | 28,545,194 | 474,164 | 60 | 35,431,771 | 261,073 | 136 | 94.18 |
| Jacobabad | 18,571,793 | 145,233 | 128 | 7,367,028 | 30,577 | 241 | 178.75 |
| Larkana | 21,349,284 | 228,227 | 94 | 13,799,575 | 93,086 | 148 | 118.16 |
| TMK | 11,098,459 | 108,224 | 103 | 6,068,923 | 23,633 | 257 | 171.96 |
| Badin | 22,664,287 | 248,313 | 91 | 12,879,123 | 193,305 | 67 | 80.18 |
| Kambar Shahdadkot | 12,244,589 | 89,773 | 136 | 10,298,090 | 24,477 | 421 | 264.34 |
| Kashmore | 15,542,978 | 171,396 | 91 | 7,596,046 | 13,074 | 581 | 311.33 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Unit cost  (US$ per beneficiary per year)** | | | | | | |
|  | **Micronutrients powders  (Community)** | | | **Micronutrients powders  (Health Facility)** | | | **Micronutrients powders** |
| Province/District | Total programme costs | # beneficiaries | Total unit cost per average case | Total programme costs | # beneficiaries | Total unit cost per average case | Total unit cost per average case (assumed 55% community and 45% health facilities) |
| **Sindh** | **1,590,016** | **2,313,703** | **0.82** | **1,008,174** | **833,547** | **2.05** | **1.37** |
| Tahrparkar | 241,195 | 545,515 | 0.44 | 84,474 | 104,414 | 0.81 | 0.61 |
| Umerkot | 166,852 | 302,858 | 0.55 | 74,240 | 89,908 | 0.83 | 0.67 |
| Sanghar | 259,502 | 474,164 | 0.55 | 322,107 | 261,073 | 1.23 | 0.86 |
| Jacobabad | 168,834 | 145,233 | 1.16 | 66,973 | 30,577 | 2.19 | 1.63 |
| Larkana | 194,084 | 228,227 | 0.85 | 125,451 | 93,086 | 1.35 | 1.07 |
| TMK | 100,895 | 108,224 | 0.93 | 55,172 | 23,633 | 2.33 | 1.56 |
| Badin | 206,039 | 248,313 | 0.83 | 117,083 | 193,305 | 0.61 | 0.73 |
| Kambar Shahdadkot | 111,314 | 89,773 | 1.24 | 93,619 | 24,477 | 3.82 | 2.40 |
| Kashmore | 141,300 | 171,396 | 0.82 | 69,055 | 13,074 | 5.28 | 2.83 |

1. The coverage of micronutrient powders was made available only for those nine districts covered by the NSP. As a consequence**, the calculated average coverage for the province of Sindh is around 6% (or 20% for the nine NSP districts).**

|  |  |  |
| --- | --- | --- |
| **Baseline coverage (2019)** | | |
| **Programme** | **Province/District** | **Micronutrients powders** |
|  | **Sindh** | **6%** |
| **NSP** | Tahrparkar | 10% |
| Umerkot | 10% |
| Sanghar | 30% |
| Jacobabad | 16% |
| Larkana | 26% |
| TMK | 30% |
| Badin | 16% |
| Kambar Shahdadkot | 18% |
| Kashmore | 20% |

## Zinc for treatment + oral rehydration solution (ORS)

1. There is a good evidence base for the efficacy of oral zinc tablets in the treatment of diarrhoea in children 0-59 months of age, specifically when used with oral rehydration solution (ORS) and continued breast-feeding. For infants 0-6 months WHO recommends 10 mg zinc for 10-14 days per episode; children older than 6 months 20 mg zinc for 10-14 days per episode. Three sachets of ORS per case is the recommended treatment for those children seeking treatment.
2. The unit cost for this treatment was obtained from the NSP financial reports by dividing total costs by the number of beneficiaries of the intervention. **The estimated average unit cost for the treatment of diarrhoea with zinc and ORS (assumed 85% implemented at community and 15% at health facilities) was around US$ 1.38 (PKR 151) per child.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Unit cost  (PKR per beneficiary per year)** | | | | | | |
|  | **Zinc for treatment + ORS (Community)** | | | **Zinc for treatment + ORS (Health Facility)** | | | **Zinc for treatment +ORS** |
| Province/District | Total programme costs | # beneficiaries | Total unit cost per average case | Total programme costs | # beneficiaries | Total unit cost per average case | Total unit cost per average case (assumed 85% community and 15% health facilities) |
| **Sindh** | **66,893,691** | **651,896** | **159** | **55,077,777** | **270,953** | **106** | **151.36** |
| Tahrparkar | 10,431,442 | 143,886 | 72 | 6,573,474 |  |  | 61.62 |
| Umerkot | 9,525,358 | 133,562 | 71 | 5,925,745 |  |  | 60.62 |
| Sanghar | 7,800,792 | 82,991 | 94 | 7,492,682 | 71,027 | 105 | 95.72 |
| Jacobabad | 8,182,032 | 141,636 | 58 | 5,364,982 | 45,324 | 118 | 66.86 |
| Larkana | 6,563,870 | 61,573 | 107 | 5,852,704 |  |  | 90.61 |
| TMK | 5,331,915 | 13,024 | 409 | 4,804,897 |  |  | 347.98 |
| Badin | 7,245,429 | 58,379 | 124 | 7,158,442 | 54,714 | 131 | 125.12 |
| Kambar Shahdadkot | 6,092,857 |  |  | 6,828,664 | 99,888 | 68 | 10.25 |
| Kashmore | 5,719,995 | 16,845 | 340 | 5,076,187 |  |  | 288.63 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Unit cost  (US$ per beneficiary per year)** | | | | | | |
|  | **Zinc for treatment + ORS (Community)** | | | **Zinc for treatment + ORS (Health Facility)** | | | **Zinc for treatment +**  **ORS** |
| Province/District | Total programme costs | # beneficiaries | Total unit cost per average case | Total programme costs | # beneficiaries | Total unit cost per average case | Total unit cost per average case (assumed 85% community and 15% health facilities) |
| **Sindh** | **608,124** | **651,896** | **1.45** | **500,707** | **270,953** | **0.96** | **1.38** |
| Tahrparkar | 94,831 | 143,886 | 0.66 | 59,759 | - |  | 0.56 |
| Umerkot | 86,594 | 133,562 | 0.65 | 53,870 | - |  | 0.55 |
| Sanghar | 70,916 | 82,991 | 0.85 | 68,115 | 71,027 | 0.96 | 0.87 |
| Jacobabad | 74,382 | 141,636 | 0.53 | 48,773 | 45,324 | 1.08 | 0.61 |
| Larkana | 59,672 | 61,573 | 0.97 | 53,206 | - |  | 0.82 |
| TMK | 48,472 | 13,024 | 3.72 | 43,681 | - |  | 3.16 |
| Badin | 65,868 | 58,379 | 1.13 | 65,077 | 54,714 | 1.19 | 1.14 |
| Kambar Shahdadkot | 55,390 |  |  | 62,079 | 99,888 | 0.62 | 0.09 |
| Kashmore | 52,000 | 16,845 | 3.09 | 46,147 | - |  | 2.62 |

1. Reported current coverage (2019) levels for the treatment of diarrhoea with zinc and ORS were over 100% for all nine NSP’s districts. As these coverages are unrealistic, they should be revised by focal points for future analysis.

## Lipid-based nutrition supplements (LNS)

1. **A Lipid-based nutrition supplements (LNS) programme in Sindh was supported by WFP, who provided technical assistance to the provincial government to implement a nutrient based stunting prevention operational research project in the district of Thatta and Sajjawal.** The model is based on targeting the first 1000 days of life approach and it is aiming to the prevention of acute and chronic malnutrition. It was implemented through primary health care system (PHC) of the government, with the provision of locally produced specialized nutritious products for prevention and behavior change communication, to the target groups (PLW, children 6-23 months) through the Lady Health Workers (LHW) of the PHC. The project was rolled out in 29 Union Councils, selected by Lady Health Workers (LHWs). During the project cycle about 48,891 pregnant and lactating women (PLW) and 59,809 Children (6-23 months) have completed the project cycle covering the first 1,000 days of life.
2. **The unit costs (provided by WFP) for this pilot programme were US$ 140 (PKR 15,415) for children and US$ 187 (PKR 20,572) for PLW.** This is based on the currency conversation rate used in this analysis: 110 PKR to 1 US$. **Estimated geographical coverage was 44% in the two districts only.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Monthly Ration for child** | | **Costs (children)** | | | | |
| **LNS  ( Wawa mum)  Kg  Monthly ration** | **Quantity for 18 months (Kg)** | **LNS-Wawamum cost ( commodity only per Kg)** | **LNS Wawamum cost ( commodity for 18 months)** | **Operational cost/child  for 18 months  ( 6-23 months)** | **Unit cost for 18 months for 1 child** | |
|  |  | **PKR** | **PKR** | **PKR** | **PKR** | **USD** |
| 1.5 | 27 | 338 | 9,119.07 | 6,296.50 | **15,415.57** | **140.14** |
|  |  |  |  |  |  |  |
| **Monthly Ration for PLW** | | **Costs (PLW)** | | | | |
| **LNS  ( Mamta)  Kg  Monthly ration** | **Quantity for 15 months (kg)** | **LNS cost( commodity only per Kg) in PKR** | **LNS cost( commodity for 15months)** | **Operational cost/PLW  for 15 months** | **Unit cost for 15 months for 1 PLW** | |
|  |  | **PKR** | **PKR** | **PKR** | **PKR** | **USD** |
| 2.25 | 33.8 | 365.1 | 12,321.60 | 8,250.60 | **20,572.20** | **187.02** |

Fortification of staples



1. Fortification of staples is a preventive food-based approach to improve micronutrient status of population over time. The fortification is proven to be effective when industrially produced staples are regularly consumed by a large population group in a country. **Nutrition International supports food fortification efforts in Sindh working with the provincial government expanding the fortification of wheat flour with iron/folate, B12 and zinc; the fortification of cooking oil with vitamin A; and the provincial salt iodization programme.**
2. Unit costs and coverage information for the three food fortification programmes were provided by Nutritional International and are summarised in the table below. **The fortification of wheat flour is the costliest intervention (US$ 0.2 or PKR 25) covering only 5% of the province of Sindh. The fortification of oil with vitamin A has a much broader coverage across the province (80%) and cost US$ 0.1 (PKR 9) per unit. The iodization of salt fully covers the whole province at a cost of US$ 0.012 (PKR 1.3) per beneficiary.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Unit cost  (PKR per beneficiary per year)** | | | **Unit cost  (US$ per beneficiary per year)** | | | **Baseline coverage (2019)** | | |
| Province/District | Iron Folic Acid, B12 and Zinc fortification of wheat flour | Vit. A fortification of oil | Iodine fortification of salt | Iron Folic Acid, B12 and Zinc fortification of wheat flour | Vit. A fortification of oil | Iodine fortification of salt | Iron Folic Acid, B12 and Zinc fortification of wheat flour | Vit. A fortification of oil | Iodine fortification of salt |
| **Sindh** | **25.0** | **9.0** | **1.3** | **0.2** | **0.1** | **0.012** | **5%** | **80%** | **100%** |
| Tahrparkar | 25.0 | 9.0 | 1.0 | 0.2 | 0.1 | 0.009 | 5% | 80% | 100% |
| Umerkot | 25.0 | 9.0 | 1.2 | 0.2 | 0.1 | 0.011 | 5% | 80% | 100% |
| Sanghar | 25.0 | 9.0 | 1.1 | 0.2 | 0.1 | 0.010 | 5% | 80% | 100% |
| Jacobabad | 25.0 | 9.0 | 0.8 | 0.2 | 0.1 | 0.007 | 5% | 80% | 100% |
| Larkana | 25.0 | 9.0 | 1.8 | 0.2 | 0.1 | 0.016 | 5% | 80% | 100% |
| TMK | 25.0 | 9.0 | 1.8 | 0.2 | 0.1 | 0.016 | 5% | 80% | 100% |
| Badin | 25.0 | 9.0 | 1.3 | 0.2 | 0.1 | 0.012 | 5% | 80% | 100% |
| Kambar Shahdadkot | 25.0 | 9.0 | 0.6 | 0.2 | 0.1 | 0.006 | 5% | 80% | 100% |
| Kashmore | 25.0 | 9.0 | 0.6 | 0.2 | 0.1 | 0.006 | 5% | 80% | 100% |
| Ghotki | 25.0 | 9.0 | 1 | 0.2 | 0.1 | 0.009 | 5% | 80% | 100% |
| Khairpur | 25.0 | 9.0 | 0.46 | 0.2 | 0.1 | 0.004 | 5% | 80% | 100% |
| Naushero Feroze | 25.0 | 9.0 | 1.65 | 0.2 | 0.1 | 0.015 | 5% | 80% | 100% |
| Dadu | 25.0 | 9.0 | 0.75 | 0.2 | 0.1 | 0.007 | 5% | 80% | 100% |
| Shikarpur | 25.0 | 9.0 | 0.73 | 0.2 | 0.1 | 0.007 | 5% | 80% | 100% |
| Sujawal District | 25.0 | 9.0 | 1.18 | 0.2 | 0.1 | 0.011 | 5% | 80% | 100% |
| Thatta District | 25.0 | 9.0 | 0.90 | 0.2 | 0.1 | 0.008 | 5% | 80% | 100% |
| Mirpurkhas | 25.0 | 9.0 | 2.34 | 0.2 | 0.1 | 0.021 | 5% | 80% | 100% |
| Sukkur | 25.0 | 9.0 | 1.20 | 0.2 | 0.1 | 0.011 | 5% | 80% | 100% |
| Hyderabad | 25.0 | 9.0 | 1.12 | 0.2 | 0.1 | 0.010 | 5% | 80% | 100% |
| Jamshoro | 25.0 | 9.0 | 0.88 | 0.2 | 0.1 | 0.008 | 5% | 80% | 100% |
| Karachi Central | 25.0 | 9.0 | 1.12 | 0.2 | 0.1 | 0.010 | 5% | 80% | 100% |
| Karachi East | 25.0 | 9.0 | 1.46 | 0.2 | 0.1 | 0.013 | 5% | 80% | 100% |
| Karachi South | 25.0 | 9.0 | 2.30 | 0.2 | 0.1 | 0.021 | 5% | 80% | 100% |
| Karachi west | 25.0 | 9.0 | 1.21 | 0.2 | 0.1 | 0.011 | 5% | 80% | 100% |
| Korangi | 25.0 | 9.0 | 1.09 | 0.2 | 0.1 | 0.010 | 5% | 80% | 100% |
| Malir | 25.0 | 9.0 | 2.15 | 0.2 | 0.1 | 0.020 | 5% | 80% | 100% |
| Matari | 25.0 | 9.0 | 2.66 | 0.2 | 0.1 | 0.024 | 5% | 80% | 100% |
| Shaheed Benazirabad | 25.0 | 9.0 | 1.84 | 0.2 | 0.1 | 0.017 | 5% | 80% | 100% |
| Tando Allah Yar | 25.0 | 9.0 | 1.68 | 0.2 | 0.1 | 0.015 | 5% | 80% | 100% |

## Water, Sanitation, and Hygiene Interventions (WASH)

1. Water, Sanitation, and Hygiene (WASH) unit costs and coverage information were provided by the Planning and Development Department of the GoS, based on the budgets for both the AAP and the Saaf Suthro (SSSP) programmes.
2. The unit costs and coverage for each intervention are reported below. **Handwashing is the most expensive of all interventions and it includes the construction of hand wash facility at schools (AAP target 200 schools and SSSP 169). The unit cost for its construction is US$ 16 (PKR 1,787) and has limited coverages across the province (2%).**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Unit cost  (PKR per beneficiary per year)** | | | | **Unit cost  (US$ per beneficiary per year)** | | | | **Baseline coverage (2019)** | | | |
| Province/District | Handwashing | Hygienic disposal | Improved sanitation | Improved  water source | Handwashing | Hygienic disposal | Improved sanitation | Improved  water source | Handwashing | Hygienic disposal | Improved sanitation | Improved  water source |
| **Sindh** | **1,787** | **40** | **90** | **31** | **16.25** | **0.36** | **0.82** | **0.28** | **2%** | **22%** | **34%** | **22%** |
| Tahrparkar | 1,471 | 29 | 23 | 22 | 13.37 | 0.26 | 0.21 | 0.20 | 2% | 50% | 50% | 50% |
| Umerkot | 1,471 | 39 | 31 | 30 | 13.37 | 0.35 | 0.28 | 0.27 | 3% | 50% | 50% | 50% |
| Sanghar | 1,471 | 22 | 17 | 17 | 13.37 | 0.20 | 0.16 | 0.15 | 1% | 50% | 50% | 50% |
| Jacobabad | 1,471 | 46 | 36 | 35 | 13.37 | 0.42 | 0.33 | 0.32 | 3% | 50% | 50% | 50% |
| Larkana | 1,471 | 27 | 21 | 21 | 13.37 | 0.24 | 0.19 | 0.19 | 2% | 50% | 50% | 50% |
| TMK | 1,471 | 72 | 56 | 55 | 13.37 | 0.65 | 0.51 | 0.50 | 5% | 50% | 50% | 50% |
| Badin | 1,471 | 29 | 23 | 22 | 13.37 | 0.26 | 0.21 | 0.20 | 2% | 50% | 50% | 50% |
| Kambar Shahdadkot | 1,471 | 36 | 29 | 28 | 13.37 | 0.33 | 0.26 | 0.26 | 2% | 50% | 50% | 50% |
| Kashmore | 1,471 | 44 | 35 | 34 | 13.37 | 0.40 | 0.32 | 0.31 | 3% | 50% | 50% | 50% |
| Ghotki | 2,198 |  | 125 |  | 19.98 | - | 1.14 | - | 1% | 0% | 34% | 0% |
| Khairpur | 2,198 |  | 88 |  | 19.98 | - | 0.80 | - | 1% | 0% | 34% | 0% |
| Naushero Feroze | 2,198 |  | 156 |  | 19.98 | - | 1.42 | - | 1% | 0% | 34% | 0% |
| Dadu | 1,471 | 26 | 21 | 20 | 13.37 | 0.24 | 0.19 | 0.19 | 2% | 50% | 50% | 50% |
| Shikarpur | 1,471 | 36 | 28 | 28 | 13.37 | 0.32 | 0.26 | 0.25 | 2% | 50% | 50% | 50% |
| Sujawal District | 1,471 | 62 | 49 | 48 | 13.37 | 0.56 | 0.44 | 0.43 | 4% | 50% | 50% | 50% |
| Thatta District | 1,471 | 53 | 42 | 41 | 13.37 | 0.48 | 0.38 | 0.37 | 4% | 50% | 50% | 50% |
| Mirpurkhas | 2,198 |  | 136 |  | 19.98 | - | 1.23 | - | 1% | 0% | 34% | 0% |
| Sukkur | 2,198 |  | 127 |  | 19.98 | - | 1.16 | - | 1% | 0% | 34% | 0% |
| Hyderabad | 2,198 |  | 86 |  | 19.98 | - | 0.78 | - | 1% | 0% | 34% | 0% |
| Jamshoro | 2,198 |  | 227 |  | 19.98 | - | 2.06 | - | 2% | 0% | 34% | 0% |
| Karachi Central |  |  |  |  | - | - | - | - | 0% | 0% | 0% | 0% |
| Karachi East |  |  |  |  | - | - | - | - | 0% | 0% | 0% | 0% |
| Karachi South |  |  |  |  | - | - | - | - | 0% | 0% | 0% | 0% |
| Karachi west |  |  |  |  | - | - | - | - | 0% | 0% | 0% | 0% |
| Korangi |  |  |  |  | - | - | - | - | 0% | 0% | 0% | 0% |
| Malir |  |  |  |  | - | - | - | - | 0% | 0% | 0% | 0% |
| Matari | 2,198 |  | 296 |  | 19.98 | - | 2.69 | - | 2% | 0% | 34% | 0% |
| Shaheed Benazirabad | 2,198 |  | 154 |  | 19.98 | - | 1.40 | - | 1% | 0% | 34% | 0% |
| Tando Allah Yar | 2,198 |  | 270 |  | 19.98 | - | 2.45 | - | 2% | 0% | 34% | 0% |

## Family planning

1. Family planning unit costs information were provided by the Planning and Development Department of the GoS. The unit cost for family planning was recalculated based on relative distribution of utilization of each individual contraceptive methods. **Therefore, the proportional average unit cost for family planning in Sindh was estimated US$ 0.08 (PKR 8.62).**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Unit cost  (PKR per beneficiary per year)** | | | **Unit cost  (US$ per beneficiary per year)** | | |
| **Method** | **Distribution** | **Cost** | **Proportional Cost** | **Distribution** | **Cost** | **Proportional Cost** |
|  | A | B | AxB | A | B | AxB |
| Condom | 87% | 4.22 | 3.67 | 87% | 0.04 | 0.03 |
| Male sterilization | 0% | - | - | 0% | 0.00 | - |
| Female sterilization | 0% | - | - | 0% | 0.00 | - |
| Injectable | 4% | 71.00 | 3.05 | 4% | 0.65 | 0.03 |
| Implant | 0% | - | - | 0% | 0.00 | - |
| Pill | 8% | 21.24 | 1.80 | 8% | 0.19 | 0.02 |
| Withdrawal | 0% | - | - | 0% | 0.00 | - |
| Fertility awareness | 0% | - | - | 0% | 0.00 | - |
| IUD | 0% | 45.26 | 0.10 | 0% | 0.41 | 0.00 |
|  | **100%** |  | **8.62** | **100%** |  |  |

1. **As a proxy for the coverage of family planning interventions in Sindh for 2019, we used the Contraceptive Prevalence Rare (CPR) for any method of contraceptive in Pakistan from the UNFPA website (**[**https://www.unfpa.org/data/world-population/PK**](https://www.unfpa.org/data/world-population/PK)**), 42%.**
2. **Annex: Methodology and Data Collection Strategy**

# Methodology and Data Collection Strategy

The purpose of this document is to outline and propose an analytical strategy to collect data and estimate coverage and unit costs of key high-impact, evidence-based nutrition interventions in Pakistan to inform allocative efficiency analysis using Optima nutrition.

## Background

Without adequate human capital, countries cannot sustainably improve their economic growth and competitiveness or prepare their workforce for expanding high skill jobs of the future. Compelling scientific and economic evidence shows experiences in the early years have a profound impact on brain development, affecting learning, health, adult productivity and ultimately, the economic competitiveness of nations. Worldwide, 25% of children under age five (156 million) suffer from chronic malnutrition, which means they are stunted (low height for age). The World Bank Group (WBG) estimates that the average country’s GDP per capita is 7% lower than it could have been if steps had been taken to prevent stunting among workers when they were children. In Sub-Saharan Africa and South Asia, the difference is even greater (9 to 10%).

In response to the convincing evidence on the benefits of investing in young children, and the growing demand from countries, the WBG is increasing its support to countries to invest in the early years of life. Specifically, the WBG has committed to expanding its investments in the key interventions required to deliver on these priorities through the Investing in the Early Years (IEY) Initiative. The WBG’s priorities are threefold: 1) reduce childhood undernutrition, especially stunting; 2) ensure children receive early stimulation and learning; and 3) protect vulnerable children. The WBG is engaging with priority countries to identify opportunities to expand key interventions and consider where it can best provide support through its financial and knowledge services. It is also helping build the evidence base so countries can better appreciate the challenges of early childhood development and identify the most cost-effective opportunities to respond.

One key and persistent question asked by policy makers and nutrition and health program managers which has not been addressed to-date is: what allocation of funding across different interventions would allow us to maximize nutrition and health impact while minimizing costs? Optima nutrition is a mathematical model that uses an integrated analysis of nutrition status, program, and cost data to determine an optimal distribution of investment at different funding levels to better serve the needs of decision-makers and planners. An initial pilot application for Optima nutrition has been developed through a partnership between the World Bank, the Bill and Melinda Gates Foundation, and the Burnett Institute. Currently, the application is focusing on child undernutrition (stunting, wasting, and anemia) and incorporates key nutrition interventions that have shown to impact undernutrition either directly or indirectly through diarrhea incidence and birth outcomes (complementary feeding education, public provision of complementary foods, zinc supplementation, breast feeding promotion, vitamin A supplementation, micronutrient supplementation in pregnancy, balanced energy-protein supplementation, intermittent preventive malaria therapy in pregnancy, etc). The application allows the user to 1) estimate the impact an intervention scale-up will have on stunting prevalence and child mortality; 2) calculate the cost of scale up under different cost function assumptions; 3) for a given budget, calculate the optimal allocation of resources among the key interventions (that is, identify an allocation that will produce maximum reductions in stunting or/and mortality); 4) for a given budget, calculate the optimal allocation of resources among different geographic areas in a given country; and 5) for a given budget, calculate the optimal allocation of resources among different interventions and geographic areas

## Objective

The objective of this analysis is to estimate the coverage and the cost to provide high-impact evidence-based nutrition interventions in Pakistan, to inform an application of an early version of the Optima nutrition tool and conduct allocative efficiency analyses of nutrition investments. The analysis in turn are aimed at informing activities carried out under various initiatives introduced/to be introduced by the Government of Pakistan with support from development partners including the WBG.

For each key nutrition intervention, the following outputs are expected:

1. **Target population**
2. **Intervention coverage**
3. **Intervention unit cost**

***Target population***

Target population is defined as the population that could possibly receive the nutrition intervention. Examples of target populations include: pregnant women; children aged 6-59 months; etc. Defining the target population is important to calculate the number of beneficiaries requiring the intervention, per year. For most preventive care interventions, the share will be 100% of the total target population. For example, daily and folic acid supplementation will be required for all pregnant women. The target population can be interpreted as the incidence and prevalence of conditions for interventions such as treatment of moderate/severe acute malnutrition (MAM/SAM).

***Intervention coverage***

The data collection process will include intervention geographical and population coverage, nationally and by region. Intervention coverage refers to how many people, out of the target population, are receiving the intervention.

***Intervention unit cost***

Unit costs for each intervention will be based on the so-called “**ingredients approach**” and broken down by direct costs (drugs, supplies, transportation, medical personnel, etc.) and program costs (program personnel, technical support, monitoring and evaluation, supervision, advocacy, etc.). Wherever applying the ingredient approach is not practical, unit costs can be estimated using the “**program experience**” approach, based on the actual financial costs of programs implemented in Pakistan. If no unit costs are available for a given intervention in Pakistan, the mean unit cost for other countries in the region can be used.

Unit costs information will be collected using a customised Excel-based template drawing from the structure and logic of the **Onehealth tool**(OHT)[[1]](#footnote-1). Costs are classified and divided into ‘direct costs’ and ‘programme costs’ (Annex 2). Direct costs are costs for inputs per beneficiaries incurred at the point of delivering the intervention, such as medical drugs and supplies, and medical personnel costs. Programme costs refer to costs that operate across a number of different service delivery points at a level other than the delivery point of an intervention to beneficiaries, like training, coordination, monitoring and evaluation, etc. Activity costs referring to multiple interventions, such as nutrition governance and information systems are shared and allocated equally to each individual intervention.

## Scope of the analysis

Most of the key nutrition-specific interventions included in this analysis are also supported by scientific evidence from the Lancet series 2008 and 2013 on Maternal and Child Undernutrition. Some nutrition-sensitive interventions that have proven to be very efficacious in averting stunting and reducing child mortality are also considered: these interventions include family planning and social protection (cash transfer).

The key nutrition interventions includes both nutrition-specific and nutrition-sensitive actions and are grouped into seven separate packages: (i) Infant and Young Child Feeding (IYCF); (ii) Micronutrients supplementation; (iii) Treatment and prevention of acute malnutrition; (iv) Disease prevention and management; (iv) Child care; (v) Family planning; (vi) Social protection. The list of the key nutrition interventions and associated target groups is contained in Annex 1.

Expenditures estimated in this model are **financial costs** of goods and services required to deliver each of the interventions from a supply-side prospective, and do not reflect the full economic and social value of how resources could be used differently, such as opportunity costs of time of beneficiaries seeking and accessing the health services (lost wages, etc.).

## Process of undertaking costing exercise

The process is based on the analysis of the country current support to nutrition, relative to national priorities, including the examination of government policies and protocols as we well as other implementing partners programs. The approach uses information gathered from key stakeholders during meetings, workshops, one-to-one interviews and email exchanges.

Key stakeholders include relevant ministries and governmental agencies, UN agencies, donors and int’l NGO implementing nutrition activities. Information collected during the process may include: Key national nutrition policy documents; Programs budgets, expenditures documents, grants applications, etc.; Demographic data by intervention and target groups including; epidemiological data such as prevalence of stunting, wasting, etc,; Baseline intervention coverage data from the most recent Demographic and Health Survey (DHS) or other surveys such as the Multiple Indicator Cluster Surveys (MICS).

The 4 steps process described below support a participatory dialogue within key stakeholders at country level and include tools and templates to be used by designed focal points and by the WB facilitator:

1. **Inception**

1.1. WB facilitator develops the work plan and analytical strategy

1.2. Key stakeholders to:

* Identify and validate the list of key nutrition specific and sensitive interventions
* Take stock of existing data, documentations and concurrent exercises
* Identify focal points for each intervention

1.3. WB facilitator customizes templates based on inputs from key stakeholders

1. **Data collection**

2.1. WB facilitator to:

* Distribute excel-based templates and data collection tools to designated focal points
* Follow-up with key stakeholders and focal points for introduction to templates and tools

2.2. Key stakeholders and focal points fill the templates and share with the WB facilitator

1. **Quantitative analysis**

3.1. WB facilitator reviews data for accuracy and calculates first draft of coverage and unit cost for each intervention.

3.2. WB facilitator engages with key stakeholder and focal points to review data and to seek clarifications and further inputs as needed

1. **Data validation and reporting**

4.1. WB facilitator prepares and disseminates preliminary results

4.2. WB facilitator and key stakeholders validate results in workshop

4.3. WB facilitator prepares and disseminates results and report

1. **Inception**

**2. Data collection**

**3. Quantitative analysis**

**4. Data validation and reporting**

**Key steps**

**Timeline**

**½ month**

* **Work plan**
* **Analytical strategy**

2.1. WB facilitator to:

* Distribute templates and data collection tools to focal points
* Follow-up with key stakeholders and focal points for introduction to templates and tools

2.2. Key stakeholders and focal points fill the templates and share with the WB facilitator

3.1. WB facilitator reviews data for accuracy and calculates first draft of coverage and unit cost for each intervention

3.2. WB facilitator engages with key stakeholder and focal points to review data and to seek clarifications and further inputs as needed

**Interventions coverage and unit cost report**

4.1. WB facilitator prepares and disseminates preliminary results

4.2. WB facilitator and key stakeholders validate results in workshop

4.3. WB facilitator prepares and disseminates results and report

**Main outputs**

**½ month**

**½ month**

**½ month**

1.1. WB facilitator develops the work plan and analytical strategy

1.2. Key stakeholders to:

* Identify the list of key nutrition specific and sensitive interventions
* Take stock of existing data, documentations and concurrent exercises
* Identify focal points for each intervention

1.3. WB facilitator customizes templates based on inputs from key stakeholders

**Process**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Annex 1: Key nutrition interventions included in the cost analysis | |  |
|  | **Intervention** | **Target population** | **Description** |
| **IYCF** | Breastfeeding counselling and support | Pregnant and lactating women | Behaviour change communication on optimal breastfeeding |
| Complementary feeding counselling and support | Mothers of children 6-23 months | Behaviour change communication on complementary feeding practices |
| **Micronutrients supplementation** | Vitamin A supplementation | Children 6-59 months | Bi-annual supplementation of vitamin A capsules |
| Home fortification of food with multiple micronutrient powders | Children 6-23 months | Use of multiple micronutrient powders for home fortification of foods consumed by children 6-23 months |
| Iron-folic acid supplementation (PW) | Pregnant women | Four months supplementation of iron-folic acid during pregnancy |
|  |  |  |
|  |  |  |
| **Treatment and prevention of acute malnutrition** | Management of severe acute malnutrition (SAM) | Children 6-59 months | Severely malnourished children admitted in either inpatient or outpatient therapeutic feeding programs |
| Public provision of complementary foods (SNF) | Children 6-23 months | For children living in poverty, provision of a small amount of nutrient-dense complementary food (Supercereal +) for the prevention of moderate malnutrition |
|  |  |  |
| **Disease prevention and management** | ORS+zinc for treatment of diarrhea | Children 6-59 months | Management of mild and moderate diarrhea with oral rehydration solution (ORS) and zinc tablets |
| Delayed Cord Clamping | Live births |  |
|  |  |  |
| **Family planning** | Promote family planning, including optimized inter-pregnancy intervals | Women of reproductive age (15-49yo) | Community-based Distribution of family planning products (Sayana press) |
| **Social protection** | Cash transfers | Targeted households | Disbursement of conditional/unconditional cash to selected vulnerable households |

Annex 2: Classification of costs

|  |  |  |
| --- | --- | --- |
|  | **Cost category** | **Example of data included** |
| **Direct costs** | *Drugs and Medical Supplies* | Albendazole, Folic acid, Vitamin A, etc. |
| *Medical Personnel* | Salaries of health workers pro rated based on time spent delivering the service at health facility level (nurses, midwifes, nutritionists, CHWs, etc.) |
| **Program costs** | Programme-Specific Human Resources | Salaries for managers and others programme and support staffs working at national, regional and county level (assumed as 10 percent of programme costs). |
| Training | In-service training, training of trainers and development of training material for: MIYCN Training, Iron and Folic Acid Supplementation (IFAS), etc. |
| Supervision | National meetings and forums, national staff visiting local staff, county staff visits to health facilities. |
| Monitoring and Evaluation | Design of M&E frameworks and systems, national surveys, routine surveillance, data quality audit. |
| Equipment | Anthropometric equipment, consumables, stationery. |
| Communication, Media & Outreach | Development of communication strategy, mass media campaigns, social outreach activities. |
| Advocacy[[2]](#footnote-2) | Advocacy strategies and activities (i.e. develop national nutrition advocacy, communication and social mobilization strategy; advocate workplace support of breastfeeding mothers). |
| General Programme Management | Programme support, development and review of country strategies and guidelines, policies, etc. |

1. The OneHealth Tool is a software designed to strengthen health system analysis and costing and to develop financing scenarios at country/regional level. The development of the tool is overseen by the InterAgency Working Group on costing comprised of members from UNFPA, UNICEF, UNDP, UNAIDS, UNWOMEN, WHO and the World Bank. [↑](#footnote-ref-1)
2. Advocacy aims primarily to change the behaviour of public leaders or decision-makers. [↑](#footnote-ref-2)