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PUBLIC EVIDENCE SERIES

UNICEF in Pakistan, 2000 to 2025, Volume I: Survive & Thrive

Child Survival, Primary Health Care, Immunization and Nutrition. Twenty-Five Years for Children in Pakistan: An Independent Assessment

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Independent study. Not commissioned, requested, reviewed or endorsed by UNICEF.

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About the Public Evidence Series

This knowledge product was independently initiated by the Centre for Social Analytics and Development Support (CSADS) under its Public Evidence Series. It was not commissioned, requested, reviewed or endorsed by any organization it covers and is not an official position of any of them. Drawing on public sources, it synthesizes what the evidence says about its subject, identifies where the evidence is too limited to support stronger claims, and considers implications for future policy, programming and planning. The Series offers briefs, reports, scorecards and notes that separate evidence from judgment. AI tools supported research and drafting, every statistic is traced to a cited source, and all content was reviewed by the principal investigator.

About this volume

Supporting documentation. Detailed technical evidence studies, analytical files and source level verification materials are maintained as supporting documentation and are available on request.

This volume consolidates two longer technical evidence studies, one on nutrition and one on child survival, primary health care and immunization, into a single externally oriented thematic assessment. The detailed technical evidence studies, analytical files and source level verification materials are maintained as supporting documentation and are available on request. This volume is designed for senior programme, evaluation, government and development partner audiences who need the principal findings, the strength of evidence behind them and the implications for future choices.

The study was independently initiated and relies primarily on publicly available evidence. It is therefore not a formal UNICEF evaluation. It did not have access to internal programme databases, complete financial records, confidential monitoring systems, staff or beneficiary interviews, field verification, an evaluation reference group, or a UNICEF management response. Its contribution judgements should be read as evidence based propositions that can be strengthened, qualified or revised if additional internal or stakeholder evidence becomes available.

The analytical standard is deliberately conservative. National improvements are not treated as UNICEF results merely because UNICEF worked in the sector. UNICEF annual reports and programme documents are used mainly to establish what UNICEF reports doing, where, when and through which mechanisms. Population trends are anchored, wherever feasible, in government surveys, harmonized international estimates and independent evaluations. Strong contribution claims require evidence of temporal fit, a plausible and observed mechanism, adequate scale, independent corroboration, consideration of alternative explanations and some indication of sustainability.

AI assisted methods were used for evidence discovery, document screening, structured extraction, cross document comparison, data harmonization support and drafting. Quantitative claims were tied back to original sources, and evaluative judgements were governed by explicit evidence rules. AI was used as a research support tool rather than as a substitute for source verification or evaluative judgement.

This revised edition rechecked the headline statistics against current official and harmonized sources in October 2026. Outcome claims remain bounded to 2000 to 2025. Where a source published after 2025 is used, it is identified as such and it describes a 2025 or earlier observation, for example the 2025 polio case count reported in January 2026.

How to use this volume

Table 1 How to use this volume

Reader	Decisions this volume can inform	Start with
UNICEF programme chiefs and country management	Which newborn, immunization and nutrition investments to prioritize for 2026 to 2030, and what claim language is defensible in results reporting	Key messages, Executive Summary, Sections 20 to 23
Federal and provincial health and nutrition departments, BISP	Where documented system support exists, and where implementation, financing and data remain the binding constraints	Sections 9 to 15 and Section 18
Development partners and evaluators	How shared attribution should be described, and what a prospective measurement compact would require	Sections 3, 16 and 23; Annex A

Source: Author compilation

Abbreviations

Table 2 Abbreviations

Abbreviation	Meaning
BISP	Benazir Income Support Programme
CMAM	Community based Management of Acute Malnutrition
DTP3	Third dose of diphtheria tetanus pertussis containing vaccine
EPI	Expanded Programme on Immunization
IYCF	Infant and Young Child Feeding
LHW	Lady Health Worker
MNCH	Maternal, Newborn and Child Health
NNS	National Nutrition Survey
PDHS	Pakistan Demographic and Health Survey
PHC	Primary Health Care
SAM	Severe Acute Malnutrition
SBC	Social and Behaviour Change
UN IGME	United Nations interagency Group for Child Mortality Estimation
WUENIC	WHO/UNICEF Estimates of National Immunization Coverage

Source: Author compilation

Executive Summary

KEY MESSAGES

- Under five mortality fell from 107.9 to 56.0 deaths per 1,000 live births between 2000 and 2024, but newborn deaths, at 36 per 1,000 in 2024, now account for the largest share of the remaining burden.
- Routine immunization reached a record 87 percent DTP3 coverage in 2024, yet 396,000 children were still zero dose in 2023 and they are concentrated in identifiable places.
- Nutrition did not follow the same path: in the latest comparable national survey (2018), stunting was 40.2 percent and wasting 17.7 percent.
- UNICEF's best evidenced contributions are to systems, standards, evidence and humanitarian continuity, and they are shared with government and partners; the public record supports no UNICEF share of national mortality or nutrition trends.
- For 2026 to 2030, the evidence points to newborn quality of care, zero dose and dropout reduction, wasting prevention alongside treatment, nutrition sensitive social protection, and an evidence architecture built into programmes from the start.

Pakistan's child survival record over 2000 to 2025 is one of substantial but incomplete progress. Harmonized mortality estimates indicate that the under five mortality rate fell from about 108 deaths per 1,000 live births in 2000 to about 56 in 2024, while neonatal mortality declined more slowly, from about 57 to 36 per 1,000. The slower newborn decline is important: as deaths after the neonatal period fall, the remaining burden becomes more concentrated around pregnancy, childbirth and the first month of life, where survival depends increasingly on quality of care rather than contact alone (UN IGME and UNICEF Data 2026; National Institute of Population Studies and ICF 2019).

Immunization shows a similarly important but uneven transition. WUENIC estimates DTP3 coverage at 59 percent in 2000 and 86 percent in 2023, and the 2024 revision reports 87 percent, the highest level recorded for Pakistan (WHO and UNICEF 2024; UNICEF and WHO 2025). The estimated number of zero dose children fell sharply after the pandemic era setback, from about 651,000 in 2021 to about 396,000 in 2023, yet residual exclusion remains concentrated geographically and socially. The next phase of immunization strategy is therefore less about raising a national average than about identifying and repeatedly reaching children in underserved urban settlements, remote rural areas, mobile populations and districts affected by insecurity or weak service management (WHO and UNICEF 2024).

Nutrition presents a more difficult picture. National Nutrition Survey data show underweight falling from 38.0 percent in 2001 to 28.9 percent in 2018, and breastfeeding indicators improving between 2011 and 2018. Yet stunting remained extremely high, 40.2 percent in 2018 after 43.7 percent in 2011, and wasting worsened from 13.1 percent in 2001 to 17.7 percent in 2018. These trends underline a central finding of this volume: Pakistan has been more successful at building treatment and service delivery systems for acute risks than at changing the structural determinants that produce chronic and recurrent malnutrition (Government of Pakistan and UNICEF 2019).

The strongest evidence of UNICEF contribution lies in system and programme pathways rather than in an attributable share of national mortality or nutrition change. In nutrition, these include development and institutionalization of CMAM approaches, support to national and provincial nutrition evidence systems, technical codevelopment of the Pakistan Maternal Nutrition Strategy, nutrition sensitive social protection through UNICEF's role alongside BISP and WFP in Benazir Nashonuma, and repeated humanitarian screening and treatment systems. In health and immunization,

strong or substantial contribution evidence is associated with vaccine system strengthening, equity focused approaches to zero dose children, demand generation, emergency service continuity and selected newborn/child health system functions. These contributions are shared with government, WHO, Gavi, the World Bank, WFP and other partners rather than attributable to UNICEF alone.

The evidence also identifies clear boundaries. UNICEF cannot credibly claim a quantified share of Pakistan's under five mortality decline from the public record. Expansion of CMAM does not establish that national wasting prevalence fell; in fact, wasting worsened over the last comparable NNS rounds. Increased skilled attendance at birth does not by itself demonstrate effective newborn care. National vaccination coverage cannot be read as proof that every geography is protected, and polio remains a joint Global Polio Eradication Initiative result with continued fragility, with 74 wild poliovirus type 1 cases reported in 2024 and at least 31 for 2025 as of January 2026 (Pakistan Polio Eradication Programme 2026). In each case, the study separates system contribution from population attribution.

Across both sectors, UNICEF's strategic value appears greatest where it connects otherwise fragmented components of the child survival system: commodities with delivery systems; national policy with provincial implementation; routine services with emergency response; PHC with community platforms; nutrition with social protection; data production with targeting; and communication with last mile service use. The most promising future direction is therefore not a larger collection of standalone interventions, but a more measurable 'survive and thrive' platform organized around effective coverage, local implementation capability and resilience.

For 2026 to 2030, the evidence supports six priorities: make neonatal survival and quality of care the central child survival frontier; organize immunization around zero dose and dropout reduction rather than national averages; treat wasting as both a treatment obligation and a prevention failure; protect breastfeeding and maternal nutrition while addressing affordability of complementary diets; institutionalize nutrition sensitive social protection and shock responsive continuity; and build a unified exposure and outcome evidence architecture so future contribution claims can be tested prospectively rather than reconstructed retrospectively.

Executive Contribution Ledger

Table 3 Executive Contribution Ledger

Outcome/ system	Pakistan trajectory	UNICEF pathway	Evidence grade	Sustainability	Main caveat
under five survival	U5MR fell markedly over 2000 to 2024	Long term support to immunization, PHC, childhood illness and newborn systems	C overall; B for specific systems	Moderate	National decline is multicausal; no defensible UNICEF share.
Neonatal survival	Decline slower than under five mortality	Newborn care, community linkage, ENAP/IMNCI related systems	C/B	Moderate	Service contact does not equal quality; newborn care is unfinished agenda.
Routine immunization	DTP3 estimated at 86% in 2023 and 87% in 2024	Supply, microplanning, data, demand generation and equity focus	B	High where recurrently financed	Shared with government, WHO, Gavi and World Bank.
Zero dose children	Large reduction after 2021 but residual clustering persists	Targeting, urban profiling, community engagement	B	Moderate	National average masks persistent exclusion.
Child wasting	17.7% in NNS 2018 after worsening long term trend	CMAM treatment system, screening, RUTF and referral	B for system; D/C for prevalence	Moderate	Treatment system success cannot be translated into prevalence impact.
Stunting	Persistently very high	Multisector nutrition, IYCF, maternal nutrition, evidence	C	Mixed	Food systems, poverty, WASH, maternal factors and infection are major drivers.

Outcome/ system	Pakistan trajectory	UNICEF pathway	Evidence grade	Sustainability	Main caveat
Breastfeeding	Early initiation and exclusive breastfeeding improved 2011 to 2018	IYCF/SBC, policy and community support	B/C	Moderate	Behavioural change is multicausal; definitions must remain comparable.
Nutrition evidence systems	NNS 2018 and expanded nutrition information architecture	Survey support, analysis, coordination and information systems	A/B	High	System contribution, not a direct nutrition outcome.
Maternal nutrition	National strategy and provincial implementation architecture strengthened	Technical codevelopment, bottleneck analysis and health system integration	B/C	Emerging	Anaemia and diet remain major population constraints.
Benazir Nashonuma	Nutrition responsive social protection scaled nationally	UNICEF SBC/nutrition contribution with BISP and WFP	B	High/ongoing	Joint programme; programme ownership is governmental.
Humanitarian survival/ nutrition	Repeated emergency continuity, screening and treatment	Coordination, supplies, outreach, vaccination and nutrition treatment	B	Variable	Emergency reach is not equivalent to durable impact.
Equity	National averages improve while geographic gaps persist	Zero dose targeting and differentiated local strategies	B/C	Moderate	Need stronger prospective district exposure and effective coverage data.

Source: Verified Master Claim Evidence Contribution Ledger, Tier 1 verification pass

Grades follow the contribution scale in Annex A and are attached to the specific claim named in each row. Claims whose exact source location is still being pinned are worded as plausible or contextual findings.

Part I: Framing the Survive & Thrive Assessment

IN THIS PART

1. Why health and nutrition should be read together

2. Research questions and claim boundaries

3. Methodology and evidence hierarchy

1. Why health and nutrition should be read together

Child survival and nutrition are analytically inseparable. Infection raises nutritional risk; wasting and micronutrient deficiencies increase the probability that common childhood illnesses become fatal; maternal nutrition influences fetal growth and newborn vulnerability; immunization reduces infection related nutritional shocks; breastfeeding affects both infection exposure and nutritional adequacy; and WASH conditions shape repeated enteric disease and environmental stress. A thematic volume that placed mortality, immunization and nutrition in separate institutional silos would therefore misrepresent the causal structure through which children survive and develop.

This integrated perspective also changes how UNICEF contribution should be interpreted. A vaccine delivered to a child, a case of severe acute malnutrition treated successfully, an LHW counselling a mother, a district manager using better coverage data, or a social protection programme linking a pregnant woman to nutrition services are different interventions, but they operate within one household to facility system. UNICEF's comparative contribution is often strongest at the interfaces between these components, standards, supplies, information, community engagement, referral and government coordination, rather than through ownership of a single national outcome.

The volume therefore uses a continuum rather than a sector bound logic: pregnancy and maternal nutrition; childbirth and newborn survival; breastfeeding and early feeding; routine immunization and disease prevention; detection and treatment of acute malnutrition; childhood illness management; and sustained access to PHC and social protection. Equity and resilience cut across every stage.

2. Research questions and claim boundaries

1. What changed in child survival, newborn survival, immunization and nutrition in Pakistan between 2000 and 2025?
2. Which UNICEF supported programme, system, policy, information, behavioural and humanitarian pathways plausibly contributed to those changes?
3. Where is the evidence strong enough to support a system level or programme level contribution judgement, and where is only plausibility established?
4. Which outcomes remained stagnant or deteriorated despite substantial programme activity, and what does that imply for strategy?
5. How did government action, other development partners, socioeconomic change, demographic pressure, crises and geographic inequality influence observed results?
6. What should UNICEF and partners measure differently during 2026 to 2030 to make future contribution assessment more rigorous and useful?

The report applies an explicit claim boundary. A national trend from UN IGME, NNS, PDHS or WUENIC establishes what changed. It does not establish who caused the change. UNICEF programme documents establish what UNICEF reports supporting. A contribution judgement is made only where the two evidence streams can be linked through timing, mechanism, scale, geography, corroboration and consideration of alternative explanations.

3. Methodology and evidence hierarchy

This is a Longitudinal Contribution and Impact Evidence Assessment. It integrates portfolio reconstruction, longitudinal trend analysis, contribution analysis, theory based reasoning, process tracing, systems analysis, equity analysis and targeted comparison of intervention and outcome evidence. The unit of analysis varies by question: national and provincial trends for mortality and nutrition; programme/system pathways for CMAM, immunization, maternal nutrition and social protection; and subnational or population group evidence where public data permit.

The evidence hierarchy prioritizes government surveys and administrative or policy sources; independent evaluations and harmonized international datasets; peer reviewed and multilateral evidence; UNICEF evaluations; UNICEF programme documents; and finally annual reports or output reporting. Organizational reports are valuable for reconstructing UNICEF's role but are not treated as independent proof of population impact.

Contribution grades are interpreted as follows: Grade A means strong contribution evidence; Grade B, substantial contribution evidence; Grade C, plausible contribution; Grade D, UNICEF activity documented but outcome contribution uncertain; and Grade E, mixed or contrary evidence. Grades are attached to the specific claim being made. A programme may therefore receive Grade B for system development and Grade D/C for population prevalence impact, as in the case of CMAM and wasting.

The evidence base has important limitations. The latest nationally comparable NNS anthropometric round within the study period is 2018, limiting post 2018 trend inference for stunting and wasting. Mortality estimates are modelled and should be read together with household surveys. Administrative immunization figures can be affected by denominator and reporting problems, which is why WUENIC and PDHS are used as triangulation. Public documentation is uneven across provinces and programme years, while exposure intensity is rarely available in a form that permits strong causal analysis. Evidence published after 2025 is used only to describe observations that refer to 2025 or earlier, and such sources are identified where they appear.

Part II: What Changed for Children?

IN THIS PART

4. Survival improved, but newborn deaths became more prominent

5. Immunization recovered to high national coverage, but zero dose exclusion persists

6. Nutrition progress was uneven and structurally constrained

7. Feeding practices improved, but complementary diets remain a binding constraint

8. Equity is now the central test of system effectiveness

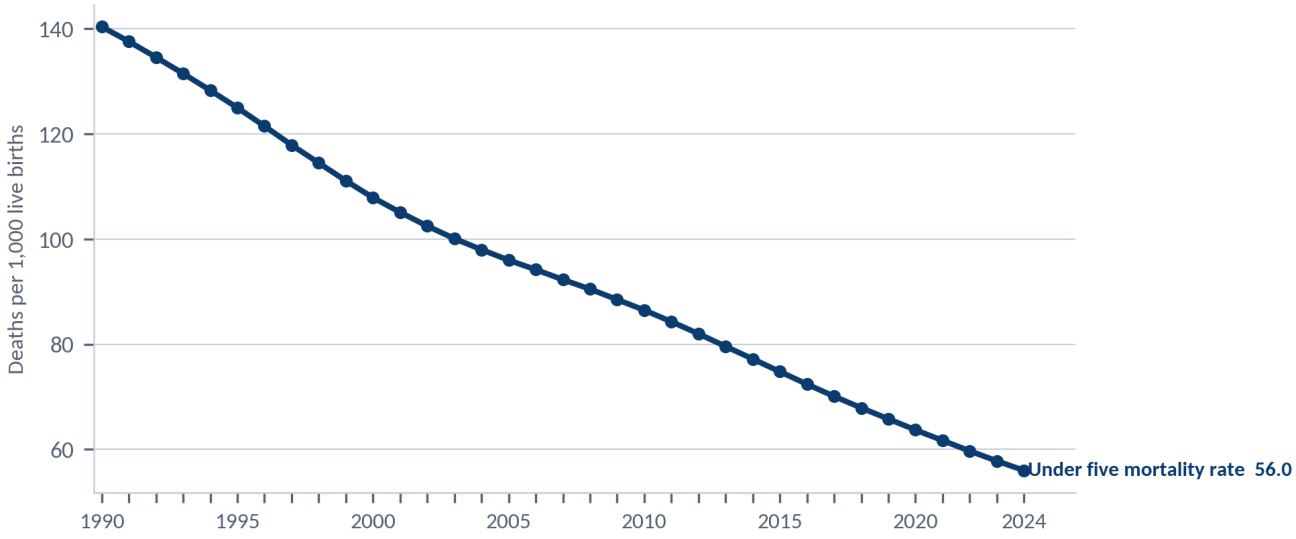
4. Survival improved, but newborn deaths became more prominent

Pakistan experienced a large long run reduction in child mortality. UN IGME/UNICEF estimates place under five mortality at roughly 108 deaths per 1,000 live births in 2000 and 56 in 2024. This is a major population achievement. It reflects the cumulative effect of multiple determinants: vaccination, maternal and newborn care, treatment of childhood illness, nutrition, WASH, female education, fertility and birth spacing, household income, public and private health services, and repeated donor supported programmes. It is therefore inappropriate to assign the decline to any single institution. In absolute terms, UNICEF Data estimates about 381,586 deaths among children under five in 2024, a reminder that a falling rate still leaves a large burden in a growing birth cohort (UN IGME and UNICEF Data 2026).

Neonatal mortality declined more slowly, from roughly 57 per 1,000 live births in 2000 to 36 in 2024 (UN IGME and UNICEF Data 2026). The relative concentration of mortality in the first month of life is a strategic signal. Interventions that successfully reduce vaccine preventable disease and postneonatal mortality can expose the remaining constraints more sharply: prematurity, birth complications, sepsis, low birthweight, maternal undernutrition, delayed referral and inconsistent quality of facility care.

The policy implication is that the next unit of progress is increasingly an effective care problem. Expanding institutional delivery remains important, but effective coverage requires competent clinical teams, newborn resuscitation, thermal care, infection prevention, early breastfeeding, referral, commodities and postnatal follow up. This shift should influence UNICEF measurement: contacts should be supplemented with indicators of quality, timeliness and completed referral.

Figure 1 **Under five mortality in Pakistan, 1990 to 2024, with neonatal mortality in 2000 and 2024**



Source: UN IGME and UNICEF Data (2026), Pakistan country profile. Neonatal values are shown for the two end years only.

5. Immunization recovered to high national coverage, but zero dose exclusion persists

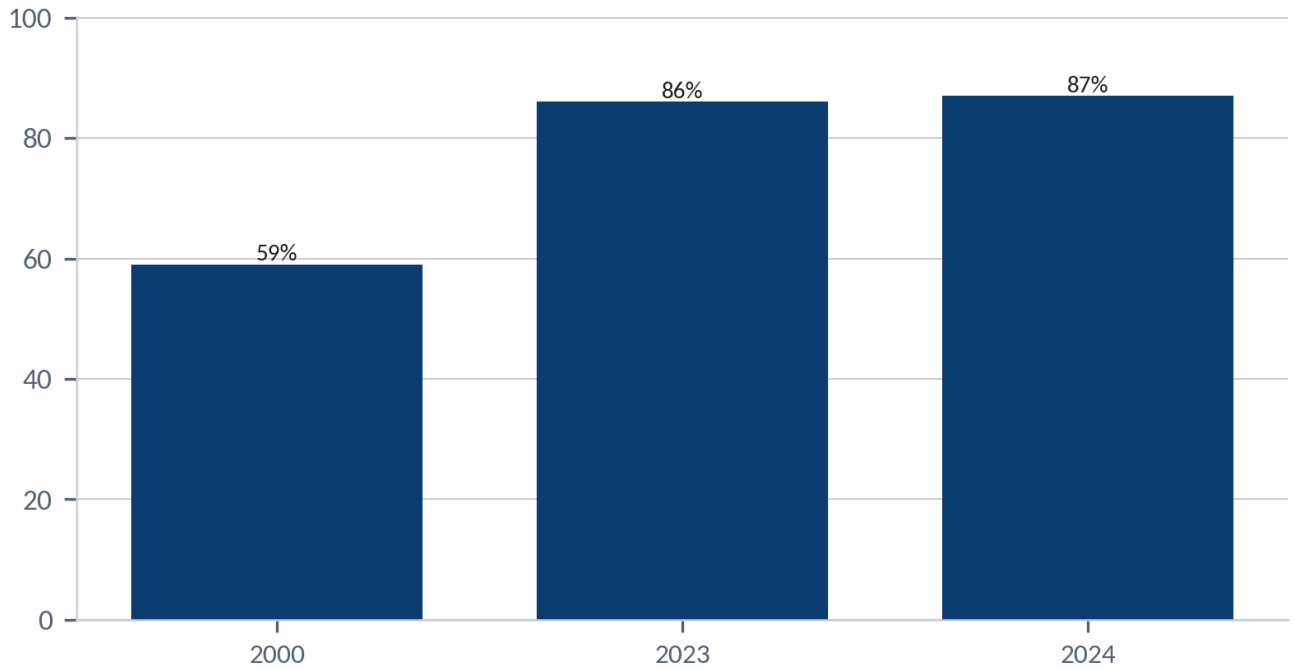
Routine immunization demonstrates both the possibility of system recovery and the limits of national averages. WUENIC estimates DTP3 coverage at 59 percent in 2000 and 86 percent in 2023. The trajectory was not linear: coverage weakened during parts of the 2000s, improved through subsequent system investments, was disrupted by

COVID-19 and then recovered, reaching 87 percent in the 2024 revision (UNICEF and WHO 2025). This pattern is important because it shows that health system gains are reversible and that resilience is itself an outcome worth measuring (WHO and UNICEF 2024).

Zero dose children provide a more equity sensitive view. WUENIC estimated approximately 651,000 zero dose children in 2021 and 396,000 in 2023. The fall is substantial, but the remaining burden is not randomly distributed. Children missed by routine vaccination are disproportionately likely to live in underserved urban settlements, hard to reach rural areas, mobile communities, insecure locations or places with weak outreach and trust. UNICEF's survey work in slums of Karachi and Hyderabad illustrates why national coverage must be complemented by local profiling (UNICEF Pakistan 2020; WHO and UNICEF 2024).

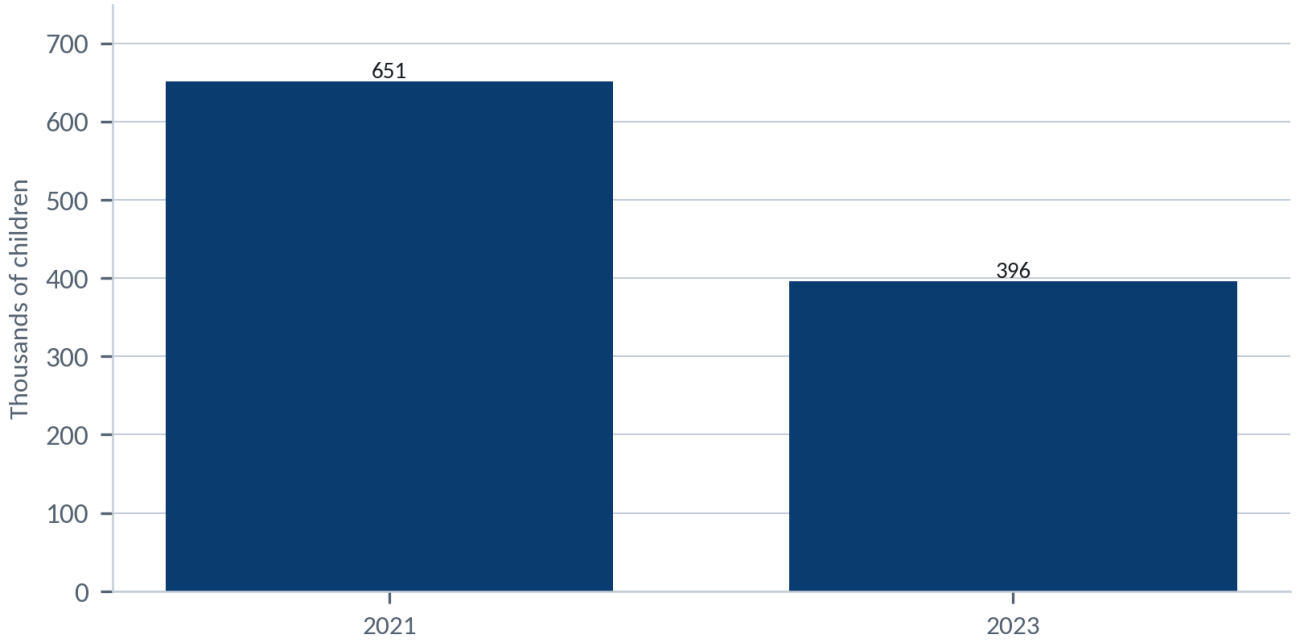
The strategic transition is therefore from national coverage maximization to repeated last mile effectiveness. This requires geocoded catchment intelligence, reliable target denominators, dropout tracking, session completion, functioning cold chain, community engagement and a management culture that treats missed children as a solvable operational problem rather than an abstract national statistic. Polio shows the same fragility. Pakistan reported 74 wild poliovirus type 1 cases in 2024 and at least 31 for 2025 as of January 2026, with 29 of the 31 in Khyber Pakhtunkhwa and Sindh (Pakistan Polio Eradication Programme 2026).

Figure 2 Routine immunization and zero dose children in Pakistan, DTP3 coverage



Source: WHO and UNICEF (2024), WUENIC 2023 revision, for 2000, 2021 and 2023; UNICEF and WHO (2025) for the 2024 DTP3 estimate. Zero dose children are those without a first DTP dose.

Figure 3 **Routine immunization and zero dose children in Pakistan, zero dose children**



Source: WHO and UNICEF (2024), WUENIC 2023 revision, for 2000, 2021 and 2023; UNICEF and WHO (2025) for the 2024 DTP3 estimate. Zero dose children are those without a first DTP dose.

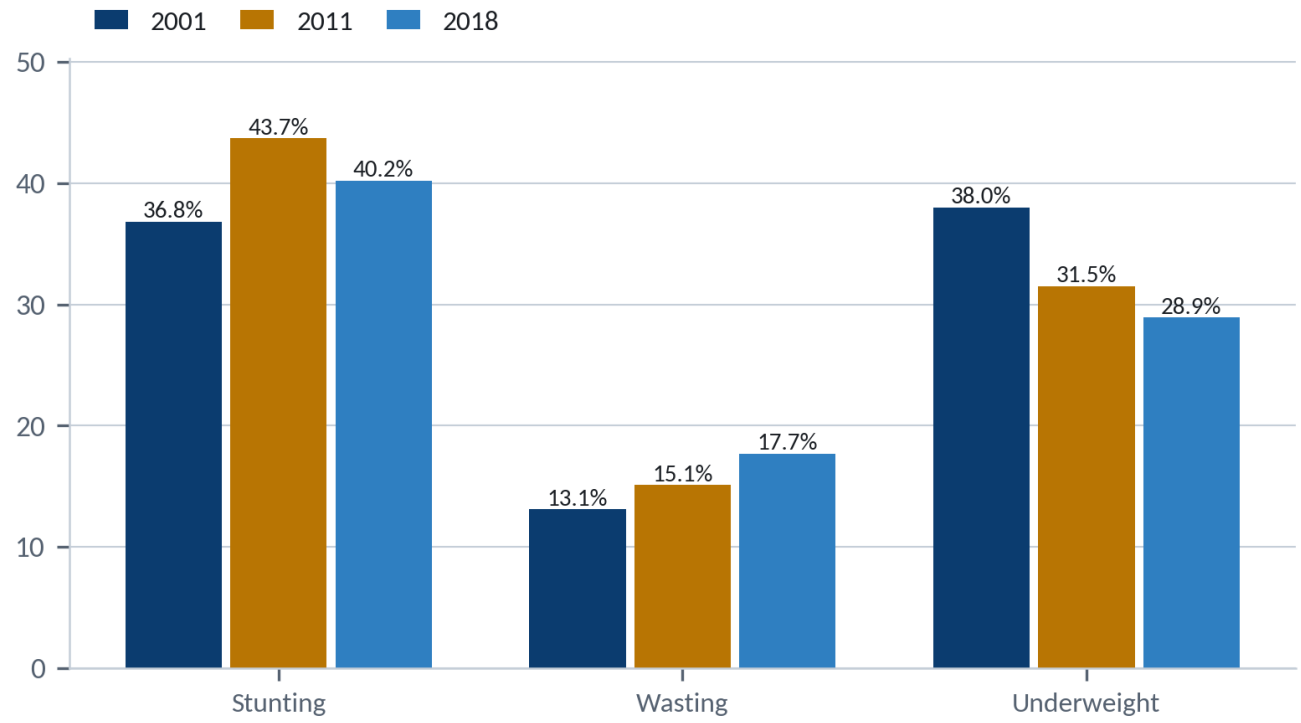
6. Nutrition progress was uneven and structurally constrained

Nutrition outcomes do not show the same broad pattern of sustained improvement as child mortality. NNS data indicate underweight fell from 38.0 percent in 2001 to 31.5 percent in 2011 and 28.9 percent in 2018. Stunting, however, was 36.8 percent in 2001, rose to 43.7 percent in 2011 and remained at 40.2 percent in 2018. Wasting increased from 13.1 percent to 15.1 percent and then 17.7 percent across the same rounds (Government of Pakistan and UNICEF 2019).

These patterns matter for contribution analysis because they prevent a promotional reading of programme expansion. Pakistan developed and scaled treatment systems for acute malnutrition, expanded screening and emergency response, supported infant feeding programmes and adopted multisector nutrition strategies. Yet national wasting worsened and stunting remained extremely high. The evidence therefore supports a distinction between building a capable treatment architecture and preventing the population level production of malnutrition.

The structural determinants are broad: maternal nutrition and low birthweight; poverty and food affordability; poor complementary diets; infection and WASH conditions; women's agency; household shocks; health service quality; population growth; and climate related food insecurity. UNICEF can influence several of these pathways but does not control them. This is why national stunting and wasting should be treated as shared system outcomes rather than agency performance indicators in isolation.

Figure 4 Child nutrition indicators across National Nutrition Survey rounds



Source: Government of Pakistan and UNICEF (2019), National Nutrition Surveys 2001, 2011 and 2018. Percent of children under five.

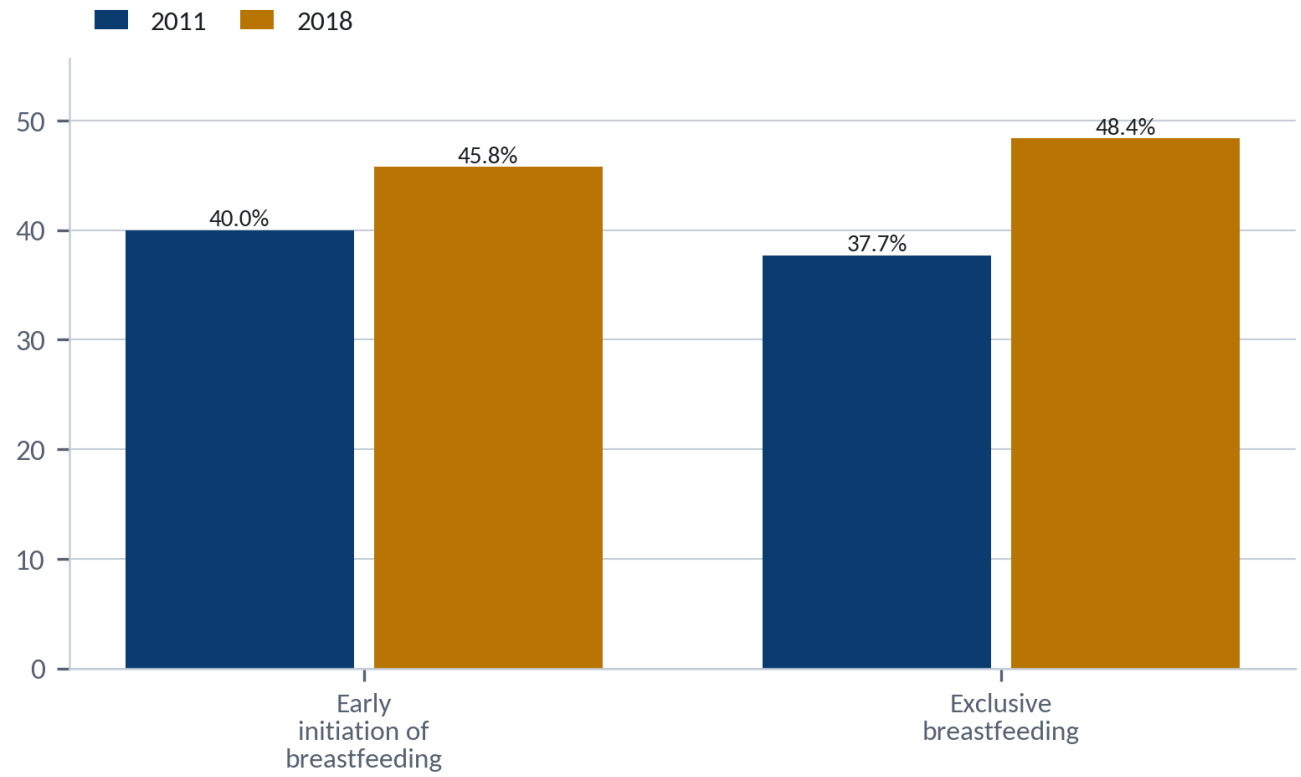
7. Feeding practices improved, but complementary diets remain a binding constraint

Breastfeeding is one area where behavioural indicators moved in the desired direction. NNS reporting shows early initiation increasing from about 40.0 percent in 2011 to 45.8 percent in 2018, and exclusive breastfeeding from about 37.7 to 48.4 percent. These changes are consistent with long running IYCF policy, counselling and communication efforts, but they remain multicausal and should not be attributed to UNICEF alone (Government of Pakistan and UNICEF 2019).

Complementary feeding is more concerning. The 2018 nutrition evidence showed very low dietary adequacy for young children. Counselling alone cannot solve a food affordability problem. When diverse foods are unavailable, unaffordable or constrained by household allocation and women's time, SBC must be accompanied by social protection, food system, market and maternal health measures. This is one of the strongest reasons for integrating nutrition with wider PHC and social protection platforms.

The implication is that future IYCF monitoring should separate knowledge from capability. A mother may know the recommended practice and still be unable to implement it because of household economics, workload, social norms or service access. Programme design should therefore measure constraints along the full behavioural pathway rather than interpret low practice as an information deficit.

Figure 5 **Breastfeeding indicators in Pakistan, 2011 and 2018**



Source: Government of Pakistan and UNICEF (2019), National Nutrition Survey 2018, and comparable 2011 survey values.

8. Equity is now the central test of system effectiveness

Progress at national level increasingly coexists with concentrated disadvantage. The same families may experience multiple forms of exclusion: a child can be zero dose, malnourished, living far from a functional facility, exposed to poor WASH, and dependent on irregular household income. This clustering means that separate sector targeting systems can repeatedly miss the same household unless data and outreach are deliberately integrated.

Equity should therefore be measured through absolute gaps, not only national averages. Provincial variation, rural and urban differences, wealth, maternal education, disability, displacement, security and informal settlement status all influence effective access. In immunization, urban slum studies demonstrate that city averages can conceal serious pockets of under vaccination. In nutrition, provincial and wealth differences persist even where national indicators move. The decision question for 2026 to 2030 should be: which children remain unreached across multiple services, and what local system failure explains their exclusion?

This leads to a practical proposition: the zero dose child can serve as a sentinel for broader PHC and social exclusion. Where feasible, UNICEF and government could test whether households with zero dose children also have lower access to maternal nutrition, growth monitoring, birth registration, social protection, safe water and early learning. Such convergence analysis would make equity targeting more operational and less sector specific.

Part III: What Did UNICEF Contribute?

IN THIS PART

9. Immunization systems: substantial but shared contribution

10. CMAM: strong treatment system contribution, weak evidence for prevalence impact

11. Nutrition evidence systems: one of the strongest system contributions

12. Maternal nutrition and the first 1,000 days

13. Benazir Nashonuma: a catalytic convergence case

14. Humanitarian continuity: substantial service contribution, uncertain durability

9. Immunization systems: substantial but shared contribution

The evidence supports a Grade B judgement for UNICEF's contribution to routine immunization system strengthening. The claim is not that UNICEF caused the rise in DTP3 coverage. Rather, UNICEF has been a sustained partner in vaccine and supply systems, cold chain support, microplanning, communication, monitoring, equity targeting and emergency continuity, operating within government EPI architecture alongside WHO, Gavi, the World Bank and other partners. The evidence is firmer for supply, microplanning, communication and equity targeting than for cold chain support specifically. Government plans document the system investment, but UNICEF's own procurement or technical role in cold chain functionality has not yet been pinned to a source, so that element is graded B/C within the wider Grade B judgement.

WUENIC provides independent/harmonized evidence that coverage changed; government plans and programme records establish the system context; UNICEF documentation identifies its functions. The causal mechanism is plausible and well established: vaccines and cold chain systems enable supply; microplans and outreach enable physical access; community engagement supports demand; data permit follow up; and government financing and management determine recurrence. Because these components are jointly produced, attribution must remain shared.

The sustainability question is more demanding than whether equipment was installed or campaigns were conducted. A mature immunization system requires recurrent financing, functioning cold chain, trained vaccinators, reliable transport, quality data, supervision and local accountability. Future contribution claims should therefore track the continued performance of UNICEF supported system assets rather than the value of the original investment alone.

10. CMAM: strong treatment system contribution, weak evidence for prevalence impact

CMAM is one of the clearest examples of why the level of claim matters. UNICEF's formal evaluation of CMAM in Pakistan supports a substantial contribution to treatment system development: technical standards, commodities, training, screening, referral and integration into government and humanitarian responses. The evaluation also explicitly cautions that programme coverage estimates were inconclusive without dedicated coverage surveys, which limits population inference (UNICEF Evaluation Office 2012:32).

The correct conclusion is therefore two part. UNICEF has substantial evidence of contribution to the capacity to identify and treat severe acute malnutrition. At the same time, national wasting prevalence worsened across NNS rounds. Treatment system expansion cannot be presented as evidence that the underlying incidence or prevalence of wasting declined. The persistence of wasting indicates that prevention, maternal nutrition, infection control, food access and household resilience remained inadequate relative to need.

This distinction should guide future measurement. Programme dashboards should report both treatment performance and the population context: admissions, cure and default rates, coverage, relapse where available, local wasting prevalence, seasonal food insecurity and shocks. A treatment system is successful when it saves children who are acutely malnourished; a nutrition system is successful when fewer children become acutely malnourished in the first place.

11. Nutrition evidence systems: one of the strongest system contributions

UNICEF's contribution to nutrition evidence and information systems receives one of the strongest grades in this volume (A/B). The National Nutrition Survey 2018 was a government led national evidence product developed with UNICEF support, and its district representative design materially improved the ability of government and partners to understand geographic variation. SMART surveys, nutrition information systems and IPC related evidence have further supported emergency and subnational decision making.

This is a system contribution rather than a direct child outcome, but it has strategic significance. Reliable evidence shapes targeting, resource allocation, programme design and accountability. It also enables independent scrutiny: the same NNS data that document programme need also show that wasting worsened and stunting remained high. A credible evidence system should make disappointing results visible as readily as achievements.

The next frontier is interoperability and longitudinal usability. Nutrition, EPI, maternal health, social protection and crisis data are often produced through separate systems. Linking exposure and outcome data at district or facility level, while protecting privacy, would allow government and partners to test whether convergence actually improves effective coverage and child outcomes.

12. Maternal nutrition and the first 1,000 days

The Pakistan Maternal Nutrition Strategy 2022 to 2027 provides unusually clear evidence of UNICEF's technical role. The strategy acknowledges joint development and supervision by the Government's Nutrition Wing and UNICEF, and provincial implementation arrangements identify UNICEF among stakeholders. This supports a B/C contribution judgement for technical codevelopment and system architecture rather than a claim of population impact (Government of Pakistan and UNICEF 2022:6, 89, 90).

Maternal nutrition is central to the survive and thrive continuum because low maternal weight, anaemia, poor diet and inadequate antenatal nutrition contribute to low birthweight, prematurity and early childhood growth failure. The persistence of anaemia and poor diets shows that a strategy document is only an enabling condition. Its value depends on commodity availability, antenatal counselling, IFA adherence, social protection, food affordability, frontline workload and provincial financing.

For 2026 to 2030, maternal nutrition should be measured as a service quality and implementation problem rather than only a policy milestone. A credible results chain would track whether targeted women were identified, received recommended interventions, adhered to them, completed referral where needed and achieved improved maternal or newborn outcomes.

13. Benazir Nashonuma: a catalytic convergence case

Benazir Nashonuma illustrates a different form of contribution: nutrition integrated into a national social protection platform. UNICEF reporting indicates partnership with WFP to help scale nutrition responsive social protection, while later process evaluation material identifies UNICEF as a key SBC implementing partner (UNICEF Pakistan 2022; Benazir Income Support Programme 2026). The programme is owned and led by BISP and the Government of Pakistan; UNICEF's contribution should therefore be described narrowly as a technical and behavioural component within a shared national platform.

Its strategic importance goes beyond direct programme reach. Pakistan's nutrition constraints are partly economic, and household counselling has limited effect when families cannot afford adequate diets or absorb shocks. Linking nutrition, maternal services and conditional support within a social protection system creates a pathway to address demand- and income side barriers together. It is a promising example of catalytic contribution because the relevant institutional platform is larger and more durable than a standalone UNICEF project.

The evaluative question is now whether integration improves outcomes and equity, not merely whether the platform expanded. Future analysis should examine participation, service uptake, maternal nutrition, infant feeding, child growth and differential effects by province and poverty level, with explicit attribution shared among BISP, WFP, UNICEF and health system actors.

14. Humanitarian continuity: substantial service contribution, uncertain durability

Pakistan's 25 year history includes the 2005 earthquake, conflict related displacement, the 2010 floods, drought, COVID-19, the 2022 floods and subsequent climate related emergencies. UNICEF repeatedly supported vaccination, nutrition screening and treatment, supplies, mobile/outreach services, sector coordination and continuity of essential services. The 2023 consolidated emergency report, for example, documents nutrition sector coleadership and very large screening and SAM treatment volumes (UNICEF Pakistan 2024:23).

The appropriate claim is a substantial humanitarian service and coordination contribution, not long term impact. Emergency reach measures whether urgent services were delivered in a crisis; resilience measures whether systems restored routine service quickly, rebuilt more durably, maintained staff and supply chains, and were better prepared for the next shock. These outcomes require different evidence.

The future programme should therefore add recovery metrics to humanitarian monitoring: duration of service interruption, time to reopen facilities, restoration of cold chain function, recovery of vaccination and nutrition coverage, retention of trained staff, and functionality six or twelve months after reconstruction. This would make the humanitarian development nexus measurable rather than rhetorical.

Part IV: Attribution, Alternative Explanations and Sustainability

IN THIS PART

15. Government leadership is the principal causal platform

16. Other partners materially shape the same outcomes

17. Demography, economics, WASH and women's status are major confounders, and causal drivers

18. Sustainability: what appears embedded and what remains fragile

15. Government leadership is the principal causal platform

Pakistan's health and nutrition outcomes are fundamentally produced through government institutions, households and pluralistic service markets. Federal ministries, provincial health departments, EPI, district administrations, BISP, LHW programmes, public facilities, private providers and local government all shape effective coverage. UNICEF's most credible long run contribution claims are therefore those in which it strengthened or influenced a government platform rather than substituting for it.

Devolution after the 18th Constitutional Amendment increased the importance of provincial implementation capacity and created divergent trajectories. National policy coherence may coexist with uneven financing, workforce, data quality and service management. A single national contribution grade can therefore conceal important provincial variation. Consolidated reporting should progressively move toward province specific evidence, especially for immunization, newborn quality and nutrition service integration.

Government adoption is not, by itself, sustainability. A policy or guideline is sustained only when budgets, staff, commodities, supervision, information systems and accountability continue. Future institutional reporting should distinguish formal adoption from operational institutionalization.

16. Other partners materially shape the same outcomes

The health and nutrition sectors are characterized by dense partnership. WHO, Gavi, the World Bank, WFP, bilateral donors, NGOs, foundations and the Global Polio Eradication Initiative have financed, designed or implemented major elements of immunization, nutrition, disease control, social protection and emergency response. In some areas, particularly polio, immunization financing and Nashonuma, joint attribution is not a caveat but the correct description of how results are produced. The World Bank's National Immunization Support Project, for example, documents external financing of the immunization system alongside government and Gavi support (World Bank 2022).

This has two implications. First, UNICEF should avoid claims that erase partner contributions. Second, contribution analysis should not become so cautious that it fails to identify UNICEF's distinctive functions. The relevant question is often not 'who produced the outcome?' but 'what function did UNICEF perform that was necessary or catalytic within the wider system?' Communication, procurement, technical standards, evidence, convening, community engagement and child equity framing can be consequential even where financing or infrastructure is supplied by others.

A future cross partner contribution map would improve accountability by showing which organization primarily financed, supplied, advised, implemented, monitored or mobilized demand for each major pathway. Such a map would also expose duplication and gaps.

17. Demography, economics, WASH and women's status are major confounders, and causal drivers

Population growth changes the interpretation of rates. A declining mortality rate can coexist with a very large absolute number of child deaths, while rising vaccination coverage requires vaccinating an expanding cohort. Likewise, national nutrition prevalence can remain high even as services expand because the number of vulnerable children grows and underlying determinants change slowly.

Household income, food prices, urbanization, female education, fertility, birth spacing, WASH access and private health care all influence survival and nutrition. These factors are not statistical noise; they are part of the causal system. A contribution assessment should therefore avoid models that 'control away' important mechanisms without interpretation. The purpose of alternative explanation analysis is to understand how UNICEF supported pathways interact with these determinants, not to isolate an artificial agency only effect.

Cross sector convergence is especially relevant. Improvements in vaccination, sanitation, maternal education, birth spacing and nutrition can reinforce one another. Future analysis should test convergence packages where data allow, because the most meaningful child outcome may arise from combined exposure rather than one programme line.

18. Sustainability: what appears embedded and what remains fragile

Table 4

1. Sustainability: what appears embedded and what remains fragile

System/pathway	Sustainability assessment	Interpretation
Routine immunization systems	Moderate to High	Government EPI, recurrent systems and partner architecture are institutionalized, but coverage can reverse under shocks and local management weakness.
Zero dose targeting	Moderate	Equity focus is increasingly embedded, but depends on high quality local data, outreach capacity and repeated follow up.
CMAM/SAM treatment	Moderate	Treatment architecture is well established but remains commodity-, emergency- and financing sensitive in many settings.
Nutrition evidence systems	High	National survey and information functions are institutionalized, though periodicity and interoperability need strengthening.
Maternal nutrition strategy	Emerging	Policy architecture exists; implementation, commodity continuity and outcome measurement remain incomplete.
Benazir Nashonuma	High/ongoing	Embedded in a national social protection platform; impact and service integration quality need continued evaluation.
Humanitarian continuity	Variable	Strong surge capacity, but durable recovery depends on local system financing and preparedness.
Newborn quality improvement	Moderate/fragile	Strategic priority is clear, but quality, referral and facility capability remain uneven.

Source: Author synthesis of the evidence reviewed in this report

Part V: Twenty-Five Years of Learning

IN THIS PART

19. What appears to have worked

20. Where results remain mixed

21. What could have been done differently

22. Priorities for 2026 to 2030

23. A proposed Survive & Thrive measurement compact

19. What appears to have worked

The long run evidence suggests that UNICEF has been most effective where it has combined technical standards with a delivery platform rather than treating either as sufficient. Vaccine supply without outreach misses children; communication without service availability disappoints demand; CMAM protocols without commodities do not treat; maternal nutrition strategies without frontline implementation do not improve diets; and data without management routines do not change decisions. Successful pathways connect these functions.

A second lesson is the value of government joint ownership. Nutrition evidence systems, immunization architecture, maternal nutrition strategy and nutrition sensitive social protection are more institutionally significant than temporary parallel projects because they can persist beyond a specific grant. UNICEF's catalytic value is greatest where a model, standard or analytical function is absorbed into a larger national or provincial platform.

Third, crises have repeatedly tested and expanded system capability. Humanitarian operations built coordination, supply and outreach functions that later influenced routine practice. But emergency intensity can also create parallel systems. The learning challenge is to identify which emergency capabilities, microplanning, mobile outreach, rapid data review, community networks, should be retained in routine PHC and which are too costly or burdensome for normal operations.

20. Where results remain mixed

The most consequential mixed result is nutrition. Pakistan built a substantial acute malnutrition treatment system while wasting worsened at population level. Stunting remained extremely high despite multisector strategies. This is not evidence that treatment or policy work had no value; it is evidence that the causal package was incomplete or insufficiently implemented relative to the magnitude of structural drivers.

Newborn survival is another area where progress has been slower than for older children. Service use indicators improved over time, but effective care, referral and maternal nutrition remain binding constraints. Future strategies should avoid interpreting facility contact as a proxy for quality.

Immunization illustrates the fragility of high coverage. The national trajectory improved, yet zero dose children remain clustered and polio transmission has repeatedly demonstrated the consequences of inaccessible or distrustful communities. Sustained performance requires local management and trust, not only national supply and campaign intensity.

Across the portfolio, evidence quality itself is uneven. UNICEF and government can often report outputs, but public data rarely link a specific programme exposure to later outcomes at district, facility or household level. This makes long run learning harder than it needs to be.

21. What could have been done differently

The public record suggests that programme monitoring could have been designed more deliberately for eventual contribution assessment. Major investments should have retained consistent geographic exposure records, start dates, intensity, implementation partners and comparable outcome measures. Without these fields, later evaluators can reconstruct a credible theory of contribution but rarely estimate differential effects.

Nutrition programming could have placed greater analytical emphasis on prevention and household constraints alongside treatment scale. Treatment admissions are essential accountability indicators, but rising admissions can mean greater access, greater incidence or both. Prevention requires stronger linkage to maternal health, social protection, food affordability, WASH and women's agency, with common outcomes and joint accountability.

Health programming could have moved earlier from coverage toward effective coverage. Cold chain expansion, institutional delivery and vaccination contacts are necessary, but the ultimate question is whether children received complete, timely and high quality protection and care. Quality, completion and equity metrics should have been given the same institutional weight as reach.

Finally, partner contribution should have been documented more explicitly. Joint programming is a strength, but institutional reporting often alternates between collective language and organization specific results. A shared results map would allow each partner to describe its contribution accurately without overstating ownership.

22. Priorities for 2026 to 2030

1. **Put newborn effective care at the centre of the survival agenda.** Track quality of intrapartum/newborn care, referral completion, early breastfeeding, postnatal follow up and maternal nutrition, not only institutional delivery.
2. **Manage immunization through zero dose and dropout reduction.** Use local target denominator quality, geocoded catchments, missed child lists, outreach completion and differentiated urban/rural strategies.
3. **Treat wasting as a prevention and treatment accountability problem.** Protect CMAM quality and coverage while measuring drivers of new cases, relapse, seasonality and links to maternal nutrition and food insecurity.
4. **Make maternal nutrition and affordable young child diets operational.** Move from policy adoption to commodity availability, adherence, service integration and household affordability constraints.
5. **Institutionalize convergence with social protection.** Use Nashonuma and related platforms to test whether integrated cash, nutrition, health and SBC pathways improve effective service uptake and outcomes.
6. **Build shock resilient PHC and nutrition systems.** Measure disruption depth, time to recovery, supply continuity, workforce retention and functionality after emergency investments.
7. **Establish a prospective contribution evidence architecture.** For major UNICEF supported pathways, record geography, timing, intensity, financing, partner roles and outcome measures so future evaluation is designed in rather than reconstructed later.
8. **Report uncertainty and counter evidence as management information.** Maintain contribution grades, alternative explanations and mixed results in executive reporting; do not reserve limitations for annexes.

Action matrix by time horizon

The matrix translates the eight priorities into sequenced actions. The final column gives the contribution grade attached to the underlying pathway so that readers can judge how much evidence supports each action. Time horizons are indicative and depend on provincial budget cycles and the next UNICEF country programme.

Table 5 Action matrix by time horizon

Priority	Lead actors	Immediate (next 12 months)	Medium term (1 to 3 years)	Longer term (3 to 5 years)	Evidence grade
1. Newborn effective care	Provincial health departments; UNICEF; WHO	Agree minimum quality indicators: referral completion, early breastfeeding, postnatal contact	Build the indicators into facility supervision and district reviews	Report newborn effective coverage next to institutional delivery	C/B

Priority	Lead actors	Immediate (next 12 months)	Medium term (1 to 3 years)	Longer term (3 to 5 years)	Evidence grade
2. Zero dose and dropout	Federal and provincial EPI; UNICEF; WHO; Gavi	Validate target denominators and compile missed child lists in priority districts	Geocoded catchments, outreach completion tracking, separate urban and rural strategies	Sustain recurrent financing and verify cold chain functionality	B
3. Wasting prevention and treatment	Nutrition Wing; provincial nutrition units; UNICEF; WFP	Protect CMAM commodities and run dedicated coverage surveys	Link treatment data to local wasting prevalence, seasonality and maternal nutrition	Test whether integrated prevention reduces new cases	B system; D/C prevalence
4. Maternal nutrition and young child diets	Federal Nutrition Wing; provincial health departments; UNICEF	Track IFA availability and adherence in provincial implementation plans	Join counselling to social protection contacts and analyse diet affordability	Measure maternal and newborn outcomes	B/C
5. Social protection convergence	BISP; WFP; UNICEF; health departments	Agree a shared results map of each partner's function in Nashonuma	Test service uptake by province and poverty level	Evaluate child growth and equity effects	B
6. Shock resilient PHC and nutrition	Provincial disaster management and health authorities; UNICEF	Add recovery metrics: interruption length, time to reopen, cold chain restoration	Preagree continuity protocols and surge staffing	Check functionality six and twelve months after reconstruction	B for service; durability variable
7. Prospective contribution evidence	UNICEF country office; government planning bodies	Fix exposure registry fields: geography, start date, intensity, partner, financing	Apply them to every major pathway in the next country programme	Commission prospective evaluations with comparison designs	Design decision
8. Report uncertainty	UNICEF management; partners	Include grades and counter evidence in executive reporting	Review grades annually against new evidence	Publish revised contribution judgements	Not applicable

Source: Author synthesis of the evidence reviewed in this report

23. A proposed Survive & Thrive measurement compact

Table 6

1. A proposed Survive & Thrive measurement compact

Measurement domain	Minimum common indicators / metadata
Population outcomes	under five mortality; neonatal mortality; wasting; stunting; low birthweight where robust; inequality gaps.
Effective immunization	DTP3/MCV2 coverage; zero dose; dropout; timeliness; verified cold chain functionality; outreach completion.
Newborn effective coverage	Skilled attendance plus selected quality standards; referral completion; postnatal contact; early breastfeeding.
Nutrition effective coverage	SAM treatment coverage and outcomes; maternal IFA coverage/adherence; breastfeeding; complementary diet; relapse/seasonality where feasible.
Equity	Province/district, rural urban, wealth, maternal education, informal settlement, displacement/security and disability where data allow.
System resilience	Stock out days; cold chain downtime; service interruption; time to recovery after shock; workforce availability.
Programme exposure	Geography, start/end date, intensity, partner, financing, target group and implementation fidelity for each major UNICEF supported pathway.
Contribution evidence	Independent outcome source, mechanism evidence, alternative explanations, sustainability indicator and planned evaluation design.

Source: Author synthesis of the evidence reviewed in this report

Conclusion

Pakistan's 2000 to 2025 survive and thrive record is neither a simple success story nor a story of programme failure. Child mortality fell substantially, routine immunization recovered to high national coverage, and treatment and information systems became more capable. At the same time, neonatal mortality declined too slowly, zero dose exclusion remains concentrated, stunting stayed extremely high, wasting worsened in the last comparable national nutrition series, and crisis exposure repeatedly disrupted services.

Within this mixed national record, the public evidence supports a credible account of UNICEF contribution. The strongest claims concern systems, treatment capacity, evidence, technical standards, community engagement, policy architecture, social protection convergence and humanitarian continuity. These are material contributions, but they are mostly produced jointly with government and development partners. The evidence does not support assigning UNICEF an independent share of Pakistan's national mortality or nutrition trends.

That conclusion should be seen as a strength of the assessment rather than a limitation of UNICEF's role. Institutions that work through national systems should expect their impact to be shared and mediated. The appropriate accountability question is whether UNICEF performed functions that were technically sound, timely, sufficiently scaled, institutionalized and equitable, and whether those functions strengthened the ability of Pakistan's systems to protect children after direct support receded.

The central lesson for 2026 to 2030 is to move from reach to effective coverage and from retrospective narratives to prospective evidence. If programme exposure, partner roles, quality and outcomes are recorded in a common longitudinal architecture, future reviews will be able to say not only that systems were supported, but where, for whom, through which mechanism, with what durability and with what measurable contribution to children surviving and thriving.

Annex A: Contribution grading and external use rules

Table 7 Annex A: Contribution grading and external use rules

Grade	Interpretation
Grade A, Strong contribution evidence	Independent or formal evaluation/system evidence demonstrates UNICEF contribution to the specified result with strong mechanism, role and corroboration. Do not extend beyond the evaluated result.
Grade B, Substantial contribution evidence	UNICEF role is well documented and consistent with observed system/service change, with meaningful corroboration; result is usually shared with government/partners.
Grade C, Plausible contribution	Timing and mechanism fit, but scale, exposure, independent corroboration or alternative explanation control are insufficient for a stronger judgement.
Grade D, Activity documented, contribution uncertain	UNICEF activity is established but outcome linkage is weak or population evidence is contrary/insufficient.
Grade E, Mixed or contrary evidence	Observed outcomes are stagnant/adverse or evidence contradicts the proposed contribution; investigate rather than suppress the divergence.

Source: Author synthesis of the evidence reviewed in this report

External use rule: a population trend and a UNICEF contribution claim require separate evidence. A Grade A or B claim is publication ready only when the original evidence can be pinned to an exact page, table or named section and UNICEF's role is evidenced separately from the outcome trend.

Status of the verification gate. Of the 44 Tier 1 claims in the cross series ledger, 22 have cleared the external use gate with calibrated wording, 11 are conditional on pinning the exact source location, and 11 are on hold for source pinning or grade review. Claims on hold are presented in this volume as plausible or contextual findings. Cold chain support is

graded B/C, and maternal and neonatal tetanus elimination and health financing are not used as headline findings. The polio statement relies on 2025 case counts reported in January 2026 and awaits pinning to the Global Polio Eradication Initiative record.

Annex B: Core source register

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World Bank. 2022. National Immunization Support Project: Project Documentation. Washington, DC: World Bank. Retrieved August 26, 2026. https://documents1.worldbank.org/curated/en/099193502072336360/pdf/P1323080192a2602e0812f0a7227639d75e.pdf

Annex C: Relationship to supporting technical evidence

Detailed technical evidence studies, analytical files and source level verification materials are maintained as supporting documentation and are available on request.

The cross series Master Claim to Evidence to Contribution Ledger provides the audit trail for headline findings and identifies whether each Tier 1 claim is exact source pinned, section pinned, conditional, held for grade review or still pending verification. Where this volume uses a claim that remains conditional, the text is deliberately qualified and avoids presenting it as a definitive impact finding.

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Ahmad Nadeem is a development professional with 25 years' experience in programme implementation, communication, resource mobilization, research and AI integration. He has led donor funded projects, helped organizations secure funding and advised on implementation. His work has involved the World Bank, European Commission, ILO, UNICEF, UNDP, UN Women, OHCHR, USIP, GCF, KfW, Government of Italy and the Canadian High Commission. At the Pakistan Poverty Alleviation Fund and the Pakistan Centre for Philanthropy, he engaged, advised and supervised a wide range of development sector organizations, including charities, microfinance institutions, private universities, NGOs and INGOs, and worked with government bodies such as the Federal Board of Revenue, NACTA and social welfare departments. He has also worked on projects involving parliamentarians, law enforcement agencies, the National Police Bureau, police training colleges and churches. He is visiting faculty at Quaid-e-Azam University and SZABIST, holds an MPhil (Gold Medal, Iqra University) and a certificate (LUMS, McGill), and leads CSADS and Manāra.

Centre for Social Analytics and Development Support (CSADS)

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CivicFrames

CivicFrames is a creative knowledge communication initiative founded by Danyal Nadeem, a student of media sciences and an aspiring storyteller. It translates credible research into accessible creative forms, bridging the gap between data and public understanding. It explores how evidence can reach people through music, poetry and stories. Danyal intends to learn how creative formats can help evidence travel. Within the Series, it helps make findings easier to understand and share. www.civicframes.org