# PAKISTAN

## DISEASE, POOR DIET, LIMITED HEALTH ACCESS AND CLIMATIC SHOCKS DRIVE ACUTE MALNUTRITION IN RURAL DISTRICTS

**IPC ACUTE MALNUTRITION ANALYSIS**
**OCTOBER 2025 – SEPTEMBER 2026**

*Published on 17 April 2026*

### KEY FIGURES — OCTOBER 2025 - SEPTEMBER 2026

**POPULATION IN NEED OF TREATMENT (45 DISTRICTS)**

**2.71M**

Cases of children aged 6-59 months acutely malnourished

IN NEED OF TREATMENT

| | |
|---|---|
| Severe Acute Malnutrition (SAM) | 706,000 |
| Moderate Acute Malnutrition (MAM) | 2M |

**1.4M**
CASES OF GIRLS

**1.3M**
CASES OF BOYS

**232,000**
Pregnant or breastfeeding women acutely malnourished

IN NEED OF TREATMENT

### PROVINCIAL DISAGGREGATION

| | Balochistan (19 districts) | Khyber Pakhtunkhwa (14 districts) | Sindh (12 districts) |
|---|---|---|---|
| Under-5 Global Acute Malnutrition (GAM) People in Need (PiN) | 420,000 | 1.1M | 1.2M |
| Pregnant or breastfeeding women GAM PiN | 47,000 | 67,000 | 118,000 |

## Overview

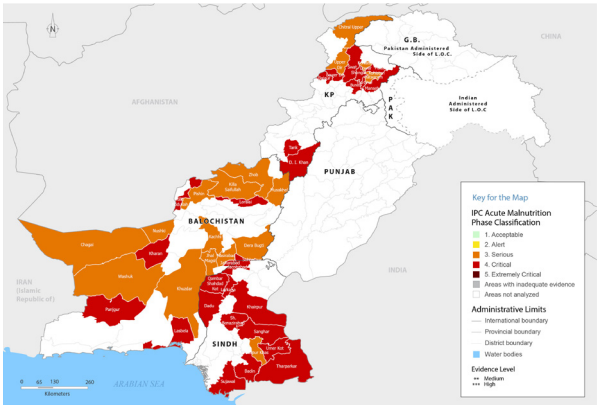
Rates of acute malnutrition for vulnerable populations are concerning across 45 rural districts in Pakistan's Balochistan, Khyber Pakhtunkhwa and Sindh provinces. The situation is driven primarily by seasonal diseases, inadequate feeding and caring practices, poor child dietary diversity, limited access to health services and recurrent natural shocks.

Over 2.71 million cases of children aged 6-59 months are currently suffering from acute malnutrition—conditions expected to persist through September 2026. This includes around 706,000 cases of children suffering from SAM, and around 2 million children suffering from MAM. Approximately 232,000 cases of pregnant and breastfeeding women (PBW) suffering from acute malnutrition are expected during the same period. Sindh province records the highest number of malnourished children with 1.18 million (44 percent of the total population), followed by Khyber Pakhtunkhwa with 1.11 million (41 percent) and Balochistan with 420,000 (15 percent).

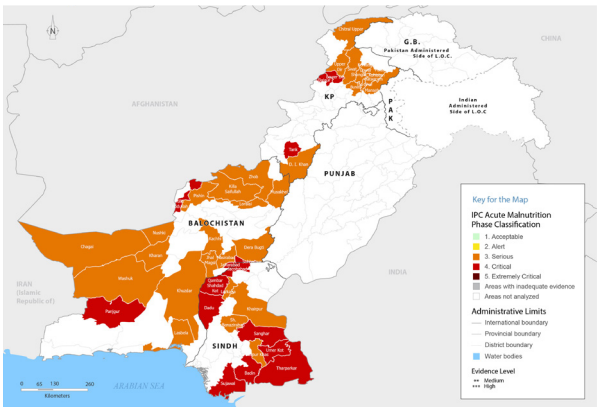
There are currently 28 districts (out of the 45 analysed) classified in IPC Acute Malnutrition (AMN) Phase 4 (Critical). In these areas,

*Disclaimer: analysis was conducted prior to the Middle East crisis, therefore, post-crisis impacts are not factored into this analysis.*

## Current Situation: October 2025 – March 2026




## Projected Situation: April - September 2026




## Contributing Factors

### Seasonal diseases

Seasonal increases in malaria, diarrhea, respiratory infections and other communicable diseases contribute to the deterioration of children's nutritional status.

### Nutrition program access

Significant cuts to nutrition programs over the past two years have reduced service coverage and compounded the impact of other drivers of acute malnutrition, limiting access to preventive and treatment services and contributing to elevated levels of AMN.

### Inadequate caring and feeding practices

Inadequate feeding and breastfeeding practices are a key driver of poor nutritional outcomes among children.

### Food insecurity and child diet diversity

Household food insecurity, compounded by inadequate utilisation and poor child dietary diversity, is a key driver of child malnutrition.

acute malnutrition among children is characterised by widespread wasting, as well as death from preventable diseases. Urgent response actions are needed, including supplementary feeding in the most affected areas to protect children and PBW from acute malnutrition. There are 17 districts in IPC AMN Phase 3 (Serious). Children and PBW in Phase 3 are facing elevated levels of acute malnutrition, characterised by a high vulnerability to diseases. Urgent response actions, including treatment of acute malnutrition, promotion of improved feeding practices and better access to health services are recommended to prevent more widespread and more severe forms of malnutrition.

The Sindh province presents the most critical situation with 11 out of 12 districts classified in Phase 4. In Khyber Pakhtunkhwa, 10 out of 14 districts are in Phase 4, while in Balochistan, 7 out of 19 districts are in Phase 4.

During the projected period (April–September 2026), a slight improvement in the nutrition situation is expected, particularly in districts affected by harsh winters and limited access to health services in the current period. The AMN classification of 16 districts is projected to remain in Phase 4, while 12 districts are expected to improve from Phase 4 to Phase 3. The 17 districts currently classified in Phase 3 are projected to remain there during the projection period. Theimprovement is also linked to the expected decline in disease prevalence, including malaria, which contributed to high GAM rates in several districts of Khyber Pakhtunkhwa and Sindh during the current period.

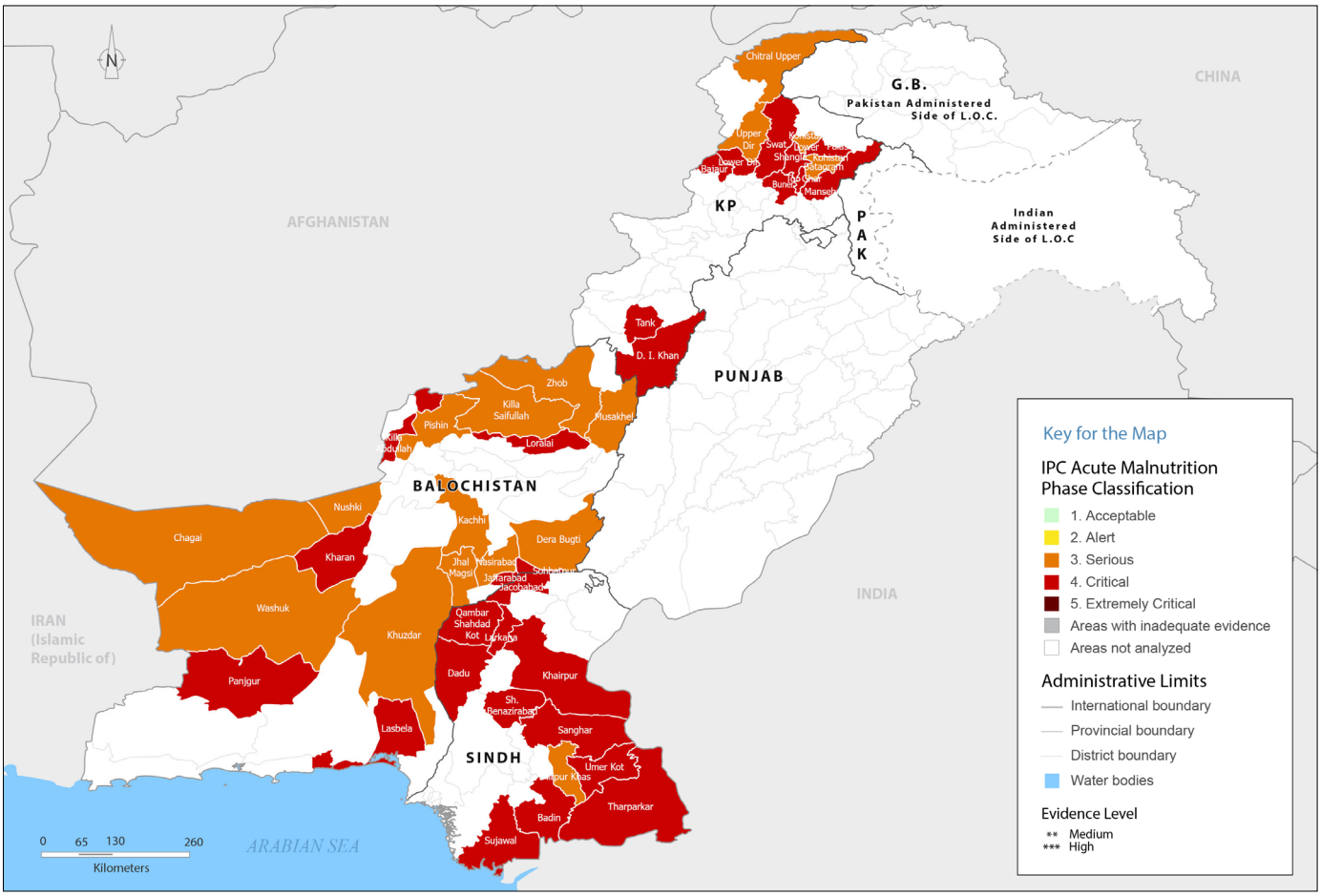
The main drivers of AMN include high disease prevalence, poor infant and young child feeding (IYCF) practices, and poor child dietary diversity, as well as natural disasters or shocks. Seasonal increases in malaria, diarrhea, acute respiratory infections and measles have significantly affected children's health and nutritional status. Poor IYCF and dietary diversity lead to inadequate nutrient intake and increase vulnerability to malnutrition. Recurrent shocks, including floods and droughts, disrupt livelihoods, food access and health service utilization, further increasing the risk of malnutrition.

The analysis of interlinkages between IPC Acute Food Insecurity (AFI) and IPC AMN across the 45 districts shows that the nutrition situation is more severe than the food security situation. Most of the districts classified in IPC AMN Phase 4 (Critical) are also in IPC AFI Phase 3 (Crisis), indicating that limited household food access is an important contributing factor to acute malnutrition. This is further reflected in poor dietary diversity among children, which contributes to inadequate nutrient intake and worsens nutrition outcomes. Additionally, high prevalence of diseases such as malaria likely contributed to higher levels of SAM in the analysed districts.

Compared to the IPC AMN analysis conducted in 2023–2024, the analysis for 2025-2026 shows a 27 percent increase in the total number of GAM cases among children (2.14 million cases of children aged 6-59 months acutely malnourished between March 2023 and January 2024). However, the 2023-2024 analysis covered 32 districts with a population of approximately 29 million, whereas the IPC 2025-2026 analysis covers 45 districts with an estimated population of around 36 million, resulting in a higher overall caseload.

Comparison with the previous IPC AMN analysis is limited to 20 districts due to differences in district coverage and reference periods, and is not feasible for Khyber Pakhtunkhwa. Within the comparable districts, Sindh remains largely unchanged with most areas in Phase 4, despite slight GAM improvements, while Balochistan shows improvement, likely linked to recovery from the 2022-2023 floods.

# ACUTE MALNUTRITION CURRENT SITUATION MAP AND OVERVIEW (OCTOBER 2025 – MARCH 2026)




## Current situation overview (October 2025 - March 2026)

The recent Food Security and Livelihood Assessment (FSLA) included an exhaustive nutrition module covering 44 districts during the period of October to December 2025, with an additional SMART survey conducted in December 2025 in Buner District in Khyber Pakhtunkhwa. The FSLA findings indicate a severe acute malnutrition situation in the current period. A total of 28 districts are facing IPC AMN Phase 4 (Critical) with a GAM prevalence of 15-29.9 percent, and 17 districts are experiencing IPC AMN Phase 3 (Serious) with a GAM prevalence of 10-14.9 percent.

The main drivers of acute malnutrition include seasonal diseases, limited coverage of nutrition programs, inadequate caring and feeding practices, and poor water, sanitation and hygiene conditions. In 2023–2024, high levels of malnutrition in Sindh and Balochistan were largely associated with the impacts of the 2022 floods. In the current analysis, the 2025 floods in Khyber Pakhtunkhwa, together with a high incidence of seasonal diseases, have contributed to elevated levels of acute malnutrition, alongside persistent challenges related to inadequate caring and feeding practices and poor child dietary diversity.

### Sindh province

- 11 out of 12 districts are classified in Phase 4, namely Khairpur, Larkana, Shaheed Benazir Abad, Badin, Dadu, Jacobabad, Qambar Shahdad Kot, Sanghar, Sujawal, Tharparkar, Umer Kot. Whereas Mirpur Khas District is classified in Phase 3.
- These 12 districts analysed in Sindh province represent almost 1.2 million cases (44 percent of the total cases) of children under five who are acutely malnourished and almost 118,000 cases (51 percent of the total cases) of pregnant and breastfeeding women acutely malnourished and in need of treatment during the period of October 2025 to September 2026. In Sindh, the IPC AMN phase classification remains unchanged; however, GAM prevalence has improved across districts within IPC AMN Phase 4 compared to the previous IPC AMN analysis conducted in 2023-2024. The main drivers of acute malnutrition include seasonal diseases, limited coverage of nutrition programs, poor WASH conditions, and

inadequate caring and feeding practices. Sindh continues to show consistently high levels of acute malnutrition, as reflected in several surveys, including Multiple Indicator Cluster Survey (MICS), National Nutrition Survey (NNS), and the IPC AMN 2023-2024 analysis.

### Khyber Pakhtunkhwa province

- 10 out of 14 districts are classified in Phase 4, namely Buner, Dera Ismail Khan, Kolai Palas, Shangla, Swat, Torghar, Bajaur, Lower Dir, Mansehra and Tank. Four districts are classified in Phase 3: Battagram, Lower Kohistan, Upper Chitral and Upper Dir.
- The 14 districts analysed in Khyber Pakhtunkhwa Province represent almost 1.11 million cases (41 percent of the total cases) of children under five who are acutely malnourished and almost 67,000 cases (29 percent of the total cases) of PBW acutely malnourished and in need of treatment during the period of October 2025 to September 2026. In Khyber Pakhtunkhwa, the high incidence of seasonal diseases—particularly malaria—and the impacts of floods, are major drivers of elevated levels of acute malnutrition.

### Balochistan province

- 7 out of 19 districts are classified in Phase 4, namely Kharan, Lasbela, Loralai, Jaffarabad, Killa Abdullah, Panjgur and Sohbatpur. Additionally, 12 districts are classified in Phase 3: Chagai, Dera Bugti, Jhal Magsi, Kachhi, Khuzdar, Killa Saifullah, Musakhel, Nasirabad, Nushki, Pishin, Washuk and Zhob.
- The 19 districts analysed in Balochistan province represent almost 420,000 cases (15 percent of the total cases) of children under five who are acutely malnourished and almost 47,000 cases (20 percent of the total cases) of PBW cases acutely malnourished who need treatment during the period of October 2025 to September 2026. In Balochistan, the acute malnutrition situation has improved compared to the IPC AMN 2023–2024 analysis, when levels were elevated largely due to the impacts of the 2022 floods.

## Contributing factors

Nutritional service coverage in Pakistan remains limited, with the full community-based management of acute malnutrition (CMAM) package not available in many districts. In 2025, only 133,422 children with wasting received treatment across Sindh, Khyber Pakhtunkhwa, and Balochistan, representing about 26.6 percent coverage. Significant gaps persist in the 45 districts, particularly in Balochistan and Khyber Pakhtunkhwa, leaving many vulnerable children without access to essential nutrition services.

Food insecurity and poor dietary diversity are among the key drivers of the current acute malnutrition situation. According to the FSLA, the proportion of children aged 6-23 months receiving a Minimum Acceptable Diet (MAD) remains critically low, at 7.6 percent in Balochistan, 8.3 percent in Khyber Pakhtunkhwa, and 8.9 percent in Sindh, indicating that only a very small proportion of children receive both adequate dietary diversity and meal frequency. Minimum Dietary Diversity (MDD) is also limited, at 19.6 percent in Balochistan, 20 percent in KP, and 21.6 percent in Sindh, reflecting poor access to diverse and nutrient-rich foods. Similarly, more than half of children do not receive meals frequently enough to meet their nutritional requirements. Most analysed districts are classified in IPC AFI Phase 3 (Crisis), significantly constraining household access to adequate and nutritious food. These combined factors increase the risk and persistence of acute malnutrition.

Suboptimal breastfeeding practices continue to affect child nutrition outcomes. National surveys, including the Pakistan Demographic and Health Survey (PDHS), MICS and NNS, indicate that early initiation of breastfeeding remains below half of all births, while exclusive breastfeeding among infants under six months remains limited. In addition, the widespread practice of prelacteal feeding further undermines optimal breastfeeding practices and increases the risk of poor nutritional outcomes among young children.

Seasonal diseases remain a key driver of the current situation. Malaria cases have increased significantly, reaching around 40,000-45,000 reported cases in Khyber Pakhtunkhwa, with a similar trend observed in Sindh. In addition, cholera cases were reported in January 2026, with 456 cases in Balochistan, 103 in Khyber Pakhtunkhwa and 53 in Sindh. Seasonal increases in diarrhoea, acute respiratory infections, measles and other communicable diseases contribute to the deterioration of children nutritional status by reducing appetite, limiting nutrient absorption and increasing nutrient losses.

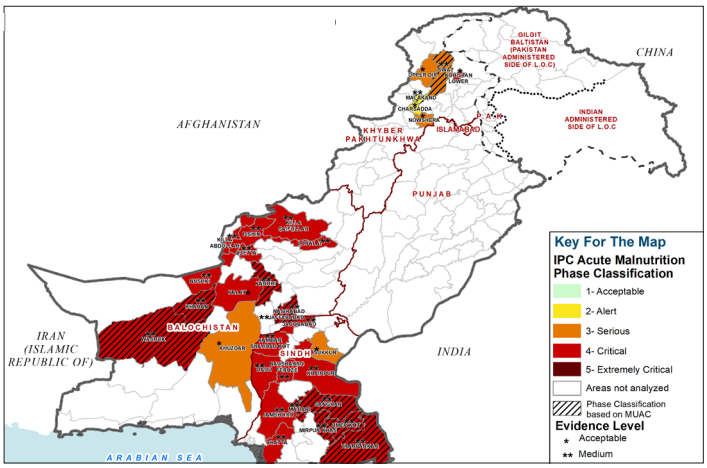
Pakistan remains highly exposed to recurrent floods and droughts, which continue to undermine nutrition outcomes in the analysed districts of Balochistan, Khyber Pakhtunkhwa and Sindh. Around 10 percent of households reported flood impacts, highest in Khyber Pakhtunkhwa, while drought affected 19 percent overall, particularly in Balochistan. These shocks reduce food and water availability, disrupt livelihoods and services, and increase disease risks, thereby contributing to acute malnutrition among children under five and PBW.

## Trend analysis

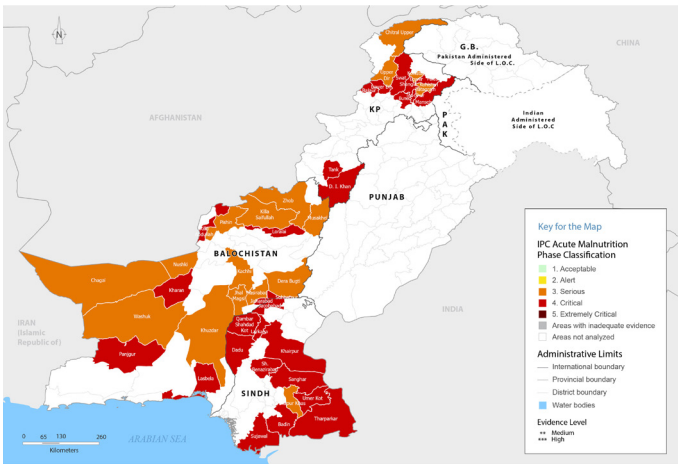
A direct comparison with the previous IPC AMN analysis is challenging because the district coverage and reference periods differ slightly. The comparison is limited to the 20 districts that were assessed in both periods.

- **Sindh Province**: The situation remains largely unchanged, with most assessed areas classified in IPC AMN Phase 4 (Critical). However, although the phase classification has not shifted, the GAM rate shows some improvements compared to the 2023–2024 IPC AMN analysis.
- **Balochistan Province:** Conditions seem to have improved more in 2025-2026 compared to 2023-2024. This improvement may be linked to the severe flooding that affected parts of the province in 2022-2023, which likely contributed to the earlier deterioration.
- **Khyber Pakhtunkhwa:** A comparison is not feasible due to differences in the districts assessed between 2023-2024 and

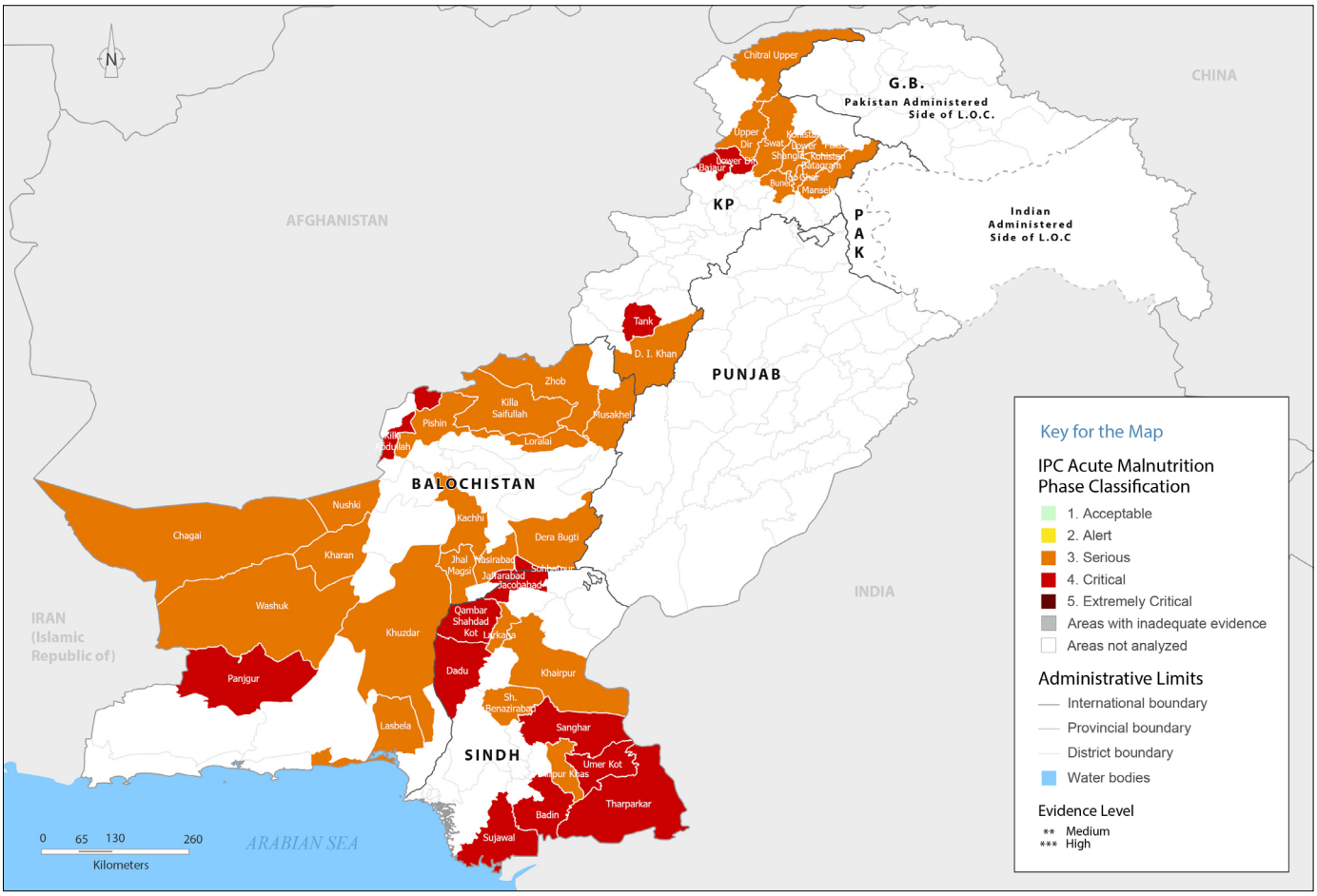
### October 2023 - January 2024




### October 2025 - March 2026



# ACUTE MALNUTRITION PROJECTED SITUATION MAP AND OVERVIEW (APRIL 2026 – SEPTEMBER 2026)




## Projected situation overview (April - September 2026)

Between April to September 2026, 15 districts will remain in IPC AMN Phase 4 (Critical). However, the situation is projected to improve with 12 districts projected to move from IPC AMN Phase 4 (Critical) to IPC AMN Phase 3 (Serious). Improvement is projected in Kharan, Lasbela and Loralai in Balochistan; Buner, Dera Ismail Khan, Kolai Palas, Shangla, Mansehra, Swat and Torghar in Khyber Pakhtunkhwa; Khairpur, Larkana and Shaheed Benizirabad in Sindh.

### Sindh province

- 8 out of 12 districts are projected to remain in Phase 4: Badin, Dadu, Jacobabad, Qambar Shahdad Kot, Sanghar, Sujawal, Tharparkar, Umer Kot. Three districts, Khairpur, Larkana and Shaheed Benazir Abad are projected to improve from Phase 4 to Phase 3, while Mirpur Khas is expected to remain in Phase 3.

### Khyber Pakhtunkhwa province

- 3 out of 14 districts are are projected to remain in Phase 4: Bajaur, Lower Dir, and Tank. Additionally, six districts: Buner, DI Khan, Kolai Palas, Shangla, Shangla, Mansehra, Swat and Torghar are projected to improve from Phase 4 to Phase 3. Battagram, Lower Kohistan, Upper Chitral and Upper Dir districts are projected to remain in Phase 3.

### Balochistan province

- 4 out of 19 districts are projected to remain in Phase 4: Jaffarabad, Killa Abdullah, Panjgur and Sohbatpur. Three districts, Kharan, Lasbela and Loralai are projected to improve from Phase 4 to Phase 3. The remaining districts, Chagai, Dera Bugti, Jhal Magsi, Kachhi, Khuzdar, Killa Saifullah, Musakhel, Nasirabad, Nushki, Pishin, Washuk and Zhob are expected to remain in Phase 3.

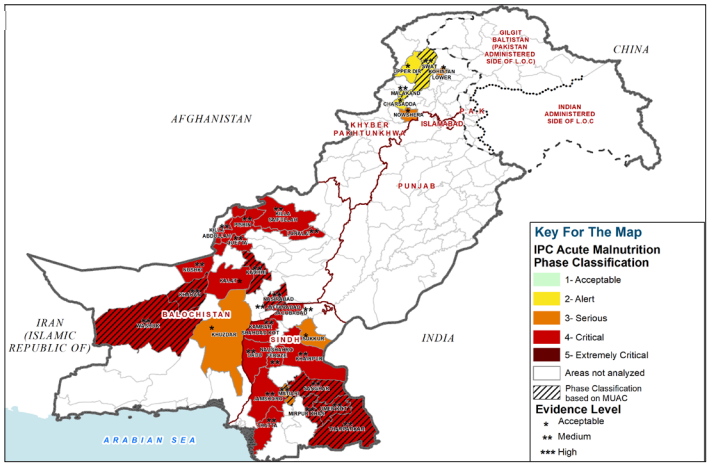
## Trends

A direct comparison with the previous IPC AMN analysis is challenging because the district coverage is not the same—only 20 districts are comparable. Among the the common districts, Balochistan province appears to show an overall improvement in 2025-2026 compared to 2023-2024. Among the 11 common districts of Balochistan, eight (Kachhi, Kharan, Loralai, Nasirabad, Nushki, Pishin, Washuk and Killa Saifullah) improved from Phase 4 to Phase 3, while Jaffarabad and Killa Abdullah remained unchanged in Phase 4 and Khuzdar in Phase 3. This positive trend may be associated with the severe flooding that affected parts of these provinces in 2022-2023, which likely contributed to the deterioration observed during that period.

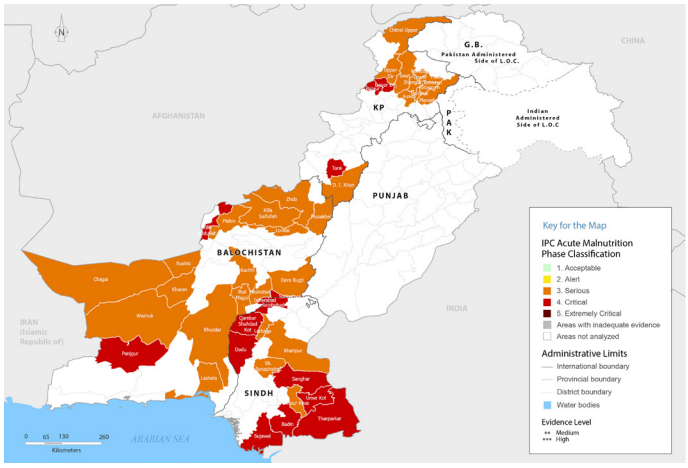
In Sindh province, out of eight comparable districts, Khairpur and Mirpur Khas have improved from Phase 4 to Phase 3 while the remaining districts—Dadu, Jacobabad, Qambar Shahdadkot, Sanghar, Umer Kot and Tharparkar—remained unchanged in Phase 4.

For Khyber Pakhtunkhwa, a meaningful comparison is not possible due to differences in the districts assessed between 2023-2024 and 2025-2026. However, three districts were comparable. Out of these, Lower Kohistan had an improvement from Phase 4 to Phase 3 while Swat and Upper Dir remained unchanged in Phase 3.

**March - September 2023**




**April - September 2026**




**Key assumptions for the projection period (April - September 2026):**

**Post-harvest period and seasonal income opportunities:** Rural households are expected to benefit from Rabi harvest stocks, seasonal fruits and vegetables, livestock sales, and improved income opportunities during Eid ul Adha. This will support food access and dietary diversity.

**Seasonal diseases:** Summer and monsoon months are expected to have an increase in diarrhea, malaria, dengue, and other infections among children. This will increase acute malnutrition.

**Limited coverage of nutrition programs:** Both preventive and curative services are expected to remain limited for addressing acute malnutrition: Service availability and utilisation will most likely also remain limited, especially in remote, insecure and scattered populations. This will reduce early detection and treatment of malnourished children.

**IYCF practices:** IYCF practices are likely to decline due to increased maternal workload, hot weather and seasonal migration.

**Low vaccination status and coverage:** Routine immunisation coverage is expected to remain low in several rural and insecure areas. This increases vulnerability to vaccine-preventable diseases will worsen malnutrition.

**Natural disasters:** Extreme heat, drought and heavy rains are likely to affect health, damage infrastructure, and disrupt service access. These shocks will also deteriorate Water, Sanitation and Hygiene (WASH) conditions and child nutrition.

**Seasonal migration:** Inter- and intra-district migration of livestock herds and households is expected during summer months. This will reduce their access to health and nutrition services.

**Conflict and insecurity in some districts:** Prolonged conflict and worsening security situation in some parts of Khyber Pakhtunkhwa and Balochistan is expected to disrupt livelihoods, markets, and population movement. Access to health and nutrition services will remain constrained, increasing malnutrition risk.

# TOTAL NUMBER OF CASES OF CHILDREN 0-59 MONTHS AND PREGNANT AND BREASTFEEDING WOMEN AFFECTED BY ACUTE MALNUTRITION AND IN NEED OF TREATMENT (OCTOBER 2025 - SEPTEMBER 2026)

***Population estimates are based on cGAM (combined GAM)***

| Province | District | Incidence Factor 1.6 | | | Estimation of the number of Acute Malnutrition cases in need of treatment (Under 5 children and PBW) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Population under 5 children | | | Global Acute Malnutrition (GAM) | | | Moderate Acute Malnutrition (MAM) | | | Severe Acute Malnutrition (SAM) | | | Pregnant & Breastfeeding Women (PBW) MUAC<210 mm | | | |
| | | All | Girls | Boys | cGAM % | GAM Girls | GAM Boys | cMAM % | MAM Girls | MAM Boys | cSAM % | SAM Girls | SAM Boys | Women Pop | PBW Pop | % MUAC <210mm | GAM PBW |
| Balochistan (19 districts) | | 1,218,329 | 633,531 | 584,798 | n/a | 218,450 | 201,646 | n/a | 156,039 | 144,036 | n/a | 62,411 | 57,610 | 3,831,323 | 306,506 | n/a | 47,031 |
| Khyber Pakhtunkhwa (14 districts) | | 2,171,287 | 1,129,069 | 1,042,218 | n/a | 576,674 | 532,314 | n/a | 446,379 | 412,042 | n/a | 130,295 | 120,272 | 6,828,125 | 546,250 | n/a | 67,077 |
| Sindh (12 districts) | | 3,096,671 | 1,610,269 | 1,486,402 | n/a | 615,070 | 567,756 | n/a | 440,493 | 406,609 | n/a | 174,577 | 161,148 | 9,738,217 | 779,057 | n/a | 117,873 |
| **GRAND TOTAL 2026 (45 Districts)** | | **6,486,287** | **3,372,869** | **3,113,418** | **n/a** | **1,410,193** | **1,301,717** | **n/a** | **1,042,911** | **962,687** | **n/a** | **367,282** | **339,030** | **20,397,664** | **n/a** | **n/a** | **231,980** |
| | | | **6,486,287** | | | **2,711,910** | | | **2,005,598** | | | **706,312** | | | | | |

| Province | District | Incidence Factor 1.6 | | | Estimation of the number of Acute Malnutrition cases in need of treatment (Under 5 children and PBW) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Population under 5 children | | | Global Acute Malnutrition (GAM) | | | Moderate Acute Malnutrition (MAM) | | | Severe Acute Malnutrition (SAM) | | | Pregnant & Breastfeeding Women (PBW) MUAC<210 mm | | | |
| | | All | Girls | Boys | cGAM % | GAM Girls | GAM Boys | cMAM % | MAM Girls | MAM Boys | cSAM % | SAM Girls | SAM Boys | Women Pop | PBW Pop | % MUAC <210mm | GAM PBW |
| Balochistan | Chagai | 40,917 | 21,277 | 19,640 | 21.1 | 7,183 | 6,631 | 12.7 | 4,323 | 3,991 | 8.4 | 2,860 | 2,640 | 128,674 | 10,294 | 9.9% | 1,020 |
| Balochistan | Dera Bugti | 54,002 | 28,081 | 25,921 | 11.8 | 5,302 | 4,894 | 8.5 | 3,801 | 3,509 | 3.3 | 1,500 | 1,385 | 169,821 | 13,586 | 15.0% | 2,038 |
| Balochistan | Jafferabad | 90,373 | 46,994 | 43,379 | 23.7 | 17,820 | 16,449 | 16.4 | 12,331 | 11,383 | 7.3 | 5,489 | 5,067 | 284,199 | 22,736 | 15.0% | 3,410 |
| Balochistan | Jhal Magsi* | 30,912 | 16,074 | 14,838 | n/a | 4,064 | 3,751 | n/a | 1,029 | 950 | n/a | 3,035 | 2,801 | 97,210 | 7,777 | 15.0% | 1,167 |
| Balochistan | Kachhi | 67,277 | 34,984 | 32,293 | 15.8 | 8,844 | 8,164 | 4.0 | 2,239 | 2,067 | 11.8 | 6,605 | 6,097 | 211,569 | 16,925 | 15.0% | 2,539 |
| Balochistan | Kharan | 39,574 | 20,578 | 18,995 | 25.3 | 8,330 | 7,689 | 20.5 | 6,750 | 6,230 | 4.8 | 1,580 | 1,459 | 124,448 | 9,956 | 15.0% | 1,493 |
| Balochistan | Khuzdar | 151,577 | 78,820 | 72,757 | 25.3 | 31,906 | 29,452 | 20.5 | 25,853 | 23,864 | 4.8 | 6,053 | 5,588 | 476,668 | 38,133 | 15.0% | 5,720 |
| Balochistan | Killa Abdul-lah | 55,020 | 28,610 | 26,409 | 14.7 | 6,729 | 6,211 | 11.2 | 5,127 | 4,733 | 3.5 | 1,602 | 1,479 | 173,022 | 13,842 | 14.0% | 1,938 |
| Balochistan | Killa Saiful-lah* | 57,790 | 30,051 | 27,739 | n/a | 8,366 | 7,723 | n/a | 6,491 | 5,992 | n/a | 1,875 | 1,731 | 181,736 | 14,539 | 15.0% | 2,181 |
| Balochistan | Lasbela | 103,509 | 53,824 | 49,684 | 24.0 | 20,669 | 19,079 | 17.8 | 15,329 | 14,150 | 6.2 | 5,339 | 4,929 | 325,507 | 26,041 | 15.0% | 3,906 |
| Balochistan | Loralai* | 41,410 | 21,533 | 19,877 | n/a | 5,995 | 5,534 | n/a | 4,651 | 4,293 | n/a | 1,344 | 1,240 | 130,222 | 10,418 | 15.0% | 1,563 |
| Balochistan | Musakhel | 27,706 | 14,407 | 13,299 | 24.2 | 5,578 | 5,149 | 17.5 | 4,034 | 3,724 | 6.7 | 1,544 | 1,426 | 87,127 | 6,970 | 15.0% | 1,046 |
| Balochistan | Nasirabad | 85,633 | 44,529 | 41,104 | 22.3 | 15,888 | 14,666 | 18.6 | 13,252 | 12,233 | 3.7 | 2,636 | 2,433 | 269,294 | 21,544 | 23.0% | 4,949 |
| Balochistan | Nushki | 31,591 | 16,427 | 15,164 | 27.4 | 7,202 | 6,648 | 19.4 | 5,099 | 4,707 | 8.0 | 2,103 | 1,941 | 99,345 | 7,948 | 15.0% | 1,192 |
| Balochistan | Panjgur | 77,487 | 40,293 | 37,194 | 32.6 | 21,017 | 19,400 | 23.1 | 14,892 | 13,747 | 9.5 | 6,125 | 5,653 | 243,675 | 19,494 | 15.0% | 2,924 |
| Balochistan | Pishin | 126,993 | 66,036 | 60,957 | 17.4 | 18,385 | 16,970 | 13.5 | 14,264 | 13,167 | 3.9 | 4,121 | 3,804 | 399,360 | 31,949 | 15.0% | 4,792 |
| Balochistan | Shobatpur | 36,496 | 18,978 | 17,518 | 26.5 | 8,047 | 7,428 | 16.2 | 4,919 | 4,541 | 10.3 | 3,128 | 2,887 | 114,771 | 9,182 | 15.0% | 1,377 |
| Balochistan | Washuk | 45,999 | 23,919 | 22,079 | 17.6 | 6,736 | 6,218 | 12.0 | 4,593 | 4,239 | 5.6 | 2,143 | 1,978 | 144,654 | 11,572 | 15.0% | 1,736 |
| Balochistan | Zhob | 54,065 | 28,114 | 25,951 | 23.1 | 10,391 | 9,592 | 15.7 | 7,062 | 6,519 | 7.4 | 3,329 | 3,073 | 170,021 | 13,602 | 15.0% | 2,040 |
| **Balochistan Total (19 districts** | | **1,218,329** | **633,531** | **584,798** | **n/a** | **218,450** | **201,646** | **n/a** | **156,039** | **144,036** | **n/a** | **62,411** | **57,610** | **3,831,323** | **306,506** | **n/a** | **47,031** |

| Province | District | Incidence Factor 1.6 | | | Estimation of the number of Acute Malnutrition cases in need of treatment (Under 5 children and PBW) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Population under 5 children | | | Global Acute Malnutrition (GAM) | | | Moderate Acute Malnutrition (MAM) | | | Severe Acute Malnutrition (SAM) | | | Pregnant & Breastfeeding Women (PBW) MUAC<210 mm | | | |
| | | All | Girls | Boys | cGAM % | GAM Girls | GAM Boys | cMAM % | MAM Girls | MAM Boys | cSAM % | SAM Girls | SAM Boys | Women Pop | PBW Pop | % MUAC <210mm | GAM PBW |
| Khyber Pakhtunkhwa | Bajaur | 195,770 | 101,800 | 93,970 | 31.8 | 51,796 | 47,812 | 23.9 | 38,928 | 35,934 | 7.9 | 12,868 | 11,878 | 615,645 | 49,252 | 15.0% | 7,388 |
| Khyber Pakhtunkhwa | Battagram | 84,228 | 43,799 | 40,430 | 28.2 | 19,762 | 18,242 | 20.7 | 14,506 | 13,390 | 7.5 | 5,256 | 4,852 | 264,876 | 21,190 | 15.0% | 3,179 |
| Khyber Pakhtunkhwa | Buner | 154,564 | 80,373 | 74,191 | 23.9 | 30,735 | 28,371 | 19.8 | 25,462 | 23,504 | 4.1 | 5,272 | 4,867 | 486,063 | 38,885 | 9.8% | 3,811 |
| Khyber Pakhtunkhwa | Dera Ismail Khan | 278,131 | 144,628 | 133,503 | 35.2 | 81,455 | 75,189 | 26.5 | 61,322 | 56,605 | 8.7 | 20,132 | 18,584 | 874,650 | 69,972 | 11.7% | 1,023 |
| Khyber Pakhtunkhwa | Kolai Palas | 42,585 | 22,144 | 20,441 | 26.9 | 9,531 | 8,798 | 21.0 | 7,440 | 6,868 | 5.9 | 2,090 | 1,930 | 133,917 | 10,713 | 15.0% | 1,607 |
| Khyber Pakhtunkhwa | Lower Dir | 250,828 | 130,430 | 120,397 | 28.6 | 59,685 | 55,094 | 21.0 | 43,825 | 40,454 | 7.6 | 15,860 | 14,640 | 788,787 | 63,103 | 15.0% | 9,465 |
| Khyber Pakhtunkhwa | Lower-Kohistan | 51,683 | 26,875 | 24,808 | 34.6 | 14,878 | 13,734 | 25.3 | 10,879 | 10,042 | 9.3 | 3,999 | 3,691 | 162,528 | 13,002 | 15.0% | 1,950 |
| Khyber Pakhtunkhwa | Mansehra*** | 273,171 | 142,049 | 131,122 | 33.9 | 77,047 | 71,121 | 28.2 | 64,092 | 59,162 | 5.7 | 12,955 | 11,958 | 859,051 | 68,724 | 15.0% | 10,309 |
| Khyber Pakhtunkhwa | Shangla | 135,470 | 70,445 | 65,026 | 29.9 | 33,701 | 31,108 | 21.9 | 24,684 | 22,785 | 8.0 | 9,017 | 8,323 | 426,018 | 34,081 | 15.0% | 5,112 |
| Khyber Pakhtunkhwa | Swat | 408,482 | 212,411 | 196,072 | 36.8 | 125,067 | 115,447 | 28.9 | 98,219 | 90,663 | 7.9 | 26,849 | 24,783 | 1,284,570 | 102,766 | 15.0% | 15,415 |
| Khyber Pakh-tunkhwa | Tank | 71,485 | 37,172 | 34,313 | 32.0 | 19,032 | 17,568 | 26.1 | 15,523 | 14,329 | 5.9 | 3,509 | 3,239 | 224,800 | 17,984 | 15.0% | 337 |
| Khyber Pakhtunkhwa | Torghar | 30,468 | 15,843 | 14,624 | 19.0 | 4,816 | 4,446 | 16.0 | 4,056 | 3,744 | 3.0 | 760 | 702 | 95,813 | 7,665 | 15.0% | 144 |
| Khyber Pakhtunkhwa | Upper Chitral | 29,720 | 15,455 | 14,266 | 20.4 | 5,044 | 4,656 | 16.2 | 4,006 | 3,698 | 4.2 | 1,039 | 959 | 93,462 | 7,477 | 15.0% | 1,122 |
| Khyber Pakhtunkhwa | Upper Dir | 164,702 | 85,645 | 79,057 | 32.2 | 44,124 | 40,730 | 24.4 | 33,436 | 30,864 | 7.8 | 10,689 | 9,866 | 517,945 | 41,436 | 15.0% | 6,215 |
| **Khyber Pakhtunkhwa Total** | | **2,171,287** | **1,129,069** | **1,042,218** | n/a | **576,674** | **532,314** | n/a | **446,379** | **412,042** | n/a | **130,295** | **120,272** | **6,828,125** | **546,250** | n/a | **67,077** |

| Province | District | Incidence Factor 1.6 | | | Estimation of the number of Acute Malnutrition cases in need of treatment (Under 5 children and PBW) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Population under 5 children | | | Global Acute Malnutrition (GAM) | | | Moderate Acute Malnutrition (MAM) | | | Severe Acute Malnutrition (SAM) | | | Pregnant & Breastfeeding Women (PBW) MUAC<210 mm | | | |
| | | All | Girls | Boys | cGAM % | GAM Girls | GAM Boys | cMAM % | MAM Girls | MAM Boys | cSAM % | SAM Girls | SAM Boys | Women Pop | PBW Pop | % MUAC <210mm | GAM PBW |
| Sindh | Badin | 295,956 | 153,897 | 142,059 | 30.7 | 75,594 | 69,779 | 22.0 | 54,172 | 50,005 | 8.7 | 21,423 | 19,775 | 930,705 | 74,456 | 15.0% | 11,168 |
| Sindh | Dadu | 264,833 | 137,713 | 127,120 | 24.3 | 53,543 | 49,424 | 17.9 | 39,441 | 36,407 | 6.4 | 14,102 | 13,017 | 832,829 | 66,626 | 14.4% | 9,594 |
| Sindh | Jacobabad | 178,463 | 92,801 | 85,662 | 25.0 | 37,120 | 34,265 | 17.2 | 25,539 | 23,574 | 7.8 | 11,582 | 10,691 | 561,218 | 44,897 | 16.1% | 7,228 |
| Sindh | Qambar Shahdad Kot | 230,260 | 119,735 | 110,525 | 22.9 | 43,871 | 40,496 | 16.2 | 31,035 | 28,648 | 6.7 | 12,836 | 11,848 | 724,107 | 57,929 | 14.6% | 8,458 |
| Sindh | Khairpur | 394,825 | 205,309 | 189,516 | 19.3 | 63,399 | 58,523 | 14.3 | 46,975 | 43,361 | 5.0 | 16,425 | 15,161 | 1,241,622 | 99,330 | 15.0% | 14,899 |
| Sindh | Larkana | 271,237 | 141,043 | 130,194 | 20.3 | 45,811 | 42,287 | 14.4 | 32,496 | 29,997 | 5.9 | 13,314 | 12,290 | 852,969 | 68,237 | 15.3% | 10,454 |
| Sindh | Mirpur Khas | 255,571 | 132,897 | 122,674 | 22.9 | 48,693 | 44,948 | 18.5 | 39,337 | 36,311 | 4.4 | 9,356 | 8,636 | 803,703 | 64,296 | 17.5% | 11,252 |
| Sindh | Sanghar | 350,887 | 182,461 | 168,426 | 26.9 | 78,531 | 72,490 | 18.0 | 52,549 | 48,507 | 8.9 | 25,982 | 23,984 | 1,103,446 | 88,276 | 15.0% | 13,241 |
| Sindh | Shaheed Benizira-bad | 280,456 | 145,837 | 134,619 | 25.0 | 58,335 | 53,847 | 16.4 | 38,268 | 35,324 | 8.6 | 20,067 | 18,524 | 881,959 | 70,557 | 15.0% | 10,584 |
| Sindh | Sujawal | 127,572 | 66,338 | 61,235 | 20.1 | 21,334 | 19,693 | 14.5 | 15,390 | 14,206 | 5.6 | 5,944 | 5,487 | 401,182 | 32,095 | 12.9% | 4,140 |
| Sindh | Tharparkar | 270,318 | 140,565 | 129,753 | 21.5 | 48,354 | 44,635 | 15.4 | 34,635 | 31,971 | 6.1 | 13,719 | 12,664 | 850,079 | 68,006 | 15.0% | 10,201 |
| Sindh | Umer Kot | 176,294 | 91,673 | 84,621 | 27.6 | 40,483 | 37,369 | 20.9 | 30,655 | 28,297 | 6.7 | 9,827 | 9,071 | 554,399 | 44,352 | 15.0% | 6,653 |
| **Sindh Total** | | **3,096,671** | **1,610,269** | **1,486,402** | **n/a** | **615,070** | **567,756** | **n/a** | **440,493** | **406,609** | **n/a** | **174,577** | **161,148** | **9,738,217** | **779,057** | **n/a** | **117,873** |

***Estimation of Malnutrition cases for the 12 month is PIN = Population (N) x Prevalence Acute Malnutrition (P) x Incidence Factor (K).***

*Population of Under 5 and PLW from National Census 2023 | Prevalence: combined-GAM for under 5 from FSLA 2025 & underweight (BMI<18.5) for WRA from NNS 2018 | Incidence factor: K=2.6 for under 5 & k=1 for PLW*

*Population estimates are based on cGAM (combined GAM).*

**Due to some data quality challenges in FSLA 2025; three districts combined GAM have not been calculated and 'similar near by area combined GAM has been use for PIN calculation. Pishin extrapolated to Loralai and Killa Saifullah & Kacchi extrapolated to Jhal Magsi districts | **Prevalence of Underweight using BMI<18.5 for women is reproductive age from NNS 2018 | ***Mansehra underweight prevalence is not available from the NNS 2018, so average of 9.1% for KP has been calculated and used on Mansehra. | ****For prevalence of GAM for Pregnant and Breastfeeding Women (PBW) the SMART surveys 2025 estimates in Buner (KP); SMART surveys 2023 estimates of Chagai, Killa Abdullah, Nasirabad (Balochistan); Dera Ismail Khan (KP); Dadu, Jacobabad, Qambar Shahdad Kot, Larkana, Mirpur Khas, Sujawal (Sindh) & SMART survey 2021 estimates in Sujawal (Sindh). In absence of historical GAM for PBW, a fixed 15% GAM for PBW as been agreed and applied to the remaining 36 districts.*

# LINKAGES BETWEEN ACUTE FOOD INSECURITY AND ACUTE MALNUTRITION

Across the 45 analysed districts, the analysis of linkages between IPC Acute Food Insecurity (AFI) and IPC Acute Malnutrition (AMN) shows that districts experiencing high levels of food insecurity also face severe levels of acute malnutrition. Under IPC AFI, 40 districts are classified in IPC AFI Phase 3 (Crisis) and five districts in IPC AFI Phase 2 (Stressed), while the IPC AMN analysis classifies 28 districts in IPC AMN Phase 4 (Critical) and 17 districts in IPC AMN Phase 3 (Serious). However, in several districts including Mansehra, Swat, Dadu, Qambar Shahdadkot, Khairpur, Larkana and Sanghar, AMN classifications are two phases higher than AFI, indicating that acute malnutrition is also driven by factors beyond food access. Evidence from the FSLA shows that while household food consumption indicators such as Food Consumption Score (FCS) and Household Dietary Diversity Score (HDDS) remain relatively moderate, child feeding indicators including MDD, Minimum Meal Frequency (MMF) and Minimum Acceptable Diet (MAD) remain poor, suggesting that children are not consuming sufficiently diverse and frequent diets.

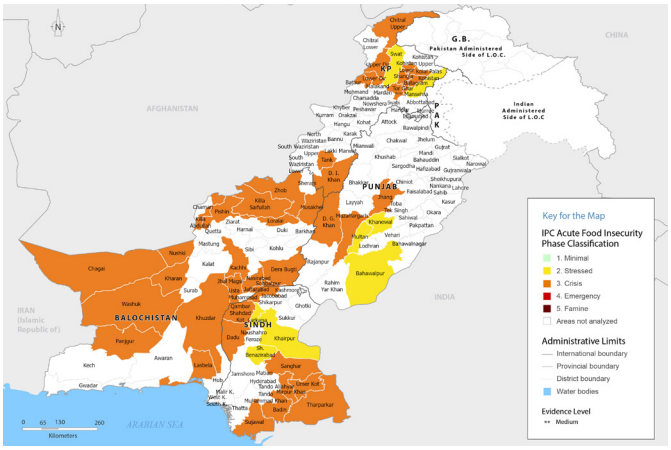
Health and disease conditions appear to play a significant role in explaining this divergence. Malaria cases have increased substantially in several districts of Sindh including Khairpur, Sanghar, Shaheed Benazirabad, Dadu, Larkana and Qambar Shahdadkot, with seasonal trends showing a sharp rise in reported cases. In Kyber Pakhtunkhwa, secondary health data indicate a significant increase in malaria cases, reaching approximately 40 000-45 000 reported cases during the analysis period. In addition, cholera cases were reported in January 2026, with 456 cases in Balochistan, 103 cases in Khyber Pakhtunkhwa and 53 cases in Sindh. Seasonal increases in diarrhoea, acute respiratory infections and measles further contribute to deteriorating health conditions, increasing children vulnerability to acute malnutrition by reducing appetite, limiting nutrient absorption and increasing nutrient losses.

In addition to disease burden, poor IYCF practices also contribute to the severity of nutritional outcomes. Indicators related to exclusive breastfeeding, continued breastfeeding and early initiation of breastfeeding show generally poor conditions across districts such as Mansehra, Swat, Dadu, Larkana, Khairpur, Shaheed Benazirabad, Qambar Shahdadkot and Sanghar. These findings indicate that although food insecurity conditions remain severe in many districts, inadequate feeding practices, high disease prevalence and limited child dietary diversity are key underlying factors driving the higher severity of acute malnutrition. This explains why AMN classifications appear more severe than AFI classifications in several districts, highlighting the importance of integrated interventions addressing nutrition, health, WASH and behaviour change alongside food security responses.

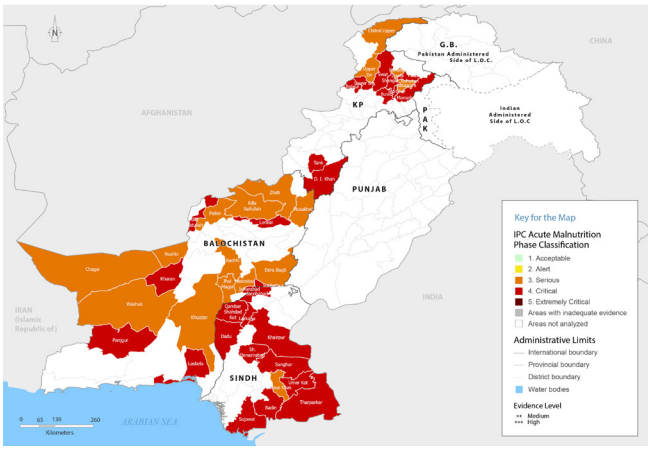
## Acute Food Insecurity

## Acute Malnutrition

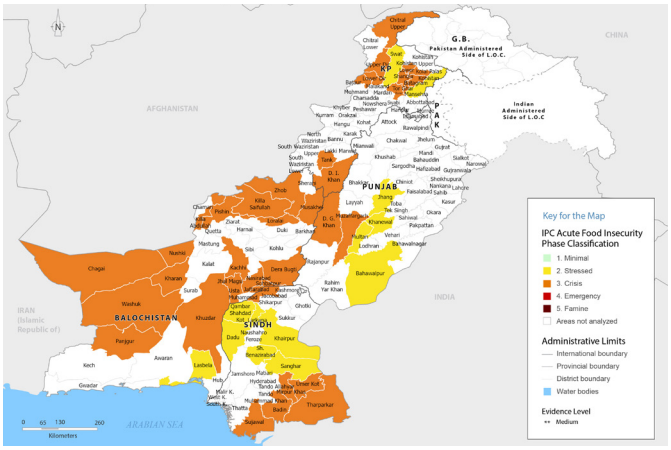
December 2025 - March 2026



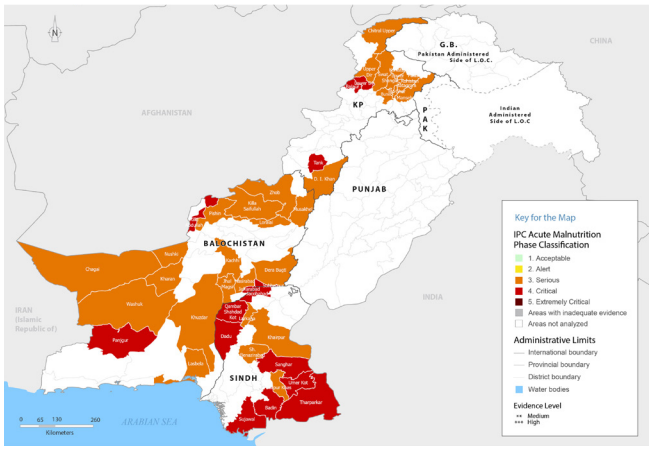

October 2025 - March 2026




April - September 2026




March - September 2026



# RECOMMENDATIONS FOR ACTION

### Response priorities

Ensuring timely treatment for all children with acute malnutrition must remain the top priority, requiring a rapid scale up of existing services alongside strengthened early detection and referral systems—particularly for children with moderate acute malnutrition who are at high risk of deteriorating into severe, life-threatening conditions. At the same time, the severity and persistence of acute malnutrition across affected districts demand both immediate lifesaving action and longer term system strengthening, with efforts focused not only on expanding treatment coverage but also on addressing key contributing factors by improving children's dietary quality and quantity, expanding access to safe water, sanitation, and hygiene services, reducing disease burden, improving child feeding and care practices, and safeguarding household food security through integrated, multi sectoral interventions.

### Immediate / short-term strategic priority response objectives

- Stabilise acute malnutrition levels through strengthened and scaled up Emergency Response Plan (ERP) and CMAM services through nutrition sector, including timely identification, referral, TSFP, and micronutrient supplementation.
- Improve access to adequate and safe food for vulnerable households through emergency food and cash assistance.
- Reduce disease incidence by reinforcing primary health outreach, essential preventive services, and targeted vaccination campaigns (measles, polio, cholera, etc.), particularly in high risk and hard to reach areas.
- Enhance early detection of wasting through community-based screening, lady health workers (LHWs), family mid-upper arm circumference (MUAC), and improved surveillance for diarrhea, ARI, malaria, and other outbreaks.
- Strengthen IYCF/MIYCAN practices through rapid, community-based counselling that supports breastfeeding, timely complementary feeding, and caregiver decision making.
- Improve access to safe drinking water and basic sanitation through emergency WASH actions, including water treatment, hygiene kits, temporary sanitation, and contamination prevention in flood prone areas.
- Ensure continuity of essential health and nutrition services during monsoon, harvesting, and seasonal stress periods through outreach teams, mobile services, and emergency response team deployment.
- Strengthen community engagement via behavior change communication, support groups, and awareness on early care seeking, hygiene, and risk factors for acute malnutrition.

### Medium to long-term strategic priority response objectives

- Improve household food security situation and dietary diversity through resilient agriculture, diversified food systems, and livelihood skill-based trainings support linked to markets.
- Improve sustained access to quality nutrition and health services by operationalising any nonfunctional health facilities, expanding nutrition rehabilitation units, and strengthening immunization and disease surveillance.
- Institutionalise improved feeding, caring, and hygiene practices through sustained Social and Behaviour Change Communication (SBCC), early childhood development approaches, and community-based prevention platforms.
- Enhance WASH infrastructure and services by investing in safe drinking water systems, sanitation networks, climate resilient designs, and long-term hygiene behaviour change.
- Strengthen community and local government capacity for disaster risk reduction, shock responsive systems, and climate adaptation to mitigate the impacts of floods, droughts, and displacement on food security and nutrition.
- Build and retain local human resource capacity by training health workers, community volunteers, and LHWs in nutrition, maternal and child health, and emergency preparedness.
- Develop and expand social protection systems that are nutrition sensitive, seasonally responsive, and capable of supporting vulnerable households during shocks.
- Promote food fortification (e.g., wheat flour, edible oil, essential micronutrients) to improve population level micronutrient intake.
- Strengthen monitoring, evaluation, and early warning through robust nutrition surveillance, integrated databases, and routine learning and coordination platforms.

### Situation monitoring and update

- Once new data becomes available, an update or a new round of AMN analysis should be conducted to reassess the severity and geographic spread of acute malnutrition. The nutrition situation in districts not covered in the current analysis remains a concern, and expanding data collection to include additional districts will be important to provide a more comprehensive national picture.
- Data gaps related to disease incidence and morbidity patterns persist and limit a full understanding of the underlying drivers of malnutrition. Strengthening health and nutrition information systems, particularly routine disease surveillance, screening data, reporting quality and timeliness—will be essential to improve the evidence base for future IPC AMN analyses and response planning.

## RISK FACTORS TO MONITOR

These factors directly impact the nutritional status of children and contribute to acute malnutrition:

- **Seasonal disease outbreak:** Malaria, dengue, ARI and diarrhea outbreak. These diseases contribute to dehydration, nutrient loss, and increased vulnerability to malnutrition
- **Heatwave/Extreme Summer:** These environmental factors can exacerbate dehydration, reduce food availability, and strain health facilities due to increased disease burden.
- **Infant and young Child Feeding Practices**: Inadequate breastfeeding and complementary feeding, poor feeding habits, or delays in the introduction of solid foods lead to malnutrition in young children.
- **Security situation:** Ongoing conflicts affected districts face restrict access to health services, food assistance, and safe environments, leading to increased vulnerability to malnutrition.
- **Animal diseases:** Increased livestock diseases (Foot-and-Mouth Disease, Lumpy Skin Disease, Peste des Petits Ruminants, Crimean-Congo Hemorrhagic Fever) due to flooding may reduce milk production, herd productivity, and household income, constrain dietary diversity and heighten acute malnutrition including children under five.
- **WASH services:** Poor access to clean water, sanitation, and hygiene contribute to waterborne diseases and poor nutritional absorption, worsening malnutrition. These systemic factors shape the broader environment, indirectly influencing the other factors that contribute to malnutrition:
- **Low vaccination coverage:** Inadequate immunisation rates leave children vulnerable to preventable diseases, which can exacerbate malnutrition.
- **Food insecurity and children's dietary intake:** Food insecurity driven by rising food prices, general inflation, declining household income due to limited livelihood opportunities, poor access to nutritious foods, restricted dietary diversity, and overall low household food security reduces the availability and intake of nutrient-dense foods, thereby elevating the risk of malnutrition among children under five.
- **Reproductive health services (neonatal, infant, under-five and maternal mortality):** Inadequate maternal and child health services, including neonatal and maternal mortality, limited access to care during critical life stages, impacting child nutrition outcomes.
- **Natural Disasters:** Glacial Lake Outburst Flood, flash floods and riverine floods could disrupt access to health services, and disruption of nutrition services and supplies.

# PROCESS AND METHODOLOGY

A team of nutrition, health, WASH, food security and statistics experts working at federal and provincial ministries/departments, UN organisations and NGOs (both national and international) in Pakistan carried out the analysis process using the standard IPC Manual version 3.1. These experts represented the Ministry of Planning, Development and Special Initiatives, Ministry of Health, National Disaster Management Authority (NDMA), Pakistan Agriculture Research Council, Provincial Health Departments of Sindh, Balochistan and Khyber Pakhtunkhwa, Provincial Bureau of Statistics, Provincial Disaster Management Authorities (PDMAs), Provincial Livestock Departments, People's Primary Healthcare Initiative (PPHI)-Sindh, Welthungerhilfe (WHH), Secours Islamique France (SIF), Islamic Relief, International Rescue Committee (IRC), Action Against Hunger (ACF), Pak Mission Society (PMS), SAIBAN, Youth Organization, MERF, Indus Hospital & Health Network, Shine Humanity and UN Agencies (FAO, WFP, UNICEF). The contribution of these experts/analysts in completing this analysis is highly acknowledged. The IPC training and analysis workshop took place between 29 January and 6 February 2026 in Peshawar and was technically supported by the IPC Global Support Unit (GSU). Prior to the analysis, all analysts underwent a four-day training on the IPC Acute Malnutrition scale. This training was based on the IPC Technical Manual version 3.1. All participants who took part in the training were also involved in the analysis.

The data used in the analysis was organized according to the IPC AMN analytical framework and includes data on contributing factors and outcome indicators of acute malnutrition. The data was mainly collected from the FSLA from 44 districts and SMART survey for Buner (conducted by ACF). Other data sources are listed below.

## Sources of data

- The main data source for outcome and contributing factors was the Food Security and Livelihood Assessment (FSLA) conducted between October and December 2025.
- A SMART survey was used for Buner district conducted in December 2025
- Data on diseases and other program related information were obtained from the Health Departments.

## Limitations of the Analysis

For outcome indicators, GAM based on weight-for-height (WHZ) from the FSLA was used for 41 districts reaching from Excellent to Acceptable quality for anthropometric measurement, while for the three remaining districts, anthropometrics quality checks were problematic according to the IPC and SMART survey standards. In line with the IPC protocols, similar and/or nearby area approach/protocol was used as an alternative for three districts of Balochistan, namely, Loralai, Killa Saifullah and Jhal Magsi.

- Geographic coverage limited to 45 rural districts.
- Seasonal timing of survey (Nov-Dec) in the lean season.
- Limited mortality and morbidity data (under five mortality data and reliable death rates).
- Analysis was conducted pror the Middle East crisis, therefore, the post-crisis impacts are not factored into the analysis.

## Sources of data

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## Acute Malnutrition Phase name and description

| Phase 1 Acceptable | Phase 2 Alert | Phase 3 Serious | Phase 4 Critical | Phase 5 Extremely Critical |
|---|---|---|---|---|
| **Less than 5%** of children are acutely malnourished. | **5–9.9%** of children are acutely malnourished. | **10–14.9%** of children are acutely malnourished. | **15–29.9%** of children are acutely malnourished. The mortality and morbidity levels are elevated or increasing. Individual food consumption is likely to be compromised. | **30% or more** children are acutely malnourished. Widespread morbidity and/or very large individual food consumption gaps are likely evident. |

## What is the IPC and IPC Acute Malnutrition?

The IPC is a set of tools and procedures to classify the severity and characteristics of acute food and nutrition crises based on international standards. The IPC consists of four mutually reinforcing functions, each with a set of specific protocols (tools and procedures). The core IPC parameters include consensus building, convergence of evidence, accountability, transparency and comparability. The IPC analysis aims at informing emergency response as well as medium and long-term food security policy and programming.

For the IPC, Acute Malnutrition is defined as any manifestation of malnutrition found in a specified area at a specific point in time of a severity that threatens lives or livelihoods, or both, regardless of the causes, context or duration. The IPC Acute Malnutrition Classification's focus is on identifying areas with a large proportion of children acutely malnourished preferably by measurement of Weight for Height Z-Score (WHZ) but also by Mid-Upper Arm Circumference (MUAC).highlights the major contributing factors to acute malnutrition, and provides actionable knowledge by consolidating wide-ranging evidence on acute malnutrition and contributing factors.

## Contact for further Information

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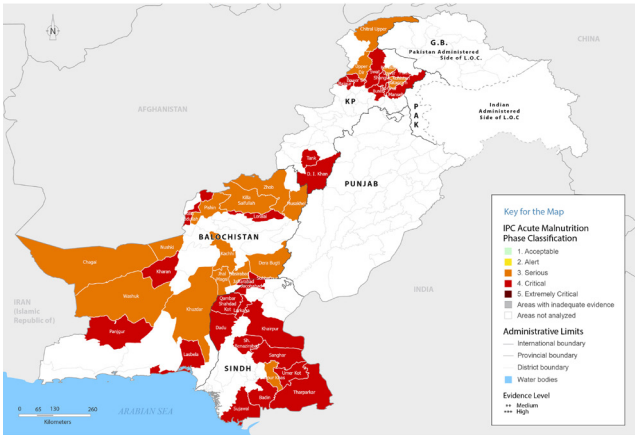
This analysis has been conducted under the patronage of the Government of Pakistan and funded by the European Union.

Classification of food insecurity was conducted using the IPC protocols, which are developed and implement-ed worldwide by the IPC Global Partnership - Action Against Hunger, CARE, Catholic Relief Services (CRS), CILSS, EC-JRC, FAO, FEWSNET, Global Food Security Cluster, Global Nutrition Cluster, IF-PRI, IGAD, IMPACT, Oxfam, SICA, SADC, Save the Children, UNDP, UNICEF, the World Bank, WFP and WHO.

**Analysis Partners:**

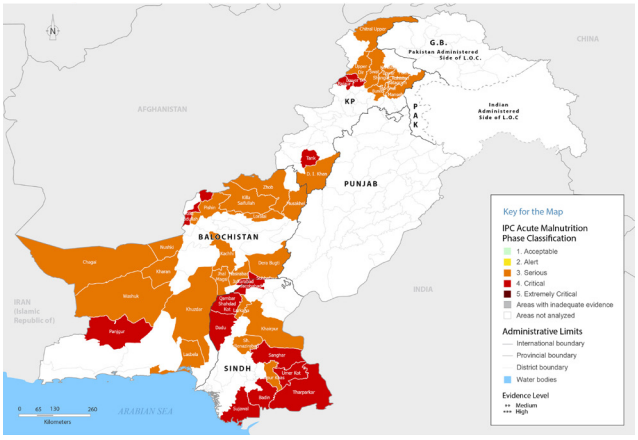
# SNAPSHOT OF ACUTE MALNUTRITION (OCTOBER 2025 - SEPTEMBER 2026)

## CURRENT ACUTE MALNUTRITION: OCT 2025 - MAR 2026




| | |
|---|---|
| **28 DISTRICTS** CRITCAL | |
| **17 DISTRICTS** SERIOUS | |
| **0 DISTRICTS** ALERT | |
| **0 DISTRICTS** ACCEPTABLE | |

## PROJECTED ACUTE MALNUTRITION: APR - SEPT 2026




| | |
|---|---|
| **16 DISTRICTS** CRITCAL | |
| **29 DISTRICTS** SERIOUS | |
| **0 DISTRICTS** ALERT | |
| **0 DISTRICTS** ACCEPTABLE | |

## KEY FIGURES — OCTOBER 2025 - SEPTEMBER 2026

### POPULATION IN NEED OF TREATMENT (45 DISTRICTS)

**2.71M**

Cases of children aged 6-59 months acutely malnourished

IN NEED OF TREATMENT

| | |
|---|---|
| SAM | 706,000 |
| MAM | 2M |

**1.4M**
CASES OF GIRLS

**1.3M**
CASES OF BOYS

**232,000**
Pregnant or breastfeeding women acutely malnourished

IN NEED OF TREATMENT

# ANNEX 1.1 SUMMARY CONTRIBUTING FACTORS TO ACUTE MALNUTRITION IN BALOCHISTAN

| | | RISK FACTORS TABLE | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **VERY LOW** Risk Factor | PAKISTAN | | | | | | | | | | | | | | | | | | |
| 2 | **LOW** Risk Factor | Balochistan | | | | | | | | | | | | | | | | | | |
| 3 | **MEDIUM** Risk Factor | Nushki | Chagai | Washuk | Kharan | Panjgur | Khuzdar | Lasbela | Kila Abdullah | Pishin | Killa Saifullah | Loralai | Zhob | Musakhel | Kachhi | Jhal Magsi | Dera Bugti | Jaffarabad | Naseerabad | Sohbatpur |
| 4 | **HIGH** Risk Factor | IPC AMN Phase Classification | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN |
| 5 | **VERY HIGH** Risk Factor | (Current Period : October 2025 – March 2026) | Phase 3 | Phase 3 | Phase 3 | Phase 4 | Phase 4 | Phase 3 | Phase 4 | Phase 4 | Phase 3 | Phase 3 | Phase 4 | Phase 3 | Phase 3 | Phase 3 | Phase 3 | Phase 3 | Phase 4 | Phase 3 | Phase 4 |
| 8 | No Data Available | IPC AMN Phase Classification | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN |
| | | (Projection Period : April – September 2026) | Phase 3 | Phase 3 | Phase 3 | Phase 3 | Phase 4 | Phase 3 | Phase 3 | Phase 4 | Phase 3 | Phase 3 | Phase 3 | Phase 3 | Phase 3 | Phase 3 | Phase 3 | Phase 3 | Phase 4 | Phase 3 | Phase 4 |
| Individual Food Intake | Minimum Dietary Diversity (MDD) | | | | | | | | | | | | | | | | | | | |
| | Minimum Meal Frequency (MMF) | | | | | | | | | | | | | | | | | | | |
| | Minimum Acceptable Diet (MAD) | | | | | | | | | | | | | | | | | | | |
| | Minimum Dietary Diversity – Women (MDD-W) | | | | | | | | | | | | | | | | | | | |
| Health Status | % of under 5 with Diarrhoea | | | | | | | | | | | | | | | | | | | |
| | Dysentery | | | | | | | | | | | | | | | | | | | |
| | % of under 5 with Malaria/fever | | | | | | | | | | | | | | | | | | | |
| | % of under 5 with Acute Respiratory Infection (ARI) | | | | | | | | | | | | | | | | | | | |
| | HIV/AIDS | | | | | | | | | | | | | | | | | | | |
| | Case of Cholera or Acute Watery Diarrhoea (AWD) | | | | | | | | | | | | | | | | | | | |
| | Case of Measles | | | | | | | | | | | | | | | | | | | |
| Health Services and Health Environment | MEASLES vaccination coverage | | | | | | | | | | | | | | | | | | | |
| | POLIO vaccination coverage | | | | | | | | | | | | | | | | | | | |
| | VITAMIN A supplementation coverage | | | | | | | | | | | | | | | | | | | |
| | VACCINATION Coverage of all basic vaccinations | | | | | | | | | | | | | | | | | | | |
| | Skilled attendant at delivery | | | | | | | | | | | | | | | | | | | |
| | IRON/FOLIC ACID Pregnancy supplementation coverage | | | | | | | | | | | | | | | | | | | |
| | Coverage of outreach programmes – CMAM (SAM, MAM, or both) | | | | | | | | | | | | | | | | | | | |
| | WASH - Access to a sufficient quantity of water | | | | | | | | | | | | | | | | | | | |
| | WASH - Access to improved sanitation facilities | | | | | | | | | | | | | | | | | | | |
| | WASH - Access to an improved source of drinking water | | | | | | | | | | | | | | | | | | | |
| | WASH - Water availability for handwashing | | | | | | | | | | | | | | | | | | | |
| | WASH - Soap availability for handwashing | | | | | | | | | | | | | | | | | | | |
| Shocks / Hazards | Conflict & Insecurity | | | | | | | | | | | | | | | | | | | |
| | Economics & Political Factors | | | | | | | | | | | | | | | | | | | |
| | Epidemic & Disease Outbreak | | | | | | | | | | | | | | | | | | | |
| | Natural Factors | | | | | | | | | | | | | | | | | | | |
| | Population Displacement | | | | | | | | | | | | | | | | | | | |
| Basic Causes | Human capital | | | | | | | | | | | | | | | | | | | |
| | Physical capital | | | | | | | | | | | | | | | | | | | |
| | Financial capital | | | | | | | | | | | | | | | | | | | |
| | Natural capital | | | | | | | | | | | | | | | | | | | |
| | Social capital | | | | | | | | | | | | | | | | | | | |
| | Policies, Institutions and Processes (PIPs) | | | | | | | | | | | | | | | | | | | |
| Other Issues | Anaemia among children 6-59 months | | | | | | | | | | | | | | | | | | | |
| | Anaemia among pregnant women | | | | | | | | | | | | | | | | | | | |
| | Anaemia among non-pregnant women | | | | | | | | | | | | | | | | | | | |
| | Vitamin A deficiency among pre-school children (6 – 71 months) | | | | | | | | | | | | | | | | | | | |
| | Vitamin A deficiency among non-pregnant women (15 – 49 years) | | | | | | | | | | | | | | | | | | | |
| | Low birth weight | | | | | | | | | | | | | | | | | | | |
| | Fertility rate | | | | | | | | | | | | | | | | | | | |

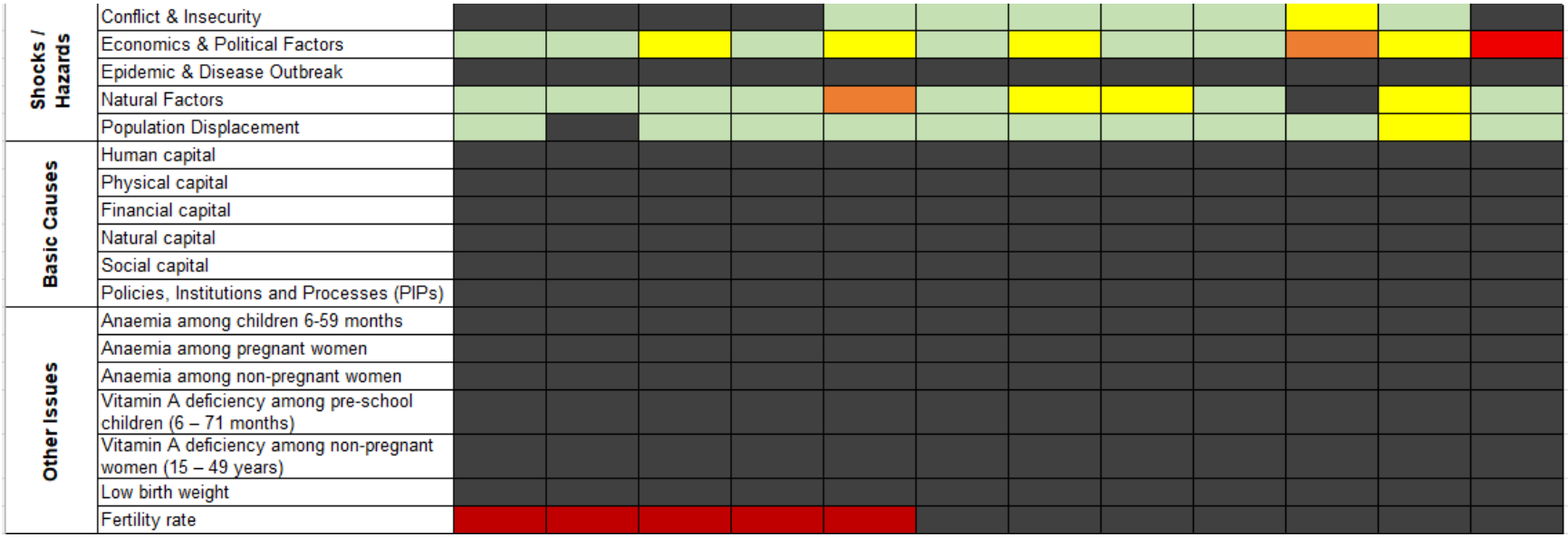
# ANNEX 1.2 SUMMARY CONTRIBUTING FACTORS TO ACUTE MALNUTRITION IN KHYBER PAKHTUNKHWA

| | | RISK FACTORS TABLE | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **VERY LOW** Risk Factor | PAKISTAN | | | | | | | | | | | | | |
| 2 | **LOW** Risk Factor | Khyber Pakhtunkhwa | | | | | | | | | | | | | |
| 3 | **MEDIUM** Risk Factor | Lower Dir | Upper Dir | Upper Chitral | Bajaur | Battagram | Shangla | Swat | Buner | Mansehra | Kolai Palas | Lower Kohistan | Torghar | Tank | Dera Ismail Khan |
| 4 | **HIGH** Risk Factor | | | | | | | | | | | | | | |
| 5 | **VERY HIGH** Risk Factor | | | | | | | | | | | | | | |
| 8 | No Data Available | | | | | | | | | | | | | | |
| IPC AMN Phase Classification | | IPC AMN Phase 4 | IPC AMN Phase 3 | IPC AMN Phase 3 | IPC AMN Phase 4 | IPC AMN Phase 3 | IPC AMN Phase 4 | IPC AMN Phase 4 | IPC AMN Phase 4 | IPC AMN Phase 4 | IPC AMN Phase 4 | IPC AMN Phase 3 | IPC AMN Phase 4 | IPC AMN Phase 4 | IPC AMN Phase 4 |
| (Current Period : October 2025 – March 2026) | | | | | | | | | | | | | | | |
| IPC AMN Phase Classification | | IPC AMN Phase 4 | IPC AMN Phase 3 | IPC AMN Phase 3 | IPC AMN Phase 4 | IPC AMN Phase 3 | IPC AMN Phase 3 | IPC AMN Phase 3 | IPC AMN Phase 3 | IPC AMN Phase 4 | IPC AMN Phase 3 | IPC AMN Phase 3 | IPC AMN Phase 3 | IPC AMN Phase 4 | IPC AMN Phase 3 |
| (Projection Period : April – September 2026) | | | | | | | | | | | | | | | |
| Individual Food Intake | Minimum Dietary Diversity (MDD) | | | | | | | | | | | | | | |
| | Minimum Meal Frequency (MMF) | | | | | | | | | | | | | | |
| | Minimum Acceptable Diet (MAD) | | | | | | | | | | | | | | |
| | Minimum Dietary Diversity – Women (MDD-W) | | | | | | | | | | | | | | |
| Health Status | % of under 5 with Diarrhoea | | | | | | | | | | | | | | |
| | Dysentery | | | | | | | | | | | | | | |
| | % of under 5 withMalaria/fever | | | | | | | | | | | | | | |
| | % of under 5 with Acute Respiratory Infection (ARI) | | | | | | | | | | | | | | |
| | HIV/AIDS | | | | | | | | | | | | | | |
| | Case of Cholera or Acute Watery Diarrhoea (AWD) | | | | | | | | | | | | | | |
| | Case of Measles | | | | | | | | | | | | | | |
| Food Dimmensions | IPC AFI or Cadre Harmonise Phase | | | | | | | | | | | | | | |
| Caring and Feeding Practices | Exclusive breastfeeding under 6 months | | | | | | | | | | | | | | |
| | Continued breastfeeding between 12-23 month | | | | | | | | | | | | | | |
| | Early Initiation to breastfeeding | | | | | | | | | | | | | | |
| | Introduction of solid, semi-solid or soft foods | | | | | | | | | | | | | | |
| | Restrict consumption by adult in order for small children to eat (rCSI question number 4) | | | | | | | | | | | | | | |
| | % HH Reduce Health & Education expense because of lack of food or money to buy food | | | | | | | | | | | | | | |
| Health Services and Health Environment | MEASLES vaccination coverage | | | | | | | | | | | | | | |
| | POLIO vaccination coverage | | | | | | | | | | | | | | |
| | VITAMIN A supplementation coverage | | | | | | | | | | | | | | |
| | VACCINATION Coverage of all basic vaccinations | | | | | | | | | | | | | | |
| | Skilled attendant at delivery | | | | | | | | | | | | | | |
| | IRON/FOLIC ACID Pregnancy supplementation coverage | | | | | | | | | | | | | | |
| | Coverage of outreach programmes – CMAM (SAM, MAM, or both) | | | | | | | | | | | | | | |
| | WASH - Access to a sufficient quantity of water | | | | | | | | | | | | | | |
| | WASH - Access to improved sanitation facilities | | | | | | | | | | | | | | |
| | WASH - Access to an improved source of drinking water | | | | | | | | | | | | | | |
| | WASH - Water availability for handwashing | | | | | | | | | | | | | | |
| | WASH - Soap availability for handwashing | | | | | | | | | | | | | | |
| Shocks / Hazards | Conflict & Insecurity:% HH facing Insecurity/conflict shocks | | | | | | | | | | | | | | |
| | Economics & Political Factors% HH experiencing job loss | | | | | | | | | | | | | | |
| | Epidemic & Disease Outbreak | | | | | | | | | | | | | | |
| | Natural Factors% HH experiencing any Natural related shocks | | | | | | | | | | | | | | |
| | Population Displacement% of IDP households in the area | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Basic Causes** | Human capital | | | | | | | | | | | | | | |
| | Physical capital | | | | | | | | | | | | | | |
| | Financial capital | | | | | | | | | | | | | | |
| | Natural capital | | | | | | | | | | | | | | |
| | Social capital | | | | | | | | | | | | | | |
| | Policies, Institutions and Processes (PIPs) | | | | | | | | | | | | | | |
| **Other Issues** | Anaemia among children 6-59 months | | | | | | | | | | | | | | |
| | Anaemia among pregnant women | | | | | | | | | | | | | | |
| | Anaemia among non-pregnant women | | | | | | | | | | | | | | |
| | Programme admission trends (SAM, MAM, or GAM) | | | | | | | | | | | | | | |
| | Vitamin A deficiency among pre-school children (6 – 71 months) | | | | | | | | | | | | | | |
| | Vitamin A deficiency among non-pregnant women (15 – 49 years) | | | | | | | | | | | | | | |
| | Low birth weight | | | | | | | | | | | | | | |
| | Fertility rate | | | | | | | | | | | | | | |
| | Crude Death Rate (CDR) – excluding trauma related deaths | | | | | | | | | | | | | | |
| | Under Five Death Rate (U5DR) – excluding trauma related deaths | | | | | | | | | | | | | | |
| | SAM based on WHZ | | | | | | | | | | | | | | |
| | SAM based on MUAC | | | | | | | | | | | | | | |
| | Stunting | | | | | | | | | | | | | | |
| | Prevalence of maternal malnutrition | | | | | | | | | | | | | | |

# ANNEX 1.3 SUMMARY CONTRIBUTING FACTORS TO ACUTE MALNUTRITION IN SINDH

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **VERY LOW** Risk Factor | RISK FACTORS TABLE | | | | | | | | | | | |
| 2 | **LOW** Risk Factor | PAKISTAN | | | | | | | | | | | |
| 3 | **MEDIUM** Risk Factor | Sindh | | | | | | | | | | | |
| 4 | **HIGH** Risk Factor | Tharparkar | Umerkot | Mirpurkhas | Badin | Sujawal | Sanghar | Shaheed Benazirabad | Khairpur | Dadu | JAcobabad | LArkana | Qambar Shahdatkot |
| 5 | **VERY HIGH** Risk Factor | | | | | | | | | | | | |
| 8 | No Data Available | | | | | | | | | | | | |
| IPC AMN Phase Classification | | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN |
| (Current Period : October 2025 – March 2026) | | Phase 4 | Phase 4 | Phase 3 | Phase 4 | Phase 4 | Phase 4 | Phase 4 | Phase 4 | Phase 4 | Phase 4 | Phase 4 | Phase 4 |
| IPC AMN Phase Classification | | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN | IPC AMN |
| (Projection Period : April – September 2026) | | Phase 4 | Phase 4 | Phase 3 | Phase 4 | Phase 4 | Phase 4 | Phase 3 | Phase 3 | Phase 4 | Phase 4 | Phase 3 | Phase 4 |
| Individual Food Intake | Minimum Dietary Diversity (MDD) | | | | | | | | | | | | |
| | Minimum Meal Frequency (MMF) | | | | | | | | | | | | |
| | Minimum Acceptable Diet (MAD) | | | | | | | | | | | | |
| | Minimum Dietary Diversity – Women (MDD-W) | | | | | | | | | | | | |
| Health Status | % of under 5 with Diarrhoea | | | | | | | | | | | | |
| | Dysentery | | | | | | | | | | | | |
| | % of under 5 with Malaria/fever | | | | | | | | | | | | |
| | % of under 5 with Acute Respiratory Infection (ARI) | | | | | | | | | | | | |
| | HIV/AIDS | | | | | | | | | | | | |
| | Case of Cholera or Acute Watery Diarrhoea (AWD) | | | | | | | | | | | | |
| | Case of Measles | | | | | | | | | | | | |
| Caring and Feeding Practices | Exclusive breastfeeding under 6 months | | | | | | | | | | | | |
| | Continued breastfeeding between 12-23 month | | | | | | | | | | | | |
| | Early Initiation to breastfeeding | | | | | | | | | | | | |
| | Introduction of solid, semi-solid or soft foods | | | | | | | | | | | | |
| Health Services and Health Environment | MEASLES vaccination coverage | | | | | | | | | | | | |
| | POLIO vaccination coverage | | | | | | | | | | | | |
| | VITAMIN A supplementation coverage | | | | | | | | | | | | |
| | VACCINATION Coverage of all basic vaccinations | | | | | | | | | | | | |
| | Skilled attendant at delivery | | | | | | | | | | | | |
| | IRON/FOLIC ACID Pregnancy supplementation coverage | | | | | | | | | | | | |
| | Coverage of outreach programmes – CMAM (SAM, MAM, or both) | | | | | | | | | | | | |
| | WASH - Access to a sufficient quantity of water | | | | | | | | | | | | |
| | WASH - Access to improved sanitation facilities | | | | | | | | | | | | |
| | WASH - Access to an improved source of drinking water | | | | | | | | | | | | |
| | WASH - Water availability for handwashing | | | | | | | | | | | | |
| | WASH - Soap availability for handwashing | | | | | | | | | | | | |


Shocks / Hazards
Conflict & Insecurity
Economics & Political Factors
Epidemic & Disease Outbreak
Natural Factors
Population Displacement
Basic Causes
Human capital
Physical capital
Financial capital
Natural capital
Social capital
Policies, Institutions and Processes (PIPs)
Other Issues
Anaemia among children 6-59 months
Anaemia among pregnant women
Anaemia among non-pregnant women
Vitamin A deficiency among pre-school children (6 – 71 months)
Vitamin A deficiency among non-pregnant women (15 – 49 years)
Low birth weight
Fertility rate

# ANNEX 2: LIST OF PARTICIPANTS IN ANALYSIS WORKSHOP

| S.NO | Name | Designation and Organisation |
|---|---|---|
| 1 | Dr. Samina Parveen Ansari | Additional Director General, Directorate General Health Services Sindh |
| 2 | Mr. Abdul Qayoom Pitafi | Statistical Officer, Bureau Of Statistics, Planning & Development Department, Sindh |
| 3 | Mr. Abid Shahzad | Assistant Director, National Disaster Management Authority |
| 4 | Mr. Syed Sadiq | Farmer Exposure Learning Specialist, FAO Balochistan |
| 5 | Mr. Ajay Kumar | Assistant Director, Rehabilitation PDMA Sindh |
| 6 | Mr. Akbar Khan | Assistant Director (Technical), Bureau Of Statistics Khyber Pakhtunkhwa |
| 7 | Ms. Arooj Fatima | Project Officer, Welthunger Hilfe (WHH) |
| 8 | Mr. Asghar Jamali | Deputy Director (Rescue/M&E), PDMA Balochistan |
| 9 | Ms. Azra Rehman | MEAL Assistant, SIF |
| 10 | Dr. Muhammad Qasim | Director, PARC |
| 11 | Dr. Farwa Asfandyar | Senior Manager - Public Health, SHINE Humanity |
| 12 | Mr. Hidayat Ullah | Deputy Director Nutrition, Department Of Health KP |
| 13 | Dr. Saadia Saeed | Program Associate , Dpt Of Health |
| 14 | Dr. Sundus Farah | Veterinary Officer, Livestock And Fisher-ies Department, Sindh |
| 15 | Mr. Azhar Hussain | Assistant Livelihood Officer, Islamic Relief |
| 16 | Mr. Farooq Ahmed | Assistant Director, BoS Balochistan |
| 17 | Ms. Fatima Javed | MEAL Officer, Islamic Relief Pakistan (IRP) |
| 18 | Dr. Gulalai Rehman | Director DGHS, Health Department Balochistan |
| 19 | Mr. Habib ur Rehman | Programs Director, BEAM |
| 20 | Mr. Hamid Ali | Training and Placement Officer, Interna-tional Rescue Committee |
| 21 | Mr. Imran Jatoi | Nutrition Officer, UNICEF |
| 22 | Mr. Muhammad Kazim | Deputy Director, Bureau Of Statistics, Sindh |
| 23 | Ms. Meena Iqbal | Nutrition and Health Specialist, Indus Hospital And Health Network |
| 24 | Mr. Mubashir Hassan | AA Specialist, FAO, Sindh |
| 25 | Mr. Aamir Saeed | Program Manager, SAIBAN |
| 26 | Mr. Muhammad Kamran | Program Manager, Youth Organization |
| 27 | Dr. Nisar ul Haq | Monitoring Officer, Livestock & Dairy Development Department (Extension) Khyber Pakhtunkhwa |
| 28 | Dr. Peer Muhammad | Senior Veterinary Officer, Livestock De-partment |
| 29 | Mr. Qamar Din Tagar | Head of Program, Action Against Hun-ger |
| 30 | Mr. Sajid Shafique | Director (Nutrition), Health/ Nutrition /PPHI Sindh |
| 31 | Mr. Saeed Alam | Information & Knowledge Management Officer (Nutrition),, UNICEF KP |
| 32 | Ms. Shagufta Hidayat | Protection Officer, General And Child Cell, PDMA KP |
| 33 | Mr. Shahid Ali | Head of Project / Project Coordinator, Welthungerhilfe - WHH |
| 34 | Ms. Shazia ejaz | Assistant Director, Ministry Of National Health Services Regulation &Coordination |
| 35 | Ms. Shahnila | Research Officer, MoPDSI |
| 36 | Mr. Sultan Ahmed | Data and Analytical Officer, UNICEF Is-lamabad |
| 37 | Dr. Tahira Gul | Public Health Specialist, MOMENTUM |
| 38 | Mr. Touseef Abbas | Nutrition & ECD Specialist, MERF |

| S.NO | Name | Designation and Organisation |
|---|---|---|
| 39 | Mr. Aman ur Rehman Khan | Program and Policy Officer, WFP |
| 40 | Mr. Muhammad Fiaz | Advisor, PMS |
| 41 | Mr. Damien Pereyra Ngono | Regional Nutrition Specialist , GSU/UNICEF |
| 42 | Dr. Syed Irshad Shah | Food Security and Systems Specialist, FAO |
| 43 | Mr. Muhammad Umer Afzal | Statistician, FAO |
| 44 | Ms. Aqsa Noor Shaikh | Data Analyst, FAO |
| 45 | Mr. Zaheer Khan | Information Management Officer, UNICEF |
| 46 | Ms. Shakila Hassin | Program associate nutrition, WFP |
| 47 | Majid Khan | Executive Director, RDS |
| 48 | Ms. Samreen Soomro | Public health officer, Sindh Integrated Health And Population Program SIHPP |
| 49 | Raja Ajmal Jahangeer | FAO |