The Government of Pakistan (GoP) has begun to place increasing policy focus on nutrition and food security. Despite periods of high growth, Pakistan failed to achieve commensurate reductions in the prevalence of undernutrition, stunting among children, and child mortality. To accelerate progress in these areas, Pakistan joined the international Scaling Up Nutrition (SUN) movement, set up Sustainable Development Goals (SDGs) monitoring units, and has developed Multi-Sectoral Nutrition Strategies (MSNS) in each province. In this research note, we analyze the nutrition history in Pakistan before and after devolution.

Before Devolution (Pre 18th amendment)

Nutrition historically has been a low priority area in Pakistan, with low visibility from the political leadership. However, Pakistan renewed its pledge to improve health outcomes of the population when it signed the World Health Organization’s (WHO) Alma-Ata Declaration in 1978, which laid the foundations for “Health for All” by the Year 2000. More than a decade later, the GoP launched its first National Health Policy in 1990. The policy focused on school health services, family planning, nutrition programs, sanitation, safe drinking water and control of communicable diseases (WHO, 1978). Among the many targets that the government set to achieve under the National Health Policy 1990, the reduction of the Infant Mortality Rate (IMR) from 120 to 50/1000 live births was one. However, progress towards achieving this target was slow and, by the year 2000, IMR had just declined to 90/1000 live births. However, life expectancy increased from 56 years to 63.7 years in 2000, a little over the target of 60 years set by the policy (GoP, 1990).

The National Program for Family Planning and Primary Health Care, commonly known as the Lady Health Worker Program, was initiated under the construct of family planning within National Health Policy of 1990. “Lady Health Workers” (LHWs) were to be the frontline healthcare providers for outreach services to rural populations and urban slums all over the country. There were about 10,000 LHWs in 1994, which has grown to over 100,000 in the country, covering 60-70% of the population. They provide promotive, preventive, curative and rehabilitative services to the community in areas of Family Planning (FP) and Maternal and Child Health (MNCH), specifically to pregnant and lactating women and children. The nutritional activities covered by LHWs are micronutrient supplementation to women of child bearing age, Vitamin A drops to children 6 to 60 months, growth monitoring, counselling on breast feeding & weaning practices, and nutrition awareness (Lashari, 2004).

After the review of the impact of the National Health Policy of 1990, the government made successive attempts to streamline it further in 1997 and 2001. The National Health Policy of 1997 emphasized the need for health promotion and health education initiatives. It proposed ambitious targets like the reduction of IMR to 40/1000 live births and the Maternal Mortality Ratio (MMR) to 200/100,000 live births by 2003. Furthermore, life expectancy was to be increased to 65 years, routine immunization coverage was targeted to reach 80%, and skilled health personnel were to attend 70% of pregnancies. These documents remained piecemeal efforts, typically ignoring the nutritional needs of the population at large (WHO, 2008).

A National Vitamin A strategy meeting was held in 1999 to develop a National Plan of Action for Vitamin A Supplementation for children between 6 to 59 months and for post-partum women. The government, with support from Canadian International Development Agency (CIDA), the Micronutrient Initiative (MI), and the United Nations
Children Fund (UNICEF) pledged to introduce Vitamin A supplementation during the National Immunization Days under the Expanded Program of Immunization (EPI). According to the latest estimates, Vitamin A supplementation now reaches more than 95% of children under the age of five, ensuring that more children can survive and thrive.

To guide efforts towards health and nutrition, and to increase the global competitiveness of the country, GoP adopted 16 targets and 41 indicators within eight goals by signing the Millennium Development Goals in 2000. Following this, the revised Health Policy of 2001 was then aligned with ten key priority areas for health reforms. One of the priority areas was aimed at bridging the basic nutrition gap in the target population, i.e., children, women and vulnerable population groups. The government planned vitamin A supplementation for all children under the age of 5, provision of iodized salt, introduction of fortified flour and vegetable oil, and mass awareness programmes through multimedia. In addition, plans were made to establish a nutrition wing within the Ministry of Health (MoH), led by nutrition experts and mass communication specialists for steering nutrition efforts (GoP, 2001).

Taking the momentum of the Millennium Development Goals (MDGs), and the revised health policy of 2001, plans for establishing a nutrition wing within MoH were brought forth in 2002. The wing was responsible for implementing and monitoring nutrition activities at the federal level, with nutrition being considered a sub-set of the health department. The Nutrition Wing had no direct role in the provinces or districts in implementation of nutrition activities. It also steered development of the National Nutrition Strategic Program, which was later not implemented.

The drive for improved nutrition kept building up and the first true multi-sectoral pilot initiative, Tawana Pakistan Project, funded by the GoP to address poor nutritional status and enrollment in primary school (girls only), was rolled out in the same year. The Department of Women Development and Bait ul Maal, as well as multiple Non-Governmental Organizations (NGOs), were strategic partners in the pilot. It was implemented in 29 high poverty districts across Pakistan, including the Northern areas and Azad Jammu Kashmir (AJK). The program showed promise as underweight, wasting and stunting were reduced by 22%, 45% and 6% respectively. Similarly, school enrolment increased by 40% as well as women’s ability to plan balanced meals. However, turf issues and low district ownership led to the discontinuation 2 years into the program (Badruddin et al., 2008).

To accelerate progress towards MDG 4 (reduce by two-thirds, between 1990 and 2015, the under-five mortality rate) and 5 (reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio), the National Maternal and Newborn Child Health (MNCH) Program was created in 2006. Initiatives under this program were geared towards improving quality and coverage of MNCH services, especially at the primary and secondary levels of the health care system, coupled with community outreach services through integrated system-wide approaches. The Program was implemented in 134 districts across the four provinces, AJK, Northern Areas, Federally Administered Northern Areas (FANA) and Federally Administered Tribal Areas (FATA). Mid-term evaluations of the program showed that progress was steady but slow considering the state of Pakistan’s economy at the time. In addition, provincial MNCH indicators were vastly disproportionate, with Gilgit Baltistan (GB) and Balochistan furthest behind. A similar observation was made when comparing urban and rural areas. The new cadres of Community Midwives (CMWs) were limited in their performance due to weak linkages to the health care system and negligible social mobilization to increase demand and acceptance. The evaluation however did not cover assessment of impact of nutrition interventions like introduction of low osmolality Oral Rehydration Solutions (ORS), use of Zinc in management of diarrhea, and micronutrient supplementation/sprinkles that were implemented on a large scale (GoP, 2012a).

Despite these efforts, the 2008 MDG Gap Task Force report revealed that Pakistan still lagged in several MDG indicators, with at least 24 indicators off track (UN, 2008). These revelations forced policy makers to draft the National Health Policy of 2009 to address domestic issues and to strive to achieve the MDGs. In addition to the rhetoric of improving health and quality of life for all Pakistanis, particularly women and children, through access to essential health services, this policy was formulated to resonate with the expectations of the provinces and to contribute to
strengthening of provincial health strategies. Unfortunately, the policy was not approved due to the promulgation of 18th amendment (GoP, 2009).

After Devolution (Post 18th amendment)

With the approval of 18th amendment to the constitution, 17 ministries from the center were devolved to provinces, thereby increasing autonomy. Moreover, devolution increased the fiscal space for the provinces as a result because of the 7th National Finance Commission (NFC) award of 2009. Funding increased to Punjab, Sindh, Khyber Pakhtunkhwa (KP) and Balochistan by 20.4%, 24.5%, 58% and 132% respectively. Devolution enabled the development partners’ direct engagement with the implementers to spearhead nutrition as a new public policy agenda (Zaidi et al., 2013).

Post 18th amendment, the provincial governments decided to steer the health sector through independent strategies. These strategies were developed in response to challenges related to the quality of service delivery and coverage, competency of the health workforce, governance and regulation of the health sector, and ensuring that the poor and vulnerable are financially covered. Focus on key strategic areas included an integrated approach through Essential Health Services Packages at all levels, contracting out of services, development of multi-sectoral nutrition strategies, restructuring of the Department of Health, and regulation of public and private hospitals was emphasized (Government of Punjab, 2012). The strategies served to guide positive steps towards reforming the health sector; however, structural and operational challenges limited their impacts.

The nutrition wing shifted to the Planning Commission (PC) and was financed through the development budget of the Commission, post devolution, which was a challenge since it was not an implementing agency. While there was much greater recognition of nutrition issues post-devolution, the progress was impeded by lack of coordination with no single institution responsible for nutrition at the federal level (USAID, 2014).

The floods of 2010 and 2011, along with findings of the National Nutrition Survey (NNS) 2011, drew attention to the dismal state of maternal and child under-nutrition. This led to collaborative efforts by UN partners towards Community Management of Acute Malnutrition (CMAM) all over Pakistan to screen and alleviate children’s suffering from Moderate Acute Malnutrition (MAM) and Severe Acute Malnutrition (SAM). Training was provided on screening and management of SAM and MAM cases, followed by a referral of those with severe complications. Supplies and equipment such as those needed for anthropometric measurements and stabilizing centers were provided by UNICEF while “Ready to Use Therapeutic Food (RUTF),” antibiotics and other emergency care medicines were also arranged (GoP, 2012b).

With this visibility in the media and among political stakeholders, the need to develop frameworks to guide nutrition efforts to address under-nutrition became necessary. The Pakistan Integrated Nutrition Strategy (PINS) was developed in 2011 to facilitate cross-sectoral action on nutrition, contrary to the previous practice of confining it to the health department. PINS were developed to link all government line departments at the federal level to encourage nutrition sensitive inter-sectoral planning and implementation of programs. Specific objectives of PINS included prevention and treatment of malnutrition among children under five, an improved nutrition status of pregnant and lactating women, children and people in emergency situations as well as other vulnerable groups. It can be said that PINS was then used as a strategic framework to guide provinces to define nutrition in their provincial post devolution development agendas (WHO, 2011).

On the international front, Pakistan also became a signatory to the Scaling Up Nutrition (SUN) movement in 2013. The SUN movement advocates that all people have a right to food and good nutrition and brings together diverse stakeholders from governments, civil society, UN agencies, donors, researchers, academia, private sector and businesses, with efforts directed towards improving nutritional status of the population. SUN roadmaps and units
have been hosted in the respective provincial Planning and Development Departments (P&DDs). As part of this movement and considering PINS, the provincial Nutrition Policy Guidance Notes and Multi-Sectoral Nutrition Strategies were drafted within the scope of Pakistan Vision 2025.

Additionally, the establishment of coordination networks, steering committees and technical working groups at the provincial level were instituted through the efforts of the P&DDs. All provincial governments developed and endorsed MSNS with varying stages of development towards integrated PC-1s (SUN, 2016). The MSNS was endorsed in Balochistan and KP with a nutrition PC-1, but there have been delays in implementation. The Balochistan Nutrition Program for Mothers and Children (BNPMC) was made a part of the PC-1 for the province to improve the nutritional status of male and female children under five in seven selected districts. Both Punjab and KP integrated the PC-1s for health reform with strong nutrition components and with integrated action across WASH, agriculture, education, livestock, and school feeding, supported by annual development funds in the concerned sectors. GB still lags with a just a drafted MSNS and a nutrition PC-1, which is pending approval from the Planning Commission, whereas FATA also has an MSNS drafted and is in final stages of approval. AJK is furthest behind in this regard with MSNS endorsed and PC-1 drafted only for the nutrition specific health component while all other sectors are pending (Ronis and Nishtar, 2007 and GoP, 2015).

Overall provincial planning for nutrition sensitive interventions has been slow, with Sindh leading the way by formulating an implementation plan known as the "Accelerated Action Plan for Reduction of Stunting and Malnutrition" and appointing a task force for this with inclusion of the Chief Minister’s office. In addition, the Nutrition Support Programme for Sindh (NSP) is underway in nine selected districts to improve the nutritional status of male and female children under five years and for pregnant and lactating women. Punjab has followed suit by trying to overcome the verticality in health programs by integrating MNCH and the LHW Programs to an Integrated Reproductive, Maternal and Child Health (IRMNCH) program in 2014 and approving the “Stunting Reduction Program” in 2017.

**Policy and programs designed for impacting nutrition outcomes**

With respect to policies directly impacting nutritional status - breastfeeding, salt iodization and food fortification efforts have also been woven into the historical context of nutrition within Pakistan. These are discussed separately below to ensure a complete picture of the status of these initiatives.

**Food Fortification**

Efforts towards setting food standards began with the passage of the West Pakistan Pure Food Ordinance in 1960 to safeguard consumers’ health through provision of quality food items, which would be free from all kinds of adulterations. This was followed by mandatory food fortification legislation of vegetable oil under the Pakistan Pure Food Rules of 1965, as fortification was one of the most cost-effective solutions to address chronic micronutrient deficiencies without requiring changes in eating habits. The “Pure Food Amendment Act” for Sindh and Balochistan were enacted in 1995, while KP and GB followed in 2001 by passing Pure Food Acts. Most recently, the Balochistan Food Authority Act was enacted in 2014, while AJK’s legislative assembly adhered to the West Pakistan Pure Food Ordinance, (Adaptation) Act, 1987. FATA, with its’ unique political status, had all federal laws extended to the province, including a Pure Food Ordinance. The Punjab Food Authority Act and the Punjab Pure Food Ordinance were amended in 2015 and 2016 respectively.

Other than oil, wheat flour is also considered an ideal commodity for fortification, with per capita consumption of wheat in Pakistan among the highest in the world (Gaffey et al, 2014). In 2008, a national standard for wheat flour fortification was set by Pakistan Standards and Quality Control Authority (PSQCA), however no national legislation existed. A Memorandum of Understanding (MOU) was signed between the MoH and the Utility Stores Corporation (USC) for to provide iron fortified wheat flour to the public through USC retail outlets in Islamabad, Karachi, Lahore and Peshawar. [Technical Resource Facility (TRF), 2012]. Donor related efforts were made in this regard through
Global Alliance for Improved Nutrition (GAIN) and Micronutrient Initiative (MI) initially in Punjab and then rolled out in other provinces. In terms of legislation, Punjab was the only province to mandate wheat flour fortification in 2014 while the rest are yet to follow. (GAIN, 2015)

The National Fortification Alliance (NFA) was established in 2013 under the Ministry of National Health Services, Regulation and Coordination. A meeting was held in May 2015 to provide foundations and grounds regarding formation of Provincial Fortification Alliances. The NFA will also foresee the revitalization of the fortification program which was suspended after devolution (GoKP, 2017, GoB, 2015, GoB, 1995 and Khan, 2013).

**Salt Iodization**

Salt iodization initiatives began as early as 1971, when a salt iodization plant was installed in Skardu, followed by another one in Peshawar in 1975, as clinical cases of goiter became more prevalent especially in KP and FATA. It was found that the cost of fortification was extremely low compared to the cost of iodine deficiency (World Bank Report 1994).

The National Iodine Deficiency Disorder (IDD) Control Program was initiated in 1989, with support from UNICEF. The GoP provided financial and logistical support to private salt processors of iodized salt and to establish an Iodine Supplementation Support Facility at the Federal level. This facility acted as a connection between the government and salt processors, and motivated them to produce iodized salt while making efforts to create mass awareness through advocacy and media to increase acceptance of iodized salt by the public.

In 2001, the nutrition division developed a semi-quantitative rapid testing kit for use in field surveys and in process quality control of iodized salt. Furthermore, an iodine laboratory was established where salt received from various sources was tested for quality. The lab also tested urine samples to determine iodine levels in the population. MI continued efforts in 2005 and conducted the first ever Pakistan Salt Sector Survey to document structure and capacity of the salt industry in Pakistan. Results of the survey showed that only 14% of salt was iodized and 80% of the salt processors had received no formal capacity building on salt iodization, or had the necessary equipment to adequately iodize salt.

The results of this survey and incorporation of lessons from the earlier National IDD Control Program paved way for the “Universal Salt Iodization (USI)” program, which was initiated by the Nutrition Wing of the Ministry of Health, with technical and financial support of MI. Phase I of the program was launched in 2006 as a pilot in 20 districts (called Salt Iodization Model Districts) where salt iodization reached over 90% of the population. The World Food Program (WFP) and MI joined hands in July 2006 to expand the program in Phase II to 29 districts in KP, AJK, GB and FATA at high risk of iodine deficiency. Successful implementation of these two phases encouraged MoH with MI to scale up the program to 16 districts in Punjab in 2007. By 2009, MI was covering 53 districts in Pakistan in northern Punjab and half of rural Sindh. In addition to supplying rapid test kits and advocacy for salt iodization, potassium iodate was subsidized and Salt Processors’ Association was established for internal monitoring and quality control. Provincial Health Managers, Food Inspectors and USI field staff were also trained for quality control and provincial IDD Control committees were established under the district head (Deputy Commissioner). Community based monitoring and mobilization was done through engaging LHWs, religious scholars, school health and nutrition supervisors and relevant locally tailored Information, Education and Communication (IEC) material was also distributed to raise awareness.

There is no legislation for salt iodization in Pakistan, but advocacy with policy makers has enabled enactment of district level legislation and amendments to the Pure Food Rules. A decision was made in 2007 to pass national legislation with respect to iodization. “The IDD Control Bill 2009” was drafted but not passed. The legislation only specified that producers of iodized salt need to be licensed/registered, whereas in other countries the emphasis is on
“all salt producers” or “producers of edible/food grade salt.” Currently only Punjab (2015) and Sindh (2013) have legislated the compulsory iodization of salt, but KP and Balochistan both mandate salt iodization province-wide through amendments to regulations that attend the provincial food laws. Most districts in Punjab have implemented by-law amendments to the same effect. Legislation is required to continue enforcement and sustain the impact of USI that has managed to increase iodized salt consumption from 17% in 2001 to 69% in 2011. As a result of increased iodized salt consumption, a significant drop in the prevalence of iodine deficiency in Pakistan has been observed. For instance, iodine deficiency in children aged 6-12 years has been cut in half between 2001 and 2011, as it decreased from 64% to 36%. Similarly, goiter prevalence among women of reproductive age dropped from 37% in 2001 to 3% in 2011 (USI Pakistan, 2018). With MI withdrawing in 2018, the provinces plan to take over salt iodization efforts completely (Gaffey et al., 2014).

Breastfeeding and Child Nutrition

The “Protection of Breast-Feeding and Child Nutrition Ordinance” became official in 2002 with the purpose of raising exclusive breastfeeding rates in the country. Despite endorsement in 2002 at the federal level, implementation of this ordinance remained a dream in the face of devolution and an absence of defined rules and procedures to make its implementation effective. In 2009, the MoH notified the Protection of Breastfeeding Rules and the National Infant Feeding Board to monitor implementation, which came into existence in 2010. Punjab introduced the legislation in 2012 while Sindh assembly unanimously passed the act in 2013. Balochistan followed and enacted a breast-feeding act in 2014. While KP did so in 2015. Provinces that enacted the legislation also notified and formed infant feeding boards. However, FATA, AJK and GB have yet to enact this legislation and establish infant feeding boards.

After seven years of delay, in 2015 Pakistan, along with its development partners, also finalized the much-needed National Strategy on Infant and Young Child Feeding (IYCF) practices for 2016-2020. The four-year national strategy was finalized in a meeting of the National Technical Advisory Group (TAG) for IYCF. In this context, the curriculum of LHWs was also revised to include IYCF advice as part of their assigned duties. Following this, all provinces constituted infant feeding boards for the effective implementation of breastfeeding laws. The National Strategy stresses having adequate legislation to protect the breastfeeding rights of working women, and to ensure that processed infant and complementary foods are safe and nutritionally adequate and in line with relevant Codex Alimentarius guidelines. The Strategy however falls short in adequately addressing the needs of mothers employed under informal contracts, such as in the agriculture sector, where approximately 74% of the female labor force is found (LFS, 2013-14). Lastly, the Strategy lays emphasis on capacity among the health system and community to support IYCF in exceptionally difficult circumstances, including emergencies and Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) among others.

Conclusion

Through its various plans, programs, and policies, the Government of Pakistan has managed to bring nutrition into the political stream by making it part of the Pakistan Vision 2025 under pillar IV (GoP, 2014). In the post-devolution context, cross-sectoral dialogues about nutrition have begun in each of the provinces, led by the P&DDs and technically supported by development partners. Whilst momentum has been built, it must be sharpened and sustained. The government has consistently noted its commitment to the goal of achieving food security and adequate nutrition all its people, even if sometimes its achievements and efforts may have fallen short of its commitments. The very nature of nutrition does not offer quick, short-term wins but instead relies on a cohesive development vision that has not been forthcoming, with development priorities in Pakistan dominated by economic growth, food security and infrastructure-dominated projects. Political commitment for nutrition-related institutions has been gradually building, however, the pace of implementation of health and nutrition programmes has been affected by the devolution and the volatile security situation in some parts of the country (Zaidi et al., 2013 and Bhutta et al., 2015).
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