



Policy Brief

WOMEN AND MALNUTRITION

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Executive Summary

Malnutrition in Pakistan is a neglected issue. This brief outlines the extent of the issue in the country. It puts particular emphasis on women's malnutrition. The brief also expands upon the causes of malnutrition including but not limited to the lack of female authority in the household, socio-cultural barriers and the state of health facilities in certain areas of the country. It brings to light the effects of malnutrition on women and their children's health. Additionally, it elaborates the current policies in place to remedy the causes of malnutrition while suggesting solutions and improvements to the current state approach to tackling malnutrition in Pakistan.

Introduction

Malnutrition in Pakistan is a cause of concern as it affects the quality of life of a large segment of the population. According to United Nations Children's Fund (UNICEF), 43.7 percent of the population suffers from stunting¹ and 15.1 percent suffers from wasting² (Malik 2015). Statistics from the National Nutritional Survey 2011 also narrate a similar story. Among women, malnutrition leads to a range of adverse health outcomes (during pregnancy and

other than pregnancy). These include but are not limited to anemia, low body mass index, fatigue, headaches, dizziness, and depression, increased susceptibility to various infections, lower productivity and slower recovery from illness.

Prevalence of Disease	Pregnant Women	Non Pregnant Women
Anemia	51.0%	50.4 %

¹ "Failure to reach linear growth potential because of inadequate nutrition or poor health, also defined as a chronic restriction of growth in height indicated by low height-for-age. Stunting is usually a reliable indicator of long-term under nutrition among young children." (NNS 2011)

² "Acute weight loss indicated by a low weight for height ratio. Wasting is usually a result of acute starvation or severe disease. Often more chronic during the first two years of life, wasting is part of a pattern of under nutrition." (NNS 2011)

Vitamin A deficiency	46.0%	42.1%
Vitamin D Deficiency	68.9%	66.8%
Zinc Deficiency	47.6%	41.3%
Iron-Deficiency	37.0%	26.8%

Table 1 Prevalence of micro nutrient deficiencies among women in Pakistan.
Source: National Nutrition Survey 2011

As mothers and caregivers, women's health also directly affects that of their children's. "A woman with poor nutritional status, has a greater risk of obstructed labor, of having a baby with a low birth weight, of producing low-quality breast milk, of death due to postpartum hemorrhage, and of morbidity for both herself and her baby" (PDHS 2012). This is also supported by the National Nutritional Survey (NNS) as pregnant women are more likely to be deficient in vitamin A and D, zinc and iron as compared to non-pregnant women. This leads to adverse effects on their children's health (see table 1).

Women in Pakistan are particularly susceptible to malnutrition because of cultural norms that result in their food intake being lesser than that of the rest of the family (Bari 2000). Moreover, in Pakistan, women face intra-household discrimination with regards

to the distribution of resources. This discrimination results in compromised nutritional outcomes.

Pregnant women in rural areas are more likely to be deficient in essential nutrients affecting their children's health (see table 2).

Deficiency/ Disease	Rural	Urban
Low Ferritin Concentration	38.1%	34.1%
Zinc	47.7%	47.4%
Calcium	92.5%	92.3%
Vitamin A	47.8%	41.5%
Vitamin D	67.2%	74.5%
Anemia	50.5%	50.3%
Night Blindness during Pregnancy	29.3%	26.0%

Table 2 Prevalence of various nutritional deficiencies among pregnant women with reference to the rural urban divide.
Source: National Nutrition Survey 2011

For non-pregnant women as well, nutritional deficiency is more prevalent in rural areas as compared to urban areas (see table 3).

Deficiency	Rural	Urban
Low Ferritin Concentration	26.8%	26.8%
Zinc	42.7%	38.2%
Vitamin A	45.1%	34.9%

Anemia	50.9%	49.3%
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Table 3 Rural Urban differences for non-pregnant women.

Source: National Nutrition Survey 2011

Regional variations have also been observed for micro-nutrient deficiencies (see table 4). For instance according to the National Nutritional Survey 2011, for non-pregnant women from six regions of Pakistan (Punjab, Sindh, Balochistan, Khyber Pakhtunkhwa, Gilgit-Baltistan and Azad Kashmir), micro-nutrient deficiencies were highest in Sindh and Balochistan and were lowest in Khyber Pakhtunkhwa and Gilgit-Baltistan.



Social Enterprise
Development Centre

Province	Anemia	Ferritin	Vitamin A	Zinc	Vitamin D
Sindh	62%	31.5%	34.5%	38.5%	71.2%
Punjab	48.6%	27.3%	41.5%	40.2%	66.4%
Balochistan	48.9%	21.8%	54.5%	43.6%	54.6%
KP	35.6%	15.6%	65.7%	52.6%	61%
Gilgit-Baltistan	23.3%	14.9%	38.7%	54.4%	80.9%
Azad Kashmir	41%	25.2%	13.7%	95.8%	73.3%

Table 4 Regional variations for micro-nutrient deficiencies.

Source: National Nutrition Survey

Anemia and low levels of ferritin concentration were the highest in Sindh while the highest deficiency of Vitamin A was recorded in Khyber Pakhtunkhwa (65.7 percent). Azad Kashmir was highly deficient in Zinc (95.8 percent) while Vitamin D deficiency was the most prevalent in Gilgit-Baltistan (80.9 percent). Such regional

disparity suggests that malnutrition is a pressing issue across all provinces.

Micro-nutritional deficiencies also show regional variation among pregnant women. Prevalence of anemia was seen to be highest in Sindh (59.7 percent) and lowest in Khyber Pakhtunkhwa (30.2 percent) while the prevalence of low ferritin levels were highest in Gilgit Baltistan (45.7 percent).

There are multiple effects of these nutritional discrepancies on the outcomes on women as well as children. Malnutrition starts from birth and continues through early life and can have adverse long term effects. The graph shows how early childhood malnutrition affects health status. It can cause stunting, impaired cognitive development and wasting. It places the child at greater risk of dying in infancy.

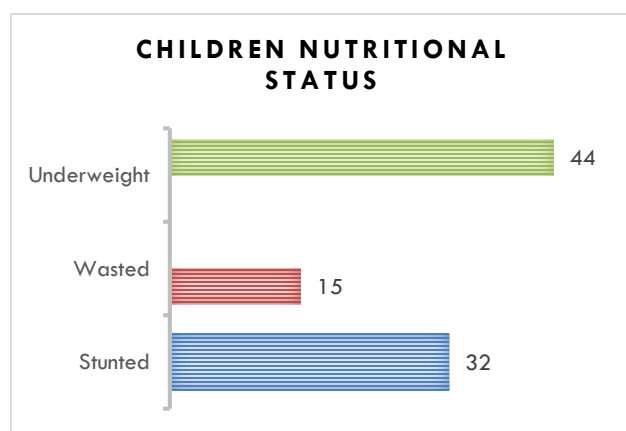


Figure 1 Prevalence of malnutrition in Pakistani children.

Source: National Nutrition Survey 2011

Child malnutrition and women's malnutrition have a correlation as undernourished

mothers are more likely to give birth to underweight and undernourished children. For instance, "children born to mothers who are thin (BMI less than 18.5: Body Mass Index- an indicator for obesity) are more than twice as likely to be underweight (44 percent) as children born to mothers who are overweight or obese (19 percent)" (PDHS 2012).

A BMI of less than 18.5 is indicative of chronic energy-deficiency specifically protein deficiency which has been linked to a greater likelihood of suffering from anemia, particularly iron-deficiency anemia and shows an overall dearth of micro-nutrient intake (iron, vitamin A, iodine) (Mehrotra 2006). As Figure 2 shows, about 14 percent of women from the ages of 15-49 (potential mothers) have a BMI less than 18.5 hence, placing them at risk of malnutrition.

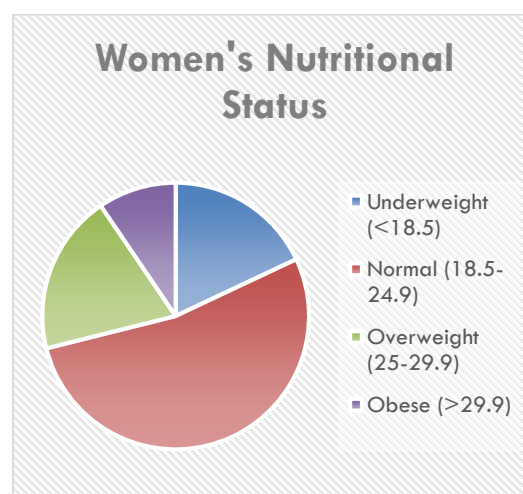


Figure 2 Source: National Nutritional Survey 2011

Determinants of Health Service Uptake

Traditional ideas of a woman's role in society and in the household have contributed to poor health of women in Pakistan.

The traditional setups have created barriers for women's health service uptake. It is usually preferred that women be treated by female doctors. Due to the relatively low numbers of female doctors in remote areas the patient's health suffers.

Other determinants of health service usage are education levels, region, mobility, occupation and religious beliefs. Prominent differences in the use of antenatal care services with respect to rural and urban women have been observed. 67 percent of rural mothers receive antenatal care from a skilled and professional health provider as compared to 89 percent of urban mothers. An increase in wealth and educational attainment of a mother increases the probability of her accessing a skilled health provider during pregnancy. It has been reported that around 97 percent of women who have received at least secondary education receive antenatal care from a skilled health care provider and maintain

their nutritional requirements whereas only 60 percent of uneducated women do the same (PDHS 2012).

Nutritional Programmes in Pakistan

The responsibility of alleviating female malnutrition across the country resides primarily with the Health Ministry at the provincial level. The Ministry is responsible for collecting data to assist in evidence-based policy making and regulating industry to ensure that health standards are met. The Government had launched multiple public health programs for improving maternal, neo-natal and child health. These include the "Women Health Project" that was introduced in 1999 and the 'National Neonatal, Maternal and Child Health Program', which was launched in 2006.

The Iodine Deficiency Disorder/ Universal Salt Iodization Program (IDD/USSI) was also launched in 2006 in collaboration with WFP, UNICEF and GAIN (Global Alliance for Improvement in Nutrition), and was rolled out across all four provinces of Pakistan by 2010. Additionally, Khyber Pakhtunkhwa and Punjab have integrated nutrition programs working in tandem with the World Food Programme (WFP) to improve nutritional outcomes for women.

A number of projects are currently running in partnership with various national and international organizations to address the issue of micronutrient deficiency among women and children. These programmes include the Balochistan Nutrition Programme for Mothers and Children (BNPMC) launched in October 2015 funded by the Pakistan Partnership for Improved Nutrition Multi Donor Trust Fund (PPIN) and the Nutrition Support Programme for Sindh (NSP) launched in August 2015 with the support of the People's Primary Healthcare Initiative (PPHI).

There are also several other programmes like Public Health Care Programme which are working to improve the nutritional outcomes for women in Pakistan.

Despite the efforts of such programmes, the nutrition levels of women and children indicate ineffective implementation of these programs and the need for further interventions.

Policy Issues Affecting Women

Nutritional Outcomes

There are several problems with the state's current approach and implementation strategies towards combatting nutritional deficiencies in women.

Firstly, scarce resources, structural mismanagement and inadequate financing

make health a vulnerable sector of the country. Pakistan is only spending approximate 0.9 percent of its GDP on healthcare which is equivalent to \$9.31 per person per year as compared to globally recommended standard of \$60 per person per year (Zhu et al. 2014). This results in limited resources being available to the policymakers and the stakeholders to effectively formulate and implement relevant strategies.

Secondly, the issue concerns one of the most vulnerable sections of the society; underprivileged women. Under representation in the political arena has led to absence of state level action formulation, creating a delay in the delivery of services. Global Gender Gap Index (GGGI) Report – 2014 records a negative trend for Pakistan in sub index, 'political empowerment' which "measures the gap between men and women at the highest level of political decision-making through the ratio of women to men in minister-level positions and the ratio of women to men in parliamentary positions" (Bekhouche et al. 2014).

Finally, agricultural growth has been an important contributor to economy-wide growth that results in curbing hunger, malnutrition and leads to sustained improvement in living standards. In rural

areas, 72 percent of women are associated with the agriculture sector ensuring household food security (Samee et al. 2015). However, the traditional household set-up offers very limited autonomy to the young women, leading to insufficient levels of nutrition and thus energy to work. . When the agricultural production gets effected, the nutritional status of women and girls suffer.

Policy Solutions for the State

Malnutrition leads to chronic health concerns for women and their offsprings alike, risking the future generation of the country.

Considering the number of issues affecting the nutritional outcomes of women; such as limited financing of the health sector, scarce resources, rampant poverty, lack of female authority in the household, socio-cultural barriers and the state of health facilities, it is extremely important for the State to find effective policy solutions to combat malnutrition.

To tackle the issue of malnutrition, a range of possible interventions can be carried out.

- Illiteracy limits the proliferation of information. Healthcare systems therefore need to participate in spreading such knowledge, specifically at centers that specialize in maternal care. It is because many more women make contact with

healthcare services during pregnancy than they do at any other time in their lives.

- Medical staff form doctors, nurses, lady health workers and midwives need to be trained in talking to families (including husbands since their support is vital) about the importance of proper nutrition for women and girls.
- Focused capacity building needs to be given to those providers who have a greater contact with the women (especially in delivering healthcare to low income and/or rural women), such as lady health workers and informally employed midwives. According to the external evaluation carried out by Hunt et al 2006, the population served under LHWP showed substantially improved health status measures when compared to populations where this intervention did not take place.
- At the micro level, the state can attempt to partner with local leaders with influence to address the importance of health and nutrition for women, and for the community in general.
- Awareness campaigns should be launched at the state level through print and electronic media (TV and

radio). Thereby positively influencing the household dynamics and the perception on women and girls.

- The state should also make greater effort to formally recognize women's contribution in the informal sector by including them within the legal framework on labor. Women's share of employment in informal sector was 60.8 percent in 2001-02 which increased to 70.9 percent in 2012-13 (Aslam et al. 2013).
- Encouraging greater independence of women through employment and education elevates their status in the household. As poor socio-economic status and unequal distribution of food resources results in malnutrition, employment and education will likely improve these which may aid in curbing malnutrition.
- An increase in agricultural productivity would lead to an income growth among farm households, which may allow higher levels of consumption and can improve the nutritional status of the family in

general and women in particular. Along with the National Food and Nutrition Security Policy, the Government should also devise programmes to support female farmers by helping them acquire microfinance loans, acquire technical services or capacity building through trainings in order to improve the socio-economic status of women, which is one of the major reasons for malnutrition (Samee et al. 2015). The government should look into successful pilot initiatives such as dissemination and breeding of orange fleshed sweet potatoes (OFSP) undertaken in countries such as Uganda and Kenya (to counter the deficiency of Vitamin A) and invest in research, development and dissemination of such micro nutrient enriched varieties in the domestic agriculture industry (Hagenimana 1999).

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