



Alternative Submission to the UN Committee on the Rights of Persons with Disabilities on the Government of Pakistan's Implementation of the Convention on the Rights of Persons with Disabilities (CRPD)

National Commission for Human Rights, Pakistan

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1. Introduction

1. The National Commission for Human Rights (NCHR) is an 'A' status National Human Rights Institution. Under the Principles relating to the Status of National Institutions (the Paris Principles) and Section 9 of the National Commission for Human Rights Act, 2012, the NCHR is mandated to monitor, review, and make recommendations regarding the Government of Pakistan's compliance with its international human rights obligations, including the Convention on the Rights of Persons with Disabilities (CRPD). Further information on the Commission is available at: <https://nchr.gov.pk/>.
2. The Commission thanks the Committee on the Rights of Persons with Disabilities (the Committee) for the opportunity to provide this focused written submission in advance of its consideration of Pakistan. The Commission remains committed to constructive engagement with the Committee in support of strengthened implementation of the CRPD.
3. This submission draws on the Commission's monitoring work, engagements with stakeholders, and analysis of publicly available national and international data. The Commission has, where appropriate, raised relevant concerns with the Government of Pakistan through its ongoing advisory and monitoring functions.
4. The present submission adopts a thematic focus on early childhood undernutrition and its implications for the emerging disability burden in Pakistan. While Pakistan has undertaken important legislative and policy measures in the disability and nutrition sectors, persistently high levels of child undernutrition present a significant risk factor for developmental delays and long-term functional limitations among children. These trends have important implications for the realization of rights under the CRPD, particularly in relation to health, education, habilitation and rehabilitation, and independent living.
5. The Commission is concerned that the scale of early childhood nutritional deprivation, when viewed alongside existing service and system constraints, may generate increasing demand for disability-related supports in the coming years. This submission therefore examines the extent to which current systems, including early identification, inclusive education, rehabilitation services, and social protection, are positioned to respond effectively.
6. The submission highlights available evidence, identifies key implementation and preparedness gaps, and draws attention to groups of children who may face heightened risk of exclusion. The Commission's recommendations are aimed at supporting the State party in strengthening preventive, early intervention, and inclusive service frameworks in line with its obligations under the CRPD.

2. Early Childhood Undernutrition in Pakistan (Articles 7 and 25)

National Trends (stunting, wasting, underweight)

1. Pakistan continues to face a significant and persistent burden of early childhood undernutrition. The Government of Pakistan's National Nutrition Survey (NNS) 2018, the most recent nationally representative assessment, indicates that nutritional deprivation among children under five remains at levels of serious public health concern. According to the survey, approximately 40.2 per cent of children under five are stunted, 17.7 per cent are wasted, and 28.9 per cent are underweight, reflecting the coexistence of both chronic and acute forms of undernutrition¹.
2. Taken together, these figures place Pakistan among the countries carrying a high burden of child undernutrition globally. UNICEF estimates that nearly 10 million Pakistani children are affected by stunting, illustrating the scale of chronic growth failure nationwide². The Global Nutrition Report similarly observes that progress in reducing stunting has been slow, with prevalence remaining well above global targets.
3. Beyond anthropometric indicators, the NNS also documents widespread micronutrient deficiencies among young children, including high levels of anaemia and deficiencies in vitamin A and vitamin D. These patterns suggest that undernutrition in Pakistan is not driven by caloric insufficiency alone but is closely linked to broader constraints in diet quality, maternal nutrition, and age-appropriate infant and young child feeding practices.

Provincial and Rural–Urban Disparities

1. National averages mask significant geographic and demographic inequalities in nutrition outcomes. Subnational findings from the NNS 2018 demonstrate wide provincial variation, with stunting ranging from approximately 32.6 per cent in Islamabad Capital Territory to over 48 per cent in the newly merged districts of Khyber Pakhtunkhwa, and several regions of Sindh and Balochistan also recording levels above the national average.
2. Rural–urban disparities remain pronounced. Evidence from national analyses indicates that children living in rural areas face substantially higher risks of stunting compared to urban children, reflecting differences in poverty levels, maternal education, sanitation conditions, and access to health and nutrition services. UNICEF similarly reports that food insecurity, poor diet quality, and

¹ Government of Pakistan, *National Nutrition Survey 2018: Key Findings* (MoNHSR&C and UNICEF)

² UNICEF Pakistan, *Nutrition situation overview*

limited service coverage disproportionately affect children in underserved and rural districts.

3. These spatial inequities suggest that improvements in child nutrition have been uneven and that particular geographic pockets continue to experience persistently elevated risk.

Socioeconomic Drivers

1. Available evidence suggests that early childhood undernutrition in Pakistan is closely shaped by structural socioeconomic factors. Secondary analyses of the National Nutrition Survey consistently show strong associations between stunting and household poverty, low maternal education, food insecurity, poor sanitation, and suboptimal infant and young child feeding practices.
2. Household food insecurity remains a particularly important underlying driver. National data indicate that a considerable share of households experience some degree of food insecurity, constraining access to adequate and diverse diets for pregnant women and young children. UNICEF has similarly emphasized the role of inadequate maternal nutrition during pregnancy, alongside suboptimal breastfeeding and complementary feeding practices, as key contributors to persistent child stunting in Pakistan.
3. Complementary feeding indicators remain especially concerning. National evidence shows that only 7.3 per cent of children aged 6–23 months receive a minimum acceptable diet, pointing to significant gaps in feeding adequacy during a critical developmental window. Dietary diversity is even more limited: only around 3 per cent of children meet minimum dietary diversity standards, indicating that the vast majority of young children are not receiving sufficiently varied diets to support optimal growth and early brain development³. Taken together with evidence on food insecurity, maternal education, and poverty, they indicate that undernutrition in Pakistan is driven by multidimensional socioeconomic and behavioural factors rather than food availability alone.

Data Limitations

1. While Pakistan has made important progress in generating nationally representative nutrition data, notable data gaps remain. The NNS 2018 employs a cross-sectional design intended to provide a snapshot of nutritional status at the time of data collection. Routine, real-time surveillance of child growth and developmental outcomes remains uneven across provinces and districts.
2. Importantly, national nutrition datasets are not consistently integrated with early childhood development or disability-related monitoring systems. This limits the State's ability to track longitudinal pathways from early nutritional deprivation to

³ Government of Pakistan, *National Nutrition Survey 2018*

later functional outcomes. Coverage of programme data also varies across provinces, and administrative reporting systems across health, nutrition, and disability sectors remain fragmented.

3. Strengthening integrated monitoring systems, improving subnational disaggregation, and linking nutrition data with early childhood development and disability indicators would enhance Pakistan's capacity to anticipate and respond to emerging risks associated with early childhood undernutrition.

3. Undernutrition as a Driver of Disability (Articles 7, 25 and 26)

Pathways from Undernutrition to Impairment

1. Early childhood undernutrition, particularly during pregnancy and the first two years of life, is widely recognized as a major risk factor for impaired physical growth and suboptimal neurodevelopment. The World Health Organization (WHO) defines stunting as impaired growth and development resulting from poor nutrition, repeated infection, and inadequate psychosocial stimulation. Evidence from multiple country contexts indicates a consistent association between chronic undernutrition and adverse developmental outcomes across motor, cognitive, and psychosocial domains.
2. While not all undernourished children will develop disabilities, persistently high levels of early nutritional deprivation increase the population-level risk of functional impairments that may affect children's full and effective participation in society. These risks are particularly concerning in contexts where early identification, habilitation, and inclusive support systems remain limited.

Physical Impacts

1. Undernutrition in early life is strongly associated with stunting and growth failure, which reflect prolonged nutritional deprivation during critical periods of development. Children experiencing stunting are more vulnerable to illness and mortality due to weakened immune function and reduced physiological resilience. Chronic undernutrition has also been linked to delayed motor development and increased susceptibility to infections, further compounding developmental risks.
2. Long-term consequences may extend into adulthood. Evidence indicates that early growth faltering is associated with higher risk of nutrition-related chronic conditions later in life, including metabolic disorders and cardiovascular disease. These physical sequelae can contribute to functional limitations and increased health system demand over the life course.

Cognitive and Psychosocial Impacts

1. A substantial body of research demonstrates that early nutritional deprivation is closely associated with impaired brain development and learning outcomes. UNICEF notes that children affected by stunting can experience "severe irreversible physical and cognitive damage" that accompanies impaired growth. Neurological studies indicate that chronic undernutrition is linked to reduced brain volume and weaker neural connectivity, which may translate into lasting functional deficits.

2. Empirical evidence further shows that stunted children tend to have poorer cognitive ability, weaker attention and memory function, and lower educational achievement compared to non-stunted peers. Severe acute malnutrition in early life has likewise been associated with poorer school performance and behavioural difficulties. These developmental effects may manifest as learning disabilities, reduced school readiness, and attention-related challenges during the early years.

Lifetime Rights Implications

1. From a rights perspective, the developmental consequences of early childhood undernutrition have significant implications for the realization of rights protected under the CRPD. Evidence indicates that children who experience stunting are less likely to enroll in school on time and tend to achieve lower educational outcomes. Early nutritional deprivation has also been linked to reduced cognitive development and long-term productivity losses, with potential impacts on employment prospects and economic participation in adulthood.
2. At the population level, high prevalence of early childhood undernutrition may therefore contribute to increased dependency ratios, intergenerational poverty risks, and heightened care burdens on families and public systems. In contexts where inclusive education, rehabilitation services, and social protection coverage remain uneven, these developmental vulnerabilities are more likely to translate into participation restrictions consistent with the CRPD framework.
3. The Commission therefore considers early childhood undernutrition not only a public health concern but also an emerging disability and human rights issue requiring anticipatory, cross-sector policy attention.

4. Projected Future Disability Burden in Pakistan (Articles 7, 26 and 28)

1. Pakistan's current nutrition profile indicates the presence of a large and growing cohort of children at elevated risk of developmental vulnerability. The NNS 2018 reported that 40.2 per cent of children under five are stunted, alongside 17.7 per cent wasted. Recent United Nations and partner assessments confirm that the burden remains substantial. UNICEF reports that nearly 10 million children in Pakistan suffer from stunting, underscoring the scale of chronic growth failure nationwide. Pakistan's stunting prevalence remains significantly higher than the global average of approximately 22 per cent, highlighting the persistence of structural nutrition challenges⁴.

Large cohort of stunted children today

1. The magnitude of stunting in Pakistan represents a major forward-looking risk for child development and human capital outcomes. Estimates based on national data indicate that around four in ten children under five experience impaired linear growth, translating into millions of children entering early childhood with heightened developmental vulnerability.
2. Subnational analyses further demonstrate that the burden is unevenly distributed. Recent research shows significantly higher prevalence in parts of Balochistan, Sindh, southern Khyber Pakhtunkhwa and southern Punjab, with some districts reporting extremely elevated levels. These geographic concentrations raise particular concern for provincial systems that already face service delivery constraints.
3. Importantly, global and World Bank analyses emphasize that the effects of chronic undernutrition in early life are often long-lasting and difficult to reverse after the first years of life, underscoring the need for early preventive action.

Many will enter school with developmental delays

1. A substantial body of evidence links early childhood stunting with poorer cognitive performance, reduced school readiness, and lower educational attainment. Research using Pakistan data confirms that children affected by stunting are more likely to experience learning and developmental disadvantages compared with their non-stunted peers.
2. UNICEF similarly notes that stunting is associated not only with impaired physical growth but also with adverse effects on cognitive development and learning potential. These developmental vulnerabilities are particularly

⁴ Global Nutrition Report (2023 or latest available)

concerning in Pakistan's context, where early childhood screening and intervention coverage remains uneven across districts.

3. As a result, a significant proportion of children affected by early undernutrition are likely to enter primary school with difficulties in attention, memory, language development, and overall school readiness. In systems where inclusive education capacity and specialized support remain limited, such vulnerabilities may translate into persistent participation barriers.

Significant proportion likely to require support services

1. Even if only a subset of undernourished children develop long-term functional difficulties, the scale of Pakistan's nutrition burden implies substantial future demand for disability-related services. These include: early identification and developmental screening; habilitation and rehabilitation services (including speech, occupational, and physiotherapy); inclusive education supports and classroom accommodations; and social protection measures for affected households.
2. The World Bank has highlighted that childhood stunting in Pakistan carries major economic implications, noting that high malnutrition rates contribute to significant losses in human capital and productivity over time. At the household level, UNICEF further emphasizes that undernutrition is closely linked with food insecurity, poor diet quality, and limited access to services, indicating that affected families often face multiple overlapping vulnerabilities.

Systems currently designed for a much smaller disability population

1. Available evidence suggests that Pakistan's disability and child development systems may not yet be fully configured to respond to the potential scale of emerging need. While the 2023 Population Census reports approximately 7.45 million persons with disabilities, it also identifies a much larger group, over 23 million persons, experiencing functional limitations, pointing to a broader population that may require varying levels of support. (Pakistan Bureau of Statistics, 2023).
2. This gap is significant. It suggests that many children experiencing developmental delays or mild functional difficulties may remain unidentified or outside formal disability certification pathways, particularly in rural and underserved areas. Research further indicates that stunting and wasting are more prevalent among children in rural and lower-wealth households, reinforcing concerns about inequitable access to early support.
3. In this context, the Commission considers Pakistan's persistently high levels of early childhood undernutrition to constitute an early warning indicator of future pressure on health, education, rehabilitation, and social protection systems.

Without strengthened early identification, preventive nutrition action, and expanded inclusive service capacity, the State may face increasing demand that current systems are not yet fully prepared to absorb.

5. Pressure Points for the State

Pakistan's persistently high burden of early childhood undernutrition has important forward-looking implications for the capacity of public systems. Available evidence suggests that while important policy and legislative steps have been taken, service delivery systems across health, education, social protection, and labour market inclusion remain uneven and may face increasing pressure as larger cohorts of nutritionally at-risk children grow up.

Health system (Articles 25 and 26)

1. The health system represents the first line of prevention and early identification; however, evidence indicates important gaps in developmental surveillance and rehabilitation capacity.
2. Pakistan has established an extensive primary healthcare network through Basic Health Units (BHUs), Rural Health Centres (RHCs), and the Lady Health Worker Programme. Government and health sector analyses indicate that the country has approximately 5,558 BHUs and 736 RHCs nationwide⁵, forming the backbone of first-level care.
3. The Lady Health Worker Programme deploys around 96,000⁶ community-based workers providing household-level outreach and preventive services. It is one of the largest community-based health worker initiatives in South Asia and globally⁷ but it has been badly impacted by lack of funds and proper strategic directions.
4. Despite this wide infrastructure footprint, routine developmental screening is not yet systematically institutionalized nationwide. Most frontline services continue to focus primarily on growth monitoring, immunization, and maternal–child health indicators rather than comprehensive developmental surveillance.
5. At the same time, access to rehabilitation and specialized child development services remains limited and unevenly distributed. Programme assessments note that persons with disabilities in Pakistan face significant barriers in accessing specialized (para-) medical and rehabilitation services, particularly outside major urban centres. The shortage and urban concentration of speech therapists, occupational therapists, child psychologists, and physiotherapists further constrains early intervention pathways.

⁵Government of Pakistan, *Pakistan Economic Survey 2022–23, Health Chapter*
https://www.finance.gov.pk/survey/chapter_22/PES11-HEALTH.pdf?utm_medium=email&utm_source=transaction

⁶<https://www.unicef.org/pakistan/media/3096/file/Performance%20Evaluation%20Report%20-%20Lady%20Health%20Workers%20Programme%20in%20Pakistan.pdf>

⁷[https://hsph.harvard.edu/research/maternal-health-task-force/lady-health-workers-in-pakistan/#:~:text=The%20Lady%20Health%20Worker%20\(LHW\),health%20workers%20in%20the%20world.](https://hsph.harvard.edu/research/maternal-health-task-force/lady-health-workers-in-pakistan/#:~:text=The%20Lady%20Health%20Worker%20(LHW),health%20workers%20in%20the%20world.)

6. In this context, a large cohort of children at risk of developmental delay may not be identified early enough to benefit from timely habilitation and rehabilitation services.
7. Pakistan is also experiencing a rapidly growing burden of non-communicable diseases that contribute significantly to disability. The International Diabetes Federation estimates that approximately 34.5⁸ million adults in Pakistan are currently living with diabetes, placing the country among those with the highest global prevalence. Diabetes is a leading cause of preventable disability, frequently resulting in vision impairment, neuropathy, kidney disease, and limb amputation when diagnosis and management are delayed. A substantial proportion of cases remain undiagnosed, increasing the likelihood of irreversible complications. Projections indicate that the number of people living with diabetes in Pakistan could rise to nearly 70 million by 2050, suggesting growing long-term demand for rehabilitation, assistive services, and chronic care systems.

Education system (Article 24)

1. Pakistan's education system has initiated steps toward inclusive education; however, capacity constraints remain substantial. The system continues to rely heavily on segregated special education models, while mainstream inclusive readiness remains uneven. While overall data is evolving, studies indicate that 67.6% of boys and 71.5% of girls with disabilities are not enrolled in school, with some regions showing up to 96% exclusion (PIDE, 2023)⁹.
2. Research indicates that children with disabilities in Pakistan continue to face significant barriers to accessing education, with many remaining excluded due to physical inaccessibility, limited trained teachers, and inadequate classroom support.
3. Teacher preparedness remains a critical bottleneck. While inclusive education policies have been introduced in several provinces, the availability of trained special and inclusive education teachers remains limited relative to system needs. For example, provincial special education departments collectively operate fewer than 350–400 public special education institutions nationwide, serving only a small fraction of children with disabilities. (Provincial Special Education Departments; Government of Pakistan reporting).
4. Moreover, many mainstream public schools lack essential inclusive infrastructure. Sector assessments note that a large proportion of schools do not have functional resource rooms, assistive devices, or structured classroom accommodations for children with developmental or learning difficulties. In the

⁸ International Diabetes Federation, *IDF Diabetes Atlas*, 10th ed. (Brussels: International Diabetes Federation, 2024)

⁹[https://pide.org.pk/research/educational-exclusion-of-children-with-special-needs/#:~:text=However%2C%20when%20this%20situation%20is,of%20school%20\(Figure%203\).](https://pide.org.pk/research/educational-exclusion-of-children-with-special-needs/#:~:text=However%2C%20when%20this%20situation%20is,of%20school%20(Figure%203).)

absence of systematic capacity expansion, the entry of larger cohorts of children with developmental vulnerabilities, linked in part to persistent early childhood undernutrition, may place increasing pressure on already stretched classroom systems.

Social protection system (Article 28)

1. Pakistan has established a range of social protection mechanisms, including the Benazir Income Support Programme (BISP) and provincial disability benefit schemes. However, disability-specific coverage remains fragmented and uneven, particularly for children requiring early and sustained support.
2. Administrative data indicate that persons with disabilities remain a very small share of major cash transfer caseloads. For example, BISP reporting shows that families including persons with disabilities represented only approximately 0.22–0.23 per cent of total beneficiary households in 2023–2024¹⁰, suggesting potential gaps in disability-sensitive targeting and outreach
3. Evidence from disability inclusion assessments indicates that persons with disabilities in Pakistan continue to face barriers in legal recognition, access to services, and social protection support. Administrative processes for disability certification, a gateway to many benefits, can involve documentation hurdles, travel burdens, and limited outreach in rural districts, potentially excluding eligible children and families. Programme reviews and inclusion assessments consistently highlight that certification and enrolment procedures remain a key bottleneck in accessing disability-linked entitlements.
4. Administrative data from Punjab indicate that approximately 11,915 disability certificates were under process¹¹, with an average processing time of around one month. While this reflects ongoing system utilization, the volume of pending cases suggests continuing pressure on certification pathways.
5. Programme data from the Ministry of Human Rights helpline further indicate continuing demand for disability-related assistance and facilitation services, with 2,689 support services provided between 2019 and 2025, reflecting ongoing access and navigation challenges for persons with disabilities and their families.
6. Recent national data further underscore system complexity. The Pakistan Bureau of Statistics (PBS) 2023 Population and Housing Census reports approximately 7.45 million persons with disabilities (3.1% of the population), while a much larger group, around 23.17 million persons (9.64%), and experience functional limitations¹². This wide gap suggests that many

¹⁰ Government of Pakistan, Benazir Income Support Programme (BISP), *Administrative Data and Programme Updates*

¹¹ Report received by NCHR from Social Welfare and Bait-ul-Maal Department, Punjab.

¹² Pakistan Bureau of Statistics, Population and Housing Census 2023.

individuals with functional difficulties may not meet formal disability thresholds or may remain outside certification systems.

7. Broader analytical work using household survey data indicates that functional difficulties are strongly associated with multidimensional poverty, with persons experiencing significant functional difficulty showing markedly higher poverty rates than those without such difficulties. This reinforces concerns that children with developmental vulnerabilities are likely to face compounded socioeconomic disadvantage.
8. Taken together, the variation in disability prevalence estimates, historically ranging from a few million formally identified persons to much larger populations experiencing functional difficulty, highlights persistent data, identification, and coverage challenges within Pakistan's disability support architecture. In practice, this suggests that a substantial proportion of children with developmental delays or mild functional limitations may remain outside formal social protection frameworks unless outreach, certification access, and child-focused disability benefits are systematically strengthened.

Labour market inclusion (Article 27)

1. Long-term inclusion outcomes also depend on labour market absorption capacity for persons with disabilities. Available evidence indicates persistent structural barriers that continue to limit equitable participation in employment.
2. Despite the existence of statutory employment quotas for persons with disabilities, generally 2–5 per cent across provinces, implementation remains uneven. Provincial frameworks typically require reserved posts (e.g., 3% in Punjab and KP, and up to 5% in Sindh and Balochistan), yet compliance gaps have been widely documented.
3. Broader labour market data similarly indicate significant disparities. According to the Pakistan Bureau of Statistics Labour Force Survey 2020–21, the unemployment rate among persons with disabilities is approximately 14.5 per cent, more than double the rate observed for persons without disabilities. Additional analyses, citing World Bank–referenced estimates, suggest that up to 71 per cent of persons with disabilities in Pakistan may be unemployed or outside the labour force, reflecting substantial exclusion from economic participation.
4. Evidence also indicates that persons with disabilities who are employed are disproportionately concentrated in informal and low-productivity sectors, with limited access to secure and adequately paid work. These patterns reflect intersecting barriers including lower educational attainment, workplace inaccessibility, transport constraints, and limited private sector inclusion.
5. Taken together, current labour market absorption capacity appears insufficient relative to the potential future scale of need. Without strengthened inclusive

education pathways, targeted skills development, effective enforcement of employment quotas, and expanded private sector engagement, future cohorts of children affected by early developmental disadvantage may face heightened risk of economic exclusion in adulthood.

5.1 Areas of Progress

Disability laws enacted

1. Pakistan has made notable legislative progress in strengthening the legal framework for the protection and inclusion of persons with disabilities, particularly following the 18th Constitutional Amendment, which devolved social sector responsibilities to the provinces.
2. At the federal level, the enactment of the ICT Rights of Persons with Disabilities Act, 2020 established a modern rights-based framework aligned with the CRPD. The Act provides for non-discrimination, accessibility, inclusive education, employment quotas, and the establishment of institutional mechanisms for implementation.
3. At the provincial level, all four provinces have enacted updated disability legislation:
 - Khyber Pakhtunkhwa Rights of Persons with Disabilities Act, 2017
 - Balochistan Persons with Disabilities Act, 2017
 - Sindh Empowerment of Persons with Disabilities Act, 2018
 - Punjab Empowerment of Persons with Disabilities Act, 2019
4. These laws collectively mark a shift from earlier welfare-based approaches toward a rights-based disability framework. Provincial statutes generally provide for:
 - establishment of provincial disability authorities;
 - protection against discrimination;
 - Employment quota provisions (typically 3–5%);
 - measures on accessibility and inclusive education; and
 - Certification and registration mechanisms.
5. Government reporting indicates that provincial disability authorities and councils have been notified in several jurisdictions, and implementation rules have been issued in phases (provincial gazettes and social welfare department reports).
6. In parallel, Pakistan has continued to expand its institutional architecture. The National Council for the Rehabilitation of Disabled Persons (NCRDP) and provincial disability authorities have been mandated to oversee policy coordination, while the inclusion of disability questions aligned with the Washington Group methodology in the 2023 Population Census represents an

important step toward improved disability measurement (Pakistan Bureau of Statistics).

7. Important progress has also been made toward strengthening disability data systems. Pakistan introduced the Washington Group Questions on disability into national statistical instruments including the Pakistan Labour Force Survey, Multiple Indicator Cluster Survey (MICS), and Pakistan Demographic and Health Survey (2017–18), marking the first systematic effort to align disability measurement with international standards. Federal authorities have further engaged the Pakistan Bureau of Statistics to integrate disability indicators within national survey systems under commitments linked to the Incheon Strategy.
8. Taken together, these legislative and institutional developments represent meaningful progress toward aligning Pakistan’s legal framework with CRPD obligations. They provide an important foundation upon which more effective implementation, service expansion, and cross-sector coordination can be built in the coming years.

Nutrition programmes

1. Pakistan has taken important steps in recent years to strengthen its institutional response to maternal and child undernutrition through multi-sector policy frameworks and targeted programme expansion.
2. At the national level, the Government has implemented the Multi-Sectoral Nutrition Strategy (MSNS) across provinces, aimed at addressing the underlying determinants of malnutrition through coordinated action in health, food security, water and sanitation, and social protection. Provincial governments have adopted context-specific nutrition action plans under this framework, reflecting growing policy recognition of the multi-dimensional nature of undernutrition.
3. Pakistan has also expanded large-scale nutrition service delivery through the Integrated Reproductive, Maternal, Newborn, Child Health and Nutrition (IRMNCH&N) Programme, which supports growth monitoring, infant and young child feeding counselling, micronutrient supplementation, and management of acute malnutrition through the primary healthcare system. Programme reporting indicates that nutrition services are now embedded across thousands of primary health facilities nationwide.
4. In parallel, the Benazir Nashonuma Programme, launched under the BISP, represents a significant step toward nutrition-sensitive social protection. The programme provides conditional cash transfers to pregnant and lactating women and young children in high-burden districts to support improved nutrition during the first 1,000 days. Administrative data indicate that the programme has

been rolled out in over 150 districts, targeting nutritionally vulnerable households.

5. Pakistan has further strengthened surveillance through the National Nutrition Survey 2018, which remains the country's most comprehensive assessment of nutritional status and has informed subsequent policy planning and provincial targeting.
6. Taken together, these initiatives demonstrate increasing policy attention to early childhood nutrition and the establishment of important programmatic platforms. Continued emphasis on coverage quality, geographic equity, and integration with early childhood development and disability systems will be important to maximize their long-term impact.

Inclusive education initiatives

1. Pakistan has taken initial steps toward advancing inclusive education through policy commitments, pilot programmes, and targeted teacher training initiatives at federal and provincial levels.
2. At the policy level, the National Education Policy Framework 2018 and subsequent provincial education sector plans have affirmed commitments to inclusive education and the integration of children with disabilities into mainstream schools. Provinces including Punjab, Sindh, and Khyber Pakhtunkhwa have introduced inclusive education components within their sector plans and teacher development programmes.
3. Pilot initiatives supported by provincial governments and development partners have focused on:
 - teacher training in inclusive classroom practices;
 - establishment of resource rooms in selected mainstream schools;
 - development of screening and referral protocols; and
 - Provision of assistive devices in targeted districts.
4. For example, Punjab's Inclusive Education Project and Sindh's inclusive education pilots, implemented with support from UNICEF and other partners, have introduced inclusive classroom models in selected public schools, demonstrating the feasibility of integration approaches at scale. Programme reporting indicates that hundreds of teachers have received basic inclusive education training in pilot districts, although national coverage remains limited (UNICEF Pakistan programme updates).
5. More recently, Punjab has taken steps to address autism-specific needs through the establishment of the Maryam Nawaz School of Autism, signaling growing recognition of the need for specialized educational pathways alongside mainstream inclusion efforts.

6. In parallel, the federal government and provinces have continued to expand specialized teacher training through the Directorate of Special Education and provincial special education departments, contributing to gradual improvements in technical capacity.
7. These initiatives represent important early steps toward system transformation. However, most inclusive education efforts remain pilot-based or geographically limited, and mainstream system readiness varies significantly across provinces and districts. Sustained scaling, standardized teacher preparation, and stronger linkage with early identification and rehabilitation services will be necessary to translate pilot gains into system-wide inclusion.

Social protection initiatives

1. Pakistan has expanded several large-scale social protection platforms that provide an important foundation for improving support to persons with disabilities and vulnerable children.
2. The BISP remains the country's flagship cash transfer programme and currently reaches over 9 million low-income families nationwide, making it one of the largest social protection schemes in South Asia. The programme is supported by the National Socio-Economic Registry (NSER), which has strengthened poverty targeting and household identification mechanisms.
3. Building on this platform, the Government launched the Benazir Nashonuma Programme, a nutrition-sensitive conditional cash transfer initiative targeting pregnant and lactating women and children under two years of age in high-burden districts. The programme has expanded progressively and is now operational in more than 150 districts, supporting improved nutrition during the first 1,000 days of life.
4. Provincial administrative data indicate that 29,376 children with disabilities are receiving stipends under the Punjab Himmat Card programme, reflecting important progress in disability-responsive social protection while also underscoring the need to assess adequacy of coverage relative to potential demand.
5. At the provincial level, disability-specific cash assistance schemes and concessions (including stipends, transport concessions, and assistive device support) have been introduced through social welfare and special education departments. While benefit levels and coverage vary by province, these measures represent important steps toward strengthening the social protection architecture for persons with disabilities.
6. Pakistan has also made progress in strengthening delivery systems. The NSER dynamic registry and biometric payment mechanisms have improved transparency and targeting efficiency in major cash programmes, creating potential entry points for more systematic disability inclusion.

7. These developments provide a substantive platform for expanding disability-responsive social protection. Continued efforts to improve disability identification within the NSER, streamline certification processes, and expand child-focused disability benefits will be important to ensure that children with developmental vulnerabilities are reached in a timely and equitable manner.

5.1.1 Contributions of the National Commission for Human Rights

1. Within its independent monitoring and advisory mandate, the National Commission for Human Rights has undertaken a range of initiatives to support the advancement of disability rights in Pakistan.
2. The broader institutional developments have provided an enabling framework within which independent monitoring bodies, including NCHR, have undertaken oversight and advisory functions relating to disability rights implementation.
3. At the legislative and policy level, the Commission has engaged with federal and provincial authorities to strengthen the disability rights framework. NCHR reviewed the Punjab Empowerment of Persons with Disabilities Act, 2022 and provided recommendations to the government, supported consultations on the draft disability legislation in Khyber Pakhtunkhwa, and advocated for the reactivation of the Provincial Council for the Rehabilitation of Persons with Disabilities in Balochistan. These engagements have sought to promote greater alignment of provincial frameworks with the Convention and to encourage the operationalization of statutory coordination bodies envisaged under disability laws.
4. Following the publication of NCHR's report examining gaps in mental health governance and service regulation, several institutional measures were initiated to strengthen the national response to psychosocial disability. These included the establishment of a dedicated mental health helpline and the constitution of a multi-stakeholder task force aimed at improving coordination across health, social welfare, and regulatory authorities.
5. These developments take place against the backdrop of a significant mental health burden in Pakistan. Mental disorders account for more than 4% of the total disease burden, with the mental health burden higher among women. It is estimated that 24 million people in Pakistan are in need of psychiatric assistance (WHO).
6. The Commission has also addressed psychosocial disability through legal and regulatory work, including the development of a draft Federal Mental Health Bill to update the Mental Health Ordinance, 2001, and the issuance of a policy brief examining regulatory and oversight gaps in mental health services and facilities. NCHR further provided technical guidance to support the establishment of a Mental Health Care Centre in Balochistan, reflecting efforts

to strengthen provincial service infrastructure for persons with psychosocial disabilities.

7. In its oversight role, NCHR has examined protection concerns affecting children with disabilities in institutional settings, including investigation of a corporal punishment incident at the National Special Education Centre for Hearing Impaired Children. This work aligns with the Commission's broader mandate to investigate violations and monitor conditions in facilities serving vulnerable groups, including persons with disabilities. Independent commissions in Pakistan are expressly empowered to investigate cases of violence and abuse against persons with disabilities under the ICT Rights of Persons with Disabilities Act, 2020.
8. The Commission has also raised systemic access barriers through provincial advisory forums, including advocacy for one-window disability certification processes, dedicated NADRA facilitation desks, and improved accessibility of public services and transport. These measures respond to persistent administrative and geographic barriers that continue to affect timely disability recognition and access to entitlements.
9. Beyond case-specific interventions, NCHR has contributed to national dialogue on disability inclusion through participation in multi-stakeholder policy forums, including the National Disability Convention, and through advocacy initiatives promoting accessible electoral participation for persons with disabilities. These engagements aim to strengthen mainstreaming of disability rights across governance processes in line with Article 33 monitoring expectations.
10. While these efforts have contributed to advancing the disability rights agenda, the Commission notes that significant structural challenges remain in early identification, service integration, workforce capacity, and equitable access to supports for children at developmental risk, as discussed in the sections that follow.

5.2 Critical Preparedness Gaps

1. Available evidence suggests that while Pakistan has established important legislative and policy foundations in disability and nutrition, significant preparedness gaps remain across prevention, early identification, service delivery, and systems coordination. These gaps may constrain the State's ability to respond effectively to the scale of developmental risk associated with persistent early childhood undernutrition.

Prevention and disability policy remain siloed

1. Pakistan has key frameworks (Multi-Sectoral Nutrition Strategy, post-18th Amendment provincial disability laws, BISP), but nutrition, ECD, and disability

programs operate in parallel rather than through an integrated life-course approach.

2. Responsibility for health, nutrition, education, and social welfare was devolved to provinces, leading to variation in design and capacity, with limited cross-sector coordination, especially at the district level.
3. Global and World Bank analyses stress that preventing developmental impairment requires coordinated action across health, nutrition, stimulation, and disability services, but Pakistan's delivery remains fragmented across vertical programs.
4. Despite the Lady Health Worker program and PHC network, developmental surveillance and referrals are not routine. Inclusive education and rehab services are managed separately, limiting care continuity.
5. The lack of cross-sector integration means early prevention opportunities are missed. Strengthening coordination across nutrition, ECD, disability, and social protection is critical for early identification and support.

Early identification systems remain limited

1. Civil registration represents a critical gateway through which children enter health, education, disability, and social protection systems. However, birth registration coverage in Pakistan remains incomplete. Data from the Pakistan Demographic and Health Survey indicate that only around 42 per cent¹³ of children under five have their births officially registered, with substantially lower coverage reported in several provinces. As a result, a significant proportion of children may remain outside formal administrative systems during early childhood.
2. Limited birth registration excludes children from accessing disability certification, education, and social protection, delaying health monitoring and developmental support.
3. Developmental surveillance is not yet institutionalized nationwide; frontline services prioritize immunization and nutrition, lacking standardized tools to identify delays during routine child health contacts.
4. Dedicated Early Childhood Intervention (ECI) centres are not established (e.g., in Khyber Pakhtunkhwa), and structured referral pathways from primary facilities (BHUs/RHCs) remain limited.
5. Children with delays are often identified only at school entry when difficulties are pronounced; specialized services (speech, occupational therapy) are concentrated in urban tertiary facilities, creating rural access gaps.

¹³ National Institute of Population Studies (NIPS) [Pakistan] and ICF, *Pakistan Demographic and Health Survey 2017–18*

6. Due to fragmented primary healthcare, ECD, and disability services, many at-risk children miss timely habilitation during the most effective early years.

Community-based rehabilitation remains uneven

1. Pakistan has endorsed community-based approaches to disability inclusion, including through Community-Based Rehabilitation (CBR) models reflected in national disability policy frameworks and provincial initiatives. However, available evidence indicates that coverage remains uneven and often limited in scale. Programme mapping suggests that formal CBR initiatives are implemented in selected districts and project areas rather than nationwide, with significant variation in provincial rollout and sustainability (Government and partner programme reviews).
2. Assessments of disability services further note that access to rehabilitation, assistive devices, and community-level support remains particularly constrained in rural and underserved districts. National and partner analyses consistently report that specialized rehabilitation services are heavily concentrated in major urban centres, requiring many families to travel long distances to access therapy and assistive support (Humanity & Inclusion country analysis; UNICEF programme reviews). Transport costs, service fees, and limited outreach further compound access barriers for low-income households.
3. Provincial information from Khyber Pakhtunkhwa indicates that no comprehensive CBR programmes are currently operational, underscoring continued reliance on institution-based services rather than community-level support systems.
4. Administrative and field evidence also indicates that, in the absence of robust community support pathways, many families continue to rely on facility-based rehabilitation centres or segregated special education institutions as primary entry points for services. This pattern places additional pressure on already limited institutional capacity and may delay early, home- and community-based intervention.
5. This uneven coverage raises concerns regarding the system's readiness to absorb larger cohorts of children requiring ongoing developmental and rehabilitation support. Strengthening district-level CBR coverage, improving integration with primary healthcare and education systems, and expanding community outreach will be critical to ensuring more equitable access to early support services.

Provincial implementation remains fragmented

1. Following the 18th Constitutional Amendment, primary responsibility for health, education, and social welfare functions has largely devolved to the provinces.

This shift has enabled context-specific policy innovation and legislative development at the provincial level. However, available evidence indicates that devolution has also contributed to variation in legal frameworks, institutional arrangements, and service delivery capacity across provinces, particularly in sectors relevant to children with disabilities.

2. Provincial disability legislation has been enacted at different times and through differing governance models, for example, Punjab (2019), Sindh (2018), Khyber Pakhtunkhwa (2017), and Balochistan (2017), each establishing separate authorities, certification procedures, and benefit structures. While these reforms represent important progress, comparative policy reviews note that implementation capacity, budget allocation, and operationalization of disability authorities remain uneven across provinces (Government of Pakistan reporting; provincial law reviews).
3. Similarly, nutrition, early childhood development, and inclusive education initiatives show uneven geographic coverage. Programme data indicate that some provinces have advanced multi-sector nutrition strategies and inclusive education pilots, while others face more limited institutional and fiscal capacity. Education sector analyses also highlight disparities in the availability of trained inclusive education teachers, resource rooms, and assistive supports between and within provinces.
4. This fragmentation complicates national-level planning, data harmonization, and workforce forecasting. It also contributes to geographic inequities in access to early identification, rehabilitation, and inclusive education services, with children in poorer, rural, and historically underserved provinces facing heightened risk of delayed identification and support. Strengthening federal–provincial coordination mechanisms, minimum service standards, and comparable data systems will be important to ensure more equitable realization of rights under the Convention across the country.

Data systems remain insufficiently integrated (Article 31)

1. Pakistan has made measurable progress in strengthening disability and nutrition data through national instruments such as the Population and Housing Census, the NNS, and the Labour Force Survey (LFS). However, important gaps remain in the integration and interoperability of these data systems, particularly for early childhood risk tracking and service planning.
2. Key administrative platforms, including the District Health Information System (DHIS2), National Education Management Information System (NEMIS), the National Socio-Economic Registry (NSER), and disability certification databases, largely operate as stand-alone systems with limited routine data exchange. This constrains the State’s ability to follow children across the life course or across service entry points.

3. Health system reviews indicate that developmental and disability-related indicators are not yet systematically embedded within routine primary health reporting, while education data systems continue to face gaps in consistent disability-disaggregated enrolment and retention data (WHO; UNICEF). Similarly, functional difficulty indicators remain only partially integrated into social protection targeting mechanisms, limiting proactive identification of at-risk children (World Bank social protection assessments).
4. As a result, routine early childhood development monitoring remains fragmented, and population-level data on developmental delay are considerably weaker than nutrition and immunization data.
5. The absence of routinely linked data limits the State's ability to:
 - track developmental risk longitudinally;
 - identify at-risk children early across service entry points;
 - plan workforce and service needs based on projected demand; and
 - Monitor outcomes across health, education, social protection, and rehabilitation systems.
6. Strengthening interoperable child development and disability data systems, particularly linkages between DHIS2, EMIS/NEMIS, NSER, and certification databases, would significantly enhance anticipatory planning and early intervention capacity.
7. Enforcement data on violence against persons with disabilities remains fragmented. Provincial authorities report the absence of a centralized database on FIRs, convictions, and punishments related specifically to violence against persons with disabilities, limiting effective oversight.

Workforce shortages persist (Articles 24 and 26)

1. Human resource constraints remain a critical system bottleneck. Available national and partner assessments indicate persistent shortages and uneven geographic distribution of key professionals required for early identification and support, including speech and language therapists, occupational therapists, physiotherapists, child psychologists, and trained special and inclusive education teachers.
2. Pakistan does not currently maintain a consolidated national registry of rehabilitation and developmental specialists, complicating comprehensive workforce planning. However, available programme data illustrate the scale mismatch. Provincial special education departments collectively operate fewer than 400 public special education institutions nationwide, serving a limited share of children with disabilities relative to need (provincial government reporting). Sector reviews further note that rehabilitation and therapy services are predominantly concentrated in major urban centres, with rural districts often

lacking regular access to multidisciplinary support (Humanity & Inclusion; UNICEF programme analyses).

3. Human resource gaps are also reflected in the education workforce. While Pakistan has over 1.5 million school teachers overall (Pakistan Education Statistics)¹⁴, only a small proportion have received formal training in inclusive education methodologies, and many mainstream schools lack access to specialized support personnel. This constrains the system's readiness to accommodate children with developmental and learning needs within general classrooms.
4. Training pipelines for specialized rehabilitation cadres remain limited in scale, and public sector retention challenges persist. At the same time, demographic pressures are likely to increase demand. With over 5 million births annually in Pakistan (UN population estimates), even modest prevalence of developmental delay would translate into substantial caseloads requiring screening, referral, and support each year.
5. As larger cohorts of children with developmental vulnerabilities enter the education and health systems, existing workforce gaps may become an increasingly binding constraint unless addressed through coordinated national and provincial human resource planning, expanded training capacity, and incentives for more equitable geographic deployment.

Overall Assessment

1. Taken together, available evidence indicates that Pakistan has established important policy and legislative foundations in disability inclusion, nutrition, and social protection. Notable progress has been made in expanding primary healthcare outreach, including through the Lady Health Worker Programme, which reaches an estimated 60–70 per cent of the rural population, alongside the enactment of provincial disability laws following the 18th Constitutional Amendment and the expansion of national data instruments such as the Population Census, National Nutrition Survey, and the National Socio-Economic Registry (Government of Pakistan; WHO country profiles).
2. However, provincial reporting also indicates the absence of a standalone comprehensive disability awareness strategy for the 2019–2025 period, suggesting continued reliance on ad hoc awareness activities rather than a coordinated national approach.
3. Pakistan has also introduced multi-sector nutrition strategies and scaled major social protection platforms. The BISP now reaches over 9 million beneficiary families, providing an important delivery channel for poverty-targeted assistance (Government of Pakistan, BISP administrative data). These

¹⁴ Government of Pakistan, Ministry of Federal Education and Professional Training, *Pakistan Education Statistics 2021–22* (Islamabad: Government of Pakistan, 2023).

developments provide a substantive institutional foundation on which more integrated child and disability systems can be built.

4. However, the scale and persistence of early childhood undernutrition, combined with current service delivery and workforce constraints, may generate increasing demand across health, education, rehabilitation, social protection, and labour systems over the coming years. Pakistan records one of the largest annual birth cohorts in the region, with more than 5 million children born each year (UN population estimates)¹⁵. Even modest prevalence of developmental delay within this cohort would translate into substantial additional demand for screening, early intervention, inclusive education, and rehabilitation services.
5. At present, service readiness remains uneven. Sector analyses indicate that inclusive education capacity, rehabilitation coverage, and community-based support services have not yet expanded at a pace commensurate with potential need. Without anticipatory planning, systems originally designed around smaller, more narrowly defined disability caseloads may face increasing pressure as identification improves and larger cohorts of nutritionally at-risk children progress through early childhood and into school systems.
6. The Commission therefore considers the current nutrition profile to constitute a forward-looking systems stress indicator, underscoring the importance of:
 - strengthening routine early developmental screening and surveillance within primary healthcare;
 - expanding accessible rehabilitation and inclusive education capacity at district level;
 - improving disability certification access, outreach, and functional difficulty identification;
 - Enhancing labour market inclusion pathways for persons with disabilities, including effective enforcement of employment quotas and skills development.
7. Proactive, cross-sector planning, grounded in integrated data systems, strengthened early childhood platforms, and strategic workforce development, will be essential to ensure that emerging cohorts of children at developmental risk are able to realize their rights on an equal basis with others, in line with the Convention on the Rights of Persons with Disabilities. International experience suggests that early investment in nutrition, developmental screening, and inclusive services yields significant long-term social and economic returns; timely action in Pakistan's context will therefore be critical to mitigating future exclusion risks.

¹⁵ United Nations, Department of Economic and Social Affairs (UN DESA), *World Population Prospects 2022* (New York: United Nations, 2022)

6. Group of children at highest risk (Article 7)

1. Available national surveys and humanitarian analyses consistently show that early-life nutritional deprivation and subsequent developmental risk are not evenly distributed. The highest-risk groups include:

Rural children

2. Risk is elevated in rural areas due to higher poverty exposure, weaker WASH conditions, and more limited access to diversified diets and services. National Nutrition Survey reporting shows higher wasting in rural than urban settings (rural 18.6% vs urban 16.2%), indicating greater acute nutritional stress in rural populations.

Children in the poorest quintiles

3. Multiple datasets show the compounding effect of poverty on early-life risk. The PDHS reports that low birth weight is substantially more common in the lowest wealth quintile (33%)¹⁶ compared to national averages among those with recorded birth weight, reflecting intergenerational nutritional deprivation that can elevate developmental vulnerability.

Girls

4. While some undernutrition indicators are higher among boys in early childhood, girls face distinct life-course vulnerabilities linked to adolescent nutrition, early marriage/pregnancy risks, and intra-household deprivation, factors strongly associated with low birth weight and intergenerational malnutrition. National Nutrition Survey findings show very high anaemia among adolescent girls (over half), with rural adolescent girls facing higher rates than urban peers.

Children in informal settlements

5. Children living in urban slums/underserved settlements face layered risk: precarious incomes, overcrowding, poor WASH, and weak routine service coverage. UNICEF studies in slums/underserved areas of major cities document substantial service access gaps (notably in routine immunization coverage), reinforcing the broader pattern that children in informal settlements are often missed by standard delivery platforms.

Children in disaster-affected areas

6. Climate shocks and disasters consistently worsen child nutrition and service access. UNICEF's consolidated emergency reporting following the 2022 floods

¹⁶ National Institute of Population Studies (NIPS) and ICF, *Pakistan Demographic and Health Survey 2017–18* (Islamabad and Rockville, MD, 2019)

notes that the floods exacerbated an already fragile nutrition situation and cites IPC-linked findings that millions of under-5 children required preventive and curative nutrition support post-flood.

7. IPC acute malnutrition analysis for flood-affected/proximate districts also quantified 2.14 million children¹⁷ suffering acute malnutrition in analysed districts (March 2023–January 2024), explicitly noting flood-related disruption of health, safe water, and sanitation as aggravating factors.

Children with low birth weight

8. Low birth weight is a key early marker of heightened developmental risk. The PDHS reports that 22% of children with reported birth weight were low birth weight (<2.5 kg), with higher prevalence among mothers under 20 (34%) and poorer households, indicating concentrated risk among vulnerable groups.

Children in food-insecure households

9. Food insecurity remains widespread and strongly linked to inadequate child diets and care. The National Nutrition Survey (using the FAO Food Insecurity Experience Scale) reports that 36.9% of households were food insecure, with worse outcomes in Balochistan and KP-NMD, underscoring concentrated vulnerability.
10. More recent IPC analysis (Dec 2025–Mar 2026) found 7.5 million people in analysed rural districts experiencing Crisis or worse (IPC Phase 3+), highlighting persistent acute food insecurity in high-vulnerability areas.

¹⁷ Integrated Food Security Phase Classification (IPC), *Pakistan Acute Malnutrition Analysis 2023* (Rome: IPC Global Support Unit, 2023)

7. Role of Provincial Systems and Implementation Gaps (Articles 4 and 33)

1. Following the 18th Constitutional Amendment, primary responsibility for health, education, social welfare, and many disability-related services shifted to the provinces. This devolution has enabled context-specific policy innovation and the enactment of updated provincial disability laws. However, available evidence indicates that it has also introduced significant variation in institutional capacity, service coverage, and implementation pace across provinces.

Post-18th Amendment fragmentation

1. Provincial governments now lead on nutrition programming, inclusive education, rehabilitation services, and disability certification following the 18th Constitutional Amendment (2010), which devolved most social sector functions to the provinces. While this shift has enabled context-specific policy innovation, it has also resulted in greater institutional divergence across provinces.
2. Public finance data illustrate the scale of decentralization. Provinces now account for over 55–60 per cent of total public expenditure¹⁸ following the 7th National Finance Commission (NFC) Award, with primary responsibility for service delivery in health, education, and social welfare (Ministry of Finance; World Bank fiscal analyses). However, sector reviews note that provincial capacity to plan and implement specialized disability and early childhood services varies considerably.
3. Evidence from education and health sector assessments shows that provincial spending on health and education ranges widely as a share of provincial budgets, reflecting differing fiscal space and prioritization. These disparities are mirrored in service availability. For example, provincial special education departments report markedly different numbers of public special education institutions, trained teachers, and outreach programmes across provinces, indicating uneven system maturity (provincial administrative data; education sector reviews).
4. In the nutrition sector, provinces have adopted Multi-Sectoral Nutrition Strategies at different times and with varying levels of operationalization. Implementation reviews have noted that district-level rollout, staffing, and monitoring capacity remain uneven, particularly in historically underserved regions. Similarly, inclusive education initiatives remain at different stages of scale-up across provinces, with many programmes still operating as pilots rather than system-wide models.

¹⁸ Government of Pakistan, Ministry of Finance, *Pakistan Economic Survey 2022–23*, World Bank, *Pakistan Federal Public Expenditure Review 2023*

5. Sector analyses further highlight that inter-provincial comparability of services, particularly for early childhood development, community-based rehabilitation, and inclusive education, remains limited. Differences in rules of business, institutional mandates, and administrative structures complicate nationwide planning, workforce forecasting, and minimum service standard-setting.
6. These structural variations have important equity implications. Children with developmental vulnerabilities in lower-capacity provinces and remote districts may face delayed identification, weaker referral pathways, and reduced access to rehabilitation and inclusive education supports compared to peers in better-resourced jurisdictions.

Uneven provincial capacity

1. Fiscal space, human resources, and institutional maturity vary significantly across provinces and between districts, with direct implications for service readiness. Public expenditure patterns illustrate these disparities. Recent fiscal analyses show that provincial spending on health and education varies considerably as a share of provincial budgets and on a per-capita basis, reflecting differing resource envelopes and implementation capacity (Ministry of Finance; World Bank provincial expenditure reviews).
2. Education sector data similarly demonstrate uneven system depth. While Pakistan has over 1.5 million teachers nationwide, the distribution of trained special and inclusive education personnel remains highly uneven across provinces. Provincial administrative reporting indicates that public special education institutions number fewer than 400 nationwide, with significant concentration in Punjab and major urban centres, leaving large areas, particularly in Balochistan and parts of Khyber Pakhtunkhwa, underserved.
3. Health system readiness shows comparable variation. Although the primary healthcare network is nationally extensive, human resource density (including specialists and allied health professionals) remains substantially lower in rural districts and in smaller provinces, contributing to weaker referral and follow-up capacity in those areas (WHO Pakistan health system assessments).
4. These disparities heighten the risk that children with developmental vulnerabilities will experience unequal access to early identification and support depending on location. Evidence from programme reviews indicates that districts with lower fiscal capacity and workforce availability are more likely to face delays in developmental screening, limited rehabilitation access, and weaker inclusive education support. Without targeted equalization measures and workforce deployment strategies, geographic inequities in early childhood outcomes may persist or widen.

Coordination gaps

1. Effective early childhood and disability response requires coordinated action across health, education, nutrition, and social protection systems. Pakistan has established several inter-sector policy platforms, including the Multi-Sectoral Nutrition Strategies and provincial coordination committees, which signal growing recognition of this need. However, programme and governance reviews indicate that operational coordination remains limited in practice, particularly at district and sub-district levels.
2. Institutional mapping shows that core service platforms, including the District Health Information System (DHIS2), provincial Education Management Information Systems (EMIS/NEMIS), the National Socio-Economic Registry (NSER), and disability certification processes, largely function as parallel administrative streams with limited routine interoperability (WHO and World Bank system assessments). While each system captures valuable sector-specific data, structured referral and feedback loops across sectors remain inconsistently embedded.
3. Field and programme evidence suggests that frontline service delivery continues to be organized vertically. For example:
 - primary healthcare platforms focus primarily on immunization, growth monitoring, and maternal–child health;
 - early childhood development initiatives remain unevenly institutionalized; and
 - Special education and rehabilitation services operate through separate administrative channels.
4. As a result, children identified in one sector are not always systematically linked to follow-up services in another. UNICEF and partner programme reviews have noted that formalized referral pathways between health facilities, early intervention services, and education systems remain uneven across provinces, particularly in rural districts. Provincial reporting further indicates that responsibility for children with disabilities in Khyber Pakhtunkhwa remains primarily within the special education system rather than mainstream inclusive education structures. The province currently operates 55 government special education institutes, with approximately 300 children on waiting lists, highlighting continuing dependence on segregated service models and limited inclusive absorption capacity.
5. These coordination gaps have important implications for early identification and continuity of care. Without stronger cross-sector protocols, case management mechanisms, and shared data platforms, children with developmental vulnerabilities may experience delays in diagnosis, fragmented service access, and missed opportunities for early intervention.

6. Strengthening district-level coordination mechanisms, institutionalizing referral pathways, and improving interoperability between DHIS2, EMIS/NEMIS, NSER, and disability certification systems would significantly enhance system responsiveness to emerging developmental risk.

Monitoring weaknesses

1. Monitoring and oversight arrangements have improved in some sectors, but important gaps remain in outcome tracking and implementation follow-through. Pakistan has expanded major administrative reporting platforms, including DHIS2 in the health sector and EMIS/NEMIS in education, which have strengthened routine data availability. However, these systems continue to prioritize input and service coverage indicators (such as facility functionality, service contacts, and enrollment) rather than longitudinal child development and functional outcomes.
2. Programme reviews and sector assessments indicate that routine measurement of early childhood development, developmental delay, and functional difficulty remains limited within core administrative datasets (WHO; UNICEF country analyses). Disability-disaggregated reporting is also uneven across sectors, with education, health, and social protection databases using differing definitions and screening approaches.
3. While the inclusion of Washington Group questions in the 2023 Population Census represents important progress in disability measurement, comparable functional difficulty indicators are not yet consistently embedded in routine service monitoring systems.
4. These limitations constrain the State's ability to:
 - assess early identification performance and referral effectiveness;
 - track rehabilitation, habilitation, and inclusive education outcomes over time; and
 - Forecast future service demand based on emerging developmental risk.
5. At the same time, independent and provincial programme evaluations note that district-level monitoring capacity, including data quality assurance, use of data for planning, and feedback loops into service improvement, remains uneven, particularly in lower-capacity districts.
6. Overall, while devolution has created important opportunities for provincial innovation, the combination of fragmented implementation, uneven capacity, and weak cross-sector monitoring may limit system readiness to respond to the emerging developmental risk associated with persistent early childhood undernutrition. Strengthened federal–provincial coordination, minimum service standards, and harmonized monitoring frameworks, including routine functional and developmental indicators, will be critical to ensure more equitable realization of rights under the Convention across Pakistan.

8. Priority Recommendations to the Committee (in line with Articles 4, 7, 24, 25, 26, 27, 28 and 31 of the Convention)

In light of the above analysis, NCHR respectfully recommends that the Committee encourage the State party to consider the following priority actions to strengthen early identification, prevention, and inclusive support systems for children at developmental risk.

1. Strengthen early prevention and identification

1. **Institutionalize routine developmental screening** within primary healthcare platforms (including BHUs, RHCs, and LHW outreach), alongside existing growth monitoring and immunization services.
2. **Integrate nutrition, early childhood development, and disability risk protocols** within the IRMNCH&N and related maternal–child health programmes, with clear referral pathways for at-risk children.
3. **Expand the Benazir Nashonuma Programme, nutrition programmes and related first-1,000-days interventions** to ensure sustained coverage in high-burden and underserved districts.
4. **Develop and implement a national Early Childhood Intervention (ECI) framework**, with standardized referral, case management, and follow-up mechanisms across provinces.

2. Expand rehabilitation and inclusive education capacity

1. **Scale up district-level rehabilitation services**, including speech therapy, occupational therapy, physiotherapy, and child psychology, with targeted expansion in underserved rural districts.
2. **Accelerate the transition from pilot-based to system-wide inclusive education**, including: standardized teacher training in inclusive practices; establishment of resource rooms in mainstream schools; provision of assistive devices; and classroom accommodation protocols.
3. **Strengthen pre-service and in-service training pipelines** for special educators and allied rehabilitation professionals to address projected workforce shortages.
4. **Develop incentives for equitable geographic deployment** of specialized personnel, particularly in lower-capacity provinces and remote districts.

3. Improve disability identification and social protection access

1. **Streamline disability certification procedures**, including mobile assessment boards, simplified documentation requirements, and child-focused outreach.
2. **Integrate functional difficulty indicators within the National Socio-Economic Registry (NSER)** to improve early identification of children requiring support.

3. **Expand child-specific disability benefits and support services**, particularly for low-income households and high-risk districts.

4. Strengthen data integration and monitoring

1. **Establish interoperable data linkages** between DHIS2, EMIS/NEMIS, NSER, and disability certification systems to enable life-course tracking of at-risk children.
2. **Institutionalize routine monitoring of early childhood development and functional outcomes**, moving beyond input and coverage indicators.
3. **Develop minimum national service standards and reporting benchmarks** for early identification, rehabilitation, and inclusive education, while respecting provincial mandates.

5. Enhance cross-sector and federal–provincial coordination

1. **Strengthen federal–provincial coordination mechanisms** on disability-inclusive early childhood development, including regular data sharing and joint planning forums.
2. **Support provinces with lower institutional capacity** through targeted technical assistance, workforce development support, and conditional financing mechanisms.
3. **Promote community-based rehabilitation (CBR) expansion** linked to primary healthcare and education systems to improve rural access.

6. Advance long-term inclusion pathways

1. **Strengthen enforcement of employment quotas for persons with disabilities** and expand skills development programmes aligned with labour market demand.
2. **Engage the private sector in disability inclusion initiatives**, including workplace accessibility and inclusive hiring incentives.
3. **Embed disability inclusion within national human capital and poverty reduction strategies**, recognizing early childhood undernutrition as a forward-looking risk factor.

9. Closing Note

The Commission emphasizes that timely investment in early childhood nutrition, developmental screening, and inclusive service systems offers significant long-term social and economic returns. Proactive action at this stage will be critical to ensuring that emerging cohorts of children at developmental risk are able to realize their rights on an equal basis with others, in line with the Convention on the Rights of Persons with Disabilities.



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