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National Health Policy 2009

Stepping Towards Better Health

March 2009

Ministry of Health
Government of Pakistan

Forward by the Minister of Health

Abbreviations

AI	Avian Influenza
AIDS	Acquired Immune Deficiency Syndrome
BHU	Basic Health Unit
BISP	Benazir Income Support Programme
BoD	Burden of Disease
CCB	Community Citizen Board
CMW	Community Midwife
CPR	Contraceptive Prevalence Rate
DALYs	Disability Adjusted Life Years
DHDC	District Health Development Center
DHIS	District Health Information System
DHQ	District Head Quarter
DOH	Department of Health
DOTs	Directly Observed Treatment – short course
EmONC	Emergency Obstetric and Neonatal Care
EPI	Expanded Programme on Immunizations
ESDP	Essential Service Delivery Package
FATA	Federally Administered Tribal Areas
FBS	Federal Bureau of Statistics
FLCF	First Level Care Facility
FP	Family Planning
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resource
IDUs	Injecting Drug Users
IMNCI	Integrated Management of Newborn and Childhood Illness
IMR	Infant Mortality Ratio
ITNs	Impregnated Treated Nets
LB	Live Births
LHV	Lady Health Visitor
LHW	Lady Health Worker
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
MTBF	Medium Term Budgetary Framework
MTDF	Medium Term Development Framework
NCD	Non-Communicable Diseases
NGO	Non Governmental Organization
NWFP	North West Frontier Province
OOP	Out of Pocket
PHC	Primary Health Care
PHDC	Provincial Health Development Center
PMDC	Pakistan Medical and Dental Council
PMRC	Pakistan Medical and Research Council

PNC	Pakistan Nursing Council
PPP	Public Private Partnership
PPRA	Public Procurement Regulatory Authority
PRSP	Poverty Reduction Strategy Paper
PSLM	Pakistan Social and Living Standard Measurement Survey
RHC	Rural Health Centre
SARS	Severe Acute Respiratory Infection
SBA	Skilled Birth Attendance
STI	Sexually Transmitted Infections
TB	Tuberculosis
THE	Total Health Expenditure (both public and private)
THQ	Tehsil Head Quarter
U5MR	Under five Mortality Rate
UN	United Nations
WHO	World Health Organization
WTO	World Trade Organization

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Vision

A health system that:
is efficient, equitable & effective
to ensure acceptable, accessible & affordable health services.
It will support people and communities
to improve their health status
while it will focus on addressing social inequities
and inequities in health
and is fair, responsive and pro-poor,
thereby contributing to poverty reduction.

By considering 2006-07 as the benchmark year for the National Health Policy 2009, the government of Pakistan, by 2015, is committed to:

- **Save additional 700,000 lives of children;**
- **Save additional 24,000 lives of mothers;**
- **Eradicate polio;**
- **Eliminate measles and tetanus;**
- **Prevent additional 5 million children from becoming malnourished;**
- **Provide skilled birth attendance to more than 4.3 million pregnant women;**
- **Ensure provision of family planning services to additional 5 million couples.**
- **Avert 13 million of new TB cases;**
- **Immunize more than 22 million children against Hepatitis B and other vaccine preventable diseases; and**
- **Reach 40 million poorest people of Pakistan to ensure provision of essential package of service delivery.**

Pakistan's National Health Policy-2009
Stepping Towards Better Health

I. Need for a New Health Policy

1. **The National Health Policy 2009:** "**Stepping Towards Better Health"** outlines a shared resolve to ensure progress towards a healthy Pakistan in which all citizens benefit from a better working health care delivery system, particularly the poorest. The Policy builds upon the National Health Policy 2001 – The Way Forward - under which modest progress was made. There was a felt need to reset the strategic direction due to: a) slow progress in improving health outcomes; b) inadequate sector performance in improving coverage and access to essential health care services especially for the poor; and; c) lack of synchronization of various policy documents and their linkages with Millennium Development Goals (MDGs). The Ministry of Health initiated the process to develop a new health policy in 2006 but the process remained slow. The new Government as part of its manifesto decided to set a new agenda to improve health care. The process included formulation of a Health Policy Task force including six working groups which took stock of the present situation and outlined the future course of action. The recommendations of the working groups, consultation with key stakeholders and strategic directions from parliamentarians and top management in Ministry and Departments of Health contributed significantly to the development of new policy.

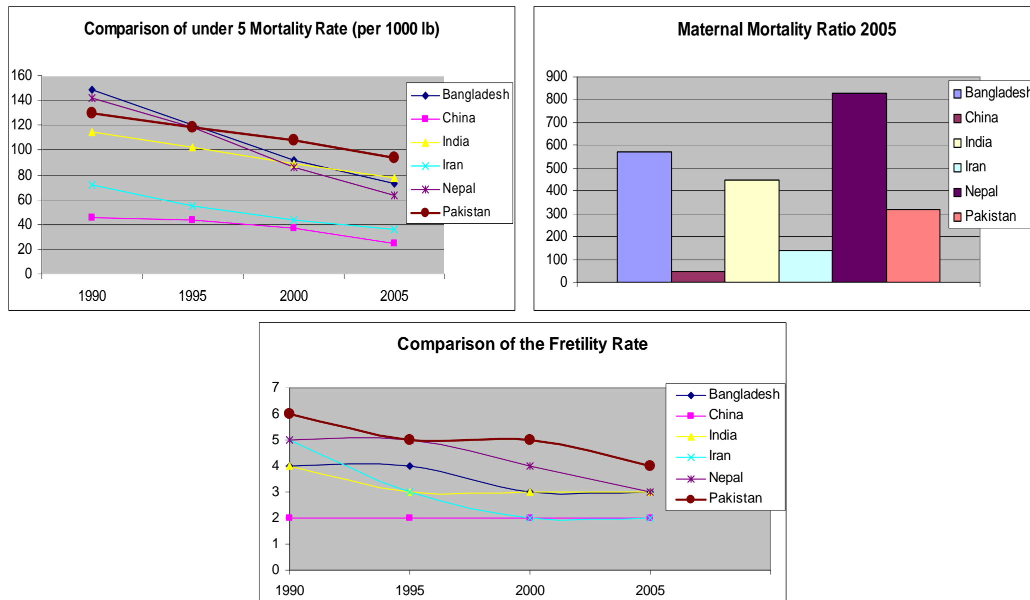
II. The State of Pakistan's Health

2. Human development is the basic right of every individual and health is a pre-requisite for the economic development. Health is an entry-point towards prosperity and reducing poverty. The links between ill health and poverty are well known. Ill health contributes to poverty due to "catastrophic costs[1]" of illness and reduced earning capacity during illness. Poor people suffer disproportionately from disease and are at higher risk of dying from their illness than are better off and healthier individuals. Women and children are particularly vulnerable. Illness keeps children away from schools, decreasing their chances of productive adulthood.

3. It is, therefore, critical to move towards a system which is able to address the challenges and prevents households from falling into poverty. In Pakistan, health sector investments are viewed as part of the government's poverty alleviation endeavor. To make progress towards achieving the MDGs is a national commitment which envisages reducing poverty by 2015.

[1]: An adverse health shock that necessitates 10% of household income in medical expenses.

4. The health of the people of Pakistan has improved since 1990; however the rate of improvement in health outcomes has been slow compared to its neighboring countries. Pakistan's under-five mortality remains the highest among the South Asian countries. High maternal mortality (deaths) combined with high fertility results in one out of every 89 women dying from pregnancy related causes. Malnutrition remains widespread and unaddressed. In addition, persisting burden of infectious diseases is now compounded by increasing burden of non-communicable diseases.



5. Pakistan's population growth rate has declined from 3% in the late 1980's to the present estimated level of 1.9% per annum, but it remains unacceptably high. In 2009, Pakistan is the sixth most populous country in 2009, as its population increased from 115 million to over 170 million people in 2009. The population is projected to be 210 million in 2025 and according to a United Nations (UN) estimate Pakistan will become the fourth most populous country in the world by the year 2050, which may lead to increasing scarcity of resources and food. Life expectancy at birth, which was 34 years in 1951 and 59 years in 1990, has increased to 65 years in 2005 with no gender disparity.

6. High fertility translates into 4.2 million new births every year i.e. 11,500 children are added every day to Pakistan's population. However, about 900 infants die every day, of which 625 are less than one month of age and 32 newborns babies become motherless due to maternal deaths. Compared to 1,140 children less than 5 years old dying every day in 1990, currently 1,080 children die every day. In addition, the latest evidence indicates that the poorest population (quintile) has seen almost no change in its under-5 mortality rate since the early 1990's. Gender does not appear to be an important determinant of child mortality in Pakistan. National surveys indicate that girls in Pakistan display the expected biological advantage in infant mortality i.e. 80 male infants dying compared to 73 female infants per 1000 live births However, gender remains an important determinant in child care e.g. compared to 100 boys only 88 girls are fully immunized. .

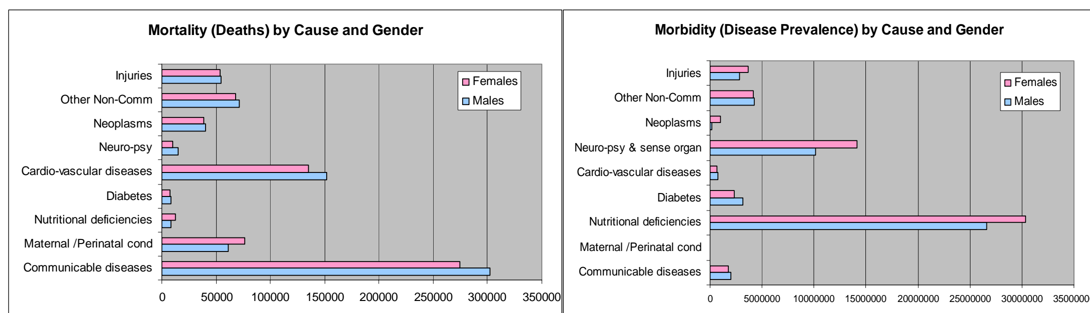
7. Maternal mortality and morbidity is difficult to measure but available evidence indicates Pakistan has made some improvements in recent years. In 1990, 50 pregnant women died out of 9,450 women giving birth every day, however, currently, 32 pregnant women are dying out of 11,500 women giving births every day. Skilled birth attendance (SBA) has improved from 18% in late 1990s' to 36% in 2006/07. 3,400 out of 9,450 births

taking place every day are performed by skilled birth attendants. Institutional deliveries have also increased with 3000 births take place in a public or private health facility. Despite improvements, Pakistan is still far behind from other countries with significant variations among provinces and districts, highlighting the need to rapidly expand the use of skilled birth attendants and deliveries in health facilities.

8. Pakistan is having the largest ever cohort of the youth population. The ongoing demographic transition[2] has provided an opportunity to convert it into a 'demographic dividend[3]'. However, this opportunity will be lost, if the fertility rate is not brought down at a more rapid pace. Pakistan's contraceptive prevalence rate (CPR) has improved since 1990, but has stagnated during last few years with less than one third of couples use contraception with only one in five use modern methods. The unmet demand for family planning persists above 30% with high rates of abortion with significant urban rural differential. In addition, high rates of abortion imply that women's lives are at risk from unsafe abortions.

9. Pakistan has the lowest prevalence of under-weight in South Asia with the exception of Sri Lanka, however, the prevalence has not changed much since 1990 with more than 9 million malnourished children. It is unlikely that Pakistan will achieve the MDG target 1B. Malnutrition increases the risk of dying in childhood but also impairs learning abilities and in long run decreases the productivity of adult workforce. This is further complicated by widespread micronutrient deficiencies significantly more prevalent in women and the poorest. About 10 million of children under-5 years, 9.2 million of child bearing age women suffer from anemia as a result of iron deficiency, 6.4 million children suffer from reduced growth and intellectual capacity as a result of iodine deficiency. In Pakistan, 10.5 million children and 15 million child-bearing age women have zinc deficiency. .

10. The burden of diseases (BoD) is heavily dominated by communicable diseases, reproductive health and malnutrition issues accounting for 50% of the total burden of diseases. This is further complicated by burden due to non-communicable disease group dominated by cardiovascular diseases, diabetes, injuries and neuro-psychological diseases. This double burden of disease is a major challenge in the health sector of Pakistan. In 2002 major causes of mortality and morbidity in Pakistan are summarized in graphs below. Ischemic heart disease account for 11% of deaths, but only 5% of years of life lost as many people who died of the disease did so at an advanced age. Considering Disability adjusted life years (DALYs[4]), communicable diseases form the dominant share in the burden of diseases, which can be prevented at relatively low cost. Respiratory infections and diarrhoeal diseases are still the major killer diseases in Pakistan.



[2] : The transition in a country from equilibrium of high fertility and high mortality, through a period of rapid growth, to a period of declining mortality coexisting with continuing high fertility, to an ultimate equilibrium of low fertility and low mortality.

[3] : A phenomenon which occurs in the last stages of the demographic transition, when changes in the population structure (decline in dependent population and increased proportion of the work force population) create an opportunity for economic benefits to individuals and the country.

[4] : A summary measures that combine information on mortality and non-fatal health outcomes to represent the health of a particular population as a single number.

11. Pakistan is still one of the four remaining countries, where polio is endemic and 118 cases have been reported in 2008. Hepatitis is an endemic disease in the general population with about 10 million carriers of hepatitis B & C in the country. Tuberculosis (TB) in Pakistan ranks 6th amongst the 22 countries, with high burden of TB in the world. TB is responsible for 5.1 percent of the total national disease burden and there are about 250,000-300,000 new cases in the country every year. Pakistan is a malaria endemic country with little change in the status over past five years. Punjab, NWFP and Sindh have low endemicity of malaria but Balochistan and FATA are high endemic areas. An emerging communicable disease challenge is the "concentrated epidemic" for Human Immunodeficiency Virus (HIV) disease among vulnerable populations particularly among Injecting Drug Users (IDUs). The evidence indicates increasing prevalence of HIV among IDUs (e.g. 30.5% in Hyderabad and 23% in Karachi) and slowly increasing prevalence in male sex workers in Karachi (3.1%) and Hijras in Larkana (27.6%). Halting its spread to become an epidemic in the general population is a major challenge in coming years. In addition, there are other emerging communicable diseases (e.g. avian influenza (AI), severe acute respiratory syndrome (SARS), leishmaniasis, dengue fever, hemorrhagic fever etc), which off and on pose threat of an epidemic, highlighting the need to strengthen the capacity for disease surveillance and immediate response system.

12. Pakistan is also facing an increasing burden of non communicable diseases with increasing life expectancy and high prevalence of risk factors. Share of injuries/ accidents is estimated to be more than 11% of the total burden of diseases and is likely to rise with increased traffic, urbanization and terrorist activities. Pakistan is among the top 10 countries in the world with high diabetes prevalence, of about 7.1%. One in four adults over the age of 40 years (26.9%) suffers from coronary artery disease, due to high prevalence of known risk factors, including smoking (41% among men over 18 years of age); high blood pressure (24% in population over 18 years of age), raised cholesterol (20% of people over 40 years of age), and overweight (28% and 23% of urban and rural adults over 18 years of age respectively).

13. The harm that tobacco use does to health is irrefutable. The tobacco use (chewing or smoking) and inhaling “secondhand” or side stream smoke from cigarettes raises the risk of many diseases and premature death. Tobacco use in Pakistan is common and there are about 22 million smokers in the country and 55% of the households have at least one individual who smokes tobacco. In Pakistan about 100,000 people die annually from diseases caused by use of tobacco.

14. Pakistan has the highest level of urbanization amongst South Asian countries resulting from rural urban migration and it is expected that 50% of Pakistan total population will be living in urban areas by 2025. Sindh is already more than 50% urban. The health outcomes in urban areas are better than rural in aggregate terms but poor households living in squatter settlements have poor health outcomes equal if not worse than rural households due to similar issues of access to preventive and curative services in a fragmented urban health care system.

Health System Performance

15. When Pakistan came into existence in 1947, the health system was premature and rudimentary. The health system has expanded gradually with a large network of health facility, workforce and services across Pakistan. Progress in health sector is evident from the following few facts:

- In 1947, there were 292 hospitals in the country which have now increased to 920 hospitals in the public sector and about 800 in the private sector. There was hardly any health facility in rural areas at time of independence. However, access to services has been increased in rural areas with more than 550 rural health centers and 5,300 basic health units besides 4,600 dispensaries and 900 Maternal and Child Health (MCH) centers in urban areas. The information on private sector remains inadequate but a rough estimate is that there about 20,000 private clinics in the country.
- Pakistan had two medical colleges in 1947; now there are 71 medical and dental colleges in the country, 32 are in public sector and 39 in the private sector. The number of registered doctors has increased exponentially from 78 in 1947 to more than 111,600 doctors and 8400 dentists including 21,500 specialist doctors and 517 specialist dentists.
- Nursing profession has also seen growth with 109 schools of nursing (76 in public and 33 in private sector), 141 schools of midwifery, 26 public health schools and 7 colleges of nursing. More than 46,000 nurses and 4500 Lady Health Visitors (LHVs) are registered with Pakistan Nursing Council (PNC), backed up by a community based workforce of about 95,000 lady health workers. Pakistan has now initiated a Programme to deploy 12,000 community midwives (CMW) in the rural areas.
- Life expectancy has increased from 34 years in 1947 to that of 65 years. Infant mortality has reduced from about 220 per 1000 live births in 1947 to 78 per 1000 live births. Maternal mortality was estimated to be 800-1000 per 100,000 live births in late 40s'; but is now estimated to be 276 per 100,000 live births.
- Smallpox and Dracunculiasis (Guinea worm) were wide spread when Pakistan came into existence; now these diseases have been eradicated. Pakistan is also very close to the eradication of Polio (decreasing Polio cases from more than 5,000 in 1993 to 118 in 2008) and the burden of deaths due to Diarrhea diseases is decreasing;
- About 525 pharmaceutical units produce more than 47,000 pharmaceutical products and medicines worth of $100 million are exported every year.
- Federal, provincial and district governments are implementing national health programmes mainly focusing on cost effective interventions. Some of recent successes are as following:

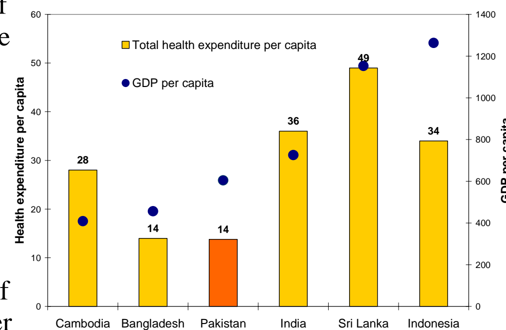
    - Increase access to MCH and FP services in rural communities through expansion of Lady Health Workers from 38,000 in 2001 to 95,000 in 2008; and about 5,000 community midwifes are under training before their deployment in their own community.
    - Improving immunization coverage (number of children 12-23 months fully immunized) to 76% in 2006-7 compared with 53% in 2001-02; 56% of pregnant women were receiving tetanus toxoid in 2006-07 as compared with 46% in 2001/02; and increase in the percentage of births attended by a skilled attendant – from 18% in 1998/99 to 36% in 2006/7;
    - TB Programme has recently passed the 2010 target of 85% of cases successfully treated – 87% with increasing case detection to 69% in 2007 (close to 2010 target of 70%).
    - HIV & AIDS prevention services provision has been established through non governmental organizations with increasing condom use by female sex workers and reduced syringe sharing among injecting drug users;

16. Despite improvements, Pakistan's health sector continues to face many challenges. The key issue remains slow progress in making progress in improving health outcomes and the performance remains inadequate. Poor are not benefiting from the health system whereas they bear major burden of diseases. Expanded infrastructure is poorly located, inadequately equipped and maintained resulting in inadequate coverage and access to essential basic

services. Private health sector continues to expand unregulated mainly in urban areas. Factors contributing to inadequate performance of health sector are deep rooted including weak management and governance, partially functional logistics and supply systems; poorly motivated and inadequately compensated staff, lack of adequate supportive supervision, lack of evidence based planning and decision making, low levels of public sector expenditures and its inequitable distribution. In addition to factors internal to the sector, external factors also contribute to poor health outcome including illiteracy, unemployment, gender inequality, social exclusion, food insecurity, urbanization, environmental dangers, lack of access to safe drinking water and inadequate sanitation.

Health Care Financing

17. Pakistan continues to spend less on health than most other countries at the same level of Gross domestic product (GDP). Over the last 15 years public health expenditures have increased by 50% in nominal terms, however taking into account population increase and inflation, the real expenditures as percentage of GDP have stagnated at 0.6%. During last five years (between 2001/02 and 2005/06) public sector investment increased by 90% in real terms as compared to by 5% during the previous 5 years, but this increase also did not meet the targets set under Poverty Reduction Strategy and Fiscal Responsibility Act. Most (75%) of the health expenditure is out of pocket (OOP). This combined with lack of social protection mechanism puts large number families at risk of poverty because of illness.



18. The federal and provincial governments have been able to secure internal resources for the health sector in recent years. However, the Government has mobilized few external resources for the sector from development partners, private sector or philanthropic sector. A rough estimate indicates that Pakistan mobilizes only about 7% of total expenditure from external sources, when the average for low income counties is above 14% and in Bangladesh it is more than 22%.

Health Sector Management and Governance

19. Pakistan has a mixed health care delivery system including both state and non-state providers and for profit and not for profit. The Ministry of Health, provincial and district health departments, parastatals, social security, non-governmental organizations (NGOs) and private sector finance and provide services mostly through vertical mechanisms.

20. The federal, provincial and district governments have clear roles and responsibilities, but there are overlapping functions in practical terms. The role of the federal government relates to policy formulation, provision of technical backstopping, coordination with different partners with in and outside the country, communicable disease control and financing for health care. However an overemphasis of the Ministry of Health towards national programmes has diminished its stewardship roles of policy making, regulation, monitoring & evaluation (including surveillance) for quality of care and health care financing. Provincial departments of health are responsible for translating the national policy into planning and implementing it, through generating the required human resource, providing specialized care through its tertiary care hospitals, besides overseeing primary and secondary health services provided by the district governments.

21. The actual service delivery takes place at the district level where the two tiers of primary and secondary health outlets are managed. The districts also run the federally financed national health programmes that bring a dichotomy in the management due to its dual command mechanism. All the preventive services are implemented at the district level where government is more or less the sole provider, besides the provision of medico-legal services.

22. Despite devolution of powers at the local level, the health system remains centralized and not able to respond to the organizational and governance challenges resulting in ineffective use of already scarce resources and its ability to deliver. The management challenges arise due to multiple supervisors, lack of clear roles and responsibilities in three level of government and multiple directions coming from different levels. Devolution remains incomplete with weak accountability mechanisms and management capacity at the district level. The public health system needs re-organization based on management principles, with the federal and provincial governments focusing on its core stewardship functions of policy, regulation, monitoring and evaluation, standard setting and moving towards quality service delivery both by the public and private sector.

Monitoring, Evaluation and Surveillance systems

23. Monitoring & evaluation and surveillance culture remains weak at all levels due to an absence of result based culture. Information systems are present in most First level care facilities (FLCFs) and in national programmes, so a culture of continuous data reporting exists. Currently, these systems are highly fragmented and often vertical leading to duplication of efforts. Health Management Information System (HMIS) developed during early 1990's is functional but there are significant issues. Data quality, its accuracy and completeness is compromised and use of information for decision making is discretely practiced. In addition it failed to evolve to develop other information sub systems initially envisioned e.g. human resource (HR) information system. The public hospital system in Pakistan lacks a standardized information system and most maintain their own information system without a regular reporting mechanism. There is also no system to gather information from large private sector for the state to undertake its function to protect public interest. The above situation of information systems is a direct result of weak institutional mechanism for monitoring and evaluation (M&E) including lack of ownership and organization support for data and information. Federal and provincial governments now focus almost entirely on routine data coming from health management information systems and data from household surveys are not fully used. Pakistan has not undertaken a national health survey for more than decade.

24. Monitoring and evaluation are key federal and provincial responsibilities and careful attention to its operation-ability will be critical for enhancing accountability and to make the system result oriented. The Ministry of Health has taken steps to strengthen M&E including a detailed assessment of HMIS; design and assessment of District Health Information System (DHIS) including the hospital sector; DHIS has been piloted and work is in progress to initiate its implementation across Pakistan; use of third party to evaluate programmes and a performance assessment of the health sector disaggregated by provinces and districts to facilitate policy development and informed decision making. The performance assessment used analysis of secondary data for intermediate health outcomes generated from Pakistan Social and Living Standards Measurement (PSLM) Survey. These are steps in the right direction but there is more to be done to generate information to facilitate informed decision making.

25. A critical aspect under the M&E and stewardship function is to ensure having an effective health surveillance system which is needed for effective prevention and disease control measures. Public health surveillance is a recognized public good and responsibility of

the state. However, Pakistan at present has vertically operating multiple small initiatives in surveillance without a system which is not in a state to generate good quality information for making key public health decisions. The fragmentation is a result of lack of organizational unit or structure at the federal provincial and district level responsible for surveillance, lack of legal framework for disease reporting and lack skilled manpower and resources for this important function. In addition, no public health laboratory network exists except a Public Health Division Laboratory in National Institute of Health. The Ministry of Health is cognizant of the situation and undertook a detail assessment. A detailed framework has been developed but not put in place. Some aspects of the plan are being implemented e.g. A training programme through Fulbright fellowships for researchers, and communicable diseases control has been started to produce skilled manpower for surveillance. This would entail development of a comprehensive system and build organizational capacity at federal, provincial and district levels for its effective functioning.

Pharmaceuticals Sector

26. At the time of independence, Pakistan had no pharmaceutical manufacturing unit and pharmaceutical needs were met through imports. The local pharmaceutical industry developed over time responding to indigenous demand growing to a size of about Rs. 88 billion (1.2 billion $) with export of US $ 100 million annually (0.22% of global pharmaceutical market) in 2007. The Pakistani market is shared equally by local manufacturers and multinationals. There are 47,000 products registered which are being produced by 525 companies including 30 multinationals.

27. The pharmaceutical sector is regulated under the Drug Act 1976. Historically drug prices were fixed by the Ministry of Health on case to case basis under the Drug Act. However, since 1993, partial deregulation (323 molecules & 821 formulations) was approved thus reducing the powers of the Ministry to regulate drugs, resulting in an extraordinary increase in prices. The decision was put on hold in 1994, which is still in place. The cost issue was also addressed partially through the introduction of Generic Drug Act (in 1972, 73), but it was not implemented and the commercial interests of stakeholders forced the policy to be reverted. The situation calls for an appropriate mechanism for drug pricing with an inbuilt monitoring mechanism.

28. As drug procurement constitutes the major portion of health expenditure (mainly out of pocket) and main contributor to the catastrophic health expenditure, an annual review of pricing based on the input cost can be beneficial to the patient as well as the industry. This calls for a pro poor drug policy that maintains prices with in the reach of the people at least of essential medicines, focusing on quality, accessibility and affordability. The availability of over the counter sale of drugs and over prescription by physicians due to unethical marketing practices is increasing the cost of treatment besides giving rise to drug resistance.

29. There is a flourishing alternate health care, herbal and other medicines (homeopathic, ayurvedic etc) market with little control. An effective approach is bringing these herbal and other alternative drugs under registration and quality inspection domain.

30. The increasing number brands in the market has generated a never ending competition that compel the manufacturers for unethical promotions and marketing tactics, while on the other hand certain in-expensive and less profitable medicines (some very essential) are not manufactured locally and the government has no binding on the manufacturers to ensure the availability (manufacturing) of these in-expensive essential drugs. Although the government would be willing to look after the interests of pharmaceutical industry for economic reasons and export potential, but access to essential drugs is an

important component of health care and health outcome; and it is imperative that the government maintains regulating the drug sector, of course not each and every formulation.

31. Ministry of Health has developed essential drugs lists for different levels of health care facilities and hospitals but in practice these guidelines are not followed completely. There is also need of rational use of drugs at the service delivery level which can only be ensured through a mechanism of supervision, availability of treatment protocols and appropriate training. The procurement of drugs at federal level is being now undertaken according to the Pakistan Procurement Regulatory Act (PPRA). The procurement process and testing of drug quality is functional but the system needs to be strengthened in terms of its effectiveness and timeliness. In addition, the process of procurement at all levels has limited internal controls and monitoring mechanism to ensure value for money being spent.

Medical Education

32. At the heart of each and every health system, the workforce is central to advancing quality of health care. At the time of independence in 1947, Pakistan inherited a weak health sector having few health establishments and limited avenues for production of doctors and paramedics with only two medical colleges. Investments during the last three decades have seen considerable improvement in the production capacity of health care providers. But the focus on human resource development remained unbalanced and lopsided with inadequate emphasis on nursing and paramedical education with significant negative impact on quality of health care. Pakistan is among the countries that still has critical shortage of health workforce. There is no well-defined policy & plans for human resource development in the health sector. The Ministry of health and the departments of health lack organizational structures responsible for human resource development. A number of critical issues limit quality of manpower produced including: curricula for the health manpower do not match local health needs; Educational institutions are ill equipped to provide quality education using obsolete traditional instructional methods and curricular formats resulting manpower not competent enough to function effectively in primary and secondary levels of health care settings. There is inadequate emphasis on use of information technology, in communication methods, medical ethics, or the bio-psycho-social model of health. Re-orientation of medical education and curricula to address the above challenges besides focusing on public health, prevention and promotion of health.

33. The mechanism for induction courses for different cadres in the health sector is not in place with very few such activities carried out by isolated projects. The in-service training mechanism through Provincial Health Development Centers (PHDC) and District Health Development Centers (DHDCs) introduced during 1990's is partially functional. Similarly there is no formal policy, national standards or guidelines for structured implementation to update knowledge and skills of health care providers, including programmes for continuing medical education and systems of re-accreditation of doctors, nurses and paramedics. Other critical areas in which there is shortage of skilled health workforce include hospital management and management of health systems. Achieving the MDGs will depend on finding effective human approaches that can be implemented rapidly. Systematic thinking in several areas is required to formulate ways of recruiting and retaining health workers with opportunities for career development.

III. Progress of Implementation of Health Policy 2001

34. Review of the 2001 policy indicates progress has been made in achieving the targets despite significant challenges. The review of health sector performance in light of MDGs or Poverty reduction strategy papers (PRSP) monitor-able indicators indicates that Pakistan is moving in the right direction, even though the pace is slow. This is evident from declining

infant & child mortality and fertility etc. However, in depth analysis indicates that this policy is inefficient in terms of resource usage for policy objectives, ineffective in terms of producing a measurable impact on intended beneficiaries and inequitable in terms of benefiting relatively more urbanites and is gender insensitive. The public sector services utilization has not changed much. Critical issues related with the health policy 2001 are summarized below:

i. The inter-linkages of the health policy 2001 with PRSP, MDGs and MTDF are not explicitly well defined; the policy is not fully synchronized with the Mid Term Development Framework (MTDF), Poverty Reduction Strategies Papers (PRSP), Millennium Development Goals (MDGs), provincial level strategic frameworks and medium term budgetary framework (MTBF) processes.

ii. No targeting strategy was envisaged to ensure pro-poor healthcare interventions;

iii. The policy lacked explicit monitoring and evaluation framework to assess results under each goal of the policy.

iv. Littler emphasis on advocacy and orientation for the policy makers in terms of role of health in reducing poverty and producing high quality human capital resulting in low financial allocation for health as compared to other sectors.

v. The policy was almost silent on expanding and increasing role of the private sector.

vi. To some degree it failed to strategize how financial as well as non-financial gap will be met and did not envisage alternate healthcare financing sources as option.

35. In summary, although the health of the population in Pakistan has improved, the pace of improvement has not been satisfactory. The existing health care system has not delivered up to the full expectation of the people due to various reasons.

IV. Summary of Key Challenges in the Health Sector:

36. In summary, **key challenges** in the health sector are:

i. Making progress in current health sector programmatic reforms to achieve MDGs and tackling effectively newly emerging and re-emerging health issues including non-communicable diseases and disasters

ii. Improving access of essential and cost effective health services especially for the poor and vulnerable

iii. Emphasizing more on quality of care and services at all levels

iv. Protecting poor from catastrophic health expenditures

v. Improving the institutional arrangements and management of health care delivery system

vi. Improving the availability (specially female) and motivation of health workforce

vii. Aligning outputs of the academic institutes in line with the needs of health system and improving the quality of education and training.

viii. Effectively engaging private health sector and civil society organizations to improve health outcomes

ix. Developing pharmaceutical sector and ensuring access to quality medicines

x. Making health system more responsive and accountable

xi. Ensuring effective research, monitoring & surveillance system to measure results and evidence based decision making at all levels

V. Future Direction – Stepping Towards Better Health

37. **Principles:** Health is an essential prerequisite without which individuals, families, communities and nation cannot hope to achieve their social and economic goals. The new policy paradigm is based on health as a right as envisioned in the Constitution of Pakistan and will be driven by the following key principles:

i. Ensuring universal coverage of an essential package of health interventions without economic, geographical, social or cultural barriers and is responsibility of the state;
ii. Overcoming social and economic inequities to improve health outcomes;
iii. Promotion of a results based culture ensuring a shift from a planning environment concentrated on the reporting of processes and outputs to outcomes;
iv. Provision of quality health care and ensuring gender sensitive and patient-centered services;
v. Ensuring good governance, promotion of meritocracy and transparency in every aspect of health care management; and
vi. Promoting evidence based decision making which must prevail at every level of the health system so that policy development and actions deriving from policies are relevant, feasible, resource appropriate and culturally and socially acceptable.

38. The principles are envisaged to be applied to all aspects of health care and will be supported by emphasis on local (district) ownership and leadership, strategic coordination, building local capacity, and expanding partnership with private sector.

39. **Vision:** The Policy envisages a long term vision to reorient the health system endorsing the concept of health for all strategy albeit - ***a health system that: is efficient, equitable & effective to ensure acceptable, accessible & affordable health services. It will support people and communities to improve their health status while it will focus on addressing social inequities and inequities in health and is fair, responsive and pro-poor, thereby contributing to poverty reduction***.

40. **Goal**: The overall goal of the policy is ***to improve health status of the people of Pakistan***.

41. **Policy Objectives:**

National Health policy aims to improve health status of people of Pakistan by achieving the policy objectives mentioned below and it is envisaged that it will also help Pakistan to make progress towards health related MDGs.

i. Enhancing coverage and access of essential health services especially for the poor;
ii. Measurable reduction in the burden of diseases especially among vulnerable segments of population;
iii. Protecting to the poor and under privileged population subgroups against catastrophic health expenditures and risk factors;
iv. Strengthening health system with focus on resources;
v. Strengthening stewardship functions in the sector to ensure service provision, equitable financing and promoting accountability;
vi. Improving evidence based policy making and strategic planning in the health sector.

VI. Strategic priorities

42. Addressing the gaps in the health sector requires a fundamental change in the thinking that informs health policy at all levels. The paradigm shift requires that the objectives of the health policy would be to serve the needs of the people especially poor and vulnerable. This implies changes in all health sector parameters: what health services to offer; who benefits from health services; what programmatic and systems reforms should be in place; and how the resource cost to be shared. In addition, it is critical that the federal, provincial/area and district governments re-affirm achieving health related MDGs by 2015. To transform this commitment into action, the federal and provincial/ area governments will develop, implement and monitor health sector strategic frameworks to achieve health related MDGs and the following policy objectives of the National Health Policy 2009.

Policy Objective 1: Enhancing coverage and access of essential health services especially for the poor

43. Given the important role of better health as a key driver of social advancement, the foremost policy priority is to enhance coverage and access to essential health services and improving the quality of health care services particularly for the poor and vulnerable especially women and children. The priority policy actions include:

Policy Actions:

1.A: Primary and Secondary Health Care Facilities:

1) Essential service delivery package which will be a series of specific health services and standards of care and not only a set of physical infrastructure, staff, equipment and supplies (Annexure III). Both public and private sectors will play their role in enhancing coverage of essential health services. However, delivering the essential service delivery package as a public good to all citizens through its own infrastructure will be ensured on priority basis, regardless of management arrangements.
2) Emphasis will be to re-vitalize Primary health care (PHC) system with a focus on reproductive health and family planning services, integration of services, improving quality of care and ownership of interventions at the local level.
3) Availability of staff (especially female staff) for service delivery particularly in primary health care facilities in rural areas will be ensured by exploring differential packages of salaries and performance incentives.
4) A system of supportive supervision and monitoring will be revitalized at the local level along with community based accountability mechanism.
5) Outreach workers (vaccinators, sanitary workers and malaria inspectors etc) will be converted into multipurpose health care workers, with their line of command at the health facility level. Number of posts will not be reduced but coverage area will be rationalized for effective delivery of multiple services with increase in frequency of visits.
6) Every district will be attached with a teaching institution in the province/ area and specialists (initially Gyne/obstetrician, pediatrician, surgical and medical specialist) working in tertiary and district headquarter hospitals will have periodical visits to remote health facilities with publicized schedule.
7) Considering the issue of urbanization and urban slums, there will be a review and re-structuring of urban primary health care system for provision of essential package of

health services especially for the poor living in urban slums and exploring the option of public private partnership.

8) Productive community involvement at the health facility level will be strengthened to improve responsiveness.

9) A comprehensive referral system both for emergencies and normal health care involving all levels of health care will be developed and implemented.

1.B: Primary and Preventive Health Care Programmes:

1) Essential health services through the National Expanded Programme on Immunizations (EPI), the Lady Health Workers (LHWs) Programme and the National Maternal, Newborn and Child Health (MNCH) Programme will be expanded with maximizing synergies between these interlinked programmes and further reinforcing linkages with the Nutrition programme.

2) The health sector will specially focus on provision of Family planning (FP) services through the healthcare network and community based lady health workers by: (i) ensuring financing and provision of at least three modern contraceptive methods and skilled manpower in all health outlets of Departments of Health (DoHs); (ii) strengthening the provision of FP services and products through the LHWs at the doorstep of community, and (iii) Fostering greater functional integration between the two vertical institutional entities, (Health and Population Welfare) in order to maximize synergies at the service delivery levels. The main constraint to be addressed through above measures will be to ensure commodity security and availability of contraceptives in each and every health outlet.

3) In relation to maternal health, Ministry and Departments of Health will ensure training and deployment of the new cadre of community midwives through National MNCH Programme and strengthening of round the clock comprehensive and basic Emergency Obstetrical and Neonatal Care (EmONC) services.

4) Pakistan's nutrition outcomes have been relatively stagnant over the last two decades. The current global increase in food prices, which is affecting Pakistan as well, is likely to compromise these outcomes further. The Ministry and Departments of Health will develop a practical programme with an objective of improving the nutrition status of women of childbearing age and children below 3 years by improving the coverage of cost effective nutrition interventions.

5) To address the persistence challenge of child mortality at facility and community level, the National MNCH and Lady Health Workers (LHW) Programmes will implement standard protocols for management of common childhood illnesses at facility and community level respectively.

6) Demand side interventions (cash transfer, vouchers scheme etc) will be pilot tested (especially for delivery services and TB treatment) before large scale replication of such interventions.

Policy Objective 2: Measurable reduction in the burden of diseases especially among vulnerable segments of population

44. Pakistan bears a double burden of diseases; although the burden of communicable diseases, childhood illnesses, reproductive health problems and malnutrition is high and remains to be tacked, non-communicable diseases (NCDs) are fast emerging as the major contributors of death and disability. The major brunt of all these diseases are borne by the poor — communicable diseases and malnutrition are commoner amongst the poor and the vulnerable whereas NCDs affect the economically productive workforce, lead to income losses, lost productivity and are known to be the major contributors to health shocks. The focus of the health policy will therefore be to address all these disease dimensions through following policy actions:

Policy Actions:

1) Expanded Programme on Immunization (EPI) will respond to the system level challenges by focusing on low performing areas, attempting to reduce dropouts and improving monitoring and supervision systems. Lady health workers will be involved to deliver routine immunization services in their catchment's areas. The feasibility of introducing new cost effective vaccines will also be explored.
2) Polio eradication will remain the priority of the government and efforts will be made to interrupt its transmission by 2010. The programme will attempt to get around overarching issues, such as low coverage of routine immunisations, security situation in NWFP/FATA and Balochistan and large scale population movements, which are responsible for the increase in the Polio transmission; there will also be an emphasis on further improving the quality of the campaign.
3) Interventions to control diseases like diarrhea and respiratory infections, etc will be reviewed for rapid expansion of Integrated management of neonatal and childhood illness (IMNCI) strategy, incorporating new knowledge e.g. use of zinc for the management of diarrhea.
4) The National Tuberculosis (TB) Control programme will continue to follow its strategic plan with a special emphasis on maintaining recent successes and expanding Tuberculosis– Directly Observed Treatment short course (TB DOTs) strategy through large network of hospitals and working with the private sector. The challenge to ensure uninterrupted availability of DOTs medicines will be addressed by strengthening the logistics and procurement system with adequate financing. The programme's strategic plan will be updated based on the results of TB prevalence survey and independent third party assessment of the programme.
5) In response to the endemic Malaria burden in Pakistan, the programme will continue to implement the Roll Back strategy with effective implementation in high risk districts, using rapid diagnostic kits, expanding the use of impregnated treated nets (ITNs) and using updated treatment protocols. In addition, a comprehensive strategy will to be developed to respond to other vector borne diseases especially dengue fever.
6) The National HIV & AIDS Control Programme will rapidly expand preventive services for the high risk population especially injecting drug users, sex workers and migrating population mainly through private and NGO sector. The focus will also be on provision of treatment and care to the positive cases; control of sexually transmitted infections (STIs), ensuring safe blood transfusion, prevention of mother to child transmission, changing behaviours to address issues of stigma and discrimination and enhancing capacity of the implementing partners.

7) Provision of safe blood will be ensured by strengthening Blood Transfusion Authorities, revision in legislation and vigorous monitoring of blood banks both in public and private sector. Provision of safe blood during emergencies and especially for children affected with diseases such as thalassaemia etc will be ensured by encouraging public private partnerships.

8) To address the growing burden and spread of Hepatitis B & C, which are mainly transmitted through sex and blood, the National Programme for Hepatitis Control will review its strategic plan to focus on primary prevention through expanding immunization for Hepatitis B in children, vaccination of high-risk groups, ensuring provision of safe blood. Tertiary hospitals will establish screening and diagnostic centres and treatment facilities.

9) While discouraging irrational use of injections giving practices, the use of auto destructible syringes will be promoted in all health facilities, hospitals and programmes in a phased manner with ban on the use of routine syringes.

10) The government will develop and implement an Integrated Disease Surveillance System by establishing operational surveillance units at all levels with skilled staff and backup networks of laboratories, ensuring Pakistan fulfil the requirements in line with international health regulations. As the system develops, existing disease specific surveillance activities will be integrated along with options to include MCH surveillance and NCD behaviours.

11) The scope of public health interventions will be broadened to address diseases that have remained neglected to date, but which paradoxically are the leading causes of death and disability. Non-communicable diseases, which include injuries, diseases of the heart, diabetes, cancers and chronic lung conditions, affect the economically productive workforce, result in income loss and lost productivity. NCD control strategies will be implemented focusing on primary prevention and reducing risky behaviours including smoking, life styles and dietary habits.

12) Emergency response system will be expanded covering all large cities in the initial phase. All THQ and DHQ hospitals will expand services to deal with emergency and trauma cases. Medical emergency technician training programme will be launched.

Policy Objective 3: Protecting the poor and under privileged population subgroups against catastrophic health expenditures and risk factors

45. Whether it is global financial crises or increased health expenditures at household level, the impact on the poor and near poor is very serious, as risk management options are limited: the poor may need to sell productive assets, nutritional standards are likely to fall and the ability to spend on private healthcare will fall. In that situation morbidity and mortality rates rose. In countries like Pakistan, when the overall economy comes under pressure, a common feature is that spending on private healthcare falls as people seek to shift to public care. The demand for public healthcare rises significantly at precisely the time that governments feel the financial need to cut back. In such situations it is the poor who are almost always squeezed out. Therefore, to protect the poor from catastrophic health expenditures and risks, the government will take following policy actions:

Policy Actions:

1) The government will work on the concept of a National Health Service. Through this, the government will ensure the poorest people to access health services and more explicitly access to a doctor. The scheme envisages using the database of Benazir Income Support Programme (BISP) and registering the poorest families at the level of the union council or sub district level and issuing a health card with basic health characteristics; the card will also entitle citizens to services (not provided by the state) through private providers. The provider will refer cases of critical illness to district level hospitals (or whatever higher tier that is required). The design, modalities and strategies will be pilot-tested before nationwide expansion.
2) There will be no user charges at primary level public health facilities. Further emergencies services (including medicines) and delivery services in all public hospitals will be free of cost. Respective governments will determine user charges only in referral hospitals to avoid unnecessary load of patients seeking primary health care. However, those patients referred from primary health care facilities will be exempted of such user charges. Other social protection initiatives (Baat-ul-mal, Zakat etc) will be made available for the poor.
3) The government will provide free specialized care (dialysis services, eye surgery, treatment of heart diseases and other long term illness and disabilities) to the poorest people who are registered with BISP.
4) Cash transfer and vouchers schemes will be tested before large scale replication to protect poor from catastrophic expenditures
5) Access to essential drugs will be ensured in all public health facilities and hospitals. Pharmacy banks for the poor will be tested in selected hospitals. Free medicines for the treatment of TB, AIDS and Malaria will be made available.
6) To avoid health risks and promote better health, Ministry and Departments of health will develop comprehensive integrated behaviour change communication strategy, which will focus on the needs of the poor and vulnerable.
7) Health insurance models will be piloted to create a market which may later on be expanded to the poorest segments with government/ zakat sharing.

Policy Objective 4: Strengthening health system with focus on Resources

46. In health sector, access to health care provider and access to medicine are the two major demands of the people. Health system's stewardship functions on human resources and medical products (including medicines) will be a priority through following policy actions.

Policy Actions:

4.A: Health Workforce

1) The government will develop a comprehensive health workforce policy by 2010, based on objective assessments of needs. The government will also enact a health workforce law encompassing all categories of health care providers, defining career structures, laying down service, promotion and recruitment rules and reviewing cadres to avoid duplication and promoting multipurpose skilled workers.
2) Role of health workforce accreditation bodies – Pakistan Medical & Dental Council (PMDC), Pakistan Nursing Council (PNC) – will be strengthened; whereas the government will review the option of establishing a new accreditation body for health technicians and paramedics.
3) The government will balance out the mix of health workforce considering the needs of the health system. Current shortfall in certain categories e.g. nurses, midwives/ Lady health visitors (LHVs), specialized technicians, health systems and hospitals managers, researchers etc, will be addressed.
4) A separate management cadre (with equal opportunities for females) at all levels will be developed in the public sector.
5) Selection and appointment of health workforce will be based on merit and having competencies fit for the post. As system to measure performance and competencies of health workforce will be developed.
6) Staff vacancies will be filled on priority basis and the issue of shortage of female health care providers and nursing staff especially in rural areas will be addressed.
7) Staff (especially in rural areas) will be employed on terms and conditions that aid recruitment, equitable deployment, retention and high performance.
8) Due attention will be paid to recruit and retain women health workforce by creating flexibilities and providing opportunities for growth.
9) All health departments will maintain database of health workforce appointed in the public sector. No posting, transfer or deputation will be made without feeding the information in the health database.
10) Dual job holdings will be discouraged other than institutional practice after working hours.
11) At least two years working at BUH/ RHC will be compulsory for post graduation and for appointment as a specialist in the public sector.
12) Competency based training will be promoted in all medic and paramedic health institutions.
13) Health institutions will establish a mechanism of continued education for all cadres of health workforce. System of continuing education i.e. Provincial Health Development Centers (PHDC) and District Health Development Centers (DHDC) will be revitalized.
14) General practitioners will be offered post graduate level training opportunities in family medicine in addition to refresher training courses on technical health issues.

4.B: Pharmaceuticals and Medical products

1) Ministry of Health will announce a new prop-poor National Drugs Policy.

2) A National Drugs Regulatory Authority will be established that will work on the principle of rationalizing rather than directly regulating the entire array of 42000 plus drugs registered in the country. The prices of only essential drugs need to be regulated, while prices of non-essential medicines should be monitored.

3) Pharmaceutical product dossier at the time of registration will be simplified and brought in conformity with regional standards. Stability testing procedures will also be standardized on the basis of best practices in the region. Cost effectiveness of drugs will be included as a criterion in the process of registration.

4) It is in the interest of registered manufacturers to maintain quality standards if they want to capture larger market shares and break into export markets. An institutional mechanism of public-private partnership for quality checks will be devised where the private sector and civil society will also participate in instituting regionally acceptable quality standards for medicines and other products.

5) National Regulatory Authority will be brought up to the standards of WHO, so that it may also facilitate production of quality biological products (vaccines, sera and anti-snake venom, antiviral etc) in the country.

6) While drug inspection is a provincial subject, high level of variation exists in inspections across provinces. Provinces will create appropriate protocols for inspection, in terms of quality and quantity of inspections. Legislation will also be done to give more powers to inspectors and for appropriate documentation on inspections and their outcomes.

7) Provincial Quality Control Boards will be established and strengthened. While there will be a need for more labs in the future, as a policy, existing quality control labs will be strengthened and their ability to carry out robust checks will be ensured. The quality control laboratories will come up to regional standards for validation. WHO will then carry out validation inspections of the laboratories. Once the labs are validated, the WHO will carry out annual audits to ensure quality.

8) One mechanism for checking counterfeit and spurious drugs is to bring in herbal and other alternative medicines under the registration and quality inspection ambit. Legislation in this regard will be put through to the parliament for approval.

9) Rational use of drugs will be promoted. For this purpose, a three pronged approach will be reviewed: i) legislation whereby superfluous or excessive use of drugs by doctors can be challenged by the patient, ii) appropriate legislation and enforcement mechanism can be devised to limit over the counter drug availability, iii) Over time the requirement of a qualified chemist at every drug outlet can be introduced. This policy action will have to be phased out to ensure that enough pharmacists are produced in the country and present in different parts of the country. Initially this policy can be introduced and enforced in large urban centers of the country.

10) The supply of essential drugs to the appropriate facility will be on the basis of specific services provided by the facility as against the present practice of supplying drugs on the basis of demand from the facility. Drug requirement for each tier of service provision will be determined specifically.

11) To check against pilferage and wastage, standard treatment guidelines at different tiers of health facilities will be made operational in the procedure of procurement and disbursal of drugs.

12) Ministry of Health, Provincial Health Departments and District Health Offices will follow a transparent procedure on procurement in line with PPRA rules and regulations.

13) Efficient supply management system will be developed to store and transport medicines at provincial, district and facility level.

14) To ensure that drugs manufactured for public sector facilities do not make their way in the market, they will be packaged separately.

15) Ministry will develop a baseline position to clearly articulate the Pakistan specific public health impact of the World Trade Organization (WTO) agreements; and will enhance capacity to take advantage to override certain provisions of WTO in the interest of making low-cost high quality drugs which are accessible to all.

Policy Objective 5: Strengthening stewardship functions in the sector to ensure service provision, equitable financing and promoting accountability

47. Strengthening of health systems performance depends upon three vital functions, i.e. service provision, financing and promoting accountability. Health System will be strengthened through following policy actions:

Policy Actions:

5.A: Service provision by public and private sector

1) Ministry and Departments of Health will explore the option of establishing Health services accreditation authority/ mechanism to ensure implementation and monitoring of essential service delivery packages, developing policy and legislation on public private partnerships (PPP), regulating partnerships and addressing patient safety issues.
2) In close partnership with private sector professional bodies, provincial governments will establish regulatory authorities. Government will also focus on formulating minimum standards of quality care and implementing quality assurance mechanism for services by the private sector.
3) Role of Health Foundations will be reviewed and these foundations will be restructured with increased involvement of private sector. The objective would be to finance private health sector for provision of priority services in the rural areas.
4) Private sector including NGOs will be mainstreamed into the development process and harnessing their potential to deliver services. The government will further promote the role of the private sector in the delivery of health services, with attention to quality and patient safety and safeguarding the interests of the poor and marginalized.
5) Ways and means will be explored to integrate the system of traditional medicine into the formal health care delivery system, ensuring patient safety and quality of care.
6) Public sector service provision will be improved by supporting decentralization and devolution of administrative and financial authorities at the local level along with community oversight. |
7) Service delivery system will have appropriate checks and balances with clear roles of the three tiers of the government, with federal and provincial governments focusing more on stewardship functions of policy making, strategic planning, monitoring and evaluation, standards setting, quality assurance, regulations and financing.
8) In public sector, the number of Tertiary level hospitals will not be increased; rather focus will be on improving quality of services by developing and implementing protocols and standards of care for general care and specialities.
9) Greater autonomy to the public sector hospitals will be encouraged following detailed planning, changes in legislation and contracts and establishing monitoring mechanism and performance assessments.
10) Telemedicine will be promoted in the country for transferring health knowledge and skills from tertiary hospitals to secondary level hospitals. This will also help in establishing linkages among international hospitals, tertiary level hospitals and districts for better provision of service delivery.
11) It is important to learn lessons from different disasters during last few years and establish a well-coordinated response and disaster relief efforts. Ministry and Departments of Health will take the initiative to build capacity of the health sector for

disaster management, devising an institutional arrangement and implementing disaster management protocols; and plan at national, provincial and district levels for an effective emergency response.

5.B: Financing

1) The government will remove all types of user fees for services at primary health care facilities and community level, with safety nets for the poor seeking care at referral hospitals.
2) Public sector health care financing will be scaled up using predominantly tax-based revenues.
3) Public sector financing will be augmented by more effective use of development aid and accessing more financial support from global initiatives, bilaterals and multilaterals.
4) The government is committed to reduce out of pocket expenditures for health especially by the poorest. Social Health Insurance may be an alternative but it needs to prove itself as effective, efficient and equitable as tax-based financing.

5.C: Accountability and Responsiveness

1) Public health sector as a part of the government is answerable to the parliament. Ministry of Health will regularly give briefings to the Standing committees on health in Senate and National Assembly and will seek advice. Same sort of briefings will be for the health committees of the provincial assemblies. Public accounts committee will review the audit reports of the public health expenditures.
2) Minister of Health will give annual progress report to the Cabinet in the month of August/ September of every year on the status of implementation of National Health Policy.
3) Provincial Ministers of Health will also share annual progress report to the provincial cabinets the month of August/ September of every year on the status of implementation of provincial health sector strategic frameworks.
4) At district level, executive district officer (Health) will regularly brief the district government and assembly on the implementation of health schemes and programmes.
5) Annual progress reports will be shared with the general population through media.
6) Ministry and Departments of Health will also be responsible for regular performance audits of service delivery and results disaggregated by districts.
7) Citizen community boards (CCBs) will monitor the progress of health interventions at the community level. Client/patient satisfaction surveys will be conducted regularly for selected health interventions.
8) Hospitals boards with members from elected representatives and technocrats will be formed to review progress of respective hospitals. Patient’s satisfaction surveys will be held regularly in selected hospitals.

Policy Objective 6: Improving evidence based policy making and strategic planning in the health sector.

48. Public health sector's decision-making cycle comprises of policy analysis, goal and target setting, resource allocation, work planning, operational implementation and performance assessment. The overall purpose of the monitoring and evaluation system will be to provide continuous information and management support to decision-making processes at each decision-making levels of the health system.

Policy Actions:

1) National Health Information System will be reformed. It will base on a strategic framework and will consist of four pillars: i) Management Information Systems; ii) Surveillance System; iii) Health Household Surveys; and iv) Research.
2) The base of Management Information Systems will be broadened by implementing District Health Information System (DHIS) in all districts; expanding it to hospitals and private sector; and aligning it with other Management Information Systems (MIS) of national programmes. Analysis and use of information will begin at local level with feedback loop and also transmitting information upward at district, provincial and federal level for decision making process.
3) Existing piecemeal infectious surveillance system will be integrated into a comprehensive Disease surveillance system with back up support of diagnostics and immediate response mechanism. Behavioral surveillance and vital registration will be linked at a later stage. Plan of action has already been developed, which will be operationalised by establishing a system at district, provincial and national level. Epidemiologist will be trained and deployed at all levels for investigative and analytical work.
4) Information will be collected through national, provincial and district level household surveys to measure progress on health outcomes and processes. Ministry and Departments of Health will coordinate with Federal Bureau of Statistics and Planning Commission to include relevant health indicators in national and provincial household surveys.
5) Pakistan Medical Research Council (PMRC) will draft a five year research strategy in line with new national health policy. A similar research agenda will be developed and implemented at provincial levels. PMRC will be responsible to disseminate research results, new discoveries, etc. to the Policy Units, parliamentarians and end users of the health care delivery system and the research markets. PMRC will regulate and coordinate research activities of national and international institutions in the country. PMRC will also be responsible to ensure availability of financial, technical and technological resources for health research in the country. Research Culture will be developed through reformulated medical education curriculum for undergraduate and postgraduate medical education.
6) All four pillars of Health Information System will feed into Health Systems and Policy Unit at federal level and Health Sector Reform Units for policy and strategic frameworks' development, implementation and monitoring. All policy and strategic units will also be responsible to conduct policy level research, which will provide evidence to inform policy and strategic decisions.
7) All spending decisions will be based on quantitative information about expected outputs and outcomes of public sector interventions. Through implementation of Medium Term Budgetary Frameworks, budget allocations will be linked with policy objectives on one end and intervention/programme outputs on the other end.

VII. Results and indicators of success

49. The key performance indicators to measure implementation progress against key policy objectives are summarized in Annexure I. The Ministry of Health will work closely with the Provincial Departments of Health and Federal Bureau of Statistic (FBS) to ensure collection of the data to tract trends and to disaggregate information by gender and income quintiles. Ministry and Departments of Health will regularly monitor progress on what is being achieved at different levels, using clearly defined and measurable output indicators for each heath sector project.

50. National Health Systems and Policy Unit established under the Ministry of Health and Health Sector Reform and Monitoring & Evaluation units will be established/ strengthened to serve the strategic function of generating evidence, measuring results, dissemination and guiding the policy. These units will be responsible to monitor progress on results and report against indicators by undertaking regular health sector performance assessments by provinces and districts which will be disseminated through MoH's/ DOHs website and via media. These assessments would become the basis for federal and provincial dialogue and setting resource priority especially focusing on those districts which are performing low in district ranking.

VIII. Translating policy into action:

1) Public sector expenditure on health will be increased in line with Fiscal Responsibility Act 2005. At present, public health expenditures are 0.6% of the GDP. In the first stage efforts will be made to increase public sector health expenditures to 0.85% of the GDP by 2011/12 and later on above 1.5% of the GDP by 2015.

2) Federal, Provincial/ Area and District governments re-affirm achieving health related MDGs. To transform this commitment, federal and provincial/area governments agree to develop costed health sector strategic plans with province specific monitoring targets for outcomes and outputs, to achieve MDGs and policy objectives of the National Health Policy 2009. Strategic frameworks will further prioritize policy actions considering available resources. After announcement of National Health Policy 2009, the strategic frameworks will be finalized and approved within a time frame of six months.

3) The policy and strategic frameworks will be disseminated widely to policy makers, legislators, local leaders, economic and finance experts, media, development partners and general public, briefing them the important role of health in reducing poverty and producing high quality human capital.

4) National Health Systems and Policy Unit at federal level and Health Sector Reform Units/Monitoring and Evaluation units at provincial level will regularly review and monitor the progress on National Health Policy 2009 and Strategic Frameworks. These units will also generate evidence and disseminate that to highlight progress or issues.

5) Detailed roles and responsibilities at different levels of the government will be agreed as part of the strategic plans.

6) All development partners will be asked to align their investments in health sector in line with strategic plans. Monitoring mechanisms will be harmonized so that results are acceptable to all. Both the government and development partners will be mutually accountable. Each year, Ministry of Health will organize two meetings of Health Development Partners Forum to review the reform process and to set agenda for the future.

7) National Health Policy-2009 will be aligned with other strategic documents i.e. Vision 2030, MTDF, PRSPs, MTBF and provincial strategic plans etc.

VIII. Annexure

- I: Outcome and Output targets – baseline, benchmarks and targets
- II: Functions and Responsibilities
- III: Essential Service Delivery Package

Annexure - I

Health Sector Indicators (Baseline, Benchmarks and Targets) for National Health Policy 2009

Policy Objective/s	Indicators	Baseline 2006-07	Benchmarks and Targets					
			2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
	HEALTH OUTCOMES							
1,2,3,4,5,6	<5 mortality rate (per 1000 lb)	**94**	78	73	68	65	60	55
1,2,3,4,5,6	Infant mortality rate (per 1000 lb)	**78**	66	62	58	55	48	43
1,2,3,4,5,6	Maternal mortality ratio (per 100,000 lb)	**276**	240	220	200	175	165	150
1,2,3,4,5,6	Total fertility rate	**4.1**	3.7	3.6	3.6	3.5	3.5	3.5
	COVERAGE							
1,2,3	% of children (12-23 months) fully immunized (Disagregation by gender and income)	**76 (47)**	78	80	82	84	84	85
1,3	Antenatal care at health facility	**53**	65	68	71	75	78	81
1,2,3	Tetanus Toxoid coverage	**56**	58	59	60	62	63	64
1,3,5	% of births attended by SBAs	**36**	46	52	56	60	65	72
1,3,5	% of institutional deliveries	**32**	40	44	48	52	56	60
1,3	Contraceptive prevalence rate - % (Disagregation by gender and income)	**30**	33	34	35	36	36	37
2	TB - Case detection rate (SS+) - %	**51**	74	77	79	80	83	84
2,3	TB - Treatment success rate - %	**87**	87	88	88.5	89	90	91
2	% of families sleeping under insecticide treated nets in high risk areas	-	5	7	11	15	20	28
2	Prevalence of Hepatitis B&C	**7**				6		5
	HEALTH SYSTEM OUTPUTS							
1,2,3,5	Health facilities utilization rate (curative) - Patients per day per facility	**33**	36	37	38	40	40	41
1,2,3,5	Patient satisfaction-% population utilizing public hosp & facilities	**20**	23	25	27	30	32	33

	HEALTH SYSTEM INPUTS							
6	Min. govt. expenditure on health as % of GDP	**0.57**	0.72	0.78	0.85	tbc	tbc	tbc
6	Total expenditure on health per capita (Rs. Per person per yr)	**305**	481	548	617	tbc	tbc	tbc
4	Doctors per 1000 population	**0.75**	0.78	0.80	0.81	0.83	0.85	0.87
4	Nurses per 1000 population	**0.34**	0.38	0.40	0.42	0.44	0.46	0.49
4	LHVs per 1000 population	**0.047**	0.054	0.056	0.059	0.062	0.065	0.068
1,4	LHWs per 1000 population	**0.54**	0.61	0.66	0.66	0.68	0.68	0.67
1,3	Hospital beds per 1000 population	**0.65**	0.64	0.64	0.64	0.64	0.64	0.64
4	% of Health facilities with stock out of essential 5 medicines	**72**	64	61	53	50	45	40
	RISK FACTORS							
2,5	IDUs always using new syringes	**41**	53	56	59	63	68	71
1,2,3	Malnutrition (weight for age) - %	**36**	35	34	33	33	32	30
1	Exclusive breast feeding	**23.1**	24	27	31	36	42	50

Annexure - II

Pakistan Health System: Core Functions and Responsibilities

Core Function	Federal	Provincial	District
SERVICE DELIVERY:			
Delivery of services	*	**	***
Preventive and primary health care programmes	*	**	***
Health education and promotion	*	**	***
Advocacy, liaison and community mobilization	**	**	***
HUMAN RESOURCE:			
Health professions regulations	***	**	
Medical colleges, nursing and paramedical schools	*	***	*
Human resource development and training	*	**	***
Integrated supportive supervision	*	**	***
Human resource management	**	**	***
INFORMATION:			
Data collection and use	*	**	***
Surveillance and diagnostics	***	***	***
Health Research	***	***	**
Surveys	***	***	*
MEDICAL PRODUCTS:			
Regulation	***	**	
Procurement	***	***	***
Supply management	***	***	***
FINANCING:			
Health financing	***	***	*
Financial Management	***	***	***
LEADERSHIP AND GOVERNANCE:			
Policy formulation and strategy development and review	***	***	
Legislation	***	***	
Business planning (includes resource projections & allocation)	***	***	***
Micro planning	*	**	***
Inter sectoral coordination	***	***	***
Inter provincial coordination	***		
Inter district coordination		***	
Intra district coordination			***
General management and administration	***	***	***
Service Delivery Standards	**	***	
Public private partnership (PPP) regulation	***	***	
Public private partnership contracts	**	***	***
Environmental health	**	**	**
Disasters and emergencies	***	***	**
Management of donor support	***	**	

Annexure - III

Essential Service Delivery Package

The Essential Service Delivery Package (ESDP) is not only a set of physical infrastructure, staff, equipment and supplies but is also a series of specific health activities and standards of care. Each provincial/ area government will further define ESDP contents considering local needs and sub classification of health facilities. Each provincial/area government will priorities the elements of ESDP to focus on in the initial phase. Emphasis would be to implement ESDP in socio-economically poor districts. These priorities would be a part of Provincial health sector strategic frameworks.

The package of services may comprises of two parts; the first part is the minimum (core) component of the programme that needs to be in place to reduce morbidity and mortality and is recommended for adoption on an as basis; the second component comprises of proposed interventions which can be added as per local requirements and priorities.

a. BHU Level Package:

The proposed package of the BHU Level health facility envisages a facility, which has a catchment's area population of around 5,000-12,000 and need not necessarily be staffed by a full time medical doctor. BHU level health facility comprises not only the physical facility but also includes the outreach and community based health workers, as the staff of the BHU level health facility is also responsible for monitoring and ensuring the outputs for the population base of the FLCF.

The minimum service package required at this level of care is proposed as follows:

CORE Package:

- Curative care for common illnesses (including first aid and provision of essential medicines)
- EPI (plus) services
- Integrated Management of Neonatal and Childhood Illness
- Nutrition advice/ services
- Prenatal and postnatal care
- Birth preparedness counselling
- Newborn care
- Treatment of diseases like malaria, tuberculosis, hypertension, diabetes and skins infection etc.
- Family Planning counselling and services including Intra uterine device (IUD) insertion and removal services
- Information and Education for Empowerment and Change (Family members, pregnant women, parents, traditional care providers etc)
- Training and management support for community based lady health workers

Additional/ Optional Services:

- 24/7 Basic EmONC services only if transportation and referral to higher level is available and can be ensured
- Obstetrical care
- Laboratory support for antenatal care
- Promotion of Iodized salt
- STI including HIV/AIDS counselling and referral
- Psychological rehabilitation
- Physical rehabilitation

b. RHC Level Package:

This is envisaged as a health facility, which is open 24/7 and staffed by medical doctors. The envisaged catchment's population of this health facility is around 12,000-40,000. This facility will also provide management support to the attached BHUs.

The minimum service package required at this level of care is proposed as follows:

CORE Package:

- Curative care for common illnesses (including first aid and provision of essential medicines)
- EPI (plus) services
- Integrated Management of Neonatal and Childhood Illness
- Nutrition advice/ services
- Prenatal and postnatal care
- Birth preparedness counselling;
- 24/7 Basic EmONC services including handling normal deliveries and availability of interventions for minor complications of delivery/ post abortion care
- Newborn care including resuscitation
- Comprehensive Family Planning counselling and services (including referral services for surgical contraceptive services)
- STI including HIV/AIDS counselling and services
- 24/7 Transportation (Ambulance) services
- Diagnostic and Treatment of diseases like malaria, tuberculosis, hypertension, diabetes and skins infection etc.
- Diagnostic services: lab and radiology
- Dental care services
- Information and Education for Empowerment and Change (Family members, pregnant women, parents, traditional care providers etc)
- Training and management support for community based lady health workers

Additional/ Optional Services:

- Advanced laboratory services
- Blood bank, Blood screening and transfusion services
- Promotion of Iodized salt
- Minor surgical operations
- Mental health services / Psychological rehabilitation
- Physical rehabilitation
- Training of midwives

c. Referral Hospital Level Package:

This is envisaged as a hospital, which is open 24/7 and staffed by medical doctors and specialists. The envisaged catchment's population of THQ hospital is around 100,000 to 300,000, whereas for DHQ hospital, the catchment's population will be around 300,000 or above.

In addition to Core and additional services offered at RHC level facility, the following services will be implemented:

- Medical, surgical, paediatric and gynaecological and anaesthesia - specialized services in all THQH. In addition to specialized services essential for all THQH, at least specialized services for ENT, ophthalmologic and cardiology would be ensured in all DHQH.

- Diagnostic services including lab & radiology
- Comprehensive EmOC services including post-abortion care
- Newborn care including incubator care
- Therapeutic feeding centres
- Comprehensive family planning services including surgical sterilization services for men and women
- Training of health care providers and paramedics

d. Tertiary Care Level Package:

In addition to Core and additional services offered at Referral level hospital, the following services will be implemented:

Support & delivery of all services offered at DHQ and THQ hospital level
All types of specialties
All diagnostic services
Training of medics and paramedics
Physical rehabilitation services including prosthesis

e. Community level (Grass root level through out-reach services):

In addition to what has been proposed by the LHWs' Programme, the following additional services may also be provided through LHWs:

- EPI services
- Psychosocial support
- Provision of clean delivery kits, Nutrition supplementation and First aid (plus) etc

The package of services for community midwives will be as prescribed by the Nursing council

REFERENCES

1: