Country Cooperation Strategy for Pakistan

2011–2017

Contents

ACRONYMS

ADB	Asian Development Bank
AJK	Azad Jammu and Kashmir
AusAID	Australian Agency of International Development
BDN	Basic Development Needs
CADD	Capital Administration and Development Division
CCA	Common Country Assessment
CCI	Council of Common Interests
CCS	Country Cooperation Strategy
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CIDA	Canadian International Development Agency
CSO	Civil Society Organization
DaO	Delivering as One
DFID	Department for International Development, United Kingdom
DHIS	District Health Information System
DoH	Department of Health
DOTS	Directly-observed treatment, short-course
DPT	Diphtheria, pertussis, tetanus
DRA	Drugs Regulatory Authority
EAD	Economic Affairs Division
EMHJ	Eastern Mediterranean Health Journal
EMR	Eastern Mediterranean Region
EMRO	WHO's Regional Office for the Eastern Mediterranean
EPI	Expanded Programme on Immunization
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
FATA	Federally Administered Tribal Areas
FLCF	First level Care Facility
FP	Family Planning

FTS	Financial Tracking System
GAM	General Acute Malnutrition
GAVI	Global Alliance for Vaccines and Immunization
GB	Gilgit-Baltistan province
GBV	Gender Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	German Agency for International Cooperation
HDI	Human Development Index
HiAP	Health in All Policies
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HMIS	Health Management Information System
HSS	Health Systems Strengthening
ICT	Islamabad Capital Territory
IDPs	Internally Displaced Persons
IDUs	Injecting Drug Users
IHP+	International Health Partnerships Plus
IPCD	Inter-Provincial Coordination Division
JICA	Japanese International Cooperation Agency
KP	Khyber-Pakhtunkhwa province
LHV	Lady Health Visitor
M&E	Monitoring and Evaluation
MCE	Malaria Control and Elimination
MDGs	Millennium Development Goals
NCDs	Non-communicable diseases
NDMA	National Disaster Management Authority
NFC	National Finance Commission
NGO	Non-governmental organisation

NIPS	National Institute of Population Studies
OCHA	United Nations Office for Coordination of Humanitarian Assistance
ODA	Official Development Assistance
OPV	Oral Polio vaccine
PC	Planning Commission
PDHS	Pakistan Demographic and Health Survey
PHC	Primary Health Care
PNC	Pakistan Nursing Council
PRSP	Poverty Reduction Strategy Paper
PSLM	Pakistan Social and Living Standards Measurement Survey
RH	Reproductive Health
Saffron	States and Frontier Regions Division
SAM	Severe Acute Malnutrition
SDH	Social Determinants of Health
TCDC	Technical Cooperation between Developing Countries
UDHR	Universal Declaration of Human Rights
UNCRC	United Nations Convention on the Rights of the Child
UNCT	UN Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UN RC	United Nations Resident Coordinator
USAID	United States Agency for International Development
WCO	WHO Country Office
WHO	World Health Organization

Acknowledgements

The World Health Organization is grateful to Dr Guido Sabatinelli, WHO Representative in Pakistan for leading the development of this document. We are particularly indebted to Mr Kumars Khoshchashm, PME consultant, WHO-EMRO for initiating the process, which was subsequently carried forward with the support of Dr Assad Hafeez Executive Director Health Services Academy. The kind leadership provided to the process by Dr Hussein A Gezairy, Regional Director, Dr Abdallah Assa'edi Deputy Regional Director and Dr Naeema Al-Gaseer Assistant Regional Director of WHO's Regional Office for the Eastern Mediterranean is gratefully acknowledged. Mention also needs to be made of the efforts undertaken by Dr Shelina Kiyani, Dr Ghulam Nabi Kazi, Dr Zulfiqar Khan, Dr Farah Sabih and other staff members of WCO Pakistan in finalizing this document. The JPRM Team members from the Regional Office including Dr Ibrahim Abdel Rahim Director Health Systems a.i., Dr Hasan El-Bushra Regional Adviser Communicable Diseases surveillance and Response, Dr Khalid Saeed Regional Adviser Mental Health and Dr Hala Safwat Medical Officer – Data Manager of Polio Eradication/Expanded Program on Immunization also provided valuable guidance for which we are most grateful. We are also grateful to Dr Ambrogio Manenti, Coordinator Programme Planning, Monitoring and Evaluation WHO EMRO for his valuable feedback.

EXECUTIVE SUMMARY

The Country Cooperation Strategy (CCS) reflects the medium-term vision for technical cooperation of WHO with a Member State and defines the strategic framework for working within that country. It is the key document to guide the biennial collaborative operation plan of the World Health Organization (WHO) with countries, usually over a period of six years. The CCS brings together the collective technical strength of WHO support at the Country, Regional Office and Headquarter levels in a coherent manner with a view to address the country's health priorities and challenges.

The current document discusses the CCS for the Islamic Republic for Pakistan for the period 2011-2017 under quite unusual circumstances when the Ministry of Health has been abolished at the national level to fulfill a constitutional requirement and devolve responsibility to the federating units or provinces of Pakistan. Certain critical residual national health functions have been distributed amongst six ministries / divisions of the Government of Pakistan giving rise to concerns that that they may not be handled with the degree of technicity required for the health sector. Furthermore, some fiscal anomalies may give rise to initial teething problems. However, the devolution of responsibility to the provinces has been generally welcomed in the country.

Largely with a view to facilitate the provision of Health for All (HFA) within the purview of the Primary Health Care (PHC) philosophy and the pursuit of the MDGs, the CCS document has critically analyzed in great detail the health situation in the country including the strengths and weaknesses of all six building blocks of the health system, activities of health development partners, and the exact pattern of financing in the Health Sector of Pakistan.

Pakistan is a large country with an area of around 800,000 kilometers and an estimated population of 173.51 million making it the fifth most populous country in the world and the largest in WHO's Eastern Mediterranean Region (EMR). The country is divided into five provinces namely Punjab, Sindh, Balochistan, Khyber Pakhtunkhwa and the relatively smaller Gilgit-Baltistan, as well as three territories, namely Federally Administered Tribal Areas (FATA); Azad Jammu & Kashmir (AJK) and Islamabad Capital Territory (ICT). The country has suffered several natural and other disasters following the massive earthquake of 2005, while militancy in its northern belt has left a lot of security-compromised areas making access to healthcare problematic. While the country has to contend with its poor health indicators and the inability of its well developed and multi-tiered health infrastructure to deliver optimal health outcomes, several social determinants of health also pose impediments to the delivery of health care, particularly to the marginalized segments. In order to address these social determinants of health, certain possible entry points include interventions on hand-washing, tobacco control, provision of safe water, sanitation, hygiene improvement, solid waste disposal, and gender and health through community action and collaboration with other sectors. Furthermore, Pakistan's strong One UN agenda can also serve as a good vehicle for promoting inter-sectoral action.

An analysis of health sector financing indicates that foreign assistance has played a critical role in developing the health sector of Pakistan and the country has historically received large volumes of aid. In 2007, Pakistan received more than US$ 2.2 billion in Official Development Assistance (ODA), ranking the country as the sixth largest recipient of official aid in the world. Generally speaking public sector investment in the development of health

care services is, however, quite low. WHO needs to play its rightful role to encourage the Ministries of Finance and Planning in addition to international donors to increase the allocations to health and other social sectors. The overwhelming share of health costs is borne by out-of-pocket expenditure by majority of the poor people with low average per capita income, warranting the need for a pro-poor and equitable healthcare delivery system with minimum quality standards. The urgency of donor support is highly visible as a pre-requisite to attaining the MDGs as currently the level of effort in maternal, neonatal and child health care and communicable disease control is not commensurate with the required targets necessitating a substantial up scaling of investment alongside more forceful interventions. Regulating the country's sizeable private health sector is another challenge for the health authorities with a view to exploit the comparative advantage of NGOs and private practitioners to complement the public health sector for provision of social safety nets for the underprivileged population segments. An emphasis also needs to be laid on rational use of drugs. The Government of Pakistan's recently introduced Economic Growth Strategy has come up with some viable strategies for the Health Sector that the provinces may like to implement. These aim at improving the efficiency of the hospitals, exploiting alternative sources of health financing, bringing about better governance and accountability, and several nutrition interventions, which are critically required in view of the finding of several nutrition surveys and rapid assessments following the floods of 2010.

During the last decade, WHO collaborative efforts were characterized with a strong continued focus on Polio Eradication and improvement in routine immunization; and Emergency response, recovery and rehabilitation, in addition to resource mobilization and implementation of Health System Strengthening interventions, support for maternal, neonatal and child health (MNCH), Family Planning, Primary Health Care, Nutrition, Tuberculosis Control, Malaria Control, Prevention & Control of Hepatitis, promoting community-based initiatives, environmental health interventions mainly for safe water and sanitation, gender and health issues such as gender-based violence, and health promotion with a strong emphasis on the Tobacco Free Initiative.

The strategic agenda of WHO in Pakistan has been developed after an exhaustive situation analysis of the health sector, through an intensive consultative process with federal, provincial and district governmental tiers, donors and UN agencies. The strategic way forward for the health sector in Pakistan is more complex as compared to other developing countries; and calls for some revamping WHO priorities for engagement with a more strategic focus on cross-cutting critical areas such as Health System Strengthening in Pakistan to create an enabling environment for provision of effective MNCH, communicable disease control, nutrition supportive interventions, and health promotion strategies. There is also an enhanced focus on social determinants of health, particularly Gender and Health and human rights issues. In the context of devolution, the strategic vision of WHO technical support to Pakistan will be mainly guided by the vacuum created by the abolition of the Federal Ministry of Health alongside the enhanced technical assistance needs of the provincial Departments of Health. The Country Cooperation Strategy will understandably have a provincial focus strongly necessitating upgrading of WHO provincial sub-offices both in technical and managerial terms to enable meaningful presence and provision of appropriate TA to the DOH for the requisite capacity building. The WHO Country Office will also need to assume a more proactive role as the principal technical adviser to the Government of Pakistan and all provincial governments on health issues necessitating strengthening of its own capacity to carry out its functions effectively in a rapidly changing environment.

Section 1: Introduction

The Country Cooperation Strategy (CCS) reflects the medium-term vision for technical cooperation with a Member State and defines the strategic framework for working within that country. It is the key document to guide the biennial collaborative operation plan of the World Health Organization (WHO) with countries, usually over a period of six years. The CCS brings together the collective technical strength of WHO support at the Country, Regional Office and Headquarter levels in a coherent manner with a view to address the health priorities and challenges in the country As a result, the document envisages a close and meaningful collaboration between different tiers of the organization.

With a fundamental view to facilitate the provision of Health for All (HFA) within the purview of Primary Health Care (PHC) philosophy, the CCS examines the health situation in the country by adapting a holistic approach encompassing the health sector, socioeconomic status, social determinants of health and upstream policies and strategies that have a major bearing on health. It identifies the country-context sensitive health priorities alongside WHO support to be provided within the stipulated timeframe in order to have a stronger impact on health policy and health system development and strengthening the linkages between health and cross-cutting issues. This medium-term strategy does not, however, preclude a response on any additional technical and managerial areas in which the country may require WHO assistance.

The CCS process takes into consideration the work of all other partners and stakeholders in health and health-related areas including community representatives and religious scholars, and is sensitive to evolutions in policy or strategic exercises undertaken at any level. In particular, the CCS is developed to assist the implementation of the United Nations Development Assistance Framework (UNDAF) and preparation of the Common Country Assessment (CCA). The overall purpose is to provide a foundation and strategic basis for planning as well as to improve WHO's contribution to the Member States, particularly in achieving the Millennium Development Goals (MDGs). Pakistan is currently lagging behind and off track in almost all the relevant health indicators, with the exception of a few which include achieving full immunization coverage in children 12-23 months, LHWs coverage population and children less than 5 years reporting diarrheal episode and ORT therapy. A strong concerted, organized effort and commitment of the Government of Pakistan ably supported by the UN partners and Donor Organizations will be required to "move as close to the MDG targets in 2015 as it possibly can" (Ref: Pakistan MDG Report 2010, Planning Commission of Pakistan).

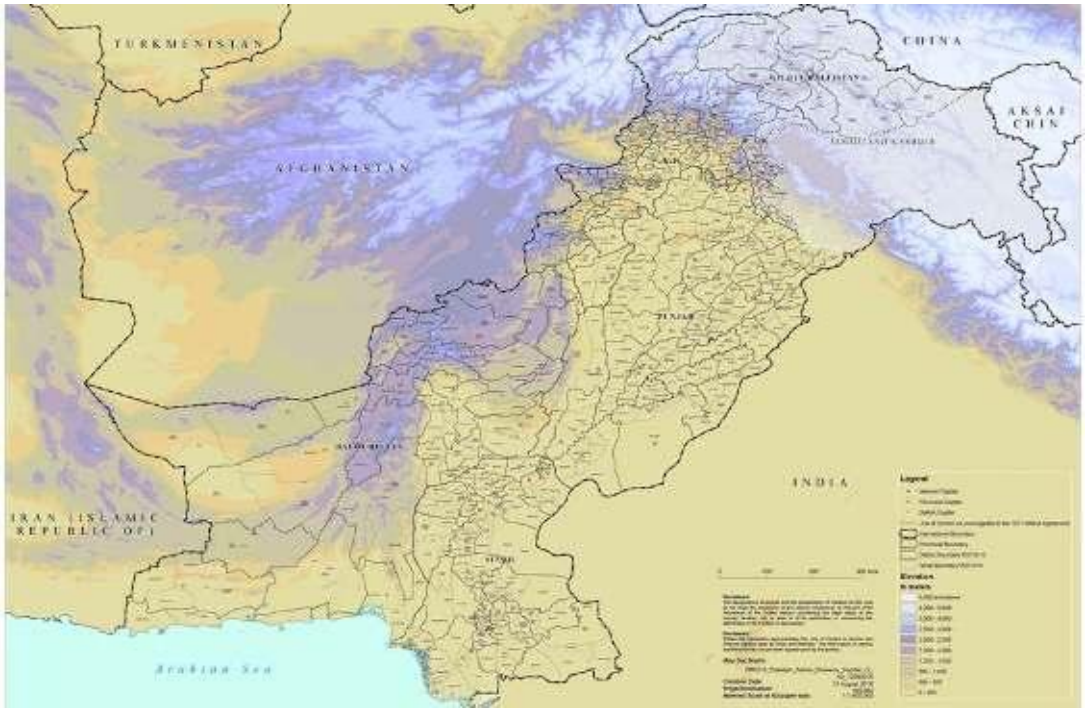
The CCS document has six chapters; the first being the current introduction. The second chapter of the document undertakes a situational analysis of key health programs and social determinants of health with identification of critical priorities and challenges. Chapter 3 pays careful attention to partnerships and aid flow to the health sector. It discusses the role of key partners and donors, the trends of external assistance and the dynamics of how partnerships and other support by internal and external donors are coordinated and managed.

The country relies heavily on external assistance, hence the flow of aid, shortfalls and gaps are analyzed and an assessment is also made of the specificity of external assistance to address key priorities of the Health Sector of Pakistan. The fourth chapter describes the WHO country program, and areas and nature of support provided in the previous 2-3

biennia and takes stock of the strengths and challenges in sustaining WHO operations. In Chapter 5, the strategic priorities are synthesized and articulated for collaboration with the country over the next CCS timeframe, and finally chapter 6 assesses the impact and how best WHO assistance can be strengthened, realigned and harmonized at all levels to support the country in addressing its most important strategic priorities. The document places a very strong emphasis on developing partnerships within the United Nations agencies, funds and offices, international donors, non-governmental organizations and other development partners, particularly those that are involved in health as a regular function as well as during disasters and emergencies.

Pakistan gained its independence in 1947, has a land area of around 800,000 kilometres and an estimated population of 173.51 million (National Institute of Population Studies, 2011), making it the fifth most populous country in the world and the largest in WHO's Eastern Mediterranean Region (EMR). Roughly two-thirds of the population resides in rural areas. The country is divided into five provinces namely Punjab, Sindh, Balochistan, Khyber Pakhtunkhwa (formerly North West Frontier Province) and the relatively smaller Gilgit-Baltistan, as well as three territories, namely Federally Administered Tribal Areas (FATA); Azad Jammu & Kashmir (AJK) and the Islamabad Capital Territory (ICT) as can be seen in the map below.

Figure-1: Political map of Pakistan



Section 2: Health and development challenges, attributes of the National Health Policy, Strategy and Plan and other response

Pakistan has recently suffered periodic major disasters starting from the massive earthquake of 2005 that left over 83,000 dead with severe infrastructure damage, the unprecedented floods in 2010 affecting close to 20 million people and the current floods in the southern province of Sindh affecting over 8 million people. Furthermore, growing militancy in the northern belt leading to armed conflict and internal population displacements has created security-compromised areas making access to healthcare problematic.

Macroeconomic, political, and social context

Human development is a basic and inalienable right of every individual, while good health is a pre-requisite for the economic development of any country. Health is an entry-point towards prosperity and reduction of poverty; and the links between ill health and poverty are well known.[1] Poor health contributes to sliding of vulnerable population segments below the poverty line due to sudden catastrophic expenditures[2] owing to ill health and reduces the earning capacity of the household. The poor suffer disproportionately from disease and are at a much higher risk of death than economically better off individuals, with women, adolescents and children being particularly vulnerable to disease and gender-based violence.

Table-1: Progress on the Millennium Development Goals

	2003	2004	2005	2006	2007	2008	2009	2010*
MDG 4: Reducing Child Mortality								
Children under five mortality rate per 100,000 live births	100.3	97.9	95.6	93.4	91.2	89.1	87	77
Infant mortality rate (0-1 year) per 100,000 live births	-	-	76	-	-	-	71	65
Children 1 year old immunized against measles, percentage	61	67	78	80	80	85	80	90
MDG 5: Improving Maternal Health								
Maternal mortality ratio per 100,000 live births	-	-	290	-	-	260	-	300
Births attended by skilled health personnel, percentage	-	-	31	-	38.8	-	-	60
Current contraceptive use among married women 15-49 years old, any method, percentage	32.1	-	-	26	29.6	27	-	51
Adolescent birth rate, per 1,000 women	23.7	-	20.3	18.1	16.1	-	-	-
MDG 6: Combating HIV/AIDS, Malaria and Other Diseases								
People living with HIV, 15-49 years old, percentage	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
HIV incidence rate, 15-49 years old, percentage	0.01	0.01	0.01	0	0	0	0	-
Condom use to overall contraceptive use among currently married women 15-49 years old, percentage	19.9	-	-	20	23	20	-	-
Women 15-24 years old with comprehensive correct knowledge of HIV/AIDS, percentage	-	-	-	-	3.4	-	-	-
Cases of malaria per 100,000 population	-	-	-	-	-	881	-	-
Tuberculosis prevalence rate per 100,000 population	510	484	455	424	398	379	373	130

Source: MDGs Data Base, UN.

*2010 Figures are taken from Pak. MDGs Report 2010

The close links between low levels of education and high fertility exacerbate the mortality risks among women and children. Illness keeps children away from schools, decreasing their chances of a productive adulthood. It is therefore critical to move towards an equitable health system that is able to address the challenges and prevent households from falling into poverty. In Pakistan, public expenditures on health are low; although they are viewed as part of the government's poverty reduction efforts and aimed at making progress towards achieving the MDGs by 2015 are depicted in Table-1.

Furthermore, there is a strong association between economic downturn, a decline in health utilization and negative health outcomes, which is likely to be precipitated by the current global financial crises. The macro economic challenges faced by the country will also definitely impact the availability of funds for the health sector leading to poor health outcomes.

Security and governance challenges in some parts of the country are emerging as a major risk to the health outcomes and state-building is fast becoming part of the orthodoxy of security and development. Some health challenges however, are more intrinsically linked to human security than others. The Commission on Human Security defines four criteria that determine the extent to which a health problem has an impact on human security in any country. These include the scale of the problem, the externalities it imposes, the intensity of its impact and the urgency of response required. By these criteria, the greatest threats to human security are health crises that arise from poverty and inequality, infectious and communicable diseases and violence and other emergencies. . Investment in health has a long-term beneficial effect, as improving health outcomes reduces poverty and helps to eliminate a major risk factor for further conflict. The health sector is seen as a legitimate entry point for wider state-building as it contains a highly skilled workforce and a relatively good evidence base.3

Other major determinants of health

Pakistan is vulnerable to a range of disasters including avalanches, cyclones/storms, droughts, earthquakes, epidemics, floods, glacial lake outbursts, landslides, pest attacks, river erosion and tsunamis. Human induced hazards that threaten the country are related to transport, industry, oil spills, forest fires, civil conflicts and internal displacements of communities due to multiple factors. High priority hazards in terms frequency and scale of impact are earthquakes, droughts, flooding, wind storms and landslides that have caused widespread damages and losses in the past. On the Global Seismic Hazard Map, Pakistan is crossed by two major fault lines and stands out as one of the most earthquake prone countries. The country, however, is not only exposed to earthquakes but also to frequent flash floods and recurrent droughts. Annually, the country suffers an average of 2,393 disaster related deaths, constituting 3.4% of the 70,000 global annual deaths, even though with a population close to 175 million, Pakistan represents only about 2.5% of the global population.

The vulnerability of the Pakistani population with regard to health stems mainly from the many challenges to its health system ranging from poor health indicators, low health investments expenditures and utilization which add to the poor social determinants of health such as illiteracy, unemployment, gender inequality, social exclusion, rapid urbanization, and environmental degradation.

The delivery of quality healthcare services assumes a highly critical role in the immediate aftermath of any disaster or calamity. As such it is imperative to ensure that the health care delivery system performs with greater dynamism, vibrancy, versatility and efficiency in such situations than otherwise. The main objective of health service providers should therefore be to provide services that substantially meet the health needs of the affected population with few interruptions. A recent WHO-Johns Hopkins School of Public Health (JHSPH) impact assessment of the 2010 floods found that following disaster, 79.1% of households required healthcare at least once, with an average of 7.7 healthcare events per household. Of these 77% reported the health issue being related to flood. Only 5.6% of households were unable to access care, for which the most common barriers were the cost (66.6%) or the distance to the healthcare facility (31%). Sixty one percent reported that their access to healthcare was either the same or better since the flood, while 66% reported the same or better access to pregnancy services compared to before the flooding. Of the 66.9% children of all households receiving vaccinations since the floods33% had been reached by a mass campaign, 94.3% reported receiving OPV and 43.6% reported receiving measles immunizations.

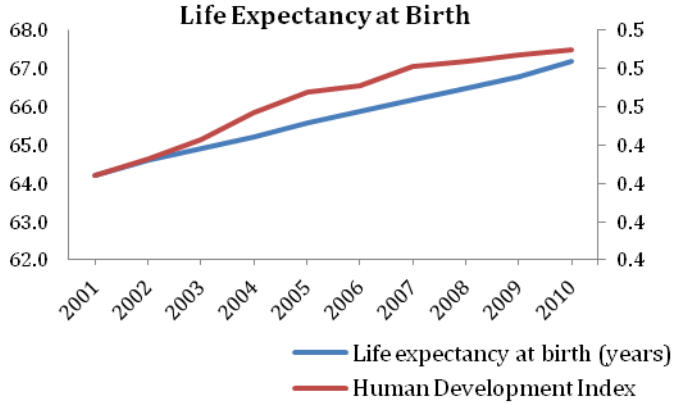
The study demonstrates that emergencies not only impact health but also paradoxically provide care providers an invaluable opportunity to perform better than in normal conditions to positively impact the health of the vulnerable population segments.

The WHO Country Office (WCO) Pakistan has been robustly supporting the government during all the past disasters since the massive earthquake in 2005, leading to a significant enhancement of the system's own capacity on disaster issues. WCO Pakistan has also prepared a contingency plan to ensure a timely, effective, coherent and coordinated response to emergencies, indicating its commitment to harmonize a comprehensive response suited to the health needs in pre and post-disaster settings in the country.

Health status of the population

The overall health status in Pakistan has improved since 1990 albeit at a much slower pace in relation to its neighboring countries. The life expectancy at birth from 64 years to 67 years in 10 years has not been substantial; it is however, more than the life expectancy at birth for India and Bangladesh, but significantly lower than the level in Sri Lanka, Indonesia and Malaysia (see adjoining Figure-2).

Figure 2: Human Development Index and Life Expectancy at Birth



Source: Human Development Report, Data base UNDP

Pakistani women continue to face the risk of limited access to reproductive health services and pregnancy related morbidity and mortality. Nearly 11,000 women and girls die annually while giving birth, signifying one of the highest maternal mortality rates in the region. In 2008-09, only 28 per cent of births were attended by a doctor and 65 per cent of women delivered their children at home.[4] While access to essential pre and postnatal medical services is limited all over the country, marked disparities exist among different provinces

and between rural and urban areas; with women in the relatively prosperous regions of urban Punjab and Sindh far more likely to visit health facilities for pre and postnatal consultations than those in rural Balochistan. The disparities in the MNCH indicators can be seen in Annex-2.

The *Demographic and Health Survey 2006-07* reported that the maternal mortality ratio stood at high 276 deaths per 100,000 live births with an estimated one out of every 89 women dying from maternal causes in Pakistan. The numbers are even worse when broken down by region; in rural areas and Balochistan, for example, the maternal mortality ratio was 319 and 785 deaths per 100,000 live births, respectively, which is much higher than the national average.[5] This situation is unlikely to change in the absence of serious state and community interventions.

Other contributing factors to disease burden and health system challenges include some of the major social determinants of health such as poverty, gender inequality, low levels of literacy and lack of public service facilities such as proper sanitation and safe water, food safety regulations, hygiene improvement and solid waste management. Pakistan's under-five mortality is the second highest in South Asia, after Afghanistan. Although a decline has occurred from 150 in the 50s to 94/1000 live births in 2007, this decrease has, however, not been matched by a proportional decrease in the neonatal mortality, which constitutes more than half of the infant mortality. The matter needs to be viewed in relation to the societal barriers on women while seeking healthcare.

Malnutrition remains widespread with few significant or positive outcomes achieved in the last two decades. Acute malnutrition levels have been consistently above the emergency threshold posing a serious public health problem, with stunting reaching 37% and severe wasting 13% (MICS 2008) due to several underlying causes vis-à-vis a rapidly growing population. The provincial disparities in the nutrition indicators can be seen in annex-3. Even though the population growth rate has declined from 3% per annum in the late 1980's to the present estimated level of 1.9% annually, the population is still expected to touch 210 million by 2025. Unless rapidly stabilized/reduced, this factor is likely to further constrain the already scarce resources, infrastructure, and social services, with further deterioration in the current shortages of water, energy and food.[6] Moreover, certain critical weaknesses in service delivery characterized by an insufficient focus on prevention, gender imbalance, inconsistencies in human resource management and planning and insufficient funds are adversely impacting the health profile of the country depicted in Table-2 below:

Table-2: Health Determinants/Profile of Pakistan	
Demographic transition	High number of youth, 37% < 15 year Females of child bearing age as particularly vulnerable group
Poor maternal and child health profile	High maternal mortality ratio (276/100,000 live births), Low antenatal care coverage, Frequent complications of pregnancy and childbirth, Low FP coverage: Hemorrhage and sepsis are the major causes for maternal deaths. 61% of pregnant women receive antenatal care from a skilled provider. Globally 62% of deliveries take place at home. Only 39% of deliveries are assisted by skilled health personnel (mostly in unregulated private setups). Only 27% of women who give birth receive

	postnatal care, with complications of pregnancy and childbirth resulting in 20% of the female deaths in their reproductive years. The overall current use of family planning is only 30%.[7] High under five, infant and neonatal mortality (94, 78 and 54/1000 live births resp.): sepsis, pneumonia, diarrhea, meningitis and prematurity are the main causes for under five and neonatal deaths Low exclusive breast feeding rate under 6 months (37% of children)[8] Low vaccination coverage: PDHS 2007 shows that according to mothers' recall and the vaccination records 80% of children aged 12-23 months have received a BCG vaccination, 75% have received the first dose of DPT, and 93% have received the first dose of polio vaccine. However only 59% and 83% of children received the third doses of DPT and polio respectively, with drop rates between the first and third doses of DPT of 22 % and that of polio of 11 %. On the other hand 60% of children aged 12-23 months have received measles vaccination.
Dual burden of disease (beginning of the epidemio-logical transition)	Pakistan's epidemiological profile is dominated by a burden of communicable diseases that could be prevented and treated at a reasonable cost, which include ARI, diarrhoea, polio, Tuberculosis, Hepatitis B and C, measles, and malaria. There are sporadic outbreaks of vector borne diseases such as Malaria, Leishmaniasis, Dengue and Crimean-Congo Hemorrhagic Fever (CCHF) such as the massive outbreak of Dengue Fever / Dengue Hemorrhagic Fever since September 2011 that has affected over 16,000 persons so far. Malaria is endemic in Pakistan for both P. Falciparum and Vivax occur, and ranks the second most frequently suspected disease following ARIs. Baluchistan, Sindh, KP and FATA hold the highest burden.[9] The prevalence of malaria is higher in rural areas. and has increased even in the province of Punjab after the 2010 floods The use of long lasting treated mosquito nets is very low with only 6 % of households having a net.[10] Pakistan is one of the four remaining countries with endemic indigenous polio transmission. Tuberculosis is also a major health concern with the country being amongst five that contribute to nearly 50% of the global TB burden. The estimated 297,000 cases of TB in 2008, is likely an underestimate of the real incidence.[11] In recent years, HIV/AIDS has also spread, with Pakistan moving from a 'low prevalence, high risk' to a state of 'concentrated phase'. While the general prevalence rate of HIV is still low at about 0.1 per cent of the total adult population (about 97,400 people in 2010), it is over five per cent in some high risk groups.[12] Injecting drug users and *hijra*[1] sex workers are the groups most at risk, with the prevalence of HIV/AIDS being 21 and 6.4 per cent, respectively.[13] In view of the prevailing behaviour patterns, low levels of awareness on disease prevention , limited impact of public medical services and societal taboos on

1 While there is no precise equivalent in the English language, the term *hijra* is used widely in South Asia to refer to men with a non-male gender identity or to intersex people. The group includes transvestites, hermaphrodites, androgynies, eunuchs, transgender and other people who usually do not identify themselves as either male or female but rather, as someone belonging to a third sex.

	interactions with some high risk groups (such as commercial sex workers), the pandemic is likely to spread further in the future. There is no nationwide disease surveillance and rapid response system, such as the Disease Early Warning System which is crucial for epidemic prone diseases and monitoring of the endemic diseases. DEWS was instituted by WHO following the 2005 earthquake to timely predict and control outbreaks. It was further strengthened during subsequent crises, and decentralized to be part of the district health system as a sustainable disease surveillance system; however, it needs to be rolled out across board by health authorities along with integration into the mainstream DHIS. This is crucial and is an integral part of disaster preparedness. Health staff in all disaster prone areas need to be familiar and trained to use the system and logistic issues such as list of diseases to be monitored, forms to do so, mechanism to monitor data coming in order to quickly manage any outbreaks need to be in place. Non-communicable diseases (NCDs) such as cardiovascular problems, diabetes, cancer and mental disorders are also on the rise; with more than 24.3% of people above 18 year being hypertensive, 25% of people over 40 years having coronary heart disease, 10% of adults suffering from diabetes, 34% from depressive disorders (with rates in women being twice as high as men) and 2.5% are disabled.[14] Pakistan has a high prevalence of blindness of nearly 1% by WHO criteria for visual impairment – mainly due to cataract. Disability from blindness profoundly affects poverty, education and overall quality of life.[15] Mental illness and trauma, already widespread in Pakistan, have been aggravated in recent years by the ongoing conflicts across the country. Mental healthcare remains a low public priority, with as little as 0.4 per cent of the healthcare budget spent on mental health and the number of psychiatrists and psychologists standing at a low 0.2 per 100,000 of the population each.[16] The primary healthcare system is poorly equipped to help people with mental health issues and specialized facilities are usually only available in large urban centers.
Access to safe water and sanitation	Lack of safe water and sanitation facilities constitute a major determinant of communicable diseases. In urban areas 66% of households have an improved source for drinking water; however, only 24 % of rural households have access to piped water. The major source of improved drinking water in rural areas is a tube well, borehole, or hand pump. Even in major cities, only 37% of the households treat drinking water appropriately. Thirty percent of Pakistani households, mostly in rural areas, do not have any toilet facility.[17]
Nutritional status	The latest National Nutrition Survey (NNS) undertaken in 2011 has revealed a Global Acute Malnutrition (wasting) rate of 15.1%, higher than the NNS 2001 which was 13%; with the wasting at 12.6% and 16.1% in the urban and rural populations respectively. The rate of stunting has also increased from 40% in 2001 to 43.6% in 2011. The Multiple Indicators Cluster Survey (MICS 2007) completed in Federally Administered Tribal Areas (FATA) in 2007 also documented acute malnutrition of 13%, with severe acute malnutrition rate of 7%. The exclusive breastfeeding rates have however, improved from 39% in 2001 to 64.7% in the recent 2011 survey.

	NNS		**NHS**		**NNS**		**NNS**	
	1985		**1990-4**		**2001 -2**		**2011**	
	Males	**Females**	Males	Females	Males	Females	Males	Females
Stunted	42.2	41.4	36.0	36.3	40.5	39.5	44.2	43.1
Wasted	10.6	11.0	11.9	11.7	15.4	14.4	15.9	14.3
Underweight	-	-	39.8	40.5	37.6	37.2	32.0	31.0

The emergency situation had serious implications on the nutritional status of children under five years, pregnant and lactating women due to the contaminated water, poor sanitation/hygiene, interruption in caring practices and limited food availability and diversity at household level. One-fifth of newborns are low birth weight and 38% of under-5 children are underweight.

Socio-economic variation	According to PDHS 2006/7, the distribution by wealth quintile varies significantly by urban and rural residence. 46% of the population in urban areas is in the highest wealth quintile in contrast to only 7% of the rural population. While more than a quarter (29%) of the rural population fall in the lowest quintile that is the case with only 3% of the urban population. The wealth quintile distribution by province also shows huge disparities with a relatively higher percentage of the population in Sindh and Punjab provinces being in higher wealth quintiles, and a high percentage of Balochistan population falling in the lower wealth quintiles.
Other social determinants of health	Illiteracy, unemployment, gender inequality, social exclusion, rapid urbanization, environmental degradation, natural disasters Low levels of education, poor resources and weak detection and monitoring systems leave people exposed to threats from pandemics. For example, the National Institute of Health confirmed the first death from the Influenza A H1N1 virus (swine flu) in December 2009. By January 2010, the virus had killed over a dozen and affected over a hundred and fifty people despite government efforts to contain the pandemic.[18]

Limited Access to Health Services

Table-3 describes the distance to the nearest health facility in the rural areas of all the four provinces; with comparison of the provincial difference in access. The rural population of Punjab generally has better access to the health facilities with 74% of the rural population having access to the nearest hospital/dispensary within 10 kms radius as compared to 67% in Sindh, 59% in KPK and 36% in Balochistan. In the case of private doctors, 49% of the population in Sindh has access within 10 km distance as compared to 70% in Punjab. Given its low population density, Balochistan suffers most in terms of access to health facilities.

Table-3: Access to Health Services (%)

Health Units	Within Distance (Km)	Punjab	Sindh	KPK	Balochistan
1. BHU	10 km	80	65	65	56
2. RHU	10km	77	65	59	32
3.Hospital/Dispensary	10 km	74	67	59	36
4. Private Doctors	10 km	70	49	56	n.a.
5. Child & Mother Centre	10 km	68	53	50	n.a.

Source: Mouza census 2008

Low utilization rates in public system and inadequate institutional frameworks for outsourcing health services; only **0.12 to 0.2** New cases/person/year in public system; with only **20 to 30% of primary health care delivered by public system**

Insufficient contact with the catchment population (e.g. measured by a utilization rate of the public system below 0.5 NC/person/year) would indicate that there is no credibility and faith in the public system due to e.g. absenteeism or unprofessional behavior of medical personnel, lack of drugs or medical supplies, poor medical practice, lack of female health workers, etc. This utilization rate was increased to 1 to 1.5 New Contact (NC)/ person/year during the 2010 flood emergency due to heavy external investment and increased burden of disease. The **outsourcing of the primary health care services** by the provincial and district health authorities to semi public systems like the People's Primary Health Care Initiative (PPHI) or the PRSP (Punjab Rural Support Programme), is an appealing and at the same time contentious design. On the one hand, services through PPHI seem to be delivered in a more consistent way leading to a doubling of the utilization rates. On the other hand, the institutional framework with the district and provincial health authorities is insufficiently developed with lack of adequate regulation and supervision from health authorities at the federal and provincial/district level. Finally, there is insufficient institutional capacity for procurement and purchase of equipment, supply and for contracting out services of maintenance.

Tackling Social Determinants of Health

It is pertinent to mention the Adelaide Statement on *Health in All Policies* (HiAP) developed in 2010 to engage leaders and policy-makers at all levels of government, emphasizing that government objectives are best achieved when all sectors include health and well-being as a key component of policy development. This is because the causes of health and well-being lie outside the health sector and are socially and economically formed. Although many sectors already contribute to better health, significant gaps still exist. The Adelaide Statement outlines the need for a new social contract between all sectors to advance human development, sustainability and equity, as well as to improve health outcomes. This requires a new form of governance where there is joined-up leadership within governments, across all sectors and between levels of government. Some of the sectors and issues that can be taken up under HiAP include economy, employment, security, justice, education, early life, agriculture, food, environmental sustainability, housing, community services, land and culture.

This approach has been strongly supported by the 62nd World Health Assembly, which has called upon the international community to take action in collaboration with WHO Member States on assessing the impacts of policies and programmes on health inequities and addressing the social determinants of health; enhancing health equity and incorporating it in all national policies addressing those determinants, and to consider developing and strengthening universal comprehensive social protection policies, including health promotion, disease prevention and health care, and promoting availability of and access to goods and services essential to health and well-being. WHO has a major role in promoting this approach.

It is imperative to implement the initiative in Pakistan as soon as practicable through the relevant officers in the provincial Departments of Health and other inter-sectoral partners. There is considerable scientific evidence to support this concept in Pakistan such as a paper entitled "Impact of wealth status on health outcomes in Pakistan" prepared by Dr Sania Nishtar and Dr Ali Yar Alam, in addition to several other reports on SDH and health inequities. Through a well documented research study, WHO Pakistan has already documented the health inequities in the urban slums of Rawalpindi.

Pakistan has also played a leading role in fostering the Basic Development Needs (BDN) approach since 1995 which substantiates a holistic vision incorporating the missing links in PHC through community involvement and inter-sectoral action to bring about human development. BDN promotes ownership for a set of essential package of community needs and recognizes local organizational capacities and mobilization skills as the major driving force for attaining a number of desired health outcomes, while ensuring their long term sustainability. This strategy has been effective in scaling up PHC services and recognized health as an essential social goal for community development. In addition to the BDN initiative, possible entry points for action on SDH, include interventions on hand-washing, tobacco, sanitation, gender and health including health sector response to gender-based violence, waste disposal, and appropriate use of pesticides. All these require collaboration with other sectors to be effective. Furthermore, Pakistan's strong One UN agenda can also serve as a good vehicle for promoting inter-sectoral action.

National responses to overcome health challenges

Pakistan has a multi-tiered and mixed health care delivery system that has grown exponentially during the past three decades, with an increasing number of programs, projects, interventions and facilities, many of them on a fragmented and time bound basis. These are supported by different levels of government and/or development partners with overlapping geographical and thematic areas, leading to duplication and wastage of resources. The health care delivery system includes both state and non-state; and profit and not for profit service provision. The provincial and district health departments, para-statal organizations, social security institutions, non-governmental organizations (NGOs) and private sector finance and provide services mostly through vertically managed disease-specific mechanisms.

Table-4 highlights the public priorities in allocation of expenditure on health. It can clearly be seen that the highest share of the expenditure is on general hospitals and clinics, which was as high as 73% in 2001-02 and declined somewhat to 68% in 2009-10. Mother and Child health care facilities received the lowest share in the expenditure of less than 1% in

2009-10. There has been a significant increase in expenditures on health facilities and preventive activities from 13% in 2001-02 to 20% in 2009-10.

Table-4: Priorities in Public (federal / provincial) Expenditure on Health (%)

	2001-02	2006-07	2009-10
General Hospitals & Clinics	73.3	70.0	68.4
Mother & Child Health	0.3	2.6	0.4
Health Facilities & Preventive Measures	13.6	16.4	20.2
Others	12.8	11.0	10.9
Total	**100.0**	**100.0**	**100.0**
Total Expenditure (Rs. in Billion)	**19.2**	**53.2**	**94.4**
% of GDP	**(0.4)**	**(0.6)**	**(0.6)**

Source: PRSP Progress Report

A sad reflection of low public policy of low priority for health is the extremely low level of spending at only 0.6 percent of the GDP in 2009-10. In 2007, public spending on health Pakistan was $PPP[2] 64 per capita, as compared to $109 in India, $179 in Sri Lanka, $233 in China, $286 in Thailand, $604 in Malaysia and $677 in Turkey. Given the low coverage of governmental health facilities, the private sector, even though totally unregulated has emerged as the principal provider of health services in the country contributing to 60-70 % of the health care in Pakistan.

In the current scenario, although the federal, provincial and district levels of health management theoretically have clear roles and responsibilities, however, in practical terms many functions overlap. Moreover, situation at the federal level is highly fragmented after the dissolution of the Ministry of Health and devolution of its responsibilities to provincial Departments of Health. According to the rules of business under the constitution, the major roles of the federal government related to policy formulation, provision of technical backstopping, coordination with different partners within and outside the country, communicable disease control and financing for health care. However an overemphasis of the defunct Ministry of Health (MoH) towards national programs diminished its stewardship and governance roles of policy making, regulation, and financing.

Provincial Departments of Health are responsible for translating the national policy into planning and actual implementation, 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 Actual service delivery takes place at the district level where the two tiers of primary and secondary health outlets are managed. Districts also implemented the federally or provincially financed health programs resulting in dichotomy in the management due to the dual command mechanism.

All preventive services are implemented at the district level where the government is virtually the sole provider, with a significant role of the private sector in the provision of curative services. This is reflected in the high expenditures by households on health (see Table-5). According to the HIES of 2007-08, the average expenditure per household per month was Rs 1673. This aggregates to over Rs 470 billion on an annual basis for the country as whole. The burden of health expenditure is high even on the lowest quintile of households who spend over --- percent of their monthly income to such expenditure.

[2] purchasing power parity

Table-5 : Monthly Expenditure on Medical Care per Household from HIEG (Rs/Month)

Quintile	Expenditure	%
1	790	10.1
2	1005	10.1
3	1243	11.1
4	1539	11.6
5	3044	12.3
Average	**1673**	**11.6**

Source: House Integrated Economic Survey 2007-08

Two significant re-assignments in the fiscal federal structure of Pakistan have taken place during the last year. First, the latest National Finance Commission (NFC) award of 2010 transferred a much larger share of the divisible pool and other resources to the provinces from the federation without re-assignment of additional expenditure responsibilities to the provinces. Secondly, service responsibilities have been re-assigned by the 18th Amendment, specifically, the Concurrent List in the Fourth Schedule of the 1973 Constitution has been abolished and the Federal Legislative List has been enhanced by shifting some items from the Concurrent List to the Federal List. However, there has been no accompanying directive on how the provinces would meet their new legislative, policy and expenditure responsibilities following the devolution of seventeen federal ministries including MoH. While the financing of these ministries were not factored in the NFC award, there is also some confusion relating to health functions which remain federal in purely constitutional terms. The current 2011-2012 federal and provincial budgets have been formulated on the basis of the NFC award allocations, without considering the impact of the 18th Constitutional Amendment.

Post Devolution scenario in the Health Sector of Pakistan

The unanimous adoption by Pakistan's Parliament of the 18th Amendment to the Constitution of Pakistan during April 2010 was a highly popular move that reverted a lot of responsibilities from the federation to its federating units or provinces. As a result, as of 30th June 2011, seventeen ministries had been totally abolished at the federal level including the Ministry of Health. Furthermore, certain critical health functions that constitutionally vest with the Federal Government and whose technicity requiring most careful handling is incontrovertible have been assigned to six ministries / divisions of the Government of Pakistan. While WHO respects the importance of these constitutional changes, it has concerns that certain critical oversight functions requiring federal role and involvement may be compromised. These functions include health policy formulation; human resource planning; enabling policies on medicines, vaccines and biologicals; responding to public health emergencies; compliance with domestic and International Health Regulations (IHR); fulfilling international commitments including the three health-specific MDGs, coordination and monitoring resource mobilization through health development partners including UN agencies, multilateral and bilateral donors. Furthermore, while the benefits of decentralization cannot be denied, particularly in the context of a large country like Pakistan, certain inherent dangers resulting from inequities in distribution of health resources in the absence of national redistributive policies, with an increase in inefficiency, insufficient managerial capacity of local institutions, escalation of political pressures on lower tiers, and a possible lack of coherence of district and provincial plans with national goals and policies will require careful handling.

With the dissolution of the Ministry of Health, the residual federal functions have been assigned to the Planning Commission (PC), Cabinet Division, Economic Affairs Division (EAD), Inter-Provincial Coordination Division (IPCD), States and Frontier Regions Division (Saffron) and Capital Administration and Development Division (CADD), which may lead to a certain degree of fragmentation with no clustering under a single entity. This is despite the existence of any constitutional barrier for establishing such an arrangement at the federal level in the form of a national commission or task force for coordination. It is pertinent to draw a comparison with the Republic of Libya some years ago, where a high level decision to abolish the Ministry of Health had to be subsequently reversed as a result of the adverse effect its absence had on the health of its people. The teething problems of the new arrangements have already begun to arise with the lack of legislation of the Drug Regulatory Authority to fill in a legal vacuum and suspension of six grants from the Global Fund to Fight AIDS, TB and Malaria (GFATM).

Currently the strategic vision of WHO for technical support to Pakistan will primarily focus on the vacuum created due to the abolition of the Federal Ministry of Health, while taking into consideration the enhanced technical assistance needs of the provincial departments of health in view of the lack of clarity on specific mechanisms and institutional arrangements to take on the additional functions traditionally restricted to the federal government; and enable provincial engagement with other ministries / departments, public sector organizations or the civil society to catalyze inter-sectoral action to promote Health in All Policies, address social determinants of health and measure equity in health outcomes. WHO is also assisting provincial governments in tandem with other development partners in developing health sector strategies giving weight age to their specific priorities and/or under-served areas.

PROVINCIAL FOCUS: As regards the strategic direction of future WHO support to the provinces, two aforementioned events in Pakistan, namely the floods of 2010 and the recently completed devolution of the Federal Ministry of Health deserve a special reference owing to their significant impact on the health care scenario of Pakistan. Innovative and coordinated health care response mounted during the flood relief and early recovery activities clearly demonstrated that improvement is possible in the provision of quality standards and services' utilization through delivery of effective health services to vulnerable populations. Subsequently, in order to introduce a new strategic vision for improving access to quality health care in the provinces, WHO embarked on the development of a TA plan for the next 5 years; following extensive consultations in line with the Health Systems Development (HSD) model and the priorities expressed by provincial health managers were undertaken by World Health Organization (WHO) Pakistan during the last and first quarter of 2010 and 2011, respectively. Devolution is being viewed as an opportunity to strengthen and establish requisite provincial capabilities to enable execution of their enhanced roles and responsibilities.

World Health Organization as the lead technical agency intends to continue requisite provincial support in the context of Health System Development, aligned to the building blocks of Health System Strengthening; namely, Leadership and Governance, Health

Information System, Health Financing & Accountability, Human Resources for Health, Medical Products & Technology, and quality Health Service Delivery. Integration and coordination of all components into a common strategy and plan will enable attainment of the overall aim of significant enhancement in access to equitable PHC services towards improving the health condition of the people of Pakistan.

It is envisaged that basic Technical Assistance would be provided to the provinces of Punjab, Sindh, Balochistan, Khyber-Pakhtunkhwa and Gilgit-Baltistan with strong linkages among provinces, and the relevant federal entities in the post devolution scenario. Overall coordination is mandatory to ensure that the same baseline criteria will be used in all provinces to work out a database of national interest and reforms.

The TA plan offers flexibility enabling it to be adapted to local conditions including internal capacity already in place, donors' interests, existing technical assistance and funds availability. It necessarily follows that the budget is flexible in terms of technical and support staff, training and equipment. In complementing the work of several partners already active on the ground, WHO intends to assume an overall coordination role owing to its long standing universal presence in Pakistan and the comparative advantage to provide a continuous, well-coordinated support by senior national staff and international experts on need basis. In this regard, WHO Provincial Sub Offices are being strengthened in specific technical aspects to support and work closely with the provincial DOH.

One of the key areas of provincial support and collaboration in terms of health policy, strategy and reform processes will be the establishment and strengthening of the Provincial Health Policy Reform Units. Such units are already functional in KPK (2002) and Punjab; while Sindh is in the process of establishing this unit for which PC 1 has been developed for the next 3 years. Balochistan is also contemplating setting up a similar unit and initial consultations with the Balochistan DoH have been recently spear headed by WHO with encouraging outcome. It is pertinent to mention that WHO had been instrumental in the establishment, continuation and strengthening of the Health System Strengthening & Policy Unit at the Federal level, which after devolution has been recently notified for placement under the Ministry of Inter Provincial Coordination. WHO with other partners will support the development of linkages and coordination mechanisms between the federal and provincial HSRU. Generally, WHO will continue to engage in diverse activities at the provincial level which broadly include Polio Eradication Initiative, Communicable Diseases Prevention & Control, Nutrition, MNCH and Health Systems Strengthening; with provision of specific technical assistance for development of protocols, guidelines & SOPs, conducting situation analysis, capacity building and training of HR. Direct implementation support in the instance of DEWS and Polio Eradication Initiative especially for surveillance will also continue. However, Health System Strengthening (HSS) will remain the prime focus of WHO support at both the national and provincial levels.

Draft National Health Policy

The draft National Health Policy, 2010 was developed after broad consultations with all the national and provincial stakeholders. It hinges on the concept of Health for All through PHC services and promotes development of minimal essential services package for health facilities with a view to ensure quality, standards and efficiency at the delivery level. The NHP 2010 is based on seven fundamental pillars of universal access to essential health services, streamlining human resource for health, reliable health information systems, effective use of health and medical technologies, safety nets, governance and accountability at all levels, and inter-sectoral linkages for improved health outcomes. Significant differences in this policy approach are a strong emphasis on preventive services, phasing in of different services, and advocacy for safety nets and increased health spending for the poorest segments of the population. In view of the devolution, the approval process of the draft policy now falls within the purview and mandate of the Council of Common Interests (CCI) headed by the Prime Minister of Pakistan and comprising of chief ministers of all the provinces.

Health systems and services and the response of other sectors

1. Human Resources for Health

The human health workforce is inadequately planned in Pakistan, resulting in more doctors than nurses, a dearth of trained midwives, high urban concentration and rural to urban disparity, intensified by continuous external brain drain. Beyond the overall numbers of health professionals, there are also individual shortages of specialists, particularly beyond certain urban centers with resultant gross disparities among geographic areas. The quality of medical care is further compromised by substandard medical curricula, lack of in-service training and continuing supervision along with a poorly defined service structure for health workers that favors tenure over competence, ignores technical capacities and does not allow for rewarding good performance or caters to accountability in health care. The health system is currently not conducive to non-physician providers such as nurses, midwives and allied health professionals that play a pivotal role in ensuring the provision of vital primary health care services in the absence of doctors.

The types and quanta of services delivered by primary health care facilities are severely constrained by the number and categories of health providers present, and the absence of a doctor / woman medical officer is often cited as the main reason for a non-functional BHU and impeding access of women to essential maternal health care. Consequently, providers deliver the types and standards of services that are most beneficial to them and not necessarily those required of them. Additionally, certain specialized fields like Nutrition lack trained human resource deployed at the health facilities compromising the quality of services. The health workforce is central to advancing quality of health care. Investments during the last three decades have resulted in considerable improvement; however, the lopsided focus on human resource development with insufficient emphasis placed on nursing and paramedical education has led to a negative impact on the quality of health care. While Pakistan has a critical shortage of health staff, there is no well-defined policy for human resource development in the health sector; and the provincial Departments of Health lack organizational structures for carrying out human resource development at the

requisite levels. Several critical issues also limit the quality of workforce produced such as curricula not matching local health needs; and educational institutions ill equipped to provide quality education. Furthermore, there is an inadequate emphasis on use of information technology, communication methods, medical ethics, or the bio-psycho-social model of health. Re-orientation of medical education and curricula is needed to introduce problem based learning relating to the true community needs, in order to increase the focus on public health, prevention and promotion of health.

Dynamic health management is required for the functioning of an efficient health care delivery system capable of achieving the desired goals and targets within the available meager resources. Health management is not generally regarded as a specialized field, and although public health courses are being increasingly offered in some institutions, managerial positions are mostly filled on a seniority basis, with medical doctors often shuffling between clinical and management positions. The mechanism for in-service training for different cadres in the health sector is not institutionalized with only a few activities carried out through donor-driven projects. Some courses are offered through the Health Services Academy, Provincial Health Development Centers (PHDC) and District Health Development Centers (DHDCs) and certain Institutes of Public Health since the nineties on an *adhoc* basis. Similarly there is no formal policy, national standards or guidelines for structured implementation to update knowledge and skills of health care providers, including programs 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 management of hospitals and health systems as a whole. Achieving the MDGs will depend on finding effective human approaches that can be implemented rapidly. Considerable and coherent thinking is required in several areas to formulate ways of recruiting and retaining health workers with adequate opportunities for career development.

2. Quality of Health Care Service Delivery

The health system has expanded gradually with a large network of health facilities, workforce and services across Pakistan, despite an uneven progress in the health sector: In 1947, there were 292 hospitals in the country which have now risen to 989 public and 800 private hospitals. There are also 596 rural health centers and 4,910 basic health units functioning at the primary health care level. Additionally there are 5,007 dispensaries and 1,140 Maternal and Child Health centers providing out-patient services in urban areas.[19] Information on the private sector is grossly lacking, however, a rough estimate indicates around 20,000 private clinics in Pakistan.

- Pakistan had two medical colleges in 1947; which have now risen to 78 medical and dental colleges, 34 being in the public sector and 44 in the private sector. The number of registered doctors has increased exponentially from 78 in 1947 to more than 113,700 doctors, 8,700 dentists, 21,800 specialist doctors and 540 specialist dentists.[20]

- The 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 4,500 Lady Health Visitors (LHVs) are registered with Pakistan Nursing Council (PNC)[21] backed up by a

community based workforce of over 100,000 lady health workers (LHWs).[22] Pakistan has also recently initiated a program to deploy 12,000 community midwives (CMWs) in the rural areas.[23]

- Currently, there are 25,000 pharmacists registered in the country with 20 institutions awarding doctoral degrees in pharmacy. About 525 pharmaceutical units produce more than 47,000 pharmaceutical products; and medicines costing US$100 million are exported every year.[24]
- Federal, provincial and district governments are implementing national health programs mainly focusing on cost-effective interventions. Recent successes include increased access to MNCH and Family Planning services in rural communities through expansion of the LHWs cadre from 38,000 in 2001 to more than 100,000 in 2010; while about 5,000 community midwifes are under training before deployment in their own communities.

However, despite improvements the health sector in Pakistan continues to face many challenges. The key issue remains slow progress in improving health outcomes and the poor who most require the services, are ostensibly benefiting the least from the health system. The expanded infrastructure is poorly located, inadequately equipped and maintained resulting in inadequate coverage and access to essential basic services. The private health sector continues to expand unregulated mainly in urban areas.]

3. Information Systems, Research, and Surveillance

Research, monitoring and evaluation (M&E) and surveillance remain weak at all levels due to a lack of focus on results and the absence of an integrated system. The need for evidence based knowledge to inform policy making and management decisions is especially imperative for the efficient use of limited resources and the benefit of the poor and marginalized people. Despite recognition of the importance of using research to influence policy and practice, understanding of how evidence uptake might be achieved is also less clear.

Information systems are present in most first level care facilities (FLCFs) and in the major national programs enabling a culture of continuous data reporting, however, these systems are fragmented leading to duplication of efforts. The Health Management Information System (HMIS) developed during the early nineties is functional, and being converted to District Health Information Service (DHIS). It continues to be confronted with major issues such as poor data quality and accuracy with negligible use of information for decision making at all levels. Other information sub-systems such as the Human Resource Information System were not established as earlier envisioned nor were their indicators incorporated in DHIS. Public hospital lacks a standardized information system, with most hospitals maintaining their own systems having no regular reporting mechanism. There is also no system to gather information from the large private sector hospitals to enable the state to undertake its function of protecting the larger public interest. Although LHWs are working at the community level, yet the nutritional status surveillance at community level is not comprehensive to combat the increasing levels of malnutrition.

Weak information systems often lead to sub-optimal institutional mechanism for M&E coupled with lack of ownership and organization support for data and information.

Governments tend to focus more on routine data coming from the health information systems as against data emerging from household surveys. Quite pertinently, the country has not undertaken a national health survey since more than a decade.

Monitoring and evaluation are key provincial responsibilities and critical for enhancing accountability and making the system results-oriented. The Ministry of Health has earlier taken steps to strengthen M&E including a detailed assessment of the DHIS incorporating data from the hospital sector. The third party evaluation of DHIS and performance assessment analyzing secondary data for intermediate health outcomes generated from Pakistan Social and Living Standards Measurement (PSLM) Survey, are steps in the right direction to generate more information to facilitate informed decision making, however, greater efforts are required.

Public health surveillance is a recognized public good and responsibility of the state. However, Pakistan at present has no single surveillance system able to generate high quality information for taking key public health decisions. The fragmentation results from a lack of i) organizational capacity for surveillance at all levels, ii) a legal framework for disease reporting, and iii) a skilled workforce and resources for this important function. In addition, no public health laboratory network exists in the provinces. A detailed framework has been developed for implementing International Health Regulations (IHR); however, it is not fully in place. Some aspects of the plan are being implemented, for instance a training program through Fulbright fellowships for researchers, and communicable disease control has been started to produce a skilled workforce for surveillance. This would entail development of a comprehensive system and enhanced capacity at federal, provincial and district levels.

4. Governance and Accountability

There is ample evidence that the health system that delivers health care is only as good as its management and the oversight afforded to it. Better governance and accountability can address both, and we cannot reasonably expect to achieve better health outcomes without addressing these issues. The institution of good governance in essential medicines will lead to more evidence-based policies and practices. Furthermore, the focus on inputs and outputs should be shifted to results-based management. By insisting on results without micro-management, programs will have to achieve the results intended within allocated budgets, by means that are best suited for the purpose and be accountable for their own actions.

Private Sector Regulation: The private sector is become increasingly involved in the delivery of health care services in Pakistan, resulting in significant changes in the roles, responsibilities, access and ownership within the sector without any formal guidance, strategy or regulation in place. Some experience has been derived from PPHI and PRSP contracting out models of BHUs in Punjab and Sindh provinces, respectively. The necessity of ensuring basic legislation and a working legal recourse governing the licensing and registration of all health professionals and facilities is required, though KP and Punjab have been endeavoring to achieve this over the last few years. Development of a Regulatory Framework for accreditation and quality standards is another pre-requisite for greater involvement of the private sector in the delivery of health care services.

5. Medical Technologies and the Pharmaceuticals Sector

At the time of independence, Pakistan had no pharmaceutical manufacturing unit and all its requirements were met through imports. The local pharmaceutical industry developed over time responding to indigenous demand growing to a size of about Rs. 88 billion (US$ 1 billion) with exports of US $160 million annually (0.22% of global pharmaceutical market) in 2007. There are over 60,000 registered products produced by 525 companies including 30 multi-nationals.[24] However, not a single one of them is approved by WHO, EMEA, FDA or any stringent regulatory authority.

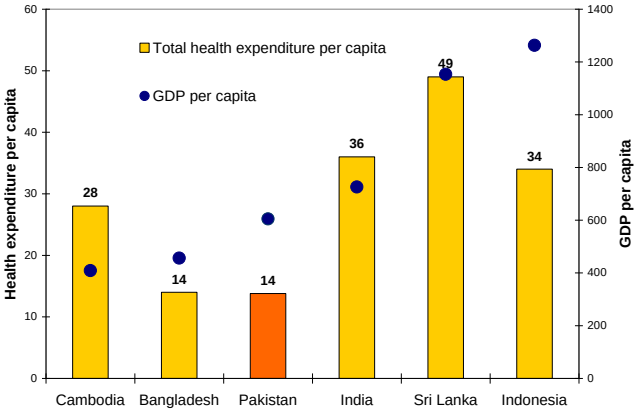
The pharmaceutical sector in Pakistan needs to be more effectively regulated in order to ensure the quality, safety, efficacy and affordability of medicines. The national medicines regulatory capacity and infrastructure has neither kept pace with the impressive growth of the pharmaceutical industry nor has it been in tandem with global regulatory trends. WHO's Prequalification Programme (PQP) is to increase the number of quality assured medicinal products for each priority medicine in order to achieve more choice, lower prices and better supply security. Increasingly important is the maintenance of the quality, safety and efficacy elements of products already prequalified. The country bioequivalence capacity is also very limited. Pakistan has also been lagging behind in improving its medicine regulatory system and although legislation was ostensibly drafted for creation of a semi-autonomous Drugs Regulatory Authority (DRA), this could not materialize in view of the devolution process.

Provision of essential medicines is an important component of Primary Health Care. Pakistan will be supported in making full use of the evidence in updating its lists as the basis for the supply, financing, reimbursement, quality assurance and rational use of essential medicines for PHC and the referral systems.The government has developed the national Essential Drugs List (EDL) for different tiers of the health system, however, the compliance with the guidelines is poor. Widespread over the counter sale of drugs and over prescription by physicians due to unethical marketing practices is increasing the cost of treatment, contributing to drug resistance and exposing the population to unforeseen hazards due to self-prescribing. There is also a need for more rational use of medicines through improved supervision, availability of treatment protocols and appropriate training. WHO will also continue to support a systematic approach to pre-service training of health staff.

As a policy initiative, WHO will facilitate the integration of traditional medicines (TM) into the national health system with a focus on regulation of traditional medicines and practitioners to ensure promotion of quality, safety and efficacy. The flourishing traditional medicines market also needs to have proper control, registration and periodic inspections.

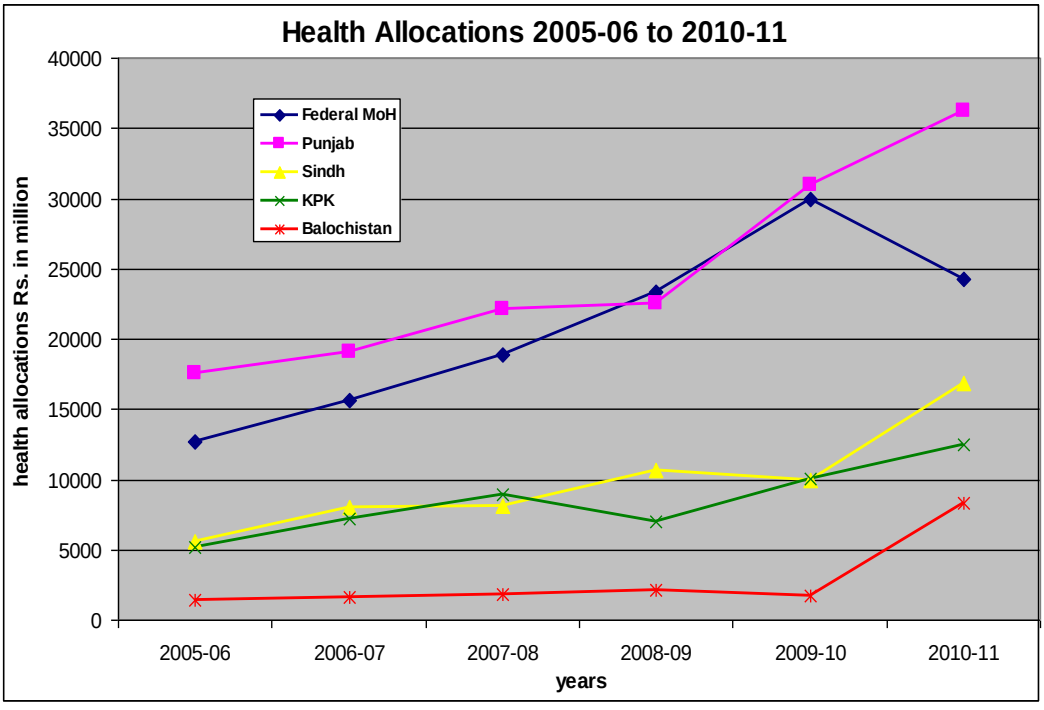
Drug procurement constitutes a major proportion of largely out-of-pocket health expenditures, underscoring the need for a pro-poor drug policy that retains the prices of essential medicines at affordable levels while ensuring the necessary focus on quality, safety, efficacy and availability. Procurement procedures need to be tuned to avoid wastage and duplication with limited internal controls. Integrated supply and management will be encouraged for diseases that pose the greatest health burden. WHO will also assist the country in addressing the issue of counterfeit medical products that challenges public confidence in the system, affecting the reputation of manufacturers, wholesalers, pharmacists, doctors, private organizations and government institutions alike.

6. Health Care Financing



Pakistan continues to spend less on health than other countries at similar levels of economic development. The total expenditure on health in Pakistan in 2008 was estimated to be US$ 18 per capita, of which the public sector expenditure was US$ 4 per capita.[25] This is far below the figure of US$34 proposed by the Commission on Macroeconomics and Health to provide essential package of health services. Over the last 15 years public health expenditures have increased by 50% in nominal terms, however taking into account population increase and inflation, real expenditure as a percentage of GDP has remained at below 0.6%.[26] Between 2001/02 and 2006/07 public sector investment increased by 90% in real terms compared to by 5% over the previous 5 years, but this increase did not meet the targets set under PRSP-I and Fiscal Responsibility Act 2005.[27] There is a general lack of information on private health expenditure in Pakistan; despite estimates that out-of-pocket spending contributes to 75% of the total health expenditure in Pakistan.[25] In the absence of social protection mechanisms this puts a large number of families at risk of poverty because of illness.

A total of 2.9% of the GDP is spent on health with 1.16% by public sector and a larger share of 1.17% by private sector. Public sources on health expenditure account for 33.3% of expenditure, semi-government agencies 5.1%, donor assistance 1.7%, while private sources make up the largest share of 59.8%. Within the private spending, out of pocket payments account for 57.3% of total health expenditure, private employees 1.6% while philanthropy accounts for around 0.9%. About 26% of the country's population has either partial or comprehensive financial cover paid by employers, while 0.32% is covered by government safety nets.[28] Progressive increases have, however, been witnessed in the public sector federal and provincial budgets with a progressive increase and particularly a conflicting trend in 2010 subsequent to revision of NFC award as depicted in the graph below.



Section 3: Development Cooperation and Partnerships

The aid environment in the country

Foreign assistance has played a critical role in developing Pakistan's health sector and the country has historically received large volumes of aid. In 2007, Pakistan received more than US$ 2.2 billion in Official Development Assistance (ODA), ranking the country as the sixth largest recipient of official aid in the world. The overall aid often comes from diverse sources through a combination of budgetary and non-budgetary arrangements. The multiplicity of donors and disjointed nature of support on one side and the overall weakness in governance in the health sector have created a complex situation that makes the coordination of the external assistance difficult.

Generally speaking the public sector investment in the development of health care services is quite low. The overwhelming share of health cost is borne by out-of-pocket expenditure by the overwhelming poor people with low average per capita income. Therefore, the external support to the health services needs to be used for optimal benefit and efficiency. The aid in the health services sector over the past 2-3 decades has assisted in capacity building, health systems development, provision of basic health services, and material support. In view of a burgeoning population, economic slump and mass disasters, the devastating effects of the earthquake and recent floods underlined the need for rapid increase in external assistance as an absolute imperative. The other factor that brings the urgency to donors' support is the national and global priority to meet the MDGs.

Stakeholder analysis

While the United States of America's development assistance historically constituted the bulk of the aid to Pakistan, the major multilateral development banks now provide more than half of all donor assistance to Pakistan. Of the $4 billion in development assistance recorded by the State Bank of Pakistan in 2009, $2.6 billion came from multilateral organizations and development banks. Several non-OECD countries, most significantly China and Saudi Arabia, are currently providing significant amounts of aid. Some bilateral donors and nearly all of Pakistan's major multilateral partners have drastically increased their funding to Pakistan in recent years (State Bank Pakistan 2009 Report)

Donors	**Annual Recorded Grant Assistance to Pakistan FY 2004-2009 ($)**	**Donors**	**Annual Recorded Loan Disbursements to Pakistan FY 2004-2009 ($)**
United States	268 million	ADB	1,197 million
Saudi Arabia	134 million	World Bank	986 million
United Kingdom	124 million	China	217 million
EC and Euro OECD members	63 million	Japan	76 million
Japan	54 million	Islamic Development Bank	71 million
Multilaterals –UN, ADB, WB, IDB	44 million	Saudi Arabia and Kuwait	68 million
China	9 million	EIB and Euro OCED members	34 million
Others	8 million	Other multilaterals	23 million

The USA yet remains the largest source of bilateral aid to Pakistan. For FY2010, the United States has budgeted approximately $1.2 billion in economic assistance through the Kerry-Lugar Berman Bill with another $300 million pending through the president's supplemental request. Of this amount, $176 million are anticipated for health sector support.

Key partners and donors and their areas of input are given below.

i. ADB: Main areas of contribution are women's health and reproductive health.
ii. DFID: Major budgetary allocation for NHF. Other spheres of collaboration are reproductive health, PHC and consumer protection.
iii. GIZ: GIZ is working in three main areas which include supporting communicable disease control particularly TB control, human resources development/management issues and health sector reform.
iv. JICA: Major areas of support are communicable diseases control including tuberculosis, HMIS, and maternal and child health. A large amount of vaccine has been provided as grant in aid.
v. Norwegian Government, through the UN system namely UNFPA, UNICEF and WHO is supporting MNCH in Sindh.
vi. UNICEF: The main area of work is maternal and child health including immunization support.
vii. USAID: Contributes budgetary support for NHF. Other areas of support are reproductive health, communicable diseases and maternal health.
viii. World Bank: Supports maternal and child health (main support is for LHW program), HIV/AIDS program and public health surveillance. A nutrition program is in the offing.
ix. UNFPA, GTZ, EU, Save the Children US and the Aga Khan Foundation contribute towards maternal and reproductive health. GFATM and GAVI have major contributions in communicable diseases and MNCH, respectively with windows for overall Health System Strengthening. UNDP, WFP, UNAIDS, UNFPA and FAO are also contributing through the UN system, while CIDA, JICA and AusAID are bilateral organizations working in the health sector. The latter in association with DFID have a constituted a Technical Resource Facility (TRF) with a view to assist provincial governments in the wake of the devolution process.

Role of private health sector in Pakistan

Pakistan has a relatively sizeable non-profit private sector with more than 80,000 not-for-profit non-governmental organizations (NGOs). Within the health sector, the NGOs are relatively less and somewhat concentrated in urban areas. The sector possesses strengths that can complement the functions of the public sector in health service delivery. These strengths include technical expertise in specific program-related areas, the flexibility to introduce innovations and outreach advantage, community distribution channels and mobile health units. Many NGOs also preferentially target special groups such as people living with HIV/AIDS (PLWHA), victims of drug abuse and rape and non-camp based refugees. In addition, successful NGOs can serve as good partners to work with, largely focusing on the marginalized; thus providing social safety nets for the underprivileged.

Investment in health and gaps

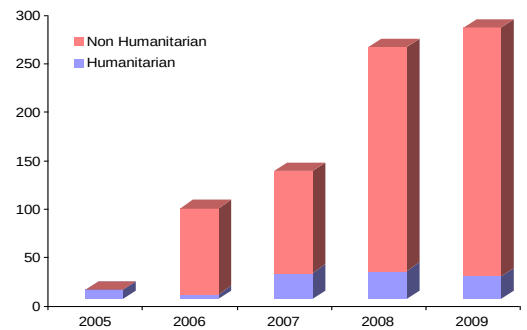
The overall investment in the health services sector during 2009 was US$ 4.853 billion, with the government providing 24%, donors 6%, the military 4%, and 1% through social security. The remaining 65% has been paid by people as out-of-pocket medical expenses. It is estimated that US$ 19.51 billion are currently required to maintain the health services on track for a 3-year period. The Government has increased its investment in health by an additional 34% from 2005-2009 (US$3.4 billion as compared with US$4.6 billion in 2010-2012). Despite this increase, however, there is a huge gap of almost US$15.0 billion. As regards the attainment of MDGs, the Poverty Reduction Strategy Paper (PRSP) -II has estimated an overall funding gap of US$ 1.3 billion. In view of a short fall of US$ 481 million from Government sources in 2009-2010 for meeting the health MDGs, the future funding gap is expected to be even greater.

External Aid Flow in Health and Nutrition Program (HNP)

Health and nutrition investment by foreign donors was around US$ 289 million and US$ 4.5 million for population welfare in 2009. The overall investment in the HNP sector accounted for approximately 14% of the overall foreign assistance in 2009. Around 88% of the foreign assistance to the health and nutrition sector was directed at non humanitarian projects while all of the foreign aid to the population welfare sector comprised of non humanitarian projects. It is estimated that approximately US$ 894 million have been invested by foreign donors in the HNP sector over the five year period (2005-09), most of which was in the shape of grant assistance. Bilateral organizations continue to be the largest foreign funding source within the HNP sector. Of this total investment approximately 64% (US$ 537 million) was financed by bilateral organizations while 34% (US$ 285 million) was financed by multilateral organizations. A review of trends shows the increasing participation of multilateral organizations in the health sector, which has increased their share from 14% of the total foreign health investment in 2006 to 43% in 2009. The UN agencies constitute an overwhelming share of 88% of the total health investment by multilateral organizations followed by Asian Development Bank and the World Bank. A breakdown of bilateral investment by funding sources reveals that USA is the largest donor comprising 38% of the total bilateral investment followed by UK (30%), Japan (7%) and Germany, Australia and Norway (4% each).

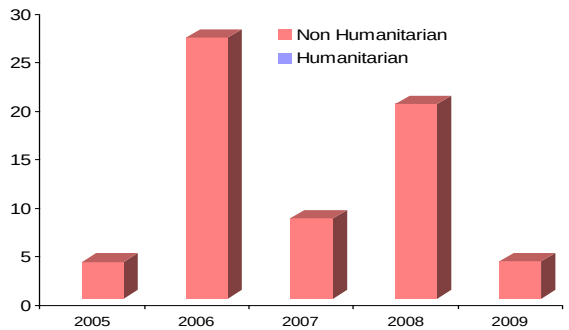
Figures 3.1, 3.2 and table 3.a, 3.b, 3.c, 3.d provide details for external assistance and the gaps;

Figure 3.1: Foreign Investment in Health & Nutrition (US$ Million)



Source: Economic Affairs Division and Donors

Figure 3.2: Foreign Investment in Population Welfare (US$ Million)



Source: Economic Affairs Division and Donors

Table 3.2: Foreign Assistance in the HNP Sectors by Nature of Funding (US$ Million)

	2005			2006			2007			2008			2009		
	Commt.	Disb.	Exp	Commt.	Disb.	Exp	Commt.	Disb.	Exp	Commt.	Disb.	Exp	Commt.	Disb.	Exp
Nature of Funding															
Health & Nutrition	**415.539**	**129.103**	**55.941**	**473.458**	**418.901**	**93.296**	**378.142**	**235.022**	**132.720**	**460.848**	**348.629**	**259.640**	**756.276**	**304.689**	**288.938**
Humanitarian	115.941	60.575	9.635	186.783	40.101	4.579	14.732	17.593	27.130	28.258	37.857	28.976	2.646	18.478	22.976
Non Humanitarian	299.598	68.528	46.306	243.808	373.772	88.717	312.412	215.178	105.590	402.140	301.492	230.664	319.079	286.211	256.682
Unallocated				42.866	5.028	0	50.998	2.251		30.450	9.280		434.551		9.28
Population Welfare	**3.442**	**4.655**	**3.789**	**9.712**	**12.436**	**26.910**	**1.324**	**5.866**	**8.262**	**1.547**	**0.913**	**20.224**	**7.822**	**4.802**	**4.467**
Humanitarian	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Non Humanitarian	3.442	4.655	3.789	9.712	12.436	26.910	1.324	5.866	8.262	1.547	0.913	20.224	7.822	4.802	4.467
Unallocated	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

x.

Table 3.3: Foreign Assistance in the HNP Sectors by Type of Funding (US$ Million)

xi.

	2005			2006			2007			2008			2009		
	Commt.	Disb.	Exp	Commt.	Disb.	Exp	Commt.	Disb.	Exp	Commt.	Disb.	Exp	Commt.	Disb.	Exp
Type of Funding															
Health & Nutrition	**415.539**	**129.103**	**55.941**	**473.458**	**418.901**	**93.296**	**378.142**	**235.022**	**132.720**	**460.848**	**348.629**	**259.640**	**756.276**	**304.689**	**288.938**
Grants	200.450	-	-	383.8915	189.4005	92.8455	299.163	202.032	-	353.406	345.423	-	247.056	191.900	
Loans	215.089	-	-	89.566	229.500	0.450	78.979	32.990	-	107.807	3.206	-	509.231	112.789	-
Unallocated	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Population Welfare	**3.442**	**4.655**	**3.789**	**9.712**	**12.436**	**26.910**	**1.324**	**5.866**	**8.262**	**1.547**	**0.913**	**20.224**	**7.822**	**4.802**	**4.467**
Grants	3.442	4.655	3.789	9.712	12.436	26.910	1.324	5.866	8.262	1.547	0.913	20.224	7.822	4.802	4.467
Loans	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Unallocated	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

xii. Source: Economic Affairs Division, Individual Donors & Funding Agencies

Table3.4: Funding Gap in the HNP Sector (US$ Million)

	2005	2006	2007	2008	2009	Total
Overall HNP Sector	-286.436	-54.557	-143.12	-112.219	-451.587	-1047.919
Humanitarian	-55.366	-146.682	2.861	9.599	15.832	-173.756
Non Humanitarian	-231.07	129.963	-97.234	-100.648	-32.868	-331.857
Unallocated	-	-37.838	-48.747	-21.17	-434.551	-542.306

xiii. Source: EAD, Individual Donors & Agencies

Table 3.5: Utilization Gap in the HNP Sector (US$ Million)

	2005	2006	2007	2008	2009	Total
Overall HNP Sector	-73.162	-325.605	-102.302	-88.989	-15.751	-605.809
Humanitarian	-50.94	-35.522	9.537	-8.881	4.498	-81.308
Non Humanitarian	-22.222	-285.055	-109.588	-70.828	-29.530	-517.223
Unallocated	0	-5.028	-2.251	-9.28	9.28	0

Source: EAD, Individual Donors & Agencies

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Foreign Assistance in HNP Sub-sectors

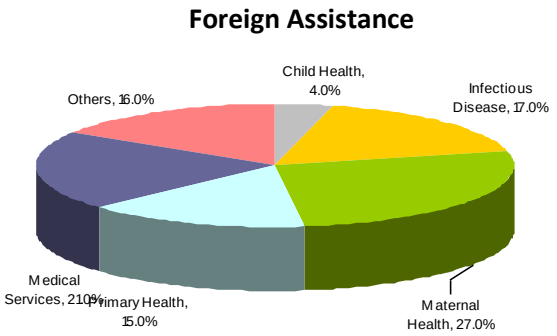
The details of external assistance to HNP sub-sector is shown on table 3.e and Figures 3.3 and 3.4.

Table 3.6: Foreign Assistance in the Health, Nutrition and Population Welfare Sub Sectors (US$ Million)

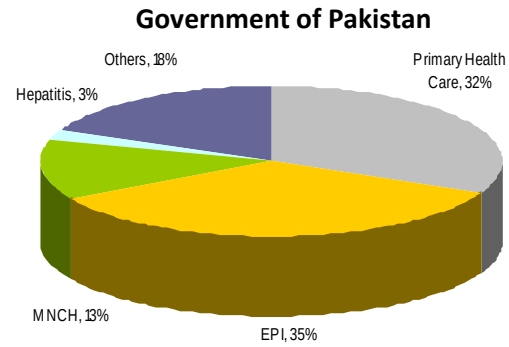
	2005			2006			2007			2008			2009		
	Commt.	Disb.	Exp	Commt.	Disb.	Exp	Commt.	Disb.	Exp	Commt.	Disb.	Exp	Commt.	Disb.	Exp
Health & Nutrition	**415.539**	**129.103**	**55.941**	**473.458**	**418.901**	**93.296**	**378.142**	**235.022**	**132.720**	**460.848**	**348.629**	**259.640**	**756.276**	**304.689**	**288.938**
Administration	0.136	0.136	0	0	0	2	0	0	0	0	0	0	22.58	7.94	7.94
Child Health	13.118	7.655	0.076	25.552	16.897	6.273	27.295	14.435	10.115	14.354	19.06	33.739	106.71	10.285	12.489
Food & Nutrition	17.899	18.355	2.32	0.0275	0.903	0.763	6.3715	2.657	0.294	45.543	26.171	21.874	12.921	23.645	0.1705
Infectious Disease Control	34.572	30.534	31.58	49.61	54.115	42.12	40.897	65.337	41.743	40.349	45.559	40.99	62.783	58.001	49.406
Maternal Health	6.179	0.378	0.308	12.435	38.889	0.147	117.77	42.015	17.952	98.339	84.202	48.078	43.966	31.368	78.276
Medical Services	1.543	1.522	1.485	8.980	0.022	0	0.006	0	0	61.585	63.156	0.005	4.546	1.745	62.022
Others	290.349	30.106	4.025	196.15	163.813	4.646	107.554	24.775	15.392	114.146	7.217	2.125	443.856	111.957	23.915
Primary Health	35.861	29.707	15.73	159.64	124.29	27.77	48.22	59.1	34.941	27.791	38.219	36.189	43.203	44.135	44.538
Secondary Health	0	0		0	0	0	0	0	0.112	0	0	0	0	0	0
Tertiary Health	0	0		0	0	0	0	0	0.112	0	0	0	0	0	0
Training/Capacity Building	0.413	0.413	0.413	2.474	2.474	2.474	2.49	2.49	2.474	1.317	1.301	1.196	1.271	1.199	1.196
Unallocated	15.469	10.297	0	18.589	17.500	7.109	27.543	24.213	9.585	57.424	63.744	75.444	14.443	14.414	8.985
Population Welfare	**3.442**	**4.655**	**3.789**	**9.712**	**12.436**	**26.910**	**1.324**	**5.866**	**8.262**	**1.547**	**0.913**	**20.224**	**7.822**	**4.802**	**4.467**
Demographic Forecasting	2.375	2.375	0	0.278	0.278	2.653	0	0	0	0.128	0.128	0.128	0	0	0
Family Planning	0	2.280	3.789	8.377	9.088	22.509	0	3.910	5.036	0	0.407	19.756	0	2.740	2.603
Fertility & Mortality	0	0	0	0	0	0	0.268	0.268	0.216	0.264	0.264	0.231	0.299	0.299	0.299
Others	1.056	0	0	1.056	3.070	1.747	1.056	1.688	3.010	1.056	0.005	0.005	5.767	0.007	0.007
Training / Capacity Building	0	0	0	0	0	0	0	0	0	0.099	0.099	0.099	1.756	1.756	1.567
Unallocated	0	0	0	0	0	0	0	0	0	0	0.011	0.005	0	0	0

Source: Economic Affairs Division, Individual Donors & Funding Agencies

Figure 3.3: %age Share of total Health Investment (2009)

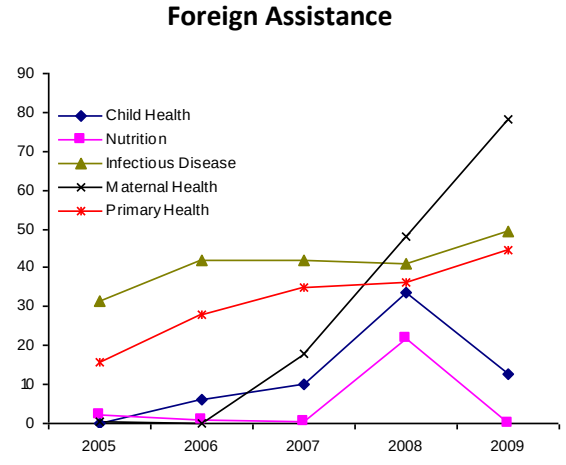


Source: EAD, Individual Donors & Agencies

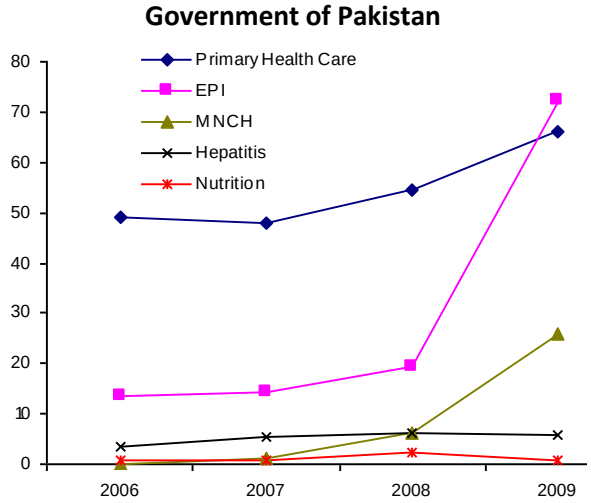


Source: Planning Commission of Pakistan

Figure 3.4: Investment in Health & Nutrition Sub Sectors (US$ Million)



Source: EAD, Individual Donors & Agencies

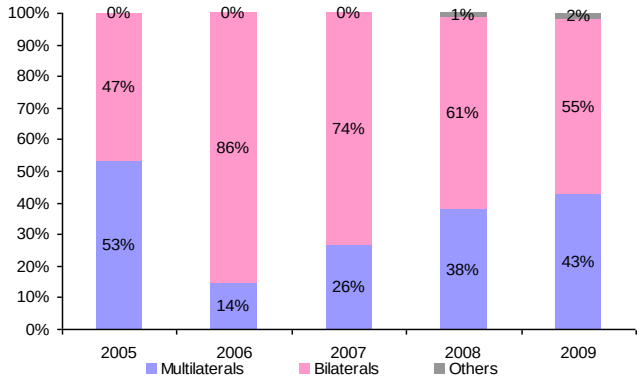


Source: Planning Commission of Pakistan

Foreign Assistance in HNP Sector by Funding Sources

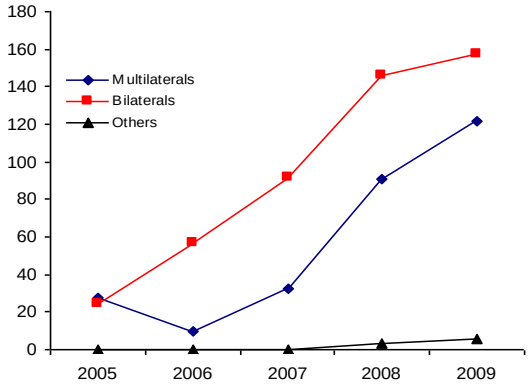
During the period (2005-09), out of US $ 844 million investment by bilateral and multilateral agencies in HNP sector 64% (US$ 537 million) was financed by bilateral organizations while 34% (US$ 285 million) was provided by multilaterals. The multilateral organizations have increased their share in the health sector investment from 14% in 2006 to 43% in 2009 (Figures 3.5 and 3.6). A detailed review of Health Investment by various funding sources is presented in Annexure I. As mentioned above, the UN Agencies constitute a considerable share of 88% of the total health investment by multilateral organizations followed by the Asian Development Bank and the World Bank (Figure 3.7). A breakdown of bilateral investment by funding sources reveals that USA is the largest donor contributing 38% of the total bilateral investment followed by UK (30%), Japan (7%) and Germany, Australia and Norway (4% each) respectively (Figure 3.8).

Figure 3.5: %age of Foreign Investment by Funding Source



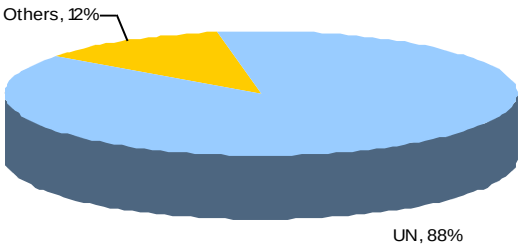
Source: EAD, Individual Donors & Agencies

Figure 3.6: Foreign Investment 2005-09 (US$ million)



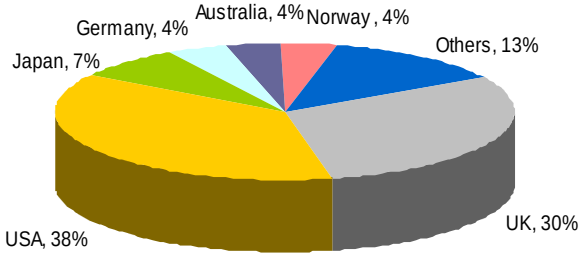
Source: EAD, Individual Donors & Agencies

Figure 3.7: %age Composition of Multilateral Investment (2005-09)



Source: EAD, Individual Donors & Agencies

Figure 3.8: %age Composition of Bilateral Investment (2005-09)



Source: EAD, Individual Donors & Agencies

Coordination and aid effectiveness in the country

It has become abundantly clear to the government as well as its development partners that unless extensive resource mobilization and coordinated investment is carried out, it is highly improbable that Pakistan will achieve most of its health targets including the MDGs. The investments in health need therefore to be embedded in broader social and economic development in order to visualize a clear link between health financing and positive outcomes; and mechanisms are needed to hold all partners accountable for their performance.

The current devolution scenario affords an opportunity to re-visit the need for coordination and planning along scientific lines. The Planning Commission that has been assigned the role of coordination has already taken the initiative to foster a meaningful dialogue on health issues between the federation, provinces, development partners and all other stakeholders in the health sector. It is also encouraging to note that the Planning Commission intends to establish a Health Sector Planning and Coordination Cell to strengthen coordination of all the partners. Additional initiatives such as the International Health Partnerships (IHP) plus, can be availed to evolve a unified country health financing strategy, monitoring framework and budgetary overview.

The Vision 2030 document of the Planning Commission reiterates the resolve of the Government of Pakistan to increase its investment in the Health Sector, while the Economic Growth Strategy calls for harnessing of the potential of youth through community organization. Although apparently the Economic Growth Strategy does not seem to place much reliance on the social sectors, some salient features of the same can provide an effective roadmap to the provinces with regard to the Health Sector adapted to their specific needs:

- Revamping/management of secondary and tertiary care hospitals through public-private partnerships and provision of autonomy, respectively;
- Developing a multifaceted and comprehensive healthcare financing strategy to move towards a National Health Services (NHS) program with introduction of social health insurance for the impoverished through BISP and encouraging private health insurance;
- Better governance in Health in terms of building partnerships, aid effectiveness, career structures, capacity building, accountability, quality and access to medicines;
- Consolidation of services by enforcement of quality standards, regulatory mechanisms, and introduction of an integrated essential health services package at PHC level focusing on maternal and child health services and health risk reduction;
- A new structure of Health Ombudsman should be introduced for better accountability;
- Development and implementation of an integrated nutrition policy and strategy.
- Preparation of a minimum dietary requirements package to promote home-grown food and ensuring household food security to reduce the prevalence of malnutrition;
- The provision of 'street food' with a minimum level of quality and safety standards setting, to make it a safe and nutritious diet;
- School nutrition programs may be reintroduced in the form of cash transfers for food;
- Micronutrient fortification programs for Vitamin A supplementation, Iodine salt, iron supplementation should be integrated and interlinked at primary healthcare level; and
- Mass awareness / BCC campaign should be enhanced through print and electronic media particularly with regard to nutritious dietary habits.

a. Overall coordination of fund-flows to Health Sector: The Economic Affairs Division is responsible for assessment of requirements, programming and negotiations of external economic assistance related to the Government of Pakistan and its constituent units from foreign governments and multilateral agencies. All issues relating to external debt management and technical assistance or credit from friendly countries or lending / re-lending of foreign loans and monitoring of aid utilization are traditionally handled by this division of the federal government as a constitutional requirement.

b. Coordination of UN assisted activities: The macro coordination of UN collaborative activities and support is undertaken by the Resident Coordinator in association with the UN Country Team (UNCT) comprising of heads of all the UN agencies, offices and funds located in Pakistan. The UNCT coordinates all external support from bilateral and multilateral donors that support the One UN joint programs including that on Health and Population. The Joint Programmes are coordinated by the respective Joint Program Steering Committees.

c. Coordination of Humanitarian Activities: OCHA is the key UN agency for coordination of humanitarian support that maintains a close liaison and inventory of support through the Financial Tracking System received by different UN agencies from their own sources and donors. In addition, OCHA also coordinates the support channeled through their office from the Central Emergency Relief Fund and other donors, while supporting resource mobilization.

UN reform status and the CCA/UNDAF process

Pakistan is one of the eight pilot countries for the UN Reform for Delivering as One (DaO). The aim of this reform is to align UN programmes and funding more closely to policy priorities at the national level in order to capitalize on the strengths and comparative advantages of the organizations working within the UN. Increased coordination and coherence achieved through this reform is expected to strengthen government leadership and ownership and assist member countries achieve their Millennium Development Goals (MDGs). An important component of that UN Reform effort is the "One UN Program" that comprises the Joint Programs and Joint Program Components through which the Participating UN Organizations will contribute to Pakistan's socio-economic development.

At the overall UN Reform Pilot level, the highest governance body is the High Level Committee on UN Reform in Pakistan, established in early 2007. It is the supreme body that brings together Government, UN and development partners. The High Level Committee oversees all aspects of the reform experience in Pakistan, monitoring of its progress, and fine tuning to enhance aid effectiveness. It is chaired by the Prime Minister or his/her representative and consists of main line agencies at the federal level, provincial governments and selected donor representatives, meeting periodically. Within the UN system in Pakistan, the United Nations Country Team (UNCT) consisting of the heads of all agencies, funds and programs represented in Pakistan is the inter-agency coordination and decision-making body, led by the Resident Coordinator. Within One UN Program context, the main purpose of UNCT is to plan, implement, monitor, fine tune and ensure the delivery of tangible results in support of the development agenda of Pakistan.

As constituent elements of the One Program, five Joint Programs are developed (Agriculture, Rural Development and Poverty; Health and Population; Education; Environment; and Disaster Risk Management). Joint Program Steering Committees (JPSC) provides strategic guidance for implementation of the Joint Program. Each JP, apart from fully addressing the issues within its substantive coverage, also integrates four cross-cutting issues (refugees and internally displaced persons(IDPs), human rights, civil society engagement and gender) in their working. These JPSCs are co-chaired by a high level government representative and a relevant UNCT member. In addition, observers by invitation could include two donor representatives, civil society and other partners as suitable. WHO is the co-chair for the Joint Program on Health and Population and an active participating agency for other four joint programmes: Agriculture, Rural Development and Poverty Reduction, Education, Environment, and Disaster Risk Management.

UN agencies participation in health sector

The UN system is currently by far the largest contributor of technical and material support to HNP and its collaborative programmes and projects with the government are quite extensive. The UN agencies with major engagement are; WHO, UNICEF, UNFPA, WFP, UNHCR, FAO, UNWOMEN and UNAIDS. Table 3.1 shows the main areas of collaboration of UN Agencies

Table 3.1: UN agencies collaboration in HNP

Agency	Main areas of collaboration
UNICEF	Maternal health Care: community maternal care, Ante-Natal care, Skilled birth Attendant, data base and information, support to prevention of HIV/AIDS UNICEF Child Protection and Empowerment of Adolescents Immunization "Plus" Project vaccination, advocacy social mobilization. UICEF a Major partner in POLIO Eradication Child survival and Development
WHO	Main Partner in Polio Eradication Health Policy and Strategic Planning: Health governance, human resources development, emergency preparedness, health information, Community Health Development :District Health System, PHC, making pregnancy safer/RH and family planning Health promotion and protection; Healthy lifestyle, reducing health risks from environmental causes, prevention of non-communicable disease, Tobacco Free Initiative, Mental Health, Nutrition, Prevention of injuries and child & Adolescent Health/IMNCI. Communicable Diseases: T.B Malaria, HIV/AIDS, Immunization, surveillance,
UNFPA	Reproductive health: Family planning, Family Friendly Facility, Emergency Obstetric Care Population and Development Strategy
WFP	Promoting Safe Motherhood through incentivizing antenatal visits
UNHCR	Immunization Services, T.B Control, Health Information System, Reproductive health services, Leishmaniasis/Malaria control and Training of PHC Workers.
UNDP	HIV/AIDS, National Commission for Human Development
UNAIDS	HIV/AIDS
WHO/UNICEF/WORLD BANK	GAVI Support for EPI

Summary of section 3

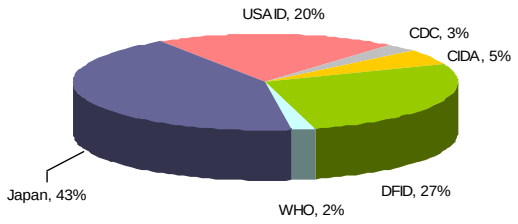
Achievements, opportunities and challenges

The aid flow, similar to many other development issues, is affected by the overall political, institutional, social and global factors. Unfortunately, the security issue, terrorism and violence have negatively impacted on the efficiency and effectiveness of development activities including health. The global economic slump like other countries has not spared Pakistan and for some years its impact will be lingering on. Furthermore, it is imperative to robustly support provincial governments, particularly Departments of Health, during this transition phase of almost total decentralization without any substantial groundwork. Based on analysis in section 3.5 above and projecting the total required investment of at least US$40 billion is required in the next 5-6 years, that translates to US$ 40 per person per year based on current population estimates, and signifies the lower limit of the minimal investment level for health development (WHO 2010 Global Report).

It is assumed that around US$ 10 billion will be provided from governmental sources; while the remaining amount of US$ 30 billion will be provided through out-of-pocket spending by the people or external assistance. This underlines the urgent need to improve the executive capacity and efficiency of the health systems for achieving better outcomes, and carrying out extensive resource mobilization from all possible sources. In order to address the above challenges in relation to aid flow and partnership building, it is important to devise mechanisms for the strategies below:

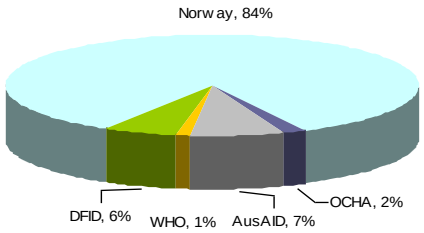
i. Bringing about enhanced coordination between the donors and external development partners as well as with the national and provincial authorities.
ii. Minimize the bureaucratic bottlenecks and strengthen transparency with a view to increase the institutional implementation capacity.
iii. Properly channelize external assistance to optimize capacity building and implementation capacity.
iv. Avail maximum advantage of the opportunities offered by the UN "Delivering as One" initiative to promote and foster a coordinated initiative to improve the governance and resource mobilization within the health sector at all levels.
v. Optimize external assistance opportunities to leverage and strengthen inter-sectoral collaboration between various governmental agencies at different levels.
vi. Facilitate the participation of NGOs and civil society in health development.
vii. Enhance the capacity of the health authorities in relation to resource mobilization and accountably to development partners.
viii. Align donor contributions to restructure the fragmented small scale projects and programs supported by various external partners within the major cluster health priorities.

Figure 3.9: %age Composition of Investment in Child Health (2005-09)



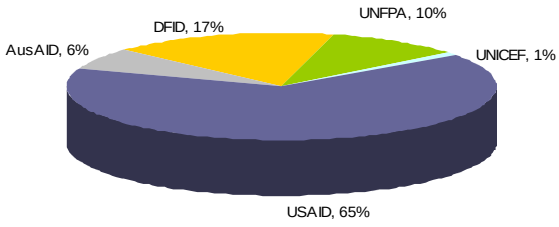
Source: EAD, Individual Donors & Agencies

Figure 3.10: %age Composition of Investment in Food & Nutrition (2005-09)



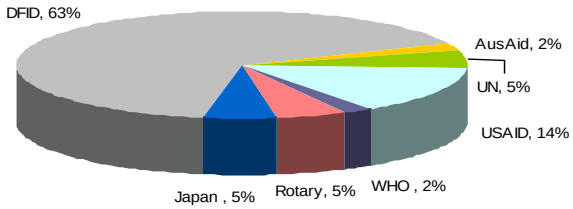
Source: EAD, Individual Donors & Agencies

Figure 3.11: %age Composition of Investment in Maternal Health (2005-09)



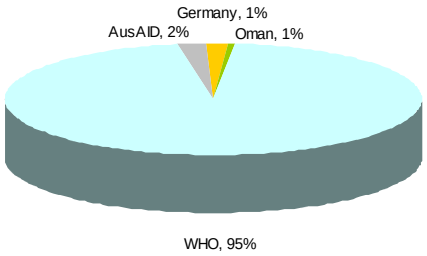
Source: EAD, Individual Donors & Agencies

Figure 3.12: %age Composition of Investment in Primary Health Care (2005-09)



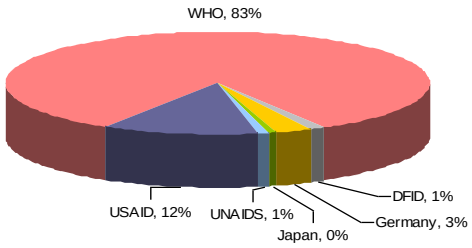
Source: EAD, Individual Donors & Agencies

Figure 3.13: %age Composition of Investment in Medical Services (2005-09)



Source: EAD, Individual Donors & Agencies

Figure 3.14: %age Composition of Investment in Infectious Disease Control (2005-09)



Source: EAD, Individual Donors & Agencies

While the emphasis on primary health care at both government and donor level is encouraging there is a considerable lack of investment in secondary and tertiary level healthcare services including training and development, accompanied by a dearth of specialist cover to people residing in rural / remote areas. Therefore concerted efforts need to be made to ensure that the investment in health services delivery in Pakistan focuses on all levels of health care, horizontally integrated with research, training and development. A detailed overview of health Investment by Funding Agency in the HNP Sub Sectors is provided in Annexure II to this report.

Section 4: Review of WHO cooperation over the past CCS cycle

Review of WHO's cooperation with stakeholders

The World Health Organization Country Office in Pakistan was established in 1960, and has since been providing technical and programmatic support to the ex-Ministry of Health, provincial departments of health and other areas of the health sector ranging from policy development, strategic planning, health system and community development, health promotion and communicable disease control. During the last decade, WHO collaborative efforts have converged on assisting several national and provincial health programs. However, the overriding engagement and resultant achievements in line with the previous CCS have been in the following key areas;

- Polio Eradication and improvement in routine immunization;
- Emergency preparedness and response, recovery and rehabilitation, especially following major disasters;
- Support to the National Program for MNCH, Family Planning & Primary Health Care (NP for FP & PHC)
- Support to Nutrition Wing (MoH) and Nutrition Cells at provincial level.

The WHO Country Office in Islamabad is headed by a WHO Representative and there are five sub-offices, one in each province (except Gilgit-Baltistan) and one for Azad Jammu and Kashmir (AJK). The WCO office is well staffed with a core group of international and national professionals, along with a variable number of consultants to assist the technical operations of the various programmes.

The priorities of the National Health policy and Strategic Planning support

In addition to the main areas of engagement mentioned above, other key programmes supported by WHO include the National MNCH program, Tuberculosis Control using the Stop TB Strategy, Malaria Control and Elimination (MCE), National Program for Prevention & Control of Hepatitis, Health System Strengthening, promoting community-based initiatives, environmental health interventions mainly for safe water and sanitation and health promotion with a strong emphasis on the Tobacco Free Initiative. In more specific terms the WHO support has been focused on the following four areas summarized below;

Health policy and strategic planning support

WHO health policy and strategic planning support relates to the development of national policies, emergency preparedness and response strategies, accreditation of hospitals and health facilities. It also provides substantial technical support at federal, provincial and district levels to strengthen the health systems in Pakistan through improvement of health financing, donor coordination, and monitoring and evaluation of national programs. In this connection WHO supported the development of the new National Health Policy and initiated work on mechanisms for alternative health financing including social health insurance, carrying out the National Health Accounts exercise in addition to capacity building of health professionals and staff, while applying a holistic sector wide approach to health.

During the last two biennia, Pakistan has been struck by two enormous calamities, namely the earthquake in 2005 and massive flooding in 2010, in addition to a host of lesser disasters and population displacements necessitating an urgent and comprehensive emergency response. As a result, from 2005 onwards, WHO has been heavily engaged in assisting the government for health relief, recovery and rehabilitation of the health infrastructure. In more specific terms WHO has been involved in revitalization of primary health care including reproductive health, communicable disease surveillance and response through the Disease Early Warning System, environmental health, health promotion and education, capacity building, and provision of essential medicine and logistics management in disaster affected areas. As part of the recovery strategy, District Health Planning was supported in the affected areas both after the earthquake and the floods. A replicable model of decentralized district management information system has been developed and tested to enhance capacity of district managers in data analysis and use of DHIS information. For planning and movement of the Humanitarian Reform in disasters, eight clusters were created with WHO leading the Health cluster and coordinating all health sector activities during all phases of the emergencies.

Health service delivery and community development - Achievements in past CCS

This area encompasses the expansion of primary health care (PHC) including maternal, neonatal and child health (MNCH), nutrition, human resource development for health, promotion of healthy lifestyle and sustainable development approaches such as the basic development needs (BDN) initiative. Assistance is provided for the promotion of healthy lifestyle interventions with a focus on smoking prevention, promotion of physical activity and healthy diet. In 2006, WHO's support has been instrumental in assisting governmental efforts to produce several important strategy documents including the National Maternal and Newborn Strategy and National Child Health Strategy. These efforts finally culminated in the approval of a PKR 20 Billion (USD 333 million) National Maternal, Newborn and Child Health program for 5 years. WHO also played a critical role in accessing support from the GAVI-HSS window and the Norwegian Pakistan Partnership Initiative (NPPI) for up scaling MNCH interventions in the country, namely in most in need areas such as Sindh province. Under the National Program for Family Planning and PHC an integrated health care services is advanced. Health programmes such as TB DOTS, MCE, EPI, PEI, health education, MCH and FP are being implemented under the integrated approach and the LHWs' knowledge and skills are being upgraded to provide support to the integrated program as community level health workers. A critical capacity building of LHWs included training in Routine EPI in selected districts through WHO GAVI HSS platform; envisaged to significantly impact on improving the Routine EPI coverage in Pakistan. The improvement of quality of health care through PHC is being promoted. Lastly, a number of essential health interventions have been implemented to reduce maternal, infant and child mortality rates and improve the quality of life. This pertains to assisting MOH in adapting global evidence based guidelines related to maternal, newborn and child health such as Pregnancy, Child birth, Postnatal & Newborn Care (PCPNC), management of severe acute malnutrition (SAM). To assist MoH sustain implementation of cost effective interventions such essential newborn care, IMNCI and SAM, efforts were exerted and technical assistance was provided to medical and health sciences schools to introduce these guidelines in the teaching programmes of under and postgraduate students in order to prepare them for resuming duties especially when resources are limited.

WHO was also instrumental in the development of an approach for provision of quality integrated PHC services through drafting of an Essential Health Services Package (EHSP) for FLCF which includes essential core health and allied interventions which are promotive, preventive and basic curative. EHSP is designed to serve as a reference standard and guide for the availability of health services at a specific level of health care to cater for universal access of PHC services to the population; and could also be utilized as a management tool to guide resource allocation, which responds to local priorities and needs. The EHSP has subsequently been costed and the current commitment for implementation of EHSP can also be an opportunity for resource mobilization from donor agencies and interested partners.

Emergency Preparedness & Response *and Disaster Risk Management (DRM)*

WHO has contributed significantly to the health sector disaster risk management capability in Pakistan. In this regard Ministry of Health was supported in the establishment of a dedicated unit for DRM, the National Health Emergency Preparedness and Response (NHEPR) Centre inaugurated by the Regional Director of WHO's Eastern Mediterranean Region Dr Gezairy on 8th March 2010.

WHO has continued to support NHEPR through provision of a technical officer and operational support especially during the series of crises faced in year 2010 including the Hunza Lake Hazard, Cyclone Phet in Gwadar and the devastating floods affecting almost all of Pakistan. Furthermore, during the floods in 2010 WHO also established a SHOC (Strategic Health Operation and Coordination) room at the NHEPR centre, PIMS, Islamabad where WHO national and international staff worked together with the Ministry of Health staff to respond to the overwhelming flood crisis. Moreover, the NHEPR Network was also created in all the five provinces and one region of AJ&K through identification of focal persons at the provincial/ regional level and in five priority districts of each province. Simultaneously, orientation of the Departments of Health and other relevant stakeholders on DRM was also undertaken. A specific provincial Emergency Cell was made in KPK; and monsoon floods contingency plans were developed with the coordination of Provincial DoHs for KPK, Sindh, Balochistan and Punjab.

The Basic Development Needs Initiative

Inadequate attention to social determinants of health has posed a growing challenge to PHC implementation with extremely limited community empowerment and inter-sectoral action. The Basic Development Needs (BDN) initiative incorporates a holistic vision establishing the missing links through community involvement and inter-sectoral action to bring about human development. It promotes ownership for a set of essential package of community needs and recognizes local organizational capacities and mobilization skills as the major driving force for attaining a number of desired health outcomes, while ensuring their long term sustainability. This strategy has been effective in scaling up PHC services, and recognized health as an essential social goal for community development. The BDN initiative was first launched in Pakistan in 1995 in the Nowshera district and subsequently replicated later in eight additional districts, with a significant impact on social transformation towards attainment of key health Millennium Development Goals (MDGs).

The Government of Sindh and other provincial governments have supported this process fostered attitudinal and behavioral changes transforming people from passive recipients to self-confident executors, mobilizing awareness, planning skills, creative initiatives, collective responsibility, accountability and leadership skills for social communication, and decision making for health and poverty reduction. Currently BDN has a total population coverage of 1.7 million in the nine districts of Dadu, Jamshoro, Multan, Kasur, Nowshera, Mastung, Peshawar FR, Muzaffarabad and Neelam having a total of 154,480 Cluster Representatives, 731 Village Development Committees and 107 community citizen boards. Briefings are conducted for representatives of district line departments, particularly health, education, local government, agriculture, and environment assigned to inter-sectoral teams in each site.

Community and public sector inputs catalyze the implementation of small scale social projects addressing community priorities. Projects for universal access to health and other social services are co-financed by communities to generate ownership and sustainability. The program focuses on cost-effective technologies and managerial skills that are feasible, affordable, practical and simple. Community groups are trained on these technologies and their managerial skills for target setting, formulating strategies, mobilizing resources, accounting, and monitoring and evaluating are enhanced. BDN interventions have attracted ownership of provincial / district governments as well as global health initiatives such as GFATM (for control of TB and Malaria) and GAVI-CSO (for MNCH interventions). The state of Kuwait has also supported a school health project recently in four BDN districts. All activities are closely aligned with government policy and community. A generous support has been mobilized from DFID, UKAID and UNDP for addressing Gender Based Violence in BDN Kasur focus on the health sector. BDN is regarded as a platform for scaling up community based public health interventions as part of an integrated development process.

Health promotion and protection

WHO collaborative program, has been engaged in advancing health promotion measures such as; nutrition, reduction of risk factors including no tobacco, healthy diet and physical activities. The prevention and control of Non- communicable diseases and prevention of blindness have been supported. WHO collaboration has substantiated the establishment of environmental health units at federal and provincial levels in the Ministry of Health.

WHO also provided technical support for development of draft national NCD strategy and launching of National Commission for NCD, which was mandated to render technical advice and strategic direction to the Ministry of Health for control & prevention of NCD. The national programme for prevention of blindness was supported for capacity building of primary health care workers to improve care for the blind and carrying out cataract surgeries to reduce the cataract burden in Pakistan.

The other key outputs of the programme included; development of training manuals, training of different carders of health staff on community mental health, Provision of audio-visual aids to WHO collaborating center for mental health, development of national essential drugs list containing of neuro-psychiatric drugs and training of master trainers for integration of mental health program.

In order to address the issue of excess mortality and monitoring the impact of increasing food insecurity on the nutritional status of the population, interventions like support for the establishment of stabilization centers (SCs) for management of cases of severe acute malnutrition in 18 districts across the country and establishment of a health and nutrition surveillance system (HANSS) at the facility and community level in 18 districts of Balochistan and Khyber Pakhtunkhwa, were put in place. Capacity building of the health care workers on facility based management of severe malnutrition was supported by WHO (580). With regards to the capacity building of departments of health at provincial level on nutrition 38 master trainers and 591 trained health care workers are supporting nutrition surveillance. A new online software for nutrition surveillance is also developed.

Prevention and control of communicable diseases

WHO collaborative program on communicable diseases control has been the main focus of WHO country support. Eradication of poliomyelitis, EPI, tuberculosis (DOTS), malaria (RBM) and HIV/AIDS and viral hepatitis infection control are among key areas being assisted. Similarly, the disease surveillance and early warning systems have been supported by WHO. Technical support is given to NIH for devising control measures for the epidemics for all communicable diseases including Zoonotic diseases.

Cross-cutting issues of Gender and Human Rights in the context of Health

Pakistan generally does not perform well in its gender indicators in relation to its neighboring countries as can be seen in the Table 4.1 below despite a 21% proportion of women in Parliament. Of particular interest to WHO are Gender and Human Rights issues having a bearing on Health. The link between gender and poverty is highly evident in Pakistan, which is a predominantly poor country, and women are the poorest among the poor and the most vulnerable among communities owing to eschewed access to economic resources and low participation in decision making. Poverty in Pakistan has a "woman's face." There are considerable intra household disparities in food distribution and investment of resources between male and female members. Among poorer households, incidence of chronic malnutrition is higher among female children.[xxix]

Table 4.1: Comparison of Gender Development Indicators in Selected Asian Countries

	Bangladesh	China	India	Indonesia	Pakistan	Malaysia	Sri Lanka	Thailand
Life expectancy at birth (years) (2007)	66.7	74.7	64.9	72.5	66.5	76.6	77.9	72.1
Adult literacy rate (% aged 15 and above) (1999–2007)	48.0	90.0	54.5	88.8	39.6	89.6	89.1	92.6
Combined Gross Enrolment ratio in education (%) (2007)	52.5	74.50	57.4	66.8	34.4	66.0	56.0	79.6
Labour Force Participation Rate (%) 2008	61.4	74.5	35.7	53.3	21.8	46.7	38.5	70.7
Estimated Earned Income PPP US$) (2007)	830	4323	1304	2263	760	7972	5450	6341

Source: Human Development Report 2009 and 2010.

The issues relating to gender and health have multi-faceted dimensions, including gender based violence impacting physical, sexual and mental health severely; gender based discrimination and patriarchal social norms hindering access of women and girls to health care services through low family investments on health, nutrition and education of women and girls as well as achievements of health related basic human rights including rights to life, survival, bodily integrity, liberty and security; rights to highest attainable standard of physical and mental health as well as benefits of scientific progress; freedom from torture or cruel, inhuman, discriminatory or degrading treatment or punishment; freedom of opinion and expression; access to food/nutrition, safe drinking water, education, information, social security and personal development. The situation warrants interventions to mainstream gender and human rights perspectives in health policies and programmes, gender sensitive evidence base, gender based barriers in achieving health, monitoring and evaluation of gender and health issues.

Women's human and health security is violated consistently despite constitutional provisions and international agreements of Pakistan to the contrary. Some of the most basic human rights enshrined in the Constitution of Pakistan, as well as in the many instruments of human rights to which the state is a signatory, such as the Universal Declaration of Human Rights (UDHR), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Convention against Torture(CAT) and the United Nations Convention on the Rights of the Child (UNCRC) are violated not merely as a result of poverty but also due to socio-cultural beliefs and traditions. All these human rights violations constitute barriers to the achievement of highest attainable standards of optimal health for women, girls and other marginalized groups of society. Through the DaO initiative, WHO has been working on Gender-Based Violence and other Gender and Health issues through advocacy, development of guidelines and capacity-building. The Gender and Health program is a WHO collaborative effort with Health and other sectors to address underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches. The program interventions have contributed towards progress on MDGs-3, 4, 5 and 6 through evidence based research, guideline development and capacity building of Health managers, professionals and care providers. There is a need to involve male parliamentarians and especially religious leaders in order to make further progress.

The health-related outcomes of the UNDAF

Besides its function of providing technical support to the government, WHO supports the country under the broader UN umbrella. WHO is an active supporter of the UN reform in Pakistan in order to "Deliver as One". Out of the 5 Joint programs of "Deliver as One", WHO is the convening agency for the joint program on health and population and an active participating agency for three of the other joint programs including Agriculture, Rural development and Poverty reduction, Environment and Disaster Risk Management. WHO assisted in the preparation of the Common Country Assessment (CCA), which is an overview of national development priorities and programmes, and the UN Development Assistance Framework (UNDAF), designed in partnership with the government. All these strategic documents guide WHO collaboration in Pakistan.

WHO's comparative advantage

To achieve its mandated goal, the WCO Pakistan possesses the following comparative advantages and strengths to accomplish its tasks effectively.

- It is the leading specialized agency of the United Nations on all health issues
- The WHO presence in all the four major provinces and Azad Jammu and Kashmir (AJK), provides a valuable opportunity for the organization to closely interact with local health institutions and district health systems, and assist public health interventions at the operational level.
- A strong and close relationship has developed between the WHO country office and the provincial Departments of Health. WHO has been present and has been a partner in all national dialogues for instituting health reform agendas through appropriate policies, strategies and programmatic interventions.
- The strong collaboration between WHO and academic institutes is providing a platform for boosting service delivery through tertiary care hospitals using WHO protocols and through production of human resource well equipped with public health programmes.
- The presence of a strong UN country team and their active engagement in health activities through their thematic working groups provides WHO with opportunity to mobilize the UN system in support of the health sector and build broader alliances with other international partners.
- The direct association of health with three of the MDGs and its relevance to many other MDGs offers WHO the legitimacy of interacting with a large number of stakeholders and promotes the central role of health in national socioeconomic development and poverty reduction.
- WHO through the BDN programme has been directly interacting with civil society organizations and local communities at the district and grass-root levels.
- The country office has managed to bring in prompt specialized technical support from the Regional Office and headquarters, which has facilitated the active role and special place of WHO in all health reform debates and development of so-called programme-based support.

The allocation of resources: human (staff skills and competencies); budget; installed capacity (connectivity, equipment, logistics and infrastructure)

International Staff	
Longer-term staff	23
Short-term staff (in support of emergency flood relief)	18
National Staff	
National Professional Officers	9
General Services staff	18
Special Services Agreements (SSAs)	500
Agreement for the Performance of Work (APWs) working in security compromised areas	124
Total	692

The WHO Representative is currently assisted by twenty three long-term international staff for the various program areas and eighteen temporary international staff supporting the current flood response, while a PHC position is vacant. There are nine national professional officers and 500 (mostly for Polio Eradication) on SSA contracts assisting various programmes at different levels. In addition WHO general staff assist the implementation of WHO activities at the WHO Representatives' office, provincial offices and technical programmes.

Financial Resources

WHO health investment in the last two biennia has been approximately US $ 182 million for priority health programmes and capacity-building. The level of support has increased considerably in the past few years, mainly due to the major emergencies that the country has encountered in recent years. US$ 4.43 million has been provided as financial input for technical assistance during biennium (2008–2009). In addition, an amount of US$ 92 million has been earmarked, from extra budgetary sources, primarily, for the Eradication Poliomyelitis However, out of the above sum, other priority areas, such as tuberculosis control, research activities, and the activities of the National Commission of Macroeconomics and Health (NCMH) have also been supported. Furthermore, WHO has facilitated resource mobilization through partnership development, e.g. GAVI, GFATM and the Global Drug Facility (GDF). WHO has been in the mainstream of resource mobilization through flash appeal and development of projects and proposals to be funded for the post disaster recovery and rehabilitation post disaster. The table below shows the resources summarized for JPRM regular budget, extra budgetary funds and those specifically for the PEI and EHA.

Program	2006- 2007 (in million US$)	2008 - 2009 (in million US$)	2010 only (in million US$)
JPRM regular budget	5.085	5.291	4.285
Extra budgetary funds	78.877	97.769	93.654
Polio eradication initiative	51.428	51.003	25.255
Emergency Preparedness and Humanitarian Action	25.529 (2005-2007)	20.500	53.985 (both IDPs and floods)

Installed capacities

In addition to the country office in Islamabad, WHO has sub-office in all the provinces, Muzaffarabad and emergency hubs wherever required the most. The offices have adequate IT and office equipment, vehicles, and staff.

Support from other levels of the Secretariat

The WHO country office receives technical as well as financial support from the Regional Office and headquarters. The support includes extra budgetary resources through resource mobilization, and visits of staff and experts for exchange of information and experiences. The Regional Office also supports a range of inter-country activities such as inter-country consultations and training while fostering operational or systems research.

Section 5: The strategic agenda for WHO Cooperation

Conducting the prioritization exercise to define the Strategic Agenda

WHO's strategic agenda in Pakistan has been developed after an exhaustive situation analysis of the health sector and through an intensive process of consultation with federal, provincial and district levels of the federal government, DoHs, donors and UN agencies. The strategic directions aim to support the government in providing adequate health coverage to all people, the ongoing devolution process and the commitment to achieve the MDGs. The strategic agenda is also aligned with the priorities set at the Global level during the 64th World Health Assembly as well as priorities set at the regional level. The agenda for cooperation is based on facts and figures from past records, assessments, data and events as impacting on the health sector in Pakistan. Over the past six months, WCO Pakistan has held various consultations, meetings and missions, with the Planning Commission, Cabinet, Economic Affairs and Inter-Provincial Coordination divisions. In addition, a mission on CCS from EMRO also reviewed the current devolution process in the country and its potential impact on the working of WHO. WHO staff in Islamabad, provincial sub-offices, emergency hubs and at district level have also been providing their technical expertise to their government counterparts to ensure that local needs and capacity gaps are bridged. Need assessments, surveys, data collection from various authenticated sources and the Disease Early Warning System and Polio Surveillance established have substantiated the existing ground realities and delineated the way forward for the health sector in Pakistan.

Defining the Strategic Agenda

Defining the strategic way forward for health system and sector in Pakistan is more complex as compared to other developing countries. Besides the low expenditure, low investment in health, there are several other factors such as the political, social and security situation which have a huge impact and affect the policies and impede the overall health service delivery in the country. This also includes implementation of the 18th constitutional amendment and the decentralization in process. The country has been repeatedly confronted with several major emergencies since 2005 rendering it more vulnerable to public health emergencies and precipitating the existing weaknesses and gaps in the health system. The frequent disasters also led to the diversion of resources - both internal and external - and facilities to the emergency affected areas, improving these areas at the cost of deprivation of those areas with poor indicators not falling in the affected region. The history of latest disaster incidents in the country illustrate that local health authorities at each level and communities are the first responders to crises, and they, in turn, need the resources to respond immediately to risks in their communities. Flood situation in 2011 illustrated that disaster has affected the health of the population well beyond the immediate risk of disease, death and injuries; and local health systems appeared to be one of the most vulnerable one to flood impact. Therefore, vulnerability and protection of the physical infrastructure, the institutions and the personnel is one of the major challenges to be addressed during crisis. Keeping all these factors in mind and looking at the current scenario, WHO is redefining its strategies in Pakistan to respond to this changing environment by calling for new ways of working in such situations.

At the country level, through the CCS process, it is envisaged that:

- WHO collaboration will be more strategic and focused on specific priority areas such as Health System Strengthening across the board in Pakistan to create an enabling environment for provision of effective MNCH, communicable disease control, nutrition supportive interventions, and health promotion and disaster risk management strategies. The previous experience of programmatic support is not encouraging and even the vertical programs can work more effectively in the presence of a dynamic and vibrant health system.
- WHO's role in the country, particularly in the provinces, will be that of a technical and policy advisor adapting to the emerging constitutional realities on the ground. Moreover, the advocacy role of WHO particularly in policy formulation and strategic guidance to the critical aspect of provincial implementation will be further emphasized particularly in the context of devolution.
- National and international partnership strengthening will be enhanced and new avenues of collaboration explored to ensure coordination in health;
- Review and redefinition of the functions within WHO Pakistan would be sought to ensure effectiveness of WHO support in the country with optimal utilisation of resources, expertise, knowledge and skills available within WHO at all levels.

The WHO Country Cooperation Strategy for the next six years has been framed to support the Government of Pakistan in achieving the Millennium Development Goals. The strategic directions take into account the national goals of the Government of Pakistan to provide adequate health coverage to all people, the desire of the senior leadership for rapid strengthening of the health sector and the ongoing devolution of governance and administration in the country. The strategic directions are guided by the spirit and essence of primary health care and Health for All. They also take into consideration that a large share of health care delivery is provided by the private sector. In addition to the residual federal health structures, provincial Departments of Health, the directions are selected to be sensitive and support other key health partners in government, civil society, and program and activities that are supported by UN agencies, development banks and donors. Lastly, the strategic directions are cognizant of the WHO mandate, means and technical domain.

WHO's strategic direction focuses on the following seven priority areas:

- Health policy and system development with community involvement
- Communicable disease control
- Maternal, neonatal, child health and nutrition.
- Non-communicable diseases control
- Social determinants of health encompassing equity, human rights and gender dimensions
- Emergency preparedness and response and Disaster Risk Management
- Partnerships, resource mobilization and coordination

1. STRATEGIC PRIORITY: Health policy and system development WHO will support in improving policy-making and governance basis; improving the service delivery, access, equity and fair financing; regulating medicines and biotechnologies; developing public-private partnership and managing human resources for health; developing an integrated health information system and promoting and supporting applied research	
***1.1 Main focus area*:** Improving policy making and governance	
• ***1.1.1 Strategic Approach*** • Policy analysis and development: conduct policy assessment and analysis and review the health system with a view to outline gaps and propose solutions as part of the new health policy/strategy.	• ***1.1.2 Strategic Approach:*** • Strengthening the capacity of the Federal bodies governing/coordinating and regulating health issues and the Provincial Departments of Health to redefine the roles and responsibilities and provide clear directions in light of the current devolution process. Attention will paid to health sector reform at provincial DoH.
• ***1.1.3 Strategic Approach*** • Capacity-building: continue building and upgrading competencies at national, provincial and district level for strategy development, planning and management including effective mobilisation and utilisation of the resources.	• ***1.1.4 Strategic Approach*** • Supervision, Monitoring and Evaluation mechanisms need to be redefined and strengthened at all levels to ensure efficient and effective health system solutions.
1.2 Main focus area: Human resources for health	
• ***1.2.1 Strategic Approach*** Prioritize, in the context of national economic conditions, public sector spending on health, as appropriate, to ensure that sufficient financial resources are available for the implementation of policies and strategies to scale-up and retain the health workforce, and to recognize it as investment in the health of the population which contributes to social and economic development;	• ***1.2.2 Strategic Approach*** Development and maintenance of a national health workforce plan as an integral part of a validated national health plan, in accordance with national and provincial responsibilities with increased efforts towards effective implementation and monitoring.
• ***1.2.3 Strategic Approach*** Develop strategies and policies to increase the availability of motivated and skilled health workers in remote and rural areas, with reference to WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved retention of the health workforce;	• ***1.2.4. Strategic Approach*** Support scaling -up education and training while ensuring quality of training and improve the retention of the health workforce including medical and allied health personnel, midwifery and nursing in particular focusing on pre-service training. Developing strategies for career pathways as a tool to ensure retention of health workers in specific areas (technical and geographical stations), be a motivating factor for career development, rationalize and orient in-service training programmes.

<table>
<tr><td colspan="2">1.3 Main focus area: Improving service delivery, access and equity</td></tr>
<tr><td>• 1.3.1 Strategic Approach
• Support in the development of an integrated framework for the provision of quality and equitable health care to the population. The application of an Essential Health Services Package will also be budgeted and tested at provincial level. Focus is provided to maternal, newborn and child health inducing their survival, nutrition, and promoting their health.</td><td>• 1.3.2. Strategic Approach
• Apply the concept of “District Health Planning” as the cornerstone for more efficient use of resources and increasing access for the population to the public health delivery system and for meaningful community engagement and participation.</td></tr>
<tr><td>• 1.3.3 Strategic Approach
• Monitoring and Supervision support to ensure that services are adequate, accessible and of the quality desired with motivated staff, availability of equipment, information and finance, and adequate drugs</td><td>• 1.3.4. Strategic Approach
• Strengthening the provincial and district departments of health capacities for implementation of priority health programmes including better management and utilization of available infrastructure and ability to respond to devolution.</td></tr>
<tr><td colspan="2">1.4 Main focus area: Achieving equitable and fair health financing</td></tr>
<tr><td>• 1.4.1 Strategic Approach
• Advocacy for more adequate budget allocations for health (aiming at a minimum of 4% of GDP by 2017) taking into account the cost estimates for the Essential Package of Health Services</td><td>• 1.4.2. Strategic Approach
• Advocacy for increased external resources (ODA) to support critical aspects of the health sector reform on provincial level and promotion of coordinated approaches and effective use in view of the devolution process</td></tr>
<tr><td colspan="2">• 1.4.3 Strategic Approach
• Review potential of introducing safety nets and social security schemes, partial cost recovery, etc</td></tr>
<tr><td colspan="2">1.5 Main focus area: Developing public–private sector partnership and regulation of private sector</td></tr>
<tr><td>• 1.5.1 Strategic Approach
• Assisting the Departments of Health to develop specific guidelines to steer public-private partnerships including roles and responsibilities of different stakeholders.</td><td>• 1.5.2. Strategic Approach
• Support in the development of models with combined governance structures with private sector having well defined roles and responsibilities for all actors.</td></tr>
<tr><td colspan="2">• 1.5.3 Strategic Approach
• Development of a mechanism on balancing the power relationships, ensuring the sustainability of partnerships and ensuring that all players are held accountable for the delivery of efficient, effective and equitable services.</td></tr>
</table>

1.6 Main focus area: Medical products, vaccines and technology	
• ***1.6.1 Strategic Approach*** Promote and support implementation of international norms and standards for quality of medical products, vaccines and technologies	• ***1.6.2. Strategic Approach*** Encourage and facilitate reliable procurement to combat counterfeit and substandard medical products, vaccines and technologies, and to promote good governance and transparency
• ***1.6.3 Strategic Approach*** Support the monitoring and supervision of the quality and safety of medical products, vaccines and technologies by generating, analyzing and disseminating signals on access, quality, effectiveness, safety and use.	• ***1.6.4. Strategic Approach*** • Promote equitable access, rational use of and adherence by providing technical and policy support to relevant stakeholders
• ***1.6.5. Strategic Approach*** • Encourage development, testing and use of new products, tools, standards and policy guidelines and establishment of drug testing laboratories	• ***Drug regulatory authority?***
1.7 Main focus area: Health information and Research	
• ***1.7.1 Strategic Approach*** • Strengthen the national health information systems to generate, analyze and use reliable information from multiple data source	• ***1.7.2. Strategic Approach*** • Strengthen and expand the DEWS to all the districts to detect, investigate, communicate and contain threats to public health security
• ***1.7.3 Strategic Approach*** • Develop mechanism for the integration of the DHIS with the DEWS	• ***1.7.4. Strategic Approach*** • Design mechanisms to integrate information from both private and public sector and to include all health components including nutrition surveillance, MNCH and non communicable diseases
• ***1.7.5. Strategic Approach*** • Promoting the use of the available information and knowledge for policy and planning and use of innovative technologies like eHealth, distant learning and HRIS •	• ***1.7.6. Strategic Approach*** Promoting and supporting the implementation of operational and applied research to strengthen policy formulation, planning, human resources development, monitoring and management at all levels, with special reference to improvement of access and equity

2. STRATEGIC PRIORITY: Communicable disease control

WHO will support the, Provincial and District health authorities in controlling communicable diseases of public health importance. Disease surveillance and Early warning system establishment for the detection and timely control of communicable diseases including Polio, tuberculosis, malaria, HIV/AIDS, Leishmaniasis, hepatitis, AWD, ARI, Malaria, Dengue fever, CCHF among other. Support will also be provided in improving immunization

2.1 Main focus area Improving immunization	
• ***2.1.1 Strategic Approach*** • Promote poliomyelitis eradication through intensive vaccination support. •	• ***2.1.2. Strategic Approach*** • Strengthen routine immunisation and vaccination against the preventable diseases including measles, DPT, BCG, hepatitis B in collaboration with UNICEF and other key partners
***2.2 Main focus area*:** Disease control	
• ***2.2.1 Strategic Approach*** • Support the provincial and district health system in the control of communicable diseases detection and timely control.	• ***2.2.2. Strategic Approach*** • Support the prevention and control of tuberculosis (Stop TB), malaria (Roll Back Malaria), hepatitis, dengue, Leishmaniasis and other neglected tropical and Zoonotic diseases.
• ***2.2.3 Strategic Approach*** • Strengthening of the HIV/AIDS programme in collaboration with other partners, especially UNAIDS	•
***2.3 Main focus area*:** Improving surveillance	
• ***2.3.1 Strategic Approach*** • Strengthening and expansion of the Disease Early Warning system in all the districts of Pakistan with a timely detection of alerts and outbreaks, investigation and control of communicable diseases	• ***2.3.2. Strategic Approach*** • Supporting health laboratories for quality control and surveillance. •
3. STRATEGIC PRIORITY: Improving the health of women and children WHO will support the Ministry of Health in improving the maternal, newborn and child health in Pakistan and to achieve the MDGs 4 and 5?	
***3.1 Main focus area*:** Improving Maternal, Newborn and Child Health including nutrition and Reproductive Health	
• ***3.1.1. Strategic Approach*** WHO would support the provincial ministries of health in improving mother, newborn and child health/ reproductive health in collaboration with other stakeholders including UNFPA, UNICEF, and USAID etc.	• ***3.1.2. Strategic Approach*** Strengthen the capacities of the provincial MNCH programs to promote safe motherhood, family planning, prevention and control of sexually transmitted infections, reducing neonatal, peri-natal mortality.
• ***3.1.3. Strategic Approach*** Develop a comprehensive policy, strategy and implementation plan on the prevention and Control of sexual and gender based violence.	• ***3.1.4. Strategic Approach*** • Improving child and Adolescent health through technical assistance, capacity building, dealing with underlying causes such

	as water, sanitation, malnutrition and education/awareness.
• ***3.1.5. Strategic Approach*** Develop comprehensive policies and strategies for adolescent and youth health, paying particular attention to the prevention and care of sexual and reproductive health	• ***3.1.6. Strategic Approach*** Develop a framework for reporting, oversight and accountability on women's, maternal and children's health •
4. STRATEGIC PRIORITY: Non-communicable diseases and mental health WHO will support the Ministry of Health and all stakeholders in the prevention, control and management of non-communicable diseases and improve the mental health status in the country.	
4.1 Main focus area: Prevention and Control of NCDs	
• ***4.1.1. Strategic Approach*** • Support and Strengthening policy coherence to maximize positive and minimize negative impacts on NCD risk factors and the burden resulting from policies of other sectors	• ***4.1.2. Strategic Approach*** • Support the development of multi-sectoral public policies that create equitable health promoting environments that enable individuals, families and communities to make healthy choices and lead healthy lives, addressing health risk factors.
• ***4.1.3. Strategic Approach*** • Support DoH and stakeholders to ensure best possible integrated health care is provided to persons with NCDs throughout the life cycle including empowerment, rehabilitation and palliation	• ***4.1.4. Strategic Approach*** • Engaging the private sector in order to strengthen its contribution to NCD prevention and control according to international and national NCD priorities;
• ***4.1.5. Strategic Approach*** • Accelerating implementation of the provisions of the WHO Framework Convention on Tobacco Control (WHO FCTC)	• ***4.1.6. Strategic Approach*** • Integrating mental health and substance abuse into primary health care services through health systems strengthening, according to capacities and priorities.
5. STRATEGIC PRIORITY: Addressing the Social Determinants of Health	
5.1 Main focus area: Promotion of Healthy Environment and Living	
• ***5.1.1. Strategic Approach*** • Promotion of healthy environment by advocating for safe water availability and utilisation as well as proper sanitation facilities	• ***5.1.2. Strategic Approach*** • Support the environmental health unit of the provincial departments to design and implement environmental health programs including water quality monitoring, health and hygiene promotion.
• ***5.1.3. Strategic Approach*** • WHO through the Health and Environment departments and in collaboration with UN agencies	• ***5.1.4. Strategic Approach*** • Participate in development of economic and social policy responses to climate change and

and other partners would promote healthy and safe behaviours and environment under the principles of Health in All Policies	other environmental degradation that take into account health equity
5.2 Main focus area: Gender mainstreaming and occupational health	
• ***5.2.1. Strategic Approach*** • Mainstreaming gender into all health programs of WHO and the Departments of Health to ensure gender equity and equality including sex disaggregated health data and information.	• ***5.2.2. Strategic Approach*** • In collaboration with ILO and other partners ensure improved working conditions for all workers and sound occupational health especially female workers.
6. STRATEGIC PRIORITY: Emergency preparedness and response and Disaster Risk Management WHO will support the National Health Emergency Preparedness and Response Network and the Provincial Disaster Management Authorities along with other health partners to ensure emergency preparedness within the health sector and respond to any event of disaster with the best possible health response.	
6.1 Main focus area: Emergency Preparedness for the Health sector	
• ***6.1.1. Strategic Approach*** • Establishing policy, legal and institutional arrangements for disaster risk reduction within the health sector.	• ***6.1.2. Strategic Approach*** • Development of the National plan, guidelines and SOPs for Health Emergency Preparedness and Response
• ***6.1.3. Strategic Approach*** • Hazard mapping and vulnerability health assessments at district and selected health facilities	• ***6.1.4. Strategic Approach*** • Development and regularly updating of the Health Emergency Management Information System (HEMIS)
• ***6.1.5. Strategic Approach*** • Development and regularly updating the Health sector contingency plan	• ***6.1.6. Strategic Approach*** • Supporting the Global Safe Hospital Initiative: One Million Safe Hospitals and Schools Campaign (including Patient safety, structural and non-structural safety, Mass Casualty Management Plans)
• ***6.1.7. Strategic Approach*** • Human resource development of various cadres on Health Emergency Preparedness and Response with special attention to provincial and disaster prone districts.	• ***6.1.8. Strategic Approach*** • Health related community based disaster risk management including community awareness raising, training and equipping on first aid at community level, health education and promotion. Etc.
7. STRATEGIC PRIORITY: Partnerships, resource mobilization and coordination	
7.1 Main focus area: Improving resource mobilization	
• ***7.1.1. Strategic Approach*** • Development of a resource mobilisation strategy for WHO Pakistan	• ***7.1.2. Strategic Approach*** • Support the health sector in resource mobilisation
• ***7.1.3. Strategic Approach*** • Development and regular updating of an information system for donors and health partners with the	

aim to support external assistance in form of data, surveys, studies and reports.	
7.2 Main focus area: Improving partnerships and coordination	
• ***7.1.1. Strategic Approach*** • Facilitating the coordination process among the various health development partners, UN Agencies, NGO/INGOs , donors, funding agencies and the health authorities at the federal and provincial level	• ***7.1.2. Strategic Approach*** • Leading the health cluster in any emergency situation and Using the health cluster approach to improve the coordination system within the health sector

It should be noted that the sequence in which the above functions are listed is not an indication of their priority. In fact, the relative importance of these functions would vary from country to country depending on its state of development and strategic priorities identified for collaboration with WHO during the process of formulation of CCS.

Enhanced Role of WHO Collaborating Centers

WHO collaborating centers are institutions such as research institutes, parts of universities or academies, which are designated by the Director-General to carry out activities in support of the Organization's programs. Currently there are over 800 WHO collaborating centers in over 80 Member States working with WHO on areas such as nursing, occupational health, communicable diseases, nutrition, mental health, chronic diseases and health technologies. WHO relies on the expertise available in these centers as the professionals working in them constitute a critical mass of technocrats of excellence in the health sector. Pakistan has currently five such active collaborative centers whose role can be enhanced in view of the devolution to provide technical assistance to the provinces. There details can be seen below:

Reference	Institution name	City	Title
PAK-15	College of Physicians and Surgeons	Karachi	WHO Collaborating Centre for Training in Research and Educational Development of Health Personnel
PAK-19	Aga Khan University Karachi Pakistan	Karachi	WHO Collaborating Center for Emergency Medicine and Trauma Care
PAK-10	Rawalpindi Medical College	Rawalpindi	WHO Collaborating Centre for Mental Health Research, Training and Substance Abuse
PAK-13	Diabetic Association of Pakistan	Karachi	WHO Collaborating Centre for Treatment, Education and Research in Diabetes and Diabetic Pregnancies
PAK-14	Al-Shifa Trust Eye Hospital	Rawalpindi	WHO Collaborating Centre for Prevention of Blindness

Section 6: Implementing the strategic agenda

Implications for WHO secretariat, follow-up and next steps at each level

The Country Cooperation Strategy (2011-2017) will be a significant step in the collaborative work of WHO and the Government of Pakistan. It will streamline and strengthen the contribution of WHO to national health development under extremely peculiar circumstance of the absence of a Ministry of Health or any single entity at the federal level assigned to handle health issues. Implementation of this strategy will have considerable implications on the working of WHO at various levels and will significantly contribute to the development of its strategic vision.

Implications for the country office

In order to meet the strategic requirements arising out of the devolution and ensure strengthened provincial visibility, the Country Cooperation Strategy will necessarily have a provincial focus strongly warranting the upgrading of the WHO sub-offices in the country both in the technical and administrative capacity. The growing shift from the role of program implementation to one of an effective advocate and catalyst for strategic development of the health sector has immediate implications for the WCO Pakistan. The implications and changes are required to be adopted as soon as possible. The strengthening of the capacities of the country and sub-offices to fulfill its essential technical, managerial, advocacy, representation and partnerships functions is to be facilitated by all levels of the organization. The Provincial Operations Officers will be assigned fixed term position of National Professional Officers (NPOs) and as the heads of WHO sub-offices will lead all WHO activities in their respective provinces. They will be given a greater degree of delegated financial and managerial powers to facilitate execution of enhanced roles and responsibilities including HSS work. A focal person in WCO for each province maybe assigned to support and coordinate province specific activities.

7.1.1. Technical functions

- Stronger human resources and technical core group to be developed in the next biennium at the sub-office level, especially in the areas of health policy, strategy and programming; health systems development and health care delivery; epidemiology; mother and child health care; control of communicable diseases and stronger technical and advocacy capacity in areas relating to environmental health and health promotion.
- Stronger capacity in information sharing, knowledge management, dissemination and advocacy. Emphasis has to be placed on improving the evidence base with systemized data collection and capacity to analyse and use the data for policy inputs
- Strengthening and supporting the functions of planning, monitoring and evaluation.

7.1.2. Managerial and administrative functions

In order to assume a more proactive technical and strategic role, specific requirements include:

- Ensuring that CCS is used to inform the strategic planning as well as the biennial programme budgeting in a highly transparent manner
- Implementation of the new expanded delegation of authority to the WR from the Regional Office, commensurate with his responsibilities including flexibility to allocate, re-allocate, and spend resources within the strategic framework.
- Redefinition, revision and assessing the need of staffing at the WCO to fulfil the expected functions of the office. This has to include revision of the terms of reference (TOR) of the existing WHO country staff to incorporate the new strategic directions.
- Strengthening the roles and functions of the WHO sub-offices at provincial level. Appropriate staffing and adequate logistics have to be secured for these sub-offices to improve their performance, including recruitment of at least 3-4 fixed term national professional officers in each sub-office to handle the key issues of health system strengthening, and enabling quality implementation of MNCH, nutrition, Communicable Diseases Control and Health Promotion interventions.
- Taking the necessary arrangements for staff development and improving the attitude and skills of all members of the WHO country team including the general services staff.
- Improving the physical work environment inside the office by provision of more space and better communication system.

7.1.3. Advocacy, representation and partnership

The current visibility of WHO and the acknowledgement of its inputs and technical excellence by national and international partners need to be further strengthened. Timely flow of information between country office, Regional Office and HQ, and availability of up-to-date guidelines; and strengthening of WHO work in knowledge management and system development for facilitating access to scientific resources are among key priority areas for CCS implementation. The main strength of WHO and the platform on which it can build its technical leadership role, is its technical credibility and ability to draw on leading international expertise for the full range of specific topics and disciplines required. With the support of the Regional Office and HQ to help the Country Office with the above requirements, the three level of the Organization should be building partnerships and alliances with all segments of the civil society bring synergies, resources and unified actions between all stakeholders. CCS should lead to an expansion of partnerships with the government at district, province and federal levels, other national stakeholders like the media, local NGOs, professional associations, communities, and international organizations.

7.1.4. Implications for the Regional Office and Headquarters

The new Country Cooperation Strategy for Pakistan would require the country office to assume the lead role in decision-making and program planning and implementation at national level. The execution of this changed function and the minimal requirements stated above will depend to a large extent on the increasing transformation from decisive to supportive management at Regional Office and HQ levels. The staff at these levels of the organization will be willing to accept this change for a proactive response to the needs and requests of the country offices. It will involve new ways of thinking, enhanced operating procedures and more

effective mobilization of resources to bridge the gaps in the health system. WHO EMRO and HQ will work closely to track technical resources to support the country office activities by developing standards, guidelines and protocols and providing documents and publications. The traditional and modern communication and information technology will be utilized for the dissemination of the technical resources between different levels of WHO.

Moving focus from the Regional Office and Headquarters to the country level will necessitate moving some technical/staff capacity to the country level to provide the health systems, disease control and health promotion expertise required for WHO to take the anticipated strategic and technical leadership role. More specifically, the Regional Office will continue to:

- provide technical support and more systematic response to urgent technical requirements of the country
- Share of regional experiences (TCDC), resources (WHO-CC, regional centres of excellence) and development of guidelines and protocols especially in the priority areas in the CCS
- Strengthen monitoring and evaluation
- Mobilize and allocate additional resources to the country office.
- Build capacity of technical as well as administrative capacities of staff at country level, by involving them in regional and inter country meetings and training.

Similarly, the WHO Headquarters will provide the necessary backstopping technical and financial support to the Country Office in close coordination with the Regional Office. This synergy of efforts at the various tiers of WHO is expected to lead to an effective cooperation with the Government of Pakistan over the envisaged period.

ANNEX 1. Health Sector Aid Assistance

1. Overview of External Aid Flow and Development

- Historically, external assistance has played an important role in Pakistan's development. Between FY2003 and FY2007, Pakistan received $15.7 billion in assistance from multilateral and bilateral sources, an annual average of over $3 billion. This included project aid, budget support, and assistance for relief and rehabilitation after the earthquake of October 2005. Over time, the proportion of project aid in total external assistance has declined, reflecting increased budget support operations financed mainly by multilateral development partners. ADB and the World Bank are Pakistan's most important development partners, accounting for about 70% of Pakistan's annual external assistance in FY2007. In addition to other multilateral and bilateral development partners, international NGOs and their local partners have provided extensive assistance over the years to improve livelihoods and reduce poverty.

- The Government has significantly increased development spending in recent years. The annual development expenditure of the federal government has risen by over 235%, from PKR 129.2 billion in FY2003 to PKR 434 billion in FY2007. For FY2008, the Government planned to further increase development spending to PRs520 billion but a deteriorating fiscal situation forced it to slash the Public Sector Development Program by PRs70 billion in February 2008. Still, development expenditure totaled a robust PRs452 billion in FY2008. The increase in development spending is not confined to the federal government; in Punjab, for example, the annual development program tripled in just 3 years—from PRs50 billion in FY2006 to PRs150 billion planned in FY2008.

- The Official Development Assistance (ODA) from the members of the Development Assistance Committee of the OECD rose to $119 billion in 2008, an increase of 10 percent in real terms over 2007. However, the share of ODA in the Gross National Income (GNI) of the developed countries which rose from 0.28 percent in 2007 to 0.30 percent in 2008 remained below 0.33 percent in 2009, largely as a result of debt relief granted to Iraq and Nigeria.

- In addition to the fall in the overall target for ODA, there is also a serious problem of distribution or 'coverage' of ODA among the recipient countries. The distribution of ODA across countries is highly skewed in favour of countries in which the loaners perceive a political stake. Pakistan, which like Iraq and Afghanistan is also an ally in the war on terror, received a small fraction of the ODA per capita received by the other two countries. In 2007, the per capita ODA receipts of Iraq, Afghanistan and Pakistan were $311, $150 and $13, respectively. An equally serious problem related with ODA, from the viewpoint of the recipient country is aids volatility, which makes it difficult for them to use these resources in their development plans. Some components of aid, such as humanitarian assistance and debt relief, are inherently unstable, but even longer-term development assistance has often proved volatile, even when donor countries are not facing serious economic difficulties. *Pakistan has been a particular casualty of this volatility and unreliability*. For example, the budget for 2009-10 announced in June

2009, included a component of $ 2.3 billion as expected aid from a number of donor sources – which later became a banner group called the Friends of Democratic Pakistan – and Pakistan's development strategy for the year was predicated on receiving these funds. However, for numerous reasons, the money did not come through and eventually huge reductions had to be made in the PSDP. Similarly, the Kerry Lugar Act approved by the US Administration, has scheduled large payments to Pakistan for five years, and the Government of Pakistan has been waiting for this aid to come through so that it can be used for development purposes. The *uncertainty of even promised and agreed to aid, can make MDG targets further out of reach* of countries who hope to fill this gap through multilateral and bilateral assistance.

2. Major Partners

While American development assistance once constituted the lion's share of aid to Pakistan, the major multilateral development banks now provide more than half of all donor aid to Pakistan. Of the $4 billion in development assistance recorded by the State Bank of Pakistan in 2009, $2.6 billion came from multilateral organizations and development banks. Several non-OECD countries, most significantly China and Saudi Arabia, now give significant amounts of aid. Some bilateral donors and nearly all of Pakistan's major multilateral partners have drastically increased their funding to Pakistan in recent years (State Bank Pakistan 2009 Report)

Donors	Annual Recorded Grant Assistance to Pakistan FY 2004-2009 ($)	Donors	Annual Recorded Loan Disbursements to Pakistan FY 2004-2009 ($)
United States	268 million	ADB	1,197 million
Saudi Arabia	134 million	World Bank	986 million
United Kingdom	124 million	China	217 million
Other EC and Euro OECD members	63 million	Japan	76 million
Japan	54 million	Islamic Development Bank	71 million
Multilaterals (WFP, ADB, WB, UN, IBD)	44 million	Saudi Arabia and Kuwait	68 million
China	9 million	EIB and other Euro OCED members	34 million
Others	8 million	Other multilaterals	23 million

However, the United States is the largest source of bilateral aid to Pakistan. For FY2010, the United States has budgeted approximately $1.2 billion in economic assistance through the Kerry-Lugar Berman bill to Pakistan, with another $300 million pending through the president's supplemental request. Of this direct 176 million is anticipated for health sector support.

3. Coordination, Organization and Management Mechanisms of External AID

- It has become abundantly clear to the ministry and provincial departments as well as development partners that unless current efforts are significantly expanded in a coordinated manner, it is unlikely that Pakistan will achieve many of its health targets and the MDGs. There is a growing awareness that health outcome-related targets cannot be achieved and sustained without adequate "coordinated investment" in the systems that underpin health service delivery; that increased financing for priority disease interventions based on country priorities and sound health plans is necessary; that investment in health needs to be embedded in broader social and economic development; that countries need long-term predictable aid from development partners; that partners need to see a clear link between financing and results; and that mechanisms are needed to hold all partners accountable for their performance.

- The 18th amendment devolution scenario/envisioned changes give us a great opportunity to re-visit the need for coordination and plan systematically. There are also international initiatives such as IHP+ that can be availed to help provide a platform to bring together all the national and provincial government and other stakeholders for a unified country strategy, monitoring framework and budget overview.

4. Needs Assessment and Resource Mobilization

- It is apparent by the review of resource allocations by donors and source that the government mobilizes few external resources for the health sector. Initial estimates indicate that Pakistan mobilizes only about 11% of total expenditure from external sources, when the average for low income counties is above 14% and in Bangladesh it is more than 22% (World Bank 2009 report)

- Resource mobilization and other means of health financing should be seen as tool not just an input**.** The ministry and departments of health do not have health care financing units and have almost no health economists. They do relatively little to mobilize additional resources for the sector and have little understanding that financing can be used as a tool to direct the sector through the resource mobilization, risk pooling, and purchasing functions.

Annex-2 Provincial disparities in MNCH Indicators:

Indicators of MNCH					
Indicator Units	**Punjab**	**Sindh**	**KPK**	**Balochistan**	**Pakistan**
Total Fertility Rate (TFR)	3.9	4.3	4.3	4.1	4.1
Knowledge of contraceptive	96.9	97.3	91.9	88.2	95.7
Contraceptive Prevalence Rate (CPR)	33.2	26.7	24.9	14.4	30
Median age of Marriage	21	19.2	19.9	20.1	20.5
Unmet need of Family Planning	22.8	25.4	30.5	31.4	24.9
Neonatal Mortality rate (NMR)	58	53	41	30	54
Infant Mortality rate (IMR)	81	81	63	49	78
Under Five Mortality	97	101	75	59	94
Birth Asphyxia	23.9	21.5	18.3	16	22.1
Neonatal Sepsis	13.4	16.1	14.2	11.3	14.2
Pneumonia	12.2	13.7	17	13.8	13.3
Diarrhoea	11.9	10.1	6.8	13.1	10.8
Fully Immunized	52.6	37	46.9	35.2	47.3
TT Vaccination	59	51.2	43.2	29.7	53
Pre Natal visit	60.9	70.4	51.3	40.7	60.9
Deliveries Assisted by Skill Birth Attendant	37.7	44.4	37.9	23	39
Post Natal Check up	39.9	60	27.4	40.5	43
Maternal Mortality Ratio (MMR)	227	314	275	785	276

Annex-3: Provincial Disparities in Nutrition indicators based on the National Nutrition Survey 2011

Indicators		Provinces / Administrative Areas					Urban / Rural		Gender	
	Pakistan Overall	Balochistan	Khyber Pakhtun-khwa	Sindh	Punjab	AJK	Urban	Rural	Male	Female
Stunted	**43.6**	52.2	47.8	49.8	39.2	31.7	36.9	46.3	44.2	43.1
Wasted	**15.1**	16.1	17.2	17.5	13.6	17.6	12.6	16.1	15.9	14.3
Underweight	**31.5**	39.6	24.1	40.5	29.8	25.8	26.7	33.3	32	31

Indicators		Provinces / Administrative Areas							Urban / Rural	
	Pakistan Overall	**Balochistan**	**Khyber Pakhtun-khwa**	**Punjab**	**Sindh**	**AJK**	**FATA**	**GILGIT**	**Urban**	**Rural**
Exclusive Breastfeeding Under 6 mths	**64.7**	63.6	88.7	57.5	68.6	58	50	71.2	59.5	68.1
Introduction of Semisolid food 6-8 mths	**52.1**	48.6	36.1	49.8	64.2	36.8	55.2	52.1	69.8	45.3

REFERENCES:

1 WHO, Investing in Health, A Summary of the Findings of the Commission on Macroeconomics and Health; CMH support unit, WHO HQ, Geneva

2 Lancet • Vol 362 • July 12, 2003 • www.thelancet.com

3 Health & Fragile States Network, Health Systems Reconstruction and State-building, HLSP Institute 2008

4 GOP 2010.

5 NIPS and MII 2008.

6 Adapted from "National Health Policy 2010" draft 2010, Ministry of Health

7 A.F. Shadoul, F. Akhtar and K.M. Bile, *Review*: Maternal, neonatal and child health in Pakistan: towards the MDGs by moving from desire to reality**,** EMHJ, Volume 16, 2010 sup,

8 Demographic and Health survey 2006-07

9 Q. Kakar, M.A.Khan and K.M. Bile, Malaria control in Pakistan: new tools at hand and challenging epidemiological realities, EMJH,//vol.16 supplement 2010

10 Pakistan Demographic and Health Survey, 2006/7, National Institute of Population Studies, Ministry of Population Welfare, Government of Pakistan, Islamabad,

11 P. Metzger, N.A. Baloch, G.N.Kazi and K.M.Bile "Tuberculosis in Pakistan: reviewing a decade of success and challenges, EMJH, vol.16 supplement 2010

12 Government of Pakistan 2010.

13 Government of Pakistan 2010.

14 Health indicators of Pakistan, Heartfile, WHO and MoH, 2005

15 National Health Policy, final draft 2010

16 WHO 2005.

17 PDHS 2006/7

18 Daily Times 2009 and 2010.

19 http://202.83.164.26/wps/portal/Moh/!Ut/p/

20 http:/dev.plexushosting.com/PMDC/Statistics/

21 Database of Pakistan Nursing Council

22 Management Information System of Lady Health Workers' Program, Ministry of Health

23 Project document (PC-1) of National Maternal, Newborn and Child Health Program, Ministry of Health

24 http://www.dcomoh.gov.pk/

25 http://www.int/nha/country/pak/en/

26 Government of Pakistan, National Economic Survey 2007-08, Ministry of Finance 2008

27: http://www.pakistan.gov.pk/divisions/economicaffairs-division/media/ACT-NO-VI-2005-FISCAL-RES-DEBT-LIM-ACT.pdf

28 Sania Nishtar, Choked Pipes, Oxford University Press, Karachi, 2010

ADDITIONAL SOURCES:

The Economic Growth Strategy, Planning Commission, Government of Pakistan, 2011

Vision 2030, Planning Commission, Government of Pakistan

Medium Term Development Framework, Planning Commission, Government of Pakistan