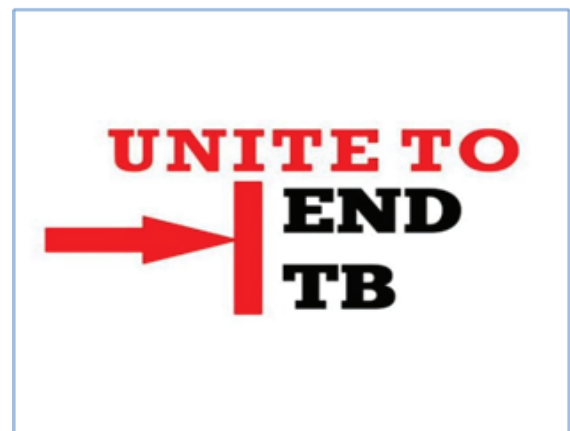
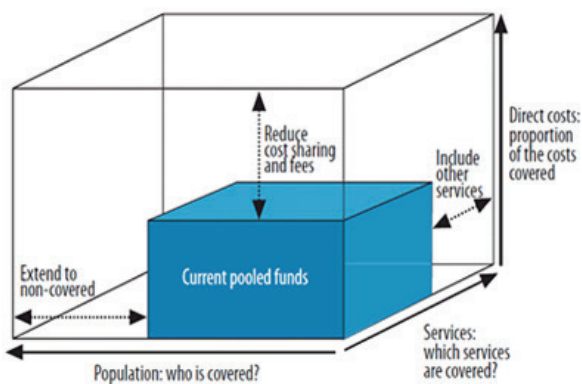


# ANNUAL REPORT HEALTH & POPULATION THINK TANK

Ministry of National Health Services, Regulations & Coordination



**HEALTH SERVICES ACADEMY**  
Islamabad



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**Ministry of National Health Services, Regulations & Coordination**

**2017-2018  
HEALTH SERVICES ACADEMY  
Islamabad**



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# ACKNOWLEDGEMENTS

Ministry of National Health Services, Regulations & Coordination acknowledges the financial and technical support extended by USAID Pakistan office and JSI Research & Training Institute Inc. for establishing and operationalizing the Health & Population Think Tank during the period of 2016-2018.



# LIST OF ACRONYMS

ACR	Annual Confidential Report	GIZ	Gesellschaft für Internationale Zusammenarbeit
ADPs	Annual Development Plans	GoP	Government of Pakistan
AIDS	Acquired Immune Deficiency Syndrome	GP	General Practitioner
AJK	Azad Jammu & Kashmir	HIV	Human Immunodeficiency Virus
AMTSL	Active Management of Third Stage of Labor	HMIS	Health Management Information System
BHU	Basic Health Unit	HPSIU	Health Planning, System Strengthening & Information Analysis Unit
BISP	Benazir Income Support Program	HPPT	Health & Population Think Tank
BPD	Biological Production Division	HR	Human Resource
CBOs	Community Based Organizations	HRH	Human Resource for Health
CCI	Council of Common Interests	HSA	Health Services Academy
CCT	Conditional Cash Transfer	HSRU	Health Sector Reform Unit
CDC	Center of Disease Control	IHR	International Health Regulations
cGMP	Current Good Manufacturing Practices	JICA	Japan International Cooperation Agency
CHX	Chlorhexidine	JSI	John Snow International
CMW	Community Midwife	KfW	Kreditanstalt für Wiederaufbau
CoC	Continuum of Care	KP	Khyber Pakhtunkhwa
COP	Community of Practice	LHV	Lady Health Visitor
CPD	Continuing Professional Development	LMICs	Low & Middle Income Countries
CRVS	Civil Registration & Vital Statistics	LSTM	Liverpool School of Tropical Medicine
CSOs	Civil Society Organizations	M&E	Monitoring & Evaluation
DG	Director General	MDGs	Millennium Development Goals
DHQ	District Headquarters	MDR	Multi Drug Resistance
DOTS	Directly Observed Treatment & Short Course	MIS	Management Information System
DRAP	Drug Regulatory Authority Pakistan	MMR	Maternal Mortality Ratio
ECNEC	Executive Committee of National Economic Council	MNCH	Maternal, Newborn & Child Health
EMRO	Eastern Mediterranean Regional Office	MoNHSR&C	Ministry of National Health Services, Regulations & Coordination
EPI	Expanded Program on Immunization	NADRA	National Database & Registration Authority
FATA	Federally Administered Tribal Areas	NFC	National finance Commission
FELTP	Field Epidemiology & Lab Training Program	NGOs	Non-Governmental Organizations
GAVI	Global Alliance for Vaccines & Immunization	NHV	National Health Vision
GB	Gilgit Baltistan	NIH	National Institute of Health
GDP	Gross Domestic Product	NMR	Neonatal Mortality Rate
GF	Global Fund	NRA	National Registration Authority
GHSA	Global Health Security Agenda	NRSP	National Rural Support Program
		NTP	National Tuberculosis Program
		NUMS	National University of Medical Sciences
		OOP	Out of Pocket

OPD	Outdoor Patient Department	RMU	Rawalpindi Medical University
P&D	Planning & Development	SDGs	Sustainable Development Goals
P4H	Partnership for Health	SHI	Social Health Insurance
PC1	Planning Commission Proforma 1	SHP	Social Health Protection
PDHS	Pakistan Demographic & Health Survey	SoPs	Standard Operating Procedures
PHC	Primary Health Care	TB	Tuberculosis
PMNHP	Prime Minister National Health Program	TBA	Traditional Birth Attendant
PMT	Proxy Mean Test	ToRs	Terms of Reference
PPH	Postpartum Hemorrhage	UC	Union Council
PPHI	Peoples' Primary Healthcare Initiative	UHC	Universal Health Coverage
PPM	Public Private Mix	UN	United Nations
QoC	Quality of Care	UNDP	United Nations Development Program
RHC	Rural Health Center	UNFPA	United Nations Fund for Population
RMNCH	Reproductive, Maternal, Newborn & Child Health	UNICEF	United Nations Children's Emergency Fund
		USAID	United States Agency for International Development
		WB	World Bank
		WHO	World Health Organization

# FOREWORD

This report encompasses the two years evolution and progress of the Health & Population Think Tank (HPTT). From the conception of the idea of creating HPTT to developing its Terms of Reference, and later inclusion and notification of its members by the Ministry is included in this report. Moreover, this report captures all the proceedings of the thematic round tables held under the aegis of HPTT, their concept notes, reports and the policy briefs developed for the MoNHSR&C and provincial health departments.

This report will be equally useful for the other line ministries, development partners, NGOs, researchers, academia and students of public health and social sciences to understand the functions and mandate given to HPTT by the MoNHSR&C, and the way it progressed and performed in the wake of its prime role assigned i.e. furnishing policy options and an action-oriented roadmap on different public health issues in the country.



# Concept Note - Health & Population Think Tank

## What are think tanks?

Globally, think tanks are solution and goal-oriented groups of experts, who deliberate, negotiate, research, critically analyze and provide solutions to different world problems. As they are policy-oriented, the research of think tanks delivers direct policy options leading to policy advice for decision makers.

The basis for the think tanks existence and the environment in which it belongs has an impact on its capacity to influence the policy-making process. Globally many governments are affiliated with think tanks directly or indirectly. The Ministry of National Health Services, Regulations & Coordination (MoNHSR&C) Health and Population Think Tank will fall under the classification of “Government-linked think tank”.

## Why it matters in health sector?

1. To facilitate development of people centered health and population policies
2. To ensure evidence-based decision making for steering health and population sectors
3. To suggest innovations in public health
4. To watch alignment of health policies and strategies with country’s overall social and economic frameworks and policies.

## Need and rationale for establishing a think tank for Pakistan

Post 18<sup>th</sup> amendment, health and population became exclusively provincial subjects with regard to policy making, financing, program implementation, and M&E.

However, after the passage of 5 years, it is felt that the rapidly changing health systems dynamics globally, influence of external factors such as poverty, environment, education, water, energy, employment etc, and implications of globalization pose serious challenges that the provincial departments of health and population might not be able to cope with. More so, to meet with the international commitments of International Health Regulations, Sustainable Development Goals, and Family Planning 2020, provinces certainly require support, advice and direction from an expert and technically sound group of professionals, and that can be formed as a think tank.

Nevertheless, there is need adopt systems approach to streamline functions by establishing platforms; to ensure implementation of National Health Vision 2016-2025, SDGs and Global Health Security Agenda; and to develop an over-arching monitoring and tracking system.

Moreover, in the **local context**, number of factors call for such an advisory group/think tank:

- a) Changing disease patterns
- b) Growing inequalities and disparities between the provinces
- c) Deteriorating allocative efficiency
- d) Dearth of Human Resource for Health, and their skewed deployments in large hospitals and urban areas
- e) Lack of skills for interpreting health information for decision making
- f) Increasing pressure of medical technologies and drugs on patient’s pocket

- g) Deficient capacity of provinces to improve governance and stewardship for a more responsive health system
- h) Absence of multi-sectoral, collaborative and integrated efforts for health system strengthening

## Vision & Aim

The main vision is to foster **multi-sectoral partnership and collaboration**, with the intention of reviewing, analyzing, debating, brainstorming, and “building healthy public policy. The main aim of the HPTT is to promote and protect the health and wellbeing of all Pakistani’s from all ethnic and religious groups.

The key **objectives** (but not exhaustive) would be:

- i. To ensure that a multi-sectoral participation and collaboration is supported.
- ii. To ensure that important thematic areas in health and population sector are deliberated upon in order to provide guidance to policy decisions, at the highest level.
- iii. To ensure that the decision making process is guided by scientific evidence, societal priorities and local realities by making use of collective wisdom.
- iv. To ensure that the concept of “Health in All Policies” is introduced and acted upon.

## ToRs Think Tank

The Think Tank will operate as an independent entity of M/o NHR&C linked to its planning/policy arm i.e. Health Planning, System Strengthening & Information Analysis Unit (HPSIU), and will be housed in an academic environment i.e. Health Services Academy (HSA). The main roles being proposed include:

- i. Identify researchable needs and conduct analysis on existing research (to inform the priority areas e.g. SDG3 for policy discussion)
- ii. Provide a platform for discussion/deliberation on priority health issues either identified by the Ministry, UN, the development partners or by the popular press/media in Pakistan.
- iii. Reviews current health policies nationally, regionally and globally
- iv. Ensure that implementation of National Health Vision is guided by scientific evidence, societal priorities and local realities by making use of collective wisdom
- v. Organize policy discussion forum/round table discussions with decorated external subject matter experts to weigh in on debates
- vi. Develop policy briefs and guidelines for knowledge uptake, as and when required by the Ministry.

## Requisites for establishing Think Tank

- i. Think Tank requires the formation of a full time staffing structure, including a technical lead person/department head, administrative staff, and researchers.
- ii. HSA will be enlisted to act as the secretariat for the Health and Population Think Tank, providing it with administrative and technical support in conducting policy research and analysis and steering the agenda for discussion. Office for the Think Tank will be established in the HSA building.
- iii. Moreover, 5-6 interns will be inducted on periodic basis for short term to assist the functions of think tank. Interns would be inducted from HSA student body or/and other notable universities.
- iv. Think Tank Board Members will be inducted based on level of expertise and availability to serve on a voluntary basis. Ideal candidates include, but are not limited to, senior level experts of both the public and private sector from within the country as well as abroad. S/he would dedicate time twice



- a year to meet to debate and deliberate on think tank's agenda, especially National Health Vision implementation and challenges faced *en route*.
- v. In addition to the board members, external subject matter specialists will be invited to provide their relevant expertise on the agenda items. Each specialist will represent their respective program areas, such as Maternal Neonatal & Child Health, Non-Communicable Diseases, or any other related departments, in each of the discussion forums.




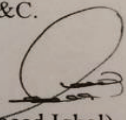
## **Deliverables**

1. Organize at least two meetings annually.
2. Generate evidence through primary and secondary research to be published in peer reviewed journals
3. Design the interns program with Universities in gathering data to support members of Think Tank.
4. Delivers direct policy options through policy briefs leading to policy advocacy for decision makers at both Federal and Provincial level.

## **Financial Support**

The Think Tank though functioning as an entity in the Federal Government, will be funded through the M/o NHR&C and grants from development partners of the Ministry.

## Notification

	<p>Government of Pakistan Ministry of National Health Services, Regulations &amp; Coordination <u>HEALTH SERVICES ACADEMY</u> *****</p>															
<div style="border: 1px solid black; padding: 2px; display: inline-block;">"SAY NO TO CORRUPTION"</div>																
F.No.4-27/2017-HPTT/HSA		March 14, 2017														
Subject:	<b><u>ESTABLISHMENT OF HEALTH AND POPULATION THINK TANK (HPTT) AT HEALTH SERVICES ACADEMY, ISLAMABAD</u></b>															
<p>In pursuance of proposal contained in the PC-1 regarding strengthening of HSA under USAID support, a think tank is being established to foster multi-sectoral partnership and collaboration, with the intention of reviewing, analyzing, debating, brainstorming, and building health policy. JSI under Health Systems Strengthening Component of USAID's MCH Program has provided necessary in-kind support for functioning till the approval of PC-1 and allocation of funds. The setup of the HPTT is as follows:</p>																
<table border="0" style="width: 100%;"><tr><td style="width: 50%;">- Dr. Assad Hafeez, Executive Director, HSA</td><td style="width: 50%;">Lead/Head of Think Tank (HPTT)</td></tr><tr><td>- Dr. Babar Tasneem Shaikh</td><td>Associate Professor/Technical Lead (HPTT)</td></tr><tr><td>- Dr. Fazli Hakeem Khattak</td><td>Advisor (HPTT)</td></tr><tr><td>- Mr. Nadeem Sajjad</td><td>Dy. Director/Focal Person for coordination with donor, logistic and administrative arrangements</td></tr><tr><td>- Internees</td><td>MSPH students to be deputed from time to time for follow-up and secretarial support</td></tr><tr><td>- Venue</td><td>Bungalow 1, CAT 1, HSA</td></tr><tr><td>- Logistics, utilities &amp; in kind assistance</td><td>JSI/HSS a component of USAID's MCH</td></tr></table>			- Dr. Assad Hafeez, Executive Director, HSA	Lead/Head of Think Tank (HPTT)	- Dr. Babar Tasneem Shaikh	Associate Professor/Technical Lead (HPTT)	- Dr. Fazli Hakeem Khattak	Advisor (HPTT)	- Mr. Nadeem Sajjad	Dy. Director/Focal Person for coordination with donor, logistic and administrative arrangements	- Internees	MSPH students to be deputed from time to time for follow-up and secretarial support	- Venue	Bungalow 1, CAT 1, HSA	- Logistics, utilities & in kind assistance	JSI/HSS a component of USAID's MCH
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- Dr. Babar Tasneem Shaikh	Associate Professor/Technical Lead (HPTT)															
- Dr. Fazli Hakeem Khattak	Advisor (HPTT)															
- Mr. Nadeem Sajjad	Dy. Director/Focal Person for coordination with donor, logistic and administrative arrangements															
- Internees	MSPH students to be deputed from time to time for follow-up and secretarial support															
- Venue	Bungalow 1, CAT 1, HSA															
- Logistics, utilities & in kind assistance	JSI/HSS a component of USAID's MCH															
<p>2. This issue with the approval of Competent Authority i.e. Secretary M/o NHR&amp;C.</p>																
		 (Saeed Iqbal) Admin Officer-HSA														
<p>Distribution: All Concerned</p>																
<hr/> <p>Health Services Academy, Chak Shahzad, Islamabad, Pakistan Tel: (92-51)9255590-94, Fax: (92-51)9255591 Email: <a href="mailto:academy@hsa.edu.pk">academy@hsa.edu.pk</a> Website: <a href="http://www.hsa.edu.pk">www.hsa.edu.pk</a></p>																

## Core Members Notified

LETTERS SENT FROM SECRETARY HEALTH'S OFFICE TO THE FOLLOWING PROPOSED MEMBERS OF HEALTH & POPULATION THINK TANK.

### 1<sup>st</sup> Cohort HPTT

1. Dr James Blanchard, Professor of Community Health Sciences, University of Manitoba, Canada
2. Dr. Sameen Siddiqi, Chair Community Health Sciences, Aga Khan University, Karachi
3. Dr Abdul Ghaffar, ED, Alliance for Health Policy & System Research, Geneva
4. Dr Mubashar Riaz Sheikh, WHO Geneva
5. Dr. Zafar Mirza, Director Health Systems, WHO EMRO, Cairo
6. Dr. Abdul Bari Khan, CEO, Indus Hospital, Karachi
7. Mr Ejaz Rahim, ex Federal Secretary
8. Ms Asma Hyder, Member Social Sector, M/o Planning, Development & Reforms
9. Mr Mushtaq Chappra, CEO Citizens Foundation, Karachi
10. Dr Mian Naeemuddin, CEO CONTECH International, Lahore
11. Dr Zulfiqar Bhutta, Sick Kids Hospital, Toronto
12. Dr Zeba Sathar, Country Representative, Population Council, Islamabad
13. Dr Inaam ul Haq, World Bank, Islamabad

### 2<sup>nd</sup> Cohort HPTT

1. Dr Adnan Hyder, Johns Hopkins School of Public health, US
2. Dr Aziz Sheikh, PCT, Edinburgh, UK
3. Dr. Amir Hossein Takian, School of Public Health, TUMS, Iran
4. Mr. Sohail Naqvi, VC Lahore University of Management Sciences, Lahore
5. Dr Mukhtar Ahmad, Chairman Higher Education Commission, Islamabad
6. Prof. Dr. Hakim Abdul Hannan, VC Hamdard University, Karachi
7. Dr. Rehan Hafiz, GAVI, Geneva
8. Dr Karima Saleh, Health Economist, World Bank
9. Dr Khalif Bile, International Consultant
10. Dr Senait Fessiah, The Susan Thompson Buffett Foundation, US

Note: All DGs and Secretaries of provinces/areas DoHs and Heads of UN agencies and development partners are invited as ex-officio members.



# Report: Core Group Meeting of Health and Population Think Tank

## Ministry of National Health Services, Regulations & Coordination May 15, 2017

The first meeting of the Health & Population Think Tank was hosted by Ministry of National Health Services Regulation and Coordination (MoNHSR&C) on May 15, 2017 at Islamabad Serena Hotel. The main objective of the meeting was to introduce the members and to inform about the background and terms of reference of the Health and Population Think Tank (HPTT).

The meeting was chaired by the Secretary Health who introduced the HPTT as an independent entity of M/o NHSR&C linked to its planning/policy arm i.e. Health Planning, System Strengthening & Information Analysis Unit. Welcoming the members of HPTT, he shared that this Government-linked think tank has been established to create a forum where experts like you can get together to deliberate on important national health issues, and guide the ministry to decide its course of action. He remarked that the ministry is cognizant of the fact that after the 18th constitutional amendment, health and population became exclusively provincial subjects. Yet, there are several factors in interplay globally, regionally and even locally at national level, which called for establishing a think tank for Pakistan, particularly international commitments compliance such as International Health Regulations, Sustainable Development Goals, and Family Planning 2020 to mention a few. He said that the M/o NHSR&C will seek HPTT members' valuable perspectives on some of the key national health issues specially to support and advice the provinces to translate the National health Vision 2016-2025 into their next health strategies.



Director General Health presented a comprehensive background of the creation of HPTT. He said that post-18<sup>th</sup> constitutional amendment, health and population became provincial subjects with regard to financing, program implementation, and others. Nevertheless, there are certain constitutional roles for federal government including Coordination among all stakeholders. He presented the vision of HPTT which is to foster multi-sectoral partnership and collaboration, with the intention of reviewing, analysing, debating, brainstorming, and “building healthy public policy. Key objectives of HPTT will be to ensure a multi-sectoral participation and collaboration to deliberate and guide decisions of the government regarding health and population sector in the light of credible evidence, societal priorities and local realities. He briefed the participants that this meeting is an ice-breaking and to listen to members' ideas about the constitution of HPTT and its envisaged roles and functions.





Technical Lead HPTT presented the proposed structure and composition of Think Tank, its membership criteria, and expected contributions from the members. ToRs of the HPTT were presented at this occasion which are: a) Identify researchable needs and conduct analysis on existing research (to inform the priority areas e.g. SDG3 for policy discussion; b) Provide a platform for discussion/deliberation on priority health issues either identified by the Ministry, UN, the development partners or by the popular press/media in Pakistan; c) Reviews current health policies

nationally, regionally and globally; d) Ensure that implementation of National Health Vision is guided by scientific evidence, societal priorities and local realities by making use of collective wisdom; e) Organize policy discussion forum/round table discussions with decorated external subject matter experts to weigh in on debates; f) Develop policy briefs and guidelines for knowledge uptake, as and when required by the Ministry. He shared with the members that HPTT will deliver direct policy options through policy briefs leading to advocacy with decision makers at both Federal and Provincial level.

Advisor HPTT highlighted the need for HPTT linkages with the other ministries as well as the provinces. He shared that HPTT will liaise with the province and will identify priority themes to be discussed on this platform. It is envisaged that provinces will benefit from the HPTT members' vast experience and insights. He also briefly captured the proceedings of the first round table held on the theme of Indigenization of vaccine production in Pakistan, and showed the process of developing a paper for the ECNEC.

## Discussion

- i. It was agreed that the major focus of the HPTT shall be facilitation of health policy planning. The think tank is envisioned to serve as a forum to decide future direction and action in regards to health system reforms and strengthening. The 18<sup>th</sup> constitutional amendment has posed newer challenges for the provinces and one of the major roles of the HPTT will be to give policy guidance to the provinces to cope with these challenges.
- ii. The technical and financial gaps in the health system were discussed in detail and it was agreed upon that the HPTT will handle the priority agenda items in terms of improving the health system in Pakistan. The role and contribution of donors in this regard was also discussed in detail.
- iii. Involvement and representation of the provinces in HPTT was emphasized and that it is crucial to the success of the initiative.
- iv. A multi-sectoral approach towards addressing the current issues was agreed upon. It was discussed that involvement of all sectors of life is essential to improve the health status of the population in Pakistan.
- v. The issue of dearth of research in Pakistan was highlighted. It was iterated that the HPTT will not conduct new research but rather promote and facilitate academic and research institutions to conduct research. The role of HPTT is envisioned to assimilate present and future evidence to guide policy making and action.
- vi. Members agreed that Public health has taken a huge momentum in Pakistan but still the health indicators and outcomes pose a very grim picture. What is needed now is to give direction to this momentum otherwise this momentum will die away and the opportunity of taking advantage of such a momentum to improve the health system will be lost.
- vii. It was discussed that Pakistan is a middle-income country and the government is committed to improve the financial allocations to health. However, the out of pocket expenditure for the people is

still very high. Some participants commented that the health system in Pakistan is donor dependent. This misconception was cleared by DG MoNHSR&C stating that more than 90% of the health expenditure in Pakistan is Government contribution and the donor contribution is just a small portion. However, forum like HPTT must brainstorm as to how to lower out of pocket expenditure and broaden the social health protection issues.

- viii. Universal Health Coverage (UHC) was flagged as one of the goal of the government, but the population growth rate is very high and this population explosion is posing potential threat to achieving UHC. Moreover, it was suggested that the budget allocations also need to be improved if the target of UHC is to be made a reality. It was proposed that HPTT should provide technical inputs in this regard.
- ix. Another major role suggested for HPTT will be to develop a gap map to identify weaknesses in the system and come up with practical solutions to plug these gaps. There was a great emphasis from the participants on focusing on the social determinants of health for improving health outcomes for the people of Pakistan.
- x. To institute close monitoring of the SDG targets, it was shared that the MoNHSR&C has established a Health Planning, System Strengthening and Information Analysis Unit, and crated a Health Dashboard to provide policy guidance and provide the provinces with critical analysis for focused planning and action.
- xi. Another area discussed was alternative medicine sector such as *Hikmat* and Homeopathy, and the need to mainstream it in the larger health system. Representation from these disciplines should be encouraged and should be made a part of the National Health Policy.
- xii. Members suggested that there is a need for the core group of HPTT comprised of relevant people so that targeted and focused working could be ensured. The core group needs to be a closed group which is outcome focused. The core group should be able to provide technical insights and ensure healthy public policy which is evidence informed.
- xiii. Members emphasized that the role of MoNHSR&C should be very clear for technical guidance and policy direction to the provinces. Moreover, it was suggested that ministry must act are bridge between the provinces and the international development partners. Involvement of all sectors is the key to improving quality of care in Pakistan and this should be a topic for deliberation and brainstorming for the HPTT.
- xiv. DG MoNHSR&C said that HPTT is still in the learning and evolving process and inputs from the technical experts will help in crafting a responsive and efficient role to assist the health system in Pakistan.
- xv. Action items
  - a. An e group of HPTT will be formed for all future communications and for the participation of the distant group members.
  - b. Provinces should be given due representation on the HPTT forums.
  - c. Concept note and ToRs of HPTT will be reviewed again by members of HPTT, in order to tune it to the needs and dynamics of the health sector of the country.
  - d. HPTT must define a core group within its larger membership, and it should be outcome focused.

## Conclusion

In the end, Secretary MoNHSR&C informed that there are enough resources available to the health sector and there is a need to allocate right resources to the priority issues. The success of all endeavors will depend upon a strong will, resilient commitment and sincere efforts. Secretary MoNHSR&C discussed a concept note on social health protection which has been submitted to the Prime Minister. HPTT is expected to provide the costing, budgeting and calculations for this concept note which will go into a detailed proposal to be presented to the Prime Minister. Moreover, HPTT is expected to provide evidence of best practices in implementing such a program.



He thanked all the HPTT members for their willingness to join and contribute their time to HPTT, and hoped for a constructive interaction among the members in the forums to come, assisting the MoNHSR&C in deciding its future course of action particularly in line with the National Health Vision 2016-2025.



## Round Table Meetings

### 1. Indigenous Production of Vaccines in Pakistan

#### Concept Note

Vaccines are cost effective and most efficacious agents for treating infectious diseases and for saving millions of lives every year. Expanded Program of Immunization (EPI) in Pakistan vaccinates around 6.8 million children each year. The EPI was established in 1978 with smallpox eradication, and was rapidly followed by the introduction of 5 antigens within the national immunization schedule (BCG, Polio, DPT). Currently, the program offers more than 9 antigens (DPT-HepB-Hib, OPV, BCG, IPV, Measles, PCV). Rota would be introduced in 2017. Timely and effective administration of these vaccines saves millions of lives each year.

With the given population growth rate and the burden of disease, the demand and need for vaccines for communicable diseases is exorbitantly increasing every year in Pakistan. Government of Pakistan procures vaccines of around PkRs22-25 billion, comprising various EPI antigens and vaccines from UNICEF as well as non-EPI vaccines from the local market. This expense causes huge encumbrance on the government exchequer. Many other regional and neighboring countries manufacture and maintain their own requisite vaccine demand. Examples are China, Indonesia, India and Iran to name a few. Egypt and Tunisia although do not fully meet their country needs but are geared to achieve self-reliance. Strategic vaccines (EPI schedule) apparently is warranted via UNICEF; however, calamity vaccines e.g. cholera, typhoid, tetanus, rabies, snake bite etc. need to be produced indigenously in required quantities.

National Institute of Health (NIH) established in 1965, and given the autonomy in 1980, carried the mandate of vaccines and sera production for prophylactic and therapeutic use, and was supposed to cater not only the domestic but also the foreign demands. NIH possesses a modest infrastructure, human resource and technical capability of performing this function. However, for a variety of reasons and impediments, its performance has been not up to the mark in terms of production, and its capacity has been undermined vis-à-vis its potential. Up gradation of technology, capacity enhancement of the HR, and physical expansion are essential requisites to meet the current good manufacturing practices (cGMP) requirements.

The Biological Division of NIH produces life-saving vaccines and anti-sera for immunization and therapeutic use to control the communicable diseases in the country. This division could have been one of the major revenue-generating department of NIH. Through its current revenues the institute not only supports the significant expenditures of this division, but also operational expenses of its various other divisions and sub-divisions. Only traditional vaccines are currently produced with using basic technologies. The vaccines produced here include antigens for Cholera, Typhoid, Measles, Rabies and Tetanus, and are available at affordable prices. Similarly, anti-sera produced are used for the treatment of snakebite and animal bite. Moreover, oral rehydration salt is produced to counter the diarrheal diseases.

In the private and commercial sector, there are multiple companies involved in vaccines business, notably GSK, Amson, Ferozsons, Sanofi, Bayer, Novartis, Wyeth and few other smaller producers. They produce different anti sera and antigens in different quantities according to their capacity, and demand of the market, inclusive of GoP. Examples are vaccines such as tetanus, typhoid and hepatitis B are produced from imported bulk; and labeling /packing of naked vials of rabies vaccines mainly used in the private sector.

To bridge the gap of supply and demand of vaccines, development partners and donors pitched in their resources and expertise to assist the Immunization efforts of the GoP, and to date GAVI, UNICEF, WHO,

WB, JICA, USAID, CDC, Gates etc. have been providing financial as well as the technical assistance in this regard. Nevertheless, major financier of EPI remains the GoP and a large proportion of allocations are consumed in one head i.e. procurement of vaccines. This money could potentially be saved or spent in an economized manner for the sake of improving other deficiencies of the program.

WHO observatory requires any country to meet the following pre-requisites for indigenous vaccines production:

- a) Licensing
- b) GMP
- c) Lab access
- d) Lot release
- e) Surveillance
- f) Clinical trail

Questions for deliberations call for pondering in different aspects of this serious matter brought to the attention of MoNHSR&C, Planning Commission and Ministry of Finance.

1. Should Pakistan improve its readiness and capacity to start manufacturing its own vaccines?
2. What is needed to achieve self-sufficiency and self-reliance in vaccines production in this given scenario?
3. Will manufacturing be more feasible in public sector (NIH) or should it be mandated to the private for-profit sector?
4. How the private sector be regulated for quantity, quality (safety and efficacy), and prices?
5. What should be the role and responsibilities of the GoP (MoNHSR&C, NIH, DRAP, EPI, Provinces)?

## Report

# Indigenous Production of Vaccines in Pakistan

Health & Population Think Tank, M/o NHR&C, Islamabad

March 27<sup>th</sup>, 2017 at Health Services Academy

## Background

The vaccine industry has reinvented itself in the past decades since Pakistan was producing vaccines, by bringing innovations (such as virus like particles (VLP), re-assortment, and deletion mutation, reverse vaccinology, administration routes) to the traditional manufacturing processes. These changes are transforming the vaccine industry environment, increasing the entry barriers, making the regulation more stringent and the market very multi-faceted<sup>1</sup>. Consequently, there has been reduction of the number of manufacturers in the world. In 1997, there were at least 55 countries producing vaccines<sup>2</sup>, in 2015, less than 20 countries have any kind of vaccine production facilities in place. Almost all the public sector vaccine manufacturers disappeared with very few exceptions for countries with large populations or captive markets.

Further there is a concentration of the number of vaccine manufacturers due to mergers and acquisitions which have been quite active over the last 2 decades, with a great acceleration in the recent period ending with the formation of 4 mega-producers of vaccines (GSK, Pfizer, Sanofi Pasteur and Merck) representing more than 80% of global sales by value.

Now even in its most basic form vaccine manufacturing is a complex, highly regulated set of processes. It is significantly different from the manufacture of solid form pharmaceuticals. Each vaccine is different requiring different manufacturing processes, some are more basic while others are complex in terms of equipment and knowledge. The development of vaccine manufacturing is neither fast (5-20 years from inception to first possible output) nor cheap (minimum basic investment US\$100m) both factors based on many different criteria and can vary dramatically. The barriers to entry are considerable at many levels and delays are all but inevitable in any road-map of action. Experiences from other countries indicate the potential challenges and may offer some solutions; these should be closely assessed for relevance in the Pakistan context.



<sup>1</sup> VPMA study report 2015.

<sup>2</sup> Milstien J, Batson A, Meaney W. A systematic method for evaluating the potential viability of local vaccine producers. Vaccine 1997; 15: 1358-63.



Of primary importance in any vaccine manufacturing are the quality, safety and efficacy of the end products. Vaccines are in the most part provided as preventative measure to otherwise healthy individuals particularly infants and mothers. Any vaccine procured or produced should therefore meet the highest quality standards to ensure best possible coverage of vaccine preventable disease and maintain the highest level of public confidence. Therefore, the need to have a fully functional NRA as assessed to internal standards with the ability to either perform or access all the necessary functions is of utmost importance.

## Questions posed by the MoNHSR&C

### 1. Should Pakistan improve its readiness and capacity to start manufacturing its own vaccines?

Milstein et al (1997)<sup>1</sup> identified seven factors to viable production listed below, to successfully address this question. These factors would have to be adequately considered in the Pakistan context. The below table indicates a brief summary response to these indicators with the information available at this stage. By analyzing the characteristics of successful producers, seven critical elements were identified for viability, each defined by several indicators:

Indicators	Pakistan initial evaluation
1. Economics/scale given volume and product portfolio	Pakistan has the current and projected population required to sustain indigenous production.
2. GMP and consistency of production	None of the facilities under the oversight of NIH BPD meet current GMP requirements, most of them are more than 25 years old with minimal up-gradation. Two options could therefore be considered: the assessment of up-gradation potential of these facilities or starting from a clean slate.
3. Historical ability and systems in place to access new technologies	While there was in the past some vaccine production in Pakistan, there is little experience with accessing new technologies.
4. Historical performance to meet demand and to scale up production	Historical vaccine production was not sufficient to meet the national demand or to scale up production.
5. Credibility of quality and the power of the NRA	The Pakistan NRA (DRAP) is well established but does not currently meet international standards to effectively monitor and regulate local vaccine production. Past WHO reviews have made recommendations on what action needs to be taken to meet the standards. These recommendations need to be prioritized, funded and acted on utilizing the available (external) resources to achieve the necessary standards.

6. Management structure:	Reviews of NIH BPD <sup>3,4</sup> have concluded that significant changes to the management and governance structure of BPD would be required to achieve effective vaccine production.
7. Legal status, adequate autonomy	Reviews have also provided considerable feedback on the necessary changes required in Legal status and autonomy, neither of which are optimal from a manufacturing perspective currently.

## 2. What is needed to achieve self-sufficiency and self-reliance in vaccines production in this given scenario?

Self-sufficiency is not achievable in vaccine production. The variety of vaccines used in the Pakistan (just within the EPI program) is considerable. The variable complexity of processes and manufacturing of these vaccines would make it extremely difficult to achieve self-sufficiency even within a very long time frame (20+ years). In addition, a number of the new vaccines are under IP protection which would not allow for local production in the strictest sense.

While many stakeholders have expressed an interest in reinvigorating vaccine production in Pakistan the target level of production on the value chain has not been articulated<sup>5</sup>. The goal of any activities needs to be focused to ensure all stakeholders have the same level of expectation.

### Vaccine Manufacturing Value Chain



Currently BPD is involved in the distribution of imported vaccines (Level One), some stakeholders consider the level of attainable vaccine production to be fill and finish from bulk (Level Three) while others consider that Pakistan should be able to achieve all 5 levels of manufacturing. At this point, there is no consensus in this regard but other factors also come into play such as:

- Which vaccines?
- What volumes?
- Availability of favorable ecosystem: o Equipment and materials?
- Reliable infrastructure
- Knowledge and HR capacity?

## 3. Question Three: Will manufacturing be more feasible in public sector (NIH) or should it be mandated to the private for profit sector?

There is certainly not enough available information to provide a definitive answer to this question. However, a number of considerations should be taken into account:

- For at least the last 9 years since the reviews of NIH and the question of reinvigorating indigenous vaccine production have been raised again, little to no action has been taken on the recommendations

<sup>3</sup> Pakistan Vaccines and Biological: An Analysis for Indigenous Growth, January 2008.

<sup>4</sup> Restructuring of National Institute of Health WHO July 2008

<sup>5</sup> Adapted from WHO-UNIDO AVMI VPMA Study Presentation 2015.

made in regards to NIH BPD. No official review of the failure to act on the recommendations has taken place. It is however suspected that there has been little appetite to proceed.

- Previous attempts to engage with private sector have not come to fruition, this should be further investigated.
- The government's role in attracting private sector involvement in vaccine production needs to be considered. Its primary roles would be policy, legislative and regulation. However, obstacles to entry should be determined to ascertain the necessary actions to create a more enabling environment to support private sector involvement should this be the course of action undertaken.
- Experiences from other countries show that the most successful outcomes have been achieved through Public-Private Partnership. However, there is huge variability in the measure of "success" and a review of the different models and arrangements is of first importance.
- Technology transfer is a term used very broadly in the vaccine world and can mean very different things to different people. It is not however a "cure-all" or a simple way of reinitializing vaccine production. Tech transfer can cover such a wide variety of activities and knowledge and exchange with partners other than simply multi-nationals<sup>6</sup>. An extremely clear laid out plan of action with structured timed deliverables are required to ensure any agreement between two or more parties actually results in the desired outcome. This requires a great deal of knowledge and skills to establish, to ensure a practically feasible agreement.
- There is a tech transfer facilitating group in WHO which can provide advice and information on this aspect.

#### 4. How the private sector be regulated for quantity, quality (safety and efficacy), and prices?

This question should be separated into:

- a) Quality and Safety
- b) Quantity
- c) Pricing

The answer to 4a is quite simple: Pakistan will need a fully functional national regulatory authority. As indicated previously the DRAP will be required to put in place a clear appropriately timed, financed and achievable plan of action to reach all the necessary international standards. These activities should be initiated immediately and operate in parallel with any further action on vaccine production development. The DRAP should be involved throughout any vaccine production development process as both an oversight and advisor, to ensure that the standards of production will ultimately meet the international standards incorporated into their own policies and practices.

Quantity (4b) is an interesting question at this stage and one that requires considerably more analysis. As noted previously vaccine production development is not a quick process. There is no point in developing a plan to produce a vaccine that will no longer be relevant or used when ultimately the production facility would be online. The example in the table below is provided to be illustrative rather than specifically indicative.

Vaccine Used 10+ years ago	Vaccines used today	Vaccines tomorrow?
DTP or DTP	DTPHepBHib	DTPHepBHibIPV
TOPV	BOPV, IPV	DTPHepBHibIPV
Measles	MR, MMR	MMRV

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<sup>6</sup> Examples provided in presentation by Jan Hendricks Intervac. 27 March 2017



Consideration needs to be given to the quantities required in the future based on projections of population growth, antigens utilized/needed in Pakistan, likely global supply and demand and potential pricing. Local production should not limit clinical choice. If there is a need for a vaccine and a clinical and programmatic recommendation to implement that vaccine is appropriately made, it should be considered irrespective of the ability to locally produce it.

Pricing (4c) does not have a simple answer either; newer vaccines are not cheap but relatively some of the older vaccines are, the price of a vaccine is determined by:

- The complexity of manufacturing processes;
- Level of competition
- Size of demand
- Supply capacity
- Market accessibility
- Procurement and contracting terms
- Patents and IP management

Just because a product can be manufactured locally does not automatically mean it will be cheaper than the importation options. An example provided during discussion noted that while local manufacturer could, in principle, make a less complex traditional vaccine, how much added value is the fact it is locally produced? Would it be worth 3 times the price of an imported product? Further some of the arrangements that have been put in place in order to allow for development of locally manufactured (form and fill) versions of newer vaccine have required the country to agree to pay higher prices to subsidize the investment made by the company onto local manufacturing. For each vaccine considered for any local production an analysis of viability in terms of market and price would need to be considered.

## **5. What should be the role and responsibilities of the Government of Pakistan (MoNHSR&C, NIH, Drug Regulatory Authority (DRAP), EPI, Provinces)?**

Ultimately the answer to this question depends very much on the structure of any road map and action plan agreed. With the exception of the DRAP which has a very clear mandate in these activities. The government has a clear role in legislative, policy and regulation to create an enabling environment to support local production whether public, private or mixed. The NIH and EPI will continue to have a role in ensuring the security of supply of vaccines and the best possible outcomes in terms of vaccine preventable disease in Pakistan. Their experience along with their colleagues at a provincial level is essential in forecasting demand both short and long term.

## **Additional questions and issues raised during the Roundtable**

**GAVI Graduation** – The issue of reducing donor support due to potential graduation specifically from GAVI was raised as a concern both in terms of increasing need for foreign exchange for the importation of vaccines each year and post-graduation pricing. The exact date of the start of the graduation process from GAVI is at this time unknown due to the reliance on the prediction of likely GNI in the future, however it could be assumed that this process may start within the 5 to 8 years. The current graduation process once initiated takes 5 years increasing annually until the full financial burden is borne by the government. However, preparing for this scenario should start as early as possible. It is however unlikely that significant local production could be in place that would significantly minimize the impact of the need for foreign exchange in that period. Gavi and partners have put in place post-graduation price ceilings

for some products even when procured solely with government funds as long as these products continue to be procured through their procurement partner, UNICEF Supply Division. Further information on current graduation policies and post-graduation pricing is available from Gavi.org.

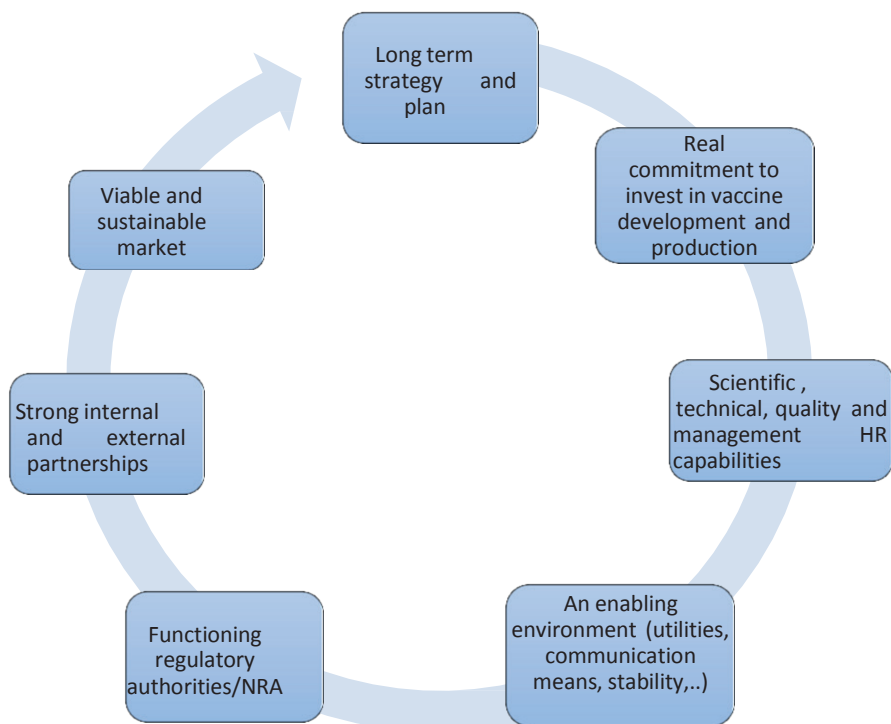
**Current predominate supply from India** - Pakistan EPI is predominately supplied by Indian manufacturers through the procurement services of UNICEF Supply Division (SD). This is because logistically this is the most financially efficient allocation, the cost of transport from other manufacturers would significantly increase the overall cost of delivery to country. This current supply method used by Pakistan does afford risk mitigation and also ensures the lowest possible prices for many of the expensive vaccines. The UNICEF SD system mitigates the supply risk through the pooling of demand and allocation of global supply across countries and suppliers. One of the concerns raised was a reliance on India, that risk could be mitigated by using other manufacturers acknowledging that this may result in a price increase to the overall delivered price. Should Pakistan choose to minimize its reliance on Indian manufacturers it should consider the potential increase in cost versus the no additional health benefit of this action.



### Proposed Next Steps and Action Points

Not all of the questions and issues can be addressed with the information available at this time. The documentation and various meetings have highlighted the need for a strategic road-map to be developed to fully inform decision makers before taking any specific significant steps such as issuing an EOI etc. The following critical factors were highlighted during the Roundtable discussion.

### Critical Factors to Successful Vaccine Production





There are key pieces of the road map that require further evaluation to ensure the most accurate information is made available and that expectations are aligned. The gaps in information need to be filled. It is therefore proposed that MoNHSR&C should commission a multi-faceted analysis using the tools and expertise of partners and stakeholders to address the information gaps. One of the established taskforce teams or committees could be utilized to oversee, monitor and facilitate the progress of the analysis. These types of analyses have been conducted in other countries and advice could be sought from partners to help inform any development of the project ToRs etc. The analysis could include but potentially not be limited to the following areas of investigation:

With assistance from the WHO under its NRA development program; the development of the NRA plan of action to achieve WHO prequalification, the timing, financial and HR requirements to achieve the necessary outcomes:

- 1) A review of the production potential of the BPD manufacturing facilities for potential up-gradation or building new facilities; what are the current skills and expertise what likely vaccines could be produced. Review should include availability of supportive infrastructure;
- 2) With inputs from NIH, EPI, the provinces and international strategic demand forecasts develop a scenario-based demand forecast of needs in 5, 10 and 20 years for vaccines, antigens, presentations and formulations.
- 3) Utilizing the technology transfer hub at WHO investigate potential options for technology transfer in terms of systems and processes as well as end product options;
- 4) In consultation with potentially interested private entities conduct a needs assessment of the options for government to create an enabling environment for private overseas investment either in a PPP or predominantly commercial environment.
- 5) Conduct a more in-depth assessment of the structure and function of other local manufacturers around the world focusing on the opportunities, challenges and solutions they provide.
- 6) Based on the outcomes of analyses 2-6 conduct a cost effectiveness, impact and return on Investment analyses considering counterfactual alternatives to local production;
- 7) Map the potential innovative financing options available to Pakistan to achieve its ultimately articulated goal.

Using the information gathered from these various facets of enquiry, the oversight committee could then develop a road map incorporating the views of each of the stakeholders for ultimate decision makers.



## Policy Brief

March 2017

## Indigenous Production of Vaccines in Pakistan

Vaccines are cost effective and most efficacious agents for treating infectious diseases and for saving millions of lives every year. Expanded Program of Immunization (EPI) in Pakistan vaccinates around 6.8 million children each year. The EPI was established in 1978 with smallpox eradication and was rapidly followed by the introduction of 5 antigens within the national immunization schedule (BCG, Polio, DPT). Currently, the program offers more than 9 antigens (DTP-HepB-Hib, OPV, BCG, IPV, Measles, PCV). Rota would be introduced in 2017. Timely and effective administration of these vaccines saves millions of lives each year.



With the given population growth rate and the burden of disease, the demand and need for vaccines for communicable diseases is exorbitantly increasing every year in Pakistan. Government of Pakistan procures vaccines of around PkRs22-25 billion, comprising various EPI antigens and vaccines from UNICEF as well as non-EPI vaccines from the local market. This expense causes huge encumbrance on the government exchequer. Many other regional and neighboring countries manufacture and maintain their own requisite vaccine demand. Examples are China, Indonesia, India and Iran to name a few. Egypt and Tunisia although do not fully meet their country needs but are geared to achieve self-reliance. Strategic vaccines (EPI schedule) apparently is warranted via UNICEF; however, calamity vaccines e.g. cholera, typhoid, tetanus, rabies, snake bite etc. need to be produced indigenously in required quantities.

National Institute of Health (NIH) established in 1965, and given the autonomy in 1980, carried the mandate of vaccines and sera production for prophylactic and therapeutic use, and was supposed to cater not only the domestic but also the foreign demands. NIH possesses a modest infrastructure, human resource and technical capability of performing this function. However, for a variety of reasons and impediments, its performance has been

not up to the mark in terms of production, and its capacity has been undermined vis-à-vis its potential. Up gradation of technology, capacity enhancement of the HR, and physical expansion are essential requisites to meet the current good manufacturing practices (cGMP) requirements.

The Biological Division of NIH produces life-saving vaccines and anti-sera for immunization and therapeutic use to control the communicable diseases in the country. This division could have been one of the major revenue-generating department of NIH. Through its current revenues the institute not only supports the significant expenditures of this division, but also operational expenses of

its various other divisions and sub-divisions. Only traditional vaccines are currently produced with using basic technologies. The vaccines produced here include antigens for Cholera, Typhoid, Measles, Rabies and Tetanus, and are available at affordable prices. Similarly, anti sera produced are used for the treatment of snakebite and animal bite. Moreover, oral rehydration salt is produced to counter the diarrheal diseases.

In the private and commercial sector, there are multiple companies involved in vaccines business, notably GSK, Amson, Ferozsos, Sanofi, Bayer, Novartis, Wyeth and few other smaller producers. They produce different anti sera and antigens in different quantities according to their capacity, and demand of the market, inclusive of GoP. Examples are vaccines such as tetanus, typhoid and hepatitis B are produced from imported bulk; and labeling /packing of naked vials of rabies vaccines mainly used in the private sector.

To bridge the gap of supply and demand of vaccines, development partners and donors pitched in their resources and expertise to assist the Immunization efforts of the GoP, and to date GAVI, UNICEF, WHO, WB, JICA, USAID, CDC, Gates etc. have been providing financial as well as the technical

assistance in this regard. Nevertheless, major financier of EPI remains the GoP and a large proportion of allocations are consumed in one head i.e. procurement of vaccines. This money could potentially be saved or spent in an economized manner for the sake of improving other deficiencies of the program.

WHO observatory requires any country to meet the following pre-requisites for indigenous vaccines production: a) Licensing, b) cGMP, c) Lab access, d) Lot release, e) Surveillance, and f) Clinical trial.

The current state of affairs calls for pondering in different aspects of this serious matter brought to the attention of MoNHSR&C, Planning Commission and Ministry of Finance. The Health & Population Think Tank convened a round table meeting to discuss challenges and potential way forward around indigenization of vaccine production in Pakistan. The round table meeting aimed to generate discussion in order to figure out the answer of the following questions:

1. Should Pakistan improve its readiness and capacity to start manufacturing its own vaccines?
2. What is needed to achieve self-sufficiency and self-reliance in vaccines production in this given scenario?
3. Will manufacturing be more feasible in public sector (NIH) or should it be mandated to the private for profit sector?
4. How the private sector be regulated for quantity, quality (safety and efficacy), and prices?
5. What should be the role and responsibilities of the GoP (MoNHSR&C, NIH, DRAP, EPI, Provinces)?

At present, the country has the current and projected population required to sustain indigenous production. However, none of the facilities under the oversight of NIH meet current GMP requirements, most of them are obsolete and must be replaced, or need major up-gradation. Self-sufficiency is not achievable in

vaccine production with the current HR, technology, and infrastructure. Reforms are needed in the management and governance structure of the Biological Production Department in NIH. Moreover, DRAP is well established, but still lacks international standards to effectively monitor and regulate local vaccine production. If NIH's capacity and appetite for vaccine production is limited, then the government's role in attracting private sector involvement in vaccine production needs to be considered, ascertaining the necessary actions to create a more enabling environment. WHO *en route* can play its part by facilitating technology transfer.

#### Action items:

- i) Government to limit its role in legislation, policy and regulation to create an enabling environment to support local production whether public, private or under PPP.
- ii) NIH and EPI to ensure the security of supply of vaccines and the best possible outcomes in terms of vaccine preventable disease in Pakistan.
- iii) DRAP to be mandated for ensuring the standards of production meet the international standards.
- iv) Exact quantities to be calculated carefully in the wake of projections of population growth.
- v) For each vaccine considered for any local production an analysis of viability in terms of market and price would need to be considered.
- vi) MoNHSR&C to commission a multi-faceted analysis in order to determine:
  - a. Capacity building needs of DRAP for meeting WHO criteria.
  - b. Vaccine production potential of NIH as well as interested private sector.
  - c. Options for technology transfer i.e. systems, processes, or end product.
  - d. Cost effectiveness, impact and return on Investment analyses considering counterfactual alternatives to local production.

This policy brief was developed in pursuance of the ECNEC meeting held on 8<sup>th</sup> March, 2016 considering the EPI PC-1 worth Rs37.47 billion, directed that the vaccines production shall be indigenized, to meet the national requirements. Besides the round table deliberations, key documents consulted for this brief included: i) Pakistan Vaccines and Biologicals; An Analysis for Indigenous Growth January 2008; ii) Restructuring of National Institute of Health, WHO July 2008; and iii) Indigenization of Vaccine Production: Report of the Vaccine Advisory Committee 2016.

## 2. Social Health Protection in Pakistan

### Are we moving towards achieving the Universal Health Coverage?

#### Concept Note

To overcome financial constraints and enhance access to health care, different social protection mechanisms have been launched worldwide. These range from supply side financing for national health services covering for certain preexisting chronic diseases and fatal injuries to demand side or output based financing (vouchers and conditional cash transfers) to cover specific and limited health services such as family planning. Many governments also arrange budget transfers into these systems in order to ensure their financial sustainability [equally to extend population coverage to those who cannot afford to pay contributions or those from whom it is difficult to collect contributions]. The other popular form is the output based financing or targeted vouchers. In Bangladesh, Kenya, Nicaragua, Ghana, Cambodia, Taiwan and lately in Pakistan, vouchers or output based financing has demonstrated a convincing effect on health and health services utilization. Conditional Cash Transfers (CCT) help breaking the cycle of poverty through the development of human capital, by inculcating behavioral changes towards health. Colombia, Guatemala, Mexico and other Latin American & African countries have lot of success stories in this regard. Nonetheless, social health insurance (SHI) is one of the most popular and authenticated organizational mechanisms for revenue raising, pooling and purchasing health services, along with tax-financing, private health insurance, community insurance, and others. Typical in most European countries, where working people and their employers, as well as the self-employed, pay contributions that cover a package of services available to the insurees and their dependents. In most cases they are obliged to make these contributions by law. Social Health Insurance programs of Philippines, Thailand and Mexico are some success stories:

- a) The Philippine Health Insurance Corporation (PhilHealth) was created in 1995 to implement universal health coverage in the Philippines. It is a tax-exempt, government-owned and government-controlled corporation, attached with the Department of Health. In 2010, it claimed to have achieved "universal" coverage at 86% of the population. This social insurance program provides a means for the healthy to pay for the care of the sick and for those who can afford medical care to subsidize those who cannot. Both local and national governments allocate funds to subsidize the indigent.
- b) In Thailand, the National Health Security Act was enacted in 2002. The Compulsory Social Security Scheme is financed by contribution from employees, employers, and central government contributions, and covers the formal private sector. The Civil Servant Medical Benefit Scheme (covers the formal public sector) and the Universal Coverage Scheme (UCS) (covers the informal sector) are financed from general tax revenues. The latter is financed through general tax revenues paid to local contracting units on the basis of population size. Since October 2001, the UCS or 30 Baht Scheme (co-payment) expanded the coverage to an additional 18 million people. The 30 Baht scheme was abolished by the government in November 2006, and the system is now totally free of charge at the point of entry.
- c) In Mexico, the social security schemes offer different services, including health insurance and pensions, for salaried workers in the formal sector of the economy. The publicly subsidized system, the SPSS, offers health insurance to all Mexicans not covered by any of the social security schemes. Services covered by the SPSS are mainly provided by the public health facility networks managed by the states.

Achieving universal health coverage (UHC) means to facilitate the individuals and households who suffer the consequences of poor access to health care services and a high financial burden when they actually seek care. The starting point for bottom-up UHC programs is, in a single word, inequality—all too often the poor and vulnerable groups get much less from their health systems than the better off. The global movement

towards (UHC) is accelerated after its endorsement as an explicit target in the SDGs. More than 100 LMICs have initiated UHC reforms in the last few years.

The poor who typically have worse health outcomes have worse access which further worsens the inequality. Countries where government financing for health care is meagre, the situation is even worse. Progress towards UHC needs not only strong political commitment but also a coherent strategy which ensures that the different aspects of the health system are aligned and coordinated with each other in order to address core performance challenges effectively.

Pakistan spends around 3% of its GDP on health [0.5% GDP in public sector], resulting in US\$39.5 per capita health expenditure. Government of Pakistan has pledged in Vision 2025 to increase the allocation of health to 3% of GDP. With limited public spending on health for the last six decades, federal and provincial ministries of health have committed to enhance public health spending by signing the National Health Vision 2016-2025. Slowly improving indicators of maternal and child health present a classical case for scaling up Pakistan's social protection mechanisms and health insurance for the poor segments of population.

The Government of Pakistan's Health insurance program has started to cater a significant portion of the poor population. Still in the total health expenditure, 68% is the share out of pocket. It is important to note that in Pakistan, the catastrophic health expenditures [spending 40% of the non-food expenses] are responsible for a major proportion of the economic shocks faced by poorer households.

- a) The Prime Minister National Health Program (PMNHP), with an aim to prevent 100 million individuals from catastrophic health expenditures across the country in a phased wise manner. This program is a milestone towards social welfare reforms; ensuring that the identified under-privileged citizens across the country get access to their entitled medical health care in a swift and dignified manner without any financial obligations. The premium of PKR 1300 is paid by the government to the selected insurance company which cover expenses up to PKR 600,000 for indoor treatment. In the current phase, people who are living in 60 priority districts and earn less than US\$2 a day (according to BISP Survey), are the beneficiaries of PM National Health program. This program is to be scaled up to all the districts in coming years.
- b) For the province of Punjab, the Punjab Health Initiative Management Company has been mandated the execution /implementation of PMNHP. The program's objective is to improve access of the poor population to good quality medical services, through a health insurance scheme.
- c) Khyber Pakhtunkhwa's (Sehat-Sahoolat) program was launched in 4 designated districts, with the financial assistance of German bank, KfW. However, it is included in the provincial annual development program and has been extended to the entire province (25 districts). Program will be run as regular scheme through legislation. Under it, health insurance cards will be issued to 1.8 million households through which eight individuals will stand entitled to free medical treatment from designated private and public-sector hospitals for inpatient facilities. The program, besides ensuring free medical treatment to the deserving population will also help reduce poverty rate in the province. Premium for health insurance card is around Rs1700 for household, which will be paid by the provincial government.
- d) Gilgit Baltistan has also launched its own social protection (Sehat-Hifazat) program with the financial assistance of German bank, KfW. Focus of this program so far has been to provide below poverty households (21%) in Gilgit district for a coverage for the illnesses requiring hospitalization. In the first phase of the program, 5,000 families in Gilgit city would benefit from the scheme under which the provincial government would provide the premium of Rs1700 for each family. The benefits will be up to a maximum of Rs 25,000 per person per annum. This scheme will provide cashless facilities at



empaneled hospitals. Scheme will be extended to 4 other districts of Gilgit Baltistan in the next phase, which will include Hunza, Nagar, Astore and Ganche.

Several other revenue pooling mechanisms have been in place for the last two decades. i) Zakat and Bait-ul-Maal are the two mainstream publicly mandated health financing agents; many charitable organizations, hospitals, and health equity fund models are extending health social protection. ii) Another initiative is the National Rural Support Program (NRSP) in more than half of the districts of Pakistan, working for rural development and poverty reduction through offering micro health insurance schemes. NRSP microfinance poverty program has enabled the rural men and women with knowledge and skills to seek timely and appropriate healthcare. iii) Benazir Income Support Program (BISP) is another safety net arrangement by the federal government which uses targeting process to identify poor for offering microcredit options, exclusively for the rural women in Pakistan. BISP in the recent years has been providing health insurance program for the beneficiaries with the name of *Waseela-e-Sehat*. iv) Few NGOs offered safety nets for health in the form of vouchers for certain reproductive health services and the transport fare, partially cover the peri-urban and rural areas where majority of the vulnerable population lives; but they need to expand and scale up their scope of work.

Donors and development partners have presented variety of models and frameworks over time. One such example is of Conditional Cash Transfers (CCT), linking it with behavior change interventions e.g. seeking antenatal care, institutional delivery, completing child's vaccination, birth spacing, exclusive breast feeding etc. These funds provide a definite scalable opportunity to promote healthy behaviors. Donors must fill in the interface between the public and private sector by plugging in the financial gaps.

With limited government's fiscal space, narrow tax base and allocation of resources skewed towards other sectors, adoption of risk pooling mechanisms and provision of accessible and quality reproductive health services seems feasible through a meaningful public private partnership in times to come. Further, there is an established evidence of indigenous philanthropy for specific services [ambulance, MNCH centers and free dispensaries] providing health social protection in the country.

The political commitment and GoP ownership for UHC, the Ministry of National Health Services Regulation and Coordination is putting forth the following questions to the stakeholders for an evidence-based debate for sustaining and up scaling the social protection and health insurance initiatives in the country:

1. Which is the best sustainable social protection model of health in the light of international best practices, and existing funding mechanisms in the country?
2. How to make the current national and provincial social health protection initiatives programmatically and financially, sustainable by taking legislative and regulatory measures?
3. How the social protection be made more inclusive i.e. covering all the vulnerable and poor below poverty line [OOP spending is actually out patient, largely on drugs, which cannot be reduced by hospitalization insurance alone]?
4. Given the country's socio-economic situation, which path (contributory or non-contributory) should be taken to extend coverage to the non-poor informal population group?
5. How to monitor and evaluate these programs, establish their linkages with the achievement of the SDG3 targets?





## Report

# Social Health Protection in Pakistan - Are we moving towards achieving the Universal Health Coverage?

Health & Population Think Tank, M/o NHR&C, Islamabad

May 16<sup>th</sup>, 2017 at Health Services Academy

## Preamble

Sustainable Development Goal 3 includes a specific target to reach universal health coverage by 2030: “Achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all”. With this context, this round table of the Health & Population Think Tank, MoNHR&C was organized around the theme of ‘social health protection’, a subject of immense significance which has gained political commitment from the highest echelons of the government of Pakistan. This commitment has also been translated into tangible actions and progress has started to become visible.

## Background

Achieving universal health coverage (UHC) means to facilitate the individuals and households who suffer the consequences of poor access to health care services and a high financial burden when they actually seek care. The starting point for bottom-up UHC programs is, in a single word, inequality—all too often the poor and vulnerable groups get much less from their health systems than the better off. The global movement towards UHC is accelerated after its endorsement as an explicit target in the SDGs. More than 100 lower and middle-income countries have initiated UHC reforms in the last few years. The poor who typically have worse health outcomes have worse access which further worsens the inequality. Countries where government financing for health care is meagre, the situation is even worse. Progress towards UHC needs not only strong political commitment but also a coherent strategy which ensures that the different aspects of the health system are aligned and coordinated with each other in order to address core performance challenges effectively. UHC necessitates social health protection or other forms of safety nets to overcome financial constraints and enhance access to health care.

Different social protection mechanisms have been launched worldwide. These range from supply side financing for national health services covering for certain pre-existing chronic diseases and fatal injuries to demand side or output based financing (vouchers and conditional cash transfers) to cover specific and limited health services such as family planning.

Social health protection (SHP) initiatives currently in vogue in Pakistan are predominantly government initiatives, while others are small scale programs offered by the NGO sector or some are offered by the insurance companies and the corporate sector. Prime Minister’s program with an aim to prevent 100 million individuals from catastrophic health expenditures across the country, is progressing in phases, covering population under USD2 a day. At the provincial level, Punjab is following the footsteps. KP and GB with the support of KfW are scaling up their respective SHP initiatives. Pakistan Bait ul Maal and Zakat are two other mainstream public funding sources to protect poor from health expenditures. Rural support programs and few NGOs have had their share in providing relief to the poorest of the poor for health coverage.

The main purpose of the roundtable discussion was to gather insights from the currently working SHP programs in Pakistan and in the region to discuss issues such as scalability of such programs and universal

health coverage (UHC). In the wake of political commitment and ownership of UHC shown by GoP, the Ministry of National Health Services Regulation and Coordination put forth the following questions to the stakeholders for an evidence-based debate for sustaining and up scaling the social protection and health insurance initiatives in the country:

- i. Which is the best sustainable social protection model of health in the light of international best practices, and existing funding mechanisms in the country?
- ii. How to make the current national and provincial social health protection initiatives programmatically and financially, sustainable by taking legislative and regulatory measures?
- iii. How the social protection be made more inclusive i.e. covering all the vulnerable and poor below poverty line [OOP spending is actually out patient, largely on drugs, which cannot be reduced by hospitalization insurance alone]?
- iv. Given the country's socio-economic situation, which path (contributory or non-contributory) should be taken to extend coverage to the non-poor informal population group?
- v. How to monitor and evaluate these programs, establish their linkages with the achievement of the SDG3 targets?

## Inaugural Session

Technical Lead HPTT briefed the participants on the mandate and composition of the HPTT. He briefly described as to how the HPTT is envisioned to inform and guide policy making based on the deliberations in such round table meetings. Themes for such round tables are identified by the Ministry particularly those which are important to national health agenda outlined in the National Health Vision 2016-2025. Universal health coverage is an important pillar of health system development and is reflected by the government's commitment through the PM's National Health Program covering the poorest of the poor from health shocks.

The Minister for State MoNHSR&C presiding the inaugural session said that the PM's National Health Program is a milestone towards social welfare reforms ensuring that identified underprivileged population gets access to entitled healthcare in a dignified manner without any financial obligations. The program is being scaled up to reach the poorest identified through a poverty scoring system all across the country.



During its expansion there will be challenges and issues so the MoNHSR&C looks towards the HPTT to help pave a way forward. The SHP programs currently running in the country are not perfect and there is a need to learn lessons from the neighbours and across the globe to improve health protection strategies. The Government of Pakistan aims to extend maximum health benefits to the poor and save them from shocks of huge expenditures incurred on chronic diseases and fatal injuries. The MoNHSR&C aspires to achieve the UHC in line with

Vision 2025, National Health Vision 2016-2025 and SDG commitments. We look towards a meaningful public-private partnership to achieve all such targets. She iterated that there is a dire need for educating the masses on health-related issues as the services are there but utilization of the services is still very low. She emphasized the fact that health is no more a political issue, it is purely a technical issue and the government looks towards the technical experts to guide the ministry.

The Secretary MoNHSR&C in his remarks stated that it is a known fact that rising poverty has direct implications on health seeking and that it affects the most poor and vulnerable. He iterated the fact that government is totally committed to address the issue of social health protection and is endeavouring to expand the coverage of the PM's National Health Program to 60 priority districts in the first phase and to all the districts across the country in the second phase. He added that there is a lot to be done to actually provide safety net to each and every poor of the country in order to protect the households from catastrophic shocks of health expenditure. He remarked that we should all vow to protect the poor dying due to a preventable cause and suffering from financial hardship whilst seeking healthcare. He went on to inform an idea that was discussed with the PM for providing health coverage for 100% population of Pakistan.



He said that the four provinces and the federal government cumulatively spend Rs. 123 billion a year for providing hospital services. In a country of 195 million population and number of estimated households of 28.6 million, the premium for insurance (Rs. 1300 per household) for all the household would be Rs 37 billion. After spending Rs. 123 billion, we still have poor hospital services offered by the public hospitals. In contrast, just by spending Rs. 37 billion, high quality hospital services could be provided through private health facilities. However, there is a need to understand the details of the various expenditure heads (development vs. non-development expense). The HPTT is expected to provide advice and technical inputs in the preparation of a detailed proposal to be submitted to the PM secretariat. (see annex 1 & 2)

The Director General, MoNHSR&C gave the background and context of the roundtable meeting. He stated the purpose of this meeting is to hold a discussion on issues around SHP and UHC. He explained that Pakistan being a lower-middle income country is faced by issues of financial constraints yet the government is committed to move toward the goal of UHC to protect the poor populace of Pakistan from catastrophic expenditures which push them further into the poverty cycle. There are many SHP's currently running in Pakistan especially the Benazir Income Support Program (BISP) and SHP programs introduced by Punjab, KP and GB. There is a need to discuss the SHP strategies implemented locally and globally and learn the best practices. He reiterated that this meeting has been convened to gather deliberations from the experts and learn from their experiences so that a way forward could be chalked out for guidance of SHP in Pakistan and moving towards the goal of UHC in Pakistan.

## Session 1: Social Health Protection and Universal Health Coverage

- i. Awad Mataria, Health Financing Specialist from WHO EMRO joined on skype, and presented some regional experiences of countries in the Eastern Mediterranean Region in terms of SHP and UHC. He remarked that all countries at their different level of development are able to take steps to take the goal of SHP and UHC further. He emphasized that political will is required from the political leadership which is very evident in Pakistan. Another prerequisite for UHC is evidence which needs to be generated. This evidence will come from Health Accounts, costing, measuring financial risk protection and policy analysis; and once these prerequisites are in place then it would be very easy to translate them into policies and strategies.
- ii. Dr. Eduardo Bazon, Health Specialist Asian Development Bank (former CEO PhilHealth) also joined on skype from Philippines and enlightened the audience by explaining some of the key components of Philippines' universal health insurance program. Commenting on cost of treatment rising after some

years, he said that premium amount has to be revised. There came the legislation point also for the PMNHP to make it sustainable.

- iii. Dr. Zafar Mirza, Director Health Systems Development WHO EMRO also participated on skype discussion and shared some key points on the SHP initiatives in Pakistan. Firstly, he welcomed the SHP initiative of the Government and stated that UHC is no more an option rather is a mutually agreed policy and Pakistan is in line with the rest of the world with its initiatives to move towards UHC. PMNHP is one of the most important initiatives taken in Pakistan and can really be a beginning of UHC in Pakistan. He further added that this program should not be viewed as an end rather it is a means to an end, with the end being UHC in Pakistan. The current focus is on secondary and tertiary level healthcare in terms of SHP. We have to be aware that such an approach will not be sustainable in the long run unless more focus is given to PHC being included in SHP programs. There is a strong need to have legislative coverage for SHP programs in Pakistan. In the end, he concluded that WHO can offer to Government of Pakistan the development of an outcome document for this initiative.

**Discussion:** There was a clear emphasis on the need to focus on PHC in PMNHP which would be critical to the success of such a program. It was mentioned that OOP expenditure will not be curtailed unless the package of benefits offered is not comprehensive enough and do not cover the essential services which people have to buy out of pocket. Co-payments also can be cumbersome when one has to pay for lab or pharmacy services. Lastly, in many countries, there are substantial under the table payments where the healthcare provider would charge the patient an equal amount to what he would claim from the insurance.

## Session 2: Health Insurance Programs

- i. An overview of the **Prime Minister's National Health Program (PMNHP)** was given. Started in late 2015, PMNHP is a social health protection initiative which is being implemented in a phased manner. In the first phase, the focus is on people living below the poverty line of US\$2 per day and service provision is for inpatient care only. In the second phase, the OPD services will be added and the coverage extended to include upper quintiles of the population also. Currently, two packages of services are being offered; 1) Secondary care package- Coverage of Rs. 50,000/family/year for inpatient care, emergency care, follow up and referrals. 2) Priority care package – Coverage of Rs. 250,000 / family / year for high burden diseases like Diabetes mellitus, heart disease, organ failure, chemo/radiotherapy. Moreover, there is excess of loss package with the help of BaitulMaal in which excess amounts are provided to the registered families, if they run out of their credit. The service provision is through empanelled hospitals which are 81 in number all across Pakistan. PMNHP is based on an innovative financing mechanism in which the federal and provincial governments are collaborating and using economies of scale to bring the premium down and offer better services to the beneficiaries. The financial collaboration is that the federal government pays premium for priority diseases and the provincial government pays premium for secondary care. In 16 months since the program is implemented, 16 districts have been covered and one district is being added every month. The program has enrolled 1million families which translates to about 5.5 million individuals. The aim is to extend coverage to all districts across Pakistan by the year 2021.
- ii. **Punjab Health Insurance Initiative** is implemented by the Punjab Health Initiative Management Company. Currently, the program is implemented in four districts of Punjab: Rahim Yar Khan, Khanewal, Narowal and Sargodha. Up until now 0.8 million families and 4.8 million individuals have been enrolled in the program. The process of enrolment was discussed in detail. The services are rendered through 52 empanelled hospitals. The goal is to reach all 36 districts in the next 2-3 years. The monitoring and evaluation system of the program was discussed in detail.
- iii. **Sehat Sahulat Program- SHP Initiative of Government of KP** had a target for end 2017 to cover 40% of the population of KP, whereas up until now the program has covered 51% of the population. The program started with four districts and has now moved to 25 districts in KP. Initially, only



secondary care was provided but now tertiary care is also included and in the next phase OPD services will also be covered. As per the National Health Accounts 2013-14, the out of pocket payments in KP were 67% which have now reduced significantly, as the government's share has increased through this program. Health insurance scheme which is run through State Life Insurance Corporation, enrolled 1.29 million population (51%) of the population of KP. The services are provided through 104 empanelled public and private hospitals. The premium is Rs. 1549 per household per year. The program currently offers two packages of services; 1) Basic benefits package – This provides secondary healthcare level services of Rs 240,000 per household per year and the limit is Rs. 30, 000 per individual per year for healthcare services. 2) Tertiary care package – This provides a benefit of Rs. 300,000 per household per year for a list of diseases including cardiovascular diseases, complications of diabetes mellitus, all emergencies and trauma, all cancers, organ failure and kidney transplantation to name a few. The program also includes other benefits like wage replace of Rs. 250 per day for three days in case of hospitalization to incentivize hospital admissions, Rs. 2000 for transportation in case of a referral, Rs. 1000 for transportation of the patient in case of maternity issues, a free OPD voucher for follow up as required and Rs. 10,000 burial allowance in case of mortality. There is also a reserve fund for adding more credit to a household's account if they run out of their credit. The program has an agreement with State Life Insurance Corporation that yearly 80% of the unused funds will be returned back to the government. The enrolment of the poor is through the Benazir Income Support Program database. As a way forward, the program is working on various projects such as the health insurance scheme for the healthcare providers in the province, private voluntary insurance, healthcare insurance schemes for various population subgroups like lawyers, judiciary and actors. Once the program is able to work out an insurance plan for these subgroups then the coverage will reach to 80% of the population. Moreover, there are various vertical programs running in KP such as Insulin for Life Fund, Cancer Treatment Fund and Hepatitis Emergency Services, which are envisioned to be incorporated in the mainstream program over the next one and a half years.

- iv. NADRA's **National Poverty Database** was presented. The Benazir Income Support Program (BISP) database is hosted by NADRA and this program was launched in 2010. The identification of the poor started in 2010 and it was completed in 2013. During this targeting, a massive door-to-door survey was conducted and 27 million households were surveyed and the Proxy Mean Test (PMT) formula, developed by World Bank was applied to the surveyed population. A total of 5.7 million beneficiaries were identified through this system. In 2012, the case management system was incorporated to the database which allows for the database to be updated but has not been utilized effectively. In 2014, the debit card scheme for payments to the beneficiaries was introduced to the BISP. In 2016 the recertification of the BISP scorecard has been initiated, an initial pilot has been completed and gradually a resurvey is being conducted in rest of the country. The scorecard had demographic information and 13 questions to which the PMT weights were applied to assess the poverty of the household. Through a data validation tool all the beneficiaries were validated using the national ID database. Each beneficiary is biometrically verified through NADRA before the payments are made. So far Rs. 490 billion have been disbursed under the BISP Unconditional Cash Transfer Program.

### Session 3: Discussion and Way Forward

- i. Participants were requested to comment on and advise the forum on topics such as the laws and legislations required, ways and means to expand the coverage, how to extend the SHP benefits to population sub groups other than the poor such as the government servants, and whether to sell the insurance package to the non-poor through the private sector.
- ii. Jubilee General Insurance started micro-insurance program in 2005. Up till now they have enrolled 22 million persons in 90 districts of Pakistan. The model followed by Jubilee General Insurance is NGO-Insurance company model where they work with the Rural Support Programs. Secondly,

- technological tools for monitoring have been incorporated which has really added to the program success.
- iii. State Life Insurance Corporation feels that there is paucity of good hospitals in peri-urban and rural areas. Moreover, hospitals in Pakistan are not used to the concept of insurance and risk pooling, rather they are used to billing for services. Hospitals need reforms either through legislation or through incentives like tax breaks. There is a difference in the rates offered by hospital for similar procedures. As PMNHP scales up, there would be a need for hospital beds and as the demand increases, it would get more difficult to negotiate the best deal for the beneficiaries. Monitoring is the key to success – as the poorest segment of the population is involved who are exploited by hospitals, doctors and insurance agents. There is a need to put in systems and mechanisms to minimize frauds. There is a need to develop policies and procedures that are practical and work in the field. The standards to gauge the performance of the insurance companies have to be practical and realistic and in line with the prevailing conditions in the country. Preventive care is the crux for a strong healthcare system as it controls costs and reduces problems and issues. Lack of qualified human resource is a big problem. The insurance HR is all home trained. Good schools, training institutes and infrastructure are the need of the hour and we should start investing in them. Moreover, we need to start investing on finance and management HR as our hospitals are still run by medical doctors and it gets difficult to talk business and management with doctors. Enrolment is a problem as the database of BISP was old. The social protection program should be a partnership between the government, insurance company and development partners so that the resources could be utilized more effectively for the benefit of the people e.g. Government has huge on the ground resources like lady health workers and healthcare professionals which should be utilized for effective implementation of such programs.
  - iv. Alfalah Insurance Company thinks that many financing mechanisms could be employed, tax based, voluntary pooling etc. The population could be divided into segments and a package devised for each segment of the population according to their needs. He added that shortage of trained HR in insurance and health sector is to be addressed on priority.
  - v. Preliminary results of an evaluation of Sehat Sahulat Program in KP and Health Insurance Initiative of GB show a wide range of pricing e.g. price ranging from Rs 7500 to 25000 for the same procedure, issues with standard of care and guidelines. The evaluation suggests inclusion of outdoor services with immediate effect.
  - vi. It was discussed that reducing OOP payments and protecting the poor from catastrophic expenditure are the main objectives of any SHP program. It is still not clear as to who is responsible and accountable for this task; is it the government or the insurance company, the healthcare provider or the management companies? It needs to be defined as to who will measure these and will be held accountable for this. There has to be accountability as there can be leakages at various levels which could drain the system. Moreover, tracking and analysing data from healthcare providers is very important. Another important aspect is cost containment through negotiated fee schedules and rational planning in distribution of high cost services. For effective management of the system, HR with expertise in management is essential.
  - vii. Chief of Party, JSI Pakistan shared that capacity building is an extremely important area which cannot be overlooked. We cannot expect an overnight change without investing in capacity building. The approach adopted has to be holistic which means capacity building at the individual, institutional and systems level. Health care commissions and health insurance initiatives need to link together. In Pakistan, organizations and institutions are working in silos and not necessarily talking to each other. Be it regulations, capacity development, compliance, monitoring, supervision or validity of whatever is happening, unless all of them come together as a package of health system strengthening, it will be very difficult to work in isolation.
  - viii. As for vouchers piloted in Pakistan, sustainability has emerged as the biggest concern. Also, the quality of care received remains questionable. For voucher payments, there is a need to define the key performance indicators and how to monitor them both internally and externally. There is a need for harmonization of the monitoring and evaluation frameworks because at times different

implementing partners are involved, and if they implement and measure these differently, then we will not be able to make comparisons.

- ix. Capacity of public health care set up came under discussion. Government should not contract the risk of the poor to private insurance system without any evidence that this would work. This could lead to transitional risks. The problem that has been created by these additional funds is that the public health system is not ready for such a step. To what extent we want to hold the current health budget as such to finance the system, or do we want to transition to a private health insurance system partly funded by government and insurance contracts, or do we want a public insurance system which might be cheaper in terms of administration cost. Government has to decide before contracting as which package to offer the OPD, secondary care or tertiary care package as it cannot be added to the old package and a new package has to be negotiated. The insurance company has to learn how to manage the benefits package, services package and treatment lists in accordance to your prices. This means that the insurer has overtaken the risk which means that the insurer is responsible for the service cases in the hospital. A hospital should be interested in a contract, at least the private health system is. The public health system is not ready and needs to be trained in this regard. But if you offer volume and a good price every hospital would be interested in a contract.

## Conclusions

- a) As regards the **sustainability** of PMNHP, BISP was cited to have the legislative cover, so it is still working at its best. Therefore, this is the need for PMNHP today. This program has the potential to cover entire population i.e. UHC with SP.
- b) For its **financial stability**, government is not short of resources; these can be mobilized from other heads also for scaling up PMNHP for all Pakistanis.
- c) More **inclusiveness** can be achieved in the PMNHP by offering the coverage of the outdoor services and the cost of medicines & diagnostics, the expenses which still adversely affect a large proportion of poor population in the country.
- d) Extending **coverage to the non-poor population** can be two ways: contributory or non-contributory (given the government has resources to cover entire population with the same premium for the same basket of services as in PMNHP).
- e) To **monitor and evaluate** the social protection program, there need to be a periodic third party monitoring to gauge the effectiveness of the health coverage to its beneficiaries, in terms of utilization, expenses incurred, patient satisfaction, and on the supply side, to assess the capacity, quality of care and responsiveness of the health care facilities empaneled under the program.

## Annex 1

### Estimation of Public sector expenditure on Inpatient care

Civilian territorial government current health expenditures 2013-14 by function							
Function (CoA)		million Rs.					
		Federal	Punjab	Sindh	KP	Baluchi- stan	Pakistan
015	General Services	-	-	-	19	36	55
076	Health Administration	1,110	8,022	5,480	983	1,153	16,757
<b>073</b>	<b>Hospital Services</b>	<b>8,533</b>	<b>60,973</b>	<b>27,607</b>	<b>16,506</b>	<b>9,335</b>	<b>122,954</b>
071	Medical Products, Appliances & Equipment	233	-	70	38	21	362
074	Public Health Services	382	1,096	2,250	1,093	294	5,115
075	R & D Health	-	-	-	-	-	-
045	Construction and Transport	-	-	-	-	-	-
041	Economic, Commercial & Labour Affair	-	-	-	-	-	-
014	Transfers	-	-	-	-	-	-
108	Others	-	-	-	945	64	1,009
Total		10,258	70,091	35,416	19,584	10,903	146,252

The above table shows the federal and provincial (including districts) health expenditures by minor functions of Chart of Accounts (CoA) classification adopted by AGs and AGPR to record the government expenditures under the PIFRA. This classification is based on “Government Finance Statistics by IMF”, so they are completely in line with the international classifications. About 84% of the current expenditures are on hospital services, around 11% on health administration and about 3.5% on public health services<sup>1</sup>.

<sup>1</sup> These figures should be read with caution, as NHA does not provide break up of development and non-development expense. Moreover, while making projections for the entire population coverage (and even for the poor under \$2 a day), it should be noted that these costs do not cover outdoor services, cost of medicines and diagnostics which are generally an out of pocket expense.



## Annex 2

Premium amount required to cover the inpatient care

Province/Region	% of Pakistan Population*	Estimated Population 2016**	Avg. Household Size	Estimated Households ***	Avg. Cost per family** (PKR)	Estimated Cost (PKR Millions) for entire population	Estimated Cost for covering those living under US\$2 per day (PKR Millions)	Estimated Cost for covering those living under US\$1.25 per day (PKR Millions)
KPK	13.4%	26,130,000	8	3,266,250	1,300	4,246	2,556	893.38
FATA	2.4%	4,680,000	9.3	503,226	1,300	654	394	137.64
PUNJAB	55.7%	108,615,000	6.9	15,741,304	1,300	20,464	12,317	4,305.56
SINDH	23.0%	44,850,000	6	7,475,000	1,300	9,718	5,849	2,044.56
BALUCHISTAN	4.9%	9,555,000	6.7	1,426,119	1,300	1,854	1,116	390.07
ICT	0.6%	1,170,000	6.2	188,710	1,300	245	148	51.62
<b>TOTAL</b>	<b>100.0%</b>	<b>195,000,000</b>	<b>43</b>	<b>28,600,609</b>	<b>7,800</b>	<b>37,181</b>	<b>22,379</b>	<b>7,822.84</b>

\*: Derived from Population census of Pakistan - 1998

\*\* : Derivations based on 2016 population estimate of 195 million-Pakistan Economic Survey

\*\*\*: Estimates derived from Pakistan Economic Survey 2013

\*\*\*\*: Definition of family is assumed to be different from the definition of Household that are used for surveys and census



## Policy Brief

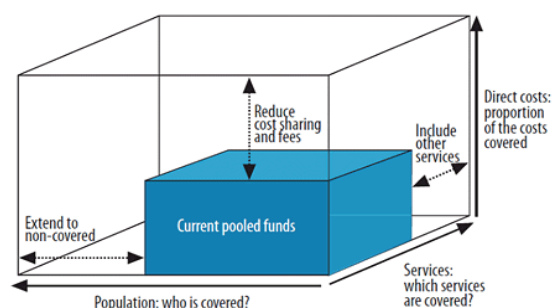
May 2017

### Social Health Protection in Pakistan:

#### Are we moving towards achieving the Universal Health Coverage?

To overcome financial constraints and enhance access to health care, different social protection mechanisms have been launched worldwide. These include supply side financing as well as demand side or output based financing. Social health insurance (SHI) is one of the most popular and authenticated organizational mechanisms for revenue raising, pooling and purchasing health services. Programs of Philippines, Thailand and Mexico are some success stories.

The global movement towards universal health coverage (UHC) is accelerated after its endorsement as an explicit target in the SDGs. More than 100 LMICs have initiated UHC reforms in the last few years. Achieving UHC means to facilitate the



Three dimensions to consider when moving towards universal coverage

individuals and households who suffer the consequences of poor access to health care services and a high financial burden when they actually seek care. The starting point for bottom-up UHC programs is, in a single word, inequality—all too often the poor and vulnerable groups get much less from their health systems than the better off. Progress towards UHC needs not only strong political commitment but also a coherent strategy which ensures that the different aspects of the health system are aligned and coordinated with each other in order to address core performance challenges effectively.

Pakistan spends around 3% of its GDP on health [0.5% GDP in public sector], resulting in US\$39.5 per capita health expenditure. Government of Pakistan has pledged in Vision 2025 to increase the

allocation of health to 3% of GDP. With limited public spending on health for the last six decades, federal and provincial ministries of health have committed to enhance public health spending by signing the National Health Vision 2016-2025. Slowly improving indicators of maternal and child health present a classical case for scaling up Pakistan's social protection mechanisms and health insurance for the poor segments of population. The Government of Pakistan's Health insurance program has started to cater a significant portion of the poor population. Still in the total health expenditure, 68% is the share out of pocket. It is important to note that in Pakistan, the catastrophic health expenditures [spending 40% of the non-food expenses] are responsible for a major proportion of the economic shocks faced by poorer households.

Till the recent past, other revenue pooling mechanisms have been in place acting as safety nets for health of the poor and this included Zakat and Bait-ul-Maal, two publicly mandated health financing agents; besides charitable organizations, NGOs, hospitals, and health equity fund models. Benazir Income Support Program (BISP) came on the scene as another safety net arrangement by the federal government which provided *Waseela-e-Sehat* facility for some time before The Prime Minister National Health Program (PMNHP) became functional in 2015.

PMNHP has an aim to prevent 100 million individuals from catastrophic health expenditures across the country in a phased wise manner. The premium of PKRs1300 is paid by the government to a selected insurance company which cover expenses for indoor treatment. In the current phase, people who are living in 60 priority districts and earn less than US\$2 a day (according to BISP data), are the beneficiaries of PMNHP. Currently, two packages of services are being offered; 1) Secondary care package- Coverage of PkRs50,000/family/year for inpatient care, emergency care, follow up and referrals; and 2) Priority care package – Coverage of PkRs250,000/ family/year for high burden diseases such as Diabetes mellitus, heart disease, organ failure, chemo/radiotherapy. Moreover, there is excess of loss package with the help of *Bait ul Maal* in which excess amounts are provided to the registered families, if they run out of their credit. This program is to be scaled up to all the districts in coming years. Punjab, KP and GB also launched their respective programs and are gradually

expanding. The aim is to cover all the districts of Pakistan by 2021.

Sustainable Development Goal 3 includes a specific target to reach universal health coverage by 2030: “Achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all”. With this context, the M/o NHR&C convened a round table under its Health & Population Think Tank initiative, looking for answers to the following questions:

1. Which is the best sustainable social protection model of health in the light of international best practices, and existing funding mechanisms in the country?
2. How to make the current national and provincial social health protection initiatives programmatically and financially, sustainable by taking legislative and regulatory measures?
3. How the social protection be made more inclusive i.e. covering all the vulnerable and poor below poverty line [OOP spending is actually out patient, largely on drugs, which cannot be reduced by hospitalization insurance alone]?
4. Given the country’s socio-economic situation, which path (contributory or non-contributory) should be taken to extend coverage to the non-poor informal population group?
5. How to monitor and evaluate these programs, establish their linkages with the achievement of the SDG3 targets?

PMNHP is a milestone towards social welfare reforms ensuring that identified underprivileged population gets access to entitled healthcare in a dignified manner without any financial obligations. Four provinces and the federal government cumulatively spend PkRs123 billion a year for providing hospital services. In a country of 195 million population and number of estimated households of 28.6 million, the premium for insurance (PkRs1300 per household) for all the household would be PkRs37 billion. After spending

PkRs123 billion, we still have poor hospital services offered by the public hospitals. To find answer to such questions, National Health Accounts must be strengthened and computed more frequently. Moreover, with the rising cost of treatments, amount of premium has to be revised, and therefore the PMNHP ought to have a legal cover from the parliament. The current focus of PMNHP on secondary and tertiary level healthcare will have to be expanded to cover the primary health care to cover costs/expenditure incurred on essential health services, in order to achieve the UHC goals.

#### Action items:

- i. PMNHP to have a legislative cover in order to sustain.
- ii. Resources to be mobilized from other sources for scaling up.
- iii. PMNHP to work on awareness raising and demand creation component to improve the utilization of the health services.
- iv. More hospitals in peri-urban and rural areas are needed with capacity to be empanelled in PMNHP.
- v. Health Care Commissions to play their role for ensuring quality of care in the existing empanelled hospitals through reforms and legislation.
- vi. More inclusiveness to be achieved with coverage of outdoor services and cost of medicines & diagnostics.
- vii. Human resource to be trained in Health Insurance Program Management.
- viii. Coverage to the non-poor population can be two ways: contributory or non-contributory (given the government has resources to cover entire population with the same premium for the same basket of services as in PMNHP).
- ix. Periodic third-party monitoring to gauge the effectiveness of the program (supply and demand side both).

This policy brief was developed to apprise all SHP stakeholders of the different health insurance programs, share best practices from the region, and to inform the development of a new PC1 for Prime Minister National Health Program for Phase II.

### 3. Quality of Care around the Time of Birth

#### Concept Note

##### Introduction

Health care system of Pakistan has progressed, transformed and improved its services, functions and dynamics over the last one decade. Since Pakistan Demographic & Health Survey 2006-07<sup>1</sup>, maternal, infant and child mortality indicators have no doubt improved, however, there is still need to look into few other areas where indicators are either stagnant, deteriorating or not improving as desired. Neonatal mortality according to the Pakistan Demographic & Health Survey 2012-13 has not improved since decades<sup>2</sup>. Similarly, maternal mortality although is reported to decline from 276/100,000 to 170/100,000 live births, owing to wide outreach of national LHW program, and better skilled birth attendance availability<sup>3</sup>. Unsafe deliveries and inadequate post-natal care services are major challenges to maternal and newborn health. These have proven to be major contributors to high maternal mortality ratios and neonatal mortality rates in the developing world. In developing countries maternal complications during labor compounded by social, cultural and economic factors predispose newborns to greater risk of dying. It is estimated that about four million newborns die within 28 days of birth all across the globe with the developing countries bearing this burden far more than the developed world. Pakistan ranks third amongst the 10 countries of the world with the highest burden of neonatal deaths. Latest estimate of neonatal mortality in Pakistan is 55 per 1000 live births<sup>2</sup>, which is almost stagnant since last three decades, despite increase in the proportion of institutional deliveries. Understanding of the determinants of neonatal mortality is paramount for devising successful interventions to lower the burden of neonatal mortality in Pakistan. Ministry of National Health Services, Regulations & Coordination has already spelled out ‘improving quality of care at primary and secondary level care facilities’ as one of the propriety actions to accelerate progress on maternal, newborn and child health<sup>4</sup>.

WHO has defined “quality of care” and has proposed a framework for improving the quality of care for mothers and newborns around the time of childbirth<sup>5</sup>. There is need to adopt these standard guidelines and protocols and to ensure the implementation with supportive supervision.

#### Determinants and factors associated with Maternal Mortality, Stillbirths and Neonatal Mortality

##### *Maternal Mortality*

The risk of complications is markedly reduced in situations where proper medical attention is given and hygienic practices are adhered to thus lowering the probability of maternal and neonatal mortality. As per Pakistan Demographic and Health Survey (PDHS) 2012-13, more than half (52%) of the childbirths take place at home. Of the 48% of childbirths that do take place in a health facility, only 15% take place in a public facility and 34% occur in a private health facility<sup>2</sup>. The situation is worse in the rural areas where only 40% of the deliveries take place in a health facility as compared to 68% in urban areas. Hence, addressing the risk maternal mortality occurring at home, QoC provided by the CMWs and traditional birth attendants (TBAs) ought to be enhanced. Pakistan remains one of the few countries in the world where the maternal health indicators are still lagging behind. Over the years the maternal

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1. National Institute of Population Sciences & Macro International. Pakistan Demographic & Health Survey 2006-07. Government of Pakistan, Islamabad: 2008.
  2. National Institute of Population Sciences & Macro International. Pakistan Demographic & Health Survey 2012-13. Government of Pakistan, Islamabad: 2013.
  3. Ministry of Finance. Economic Survey of Pakistan 2016-17. Government of Pakistan. Islamabad: 2016.
  4. Ministry of National Health Services, Regulations & Coordination. National vision 2016-2025 for coordinated priority actions to address challenges of reproductive, maternal, newborn, child, adolescent health and nutrition. Islamabad: 2016.
  5. World Health Organization. Guidelines on maternal, newborn, child and adolescent health. Recommendations on newborn health. WHO guidelines review committee. Geneva: 2012.

mortality ratio has somewhat improved, but still remains unacceptably high. PDHS reports postpartum haemorrhage (PPH) to be responsible for 27.7% of maternal deaths in Pakistan. It is widely recognized that active management of third stage of labor (AMTSL) reduces the occurrence of severe PPH by approximately 60-70%. WHO recommends AMTSL as a critical intervention for PPH prevention, and therefore AMTSL has become a central component of the PPH reduction strategies<sup>6</sup>. AMTSL consists of three interventions: administration of an uterotonic within one minute of birth, controlled cord traction during contractions to deliver the placenta, and uterine massage once the placenta has delivered. It is recognized that healthcare providers need to be trained to recognize and treat postpartum haemorrhage. Studies advocate that provision of quality healthcare at birth requires the birth attendants to be trained in AMTSL<sup>7</sup>. Moreover, many studies have found oral Misoprostol to be effective in controlling as well as preventing PPH<sup>8</sup>. Use of oral Misoprostol in the community settings where issues of staff shortages, refrigeration hurdles and high caseloads are common is recommended and shown to be successful in managing the third stage of labor in many studies<sup>9,10</sup>. An operations research project was conducted in two districts under Pakistan Initiative for Mothers and Newborns to assess the feasibility of home administration of Misoprostol for prevention of PPH. The study concluded that the home administration of Misoprostol involving TBAs was very feasible<sup>11</sup>. Furthermore, with proper training TBAs and CMWs can play a key role in reducing maternal mortality due to PPH in Pakistan.

### ***Stillbirths***

Incidence of stillbirths was found to be 47/1000 live births in 2011<sup>12</sup>; and since then decline in this rate has been negligible. Latest data shows Pakistan categorized as having the highest rate in the world (43/1000 live births) in the recent global estimates<sup>13</sup>. Majority of stillbirths that occurred in the third trimester of pregnancy are preventable with a better obstetrical care, and therefore community midwives need to grossly improve their skill set<sup>14</sup>. A greater focus is needed on 'task-shifting' to other groups of health workers such as nurses, midwives and auxiliary staff with improved in-service training, supervision and incentive of career progression<sup>15</sup>. Antenatal visits and screening of anemia, malnutrition and any other medical complication are the most cost-effective interventions for averting many still births. An increased investment for integrated service delivery programs around perinatal period would be another requisite<sup>16</sup>. This can help address main caveats of human resource shortage, service accessibility, and quality of essential emergency obstetric care<sup>17</sup>.

### ***Neonatal mortality***

Where infant and under 5 mortalities have improved by 19% and 24% respectively, early and late neonatal mortality rates have been stagnant in Pakistan since last two decades<sup>2</sup>. The causes are known with enough evidence to address the issue. Prematurity, birth asphyxia, hypothermia, sepsis of the cord

6. WHO, USAID, MCHIP. Active Management of Third Stage of Labour. [http://apps.who.int/iris/bitstream/10665/119831/1/WHO\\_RHR\\_14.18\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/119831/1/WHO_RHR_14.18_eng.pdf) [accessed 19 July 2017]
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16. Bhutta ZA, Yakoob MY, Lawn JE, Rizvi A, Friberg IK, Weissman E, et al. Stillbirths: what difference can we make and at what cost? *Lancet* 2011; 377: 1523-38.
17. Black RE, Levin C, Walker N, Chou D, Liu L, Temmerman M, et al. Reproductive, maternal, newborn, and child health: key messages from Disease Control Priorities 3rd Edition. *Lancet* 2016; S0140-6736 (16) 00738-8.



are the leading causes of early neonatal mortality; while delay in initiation of breast feeding could lead to late neonatal mortality. Interventions such as use of Chlorhexidine for umbilical cord care, and kangaroo mother care for preterm babies have proven to save many lives. Breastfeeding trends are also not encouraging in Pakistan. Initiation of breastfeeding in first hour has declined from 29% to 18% and initiation in one day has declined from 70% to 58%. Mean duration of exclusive breastfeeding at the national level is currently 3 months<sup>2</sup>. Neonatal survival is also a highly inequitable health outcome because many deaths during this period are unregistered, and often the child does not have a birth certificate (e.g., only about 34 per cent of under-5 children in Pakistan are registered at birth). Thus, an effective focus on neonatal survival could reap a “triple return” on the investments made, through (1) the improved survival of women during delivery; (2) prevention of stillbirths; and (3) neonatal survival itself<sup>18</sup>. Also, there is a need to implement interventions focusing on antenatal care, effective referral system and retraining of healthcare providers to manage delivery complications and smaller than average birth size babies in resource poor communities of Pakistan<sup>19</sup>. Besides, better care at the time of delivery, certain behavior change interventions for the health providers’ and parents must be implemented to bring this mortality rate down<sup>20</sup>.

### ***Supply and Demand Side Factors***

A range of actions is needed, acting upon the social determinants within the health and social sectors, if a wider impact is to be achieved<sup>21</sup>. There is ample body of evidence available to suggest that a vast majority of people living in the developing world do not have access to appropriate healthcare services especially the poor and the marginalized populace. This problem is two pronged where appropriate, good quality and effective healthcare services may not be offered from the supply side, and on the demand side where the people do not utilize the healthcare services offered which could be beneficial for them. On the supply side, lack of resources may be a barrier in providing appropriate health care services and interventions to the people. WHO suggests that in many developing countries a significant gap exists in actual health spending and the spending required to provide essential health services<sup>22</sup>. According to the State of World’s Midwifery report, in the developing countries 15% of pregnancies result in obstetrics complications and the main reason is the non-availability of enough qualified midwives and birth attendants for managing the high number of pregnancies<sup>23</sup>. On the demand side, as per PDHS 2012-13, in Pakistan only 7 in 10 women receive antenatal care from a skilled provider, and only 37% of the women are able to make four or more antenatal care visits during their pregnancy. There is a clear need of a composite measure of continuum of care (CoC) including antenatal care, delivery assistance and postpartum care. The largest gap in CoC was observed at antenatal care followed by delivery and postnatal care within 48 hours after delivery<sup>24</sup>.

Given the fact that use of antenatal care, skilled birth attendance, institutional deliveries, and postnatal care is on the rise; it is unfortunate that the stillbirths and neonatal mortality rates are stagnant, and the maternal mortality is not declining at the expected pace. Taking stock of the current situation mainly attributed the quality of care around the time of birth, the MoNHSR&C is now putting forth the following questions to the stakeholders for an evidence-based debate on the subject to support the accomplishment of the government’s vision.

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  23. ten Hoope-Bender P, Campbell J, Fauveau V, Matthews Z. The state of the world’s midwifery 2011: delivering health, saving lives. *Int J Gynecol Obstet* 2011; 114 (3): 211-212.
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## Questions for discussion

1. Is there a need to have a national/ provincial strategic framework for QoC around the time of birth?
2. What are the priority actions needed to improve QoC?
3. How is the issue of accountability for QoC being addressed?



## Report

# Quality of care Around the Time of Birth.

Health & Population Think Tank, M/o NHSR&C, Islamabad

August 17<sup>th</sup>, 2017 at Health Services Academy.

## Background

Where many indicators of health have improved in Pakistan because of disease specific and health system level interventions, there are few remaining where either minimal or no improvement is visible. Maternal mortality is decreasing at a very slow pace, still births rate is the highest in the world, and neonatal mortality rate is stagnant since last 3 decades or so. In spite of advancement in medical field, introduction of standards and SoPs, training and refreshers, adoption of WHO guidelines for maternal and newborn care, and with deployment of LHWs and CMWs, the progress has not been encouraging. Besides other broader and system related factors (financing, human resource, governance, information system, supplies and technology), the quality of care at the service delivery point has been questionable too. Nonetheless, all three indicators: maternal mortality, newborn mortality and still births could be well attributed to the notion of quality of care. Moreover, a standard service delivery package and monitoring framework is critical for tracking the progress in this regard at the national level. This is important for the sake of reporting on SDGs at the national, regional and global forums.



Since service delivery and its SoPs are the prerogative of provincial /area governments (post 18<sup>th</sup> amendment), the Health & Population Think Tank (HPTT) of the Ministry of National Health Services, Regulations & Coordination convened a consultative meeting on the subject with all the provincial DoHs and Area (AJK, GB & FATA) representatives. Other important stakeholders including the NGOs, private sector, development partners and academia/researchers were also invited to brainstorm, deliberate and exchange views on the host of issues around quality of care especially at the time of birth.

## Proceedings

Technical Lead HPTT presented the background, and explained the rationale and objectives of the meeting on QoC around the time of birth. He emphasized that 3 indicators a) still birth b) neonatal mortality and c) maternal mortality are very alarming and highlighted that agenda behind the meeting is that all provinces/areas share what has been/is being done at the health system level to address this issue of QoC, and that what type of support they need from the federal government for the improvement of the current situation. Advisor HPTT highlighted the structure, role and activities of HPTT. He

addressed the importance of NHV 2016-25 which contains many commitments and for the fulfillment of these commitments, linkages between federal, provincial and area governments are required.

DG Health presented to the audience the concept of the Think Tank development with a focus on the coordination between federal and provincial/area governments. He stressed that HPTT is a forum for brainstorming and sharing of experiences, and not a policy formulation body. Additional Secretary MoNHSR&C said that access to care facilities is the right of every one and for the improvement of newborn death ratios, proactive approach is required. He highlighted the importance of this forum that if all the stakeholders use this forum positively, government can make a policy which can improve the death rates of mothers and newborns.



Federal Minister underscored the immense importance of exclusive breastfeeding, family planning and advised to invite Population welfare department and women development department s to the forum. She suggested to develop a health card for pregnant women (just like EPI card) which should track record of her antenatal, delivery, post-natal, immunization status. She recommended to think of task shifting, and not to depend only on doctors, as we may never get enough of them in the rural areas, and for that she quoted example of Europe where maternity services

are provided by the midwives, and have lowest maternal mortality ratio in the world, even lower than US. She expressed her concern on the issue of accountability of service providers, but at the same time allocating more resources of awareness raising in the general public for generating demand for quality services.

Development partners expressed their concurrence on the importance of the theme selected for the consultation. **WHO WR** remarked that this type of forum was badly needed where all the stakeholders can share their health system initiatives as well as issues. He then discussed two important tools: one developed by WHO (save child checklist) and another one by UNICEF for QoC; and highlighted their significance by sharing the stats which showed that how newborn deaths were decreased with the use of these tools. He urged the provinces to employ these tools for better results. **UNICEF representative** pledged to continue the MNCH work, particularly with community-based workers i.e. LHWs and CMWs. **JSI representative** added that accountability for QoC is the main aspect which requires federal and provincial/area governments' attention. **UNFPA representative** maintained that we should work on the health systems and should empower/educate the public because without this, we can't achieve our goals. **USAID representative** advocated for birth spacing which can resolve many problems including the high newborn death rates.

## Provincial presentations

### a) Khyber Pakhtunkhwa

Some general across the board initiatives taken to improve the quality and performance of health services include increase in HR, increased beds strengths in the hospitals, and *sehat insaf* card for poor stratum of population. Moreover, private health sector mapping was done to improve and



ensure regulation and mainstreaming. For this, KP Health Regulatory Authority has been established. An Independent Monitoring Unit is established to regularly evaluate performance of the public-sector healthcare facilities and take measures to improve quality of services at the government hospitals in the province. For MNCH in particular, all essential equipment has been supplied and made functional at all levels after a thorough gap analysis. Strength of LHWs has been increased too. Nevertheless, KP health system is faced with various challenges of which one is of internally displaced population which is an extra load on the service delivery structures.

### b) Punjab

Key initiatives taken to improve the QoC at the health service delivery level include refresher training of LHWs, provision of Ultrasound at the BHUs and training of LHV to use it. Checklists have been developed for newborn (CHX, cord care, drying), and for ensuring continuum of care, registration cards have been developed which cover record from ANC to child care up to 5 years, almost 800 BHUs have been switched to 24/7 service provision mode. At the systems level, integration of RMNCH and Nutrition programs has been instrumental in pooling resources at the provincial level. Financial devolution to the hospital level has also improved the performance. DoH has introduced third party evaluation of services. Free ambulance service for expecting mothers (for pick and drop) is in operation, and its utilization rate is very encouraging. Health Care Commission of Punjab is mandated the task of licensing of health facilities, both in public and private sector, after gauging their quality of services.

### c) Sindh

A 50 points checklist has been developed to check the progress in health sector. New indicators have been introduced to monitor neonatal in the province. Around 600 new labor rooms have been established across the province. Number of LHWs has been increased too but department is facing challenge is finding qualified girls to be recruited. Health Care Commission is active and is exercising its role of regulation and standardization to improve the QoC at all levels, along with technical and management capacity. District Action Plans have been developed and implemented, and these are purely need based and reviewed periodically on the basis of district health system performance.

### d) Balochistan

DoH is all set to increase the number of LHWs and CMWs, but availability of qualified HR in the province is the biggest issue. Compounding on that are the security concerns, and difficult deserted far flung areas where young girls do not want to go and serve the health system. Development expenditure has to be increased. PPHI has made some difference and it has got far better level of QoC and responsiveness. However, there is lack coordination between PPHI and DoH. It was

suggested that performance yard stick should be different for different provinces, and that local problems should be solved with local solutions.

e) **FATA**

HR issues are too grave i.e. vacant posts, availability of qualified HR, willingness to serve hard areas in spite of incentives, security concerns, political interference in transfer/postings, etc. Data is scarce on health indicators of the area, and hardly any research is conducted because of the security situation.

f) **AJK**

Following the WHO guidelines, SoPs have been introduced for labor rooms' staff. Free emergency obstetric services are offered in all 10 districts. Like other difficult areas, availability, recruitment and retention of HR is an issue in AJK as well. Increased salary package for far flung has been approved to overcome the issue.

g) **GB**

Number of LHWs and CMWs is being increased gradually. Sick born units are established at all district level facilities. However, HR availability is a big issue because of the difficult terrain and remote geo-location of GB. Training and supervision of the existing staff is being strengthened with the help of development partners. Increased incentives have been offered to ensure retention of the staff. Lack of essential equipment is a big issue to ensure optimal QoC.

### Guest speakers

- a) Dr Monir Islam from Liverpool School of Tropical Medicine, UK alluded to the fact that 80% deliveries are normal while the 20% needs attention. What the governments need to do is to take the right measures to apply the concept of QoC. Strategies are required for effective implementation as quantity and quality both goes together and cannot neglect any one of them, and as he quoted ***"No poor option for poor people, every women and the newborn deserves the best"***. He recommended to re-organize the services by empowering the provinces and districts for implementation. He emphasized working on short term measures such as HR, training, standardization of services, etc; and then focus on longer term and more impactful interventions at the societal level such as girls' education. He invited GoP to become member of the LSTM QoC MNCH network.
- b) Dr Zulfiqar Bhutta from Sick Kids Hospital, Toronto reiterated that Maternal & Neonatal Mortality Rates are still unacceptably high. ***There is a need to look into causes of causes***. He shared the experience of using Multi-Dimensional Poverty Index to understand the disparities and inequalities in the population. He stressed to focus on malnutrition which starts from fetal life, and which is a result of maternal malnutrition. He insisted to look into the globally proven interventions to save lives of mothers and newborns.

## Questions for Round table

### Q1. Is there a need to have a national/ provincial strategic framework for QoC around the time of birth?

- A general consensus emerged from discussion was that there must be one country customized framework of QoC around the time of birth. Which framework to adapt and what to include can be deliberated.
- Since QoC is a health system's issue, the framework must also include FP/birth spacing which will help in decreasing anemia among the women of reproductive age, and subsequently the incidence of premature births.



- WHO/UNICEF/UNFPA developed a manual of 200 standards for quality prenatal, intra-natal and post-natal care; which can be reviewed to pick and choose what is relevant in the context of health care delivery system of Pakistan.

**Q2. What are the priority actions needed to improve QoC?**

- QoC standards first need to be defined. Then it would be imperative to build capacity of the health care providers to bring in practice those QoC standards.
- Next the authority to exercise and implement those SoPs should be delegated to the facility level.
- Once all the pre-requisites are met; then accountability comes into inter play.

**Q3. How is the issue of accountability for QoC being addressed?**

- After the integration of RMNCH and Nutrition, a monitoring tool is being used for the implementation of SoPs for QoC around the time of birth. (Punjab)
- Due to awareness, the users demand for QoC; then the services have to be responsive and ought to deliver quality services. (KP)
- Accountability framework includes a third-party audit, annual review, complaint redressal system, clinical audits, verbal autopsy, as well as activities for public demand creation. Nevertheless, the center should give backstopping (AJK)

**Way Forward**

- Having teased out the theme of QoC around the time of birth, it was concluded that the societal change is slow, but women should not die because of eclampsia, for instance. Therefore, there is a need for embarking upon short term interventions first, and then work on long term options.
- Quality of care is holistic, and therefore it must be employed throughout the continuum of care.
- Accountability can be ensured once all pre-requisites are met such as training, resources, supervision, reward, authority/delegation, etc. However, transparency and impartiality in accountability will guarantee its credibility.
- Similar consultations will be convened at provincial level to further work on and finalize the QoC framework.



## Policy Brief

August 2017

### Improving Quality of Care Around the Time of Birth in Pakistan

#### The context

Globally, progress in the reduction of maternal and child mortality has been achieved, but newborn mortality decline has been slow<sup>1</sup>. In Pakistan, the maternal mortality has fallen by 59% since 1990. Maternal, infant and child mortality indicators have no doubt improved<sup>2</sup>. For instance, maternal mortality is reported to decline from 276/100,000 to 170/100,000 live births, owing to wide outreach of national LHW program, and better skilled birth attendance availability<sup>3</sup>. However, the rate is still unacceptably high.

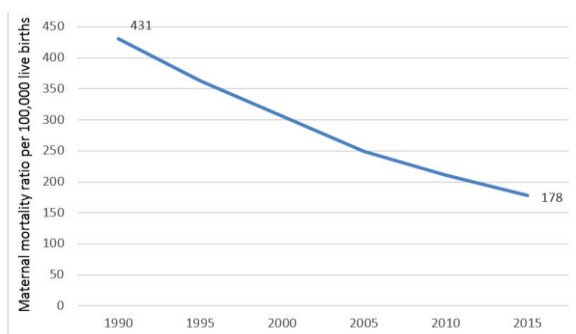


Figure 1. Trends of maternal mortality ratio, 1990-2015.

The global under-five mortality rate has dropped by 42% since 1990, but the neonatal mortality rate has remained unchanged. Despite the increase in the institutional deliveries, neonatal mortality has not improved since decades and remains stagnant at about 55 per 1000 live births<sup>4</sup>. Evidence shows that giving birth in a health facility with a skilled attendant is not sufficient to reduce maternal and newborn deaths. Besides, better care at the time of delivery, certain behaviour change interventions for

the health providers' and parents must be implemented to bring this mortality rate down<sup>5</sup>.

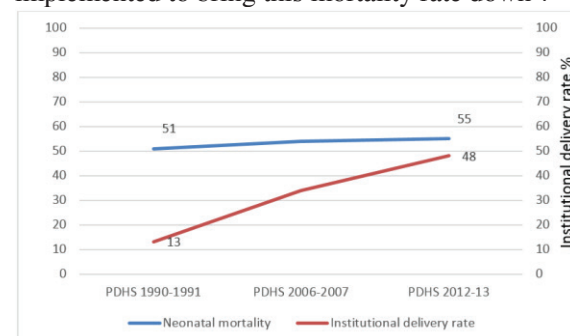


Figure 2. Trends of institutional deliveries and neonatal mortality, 1990-2012.

Incidence of stillbirths was found to be 47/1000 live births in 2011<sup>6</sup>; and since then decline in this rate has been negligible. Latest data shows Pakistan categorized as having the highest rate in the world (43/1000 live births) in the recent global estimates<sup>7</sup>. To achieve new-born mortality and still birth targets set by the Sustainable Development Goals (SDGs), Pakistan needs to accelerate the annual rate of reduction in neonatal mortality from 1.9% to 8.9%, and stillbirth rate from 1.4% to 8.5%<sup>8</sup>.

#### Quality of maternal and newborn care at around time of delivery

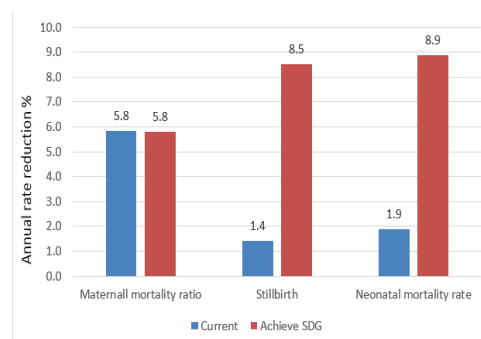


Figure 3. Current trends versus accelerated trends needed to meet the SDG target by 2030

1. WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Trends in maternal mortality: 1990 to 2015. Geneva: 2015.
2. National Institute of Population Sciences & Macro International. Pakistan Demographic & Health Survey 2006-07. Government of Pakistan, Islamabad: 2008.
3. Ministry of Finance. Economic Survey of Pakistan 2016-17. Government of Pakistan. Islamabad: 2016.
4. National Institute of Population Sciences & Macro International. Pakistan Demographic & Health Survey 2012-13. Islamabad: 2013.
5. Ejaz I, Shaikh BT. Social marketing for early neonatal care: saving newborn lives in Pakistan. World Health & Popul 2010; 11(3): 18-24.

6. Cousens S, Blencowe H, Stanton C, Chou D, Ahmed S, Steinhardt L, et al. National, regional, and worldwide estimates of stillbirth rates in 2009 with trends since 1995: a systematic analysis. Lancet 2011; 377: 1319-30.
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8. United Nations. Transforming our world: The 2030 Agenda for Sustainable Development. 70th General Assembly; New York: 2015. [http://www.un.org/en/ga/search/view\\_doc.asp?symbol=A/RES/70/1](http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/70/1)

A range of actions is needed, acting upon the social determinants within the health and social sectors, if a wider impact is to be achieved<sup>9</sup>. With increasing numbers of women accessing health care services, improving quality of care and patient safety are therefore critical if we want to accelerate reductions in maternal and newborn mortality. Nevertheless, many women and their babies die from poor care practice, even after reaching a health facility. Poor infection control, lack of maternal and newborn death review, non-functioning medical equipment, lack of qualified staff and medical supplies are common in government health facilities<sup>10</sup>. Majority of stillbirths that occurred in the third trimester of pregnancy are preventable with a better obstetrical care<sup>11</sup>. An effective focus on neonatal survival could reap a “triple return” on the investments made, through (1) the improved survival of women during delivery; (2) prevention of stillbirths; and (3) neonatal survival itself<sup>12</sup>. There is a clear need of a composite measure of continuum of care (CoC) including antenatal care, delivery assistance and postpartum care. The largest gap in CoC was observed at antenatal care followed by delivery and postnatal care within 48 hours after delivery<sup>13</sup>.

### Government's commitment

The slow progress in maternal and neonatal outcomes and the high still birth rates is a major concern for the Government of Pakistan. Ministry of National Health Services, Regulations & Coordination has already spelled out ‘improving quality of care at primary and secondary level care facilities’ as one of the propriety actions to accelerate progress on maternal, newborn and child health<sup>14</sup>. Recognizing its national importance, it was made an essential component of the service delivery package in the National Health Vision 2016-2025, endorsed by all the provinces<sup>15</sup>. Government is committed to adopt the WHO framework for improving the quality of care for mothers and newborns around the time of childbirth and to ensure the implementation with supportive

supervision<sup>16</sup>. To address the concern, the Ministry of National Health Services, Regulations and Coordination convened a national consultative meeting under the aegis of Health and Population Think Tank to deliberate on the theme of ‘Quality of care around the Time of Birth’ and to make policy recommendations for the Federal as well as Provincial governments.

### Policy recommendations

1. Develop a national Quality of Care Strategic Framework for subsequent adaptation by the provincial Governments. The framework will:
  - a. guide the reorganization of MNCH services and the establishment of the corresponding MNCH services standards.
  - b. facilitate the tracking, monitoring, and reporting of the adherence to the standards as part of the accountability measures.
  - c. identify appropriate accountabilities for the different tiers of government with respect to MNCH quality of care.
2. Select and include in Essential Health Service Package high impact and cost effective MNCH interventions around the time of birth.
3. Invest resources for inputs such as adequate staff and equipment but also in-service training, improved data collection system, and monitoring and reporting system.
4. Create an exclusive budget line on improving quality of care for MNCH to support the activities and solicit commitment from the development partners.
5. Establish women groups at the community level, hence raising demand creation for services with quality of care and enable communities to voice their needs and aspirations.
6. Mobilize and sensitize professional associations, academics and civil society to do advocacy for quality of care around the time of birth.

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## 4. Human Resources for Health in Pakistan

### Concept Note

#### Preamble

Human Resource in health is the most critical factor in provision of quality preventive, promotive and curative services<sup>1</sup>. The public sector is inadequately staffed and job satisfaction and work environment need improvement<sup>2</sup>. The overall health sector also faces an imbalance in the number, skill mix and deployment of health workforce, and inadequate resource allocation across different levels of health care i.e. primary, secondary and tertiary. As a result, there are geographical disparities in coverage between provinces, districts and rural-urban area<sup>3</sup>. Appropriate number, distribution and skill mix of HR improve equity, quality, access and coverage. Public and private sector must share the cooperation and intent to improve the staffing of health sector<sup>4</sup>.

Government of Pakistan is cognizant of the fact that health sector is facing HR crises, and that HR is an important pillar of health system strengthening<sup>5</sup>. Watching the burden of disease evolving in Pakistan, it is imperative that human resources are also strategized accordingly in the years to come<sup>6</sup>. A major strength of government's health care system in Pakistan is an outreach primary health care, delivered at the community level by more than 100,000 Lady Health Workers (LHWs) and an increasing number of community midwives (CMWs), and other community-based workers who have earned success and trust in the communities<sup>7</sup>. Quality workforce for health sector will necessitate quality of medical and allied education both in public and private sector<sup>8</sup>. With the right policies in place, investment in education and job creation in the health sector will contribute to promoting inclusive economic growth and implementation of 2030 Agenda for Sustainable Development and to meet the targets of the SDGs<sup>9</sup>.

#### Issues & Challenges

- a) Pakistan has one of the lowest doctors, dentists, nurses and paramedics to population ratios.
- b) There is a serious mal-distribution of HR, skewed towards urban areas and bigger hospitals.
- c) There are HR retention issues because of low satisfaction levels with the work-place, resulting in HR attrition from public to private, and from within to outside the country.
- d) No or just occasional structured in-service training, refresher courses and continuing professional education affect the capacity and competence of the work force.
- e) Licensing and renewal of licensing of health practitioners is weak, and is not linked with improved qualification or performance.
- f) Inadequate number of community health workers result in stagnancy in the outreach coverage for preventive services.

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## Way Forward

- a) Medical and allied health education must be tailored according to the health needs of the population, focusing on social determinants of health, ethics and public health laws.
- b) Continuous Professional Development needs to be institutionalized across both public and private sectors in conjunction with associations and linking up with re-licensing of the health professionals.
- c) Owing to the rapidly growing population, disease patterns and the health needs, further expansion and strengthening of existing workforce is the need of the hour.
- d) Appropriate and adequate skill mix of human resource production and task shifting is required.
- e) Fields of Public health, Allied health institutions and Family Medicine ought to be nurtured and institutionalized to increase the cadre of managers, regulators, administrators, specialized allied health staff and family physicians.
- f) Responsive management should be introduced in the health departments, and incentives must be offered to boost the performance and to make the rural appointments attractive.
- g) HR database at provincial and national level has to be created for the sake of forecasting and developing workforce.
- h) Developing a comprehensive National HR strategy for health sector based on National Health Vision 2016-2025.

## Questions for discussion

- 1. What are the current practices about HR development, deployment, regulation, management, retention and motivation?
- 2. What are the roles of different regulatory bodies such as Pakistan Medical & Dental Council, Pakistan Nursing Council, All other councils, Health care commissions etc.?
- 3. What should be the position and role of private sector in addressing the HR challenges in the country?
- 4. What type of HR reforms needed in the country in view of SDG3 targets?

## Report

# Human Resources in Health Sector of Pakistan: Issues, Challenges and Way Forward

**Health & Population Think Tank, M/o NHR&C, Islamabad**

**December 8<sup>th</sup>, 2017 at Health Services Academy**

Human Resource in health is the most critical factor in provision of quality preventive, promotive and curative services. The public sector is inadequately staffed and job satisfaction and work environment need improvement. The overall health sector also faces an imbalance in the number, skill mix and deployment of health workforce, and inadequate resource allocation across different levels of health care i.e. primary, secondary and tertiary. As a result, there are geographical disparities in coverage between provinces, districts and rural-urban area. Appropriate number, distribution and skill mix of HR improve equity, quality, access and coverage. Public and private sector must share the cooperation and intent to improve the staffing of health sector.

Government of Pakistan is cognizant of the fact that health sector is facing HR crises, and that HR is an important pillar of health system strengthening. Watching the burden of disease evolving in Pakistan, it is imperative that human resources are also strategized accordingly in the years to come. A major strength of government's health care system in Pakistan is an outreach primary health care, delivered at the community level by more than 100,000 Lady Health Workers (LHWs) and an increasing number of community midwives (CMWs), and other community-based workers who have earned success and trust in the communities. Quality workforce for health sector will necessitate quality of medical and allied education both in public and private sector. With the right policies in place, investment in education and job creation in the health sector will contribute to promoting inclusive economic growth and implementation of 2030 Agenda for Sustainable Development and to meet the targets of the SDGs.

### Issues & Challenges

- a) Pakistan has one of the lowest doctors, dentists, nurses and paramedics to population ratios.
- b) There is a serious mal-distribution of HR, skewed towards urban areas and bigger hospitals.
- c) There are HR retention issues because of low satisfaction levels with the work-place, resulting in HR attrition from public to private, and from within to outside the country.
- d) No or just occasional structured in-service training, refresher courses and continuing professional education affect the capacity and competence of the work force.
- e) Licensing and renewal of licensing of health practitioners is weak, and is not linked with improved qualification or performance.
- f) Inadequate number of community health workers result in stagnancy in the outreach coverage for preventive services.

A Health and Population Think Tank (HPTT) Round Table meeting was held on December 8, 2017, at the Health Services Academy, Islamabad. The objectives of the meeting were to deliberate on the issues of current situation and practices regarding HR development, deployment, regulation, management, retention and motivation; roles of various regulatory bodies such as PMDC and Nursing Council; prospective role of private sector in addressing HR challenges in the country, and HR reforms needed in view of SDG3 targets.



Welcome and brief overview of HPPT given by **Dr Assad Hafeez Director General MoNHSR&C**, explaining the rationale for establishing the HPTT, its objectives and the mandate given by the MoNHSR&C. He shared with the participants that this particular meeting is envisioned to discuss the issues pertaining to human resources in health sector and valuable inputs from the participants is sought so that these could be incorporated in the Human Resources for Health Vision which is set to be launched by March 2018.

**Dr Babar Tansneem Shaikh Technical Lead HPTT** set the stage by providing brief overview of HRH and linked it as an off shoot of the NHV 2016-2025. He presented an array of issues and challenges related to HRH which provided enough justification as to why HRH should be deliberated upon by the HPTT. These issues ranged from number of posts, deployment, distribution, gender balance, to motivation, retention, attrition, and incentives to HR. Human resource is a vital component when it comes to health system strengthening be it preventive, curative services or promotion of health. He pointed at dearth of an appropriate skill mix and alluded to the need of continuous professional development of HRH in the light of evolving field of medicine. It was mentioned that our international commitments such as SDGs, UHC and IHR/GHSA. Looking at literature and facts/figures it is very much evident that there is a need for fresh stock taking and during evolving times when the health system is changing its dynamics, when the paradigm of health is changing, when the notion of health is changing globally, there is a need to sit and discuss the challenges pertaining to human resource in health. He ended with a remark that access and coverage of health system will improve only when HRH are well trained and responsive to the needs of the population.

**The Federal Minister MoNHSR&C** thanked the HPTT and reiterated the resolve of the ministry to improve health and address the challenges one by one. She reminded the audience that MoNHSR&C has two main responsibilities: coordination and regulation. She underscored that we have to turn around the picture of epidemics and infectious diseases, non-communicable disease burden, and maternal and child health issues in order to achieve the targets set in SDGs. She however maintained that these challenges are too daunting to be addressed without an adequate trained and committed workforce in the health sector, especially in a country with growing population. She shared that the ministry and the Government of Pakistan is cognizant of the fact that health sector is facing HR crises, and that HR is a critical building block of any health system. She hoped that this meeting too, like all other previous meetings, will inform policy decisions to improve the situation of human resources in health sector of Pakistan, and particularly deliberations will feed into the National HR strategy underway for health sector based on National Health Vision 2016-2025, and the discourse will help it reaching a final shape. **Dr Raza Zaidi** pointed at the centrality of health in SDGs and that HR is pre-requisite to implement the NHV 2016-2025 and to realize the dream of UHC. He made a detailed presentation on the current status and 2030 projections of HRH needed in light of demographic shifts seen in the Census 2017 and the declining trends in communicable diseases & rising trends of non-communicable diseases. The key question raised was about the number of HRH per 1000 population (should it be 4.45/1000?). Should this focus on specialists or allied health or community health workers? While working on the HR/Population ratio, one must account for the brain drain from Pakistan, especially towards the Gulf counties for greener pastures. Looking at the double burden of disease, there is a need to develop a skill mix in terms of health workforce. He hinted towards the dire need of HRH education and an HRIS. As for the status of professional medical institutions, there are 156 medical colleges in the country out of which 55 are in the public sector and 101 are in the private sector. There are 135 nursing colleges which are mostly in the public sector. Domination of the private sector is good but needs a strong regulatory mechanism. In terms of production capacities, we are currently producing 159,000 doctors every year and in next 12 years will be producing 180,000. The situation is grave for the production of nurses as we need over a million nurses today but we have only a quarter of this capacity. He underscored the huge traditional workforce available in Pakistan, and suggested to think of ways and means to integrate this workforce into our health workforce structure.

Remarks and comments were taken from the participants which are as follows;

**Dr Muhammad Assai, WHO Representative**

in Pakistan stated that the issue of HR in health is of utmost importance and WHO is going to work very closely with the MoNHSR&C in an effort to devise a National Human Resource Strategy for Pakistan. He added that keeping in mind the needs of Pakistan we need to focus not only on doctors but also on allied health workers. Currently, we are focusing on a vertical approach in building the capacity of health workers, whereas we should focus on an integrated approach in this regard and having a workforce of multipurpose health workers to deliver a package of services is needed. The solutions to the health issues in Pakistan are allied health workers and we should start thinking about investing in this cadre of healthcare workers.



**Dr James Blanchard of University of Manitoba** iterated that the health system in Pakistan already has a lot of resources. We need to think about how to better deploy this human resource as the regeneration of more HR will take considerable time and efficient deployment of the already available HR will help in taking care of the burning issue in the health system. If we do good technical analysis and bottom up planning in terms of the existing HR, we can really optimize as to what can be done quickly.

**Lt Gen. Dr Imran Majeed, VC NUMS**

VC NUMS remarked that only 18% of the high achieving youth get admission in to the medical colleges. We need to think of ways and means to harness this high achieving youth. The idea is to not make all of them doctors as we will again have the issue of attrition. Suggested increasing the number of nurses, but at the same time being watchful of the absorptive capacity of the health system.

**Dr Hassan Mohtashami, UNFPA**

Suggested waiting for the full census report to come out (since it surprised everyone in terms of its findings – no one projected a growth rate of 2.4%). He was of the opinion to look at the upcoming PDHS 2018 and do further analysis combining both census and PDHS before taking HRH decisions. He emphasized on the importance of the role of community midwives and midwifery should be recognized as a standalone discipline within the health system. We need to focus on midwifery for reduction in maternal mortality, for promotion of family planning, reducing the fertility rate and for improving maternal health.

**Dr Sameen Siddiqui, WHO**

Remarked that there should be short term & a long-term response regarding HRH. Indicated the need for Fed/provincial level HRH offices, who should be doing cost projections of increasing HR – that too of all potential numbers i.e. what will it cost to have 3.3 or 4.45/1000 (just a WHO guiding principle). He pointed out that nursing and midwifery has always been neglected. He took up issues around the HRH Quality issues (mentioned structures for CPD, Accreditation, re-configuring curriculum of medical schools is needed). He emphasized the need to see absorption of nurses in the public sector and suggested reviewing the need to give more role to nurses in hospitals. He advocated to look at the potential of giving higher level of charge/control of hospitals to nurses. He showed extreme reservations of “Virtual learning & teaching” of medicine, since it is all a skills-based learning. He raised the need of training managers for hospitals. We can do that through hiring management personnel or imparting management education and training to the physicians.

**Dr Zeba Sathar-Population Council**

Dr Sathar suggested looking at HR numbers at tehsil/district level deployment, where one would find the actual gaps and disproportionate distribution. In the scenario after devolution of health, LHWs have become dysfunctional in the provinces. One strategy that she proposed was to invest in women for HRH, and that the LHWs system should be upgraded. On a critical note on census, she acknowledged



the labor work force – census shows large portion is of young population – and that they should be trained for other countries to increase the foreign remittances. We should also think about developing a younger workforce with more female representation in response to attrition and brain drain and make the work environment more attractive for the health workforce to work in.

**Alia Zafar, UNDP**

Raised the issues of many female doctors not practicing. What is the proportion of female doctors practicing after medical education should be looked into and addressed. Females not working or practicing could be used for telemedicine initiatives. Gender mainstreaming is needed in the medical system. She said “What HRH is fit for purpose” has to be seen. HR Management is critical – so take a step back, look what the SDGs 2030 agenda is & this also needs to connect with the private sector. Look at the SDGs indicators and work backwards to develop your HRH strategy.

**Prof James Blanchard, University of Manitoba**

Reiterated the need for a short term and long term approach to HRH strategy. Suggested an analytical component to be taken up in identifying and reducing existing HRH inefficiencies of allocation. This analysis should be bottom up – community upwards to re-deploy specialists (where there are inequalities). He mentioned HRH Quality issue is important and the HR should be fit for purpose. There should be an understanding of what the essential health care package is and what the training needs are. Health system must concentrate on mechanisms of in-service mentoring and supportive supervision. Uttar Pradesh in India has put in place an HRIS in a year’s time. He offered to establish the link between Pak/India for sharing experience. He suggested the role of medical colleges (with a clear catchment area) to become responsible for mentoring for their regional health care system (both public and private) within their jurisdiction. Therefore, the role of medical colleges/universities needs to be re-defined.

**Prof Rizwana Chauhdary-CPSP**

She reiterated the need for having nursing schools at all hospitals. It does not even need much investment. Young population should be trained and exported to other countries where there is a need of HRH. She also highlighted the need to invest in HR of neonatal units – which will eventually have an impact on reduction of NMR.

**Dr Fazli Hakim Khattak- Advisor HPTT**

Issue of attrition rates vs cadres should be explored further. There is a need to reduce the factors causing de-motivation among LHWs and Doctors. Consultation of the HRD Study (5 Vol) 90s, will provide a better-informed benchmark to carry forward the subject endeavor. Economic appraisal of each HRH cadre could help balancing the demand and supply sides within the estimated budget using the unit cost method. Attrition rate vs production of each cadre per annum will take it towards accurate HR projections and cost. The 6 components of a proposed HRH Framework may include; 1. Leadership 2. Partnership.3. Policy.4 Finance 5. Education and 6. HRH Management System. There are about 25 sub components that covers the complete sets of HRH and shall be considered in total for long run by 2030.

**Dr Zulfiqar Bhutta, Sick Kids Hospital, Toronto**

Dr Bhutta raised the concern of more in number and trained workforce to deal with maternal, newborn and child survival. He remarked that the country has spent proportionately significant resources in producing doctors over the years. We have also created a force of LHWs; but we neglected the cadre of nurses, LHVs and midwives and therefore the ratios are disturbed. We must have quality HR at district level so that an efficient referral system can come in function. Political will has to be built for addressing the HR deficiencies.

**Hakeem Abdul Manan, VC Hamdard University**

Emphasized on the mainstreaming of the alternative medicine, whereby many countries in the region are already doing it. It is an upcoming field and HR in this can be used effectively to fill in the gaps, if mainstreamed. Traditional medicine has a big workforce which has not been considered useful so far but the neighbouring countries have been reaping the benefits of developing and utilizing such a workforce. Currently there are seven universities in Pakistan offering graduation in eastern medicine.

The curriculum and training structure at these universities is at par with the allopathic medicine curriculum and training structure. Thus, this workforce could be used with confidence for rendering the health services.

**Dr Fethiye Gulin Gedik, HR Coordinator WHO EMRO**

The HR Coordinator at WHO EMRO joined the meeting via skype. She stated that HRH is getting attention globally and increased funding is coming into the health systems for development of HR through partnerships. We must realize that even if supply side is there still in the absence of trained HR there are not services and therefore no health. Currently there is a global HRH crisis. Over time with increasing production rates, we still face challenges with HRH. Globally increased production of HRH is not proportional to population growth and this is the case in EMRO also where despite increases in health workforce institutes over the last 2-3 decades the workforce has remained stagnant. Recognizing this issue, the WHO was asked to develop a strategy on HRH which was adopted in 2016 in the World Health Assembly.

**Brig Dr Naila Azam, AFGMI**

We must look at the duration of training (reducing the duration!) to improve quality of service. As regards the MBBS graduates– there is a serious retention issue. Doctors should be placed to serve near their respective communities. De-urbanizing medical education and making doctors serve in their place of residence is the solution.

**Pharmacist-QAU**

Pharmacists are the 3<sup>rd</sup> largest work force in Pakistan – 4000/year pharm degrees are added. How can they be involved in Integrated HealthCare Work Force?

**Dr Iqbal Memon – DD DGHS Sindh**

Public health as a specialty is not recognized. Policy on national level on health management cadres should include multidisciplinary backgrounds. There is a lack of HR sections and should have HR professionals placed there. Health sector should be managed by technical/medical professionals – since this leads to de-motivation and frustrations and leads to retention issues. He pointed to the inefficiencies within HR departments. DoH has to work on retention policies: i) heavy incentives for far-flung areas; ii) Mandatory training program before, in-service and then CPD, iii) promotions should be linked to these mandatory trainings.

**Dr Khalid – ADG HR KP**

HR information is currently being computerized in KP. The latest figures will be shared with HPSIU for incorporating in the HRH strategy work under way in MoNHSR&C.

**Dr Zaeem – Director Health Info GB**

He raised the absence of postgrad or house-job facility in GB. There is not a single medical college or nursing college to cater to the medical & allied education needs of local population.

**Dr Masood Bokhari – ADH (H) AJK**

He shared that average 500 doctors per year and only 30 nurses per year are being produced in AJK. How to reduce this imbalance and how to address the imbalanced skill mix of HRH?

**Dr Anisa Afridi- Health Secretariat FATA**

Raised issues similar to AJK/GB. She shared the issue of capacity to retain senior staff (who like to move to KP). No computerized data on HR exists. There is no public health or HR development unit. She said that appraisal mechanisms need to be reviewed, because the old traditional ACR system does not seem to be working, as there is hardly any accountability.

**Dr Naseer Nizamani- Nutrition International**

GoP should think about developing HR export strategy. We can go to 4.45/1000 HRH ratio. He suggested two actionable points: – for urban areas (have more specialists) and for rural and remote areas (have more midwives and LHWs). We need to consider improving the skills of present workforce like

LHWs, CMWs and nurses to do higher skill level jobs. We should look at task-shifting and short term strategies. Private sector should take up the training part, as the public sector alone cannot take the entire load of capacity building.

**Dr Shaista Siddiqui-KAIZEN**

One solution for brain drain vs retention could be to develop the district level nursing, in order to retain maximum workforce at the respective districts.

**Adeel Alvi, Program Manager, Contech**

HR information system must be made an integral part of the National HMIS. The concept of district health hubs must be thought out, whereby DHQ hospital will be converted into a teaching hospital with nursing institute in each district. We should think about making each DHQ a teaching facility for private medical colleges through public private partnerships, so that the opportunities in the private sector could be harnessed.

**Dr Muhammad Umar – VC RMU**

Dr Umar remarked that the role of a University is – education, research & services. Education/training should include and establish preventive health research units. We must try to establish ‘research’ as a specialty. Services should be the role of university. There are no university hospitals in public sector. AKU is one but it runs on a business model. So, a medical university can be made responsible for Rawalpindi District with a population of 3.5 million. Medical University City is another model – both curative and preventive services, and involved in “advocacy to stay healthy”.

**Dr Khalif Bile, International Consultant HSD**

Dr Bile advocated for a unified national HR policy and strategy (implementation strategies may differ in provinces). HRH is not a politically controversial issue, it is purely a technical issue and certainly consensus building is easier. Skill mix is important so as to address the need of health promotion and disease prevention. Community dimension is the area to look at in HRH strategy – LHWs and CMWs should be kept as assets. Should we have short term or long term solutions – research will play a role and help answer us. Establish mechanisms for linking policy and research. There is a tradeoff between total number of HR vs Skill mix: for 1 doctor to 2 nurses and 2 mid-wives must be considered for a country where MMR is still high.

**Maj Gen. Muhammad Aslam ProVC NUMS**

He suggested that the Medical colleges in the evenings should be used for alternative medicine. Gender disparity can be addressed by giving flexi hours and part time jobs. Get customized universities for allied and para medics. Private sector should be incentivized to open nursing and midwifery schools all across the country. We need to develop geriatrics unit – due to increase in life expectancy and eventual proportion of elderly. Address Retention – compensate for the immigration by training more HRH (immigration will keep happening). He also alluded to the need for integrating multidisciplinary medicine and allied subjects.

**Dr Assad Hafeez summarized discussions**

HR numbers like 3.2 or 4.45/1000 is not set in stone – we need to see which cadre to increase. Trade-off between HR Number vs Skill Mix needs to be considered.

- Defining the skill mix of HR should be based on essential health services packages.
- Focusing on midwives, LHWs and paramedics would be needed to increase the access and coverage. Strengthening LHWs and redefining their role is needed.
- The government has a key role but it cannot do everything and it has to a public private partnership.
- Districts need to develop essential service package and plan workforce (numbers and skill mix) around that package.
- Quality control of trainings and mentoring system should be reinforced/regulated.



**Dr Babar gave vote of thanks before ending the meeting**

He thanked all the participants for the interactive discussion, which is the mandate and role of Health & Population Think Tank. He assured that the proceedings and suggestions from this meeting will definitely inform the HRH strategy 2018-2030 under way in the MoNHSR&C. He requested the participants to send any other feedback to HPTT or to the MoNHSR&C directly which they deem important to be included in the process of developing the national HRH strategy.



## Policy Brief

December 2017

## Human Resource for Health in Pakistan

Human Resource in health is the most critical factor in provision of quality preventive, promotive and curative services<sup>1</sup>. The public sector is inadequately staffed and job satisfaction and work environment need improvement. The overall health sector also faces an imbalance in the number, skill mix and deployment of health workforce, and inadequate resource allocation across different levels of health care i.e. primary, secondary and tertiary. As a result, there are geographical disparities in coverage between provinces, districts and rural-urban area<sup>2</sup>. Appropriate number, distribution and skill mix of HR improve equity, quality, access and coverage. Public and private sector must share the cooperation and intent to improve the staffing of health sector<sup>3</sup>.



Government of Pakistan is cognizant of the fact that health sector is facing HR crises, and that HR is an important pillar of health system strengthening. Watching the burden of disease evolving in Pakistan, it is imperative that human resources are also strategized accordingly in the years to come. A major strength of government's health care system in Pakistan is an outreach primary health care, delivered at the community level by around 93,000 Lady Health Workers

(LHWs) and an increasing number of community midwives (CMWs), and other community-based workers who have earned success and trust in the communities. Quality workforce for health sector will necessitate quality of medical and allied education both in public and private sector<sup>4</sup>. With the right policies in place, investment in education and job creation in the health sector will contribute to promoting inclusive economic growth and implementation of 2030 Agenda for Sustainable Development and to meet the targets of the SDGs.

### Issues & Challenges

- a) Pakistan has one of the lowest doctors, dentists, nurses and paramedics to population ratios.
- b) There is a serious mal-distribution of HR, skewed towards urban areas and bigger hospitals.
- c) There are HR retention issues because of low satisfaction levels with the work-place, resulting in HR attrition from public to private, and from within to outside the country.
- d) No or just occasional structured in-service training, refresher courses and continuing professional education affect the capacity and competence of the work force.
- e) Licensing and renewal of licensing of health practitioners is weak, and is not linked with improved qualification or performance.
- f) Inadequate number of community health workers result in stagnancy in the outreach coverage for preventive services.

With this context, the M/o NHSR&C convened a round table under its Health & Population Think Tank initiative, looking for answers to the following questions:

1. What are the current practices about HR development, deployment, regulation, management, retention and motivation?
2. What are the roles of different regulatory bodies such as Pakistan Medical & Dental

<sup>1</sup> World Health Organization: The world health report 2006. Working together for health. Geneva: 2006.

<sup>2</sup> Shaikh BT, Ejaz I, Khan D, Shafiq Y. Political and economic unfairness in health system of Pakistan: A hope with the recent reforms. J Ayub Med Coll 2013; 25(1-2):198-203.

<sup>3</sup> World Health Organization: The world health report 2006. Working together for health. Geneva: 2006.

<sup>4</sup> World Health Organization. Working for health and growth: investing in the health workforce. Report of the High-Level Commission on Health Employment and Economic Growth. Geneva: 2016.

Council, Pakistan Nursing Council, All other councils, Health care commissions etc.?

3. What should be the position and role of private sector in addressing the HR challenges in the country?
4. What type of HR reforms needed in the country in view of SDG3 targets?

Keeping in view the WHO criteria 4.45/1000, Pakistan would need to customize its HR population ratio with a justifiable distribution of doctors, nurses, paramedics, allied health workers (traditional/alternate medicine) and community health workforce. One suggestion is to have a multipurpose health workforce to deliver the essential health service package to the community. Creating additional workforce takes time, so immediate step should be to map and re-deploy the current HR in an equitable manner. More focus on midwifery is needed for reduction in maternal mortality, promotion of family planning, curtailing the fertility rate and for improving maternal health. Management training to physicians and nurses is the need of the hour. HR planning must be synced with the targets of SDGs.

#### Action items

- a) Develop a comprehensive National HRH vision for health sector based on National Health Vision 2016-2025.
- b) HR database at provincial and national level has to be created for the sake of forecasting and developing workforce.
- c) Continuous Professional Development needs to be institutionalized across both public and private sectors in conjunction with associations, and to be linked with re-licensing of the health professionals.
- d) Appropriate and adequate skill mix of human resource production and task shifting is required, and it should be linked with essential health service package.
- e) Increase the cadre of managers, regulators, administrators, specialized allied health staff and family physicians.
- f) Owing to the rapidly growing population, number of LHWs, CMWs and paramedics to be increased, and their role to be re-defined.
- g) Medical and allied health education curricula to emphasize on social determinants of health, ethics and public health laws.
- h) Responsive management should be introduced in the health departments through incentives, and to make the rural appointments attractive.

This policy brief was developed to inform the consultative process and compilation of the National HRH Vision 2018-2030 at the Ministry of National Health Services, Regulations & Coordination.

## 5. Establishing a ‘Community of Practice’ for UHC reforms in Pakistan.

### Concept Note

#### Background

Since the 2013 elections, federal and three provincial governments in Pakistan have launched social health protection programs in their constituencies. These programs are technically supported by different development partners and have been launched in more than 50 districts across the country. Thus far, they have enrolled more than 2.8 million families (with approximately 20 million individuals) below the poverty line.

With the spirit of devolution, provincial autonomy and ownership for these programs is commendable. However, as these programs are entering their expansion phase, there is an essential need to bring all the relevant stakeholders (local policy makers, practitioners, researchers, and development partners) onto a common platform through the establishment of a "Community of Practice (COP) for Universal Health Coverage (UHC) reforms in Pakistan".

#### Objectives

Main objectives of this COP will be to build a critical mass of individuals with optimal knowledge and skills for rolling out the recently initiated health financing reforms and to learn from and avoid making the same mistakes (done in other provinces or elsewhere globally) by:

- Participating and learning from the regional/global capacity building opportunities in the form of country teams (webinars, twitter chats, on-line courses)
- Sharing the local evidence (costing studies, survey results, process evaluations)
- Discussing how to customize the practitioners' manuals being developed for Lower Middle-Income Countries by development partners (like WHO, World Bank, Joint Learning Network)
- Facilitating collaboration to meaningfully engage in and move forward the health financing reform agenda

#### Steps to be undertaken for setting up and management of the COP

- This COP is planned to be established under the Think Tank initiative of the Ministry of National Health Services Regulation and Coordination.
- Its members will be all the stakeholders engaged and/or interested in health financing reforms in the country. They will include, but will not be limited to local policy makers, practitioners, researchers, and development partners.
- A concept note of the COP will be shared and orientation sessions will be held (if needed) about the COP to get the buy-in of all the organizations and programs playing a key role in the implementation of the federal and provincial health social protection programs.
- Partnership for Health (P4H) <https://p4h.world/en> – a global network for social health protection and universal health coverage, has agreed to make a country page for Pakistan on its digital platform. This page, (<https://p4h.world/en/universal-object-country/pakistan>), will be available for all the COP members for free and will be used for virtual communication between members and for sharing the relevant information.

- A good balance of face-to-face meetings and virtual interaction (to sustain the momentum between meetings) will be ensured. Three face-to-face meetings are planned in the first year. Frequency and timings of the meetings will be decided by the COP members.

## **Proposed points to be discussed**

It is expected that initial discussions at COP forum will be on:

- Health services coverage
- Priority setting for the benefits package
- Population coverage
- Provider selection and provider payment mechanisms
- Monitoring and evaluation of the social health protection programs
- Public financial management and its intersection with health financing reforms
- Knock on effect of social health protection programs on quality of health services, human resource supply, and procurement of quality medicines.

## Report

# Establishing a ‘Community of Practice’ for Universal Health Coverage Reforms in Pakistan

Health & Population Think Tank, M/o NHSR&C, Islamabad

March 20<sup>th</sup>, 2018 at Health Services Academy

The meeting started with the recitation of Holy Quran, followed by welcome remarks from Dr. Babar Tasneem Shaikh. He briefed the participants about the activities conducted by the Health & Population Think Tank in the past and elaborated on how the recently established “Community of Practice for Universal Health Coverage (UHC) reforms in Pakistan” will benefit from the broad institutional representation of the Think Tank.



The meeting was planned in two sessions. First session included an overview of the community of practice, operational updates from the four-main social health protection programs in the country, and remarks from distinguished guests. Dr. Faraz Khalid - Senior Health Financing Adviser, Palladium presented the objectives and working of the community of practice. As a background, he shared how the political focus on social health protection reforms has increased since 2013 elections. With the large-scale expansion plans for the health insurance programs, there is a need for technical

collaboration at the national level and to bring all the relevant stakeholders onto a common platform. The objectives of the community of practice are: to build a critical mass of individuals with optimal knowledge and skills, and to learn from and avoid making the same mistakes (done in other provinces or elsewhere globally). The joint learning approach to be adapted, setting and management of the community, and potential topics of discussion were shared. P4H’s virtual platform and Pakistan’s page (<https://p4h.world/en/universal-object-country/pakistan>) were also shown to the participants.

**Dr. Faisal Rifaq - Director Technical, Prime Minister National Health Program (PMNHP)** started with outlining the phase wise expansion of the program. Benefit package, financing, and current status of the program were presented. The program has been expanded to 30 districts of Balochistan, Punjab, Sindh, Azad Jammu Kashmir, Federally Administered Tribal Areas, and Gilgit Baltistan; 2.07 families have been enrolled and services have been provided to 63,168 families so far. Future plans for the program, including linkages with “Family practice program”, addition of “Outpatient services” and “Reproductive health services in the benefit package, and legislation were shared. Regarding knowledge products developed by the program, Dr. Faisal mentioned that two baseline surveys in 16 districts, an implementation process evaluation in 6 selected districts, and studies on “cost comparison analysis between PMNHP and publicly offered prices in hospitals” and “client satisfaction” have been completed so far.

**Dr. Raiz Tanoli – Program Director, Sehat Sahulat Program** shared the expansion of his program across Khyber Pakhtunkhwa (KP) province in three phases. Around 2.5 million families living below the poverty line of 2 US\$– making 69% of population in KP, are being enrolled. Transgenders have also been recently included in the program. Benefit package not only covers inpatient illnesses requiring hospitalization, but also wage replacement of Rs. 250/day, transportation allowance of Rs. 1000 to seek



care from tertiary hospitals and for maternity care, and burial charges of Rs. 10,000 in case of death of the patient. Knowledge products developed include: i) a costing study for secondary care services in 4 districts, ii) a joint review of the program in collaboration with GIZ. A costing study for tertiary care services, including the component for estimation of out of pocket expenditures incurred by patients, is planned soon.

**Mr. Hamid Masood - Director Enrollment, Punjab Health Initiative Management Company (PHIMC)** first explained how the PMNHP is being rolled out in Punjab through PHIMC. The program was launched in four districts by end of 2016. Since October 2017, the program is being extended to thirteen new districts. Knowledge products developed include a baseline survey conducted in four districts. A third-party evaluation has been commissioned to Oxford Policy Management in pilot districts and KPMG has been hired for monitoring and supervision of program's expansion.

**Mr. Ishtiaq Hussain - Project Director, Social Health Protection Initiative Gilgit-Baltistan (GB),** shared the recent launch of the program in his province and elaborated the benefit package, poverty criteria for beneficiaries' selection, and contractual relationships between Health Department GB, insurance company, consulting firms and NGOs involved in implementation of the program. Lastly, he shared that knowledge products developed so far: i) a baseline for an impact evaluation of the Social Health Protection Program, ii) a preparatory study for the Social Health Protection Project Phase II, and iii) concepts notes for the program.

**Dr. Nabeela Ali - Chief of Party, IHSS-SD/JSI,** in her remarks, applauded the launch of community of practice. She appreciated the decision of Ministry of National Health Services Regulation & Coordination (MoNHSR&C) for placing this community under the umbrella of the Health & Population Think Tank Initiative. Referring to the National Health Vision 2016-25, she stated that a responsive unified national direction is needed to achieve the goal of Universal Health Coverage and coherence needs to be built among federal & provincial efforts in consolidating the progress towards the Universal Health Coverage.

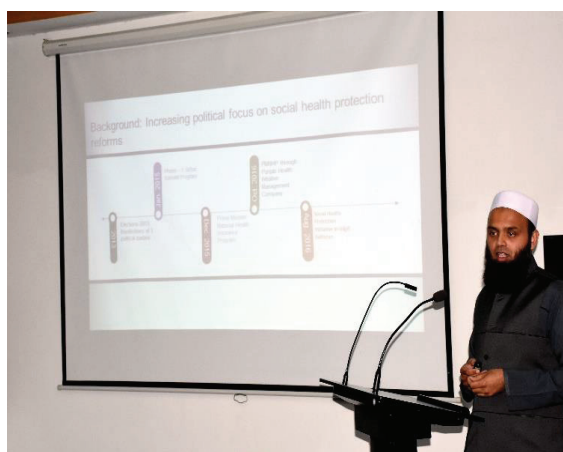


**Dr. Assad Hafeez - Director General Health, MoNHSR&C,** in his remarks explained how a political window of opportunity coincided with availability of a technical solution for the recently initiated social health protection reforms in the country. He cited Lady Health Workers Program, as another large-scale initiative, when politics and technical resolution came together. He observed that now there is a healthy competition among provinces to launch a better benefit package and to cover more population and costs of health services. Lastly, he emphasized that no reform is perfect from its outset and as long as the programs are willing to learn from their mistakes and are open to new ideas from within country and outside, there will be significant improvement down the line.

**Mr. Naveed Kamran Baloch - Secretary Health, MoNHSR&C** commended the establishment of the community of practice. He commented on political ownership and sustainability of the social health protection reforms. It was the vision of political parties, which was translated into commitments in the manifestoes, and was later materialized through the launching of these programs. The new planning instruments (PCIs) for these programs, both federal and provincial, will likely get substantial increase in their budgets. As long as these programs show results in reducing out of pocket expenditures and providing quality health services, the political ownership will stay there. Technical experts need to suggest governments how to increase the fiscal space for such programs and help the programs develop strategic purchasing mechanisms to get most out of the available budgets.

The second session covered global experiences, process evaluations and agenda for next meetings. Mr. Claude Meyer, P4H Network Coordinator, started the session by sharing experience of similar communities of practice from other Low and Middle-Income Countries and asserted the need for coherence in national efforts. He underscored the complexity of health financing reforms being carried out in many countries in South Asia. P4H is a global health network for health financing & economics and social health protection. It is an ever-expanding global health network and is a part of the UHC 2030 movement. It is present across regions and is working in 37 countries. It's the first digital knowledge network with over 1100 registered web users. It spans the full spectrum of health, social and finance sectors for better integrated policies. Its members are a mix of multilateral & bilateral organizations, who are: at the helm of the health sector, finance leaders at global level, spearheading social progress and social justice, illustrate geographical & eco dev-status balance, and are committed to Health Systems Strengthening and UHC. In the end, Claude congratulated the team involved in establishing the community of practice in Pakistan and said that P4H is proud to support the future engagement of the community through its digital platform.

**Dr. Faraz Khalid** gave an overview of the baseline surveys and implementation process evaluation conducted for PMNHP. These studies were commissioned by MoNHSR&C, supported by World Health Organization, and coordinated by Health Services Academy. Objectives and key findings of the latest baseline survey conducted in Punjab were presented, with details on the reasons for neglected inpatient care, out of pocket expenditures made by the sampled households, and incidence of catastrophic health expenditures. Following the baseline survey results, scope of the implementation process evaluation and its preliminary findings on awareness and knowledge of beneficiaries about PMNHP were presented.



**Dr. Sheraz Ahmad Khan – Deputy Director Monitoring & Evaluation, Sehat Sahulat Program** presented the Joint Progress Review of the program. This review was done in collaboration with GIZ. He started by sharing the rationale, scope, and methodology of the review. Further, he presented the key findings and recommendations for the following processes of the program: beneficiaries enrollment, data management, premium contributions by the government, provider contracting/empanelment, quality of health services, complaints redressal mechanism, and claims processing and provider payment system.

After the two sessions, an open discussion was conducted. **Muhammad Ashar from State Life Insurance Company (SLIC)** thanked the organizers for inviting its company and shared the problems being faced by the company in finding hospitals which could deliver quality health services in the rural districts and identified the issues being faced by NGOs in locating the beneficiaries while using NADRA's lists. Dr. Imran Durrani from GIZ raised the question of financial sustainability of the programs and suggested that provincial governments should do a longitudinal fiscal space analysis before moving towards the next phases of the programs. Representatives from academic/research institutions, like Aga Khan University Karachi and Khyber Medical University, Peshawar expressed interest in collaborating with the social health protection programs for implementation research. Social health program representatives appreciated the establishment of community of practice and were of the view that such a neutral technical platform is direly needed to discuss both strategic and operational challenges being faced by the programs.

**Dr. Nasir Idrees - Senior Technical Adviser, Palladium**, deliberated on the evolution of social health protection programs in Philippines and Thailand, and gave suggestions for the inclusion of formal sector in the programs. Dr. Faisal appreciated the idea of collating all the knowledge products being developed

by the programs on the P4H's digital platform. Dr. Faraz encouraged the participants to subscribe to the digital platform and use it for all the virtual discussions between the meetings. He further sought suggestions from the participants for the next meeting's agenda; discussion on inclusion of outpatient services in the benefit package and costing of treatments at both secondary and tertiary hospitals, were mostly recommended.

Overall, the meeting was well-attended and more than 30 relevant stakeholders participated representing the national and provincial social health protection programs, MoNHSR&C, Insurance companies, NGOs, academia and research institutions.

### Next steps

- Populate the Pakistan page on the digital platform and send out invitations for subscriptions.
- Engage the audience through the updates/news/forthcoming twitter chats
- Organize meeting every 3-4 months after discussing the agenda/topics of common concern with the social health protection programs.

## 6. Tuberculosis in Pakistan: A challenge that still remains.

### Concept Note

Tuberculosis (TB) is the ninth leading cause of deaths worldwide, and the top leading cause from a single infectious agent, ranking even above HIV/AIDS<sup>1</sup>. World Health Organization's (WHO) End TB Strategy and the United Nations' (UN) Sustainable Development Goals (SDGs), share a common aim: to end the global TB epidemic. Specific targets, being ambitious, include a 90% reduction in TB deaths and an 80% reduction in TB incidence (new cases per year) by 2030 compared to 2015. Achieving these targets requires provision of TB care, and more so the prevention, through a multi-sectoral action to address the social and economic determinants as well as consequences of TB. This would necessitate technological breakthroughs by 2025 so that incidence can fall faster as compared to what has been achieved previously.

Pakistan in this backdrop, ranks fifth amongst the 30-high burden TB countries. The TB incidence rate in Pakistan is 275 per 100,000 population and has a prevalence of 342 per 100,000 population; however, only 62% of these cases could be detected and reported to the National TB Program (NTP) in 2015<sup>2</sup>. It is presumed that in the high TB burden countries, more than half of TB patients remain undetected due to flaws in the systematic screening<sup>3</sup>. Furthermore, Pakistan has an ever-increasing cases of drug resistant TB with estimated annual cases of around 14000 among notified pulmonary TB cases. In the notified new pulmonary TB cases there are 10,605 RR TB cases (at the rate of 4.2% in new cases) having 2773 among notified retreatment cases (at the rate of 16% in retreatment cases)<sup>2</sup>. In Pakistan, even though the National Tuberculosis Program (NTP) has shown high treatment success among TB patients, albeit, people with TB symptoms and disease still attend private clinics for diagnosis and treatment and are thus missed by the singular focus on public facilities and centres operated by non-governmental organizations<sup>4</sup>. For the patient visiting private facilities, this can mean higher costs of treatment and sub-optimal care, outside of NTP purview<sup>5</sup>.

Many efforts have been put into controlling and eradicating TB in Pakistan which have involved Public-Private Mix (PPM) as a crucial component to meet the WHO and Stop TB Partnership targets, using Lady Health Workers to task-shift and bridge the gap of Human Resource as part of DOTS initiative, efforts to integrate TB related activities at the Primary Health Care (PHC) level to deliver services in the peripheral health facilities, opening more diagnostic centres across the country to help coverage curative services and Advocacy Communication & Social Mobilization Program to increase awareness across the communities especially to increase the diagnostic demand<sup>2</sup>. These efforts have had some benefits, but more strategic thinking and planning is needed especially in terms of implementation challenges such as drug production within the country, supply chain issues, further task-shifting for TB control etc. Last but not the least, planning in terms of securing funds for TB in Pakistan needs attention in the wake of possible exit of donor. Diagram below shows domestic funding has been low over the last 5 years and there is still about 25% of funds that were needed for the year 2017.

There is dire need of innovative and bold ideas to control and eradicate TB from Pakistan. This will also require research at the national level, especially to seek new and ground-breaking interventions

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<sup>1</sup> World Health Organization. Global tuberculosis report 2017. Geneva: 2017.

<sup>2</sup> Ministry of National Health Services, Regulations & Coordination. Annual TB Report 2016. National TB Control Program. Islamabad: 2016.

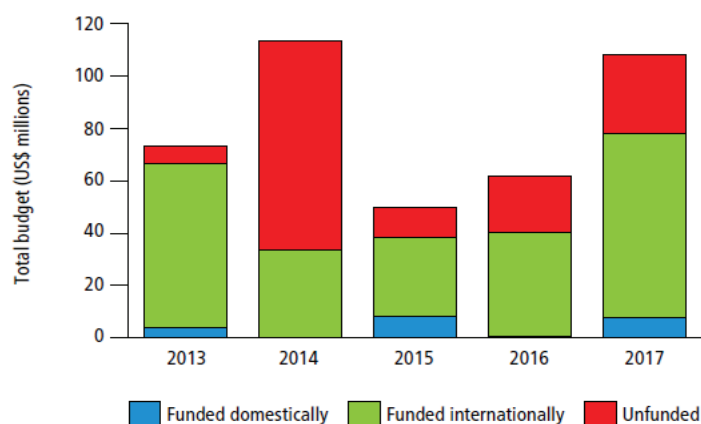
<sup>3</sup> World Health Organization. Systematic screening for active tuberculosis: principles and Recommendations. 2013. <http://www.who.int/tb/tbscreening/en/>

<sup>4</sup> Khan AJ, Khawaja S, Khan FS, Qazi F, Lotia I, et al. Engaging the private sector to increase tuberculosis case detection: An impact evaluation study. *Lancet Infect Dis* 2012; 12(8):608-16.

<sup>5</sup> Fatima R, Qadeer E, Enarson DA, Hinderaker SG, Harris R, Yaqoob A, Bassili A. Investigation of presumptive tuberculosis cases by private health providers: lessons learnt from a survey in Pakistan. *Public Health Action* 2014; 4(2):110-2.

that are needed at the community level to generate more demand, how to involve the informal health sector to help control TB, and finally how to help translate research into policy.

Pakistan stands resolute to ending TB. In November 2017 in Moscow, WHO held the Global Ministerial Conference on Ending TB in which Pakistan participated. This was followed up by a meeting in January 2018 in Geneva with TB civil society organization representatives to identify and discuss key issues and joint actions to strengthen civil society engagement for ending TB epidemic. Further to this, there is a high-level meeting being organised in summer of 2018, where for the first time in history heads of state will review progress in ending TB during the upcoming United National General Assembly High Level Meeting on TB.



WHO Global TB Report 2017

In view of this background, the Ministry of National Health Services, Regulations and Coordination has convened a round table meeting to discuss challenges and potential way forward around TB control and eradication in Pakistan. The round table meeting will aim to generate discussion in order to answer the following questions under 4 key thematic areas:

### 1. Active vs Passive TB Case Detection

- How to ensure “missing cases” are detected?
- Should we continue with Passive Case Finding (PCF)?
- Should we shift to new technologies for Active Case Finding (ACF) & is that sustainable?
- How to tackle the increasing burden of Multi-Drug Resistant (MDR) TB in Pakistan?

### 2. Implementation & Logistic challenges

- What is the way forward/ strategy to ensure funding for TB program in Pakistan after Global fund?
- How much funds needed in light of the National Strategic Plan for TB (owned by the provinces)?
- Is there is a need for domestic production of anti-TB drugs & how to ensure supply chain?
- Is task-shifting needed in implementation of TB control and eradication strategies & how to engage the informal sector (quacks/sham healers) in TB control?
- How to increase the TB diagnostic demand at the community level?

### 3. Public-Private Partnership for TB Control & Eradication

- What are the strategies that can enhance Public Private Mix (PPM) for TB?
- How do we involve NGOs & CBOs in community-based treatment of drug sensitive TB?

### 4. Research around TB in Pakistan

- What innovative and bold interventions are needed to generate demand at the community level?
- How to ensure translation of evidence on TB into policy?



## Report

# Tuberculosis in Pakistan: A challenge that still remains!

Round Table Meeting held on 27<sup>th</sup> March 2018

Health & Population Think Tank- MoNHSR&C- Health Services Academy

Tuberculosis (TB) is the ninth leading cause of deaths worldwide, and the top leading cause from a single infectious agent, ranking even above HIV/AIDS<sup>1</sup>. World Health Organization's (WHO) End TB Strategy and the United Nations' (UN) Sustainable Development Goals (SDGs), share a common aim: to end the global TB epidemic. Specific targets, being ambitious, include a 90% reduction in TB deaths and an 80% reduction in TB incidence (new cases per year) by 2030 compared to 2015. Achieving these targets requires provision of TB care, and more so the prevention, through a multi-sectoral action to address the social and economic determinants as well as consequences of TB. This would necessitate technological breakthroughs by 2025 so that incidence can fall faster as compared to what has been achieved previously.

Pakistan in this backdrop, ranks fifth amongst the 30-high burden TB countries. The TB incidence rate in Pakistan is 275 per 100,000 population and has a prevalence of 342 per 100,000 population; however, only 62% of these cases could be detected and reported to the National TB Program (NTP) in 2015<sup>2</sup>. It is presumed that in the high TB burden countries, more than half of TB patients remain undetected due to flaws in the systematic screening<sup>3</sup>. Furthermore, Pakistan has an ever-increasing cases of drug resistant TB with estimated annual cases of around 14000 among notified pulmonary TB cases. In the notified new pulmonary TB cases there are 10,605 RR TB cases (at the rate of 4.2% in new cases) having 2773 among notified retreatment cases (at the rate of 16% in retreatment cases)<sup>2</sup>. In Pakistan, even though the National Tuberculosis Program (NTP) has shown high treatment success among TB patients, albeit, people with TB symptoms and disease still attend private clinics for diagnosis and treatment and are thus missed by the singular focus on public facilities and centres operated by non-governmental organizations<sup>4</sup>. For the patient visiting private facilities, this can mean higher costs of treatment and sub-optimal care, outside of NTP purview<sup>5</sup>.



Many efforts have been put into controlling and eradicating TB in Pakistan which have involved Public-Private Mix (PPM) as a crucial component to meet the WHO and Stop TB Partnership targets, using Lady Health Workers to task-shift and bridge the gap of Human Resource as part of DOTS initiative, efforts to integrate TB related activities at the Primary Health Care (PHC) level to deliver services in the peripheral health facilities, opening more diagnostic centres across the country to help coverage curative services and Advocacy Communication & Social Mobilization Program to increase awareness

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across the communities especially to increase the diagnostic demand<sup>2</sup>. These efforts have had some benefits, but more strategic thinking and planning is needed especially in terms of implementation challenges such as drug production within the country, supply chain issues, further task-shifting for TB control etc. Last but not the least, planning in terms of securing funds for TB in Pakistan needs attention in the wake of possible exit of donor. Diagram below shows domestic funding has been low over the last 5 years and there is still about 25% of funds that were needed for the year 2017.

There is dire need of innovative and bold ideas to control and eradicate TB from Pakistan. This will also require research at the national level, especially to seek new and ground-breaking interventions that are needed at the community level to generate more demand, how to involve the informal health sector to help control TB, and finally how to help translate research into policy.

Pakistan stands resolute to ending TB. In November 2017 in Moscow, WHO held the Global Ministerial Conference on Ending TB in which Pakistan participated. This was followed up by a meeting in January 2018 in Geneva with TB civil society organization representatives to identify and discuss key issues and joint actions to strengthen civil society engagement for ending TB epidemic. Further to this, there is a high-level meeting being organized in summer of 2018, where for the first time in history heads of state will review progress in ending TB during the upcoming United National General Assembly High Level Meeting on TB.

In view of this background, the Ministry of National Health Services, Regulations and Coordination convened a round table meeting to discuss challenges and potential way forward around TB control and eradication in Pakistan. The round table meeting aimed to generate discussion in order to answer the following questions under 4 key thematic areas:

### **1. Active vs Passive TB Case Detection**

- a) How to ensure “missing cases” are detected?
- b) Should we continue with Passive Case Finding (PCF)?
- c) Should we shift to new technologies for Active Case Finding (ACF) & is that sustainable?
- d) How to tackle the increasing burden of Multi-Drug Resistant (MDR) TB in Pakistan?

### **2. Implementation & Logistic challenges**

- a) What is the way forward/ strategy to ensure funding for TB program in Pakistan after Global fund?
- b) How much funds needed in light of the National Strategic Plan for TB (owned by the provinces)?
- c) Is there is a need for domestic production of anti-TB drugs & how to ensure supply chain?
- d) Is task-shifting needed in implementation of TB control and eradication strategies & how to engage the informal sector (quacks/sham healers) in TB control?
- e) How to increase the TB diagnostic demand at the community level?

### **3. Public-Private Partnership for TB Control & Eradication**

- a) What are the strategies that can enhance Public Private Mix (PPM) for TB?
- b) How do we involve NGOs & CBOs in community-based treatment of drug sensitive TB?

### **4. Research around TB in Pakistan**

- c) What innovative and bold interventions are needed to generate demand at the community level?
- d) How to ensure translation of evidence on TB into policy?

## Proceedings of the Round Table

Dr Babar Shaikh, Technical Lead HPTT introduced the Think Tank's functions and mandate to act as a platform for all the provinces to come together, discuss and share knowledge and issues around various health matters which are of national importance and not pertinent to any single province. Highlighting the meeting's background, he shared that TB is a leading cause of death worldwide and that Pakistan ranks 5<sup>th</sup> among high burden countries. TB cases are increasing and there are challenges with detection, and of drug resistance. TB must be controlled together by public and private sector. However, there are implementation & logistic challenges, compounded by the dearth of relevant research around TB in Pakistan.

Dr Assad Hafeez DG Health reminded the house of the WHO's Global Ministerial Conference held in November 2017 in Moscow on Ending TB in which Pakistan participated. Later in January 2018 in Geneva, civil society organizations gathered to discuss strengthening CSOs engagement for ending TB epidemic. And now United National General Assembly will convene a high level meeting on TB which is expected in summer 2018. He alluded to the national responsibilities and international commitments that the government has made by signing the declaration of SDGs & and pledges to abide by the Global Health Security Agenda. He urged the participants to discuss the questions raised in the background paper so that some concrete actionable way forward can be thought out for the national and provincial stakeholders as well as NGOs, civil society and the development partners for ending TB in Pakistan. Involving researchers and academics is important so that they generate evidence on health seeking behaviors.



Dr Minghui Ren, ADG WHO HQ Geneva showed his concern about the missing cases in Pakistan, and reiterated the need for efficient use of resources (money and HR) for improving the TB interventions.

Mr Saeedullah Khan Niazi, DG (H) Gilgit Baltistan mentioned the hardships in the terrain of GB, cold weather, and hard to reach areas. He pointed at the increasing incidence of MDR TB in the region and that they have very few TB diagnostic centers.

Dr Jacob Creswell from STOP TB pointed out access to treatment

facilities as a major issue because of distrust of the people on public sector hospitals and preference of private sector which is expensive. As a result, patients with symptoms remain undiagnosed, especially marginalized and excluded groups of population. Government's roles and responsibilities must be reviewed as well as CSOs and NGOs must play their role especially to serve the hard to reach areas.

Prof Bo Lindblad from Karolinska Institute Sweden who is an international child health specialist mentioned the rising childhood TB. He linked it with socio-economic conditions in the country, whereby high resource countries have low incidence of TB and low resource countries have high TB rates. However, he was surprised that improving socio-economic conditions in Pakistan have not affected TB rates. So there must be other reasons that need to be investigated and a multi-curricular approach may be adopted.

Federal Minister for Health Mrs Saira Afzal Tarar appreciated the organizers of the meeting and its objectives. She said that technical wing of the ministry is now very strong and most of the decisions are taken on evidence. She also emphasized on poverty linking with health behaviours. Other weakness she pointed out was of the referral system, due to which service utilization remains low. She insisted on utilizing resources judiciously. She shared with the house that ministry is promulgating law of OTC sale of medicines. She appreciated the fact that dependence on GF is now



transitioning into provinces' own allocations for TB, even then the partners' role is important. She said that the financial outlay of \$250m for TB was to a great extent bridged by GF by providing \$180m. So now on its exit in 2019-2020, government has to seriously think of mobilizing extra resources because almost US\$500m will be needed to be on our own feet. She said with huge population, burden of TB was evident to be high, however, better governance in the program and transparency could improve the state of affairs. She also admitted that due to law and order situation in certain parts of the country, access to health care has been an issue. But where access is not an issue, people prefer private sector and informal sector. She emphasized to involve *ulema* to preach for cleanliness and hygiene in the community. She also pointed out at the role of media who should highlight TB as a national emergency. She shared with the house that she is going to take up the TB agenda in upcoming CCI.

Dr Nasir Mehmood, NPM TB program presented the structure of the program. He shared that besides a conventional burden of TB and the MDR TB, now there is a significant toll of childhood TB and TB as co-infection to HIV/AIDS. He referred to End TB strategy which has ambitious targets for SDGs 2030 as well as End TB 2035. For TB cases notification, he mentioned the untapped potential of private sector. He called for attention to three main challenges of the program: Provincial coordination, Inter-sectoral collaboration, and the Missing cases. He shared with the way forward and new initiatives of NTP in public sector (Use of Digital X-Rays with CAD4TB, Expanding Gene X-pert network, Training on Childhood TB, Expanding PMDT network, Engaging LHWs, Mandatory notification of TB, Multi sectoral approach, Digital M&E & Supervision- DHIS-2, Research capacity building), and in the private sector (Engaging over 5000 GPs & Specialists, Engaging NGOs, Armed forces, & other public institutions, Active case finding --Mobile vans for TB care, Youth engagement in TB control, Mass media campaigns, Zero TB cities- Urban DOTS).

Dr Karam Shah, Advisor HPSIU MoNHSR&C said that addressing TB is imperative en route to achieving targets of UHC and SHP. Government wants zero catastrophic cost on TB treatment. However, Stop TB strategy must include the provision of involving other sectors for combatting TB, because the disease cannot be controlled by the TB program alone and by public sector alone. Therefore, poverty alleviation program, education, labor, housing, food and agriculture must join hands. He took note of the fact that in the last three years, not much research has been done on TB in Pakistan. He suggested three pillars to address the multitude of the problem: Health personnel and Hospitals must engage in active TB case finding; Advocacy for community engagement and TB notifications; and Research to find innovations for the disease early detection, diagnoses and treatment. He acknowledged that the demand side activities of the program have been weak and there is a need to engage the CSOs for more robust demand creation for TB services.

Dr Inaam ul Haq, World Bank opined that we would not progress unless we do innovations on scale. He also questioned that while GF is supporting the program, why public finances were displaced. He said that since public sector has its capacity issues, public finances should have been used for engaging the private sector. He also suggested to take stock of public expenditure on TB in the last three years. He proposed to re-visit the TB program achievements and to re-check the numbers. He said that world over (including in US and Europe), TB declined with socio-economic development, whereas in case of

Pakistan, despite the developing economic indicators, TB is on the rise. For case notification in the private sector, he emphasized for immediate legislation.

Dr Rehan Hafiz, GAVI differed and said that public finances have always been there in the shape of PC1. He said that solutions are there, we need to innovate, scale up and institutionalize the same.

Dr Muhammad Assai WR WHO suggested to devise a health system's response to work on community awareness component. He suggested to use all possible mediums for this e.g electronic and print media, Interpersonal communication, mobile services, midwives, LHWs, LHVs, volunteers, and even by creating a multi-purpose worker for BCC activities on all health issues. Moreover, he suggested to install Genexpert in every DHQ and RHC of the country. He emphasized on the capacity building of the staff working in TB program at BHUs, RHCs and THQs. He agreed with the approach of multi-sectoral collaboration but indicated the need for exact roles of the partners.

Dr Zarfishan Tahir, Provincial manager TB Punjab shared with the house about Punjab government's funding allocation to the program, and the strategy of moving from 'Stop TB' to 'End TB'. She also shared that provincial program is now getting data from the GPs as well as *Hakeems*. Identifying the key populations of TB is critical eg migrant populations, harder to reach populations, drug users, HIV cases. Integrated screening (HIV, Hepatitis and TB being screened together in Punjab).

Dr Nauman Safdar from Indus Hospital highlighted the issue of those cases who are diagnosed but later they went missing; they should be traced first. This calls for strengthening our surveillance system. Use of technological innovations/user friendly technologies have to be introduced for notification of TB cases from the private sector. In India, a separate team interfaces with GPs as supporters to help them notify cases. He added that childhood TB and extra-pulmonary TB should also be given due importance as it is spreading equally.

Jacob Creswell from STOP TB added that at present there are 400 Genexpert machines installed throughout the country. The number should be increased. He agreed that Active case finding with technology can be done but it is HR intensive; therefore, passive case finding should be the basis. He disagreed with the term 'missing cases'; instead he said that these are the cases we are not reaching out. About reporting and notifying TB cases, he called for the need of an easy and user-friendly system, which a LHW can also use. He mentioned example of Ethiopia where case notification is 100%.

Dr Hussain Hadi commenting on missing cases said that there are three places where these can be found: big public sector hospital, private hospitals or in the community. He said that public sector still has huge potential to contribute to the efforts of NTP. Legislating private doctors to notify cases could be an uphill task. For active case finding, he proposed using mobile vans as a pilot.

Hakeem Abdul Hannan, VC Hamdard University was of the opinion that everybody should be checked up for TB at the time of employment. Alternative medicine for TB should also be promoted because its raw material is available in abundance in Pakistan.

Dr Rehana Siddiqui from AKU suggested mapping on accessibility of TB services across the country. Also, she was of the opinion that before involving or expecting anything from the private sector, their capacity assessment should be carried out.

Dr Inaam ul Haq said that government should pay the private sector to notify the cases, they will do the job. He lauded the NTP on involving 5000 GPs, and suggested that it should be scaled up. Federal role should be re-defined in the whole scenario.

Dr Karam Shah in the light of the comment above reminded the need for increasing domestic funding for the program.

Dr Muhammad Assai WR WHO said that we need research to respond to questions raised today, so that evidence-based financing can be done. He said that government or donors will be convinced if we tell

them the value for money i.e. how many lives saved? This research does not have to be randomized controlled trials, but simple research which can be documented and translated into policy. Sangita Patel Director Health USAID called for political commitment and declaring TB as state of emergency.

Dr Minghui Ren, ADG WHO HQ Geneva suggested to explore private sector's perspective to work with the public sector, and then devise urgent actions.

Dr Assad Hafeez DG (H) summarized and concluded the session with following actionable points:

- i) TB to be declared as a priority disease by sensitizing the Prime Minister and Chief Ministers, and the matter be taken up at CCI.
- ii) Financing for TB to be increased at federal level so that funding gaps at provincial levels are covered. Provinces to also define their exclusive allocations for TB in the respective ADPs.
- iii) Health Care Commissions to play their role in legislation about notifying TB cases especially by the private sector.
- iv) Investment in procuring Genexpert machines to be increased for MDR TB case detection.
- v) All detected cases of TB to be tested for MDR through Genexpert.

In the end, he thanked the participants, provinces, NTP, academics, researchers, WHO, STOP TB, USAID, JSI, and the Health Services Academy and the MoNHSR&C. He also praised the efforts of HPTT for organizing the event with inputs and hard work spanning over several weeks.



## Policy Brief

April 2018

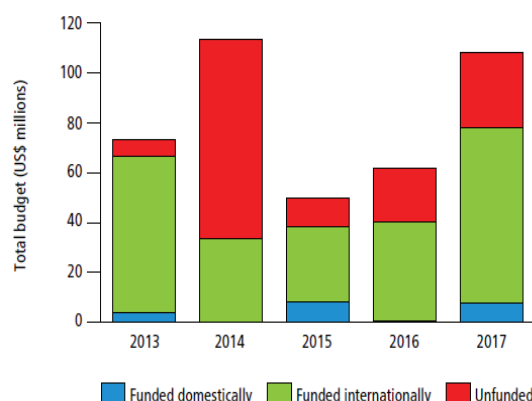
## Tuberculosis in Pakistan: A challenge that still remains!

Tuberculosis (TB) is the ninth leading cause of deaths worldwide, and the top leading cause from a single infectious agent, ranking even above HIV/AIDS<sup>1</sup>. Pakistan in this backdrop, ranks fifth amongst the 30-high burden TB countries. The TB incidence rate in Pakistan is 275 per 100,000 population and has a prevalence of 342 per 100,000 population; however, only 62% of these cases could be detected and reported to the National TB Program (NTP) in 2015<sup>2</sup>. It is presumed that in the high TB burden countries, more than half of TB patients remain undetected due to flaws in the systematic screening<sup>3</sup>. Furthermore, Pakistan has an ever-increasing cases of drug resistant TB with estimated annual cases of around 14000 among notified pulmonary TB cases. In the notified new pulmonary TB cases, there are 10,605 DR TB cases (at the rate of 4.2% in new cases) having 2773 among notified retreatment cases (at the rate of 16% in retreatment cases)<sup>2</sup>.

World Health Organization's (WHO) End TB Strategy and the United Nations' (UN) Sustainable Development Goals (SDGs), share a common aim: to end the global TB epidemic. Specific targets, being ambitious, include a 90% reduction in TB deaths and an 80% reduction in TB incidence (new cases per year) by 2030 compared to 2015. Achieving these targets requires provision of TB care, and more so the prevention, through a multi-sectoral action to address the social and economic determinants as well as consequences of TB. This would necessitate technological breakthroughs by 2025 so that incidence can fall faster as compared to what has been achieved previously.

NTP has shown high treatment success among TB patients. Yet, a significant number of patients still attend private clinics and NGO operated centres. Moreover, patients visiting private facilities pay more and are subject to sub-optimal care. NTP has ventured into a public-private mix (PPM) as a

crucial component to meet the WHO and STOP TB Partnership targets, used LHWs for DOTS, integrated TB services at PHC level, increased



WHO Global TB Report 2017

number of diagnostic centres across the country, and designed advocacy communication & social mobilization program to increase awareness across the communities specially to increase the diagnostic demand<sup>2</sup>. These efforts have had some benefits, but more strategic thinking and planning is needed to find answers to address program implementation challenges. Last but not the least, planning in terms of securing funds for TB in Pakistan needs attention in the wake of possible exit of donor. Domestic funding has been low over the last 5 years and there is still about 25% of funds that were needed for the year 2017.

Pakistan stands resolute to ending TB. Addressing TB is imperative *en route* to achieving targets of UHC and SHP. Government wants zero catastrophic cost on TB treatment. With this backdrop, the Health & Population Think Tank of Ministry of National Health Services, Regulations and Coordination convened a round table meeting to discuss challenges and potential way forward around TB control and eradication in Pakistan. The round table meeting aimed to generate discussion in

<sup>1</sup> World Health Organization. Global Tuberculosis Report 2017. Geneva: 2017.

<sup>2</sup> Ministry of National Health Services, Regulations & Coordination. Annual TB Report 2016. National TB Control Program. Islamabad: 2016.

<sup>3</sup> World Health Organization. Systematic screening for active tuberculosis: Principles and Recommendations. 2013. <http://www.who.int/tb/tbscreening/en/>



order to answer the following questions under 4 key thematic areas:

1. **Active vs Passive TB Case Detection**
2. **Implementation & Logistic challenges**
3. **Public-Private Partnership for TB Control & Eradication**
4. **Research around TB in Pakistan**

The number of missing cases is on the rise in Pakistan. Access to treatment facilities is a major issue because of distrust of the people on public sector hospitals and preference of private sector which is expensive. As a result, patients with symptoms remain undiagnosed, especially marginalized and excluded groups of population. CSOs and NGOs must play their role specially to serve the hard to reach areas. Poverty obviously affects health behaviors and health care seeking patterns. Yet, the improving socio-economic conditions in Pakistan have not affected TB rates. So there must be other reasons that need to be investigated and a multi-curricular approach may be adopted. Weak referral system has also resulted in low service utilization. There is a need for efficient use of resources (money and HR) for improving the TB interventions.

For TB cases notification, there exists an untapped potential of private sector. New initiatives of NTP in public sector include use of Digital X-Rays with CAD4TB, Expanding Gene X-pert network, Training on Childhood TB, Expanding PMDT network, Engaging LHWs, Mandatory notification of TB, Multi sectoral approach, Digital M&E & Supervision- DHIS-2, and capacity building for research. In the private sector, NTP is engaging over 5000 GPs & Specialists, NGOs, Armed forces, & other public institutions for active case finding.

Dependence on Global Fund (GF) must start transitioning into provinces' own allocations for TB. The financial outlay of \$250m for TB was to a great extent bridged by GF by providing \$180m. So now on its exit in 2019-2020, government has to seriously think of mobilizing extra resources because almost US\$500m will be needed to be on our own feet. With huge population, burden of TB is evident to be high, however, better governance in the program and transparency could improve the state of affairs. Due to law and order situation in certain parts of the country, access to health care has been an issue. But where access is not an issue, people prefer private sector and informal sector, so

their mainstreaming is crucial. Involvement of *ulema* to preach for cleanliness and hygiene in the community, and the role of media for highlighting TB as a national emergency is important. TB funding, human resource and legislation for case notification may be taken up at CCI level.

Research to find innovations for the disease early detection, diagnoses and treatment is needed. Moreover, evidence needs to be communicated and translated into policy and actions.

#### Action items:

- i) TB to be declared as a priority disease by sensitizing the Prime Minister and Chief Ministers, and the matter be taken up at CCI.
- ii) Financing for TB to be increased at federal level so that funding gaps at provincial levels are covered. Provinces to also define their exclusive allocations for TB in the respective ADPs.
- iii) Health Care Commissions to play their role in legislation about notifying TB cases especially by the private sector.
- iv) Investment in procuring Genexpert machines to be increased for MDR TB case detection.
- v) All detected cases of TB to be tested for MDR through Genexpert.

This policy brief is developed with the background of Government of Pakistan participation in the WHO's Global Ministerial Conference held in November 2017 in Moscow on Ending TB; Meeting in January 2018 in Geneva to discuss strengthening CSOs engagement for ending TB epidemic; and upcoming United National General Assembly high level meeting on TB in summer 2018. This brief is also a reflection of Government of Pakistan's international commitments on SDGs & the Global Health Security Agenda.

# Meetings with Provinces

## HPTT Linkages and Progress Review of National Health Vision & SDGs. Report Islamabad meeting

4<sup>th</sup> August 2017

### Health & Population Think Tank - MoNHSR&C

#### Introduction

A round table discussion was held on August 04, 2017, at the Health Services Academy, Islamabad. The topic of the meeting was “Provincial Health Linkages for Coordination of Thematic Areas & SDGs under Health and Population Think Tank”.

National health Vision 2016-25 is in congruence with Government of Pakistan’s vision 2025, and will go a long way to serve the health needs of the people. The role of Health and Population Think Tank (HPTT) is to set a road map for improving all the elements of health system and provide clear guidelines to define health priorities, ensure necessary planning and investments. It is a unified vision to improve health of the people across the country, yet ensuring provincial autonomy and diversity. The vision document will further strengthen coherence and coordination between Federal and Provincial efforts in consolidating the progress, learning from experiences and moving towards universal health coverage.

The 2011 devolution of health to provinces created challenges as well as opportunities. It is expected that the health benefits gained from Federal support will lead to more equitable health system coverage, in line with provincial priorities. The provincial health departments and the re-established Ministry of National Health Services, Regulation and Coordination (MoNHSR&C) are taking their new role to meet the targets of SDGs according to the National health Vision. Political devolution within Pakistan charged provincial health care systems with planning health care delivery structures, programs and Services. This responsibility and leadership is important because the targets of health related Millennium Development Goals (MDGs) were not completely achieved, and the more effort is required to work toward the even more challenging targets of the Sustainable Development Goals (SDGs).

The national Health Vision 2016-25 has adopted the following objectives to improve the health and well-being of the Pakistanis:

- Provide a **unified vision** to improve health while ensuring provincial autonomy and diversity;
- Build **coherence** between federal and provincial efforts by consolidating progress, learning from experience, and moving toward universal health coverage;
- Facilitate **synchronization** across international reporting and treaties;
- Ensure **coordination** for regulation, information collection, surveillance, and research on improved health systems;
- Create a **foundational basis** for charting and implementing SDGs in partnership with sectors.

The National health Vision builds its narrative on eight thematic pillars to ensure access, coverage, quality and safety--- essential requisites for achieving the ultimate goal of universal health coverage in Pakistan. The challenges and strategic vision for each thematic pillar or domain are explained in the NHV documents already circulated to the Provincial/Area Governments Health and Population Departments. These will form the basis of the over-arching technical support that federal government will offer and coordinate for the provinces. The eight thematic pillars are:

1. Governance
2. Health Financing
3. Packaging Health Services
4. Human resource for health
5. Health information system and Research
6. Essential Medicine and Technology
7. Cross sector wise Linkages
8. Global Health responsibilities

The monitoring and evaluation framework will be developed by MoNHSR&C. It will link and coordinate with planning commission for SDGs reporting, Provincial/Area Health department for alignment with the strategies of the thematic areas. The M&E framework and its operational plan focus on progress towards outcome by developing a mix of tools and approaches related to the proposed objectives, activities and targets.

A high level inter-provincial health and Population forum will review progress of NHV implementation and will endorse reports for presentation to parliament.

Health & Population Think Tank (HPTT) aims to foster multi-sectoral collaboration, with intention of reviewing, analyzing, debating, brainstorming, and building healthy public policy. The main goal of the HPTT will be to promote and protect the health and wellbeing of all Pakistanis. The main objectives (but not exhaustive) include:

- Conduct Analysis on existing research and Policy (to inform the priority areas for policy discussion)
- Conduct reviews and critiques of current health policies nationally (& internationally as required)
- Organize official policy discussion forum with all members
- Invite decorated external subject matter experts to weigh in on debates
- Develop Policy implementation and evaluation plans (through MoNHSR&C/ Health Planning, System Strengthening & Information Analysis Unit)
- Facilitate collaboration of cross-sectoral departments through informed debate
- Provide a platform for discussion/deliberation on priority health issues either identified by Ministry, the World health Organization or by the popular press/media in Pakistan
- A prioritizing exercise of health issues will be done for technical assistance

All the Provinces and area government shall provide nominations of their representatives/focal person to coordinate with HPTT. MoNHSR&C will provide support to the provincial area government, health and Population departments as strategized in the National Health Vision 2016-25. The provincial and area government shall also provide the names of the focal persons responsible for implementation of SDGs leading the respective units for future interaction to complete the SDG agenda in time under NHV 2016-2025.

## Participants

Key participants were Secretary and DG MoNHSR&C. Provincial departments of health, provincial departments of population welfare, federal and provincial departments of planning & development, federal provincial health policy and reform units, UN agencies including JSI, WHO, UNICEF, and academia attended the meeting.

## Proceedings

After the recitation of the Holy Quran a round of introductions took place. The DG MoNHSR&C gave a background and context of the meeting which was convened to introduce, sensitize and get advice from the provincial and regional counterparts regarding the work of HPTT. The MoNHSR&C decided to support the formation of a think tank to provide a forum for brainstorming, discussions and advice to the stakeholders on various issues of public health importance. HPTT is a semi-independent body having the intellectual independence together with linkages with the MoNHSR&C and provincial governments through the health policy and reforms units. As for the composition of the HPTT, it has representation from various geographical areas within and outside the country. The experts chosen for the HPTT through a peer review process are from diverse backgrounds including medical sciences, economics, health systems and governance having both national and international depth of experience. The HPTT has about 20 core members. The funding for HPTT is through a PC-1 which has been functional since July 1, 2017, and since its inception in February 2017 till June 2017 the bridge funding has been through USAID. The selection of issues to be discussed in the HPTT have been based on the public health significance of the issues, importance of the issues to the general public, academia and public health practitioners and the issues brought up by the media or deliberated upon by the legislators. So issues are filtered up through various channels for deliberation in the HPTT forum. Up until now two HPTT round table meetings have taken place, one on indigenous production of vaccines and the other on the issue of social health protection, both issues of utmost public health importance. The crux of the deliberation in these roundtable meetings are translated into policy briefs. The policy brief of the roundtable meeting on indigenous production of vaccines is ready to be submitted to ECNEC and one on social health protection is to be submitted to the Prime Minister of Pakistan. He added that HPTT realizes that formal linkages need to be developed with Provincial and Area governments. This meeting has specifically been convened with these stakeholders to get their inputs and gather advice as to how to steer the course of HPTT in times to come in light of the requirements of the provincial/area governments and academia. We specifically want to focus on the Sustainable Development Goals (SDGs) and National Health Vision (NHV) 2025 with its eight thematic areas.

The Secretary MoNHSR&C welcomed and thanked all the participants to take time out of their busy schedules to attend the meeting. He commented that the government as an endorsee of the SDGs expects all the implementers of SDGs which the provincial and regional government are to commit to fully achieve the SDGs in their entirety and we must accelerate the implementation of the eight thematic areas of the NHV with particular focus on SDG 3. There is a critical need to establish and strengthen linkages between HPTT and the provincial and area governments. The role of the MoNHSR&C is to create linkages, to have strong data quality, to guide the provinces and to develop platforms for knowledge sharing. The process must lead to a joint think tank which will deliberate on issues impeding progress in the health sector in a holistic and coherent manner. Policies, strategies and plans must be devised with the involvement of all stakeholders as only such an approach can ensure effective implementation. Synchronized efforts and creating enabling mechanisms for implementing SDGs in collaboration with other partners is of critical importance. Today's discussion will provide a way out for strengthening coordination between federal and provincial governments for achieving the SDG targets in time. The MoNHSR&C has established a monitoring and evaluation forum with an active role of HPTT. This forum is envisioned to coordinate and review progress on SDGs as approved by the NHV and the reports will be presented to the National Economic Forum and the Cabinet. The HPTT will visit the headquarters of the provincial and area governments to pursue the agenda of the NHV initiative and SDG3 targets. The MoNHSR&C will extend full support in making the HPTT fully functional to meet its mandated objectives.

The Advisor HPTT gave a background of the formulation of the HPTT. He went on to describe the NHV and how it is in sync with the SDGs particularly SDG3. He explained the need for the linkages with the

provincial and area governments under the HPTT and how crucial these strong linkages are to ensure the achievement of SDG3.

The Technical Lead HPTT presented the structure, role and vision of the HPTT. He stated that the HPTT was envisaged to look at the themes and areas of national importance and not specific to any province or area. HPTT comprises of experts and professionals with wealth of experience in health, economics, social sciences and finance etc. This forum has representation from the provinces and areas and all the Secretaries and DGs Health are invited to be ex officio members of the think tank. The current meeting is one attempt to introduce the structure of HPTT and play the role of coordination amongst the provinces and areas. One of the important roles of HPTT are to serve as a forum for all the provinces to share their experiences, successes and best practices so that all could benefit from them. HPTT has also been mandated to conduct secondary research for the provinces so that the provinces could understand as to what could be adopted as best practices for implementation in Pakistan. The NHV with its eight thematic areas is a guiding document for HPTT for taking up issues of public health importance in Pakistan especially to excel towards achieving SDGs and particularly SDG3. It is therefore requested that in the upcoming sessions the provincial and the area governments share with HPTT the updates on their works and efforts in terms of SDG3 and also guide the HPTT on how to make best use of the NHV document.

Zafar Ul Hassan from the Planning Commission of Pakistan gave an overview of the SDGs in Pakistan. He stated that Planning Commission is the central coordinating agency for the SDGs which has established linkages with the provincial SDG support units. The Planning Commission together with the provincial SDG support units is currently in the process of prioritization exercise as some indicators are more relevant to Pakistan and some are less relevant. The government is very mindful of the failures in achieving MDGs so networks are being developed to ensure a proactive approach towards SDGs. National performance towards SDGs must include the works and progress made by the private sector as they are coming up to be an important stakeholder in education and health.

Dr Nabeela Ali, Chief of Party JSI, opined that the HPTT must extend or reach out to the parliamentary standing committees on health so that they are informed on the progress towards SDGs and implementation status of the NHV as it is pivot for all discussions at the policy level. Since the devolution following 18<sup>th</sup> constitutional amendment WHO has sent two missions to the provinces to identify gaps. The major finding of both the missions was that there was disconnect between the provinces and the federation. Despite the fact that post 18<sup>th</sup> constitutional amendment of 2011 health is a provincial subject, there are certain tasks which are still the responsibility of the federation such as surveillance and other issues of public health importance it is imperative that the provinces work in close coordination with the federal government. In today's meeting clear guidelines and pathways for coordination must be developed. In Pakistan policies are made but there is no tracking or monitoring of implementation of the policies. The forum of HPTT must be used as a tracking body for the implementation of NHV.

Lt. General Imran Majeed, Vice Chancellor, National University of Medical Sciences, remarked that it is a great pleasure to see the HPTT progressing as per its mandate. He gave an account of the achievements of Army Medical Corps in terms of services provided to the people of Pakistan. He reiterated the need to collaborate and work together especially to take advantages of each other's strength so that we could move forward together as a nation.

## **Provincial Presentations:**

After the remarks from the distinguished guests the provinces were invited to give their presentations. Ms. Rehana Memon, Member Development, Department of P&D, Government of Sindh, presented the activities of the department in regards to implementation of SDGs in Sindh Province. She informed that a



core group for SDGs and four clusters namely environment, social, economic and inclusivity & governance will be formed. The core group will provide guidance and will formulate a framework for SDGs for monitoring and tracking progress towards SDGs. The consultation process at the provincial level has already been started. Technical sessions have been conducted to discuss the alignment of plans and pc1s with the SDGs. Sensitization process has also been initiated where the district officers have been sensitized in this regard and now media is planned to be involved for sensitization of the common people. A review of the plans and schemes for their alignment with the goals of SDGs has been completed. In 2015-16 there were 571 new schemes costing Rs. 14 billion and in 2017-18 there were 541 new schemes costing about Rs. 56 billion. Now with the help of the federal government a template is being developed for alignment of public spending with the SDGs.

Ms. Mobeen Ajai, Project Officer SDGs Cell, Government of Sindh gave an overview of the challenges and way forward. She stated that all the government line departments, private sectors, UN Agencies, development partners, donors, academia and media partners will be engaged under the above mentioned four clusters to build up on the work already been done. As for the challenges and way forward, the achievement of SDGs is a very ambitious agenda and the data gap present at the provincial and federal level is a big challenge. Another big challenge will be localizing the achievement of the SDG agenda to the district level. Getting data and progress from the district will be difficult and efforts are underway to address this challenge through the framework as presented by Ms. Rehana. Coordination amongst the stakeholders will prove to be a big challenge. With 44 line departments, more than 17 UN agencies, a very big private sector and a huge media sector as a stakeholder, coordination will be an issue. Arrangement and mobilization of resources for such an ambitious agenda will also be a big challenge. Traditional sources of funds and resources will not be enough and innovative approaches will have to be considered for generation of these financial resources. Capacity gaps of the line departments especially at the district level will come up as a big hurdle in implementation of the SDGs agenda. To move forward technical assistance and capacity building measures will have to be taken. Formalization and operationalization of the clusters as explained by Ms. Rehana Memon, are hoped to facilitate the process. Engagement of think tanks and experts for SDGs prioritization are also foreseen to be helpful. Efforts are underway to ensure close working with Provincial Bureau of Statistics, Sindh for filling in the data gaps and establishing baseline data. Development of a comprehensive dashboard for SDGs, showing indicator wise progress is also in the plans. Capacity building of Provincial Bureau of Statistics for conducting further researches are planned. A policy note will be prepared in the near future for increased resource allocation towards prioritization of SDGs as part of the provincial finance commission.

Dr. Mohammad Khaleel Akhtar, Deputy Chief, HSRU, Government of KP, presented the progress of Khyber Pakhtunkhwa in regards to the eight thematic areas of NHV 2016-2025. In regards to governance, the Government of KP has been successful to systematically analyse and recommend remedial measures for improving performance of the health sector. Governance is improved through decentralization and establishment of independent professional board of governors. The Government of KP has made necessary legislations to take forward its reform agenda e.g. Khyber Pakhtunkhwa Regulatory Authority has been established through promulgation of the Food Safety Authority Act 2014, to prevent adulteration of food and implementation of food safety mechanism at the community level; Khyber Pakhtunkhwa Injured Persons and Emergencies Medical Aid Act 2014 for provision of medical emergency treatment without interference of Police Department; Khyber Pakhtunkhwa Human Organ Transplantation Act; Under the Medical Teaching Institutes Reforms Act 2014 autonomy has been provided to eight tertiary care hospitals of the province; Khyber Pakhtunkhwa Healthcare Commission Act 2015 for regularization and monitoring both the public and private sector healthcare providers; Khyber Pakhtunkhwa Regulation of Paramedical and Allied Health Sciences Education Act to monitor the education and training of the paramedics in all disciplines; Khyber Pakhtunkhwa Health Foundation Act to monitor public-private partnership in the health sector; Legal Framework to Reduce Tuberculosis Transmission. Similarly, Safe Blood Transfusion Authority has been formulated in 2016 with regional and provincial structures. Strengthening of drug



control regimen has been formed for internal accountability which is a unique independent monitoring unit for monitoring the healthcare providers and services at the facility level and real time data is provided through android-based applications. Health Management Committees have been formed to monitor the services at district headquarter level hospitals. Reforms have been introduced for procurement and nationwide assessment of manufacturers and suppliers has been accomplished. Khyber Pakhtunkhwa Breast Feeding and Formula Milk Act and Vaccination Act is in process and have been sent to Law Department for vetting. Similarly, KP has adopted the Federal Mental Health Act and is currently in the Provincial Assembly for the final go ahead. In regards to Financing the Government of KP has enlarged its financial envelop and has increased the health related budget from Rs. 38 billion to Rs. 65 billion during 2017-18. Moreover, for improvement and beautification of MTIs Rs. 1.7 billion has been allocated and on refurbishment of district headquarter hospitals Rs. 1.12 billion have been allocated. Two medical colleges one at Swabi and the other at Nowshehra are in process. Rs. 4 billion has been allocated for the standardization of district headquarter hospitals. District Health Plans have been formulated for the standardization and improvement of primary health care and in this regard 13000 LHWs have been regularized. All vacant posts of specialists, medical officers and nurses have been filled in the province through new recruitments. In terms of social health protection, Sehat Sahulat Card Scheme was implemented in 2015 whereby 21% of the population which are the poorest of the poor are exempted from payment of any premiums. This safety net has been extended to cover all the districts and is currently covering 50% of the total population of the province. The government has allocated PKR 1 billion per year since 2013 for providing free emergency medicines and more than 20 million people are benefiting annually. For non-communicable diseases PKR 925 million have been allocated so far to provide free treatment to diabetic and renal disease patients. In order to increase the vaccination coverage PKR 6.1 billion have been committed for five years benefitting 2.5 million children. For treatment of cancer patients an additional PKR 1.9 billion have been allocated. Screening, counselling and treatment of HIV, hepatitis and thalassemia patients is done through a public allocation of PKR 500 million. In terms of primary health care, a minimum health standard delivery package has been developed. Use of information is being ensured for improved decision making and supportive supervisory mechanism at various levels. Such delivery packages are also developed for services at the secondary care level. Enhanced coverage of population through community-based services by recruitment of more CMWs and LHWs has been ensured. In terms of use of technology for enhancing transparency and improving governance, an online information system has been developed for primary health care service delivery and development of online inventory management system. An additional PKR 5.6 billion is being spent to improve the emoluments for the healthcare workers. Health professional allowance is being given to doctors for being displaced to far flung areas. A district health information system has been established in all the 25 districts of the province since 2015 and all reports are available online in real time. KPIs have been developed to monitor the performance of district health officers and medical superintendents of the DHQ hospitals. A list of essential medicines has been notified. In 2016 the food and drug testing lab has been upgraded and is now state of the art. A dashboard has been established to ensure evidence-based decision making. A disease surveillance and response unit has been set up at the DG Health office which is manned by FELTP fellows. This unit is mandated to investigate and control outbreaks of public health importance. Integrated Disease Surveillance and Response is currently being piloted in 6 districts. At the end of the presentation a linkage of the above-mentioned initiatives with the SDG3 were presented.

Dr. Farhat Shaheen from Health Department AJK gave a presentation of the progress of her province. In the office of Director General Health Service, AJK, a cell has been established for the coordination and monitoring of activities regarding SDG 3. The Government of AJK is committed to ensure good health for all as per the NHV 2025, to end epidemics of AIDS, Malaria, TB and other communicable diseases as agreed in SDGs by 2030, to achieve universal health coverage and to provide access to medicines and vaccines for all. For this purpose, AJK Government has provided free emergency medical care in all district headquarter hospitals since July 2017. The health department is supporting research and development for vaccines and medicines. MNCH and LHWs program are providing maternal and child health and family

planning services in collaboration with Population Welfare Department with targets to reduce maternal mortality ratio from 201 per 1000 live births to 140 per 1000 live births, to reduce infant mortality rate from 62 to 50 per 1000 live births and to reduce new born mortality to 40 per 1000 live births. In the same context efforts are underway to modify the development projects to make them in line with the targets of SDGs and hopefully good results will be achieved. All the new plans and PCIs are being developed in light of the targets of the SDGs. There are certain challenges in implementing the SDGs in AJK. First and foremost is the financial constraints since AJK is not a beneficiary of the NFC award and all the budgeting is based on grant from the federal government thereby bringing up a deficiency of financial resources. Secondly there is a dearth of skilled human resource in AJK. Thirdly, data gaps are a big hindrance in AJK especially the new indicators as being introduced by the SDGs as the MIS system is deficient in those indicators. Accountability is also an issue in AJK. Investment is required in data generation, analysis, communication and use of data for decision making. This includes investment in CRVS system, conducting regular standardized household surveys, well-functioning routine health facility reporting system and comprehensive administrative data sources, such as NHAs and health work force accounts. Innovative approaches are also required using advances in ICT which can also facilitate the progress on SDG targets.

Dr. Saleemuddin, Deputy Director, Planning Division, Department of Health gave an account from GB Province. GB is a new province and currently there are 10 districts with a population of 1.5 million. Governance issues are the same as in rest of the country as mainly there is political interference in postings and transfers and right person at the right place is not possible. There is no political commitment and no continuation of policies so it affects the health sector also. There are two social health protection schemes, one is the PM program which covers five districts. For health packaging and services there has not been much development except that for increasing immunization coverage at least two vaccinators have been appointed per UC and a PCI has been developed and approved. The main issue in GB is the dearth of human resource as doctors especially specialists are not available. Except for three DHQs no specialists are available in the DHQs. Various steps have been taken such as relaxing the domicile policy and introducing a special package for the healthcare professionals but still no improvements in the availability of human resource had been possible. A list of essential medicines has been developed and all the essential drugs provided at primary and secondary care levels. For the reduction of MMR, sick new born units have been developed in four districts with the support of UNICEF. The exact figures for MMR and IMR are not available for GB as there is no research going on. The MNCH, Immunization and LHW programs are being implemented as in other parts of the country. There are 1385 LHWs and 110 CMWs in GB and a new PCI has been developed and approved to recruit 600 more LHWs to cover the uncovered population. Other than the AFP surveillance system there is no surveillance mechanism for detection of communicable diseases. Recently a disease surveillance and response unit has been notified in the province and four or five graduates were trained by FELTP who will man this disease surveillance and response unit. There is no public health lab in GB and the samples have to be transported out of the province which is mostly not possible due to road blocks as it is a hilly area. For eradication of polio three permanent transit points have been established at the borders, one is at Sost at the Pak China border, the second is at the Babusar top and the third is at Shindoor. Like AJK, GB also does not have any share in the NFC award so financial constraints are also real problems. There is no tertiary care facility in GB and there are plans to establish a cardiac and cancer hospital together with a medical college.

Dr. Shahzad Ali Khan, Assistant Professor, HSA, commented that the current meeting was long awaited. The NHV 2016-2025 was conceived in consultation and participation of all the provinces and the implantation of the vision was the next logical step. He reiterated that devolution does not mean that health is now the sole responsibility of the provinces, rather the federal level has a very important role of coordination and bringing all the provinces together. He suggested the formulation of thematic groups for implementation of the NHV with one meeting dedicated to each theme and nomination of provincial focal persons in this regard.

Dr. Babar T. Shaikh, Technical Lead, HPTT stated that the purpose of the meeting today was to introduce and sensitize the provinces to the structure of HPTT. The NHV document has been developed after exhaustive consultations with the provinces and the purpose of this think tank is to ensure that the provinces and the areas work in collaboration with the federation towards achieving the SDGs and especially the SDG3. Some provinces are more resourceful in terms of finances and HR so they should share their successes at this forum to help the other provinces as we have to achieve this goal together as a nation. These meetings will be held again and again and if there is a need the meetings will be held in the provinces to discuss province specific issues and provide suggestions for progress and overcoming hurdles. As we all know that the Planning Commission of Pakistan is developing a monitoring mechanism so the provinces should synchronize their individual monitoring mechanism with the mechanism of the Planning Commission of Pakistan in order to ensure coherent and synergetic reporting in the end. We should learn from our mistakes in MDGs and try not to commit the same mistakes in our pursuit to achieve the SDGs.

Dr. Fazli Hakim Khattak, Advisor HPTT, thanked all the participants and the team for all their hard work in regards to organizing the meeting. He invited the chairperson for his closing remarks.

In the end, Secretary Health, Balochistan, summarized the proceedings of the meeting. The honourable Secretary thanked all the participants who gave their precious comments in the meeting. He stated that the valuable comments of all the participants have been noted and after compilation and analysis, the recommendations will be shared with all. The issues which require a solution at the federal level will be taken up with the appropriate authorities. He added that the HPTT will not visit all the provinces and areas and follow up with the deliberations of the current meeting. He said that if our determination is unshakeable and our faith is firm then all the impediments will be taken care of and nothing will be able to stop us from reaching our goal and destination. He thanked all and closed the meeting with his best wishes for all.

## Report Quetta meeting

22<sup>nd</sup> September 2017

### Health & Population Think Tank- MoNHSR&C

National Health Vision 2016-2025 is a vividly unified vision to improve health of the people across the country yet ensuring provincial autonomy and diversity. This vision document will further strengthen coherence and coordination between Federal and Provincial efforts in consolidating the progress, learning from experiences and moving towards universal health coverage. The 2011 devolution of health to provinces has created challenges as well as opportunities. It is expected that the health benefits gained from Federal support will lead to more equitable health system coverage, in line with provincial priorities. The provincial health departments and the re-established Ministry of National Health Services, Regulation and Coordination (MoNHSR&C) are taking their new role to meet the targets of SDGs according to the National health Vision.

MoNHSR&C has been providing support to the provincial & area governments to accelerate progress by strengthening the linkages with all working partners at national and international levels. The HPTT persuades visiting to the provincial/area governments, starting from Baluchistan to review, monitor the progress and resolve the issues falling in the ambit of MoNHSR&C. This will be in close liaison with the provincial/area government, SDGs implementation units and health departments at provincial/district levels.



### Objectives:

The objectives are:

1. To discuss and review the progress of issues, recommendations, and road map concluded in the 4<sup>th</sup> August meeting of the think tank.
2. To ensure the ownership of the provincial authorities to achieve the SDG3 and NHV targets.
3. To propose/ design strategy on the specific issues identified by the provincial/ area governments.
4. Any other item may be added by the permission of the Chair.

### Follow-up:

The HPTT as follow-up to the Round table meeting held on 4<sup>th</sup> August, 2017, has prepared the conference report and executive summary including the issues and recommendations discussed and finalized in the RTC. The report has been circulated to all stakeholders and copies included in the folder of the today's meeting.

### Major Issues:

The major issues identified by the different participants are summarized as under:

- Weak coordination between Federal Agencies (NHSR&C, PDR, and Finance Division) with the same Departments at Provincial and Regional governments.
- Under funding of Health Systems at all levels.
- Poor governance due to lack of formal M&E system.
- Absence of consensus on policy formulation and implementation due to non-availability of the evidence-based data for the purpose.
- Absence of coordination with their SDGs partners besides Health. Departments.
- Absence of common research and Analysis platform to work on Federal and Provisional Health system under the National vision 2025 and international commitments in coherence with the UN agencies and development partners.
- Enhanced food adulteration, and absence of Quality of Care, and supportive supervision.
- Non-availability of Drug Testing Labs.
- Shortage of skilled and trained Human Resources in health sector.
- Lack of equipment and medicines in FATA.
- Partial inclusion of FATA in PMNHP/Health Insurance, Program.
- Lack of dashboard monitoring for targeting the performance indicators.
- Lowest allocation of funds to Health sector.
- Lack of political commitment.
- Poor access road to Health facilities, and lack of diagnostic facilities in GB.

## Recommendations:

Keeping in view the above issues and events and current Health status recommendations were concluded:

- a) Create and establish HPTT linkages to accelerate implementation of 08 thematic areas with focus on SDGs and convene RTC in the Provincial & Area government to improve federal and provincial harmony to enhance efficiency and capacity of the Health System.
- b) Design monitoring and Evaluation mechanism and conduct follow-up visits by HPTT to monitor the programs in the Health sector of the country.
- c) Progress and Performance of the given areas shall be collated from both the Public and Private Sectors at all levels.
- d) HPTT shall reach to the standing committees of the parliament and inform them about progress on SDGs and NHV 2016-25.
- e) Improve and strengthen the ware houses and logistic arrangements of vaccines for effective immunization.
- f) Assist in resolution of the funding and technical issues of vertical program to speed-up implementation and enable achievement of the SDGs targets.
- g) Drug testing Laboratories shall be extended to the Division levels.
- h) Pooling of all resources, and conduct research for effective utilization of the resources.
- i) Diagnostic Labs shall be established in the hard areas of GB, FATA and Baluchistan.
- j) Work separately on each thematic area through nomination/identification of focal person in the concerned health departments.
- k) The PMNHP/HI shall be extended to the hard areas of FATA, and Baluchistan.

## Way Forward:

Following objectives of this meeting, the concerned stakeholders shall clearly indicate the issues, and assign priority for consideration to make them part of the Health Policy Frame/ Summaries and Approach Paper through MoNHSR&C by using the strength of HPTT.







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