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Ministry of National Health Services, Regulations & Coordination
Government of Pakistan

SDG-3

LOCALIZATION IN PAKISTAN

SDG -3 Localization in Pakistan

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EXECUTIVE SUMMARY

The link between health and development is recognized globally for a long time; the Sustainable Development Goals [SDGs] adopted in September 2015 at the United Nations General Assembly [UNGA], position health as a key feature of human development, emphasizing the fact that social, economic and environmental dimensions of development influence health and health inequalities, which in turn, benefit from a healthy population. Among the SDGs, Goal 3 calls specifically on countries to "Ensure healthy lives and promote well-being for all at all ages"; SDG3 has 13 targets, including four that address the means of implementation. However, health is not just limited to Goal 3. Across most SDGs, there are targets which have a direct or indirect influence on gains in health, therefore require special attention while developing strategies, policies and plans to achieve the health goal and to monitor the progress.

Pakistan aims to successfully implement a sustainable development agenda, through the development of national plans that are integrated with the National Health Vision 2025 (NHV), as it embarks to achieve SDGs by or well before 2030. While the earlier policies focused heavily on physical development of health services delivery infrastructure, the focus of NHV 2025 is economic and social aspects of the development in the more recent plans. Health, in these plans, has been addressed under the dimension of social development to varying degrees, with particular attention to equity, social determinants of health, and universal health coverage. Pakistan has initiated social health insurance programs targeted at those living below the poverty line.

For the purpose of SDGs indicator localization and trend analysis, an analytical framework was developed, informed by available evidence, to help map targets and indicators related to SDG3 as well as other health-related SDGs (including SDG 2, 5, 6 and 10). Data could not be made available for proxy indicators for SDG 3.8 and provincial level, disaggregated data. Using nationally reported data (and in some cases, data from secondary sources such as the World Bank, WHO and UN), the current status and past trends for majority of the 30 indicators has been provided in this report. The report has also identified the projected trends for most the indicators, while also proposing National level milestones to be reached to achieve the SDGs 2030 agenda. Four strategic approaches for future action are proposed. These include: (i) enabling environment for a shared responsibility and evidence-informed approach; (ii) alignment, integration of SDGs with existing initiatives; (iii) strengthening capacity development, stakeholder partnership, participation, and effective multi-sectoral collaboration; and (iv) awareness raising, advocacy and capacity building among the allied departments.

The subject paper provides an in-depth review of the current status of indicators and targets related to SDG3 and other health-related SDG goals, while at the same time recognizing gaps in information, particularly with respect to information on targets that are related to SDGs other than SDG3. This should be considered as an opportunity to strengthen and better link information systems. This is the first systematic attempt to document and propose prospective national targets for the health-related targets and indicators for SDGs in Pakistan. Despite the limitations, it provides a useful basis for filling the existing gaps in information, and for developing a regular system of reporting and monitoring progress in health with respect to SDGs.

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ACRONYMS

ADP	Annual Development Plans
CSO	Civil Society Organizations
DGs	Director Generals
DHIS	District Health Information System
DoMC	Directorate of Malaria Control
EPI	Expanded Program on Immunization
GNP	Gross National Product
HIV	Human Immuno-Deficiency Virus
HMIS	Health Management Information System
GBD	Global Burden of Disease
GLOF	Glacial Outburst Flooding
IDI	In-depth Interview
IHR	International Health Regulations
IMR	Infant Mortality Rate
INGO	International Non-Governmental Organization
IRS	Indoor Residual Spraying
KPI	Key Performance Indicator
LHW	Lady Health Worker
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MoNHSRC	Ministry of National Health Services, Regulations and Coordination
MPI	Multidimensional Poverty Index
MTCT	Mother to child transmission
NACP	National Aids Control Program
NFC	National Finance Commission
NHMIS	National Health Management Information System
NMR	Neonatal Mortality Rate
NNS	National Nutrition Survey
NTP	National TB Program
P&D	Planning and Development
PFC	Public Finance Commission
PDHS	Pakistan Demographic and Health Survey
PSLM	Pakistan Social and Living Standards Measurement
SBA	Skilled birth attendant
SDGs	Sustainable Development Goals
SRH	Sexual & Reproductive Health
TBA	Traditional Birth Attendant
UNDP	United Nations Development Program
UNICEF	United Nations International Children's Emergency Fund
UN IGME	United Nations Interagency Group for Mortality Estimations
UNODC	United Nations Organization on Drug Control
UNSTATS	United Nations Statistical Division
U5MR	Under 5 Mortality Rate
WDI	World Development Indicator
WHO	World Health Organization

CHAPTER 1: INTRODUCTION AND BACKGROUND TO SDGS

The United Nations World Summit of 2012 aimed to steer the path of sustainable development in the world after Millennium Development Goals. The Sustainable Development Goals (SDGs) were adopted globally in September 2015 with the purpose of comprehensive, far-reaching and people-centered set of universal and transformative goals and targets for their implementation by 2030. The Sustainable Development Goals address three inter linked dimensions - namely social, economic and developmental/environmental foci. Health is linked with all three dimensions highlighting the influence of social, economic and developmental/environmental determinants upon health and vice versa. The seventeen (17) developmental goals include 169 targets, which are concise, global and universally applicable to all developing and developed countries. The Sustainable Development Goals encompass 244 indicators related to five Ps i.e. People, Planet, Prosperity, Peace and Partnership.

Although the Millennium Development Goals provided the basis for SDGs, however the SDGs are more comprehensive, and people centered with the commitment to "leave no one behind" i.e. to reach the vulnerable populations (1).

Sustainable Development Goals (SDGs) Localization in Pakistan

The overall health situation in Pakistan has improved in the last two decades, but at a slower pace than neighboring countries. For instance, the average life expectancy at birth increased to 66 years by 2015 as compared to 59 years in 1990. The current Maternal Mortality Ratio (MMR) has reduced to 178 per 100,000 live births from 294 in the year 2000. Skilled birth attendance (SBA) has improved from 23% in the late 1990s to 52% in 2013. Despite these improvements, many challenges remain in the post-devolution situation, including the divide in health outcomes between provinces, districts and rural-urban areas. Pakistan's neonatal mortality is the third highest in the world, whereas the under-five mortality is the second highest in South Asia after Afghanistan. The number of maternal deaths during delivery in Pakistan is also highest in South Asia. Malnutrition indicators of Pakistan remain poor, with rates not having changed significantly over the last two decades. These health and nutrition indicators are compounded by an increasing population. Although Pakistan's population growth rate declined from 3.5% per annum in 1980s to the present estimated level of 1.9% per annum, it remains high enough as Pakistan is now the sixth most populous country, with a population of over 220 million people.

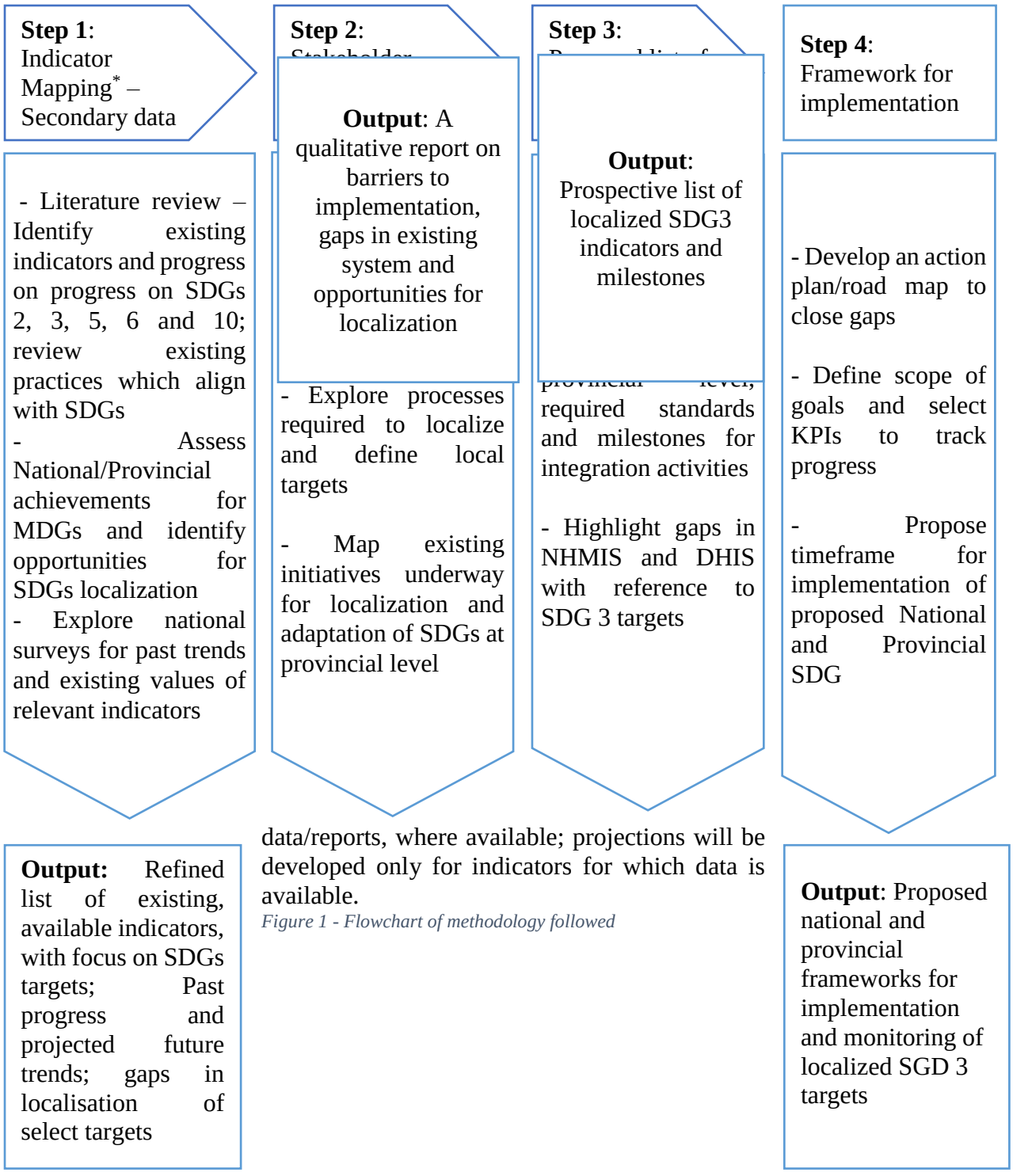
Pakistan developed National Health Vision 2016-25 in 2016, and also adopted SDGs as a national level development agenda through a parliamentary resolution that was passed unanimously in February 2016. This strategic shift put considerable responsibility on Government and development partners to address unmet agenda of MDGs while entering into SDGs through development cooperation for strengthening public institutions, social policies and planning development programs. Health is critical for achievement of all the SDGs, and in particular, SDG3 aims to "Ensure healthy lives and promoting well-being for all at all ages". SDG3 is bolstered by 13 targets, which cover a wide spectrum of disease, systems and implementation indicators. Almost all of the other 16 SDGs are directly related to health or contribute to health indirectly. Similarly, achievement of SDG3 is also dependent on all other SDGs. The SDGs framework addresses population health needs through a life-course approach, with special focus on key stages in life, from new-born to old age. It responds to the need for working across the continuum of health, including health promotion, prevention, management and treatment, rehabilitation and palliative care. To achieve SDGs, there is a strong need for SDG localization.

SDG localization implies adaptation and integration of global goals into the local development processes of any country - in this case Pakistan – in accordance to its context, situation, and needs for development. It aims to address and identify gaps in the development processes and monitoring mechanisms for gauging progress to achieving the SDGs at the country level. This adaptation further includes ownership of local stakeholders and communities (both duty bearers and rights holders) that can be achieved through awareness raising on the goals and related opportunities as well as dialogue on their localization. It includes setting up local/country specific milestones to achieve global targets, standards to follow and to be maintained, country specific indicators to measure the progress on set milestones according to the context and needs, and mapping of

identified gaps in development. These targets and milestones are subject to modifications as new data is generated, situation changes, and progress evolves through the SDG era. After localization, occurs, the agreed milestones, standards and indicators can be integrated into planning, policies and strategies, as well as systems to deliver services for populations for implementation, and national data sets to measure progress on achievement of the goals. In Pakistan, the process of SDG localization has started. The current assessment is an endeavor to measure where Pakistan is positioned since SDGs adoption in its national development agenda.

CHAPTER 2: METHODOLOGY

The SDG3 localization assessment, initiated from August 2017, included quantitative and qualitative approaches following serial methodological steps (Figure 1) detailed in the following sub-sections:



* Key inputs: all tasks will be informed by existing data/reports, where available; projections will be developed only for indicators for which data is available.

Figure 1 - Flowchart of methodology followed

1. INDICATOR MAPPING - DOCUMENTS AND SECONDARY DATA REVIEW:

A comprehensive purpose-driven desktop review was carried out to collect information, on National and Provincial progress on health, nutrition and population indicators. The desk review was based on official reports, national surveys and supported by internet search through Google Scholar, Pub Med, Medline, and BioMed Central (BMC). The desk review enabled the research team to refine study approach, design and methodology.

INFORMATION SOURCES (DOCUMENTS, DATABASES)

Secondary data pertaining to SDG3 and allied SDGs (2, 5, 6 & 10) were extracted from the following documentary resources

- Health and Population latest reports
- National Health Vision Strategy
- Provincial health strategies
- Medium term development framework
- Pakistan Demographic and Health Survey (PDHS)
- Multiple Indicator Cluster Survey (MICS)
- Pakistan Economic Survey
- National Nutrition Survey
- Pakistan Social and Living Standards Measurement (PSLM) Survey
- National/Provincial Reports generated by academia, Bilateral and Multilateral development organizations, INGOs (WHO, UNDP, UNICEF, World Bank, Save the Children)
- Indicators reported by the HMIS systems at National and Provincial levels and UN IGME

Research team then independently examined each title and abstract to exclude irrelevant reports. A document selection strategy based on the following criteria was used to select relevant documents for the review and only those documents fulfilling the eligibility criteria were included in the review and information recorded using data extraction form (appendix-1).

1. Report type: Reports that synthesized data from multiple data sources, to generate quantitative health estimates of health status and determinants that varied by time or geographic population.

1. Geographic coverage: Reports on health estimates at the National, or Provincial level

2. Types of health indicators: Reports estimating indicators of health status (e.g. total and cause-specific mortality, incidence and prevalence of diseases, injuries, disabilities, hospital admissions, and diseases attributable to a cause) and health determinants (risk factors to health, including health behaviors such as tobacco use, and health exposures such as under and over nutrition), from the targets and indicators defined in the SDGs (Appendix-2 – Indicator Checklist).

DATA EXTRACTION PROCESS/METHOD

Information was collected on National and Provincial progress reported on targets and indicators related to SDGs 2, 3, 5, 6 & 10. The following descriptive information on the

documents was recorded: the type of estimate being reported (status or determinant), year of publication, geographical population coverage (e.g. national, provincial), progress on indicator/target since culmination of MDGs. A special focus was given to factors contributing to health outcomes, especially in vulnerable groups to address cross cutting issues of gender, human rights and equality (women, children, adolescents, elderly).
The latest available data were recorded and disaggregated to the possible extent. e.g. at socio-economic levels. It was expected that there would be data gaps, but these would be highlighted as instructive to demonstrate which areas do not receive sufficient attention, and where institutional capacity may be insufficient, or where gender disaggregation or deeper analyses would be required to understand what needs to be measured and how.
This information helped discern where provinces were lagging behind the SDG targets and to articulate priority goals, using qualitative exploration.

ANALYSIS PLAN

The data extracted were used to develop a comprehensive list of indicators relevant to SDGs. The analysis yielded reported values at launch of SDGs, current status and list of indicators reported in existing reports. Although analysis of initiatives underway for integration in National and Provincial development programs was envisaged with the following steps, it could not be completed because of lack of availability of good quality data. First step of this analysis was *Definition of Information.* A baseline assessment of local progress towards the SDGs to identify suitable indicators, that are 'SMART' – Simple, Measurable, Accurate, Reliable, and Time-bound, was done. All available baseline data for the selected indicators was identified and extracted. A set of possible national indicators to measure each of the SDGs was selected in the next phase of analysis. This information was collected as it was thought that this information would be valuable for provincial departments and assist them in developing local indicators which reflected and matched the data that the federal/national departments needed to collect. However, our strategy had to be revisited since much of this information was missing and at preliminary stages.
The baseline data was then used to evaluate and compare changes over time across different groups, to determine the progress of indicators since the end of MDGs era and determining whether there has been a change over time and how large this change (i.e., the effect size) was.
In the second stage, an evaluation of factors affecting indicators was undertaken. This involved categorization of key factors into the following categories; institutional and policy frameworks, social/economic factors, and stakeholders related to the target. Information was collated in a matrix.
Information thus derived assisted in further exploration in qualitative component of this study in:

1. Defining localized targets, feasible in different provincial setups
2. Identifying the strengths and weaknesses at Provincial level and
3. Highlighting existing opportunities at each level for adaptation and implementation of localized SDG3 targets

2. STAKEHOLDERS ANALYSIS – GAP ASSESSMENT

- **Data collection methods – IDIs, Consultative focus groups**

  A qualitative approach based on in-depth interviews and consultative meeting was used, to undertake a stakeholder analysis. Data was collected from August to December 2017. Key personnel working in the departments (public and private sector) of Health, Population, Nutrition, Water & Sanitation were identified and consulted to assess efforts underway at National and Provincial departments for integration of SDG3, identify gaps and barriers to implementation of SDG targets/indicators, and existing elements in program planning/implementation which could potentially enhance local adaptation of SDGs. The respondents for this consultative process (appendix-3) were:

Table 1 - Proposed Respondents

	Region	**Department/Unit**	**Respondents**
1	Federal	Ministry of Planning and Development	Chief, Poverty Alleviation and SDGs
2	Federal	Health	Director Generals Deputy DGs Convener – SDGs Task force Chairperson
		Population and Development Departments	
		Food and Nutrition	
		Water and Sanitation	
		Education	
		National Commission on Status of Women	
3	Provincial	Health	Director Generals Deputy DGs Focal person – SDGs Task force Chairperson
		Population and Development Departments	
		Food and Nutrition	
		Water and Sanitation	
		Education	
		Punjab Commission on Status of Women	
		Sindh Ministry for Women Development	
		Women Development Department (Punjab, Sindh)	
4	Provincial	Ministry of Planning, Development and Reforms: SDG Support units	Convener SDGs task force
5	National/Provincial	UNDP	Provincial Representatives
6	National/Provincial	Local and International NGOs (Save the Children, Mercy Corps, World Bank)	Focal person SDGs

INTERVIEW/DISCUSSION GUIDE

Based on the desk/document review, a set of contextually relevant questions pertinent to localization of the SDGs were developed. Interview guides (Appendix-4) focused on the issues of:

a. Adaptation and integration of global goals in the local (National/Provincial) development processes according to context, situation, and needs of population
b. Roles and responsibilities of various departments in identifying gaps in development processes and progress to date
c. Existing levels of awareness of concerned departments on the SDGs and related opportunities at National and Provincial levels
d. Prospective socio-economic and demographic indicators for localization at provincial level, required standards and milestones for integration activities
e. Activities/interventions underway relevant to the SDGs

The guide was developed further and finalized subsequent to results of the secondary data review.

ANALYSIS PLAN

A thematic content analysis was undertaken to identify strengths, weaknesses, opportunities and threats to assess efforts underway at National and Provincial health and planning departments for integration of SDG3.

A coding structure based on pre-existing themes of interest (strengths and weaknesses in existing systems, opportunities for implementation of SDGs and potential threats to achievement of proposed milestones) and new identified themes was developed to guide the analysis process. Analysis focused on the following themes and concepts.

Table 2 - Thematic Analysis - Domains for Exploration

Themes	**Concepts to be explored**
Policy coherence	Opportunities to promote policy coherence at different levels of policy-making, with regards to the SDGs
Barriers to implementation of SDGs	Health links within the existing setup, with potential to hinder implementation of localized SDG 3 targets/indicators
Gaps and weaknesses in existing systems	Health outcomes, specifically in vulnerable groups (women, children, elderly, adolescents), nutrition, water and sanitation
Opportunities for localization	Elements in the existing setup that could be capitalized upon to integrate SDG 3 targets, enhance efficiency and improve coverage for greater impact will be categorized and highlighted
Existing capacity to achieve SDGs	Specific needs to aid governments' statistical capacity for implementing and monitoring SDG indicators

3. DEVELOP PROSPECTIVE PLAN FOR NATIONAL INTEGRATION OF INDICATORS AND MILESTONES

Using the outputs from documents' review and stakeholders' analysis, a comprehensive list of localized indicators, aligned with the national and provincial HMIS were developed for local adaptation. Gaps in the NHMIS and DHIS were highlighted, with specific reference to targets and indicators for SDG3.

Building on the results from qualitative inquiry, a framework with a road map for implementing SDG3 indicators, scope of the goals and proposed key performance indicators (KPIs) to track progress, were proposed. This systematic line of inquiry was assisted in identification of those major areas that required specific policy responses, including whether standards and regulations needed to be revised or new ones introduced in order to provide a more supportive institutional context for action.

This report provided a working document to the MoNHSR&C to finalize the milestones at national and provincial levels through a series of consultative meetings.

A series of thematic action plans were proposed based on the findings on how implementation of localized SGD3 targets may be achieved. The framework includes:

1. Aims and objectives
2. Desired outcomes
3. Key actions and policy requirements
4. Key actors and institutions – roles and responsibilities
5. Timeframe – short to long term plans
6. Financial forecasting
7. Accessing resources – local to international sources
8. Monitoring and review

CHAPTER 3: RESULT

This section is organized as under

1. Summary review of Health –related SDGs progress in Pakistan
2. Findings and analysis of desk review
    a. Overview of Health-related SDG indicators, values and historical data sources
3. Stakeholder and SWOT Analysis
4. Proposed Framework for Implementation

1. Summary Review of Health-Related SDGs Progress in Pakistan

Baseline and Progress of Pakistan on SDG 3

Based on the analyses of Health and related SDG indicators' data, the figure below shows the country's progress to date where data was available. The average progress for each indicator (as reported in 2017 WHO World Health Stats; monitoring health for the SDGs) is normalized to a scale of 0 to 10 with 2015 as the midpoint between 2000 and 2030. Blue bars show the progress to date, while the white areas represent the "unfinished" agenda. For some targets, there were few (or no) indicators with data available, hence they were not reflected in the figure.

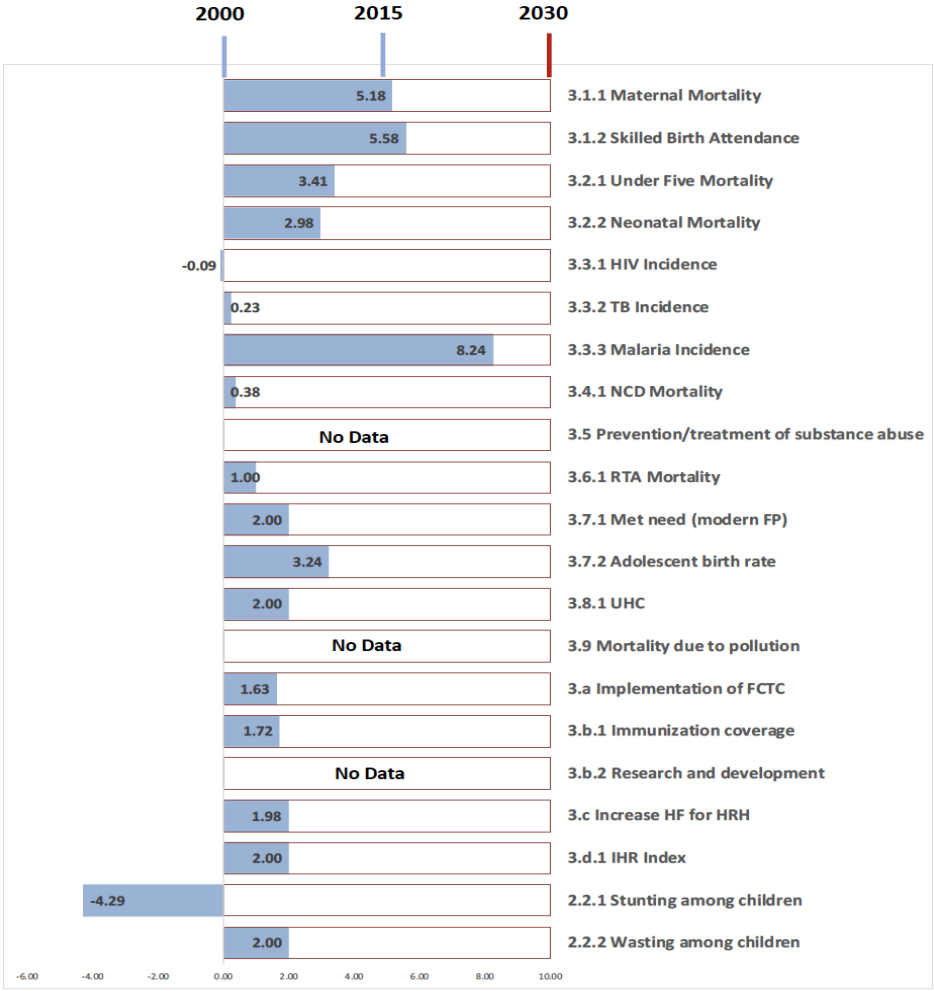


Figure 2 - Progress of health-related SGDs in Pakistan

On the whole Pakistan made great progress in three areas between 2000 and 2015, which include reductions in maternal mortality, malarial infections, and health emergency preparedness (IHR index). Maternal mortality reduced from 294 (2000) to 178, as a result of increase in service coverage for maternal care. In six areas, the progress was slow or stagnant between 2000 and 2015. These were: child mortality (under 5 and neonatal), incidence of Tuberculosis, Contraceptive Prevalence Rate (CPR), universal health coverage, mortality due to non-communicable diseases and road traffic accidents. The above assessment was based on the analysis of only a subset of indicators for which data were available.

Table 3 summarizes SDG 3 and selected health-related indicators' data availability (including degree of disaggregation & data sources) and suggested reporting interval and level of data collection.

Table 3 - SDG 3 and related data in Pakistan

Indicator		Data Availability	Disaggregation	Data sources		Suggested reporting	
				National	International	Interval	Level
3.1.1	Maternal mortality ratio	**Fair**	Age, Residence	PDHS	UNIGME	**Annual**	National, Provincial
3.1.2	Proportion of births attended by skilled health personnel	**Good**	Age, Parity, Residence, Provider, SES	PDHS	UNICEF, WHO	**2-3 years**	National, Provincial, District
3.2.1	Under-five mortality rate	**Good**	Residence, Gender, SES, Cause	PDHS	UNIGME	**Annual**	National, Provincial
3.2.2	Neonatal mortality rate	**Good**	Age, Gender, Weight, Residence, SES	PDHS	UNAIDS, WHO	**Annual**	National, Provincial
3.3.1	Number of new HIV infections per 1,000 uninfected population,	**Poor**	Age group general population, Age group, special population groups, Mode of transmission, Residence, Gender	NACP	UNAIDS, WHO	**Annual**	National, Provincial
3.3.2	Tuberculosis incidence per 100,000 population	**Fair**	Age, HIV Status, Gender	NTP, TB Prevalence Survey, National Health Survey	WHO	**Annual**	National, Provincial
3.3.3	Malaria incidence per 1,000 population	**Fair**	Age, Gender, Residence, Season	DoMC, Malaria Prevalence Survey	WHO	**Annual**	National, Provincial
3.3.4	Hepatitis B incidence per 100,000 population	**Fair**	Residence, Exposure to vaccine doses	Hepatitis Prevalence Survey, National Health Survey	WHO	**2-3 years**	National, Provincial
3.3.5	Number of people requiring interventions against neglected tropical diseases	**Poor**	Age, Gender	National Health Survey	WHO	**Annual**	National, Provincial

3.4.1	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	**Fair**	Age, Residence, Gender	Hospital data, Cancer registry, National Health Survey	WHO	**2-3 years**	National, Provincial
3.4.2	Suicide mortality rate	**Fair**	Age, Residence, Gender	Police Data, PDHS, CRVS	UNODC	**2-3 years**	National, Provincial
3.5.1	Treatment interventions for substance use disorders	**Poor**	Type of group, Gender, Age	N/A	UNODC	**Not available**	Provincial
3.5.2	Harmful use of alcohol	**Fair**	Age, Gender	N/A	WHO	**Annual**	Provincial
3.6.1	Death rate due to road traffic injuries	**Fair**	Age, Gender, SES	Police data, BOS	WHO	**2-3 years**	National, Provincial District
3.7.1	Family Planning	**Good**	Age, Residence, SES	PDHS	UNFPA	**Annual**	National, Provincial District
3.7.2	Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	**Fair**	Marital status, Residence, SES	PDHS	UNFPA	**Annual**	National, Provincial
3.8.1	Coverage of essential health services – UHC Index			Multiple Surveys	WHO, World Bank	**2-3 years**	National, Provincial
1	*Reproductive, Maternal, Newborn and Child*		Gender, Age, SES, Geographic area	Multiple Surveys (PDHS, NNS, MICS)	WHO, UN, World Bank		National, Provincial
	mCPR	**Good**					
	ANC 4+ visits	**Good**					
	DPT3	**Good**					
	ARI Care Seeking behavior	**Good**					
2	*Infectious Diseases*		Gender, Age, SES, Geographic area	PDHS, Program Data	WHO		National, Provincial
	TB treatment coverage	**Fair**					
	ART coverage	**Poor**					
	LLIN coverage	**Good**					
	Access to basic sanitation	**Good**					
3	*Non-Communicable Diseases*		Gender, Age, SES, Geographic area	Surveys, Registry	WHO, UN		National, Provincial
	Prevalence of normal BP	**Fair**					
	Prevalence raised blood glucose	**Fair**					
	Cervical cancer screening	**Good**					
	No smoking in last 30 days	**Poor**					
4	*Service coverage Access*		Geographic area	Departments of Health, Registry	WHO		National, Provincial
	Hospital access – Beds per capita	**Fair**					
	Health worker density – physicians, psychiatrists, surgeons	**Fair**					

	Health facilities with essential medicine	**Fair**					
	IHR index compliance	**Good**					
3.8.2	Financial Protection	**Poor**	Age, Gender, SES	HIES, NHA, BISP	WHO, WORLD BANK	**2-3 years**	National, Provincial
3.9.1	Mortality due to air pollution	**Poor**	Age, Gender, SES, Geographic location	N/A	WHO	**2-3 years**	National, Provincial
3.9.2	Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)	**Fair**	Age, Gender, SES, Geographic location	N/A	WHO	**2-3 years**	National, Provincial
3.9.3	Mortality rate attributed to unintentional poisoning	**Poor**	Age, Gender, SES	N/A	WHO	**2-3 years**	National, Provincial
3.a.1	Age-standardized prevalence of current tobacco use among persons aged 15 years and older	**Fair**	Age, Gender, SES	National Health Survey	GATS, WHO	**2-3 years**	National, Provincial
3.b.1	Proportion of the target population covered by all vaccines included in their national program	**Poor**	Facility type, Medicine, Commodity, Public private	PDHS, HMIS	WHO	**2-3 years**	National, Provincial
3.b.2	ODA for medical research and basic health sectors	**Good**	Type of finance (budget support, investments, grant, aid), Type of resources (technical, financial)	Pink Book, OECD, EAD/DAD	OECD, WHO	**2-3 years**	National
3.b.3	Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis	**Poor**	Facility type, Medicines available	DHIS/HMIS	N/A	**2-3 years**	National, Provincial
3.c.1	Health worker density and distribution	**Fair**	Cadre, Residence of employment, Sub-national, Practitioner	Health workforce database, HSA	WHO	**2-3 years**	National, Provincial
3.d.1	International Health Regulations (IHR) capacity and health emergency preparedness	**Good**	N/A	MoNHSRC	WHO	**2-3 years**	National
2.2.1	Stunting among children	**Good**	Gender, Age, SES, Geographic area,	NNS, MICS, PDHS	UNICEF, WHO,	**Annual**	National, Provincial, District

					WORLD BANK		
6.1.1	Wasting and overweight among children	**Good**	Gender, Age, SES, Geographic area	NNS, MICS, PDHS	UNICEF, WHO, WORLD BANK	**Annual**	National, Provincial
6.2.1	Drinking-water services	**Good**	Geographic area	PSLM	UNICEF, WHO	**2-3 years**	National, Provincial
6.2.1	Sanitation services	**Good**	Geographic area	PSLM	UNICEF, WHO	**2-3 years**	National, Provincial
7.1.1	Clean household energy	**Good**	Geographic area	PSLM	WHO	**2-3 years**	National, Provincial
11.6.1	Air pollution	**Poor**	N/A	N/A	WHO	**Annual**	National, Provincial
13.1.1	Mortality due to disasters	**Fair**	Gender, Age, SES, Geographic area	NDMA	UNISDR, WHO	**2-3 years**	National, Provincial
16.1.1	Homicide	**Fair**	Gender, Age, SES, Geographic area	Police data	UNISDR, WHO	**2-3 years**	National, Provincial
16.1.2	Mortality due to conflicts	**Fair**	Gender, Age, SES, Geographic area	PSLM, CRVS, PDHS, MICS	OCHCR, WHO	**2-3 years**	National, Provincial

Legend
Green (Good): indicator is classified as having 'Good' data availability/disaggregation if data are collected through regular national surveys and HMIS
Yellow (Fair): if data is available through periodic surveys and by international sources
Red (Poor): if data estimates available only through international/global source

SDGs Interlinkages and Strength of Influences

The targets within the set of 17 SDGs are interlinked. Using network analysis technique, a network matrix was generated (Annex 6: Table 7) to show linkages of SDG3 with other goals. For this as a first step SDGs and their targets were subjectively reviewed and analyzed for inter-connectivity with other goals and targets. This method, while seemingly straightforward, is subject to different interpretations of the wording of the targets. For example, whether a target referring to "hygiene" is recorded as having a link to the health goal depends on whether one considers that hygiene clearly and explicitly belongs to the health area. This implies that the matrix which is the basis for the network analysis may vary slightly according to the coder's understanding. The coding of the links between targets and goals was undertaken independently by 2 coders and re-examined several times by the research team to ensure consistency in coding the linkages.

Based on the coding 2-mode simple network analysis was done and maps generated for interlinkages within and between the 17 SDGs (Figure 3, 4). The line thickness indicates strength of linkage and influences.

Figure 3 - SDG 3 interconnections

The figure below (figure 4) shows the strength of SDG 3 targets with the other 16 SDGs, represented as number of indicator connections of SDG 3 with other indicators.

Figure 4 - SDG 3 strength of connections

Within the SDG 3, linkages of each of the targets with other SDGs were identified and have been ranked, in descending order (Table 4). As per the ranking, the most significant areas within health, with most sectoral linkages are SDG 3.3, 3.7, 3.9, 3.1, 3.8 and 3.2. Details of linkages are given in Annex 6.

SDG 3 – Targets leverage points			**Number of connections**
1	SDG 3.3	End epidemic of AIDS, tuberculosis, malaria and communicable diseases	34
2	SDG 3.7	Universal access to SRH	28
3	SDG 3.9	Reduce deaths from hazardous chemicals and pollution	20
4	SDG 3.1	Maternal mortality ratio	20
5	SDG 3.8	Universal health coverage	17
6	SDG 3.2	End preventable deaths of newborns and children under 5 years of age	15
7	SDG 3.5	Strengthen prevention and treatment of substance abuse	12
8	SDG 3.4	Reduce mortality from NCDs	12
9	SDG 3 b	Research and development of vaccines, medicines	12
10	SDG 3 d	International health regulations	9
11	SDG 3 c	Health workforce development	6
12	SDG 3 a	Strengthen implementation of FCTC	6
13	SDG 3.6	Reduce deaths from road traffic accidents	2

Table 4 - SDG 3 targets linkages

2. FINDINGS AND ANALYSIS OF DESK REVIEW

Pakistan committed to achieving the SDGs in October 2015 and initialized processes to adapt these global goals and align them with the national ones. The federal and provincial governments are working for localization and mainstreaming of SDGs with current health projects and plans (2). This report was launched on 9th July 2018, identifying data gaps at the national and provincial level.

After adoption of SDGs, the National Assembly of Pakistan conceded SDGs as the national developmental goals in 2016. After a year (in 2017) Ministry of Planning, Development and Reform of Pakistan established federal SDG Support Unit. The function of this unit is to co-ordinate with all development partners to support Pakistan in achieving SDGs (3). After establishment of the federal SDG unit, a data gap analysis was initiated in August 2017 by the federal government (Planning Commission) and UNDP. The 244 indicators of the 17 SDGs were examined, with regards to the available data sources, need for designing instruments, and current indicators reported nationally (2).

The main findings of the analysis highlighted that Pakistan needs to make improvements in data availability and reporting of goals related to climate change, health, peace, justice, natural resources, urban life etc. The data gap for goals related to poverty, quality education, affordable & clean energy, economic growth, gender equality is 20-40%. However, the data availability and reporting for indicators of clean water and sanitation, climate action, life below water, peace & justice and sustainable cities are between 10 % and 30 % (2).

The province of Punjab established its SDG unit in 2016. It has four key working areas namely policy review in Punjab, SDGs integration, review of alignment of existing development plans with SDGs, and identification of gaps in future SDGs integration. The Planning & Development unit of Punjab (P&D) has assigned senior officials (Additional Secretaries) in all departments as SDG focal persons and majority have been notified of their tasks. All the departments have been instructed to include SDGs in their Annual Development Plans (ADP) in context of SDG related programs and projects. Other than that, Punjab SDG unit is planning to have consultative workshops and meetings with all the departments and UNDP country office, Islamabad. The consultative meeting will help in mainstreaming, acceleration (proposed interventions and innovations) and policy support for the SDGs (4).

Other initiatives included a priority-ranking exercise engaging Civil Society Organizations (CSOs) in six sample districts of Punjab. The target population was university students, and vulnerable groups (disabled, minorities). For sequencing and prioritization, Punjab SDG unit has adopted various approaches. Firstly, it has initiated a consultative process that included government, UN agencies, Academia, CSOs, and Think Tanks. Secondly, in the near future the unit is going to launch an online survey which will take citizen feedback regarding SDGs prioritization in Punjab (4).

Other steps towards SDG localization by Punjab is financing of SDGs. Punjab SDG unit and UNDP are working on integration of SDGs with Public Finance Commission (PFC) award. The focus is on strengthening of PFC award. The finance department is working to ensure effective fiscal transfers in fiscal monitoring towards the local governments and integration of SDGs (4). In 2106, UNDP and Planning Commission launched Multidimensional Poverty Index (MPI) to determine poverty levels. In the lowest performing ten districts of Punjab, SDGs localization plans were developed. The SDGs localization plan was initiated as a pilot project in Bhakkar and Rajanpur districts of Punjab in January 2017. The project is now being replicated in eight other districts of Punjab (4).

SDG Unit in Sindh province has also been established in December 2015, with collaboration of Planning & Development (P&D) department of Sindh and UNDP. The Unit functions as a platform for mainstreaming SDGs with provincial Annual Development Plans (ADPs)

strengthening monitoring & reporting, and supporting coordination, policy and research. Moreover, the SDG Unit serves to maintain integrated innovative approaches, and knowledge management (5). The SDG Unit has conducted a few consultative workshops with stakeholders of UN agencies, line departments of Sindh, academia etc. Additionally, to sensitize district governments towards their role in achieving SDGs, six divisional workshops have been conducted (5). Government of Sindh has allocated fifty-six (56) billion rupees in their Annual Development Fund for 2017-18 for projects aligned with SDGs achievement in all line departments.

Another initiative is establishment of Parliamentary Task Force and Provincial Technical Committee. This is for policy integration and coherence in which a Core Group is leading with representatives from government departments, civil society and academia. The Core Group is responsible for developing clusters, institutional framework and roadmap for localization and implementation of SDGs in Sindh (5).

SDG Unit establishment is in process in Baluchistan and Khyber Pakhtunkhwa (KP) provinces and AJK, FATA & GB regions (3). The KP conducted an interdepartmental mapping activity existing health related projects/programs and alignment of public spending with the SDG 3 agenda. Similar mapping activities on alignment of public spending with SDGs is underway in Sind and Balochistan. The Government of Pakistan has also developed a Multidimensional Poverty Index (MPI), with collaboration of and technical support from UNDP. The index will form the basis for prioritization of resource allocation for the vulnerable groups' needs towards achieving SDGs 2030 (6).

Pakistan was a signatory of Paris Summit on climate change in 2015. It has passed Climate Change Act with progress of inclusion of climate change in 2016-17 budget brief (6). Moreover, with the advancement of The Climate Change Financing Framework, and support of UNDP, US$ 36.97 million has been given to Pakistan from the Green Climate Fund. The purpose of this fund is to reduce the risks related to Glacial Outburst Flooding (GLOF) in Pakistan, which also has indirect implications on health of the people of Pakistan (6).

OVERVIEW OF HEALTH-RELATED SDG INDICATORS: VALUES, HISTORICAL DATA SOURCES

The section below is an overview of the current status of SDG 3 and other health-related SDGs indicators in Pakistan. A detailed review of the existing literature was conducted to understand the existing situation, historical trends, and factors affecting SDG related indicators. For each of the indicators, the following is given in the sections below

1. Overview of the change in the indicators' values over time (from 2001 to 2015)
2. Contextual factors affecting the said goal
3. Projected trends, expected progress and proposed national targets

The report relies entirely on existing sources of information, and several reports have been used to complete the tabulated data. These include Pakistan Demographic and Health Surveys (PDHS), MDG report, Multiple Indicator Cluster Survey (MICS), National Nutrition Survey (NNS) and in cases when there was no access to national published reports, UN, World Bank and WHO reports and others. A spreadsheet detailing National and Provincial baseline data, proposed targets and timelines and proposed actions to achieve targets is provided as an annexure.

SDG 3: ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES: VALUES, HISTORICAL TRENDS AND SOURCES

SDG 3.1: REDUCE GLOBAL MATERNAL MORTALITY - HISTORICAL TRENDS AND PROJECTED MILESTONES

Goal 3: Ensure healthy lives and promote well-being for all at all ages																		
	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2030**		**Gaps**
3.1.1 Maternal mortality ratio																**Expected**	**Required**	**Gaps**
National	294	282	271	259	249	239	230	223	217	211	211	204	197	184	178	**95**	**<70**	Routine reporting of maternal deaths from districts is in absolute numbers and only from public sector health system. Maternal deaths in private health sector or for births attended by TBAs is missing. This information is captured through periodic surveys, using verbal autopsy systems. **Data Sources**: PDHS; MICS; UNSTATS; WDI
Punjab						227												
Sind						314												
KP						275												
Balochistan						785												
Age <20 20-24 25-29 30-34 35-39 40-44 45-49						 242 210 267 246 657 855 234												
Residence Urban Rural						175 319												
3.1.2 Proportion of births attended by skilled health personnel																**Expected**	**Required**	**Gaps**
National	23	--	--	--	31	38.8[2]	38.8	--	41	--	43	51[3]	52.1 - 58	--	--	**75**	**>90**	Delayed deployment of trained Midwives in rural areas; Delays in implementation of IHR **Data Sources**: PDHS (52.1); PSLM (58); MICS
Punjab						38						53						
Sind						44						61						
KP						38						48						
Balochistan						23						18						

Pakistan Demographic and Health Survey,2006-07

[2]Pakistan Demographic and Health Survey, 2012-13

3.1.1 Maternal mortality ratio

By 2030, global maternal mortality is to be reduced to 70 per 100,000; from the current global value of 216. Currently, Pakistan's estimated maternal mortality ratio is 178. At the current rate of progress estimated at 6.6% annual reduction from 2010 to 2015 (decline of 15.6%, over five years). Keeping the subsequent 5 year differentials at 6% annual reduction till 2020, 5.5% annual reduction till 2025 and 5.1% by 2030, MMR is projected to be 95.
Considering the requirements for SDG target achievement, Pakistan's MMR needs to be reduced to a value of 70, by the year 2030.

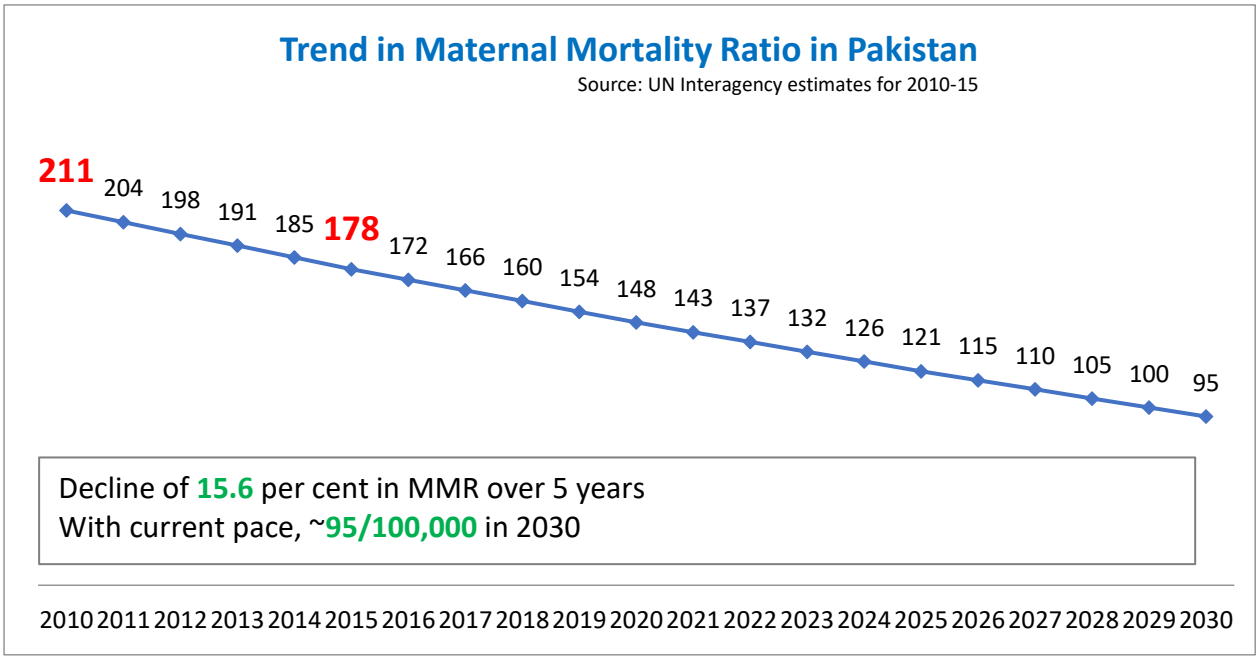


Figure 5 - Maternal Mortality in Pakistan - Historical values and Projected trends

3.1.2 Proportion of births attended by skilled birth attendants

Availability of a skilled birth attendant (SBA) at delivery is important in averting maternal and neonatal mortality and morbidity. Research evidence shows that even trained traditional birth attendants (TBAs) cannot, in most cases, save women's lives effectively because they are unable to treat complications, and are often unable to refer.

Currently, 52% of births are attended by a SBA. At the current rate of progress (shown in blue), using average year progress, by 2030, SBA is expected to increase to 75%; however, the required target for achieving the SDGs targets is 90% SBA, by the year 2030.

Considering the requirements for SDG target achievement, all births need to be attended by an SBA; which requires training and deployment of community based midwives for support with home based deliveries.

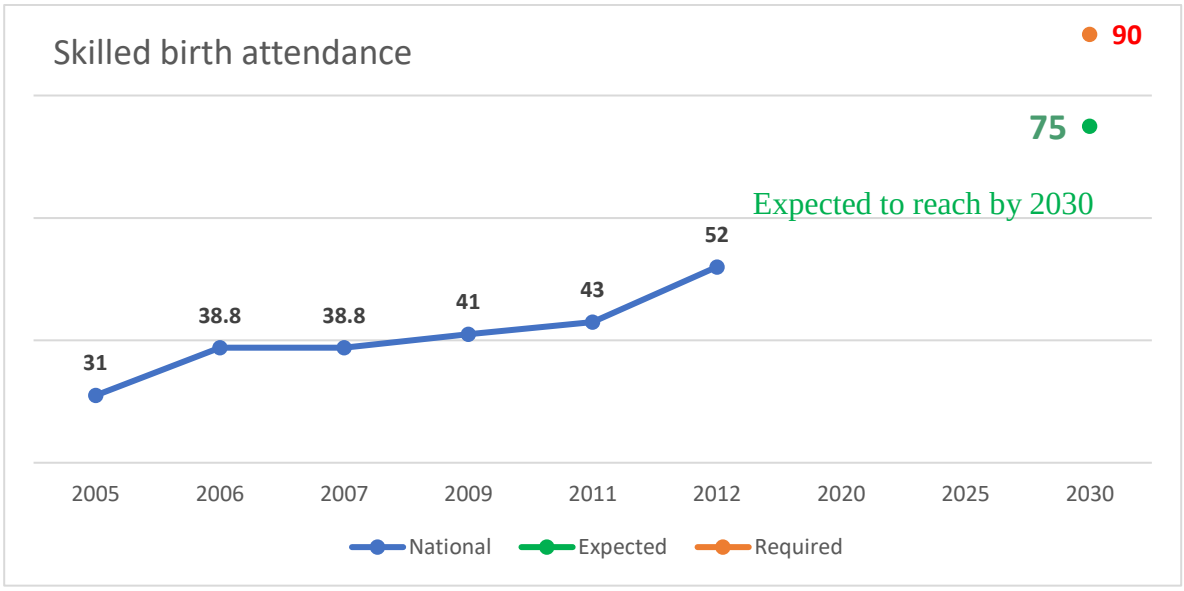


Figure 6 - Skilled Birth Attendance at Delivery - Historical values and Projected trends

1. Contextual Factors affecting key health related indicators of SDG 3.1

Goal 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births		
Factor affecting		**Existing Policy/Ministry Frameworks/Organizations**
Social Development	**Economic Liabilities**	
3.1.1 Maternal mortality ratio		
Low utilization of family planning services; Poor prenatal, natal, and postnatal care; Lack of safe motherhood services and focused reproductive health services through a life cycle approach; Birth Spacing and short birth interval; Women's empowerment & Literacy; Multi-parity and increased age; Religious and cultural constraints	Highest in women from lowest wealth quintile; Rural areas have more maternal mortality ratio than urban areas due to lack of infrastructure and services	LHW Program; MNCH Program; Family Planning Association of Pakistan; Health Care Providers at all tiers of the public health care system; Population Welfare Departments United Nations Agencies; Ministry of women Empowerment
3.1.2 Proportion of births attended by skilled health personnel		
Home deliveries; Lack of Basic Emergency Obstetric Care (BEmoC) and Comprehensive Emergency Obstetric Care (CEmoC)	Distance from health facility; Lack of transport and road infrastructure in rural areas	As above

Provincial Milestones to be suggested in consultative meetings; however, however data sources for disaggregated
provincial data need to be deliberated upon. Implementation of the IHR recommendations would impact health
worker density, directly affecting SBA. As work is in progress with UNDP, provincial milestone/standard setting
to be achieved through consensus building exercise in Health Departments, process of which should be shared with P&D departments for consideration for replication.

tSDG 3.2: End Preventable Deaths of New-Born and Children Under 5 Years of Age, with all countries aiming to reduce neonatal mortality to as low as 12 per 1,000 live births

1. SDG 3.2: New born and Child Mortality - Historical trends and projected milestones

t3.2 By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births																		
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2030	Gaps	
3.2.1 Under-five mortality rate (60% reduction)																**Expected**	**Required**	**Gaps**
National	109.8	107.5	105.3	103.2	101.2	99.3[3]	97.4	95.5	93.7	91.8	89.9	87.8[44]	85.6	83.3	81.9			Routine reporting of infant and child deaths from districts is in absolute numbers and only from public sector health system. Infant and child deaths in private health sector or otherwise is missing as birth and death reporting is not recorded in the Civil Registration and Vital Statistics (CRVS), in all areas across Pakistan. This information is captured through periodic surveys, using verbal autopsy systems.
Punjab						97						105						
Sind						101						93						
KP						75						70						
Balochistan						59						111						
Male						93						98						
Female						93						96						
Mother age																		
<20						133						120				**49**	**<25**	
20-29						92						91						
30-39						81						101						
40-49						74						94						
Birth order																		
1						110						93						
2-3						88						82						
4-6						86						95						
7+						98						150						
3.2.2 Neonatal mortality rate (63% reduction)																		
National	59	57.8	56.3	54.8	53.4	52.5[5]	51.8	51.2	50.6	50	49.2	48.4[6]	--	--	47.3			
Punjab						58						63						
Sind						53						54						
KP						41						41						
Balochistan						30						63						
Male						57						61						
Female						48						54						
Mother age																		
<20						85						79				**32**	**<12**	
20-29						51						52						
30-39						45						60						
40-49						39						67						
Birth order																		
1						73						63						
2-3						49						47						
4-6						45						52						
7+						52						89						

Data Source:
PDHS; MICS; UNSTATS; WDI; UNIGME

[3]Pakistan Demographic and Health Survey,2006-07
[4]Pakistan Demographic and Health Survey,2012-13

3.2.1 Under-five mortality rate

By 2030, SDGs require that preventable deaths of children under 5 years of age should end, with all countries aiming to reduce under-5 mortality to at least as low as 25 per 1,000 live births, from a current global value of 42. Currently, Pakistan's under 5 mortality rate is 77. At the current rate of progress (11.7% 5year reduction, from 2010 to 2015), by 2030, Pakistan is expected to reduce mortality in children under 5 years of age to 49; however, the required target is U5MR of 25 by the year 2030.

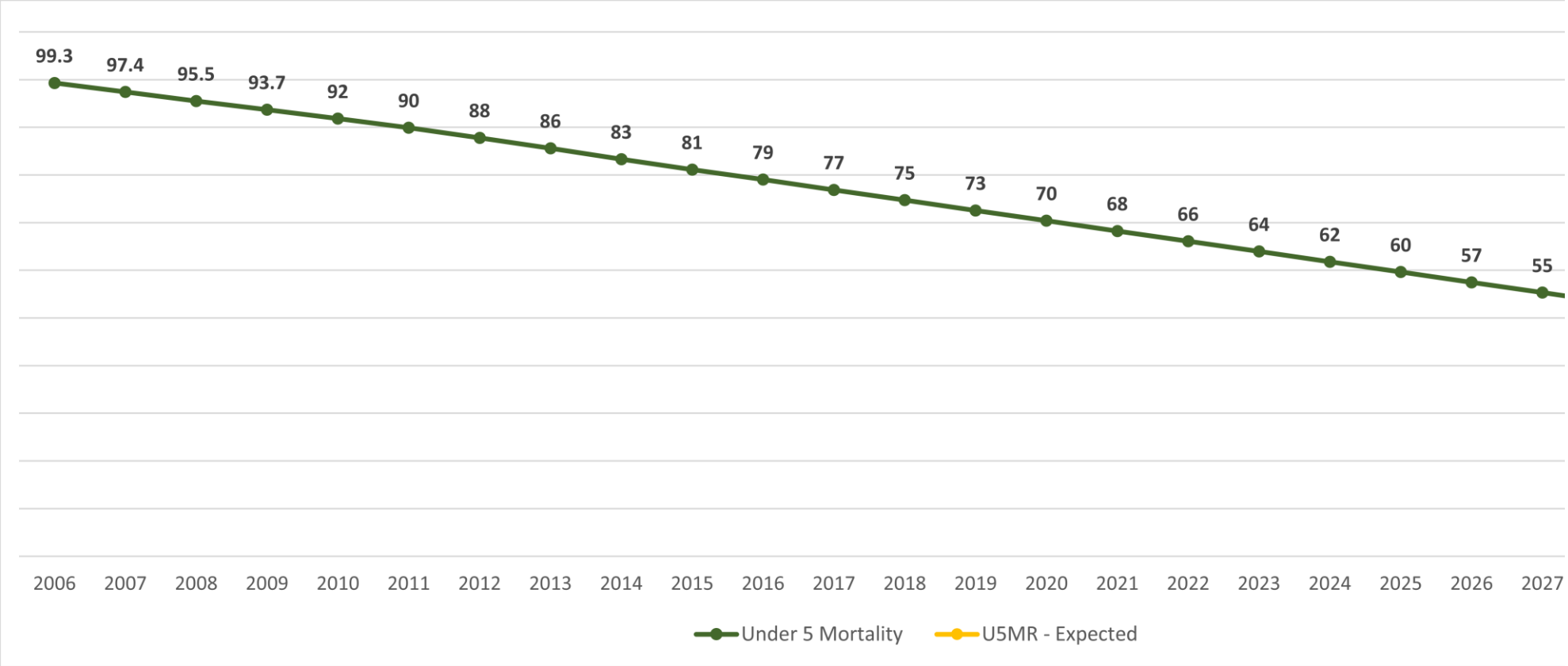


Figure 7 - Under 5 Mortality in Pakistan - Historical values and Projected trends

3.2.2 Neonatal Mortality Rate

By 2030, SDGs require that preventable deaths of new-borns should end, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births, from a current value of 19. Currently, Pakistan's NMR is 45.5. At the current rate of progress (5-year reduction), by 2030, Pakistan's projected NMR would be 32.

Considering the requirements for SDG target achievement, Pakistan's NMR needs to be reduced to a value of <12, by the year 2030.

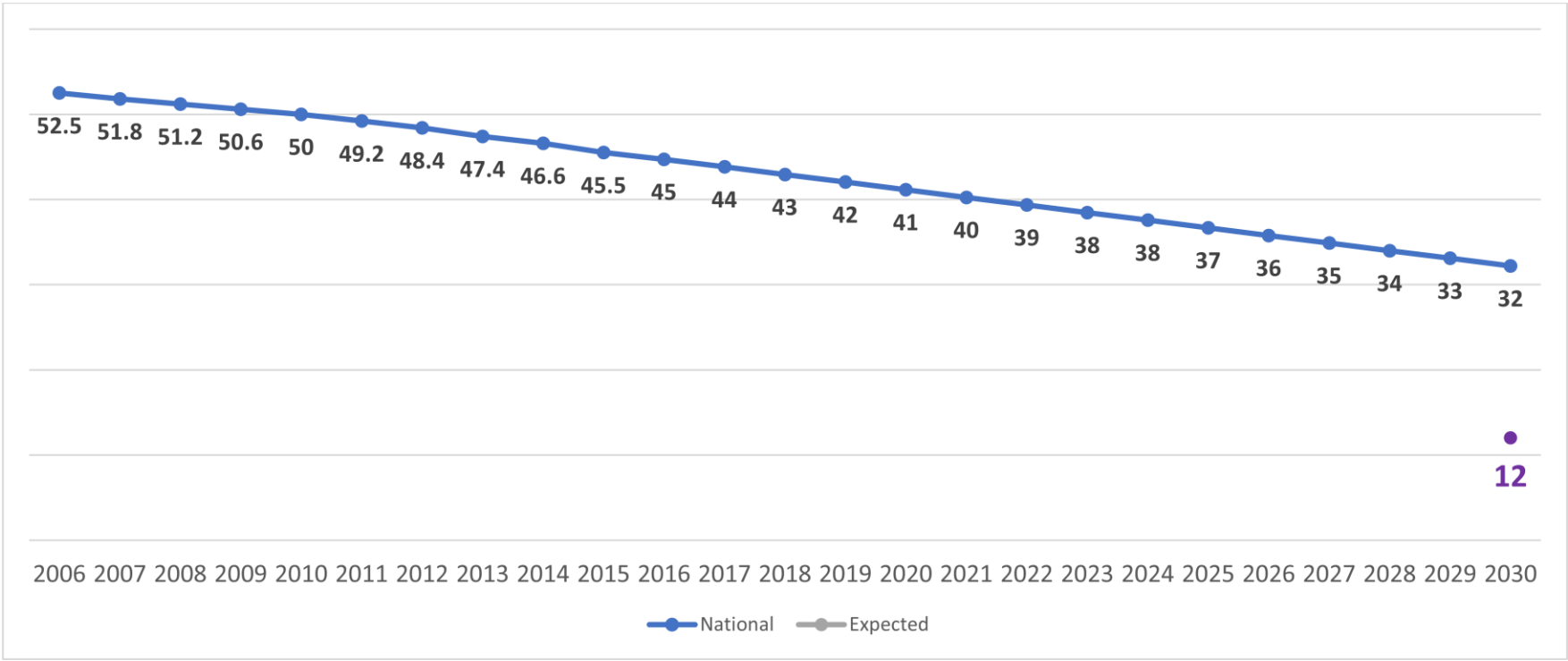


Figure 8 - Neonatal Mortality in Pakistan - Historical values and Projected trends

2. SDG 3.2: Contextual Factors

3.2 By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births		
Factor affecting		**Existing Policy/Ministry/Frameworks/Organizations**
Social Development	**Economic Liabilities**	
3.2.1 Under-five mortality rate		
Diarrhoea and pneumonia; Under nutrition; Unhygienic conditions; Unsatisfactory breastfeeding and weaning practices; Incomplete immunization and vaccination; Mothers' low literacy/education Post neonatal mortality (higher among female children due to socio-cultural discrimination towards female child); Maternal age at birth and multi parity	Economic vulnerability – household wealth, rural residence, poverty	EPI Program; MNCH Program; LHW program UNICEF; WHO and other INGOs; National Nutrition Program
3.2.2 Neonatal mortality rate		
Lack of early initiation of breast feeding; Neonatal tetanus; Low birth weight; Lack of timely antenatal care and postnatal visits; Home delivery practices; Mothers' low literacy/education Neonatal mortality (higher among male children due to biological weakness); Maternal age at birth; Short birth intervals; Place and assistance at delivery; Post-natal care and new born care	Economic vulnerability – household wealth, rural residence, poverty	As above

SDG 3.3: By 2030, End the Epidemics of AIDS, Tuberculosis, Malaria and Neglected tropical diseases and combat Hepatitis, Water-borne diseases and Other Communicable diseases

1. SDG 3.3: Epidemics of AIDS, Tuberculosis, Malaria - Historical trends and proposed milestones

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases																		
2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2030**		**Gaps**
3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations																**Expected**	**Required**	Routine reporting from districts is number of confirmed cases detected at the DHQ level; **Data Source:** NACP; UNSTATS; WDI
0.01	0.02	0.02	0.02	0.03	0.03	0.04	0.04	0.06	0.07	0.07	0.08	0.08	0.09	0.09	0.09	**0.19**	**≤0.01**	
3.3.2 Tuberculosis incidence per 100,000 population,																**Expected**	**Required**	Routine reporting from districts is on number of cases detected at the TB Centres; National level data, disaggregated by province required for provincial projections and proposing milestones setting. **Data Source:** NACP; UNSTATS; WDI
275	275	276	276	276	276	276	276	276	276	276	276	275	270	268	270	**212 - 261**	**≤54**	
3.3.3 Malaria incidence per 1,000 population[8, 9]																**Expected**	**Required**	Routine reporting from districts is on number of cases detected in public sector health facilities; **Data Source:** NACP; UNSTATS; WHO Estimates
44.82	--	--	--	40.29	--	--	--	--	13.76	--	--	--	--	8.56	--	**< 1**	**< 1**	
3.3.4 Hepatitis incidence per 1,000 population																**Expected**	**Required**	
--	--	--	--	--	--	--	72	--	--	--	--	--	--	72	--	**45**	**< 1**	
3.3.5 Number of people requiring interventions against neglected tropical diseases																**Expected**	**Required**	
--	--	--	--	--	--	--	--	--	--	--	--	--	--	31056	--	**< 10000**	**< 1**	

[5]Spectrum 2014 (UNAIDS/NACP); Pakistan Demographic and Health Survey 2012-13; Integrated Biological and Behavioural Survey 2011

[6]Pakistan Demographic and Health Survey,2006-07

[7]Pakistan Demographic and Health Survey,2012-013

3.3.1 End epidemic of HIV - Number of new HIV infections

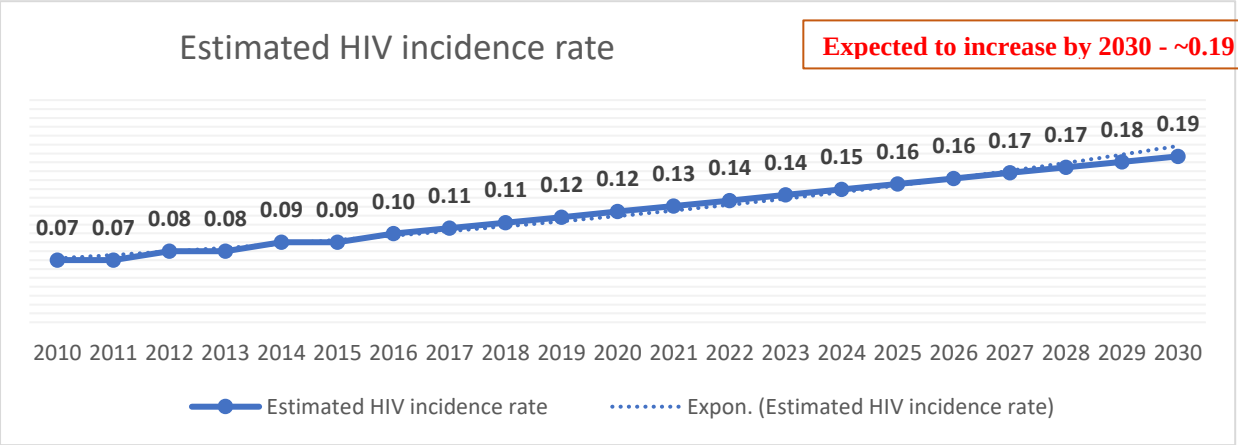


Figure 9 - HIV Incidence in Pakistan - Historical values and Projected trends

3.3.2 Tuberculosis incidence per 100,000 population

By 2030, the epidemic of Tuberculosis infections should also end. Currently, TB incidence rate in Pakistan is 271. There has been some decline in the incidence over the past years; however, at the current rate of progress using average year decrease, by 2030, Pakistan's projected TB incidence would decrease to almost 269.5.

However, taking into account the global target of 80% reduction in incidence by 2030, the TB incidence needs to be reduced drastically, to a

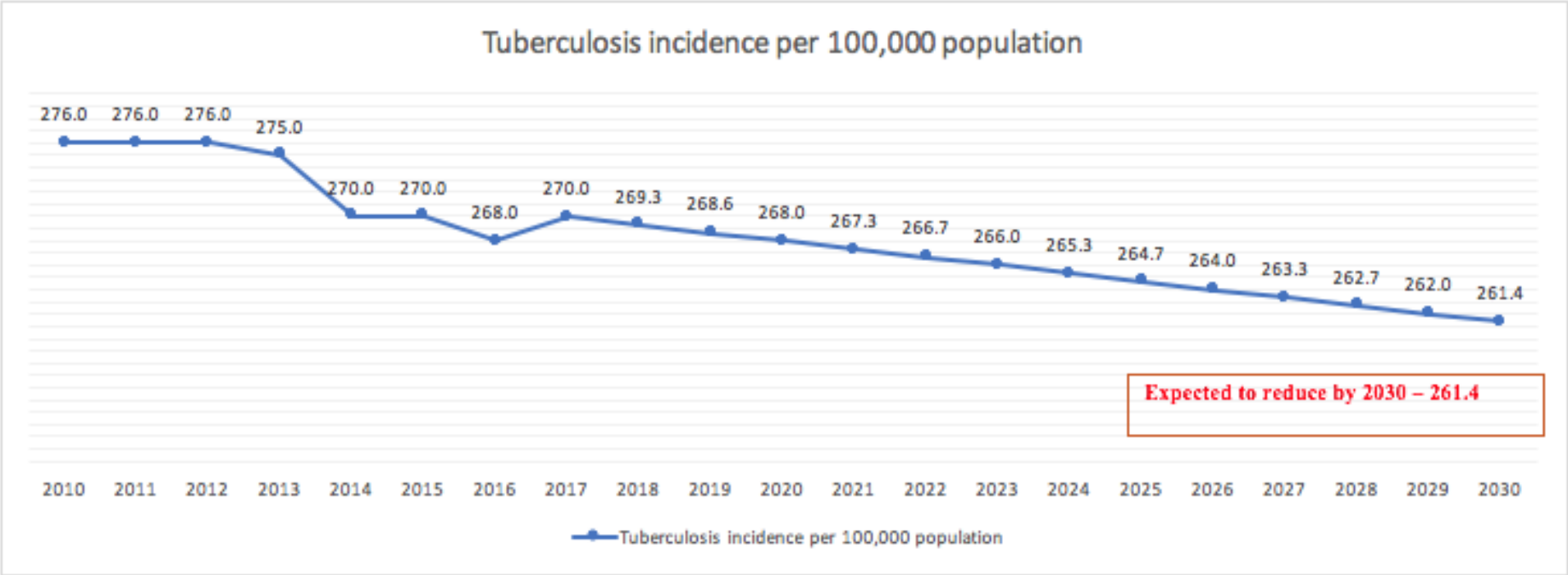


Figure 10 - Tuberculosis Incidence in Pakistan - Historical values and Projected trends

3.3.3 Malaria incidence per 1,000 population

Over the years, there have been dramatic reductions in incidence of Malarial infections primarily due to proactive campaigns of distribution of insecticide treated bed nets and residual indoor spraying of insecticides. However, the incidence of Dengue fever (a viral diseases, transmitted by a different variant of a mosquito) has risen dramatically.

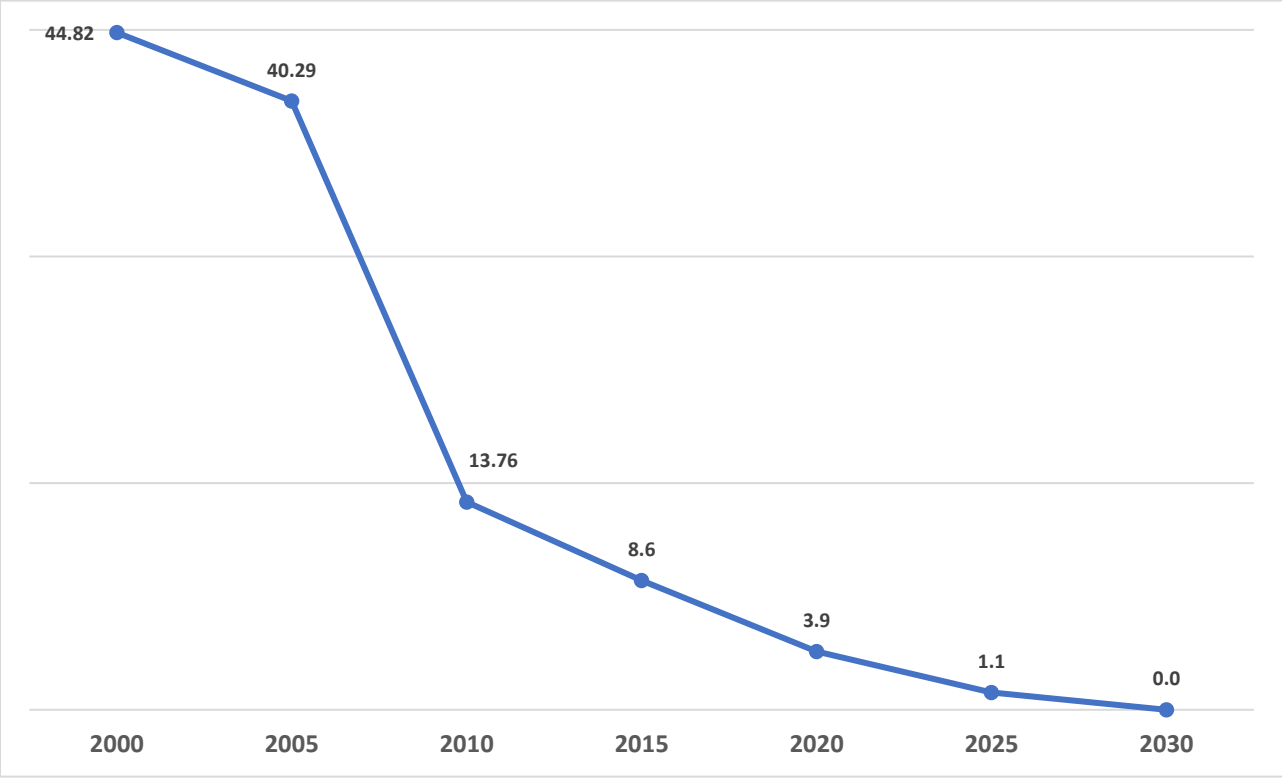


Figure 10 - Malaria incidence per 1,000 population

SDG 3.3: Epidemics of AIDS, Tuberculosis, Malaria – Contextual Factors

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases		
Factor affecting		**Existing Policy/Ministry/Frameworks/Organizations**
Social Development	**Economic Liabilities**	
3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations		
Increased bridging population; Commercial sex; Use of injectable drugs (used syringes); Multiple sexual partners; Unscreened blood transfusion; Transgender women, Low levels of literacy and education; and Gender inequalities	Economic vulnerability; Large number of migrants and refugees; Unemployed youth; Out-of-school youth and street children	NTP; NACP; UNAIDS; UNWOMEN; Ministry of National Health Services, Regulations and Coordination, Pakistan; MNCH Program; LHW Program
3.3.2 Tuberculosis incidence per 100,000 population		
Higher in people suffering from HIV, diabetes, silicosis and lung disorders; Long term therapeutic steroids and immune suppressant treatment; Malnourished persons, Smoking and harmful use of alcohol and drugs; Poor living conditions - ventilation, overcrowding; Overcrowding in healthcare facilities; Congregate settings especially prison and mining.	Malnourishment; Poor living and sanitation conditions	NTP; EPI; LHW Program; UNWOMEN (advocacy); Ministry of National Health Services, Regulations and Coordination (AIDS/TB/Malaria program)
3.3.3 Malaria incidence per 1,000 population		
Low immunity; Lack of awareness; Household availability and usage of insecticide-treated bed nets; Lack of indoor residual spraying (IRS);	Poor living and sanitation conditions	Directorate of Malaria Control (DoMC) – Pakistan; WASH Program (UNICEF); LHW Program

Lack of diagnostic and treatment to malaria cases; Unhygienic environmental conditions		
3.3.4 Hepatitis B incidence per 100,000 population		
Use of unscreened blood transfusion; Needle sharing; Lack of knowledge about Hepatitis and its transmission; Inadequate immunization coverage (Hep B); Commercial sex; MTCT (during delivery); Use of unsterilized surgical and dental instruments	Poverty; Low literacy; Urban/rural disparities	Hepatitis Control Program; EPI; MNCH Program; WHO

Routine reporting of cases is done at the district level in public sector facilities. Four infectious diseases (HIV/AIDS, TB, Malaria and Hepatitis) are endemic and sporadic cases will continue to occur. It is therefore imperative to strengthen the Integrated Disease Surveillance Response in the country to contain the epidemics of infectious and neglected tropical diseases. Furthermore, by strengthening the UHC, gains will be made in reduction of infectious morbidities.

SDG 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases 1. through prevention and treatment and promote mental health and well-being

SDG 3.4: Historical Trends and Proposed milestones

SDG 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being																	
2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2030	Gaps
3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease[8, 9]																Expected	Required	Gaps
24.8	--	--	--	24.7	--	--	--	--	24.9	--	--	--	--	24.6	24.7	20*	17	Establish cause of death reporting in CRVS; Routine reporting from districts; National level data, disaggregated by province required for provincial projections and proposing milestones setting. Data Sources: PDHS; MICS; UNSTATS;
3.4.2 Suicide mortality rate[10, 11]																Expected	Required	Gaps
2.6	--	--	--	2.3	--	--	--	--	2.1	--	--	--	--	2.1	2.1	≤1.6*	≤1	Establish cause of death reporting in CRVS; Routine reporting from districts; National level data, disaggregated by province required for provincial projections and proposing milestones setting.

* Through a consultative process, expected targets set based on current investments and ongoing projects/programs

[8] Pakistan Demographic and Health Survey,2006-07

[9] Pakistan Demographic and Health Survey,2012-013

3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease

By 2030, SDGs require that global premature mortality attributed to chronic diseases be reduced by a third (33% reduction). Globally, the rate of this is 19 and should be 6, by 2030. For the Pakistan scenario, this mortality needs to be reduced from the current rate of 25 to 17. The regression plotted below suggests that at the current rate of progress (shown in red), using average year reduction, by 2030, Pakistan would continue with the same trend in premature mortality from chronic diseases. Considering the requirements for SDG target achievement, drastic steps need to be taken to achieve the targets, especially interventions focusing on primary prevention. Realistically, Pakistan can bring down premature NCD mortality to <20, with consistent and concerted efforts.

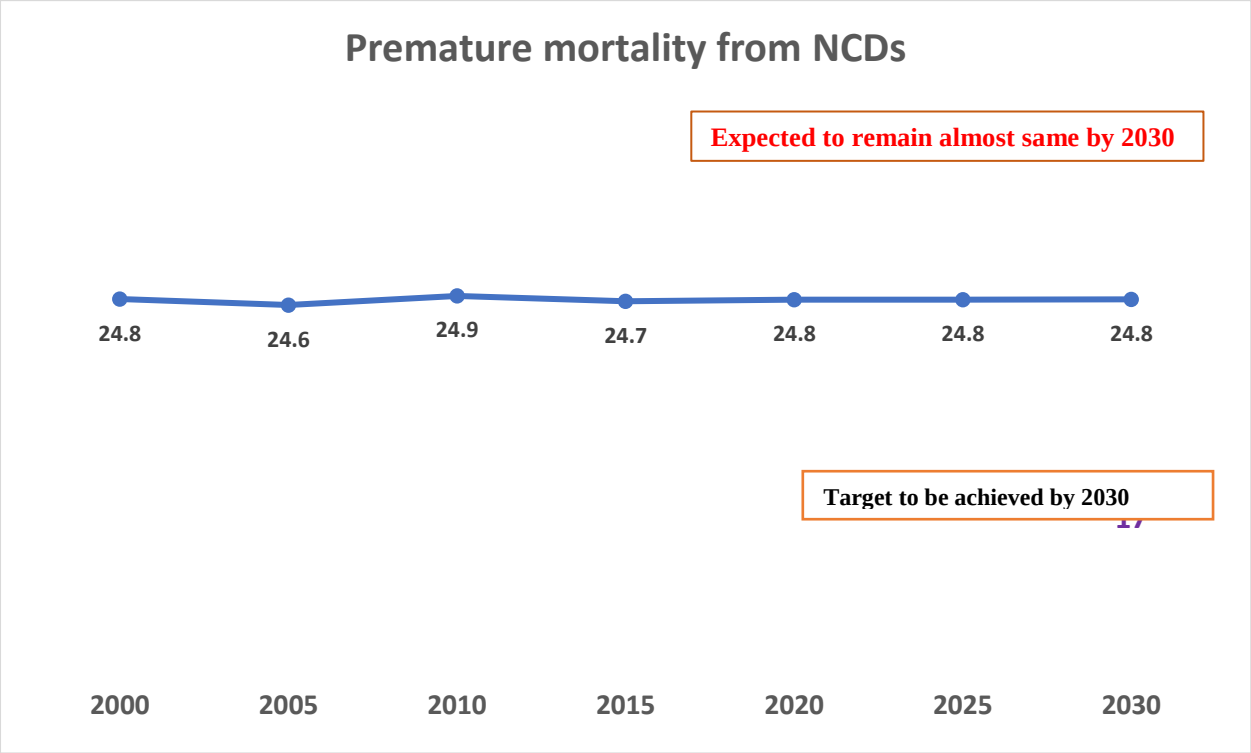


Figure 11 - Mortality due to NCDs - Historical values and Projected trends

2. SDG 3.4: Contextual Factors

3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being		
Factor affecting		**Existing Policy/Ministry/Frameworks/Organizations**
Social Development	**Economic Liabilities**	
3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease		
Tobacco use; Physical inactivity; Harmful use of alcohol and unhealthy diets; Globalization of unhealthy lifestyles; Population ageing	Rapid unplanned urbanization; Limited access to health services; Lengthy and expensive treatment	Ministry of National Health Services, Regulations and Coordination, Pakistan (National Health Vision 2025); Urban planning and development authority; Finance, transport, education, agriculture sectors; WHO and other UN agencies
3.4.2 Suicide mortality rate		
Low priority for Policy makers and governments; Lack of mental health and psychiatric hospital services; Lack of awareness; Stigma attached to mental illnesses; Societal pressures; Psychiatric comorbidity; First-degree family history of suicide or mood disorders; Early life trauma (abuse); Harmful use of alcohol	Poverty and financial crisis; War and disaster	Some civil society organizations (CSOs)

Civic Registration of Vital Statistics (CRVS) System needs to be strengthened and implementation ensured at district level. This will give an accurate figure of the burden of mortality attributable to NCDs. Representation from Bureau of Statistics and PMDC should be included in consultative process to initiate process of training physicians on reporting cause of death and action plan for implementation of CRVS at district level.

SDG 3.5: STRENGTHEN THE PREVENTION AND TREATMENT OF SUBSTANCE ABUSE, INCLUDING NARCOTIC DRUG ABUSE AND HARMFUL USE OF ALCOHOL

The above-mentioned issues are not recorded regularly; periodic surveys are conducted by PBS and UNODC. As a Muslim country, alcohol sale is controlled and limited; total alcohol consumption, per capita is 0.20 liters (WHO Global data observatory, 2015).

A comprehensive national study of drug use in Pakistan was conducted in 2012, by Narcotics Control Division of Ministry of Interior, Pakistan Bureau of Statistics and UNODC. The survey results showed considerable past-year use of cannabis, prescription opioids (painkillers), tranquilizers and sedatives, and opiates (heroin and opium). The national population prevalence is a combination of very high levels of use of these substances among men, and generally low levels of use among women, offset by considerable levels of misuse of prescription opioids and tranquilizers and sedatives among women. Although Pakistan is a country with a large population of youth, drug use was more common among those between the ages of 25 to 39 than 15 to 24.

Table 5 - Annual prevalence of use of controlled substances (type), 2012

Drug type/class	**Annual prevalence (%)**
	Estimate
Any illicit drug use	6
Cannabis	3.6
Opioids	2.4
Prescription opioids	1.5
Tranquilizers/Sedatives	1.4
Cocaine	0.01
Amphetamine – type stimulants	0.08
Solvents/inhalants	0.03

SDG 3.5: Historical Trends and Proposed milestones

SDG 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being																		
2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2030		Gaps
3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders																Expected	Required	
--	--	--	--	--	--	--	--	--	--	--	--	--	--	10	--	35*	>80	Limited local data available.
3.5.2 Harmful use of alcohol defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in liters of pure alcohol																Expected	Required	
--	--	--	--	--	--	--	--	--	--	--	--	--	--	0.2	--	<0.2	Nil	Data Sources: UNODC; WHO; ANF

* Through a consultative process, expected targets set based on current investments and ongoing projects/programs

SDG 3.5: Contextual Factors

3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol		
Factor affecting		**Existing Policy/Ministry/Frameworks/Organizations**
Social Development	**Economic Liabilities**	
3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders		
Peer pressure among youth; Experimentation with drugs; Coping with personal difficulties (bereavement or loss); Enjoyment or to get high; Self-medication; Sexual performance enhancement; Lower level of uptake of drop-in centre services; Family neglect and abuse; Poor attachment to family, school and community	Poverty; Growing up in marginalized and deprived communities Data: Limited data in PDHS; MICS - No existing mechanisms for recording and reporting; Proposed addition of some questions in MICS; Reporting mechanisms for drop-in centres for substance abusers not well established, information collected in periodic surveys	UNODC; Ministry of Interior and Narcotics Control; Narcotics Control Division; Rehabilitation organizations; Anti-Narcotics Force; Airport Security Force (ASF); Pakistan Coast Guards; Customs Services of Pakistan; Maritime Security Agency; Provincial Excise and Taxation Departments; Frontier Corps (Khyber Pakhtunkhwa and Baluchistan); Frontier Constabulary; and Pakistan Rangers (Punjab and Sindh)
3.5.2 Harmful use of alcohol defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in liters of pure alcohol		
Cultural influence; Access and availability of alcohol; Age at first use (children, adolescent and elderly more vulnerable); Family history of alcohol use disorders (Parental alcohol use)	Economic development (purchasing Power); High and low socio-economic status (high alcohol consumption in both); Unemployment Data: Limited data in PDHS; MICS - No existing mechanisms for recording and reporting; Proposed addition of some questions in MICS; Reporting mechanisms for drop-in centres for substance abusers not well established, information collected in periodic surveys	Social Welfare Department; Health care system; Community and Social institutions; WHO and UN agencies; Ministry of Interior; Office of excise & taxation

SDG 3.6: By 2030, halve the number of global deaths and injuries from road traffic accidents

3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents																	
2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2030**		**Gaps**
3.6.1 Death Rate Due to traffic Accidents[10,11]															**Expected**	**Required**	No consolidated mechanism for routine reporting from all types of health care facilities on mortality from traffic accidents; Limited data in PDHS; Proposed addition of related questions in MICS and PDHS to capture information in the periodic surveys; Recording cause of death in CRVS needs to be established Data Sources: PDHS; MICS; UNSTATS; WDI
15	--	--	14.8	14.5	14.7	14.7	15.1	15.1	15	15.1	15.3	15.6	--	14.2	**<13**	**8**	

[10]Pakistan Demographic and Health Survey, 2006-07
[11]Pakistan Demographic and Health Survey, 2012-013

SDG 3.6: Halve Mortality from Road Traffic Accidents

By 2030, SDGs require that global mortality attributed to Road Traffic Accidents (RTAs) should be reduced by 50% (halved). The current RTA rate in Pakistan is 14 (2013) and with the existing programs/initiatives, this may be reduced to <13. For the Pakistan scenario, RTA mortality needs to be reduced to 8, to meet the global SDG targets. The regression plotted below suggests that at the current rate of progress (shown in red), using average year reduction, by 2030, Pakistan would continue with the same trend in mortality due to road traffic accidents. Considering the requirements for SDG target achievement, drastic steps need to be taken to achieve the targets.

Reservations: Since the accurate data for this indicator is neither available, nor recorded accurately; the projections should hence be treated with caution.

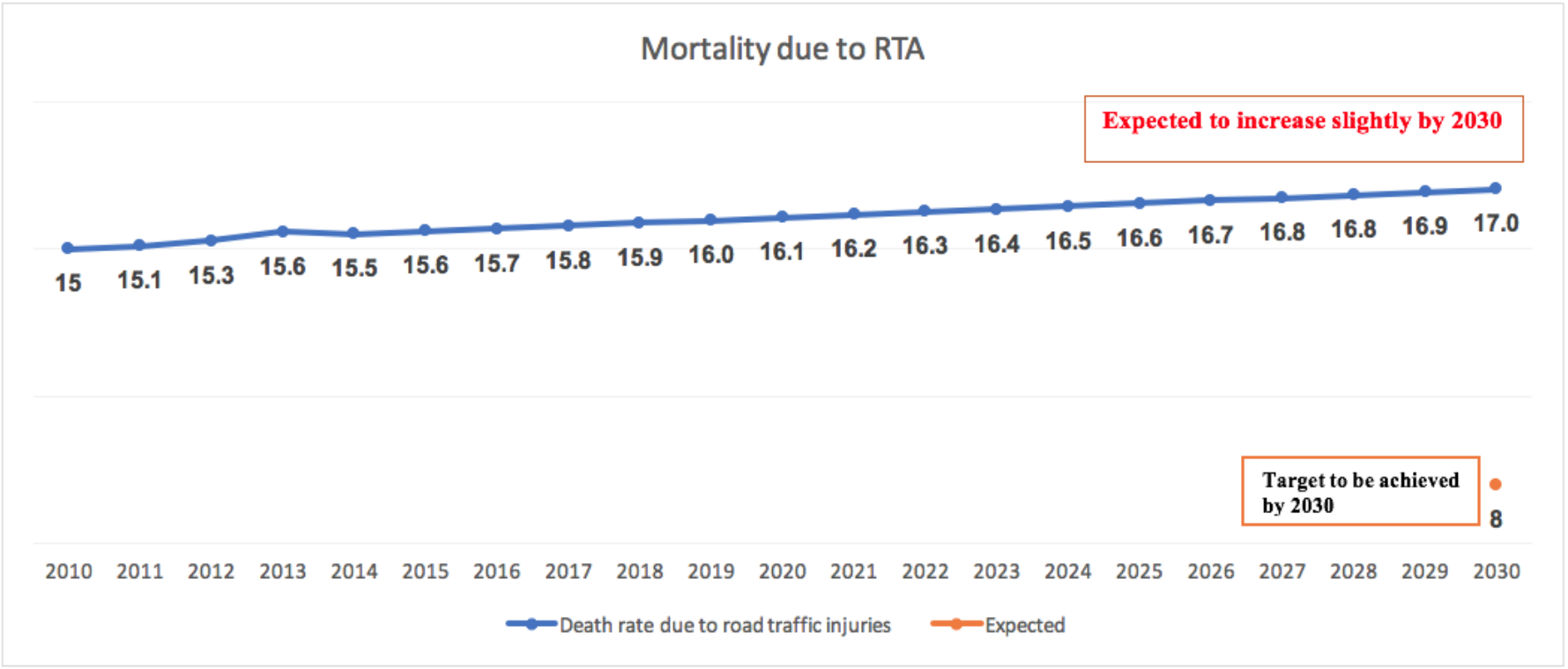


Figure 13 - Mortality due to RTAs - Historical values and Projected trends

2. SDG 3.6: Contextual Factors

3.6 By 2030, halve the number of global deaths and injuries from road traffic accidents		
Factor affecting		**Existing Policy/Ministry/Frameworks /Organizations**
Social Development	**Economic Liabilities**	
3.6.1 Death rate due to road traffic injuries		
Unfamiliarity with vehicles; Thrill-seeking; Driving under influence of drugs or alcohol; Excess or inappropriate speed; Unsafe road design; Lack of comprehensive driver training and licensing; Lack of effective law enforcement and safety regulations	Lack of or delayed emergency care on the spot; Lack of transport to a health facility; Availability and quality of trauma care; Rehabilitation	Government and Legislative Bodies (transport, public health, education, justice and finance)

SDG 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs

1. SDG 3.7: Universal access to SRH – Historical Trends and proposed milestones

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes																	
	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2030**	**Gaps**
3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods[1, 2]																**Expected** / **Required**	
National	--	--	--	--	--	39.8	--	--	--	--	--	--	47	--	--	**>70** / **>95**	Services coverage; Lack of awareness; High unmet need Data Sources: PDHS (2006-07; 2012-13); UNSTATS;
Punjab						41.3							50				
Sind						42.2							49				
KP						33.8							36				
Baluchistan						29.3							32				
Age 15-19 20-24 25-29 30-34 35-39 40-44 45-49						15.7 24.9 33.5 46.3 44.8 48.6 50.2							27 35.5 39 50 53 52 55				
Urban Rural						47.5 35.2							51 44				
Education None Primary Middle Secondary Higher						36.6 43.8 44.8 42.4 51.7							45 48 48 51 51				
Wealth Q Lowest Second						26.6							40 43 47				

[1]Pakistan Demographic and Health Survey,2006-07

[2]Pakistan Demographic and Health Survey,2012-013

Middle Fourth Highest						32.2 38.7 46.4 49.7							50 52				
3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group[18, 19]																**Expected**	**Required**	**Gaps**
National	48.7	45.9	45.1	44.2	43.3	42.5	41.6	41.5	41.3	41.1	41	40.8	40	38.6	38.3	**29***	**<10**	Culture and tradition of early marriages; Lack of awareness

* Through a consultative process, expected targets set based on current investments and ongoing projects/programs

3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods

By 2030, SDGs require that all women of reproductive age should have access to modern family planning methods. Considering the situation of Pakistan, there has been a steady increase in the percentage of contraceptive demand satisfied (by modern methods); from 39.8% in 2006 to 47% in 2013 (PDHS 2006-07; 2012-13). At the current rate of progress using average year increase, by 2030, the access would increase to 68.6%.
Considering the requirements for SDG target achievement, drastic steps in ensuring access to SRH services need to be taken to ensure universal access.

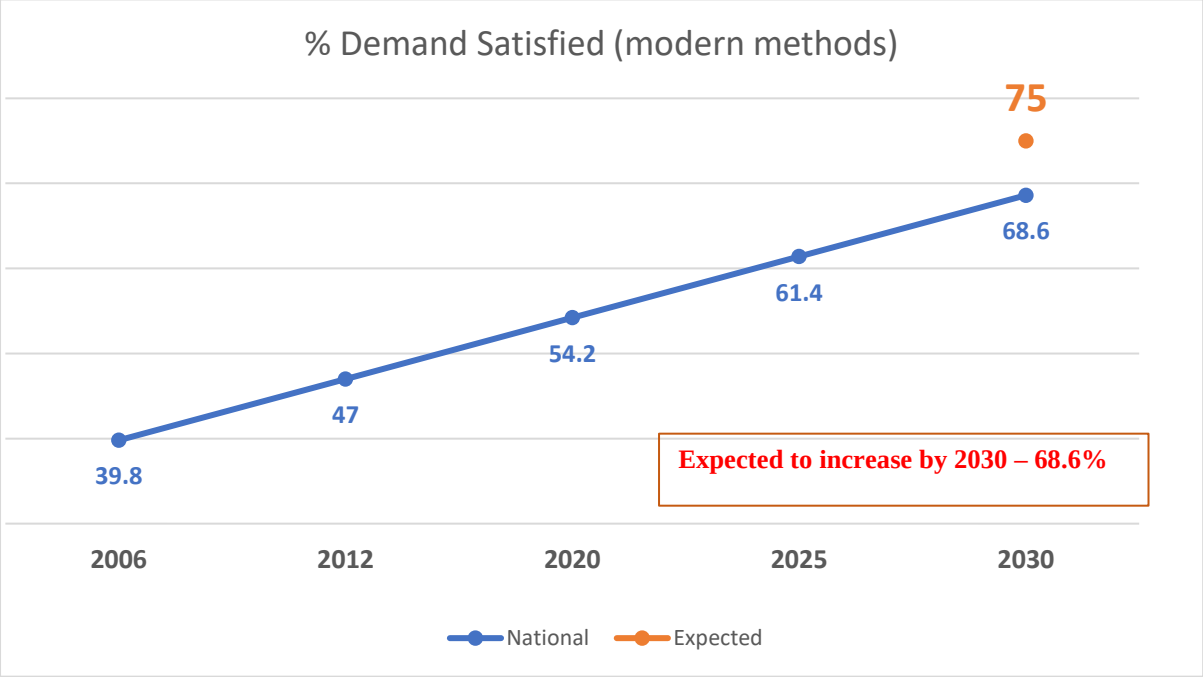


Figure 12 - Family Planning - Historical values and Projected trends

3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group

At present, birth rate among adolescents is seen to have reduced significantly, with the trend continuing for the next two decades.

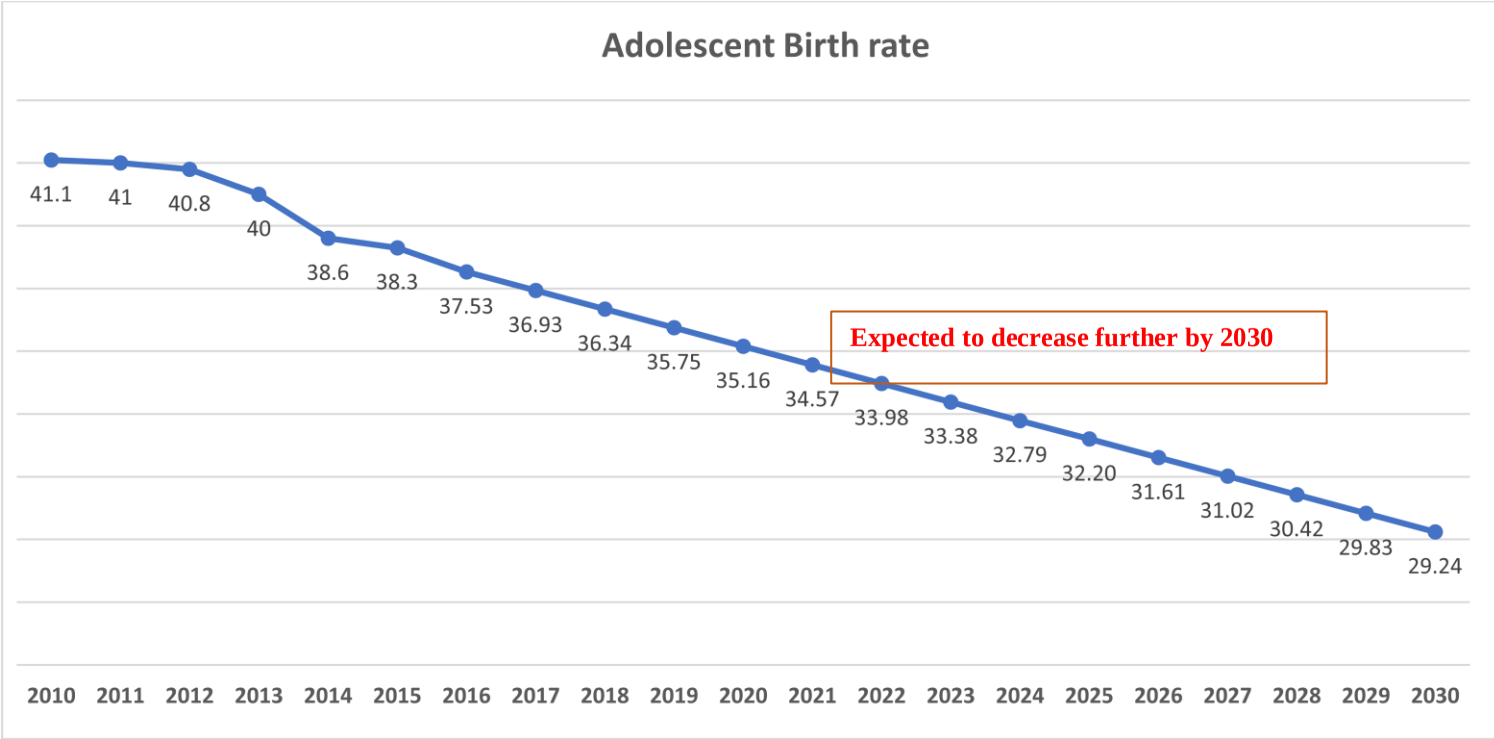


Figure 13 - Adolescent birth rates - - Historical values and Projected trends

2. SDG 3.7: Contextual Factors

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs		
Factor affecting		**Existing Policy/Ministry/Frameworks/Organizations**
Social Development	**Economic Liabilities**	
3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods		
Education level of women (higher education is related to highest satisfied demand for modern methods); Limited choice of contraceptive methods; Limited access to contraception (young people); Fear or experience of side-effects; Cultural or religious opposition; Poor quality of available services; Users and providers bias; Gender-based barriers	Access; Availability Rural /urban disparities	LHW Program; MNCH Program: Population Welfare Departments; Family Planning Association of Pakistan (FPAP) Ministry of National Health Services, Regulations and Coordination Pakistan; Population Council; UN Agencies, NGOs; FP2020 Country Commitments
3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group		
Lack of access to contraceptive services; Limited use of contraceptives; Early marriages; Low literacy/education; Partner desire to have children; Lack of parental monitoring and communication; Inadequate family support	Poverty; Limited involvement in work force	LHW Program; MNCH Program: Population Welfare Departments; Family Planning Association of Pakistan (FPAP) Ministry of National Health Services, Regulations and Coordination Pakistan; Population Council; UN Agencies, NGOs (UNICEF, WHO, UNFPA) Human right institutions

SDG 3.8: 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

Currently there is no nationally representative measure for assessing Universal Health Coverage, either as a composite index or a summary measure of essential health services coverage. Taking into account the UNDP's suggested proviso[3], indicators of tracer interventions that include reproductive, maternal, new-born and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population, a UHC index is proposed; this is a summary measure of coverage, an index of service coverage, across 16 tracer indicators (developed in consultation with Ministry of National Health Services Regulations & Coordination).
Using interventions provided through essential health services, each of the proposed 16 indicators for the UHC index for Pakistan have been given equal weightage. These indicators are:

A. *Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition*
1. Contraceptive prevalence rate (CPR – modern methods)
2. Antenatal care coverage (4+ visits)
3. Child immunizations (DPT III, Penta III)
4. Care-seeking behavior for child pneumonia

B. *Infectious Diseases*
1. Tuberculosis treatment coverage
2. ARV Therapy coverage
3. Insecticide treated nets coverage for malaria
4. Percentage population using improved sanitation facilities

C. *Non-Communicable diseases*
1. Prevalence of normal blood pressure
2. Prevalence of normal blood glucose (mean fasting plasma glucose mmol/L)
3. Cervical cancer screening
4. Tobacco control (non-smoking)

D. *Service coverage and access*
1. Hospital beds per capita (with threshold)
2. Health professionals per capita (with threshold): physicians, surgeons, psychiatrists
3. Health facilities with core list of essential medicines
4. Compliance with IHR

[3] 3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, new-born and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population) – Source: https://unstats.un.org/sdgs/indicators/Official%20Revised%20List%20of%20global%20SDG%20indicators.pdf

Indicator	Value	Data source
Reproductive, maternal, newborn and child health		
Demand satisfied with a modern method among women aged 15-49 years (%)	47	PDHS 2012-13
ANC 4+ visits	36.6	PDHS 2012-13
DPT3/Pentavalent	65.2	PDHS 2012-13
ARI care seeking	64.4	PDHS 2012-13
Infectious Diseases		
Tuberculosis treatment coverage	69	Global TB report 2017
Insecticide treated nets coverage for malaria	13.4	PDHS 2012-13
ARV therapy coverage	6	UNAIDS 2016
Percentage population using improved sanitation facilities	64	WASH
Non-Communicable Diseases		
Prevalence of normal BP in population (%)	53.8	PHRC 2017
Mean fasting plasma glucose (mmol/L) Population with Normal Sugar Level (%)	5.84 73.78	National Diabetes Survey 2017
Cervical cancer (screening coverage) (%)	0.9	PHRC 2017
Tobacco non-smoking (in past 12 months) (%)	80	GATS
Service capacity and access		
Hospital beds per capita (per 10,000) – threshold 18	6 33	MoNHSRC
Access to essential medicine	65	HFA 2012
Health worker density		
Physician (per 1,000) – threshold 0.9	72 (0.8/1.11)	UHC Data portal, WHO
Compliance with IHR	48	IHR Exec Eval 2016

Table 6 - UHC Indicators

The UHC coverage in Pakistan, based on the available services coverage data, is reported at 40% by the Global SDGs Monitoring Report (2017).

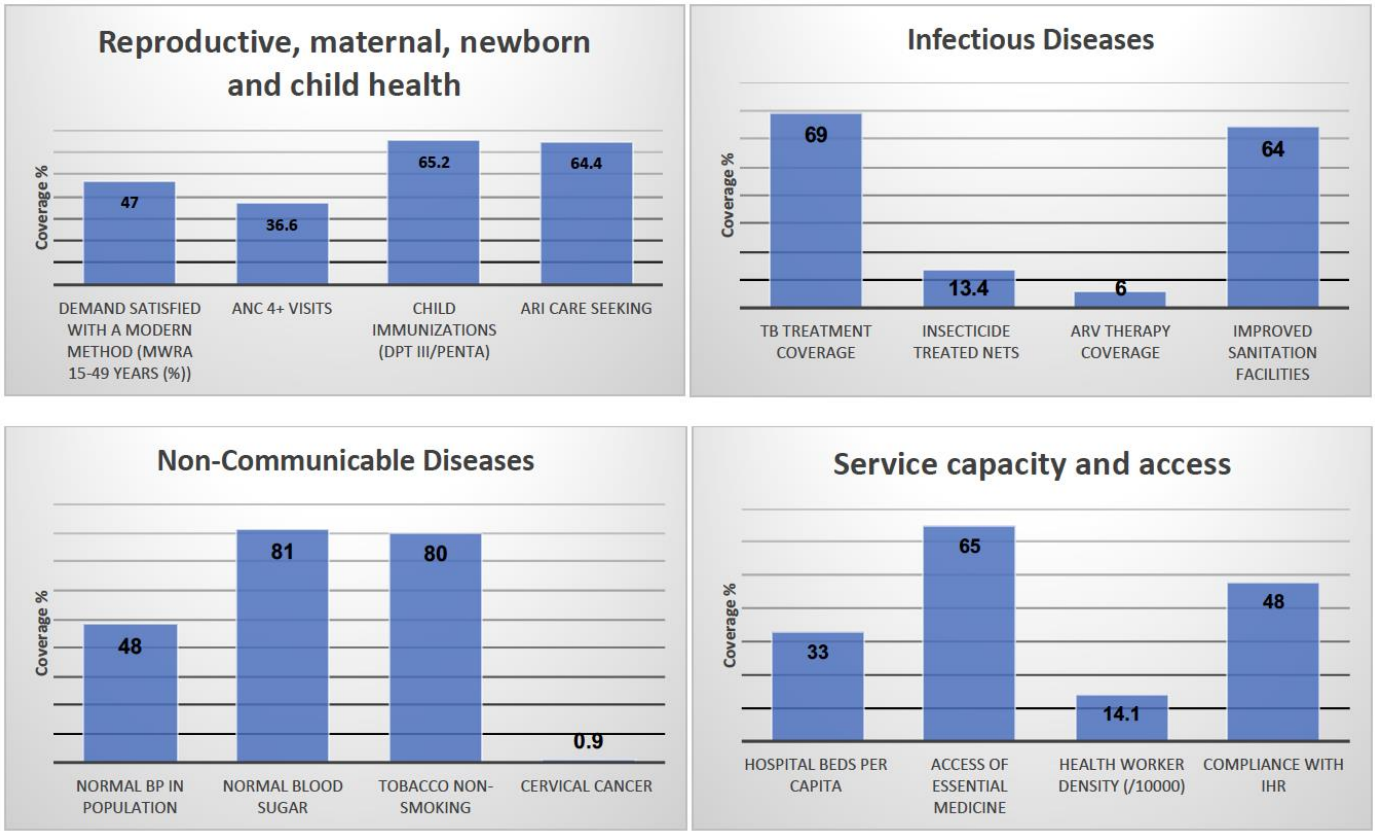


Figure 14 - UHC Coverage in Pakistan

1. SDG 3.8: Baseline

3.8 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			
3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, new-born and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)			
Baseline	**Expected**	**Required**	**Data Source**
40	**55**	**>80**	WHO/WB (2017)
3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income			
Baseline	**Expected**	**Required**	**Data Source**
1.03	**Tbd**	**Tbd**	WHO/WB (2014-15)

2. SDG 3.8: Contextual Factors

3.8 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		
Factor affecting		**Existing Policy/Ministry/Frameworks/Organizations**
Social Development	**Economic Liabilities**	
3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, new-born and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)		
Mother's education; Low use of primary health care services; Shortage of human resource (doctors, nurses); Low and inconsistent availability of drugs, supplies, facilities	Access; Availability Rural /urban disparities Low investments in public health system; Weak management of health system	Ministry of National Health Services, Regulations and Coordination Pakistan (NHV 2025); Planning & Development Departments; Health Care system; EPI; LHW Program; MNCH Program
3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income		
Populations characteristics (under 5 to 15 years and over 60 years); Disease spectrums (infectious diseases and non-communicable diseases); Out-of-pocket expenditure; Lack of social protection mechanisms	Poverty; Limited involvement in work force Low GDP and investments in health system; Social Welfare system	Health and Finance ministers; Planning Commission; Planning & Development Department

SDG 3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income - Financial Protection

As per WHO/WB estimates (2014/15) the proportion of population with large household expenditures on health as a share of total household expenditure or income is 1.03%

The total health expenditure (THE), as percent of GDP was 3.68% in Pakistan (NHA, 2013-14), in which the government's share was 33.13%. This included funding by Federal, Provincial and District Governments, Social Security Funds and Autonomous body expenditures. The out-of-pocket (OOP) expenditure on health was 60% in the year 2013-14. Alongside, since 1990, there has been considerable reduction in the percent of population living below the poverty line (defined as $1.90), from 59% in 1990 to 6.1% in 2013. At the current rate of progress, it is expected that there will be further reductions in percent of population living below the poverty line.

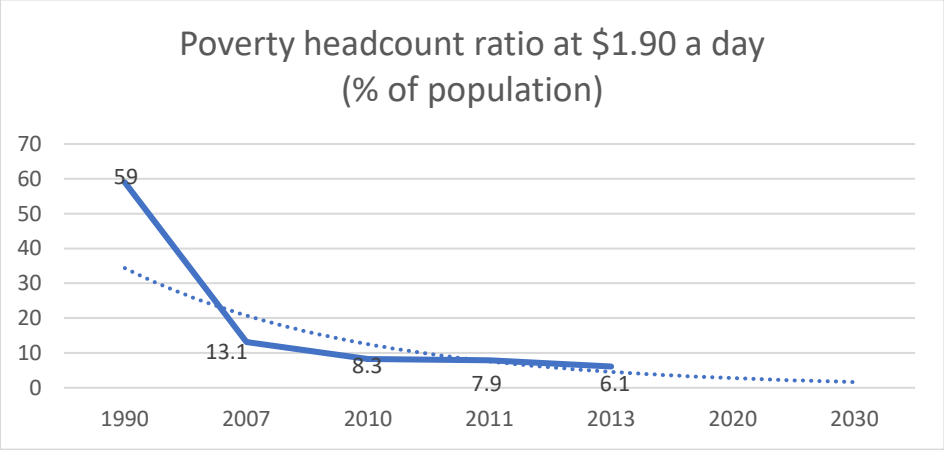


Figure 15 - Poverty headcount ratio (Source: PSLM, WDI)

Since the year 2014, government of Pakistan has initiated several social protection programs at Federal and Provincial level to provide financial protection to families living below the poverty line, against OOP, especially catastrophic health expenditures. These include

5. Prime Minister's National Health Program
    a. Coverage provided in 40 districts of Punjab, Balochistan, Sind, FATA, AJK, GB, ICT
    b. Aims to provide health insurance to more than 3.1 million families who are living below poverty line ($2 per day)
6. Sehat Sahulat Program – Social Health Protection Program of Government of Khyber Pakhtunkhwa
    a. Launched initially in districts of Mardan, Malakand, Kohat and Chitral; later extended to 69% of the population in the province in 2016
    b. Currently 1.4 million individuals enrolled in program for health insurance
7. Waseela-e-Sehat
    a. Health insurance under the Benazir Income Support Program, launched in 2010
    b. So far, 1.1 million individuals provided health insurance cover for hospital treatment

SDG 3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

Available data on morbidity and causes of death lack information on effects of hazardous chemicals and pollutants. This system needs to be established and institutionalized as part of routine reporting systems at the district level.

1. SDG 3.9: Baseline

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination			
3.9.1 Mortality rate attributed to household and ambient air pollution			
Baseline	**Expected**	**Required**	**Data Source**
87.2	**Tbd**	**Tbd**	WHO Global Health Observatory 2014-15
3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)			
20.7	**Tbd**	**Tbd**	WHO Global Assessment of Environmental Risks 2012
3.9.3 Mortality rate attributed to unintentional poisoning			
1.5	**Tbd**	**Tbd**	WHO Global Health Estimates 2015

2. SDG 3.9: Contextual Factors

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination		
Factors affecting		**Existing Policy/Ministry/Frameworks/Organizations**
Social Development	**Economic Liabilities**	
3.9.1 Mortality rate attributed to household and ambient air pollution		
Households pollution (poorly ventilated dwellings); Biomass fuel for cooking (wood, animal dung and crop waste) and coal; Lack of access to electricity; Ambient (lack of cleaner transport, energy-efficient housing, power generation, industry and lack of municipal waste management; Higher agricultural waste incineration; Forest fires and agro-forestry activities (e.g. charcoal production)	Poverty; Low income residents Inefficient cooking fuels and technologies; Lack of awareness Data and Reporting Not a routine practice in Pakistan; CRVS; PDHS; WHO Global Data observatory	Urban planning: power generation organizations, agriculture department; Municipal committees; Industrial development sector; Ministry of planning & development; Health and finance ministries; Environment development department
3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)		
Microbiological hazards from poor quality drinking water; Microbial risks from inappropriate disposal of fecal wastes, poor hygiene within the home; Absence of hand-washing; Improper domestic storage of water and potential contamination of potable water; Poor access to water supplies; Lack of latrines; Poor waste management and water treatment	Over-crowding; Low socioeconomic households Data and Reporting Not a routine practice in Pakistan; CRVS; PDHS; WHO Global Data observatory	WASH services; Community organization and institutions; WASA; Municipal committees, Planning & Development division; Urban development sector
3.9.3 Mortality rate attributed to unintentional poisoning		
Lack of safe storage practices at home, lack of knowledge about poison and safety practices; Stressful situations (e.g. serious illness, pregnancy, recently having moved home, parental absence from the home, depression)	Easy availability of, and access to, highly toxic chemicals; Overcrowded accommodation Data and Reporting Not a routine practice in Pakistan; CRVS; PDHS; WHO Global Data observatory	Public safety officials (police, fire and ambulance personnel); Ministry of National Health Services, Regulations and Coordination Pakistan; Agricultural development department

SDG 3.A: STRENGTHEN THE IMPLEMENTATION OF THE WORLD HEALTH ORGANIZATION FRAMEWORK CONVENTION ON TOBACCO CONTROL IN ALL COUNTRIES, AS APPROPRIATE

1. SDG 3.A: Baseline - Prevalence of Tobacco use

National Tobacco Program (NTP) has been implementing components of the Framework Convention on Tobacco Control to ensure reduction in use of smoking and smokeless tobacco. The Global Tobacco Surveillance System monitors adult tobacco use, while tracking key tobacco control indicators using a standardized methodology. As per the GATS report of 2014-15, current prevalence of tobacco smoking among adults is 12.4%. It is expected to drop to 10% by the year 2030 (intuitive estimates derived through a consultative process, based on current investments in projects/programs)

SDG 3.A: Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate			
SDG 3.A: Age Standardized prevalence of tobacco smoking among persons 15 years and older			
Baseline	**Expected**	**Required**	**Data Source**
12.4	**10**	**Tbd**	GATS 2014-15

The Global Adult Tobacco Survey (GATS) was conducted in Pakistan in 2014, as joint venture of MoNHSRC, PBS, PHRC, CDC and WHO. The GATS is a global standard for systematically monitoring adult tobacco use (smoking and smokeless) and tracking key tobacco control indicators. GATS is a nationally representative survey, using a consistent and standard protocol across countries including Pakistan.

Prevalence (%)	**Youth tobacco use**		**Adult tobacco smoking**		**Adult cigarette smoking**	
	Current tobacco use	**Current cigarette smoking**	**Current**	**Daily**	**Current**	**Daily**
Male	13.3	4.8	22.2	20.6	19.4	17.9
Female	6.6	0.9	2.1	2.0	1.0	1.0
Both sexes	10.7	3.3	**12.4**	11.5	10.5	9.6
Data Source: Youth: Global Youth Tobacco Survey, 2013; National, ages 13-15; Adult: Global Adult Tobacco Survey (GATS), 2016; National, ages 15+						

Table 7 - Prevalence of Tobacco use and Cigarette Smoking

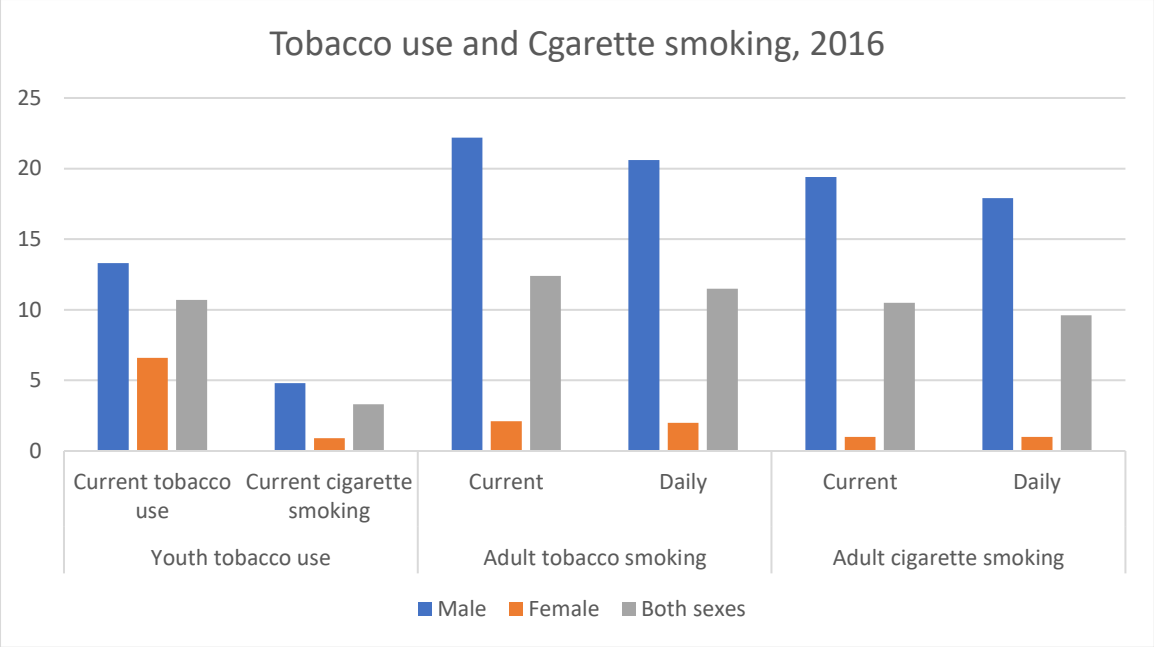


Figure 16 - Prevalence of Tobacco use and Cigarette smoking

2. SDG 3.A: Contextual Factors

3.A Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate		
Factor affecting		**Existing Policy/Ministry/Frameworks/Organizations**
Social Development	**Economic Liabilities**	
3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older		
Low literacy; Lack of awareness; Easy availability; Peer influence; Poor implementation of FCTC	Low cost (affordability) and easy accessibility of Tobacco products;	National Tobacco Control Program; Tobacco Taxation

SDG 3.B: SUPPORT THE RESEARCH AND DEVELOPMENT OF VACCINES AND MEDICINES FOR THE COMMUNICABLE AND NON-COMMUNICABLE DISEASES that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

1. SDG 3.B: Baseline

3.B Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all				
3.b.1 Proportion of the target population covered by all vaccines included in the national program				
Baseline		**Expected**	**Required**	**Data Source**
59 (2000)	65.2 (2014-15)	**>80**	**>95**	PDHS, WHO, WB, PSLM
3.b.2 Total net official development assistance to medical research and basic health sectors				
1.7		**Tbd**	**Tbd**	NHA 2015-16
3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis				
65		**>80**	**100**	WHO Global Health Estimates 2015

Considering Pakistan's progress on childhood immunizations, there has been significant improvements in terms of coverage. Over the past few years, coverage has been steady at 55 to 60%; however, to achieve the SDG targets, extensive technical and financial resources

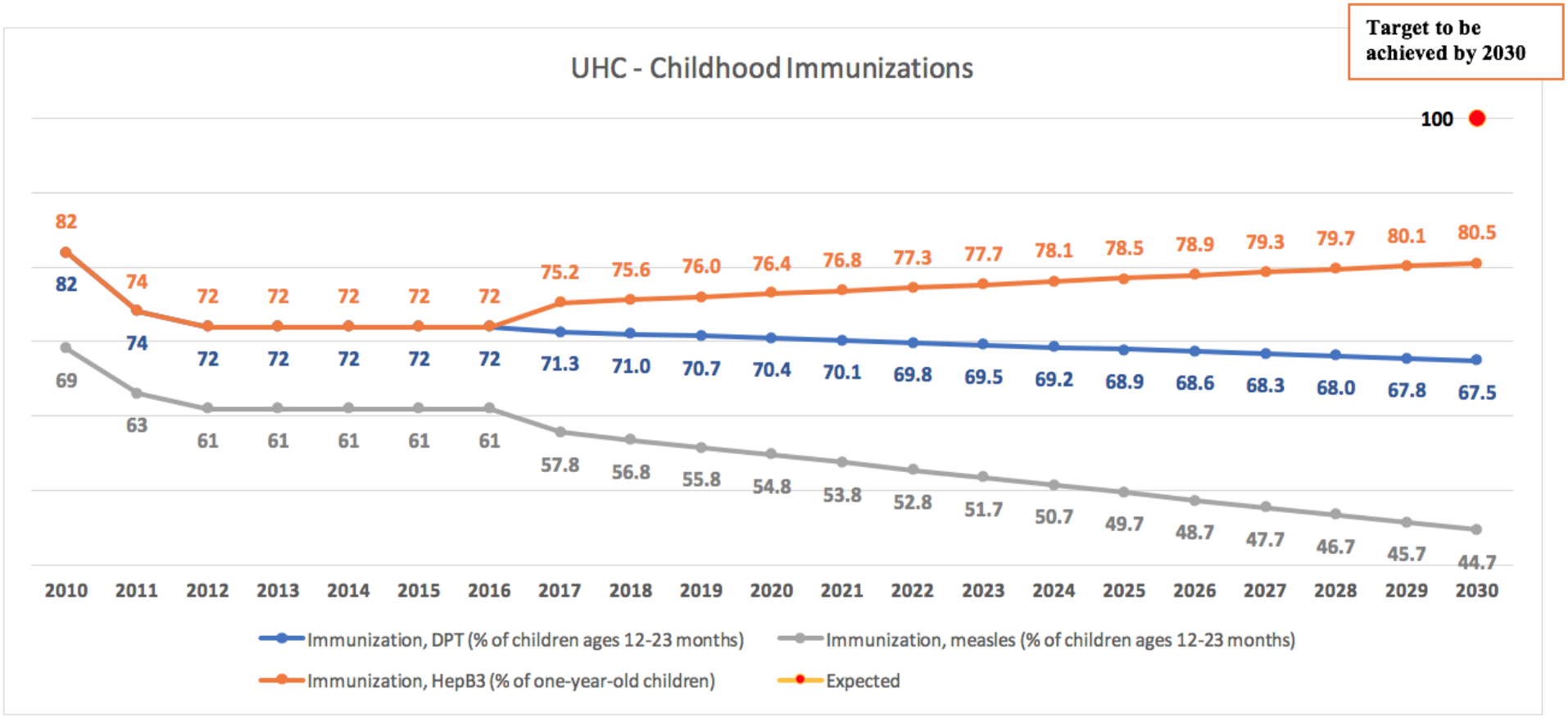


Figure 19 - Childhood immunizations - Historical values and Projected trends

2. SDG 3.B: Contextual Factors

3.B Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all		
Factor affecting		**Existing Policy/Ministry/Frameworks/Organizations**
Social Development	**Economic Liabilities**	
3.b.1 Proportion of the target population covered by all vaccines included in the national program		
Gender disparities (Boys are more likely than girls to be fully immunized); Urban/rural disparities; Increasing birth order; Mother's education and Religious influence	Lowest wealth quintile most affected by lack of coverage in (decreased vaccination coverage)	EPI; NIH; LHW Program; MNCH program; Ministry of National Health Services, Regulations and Coordination (NHSRC); United Nations Agencies (UNICEF, WHO)
3.b.2 Total net official development assistance to medical research and basic health sectors		
Lack of consistent policies; Poor representation on international forums; Poor advocacy strategy; Lack of trained and focused researchers/health advocates	Lack of transparency and poor accountability in financial managements; Corruption and poor financial management	Economic Affairs Division (EAD) International agencies (World Bank, USAID, WHO, UNICEF); Ministry of National Health Services, Regulations and Coordination (NHSRC); PHRC
3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis		
Poor availability of medicines; High price of medicines; Inefficient regulation and monitoring of medicine productions, prices and availability; Lack of a generic drugs list	Low funding for research and development in areas of medicines; Taxes and duties on essential medicines	Pharmaceutical companies; Trade & Taxation offices; Drug Regulatory Authority (DRAP)

SDG 3.B.2 Total net official development assistance to medical research and basic health sectors

The ratios of total health expenditures (THE) to GDP according to NHA 2013-14 is 3.0% while the ratio of general government health expenditures (GHE) to total general government final consumption expenditure is 9.3%. The ratio of private sector health expenditures according to NHA over total household final consumption expenditure are 2.5% (NHA 2013-14).
Donor funding has been minimal (1% of total national health expenditure), far less than that committed in Paris declaration.

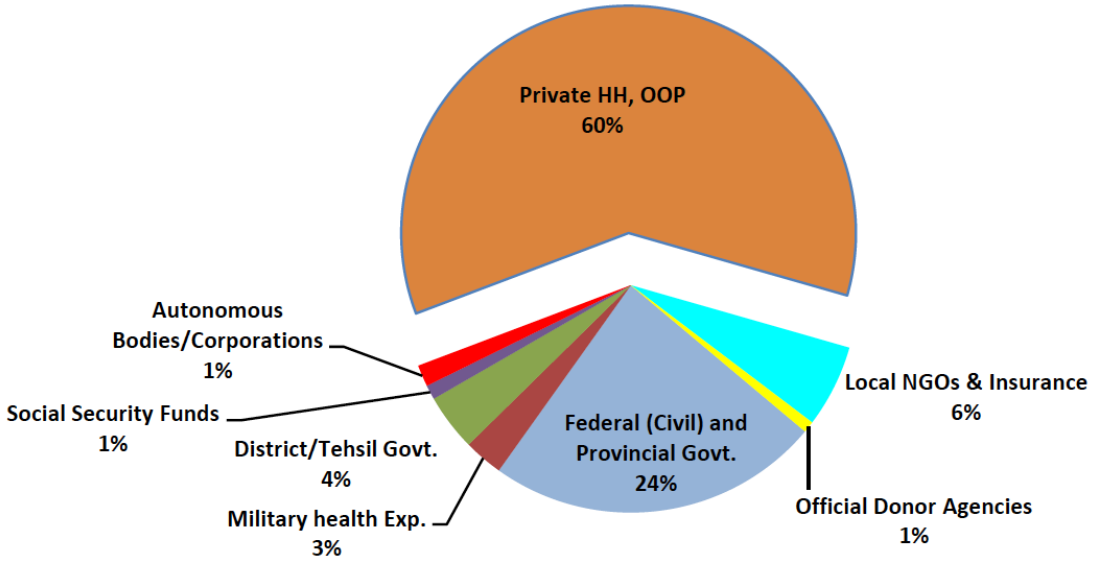


Figure 17 - Total health expenditures (%) by financing agents (2015 - 16)

Pakistan has received USD 79 Million in international funding for Health and related projects from the year 2002 to 2013. Details are in a table [4] in Annex 7.

[4]Data source: https://data.oecd.org/

SDG 3.C: SUBSTANTIALLY INCREASE HEALTH FINANCING AND THE RECRUITMENT, DEVELOPMENT, TRAINING AND RETENTION OF THE HEALTH WORKFORCE IN DEVELOPING COUNTRIES, especially in least developed countries and small island developing States

SDG 3.C: Contextual Factors

3.C Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States		
Factors affecting		**Existing Policy/Ministry/Frameworks/Organizations**
Social Development	**Economic Liabilities**	
3.C.1 Health worker density and distribution		
Lack of effective HRH workforce deployment and management plans; Urban growth; Private sector health care providers	Low HRH wages; Inadequate expenditure on health workforce development Brain-drain Lack of HRH retention policies	Ministry of National Health Services, Regulations and Coordination (NHSRC); Pakistan Medical and Dental Council (PMDC); Pakistan Nursing Council (PNC)

Historical values and Projected trends – Health Worker Density

3.C Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States				
3.C.1 Health worker density and distribution				
Baseline		**Expected**	**Required**	**Data Source**
6.6 (2000)	14.1 (2014-15)	**34.4**	**44.5**	PMDC, PNC

Considering the current numbers and production rate of health workers, below is the health worker density of Physicians, Dentists and Nurses/Midwives (Table 10).

Region	**Population**	**Physicians/1000**	**Dentist/1000**	**Nurses + Midwives + LHV/1000**	
Health worker density/1000 population, by cadre					
Pakistan	213,774,520	**0.96**	**0.10**	**0.49**	
Punjab + ICT	112012442	0.83	0.08	0.56	
KP + FATA	35523371	0.76	0.09	0.39	
Balochistan	12344408	0.50	0.05	0.22	
Sindh	47886051	1.55	0.16	0.45	
Total Health care worker density /1000 population*				**Doctor nurse ratio**	**1: 0.5**
Pakistan	1.45				
Punjab + ICT	1.39				
KP + FATA	1.15				
Balochistan	0.72				
Sindh	2.0				
*** WHO Recommended HCW Density/10,000 population: 4.45 per 1000 population; Doctor nurse ratio – 1:4**					

Table 8 - Health care worker density in Pakistan

This density has been calculated using recent population figures from the recent survey and updated numbers of health worker numbers from PMDC and PNC. Considering the increase in population, density of physicians has reduced, as compared to the previous years (figure 22). Implementation plans for the IHR and JEE recommendations, with identified milestones; should be developed with MoNHSRC, Provincial Health Departments, PMDC and PNC.

Capacities	Score	Maximum Score
National legislation, policy and financing	2	10
	3	
IHR coordination, communication and advocacy	3	5
Antimicrobial resistance	1	20
	1	
	1	
	1	
Zoonotic diseases	3	15
	3	
	2	
Food safety	2	5
Biosafety and biosecurity	2	10
	2	
Immunization	2	10
	4	
National laboratory system	4	20
	3	
	2	
	2	
Real-time surveillance	3	20
	2	
	2	
	4	
Reporting	2	10
	2	
Workforce development	3	15
	3	
	2	
Preparedness	1	10
	1	
Emergency response operations	2	20
	2	
	3	
	2	
Linking public health and security Authorities	3	5
Medical countermeasures and personnel deployment	4	10
	4	
Risk communication	1	25
	2	
	2	
	2	
	3	
Points of entry (PoE)	2	10
	2	
Chemical events	2	10
	2	
Radiation emergencies	5	10
	5	
Total Score	**116**	**240**
IHR compliance Index	**48%**	

SDG 3.D: STRENGTHEN THE CAPACITY OF ALL COUNTRIES, IN PARTICULAR DEVELOPING COUNTRIES, FOR EARLY WARNING, RISK REDUCTION AND MANAGEMENT OF NATIONAL AND GLOBAL HEALTH RISKS

Appropriate and timely training, deployment, monitoring and regulation of human resources for health is necessary for ensuring continuity in delivery of health services. Pakistan is in the process

of implementing HR related recommendations laid out in IHR and Joint External Evaluation; the cumulative score on the index is 48% (116 out of a maximum score of 240).

SDG 3.d: Baseline

3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks			
3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness			
Baseline	**Expected**	**Required**	**Data Source**
53	**>75**	**100**	JEE 2015

SDG 3.d: Contextual Factors

3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks		
Factor affecting		**Existing Policy/Ministry/Frameworks/Organizations**
Social Development	**Economic Liabilities**	
3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness		
Lack of Coordination and NFP communications; inefficient surveillance system of public health risks; Ineffective command, communications and control operations mechanisms (coordination and management of outbreak operations); Absence of national, intermediate and community/primary response level public health emergency response plans; Deficient mapping of potential hazards and hazard sites, identification of available resources, the development of appropriate national stockpiles of resources and the capacity to support operations at the intermediate and community/primary response levels during a public health emergency; Lack of risk communication (dissemination of information to the public about health risks and events, such as outbreaks of disease); inadequate and incompetent Human Resource; Lack of reliable and timely Laboratory services	Low financial allocations for HRH development	Ministry of National Health Services, Regulations and Coordination (NHSRC); Pakistan Medical and Dental Council (PMDC); Pakistan Nursing Council (PNC); Disaster Management Authorities (NDMA, PDMA); All levels of the health care system (national, sub-national and community/primary public health);

SDG 2: END HUNGER: HEALTH RELATED INDICATOR VALUES, HISTORICAL TRENDS AND SOURCES

1. SDG 2: End Hunger: Historical trends and proposed milestones

Goal 2: End hunger, achieve food security and improved nutrition, and promote sustainable agriculture																	
	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2030**	**Gaps**
2.1 By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round																	
2.1.1 Prevalence of undernourishment (under weight) %[16]																**Proposed Targets**	**Gaps**
	23.4	24.8	25.9	25.6	24.7	23.7	22.5	22.2	21.8	21.7	21.8	21.9	22	22	22	**<1**	Routine reporting from districts in absolute numbers only, hence prevalence/proportions cannot be calculated using DHIS information; Data available only from national surveys, done at different times in provinces; Milestone/standard setting should be by provinces (in consultative meetings)
Punjab Urban Rural													26 20 28.5				
Sind Urban Rural													42 34 48				
KP Urban Rural													26 19 28				
Balochistan Urban Rural													--*				
Age <6 6-9 9-11 12-17 18-23 24-35 36-47 48-59													 28.7 30 34 34 30 30 30 28				
Male Female													33 27				
Wealth quintile Lowest Second Middle Fourth Highest													 48 34 26 22 16				Data Source: PDHS; NNS; UNSTATS; WDI

[16]Pakistan Demographic and Health Survey, 2012-13

Goal 2: End hunger, achieve food security and improved nutrition, and promote sustainable agriculture																	
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2030	Gaps
2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons																	
2.2.1 Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age[17]																Expected / Required	Routine reporting from districts in absolute numbers only, hence prevalence/proportions cannot be calculated using DHIS information; Data available only from national surveys, done at different times in provinces; Nutrition surveys conducted in Pakistan include Nutrition Survey of West Pakistan 1965; National Nutrition Surveys of 1985 – 87, 1990 – 94, 2001 – 02, 2011
National	41.5	--	--	--	--	--	--	--	--	--	43	--	45	--	--	<30 / <5	
Punjab Urban Rural													40 32 43				
Sind Urban Rural													57 46 63				
KP Urban Rural													42 31 44				
Balochistan Urban Rural													--*				
Age <6 6-9 9-11 12-17 18-23 24-35 36-47 48-59													 25.5 27 34 46 49 53 49 46				Data Source: PDHS; NSWP (1965); NNS (1985, 1990, 2001, 2011); MNS (1997); UNSTATS; WDI
Sex Male Female													 48 42				
2.2.2 Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type[2]																Expected / Required	Gaps
National (underweight)	14.2	--	--	--	--	--	--	--	--	--	14.8	--	10.8	--	--	< 3 / < 1	Routine reporting from districts in absolute numbers only, hence prevalence/proportions cannot be calculated using DHIS information;
National (overweight)	--												3.2			< 5 / < 1	
Punjab													9.5				

[17] Pakistan Demographic and Health Survey, 2012-13

Urban Rural													8.6 10				Data available only from national surveys, done at
Sind Urban Rural													14 13 14				
KP Urban Rural													12 7.2 13				
Balochistan Urban Rural													--*				
Age <6 6-9 9-11 12-17 18-23 24-35 36-47 48-59													 17 20 18 18 13 7.3 9 5				
Sex Male Female													 12 10				
Wealth quintile Lowest Second Middle Fourth Highest													 17 10.5 9 8 8				

*Balochistan is not shown separately in PDHS 2012-13 as only 41 percent of the measurements were valid, preventing provincial representation. However, it is included in the total national estimates.

2.1.1 Prevalence of undernourishment

By 2030, in terms of ending hunger, the goal is to end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round. Currently, prevalence of undernourishment in Pakistan is estimated to be 22%. At the current rate of progress (shown in blue), using average year reduction, by 2030, prevalence of undernourishment is expected to remain much the same. Considering the requirements for SDG target achievement, drastic measures are needed.

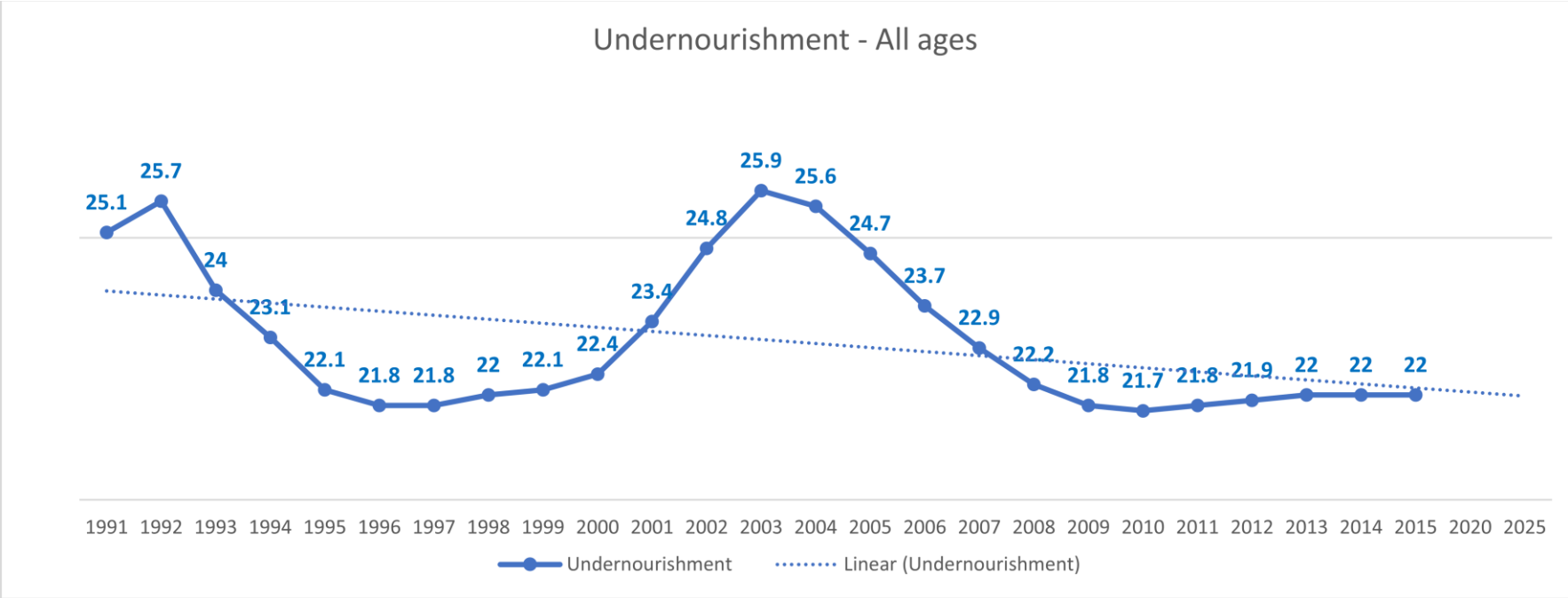


Figure 18 - Undernourishment in Pakistan - Historical values and Projected trends

2.2.1 and 2.2.2 Prevalence of stunting and malnutrition

By 2030, in terms of ending hunger and food insecurity, the goal is to end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons. At present, the available data available is for proportion of stunting and malnutrition in children under 5 years of age.

Data from 2012 shows that prevalence of stunting is 45% while malnutrition is at 10.5%. At the current rate of progress (shown in dotted lines), using average year reduction, by 2030, proportion of stunting will reduce to 32% and malnutrition to 8%. This regression model accounts for 60% of variance (R^2) for stunting, and 51% for malnutrition. Considering the requirements for SDG target achievement, drastic measures are needed to end nutritional impoverishment.

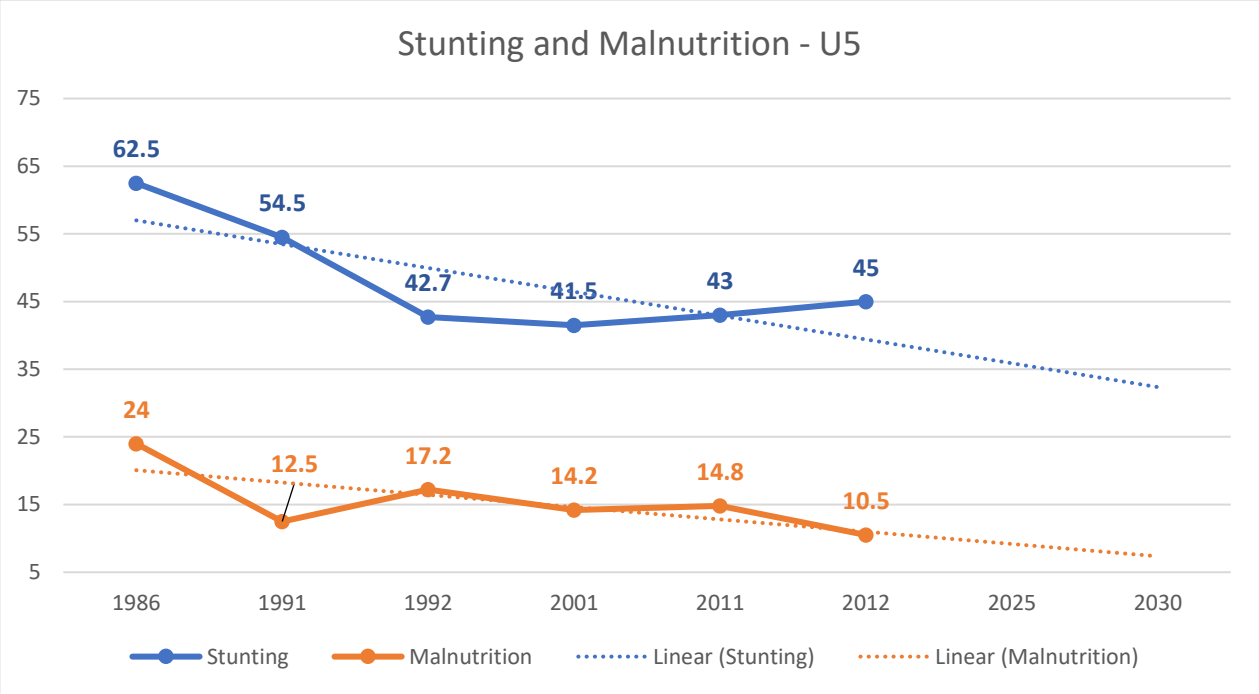


Figure 19 - Malnutrition and Stunting in Pakistan - Historical values and Projected trends

1. Contextual Factors affecting key health related indicators of Goal 2

Goal 2: End hunger, achieve food security and improved nutrition, and promote sustainable agriculture		
Factor affecting		**Existing Policy/Ministry/Frameworks/Organizations**
Social Development	**Economic liabilities**	
2.1 By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round		
2.1.1 Prevalence of undernourishment		
Mother's education; Malnourished mothers; Diarrheal diseases; Poor standard care; Lack of immunization	Household wealth Residency (Urban/Rural)	Policy and Frameworks developed by Population Council, MNCH program, The Ministry of Planning and Development Ministry of National Health Services, Regulations and Coordination (NHSRC). United Nations Agencies, other INGO's; EPI; National Nutrition Wing; Agriculture department, education department
2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons		
2.2.1 Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age		
Female literacy; Poor Exclusive Breast-Feeding practices; Poor weaning practices	Availability and affordability of high energy nutrients; GNP (Gross National Product) Residency (Urban/Rural)	Policy and Frameworks developed by Population Council, MNCH program, The Ministry of Planning and Development Ministry of National Health Services, Regulations and Coordination (NHSRC). United Nations Agencies, other International Non-Government Organizations (INGOs); Expanded Program on Immunization (EPI); National Nutrition Wing (Planning and Development); Agriculture Department, Education Department
2.2.2 Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)		
Mother's education High burden of morbidity Poor maternal and child health and nutrition	Household wealth Dietary deficiency Low micronutrient content of the soil Residency (Urban/Rural)	Policy and Frameworks developed by Population Council, MNCH program, The Ministry of Planning and Development Ministry of National Health Services, Regulations and Coordination (NHSRC), United Nations Agencies, other INGO's; EPI; National Nutrition Wing; Agriculture Department, Education Department

2. SDG 5: Achieve gender equality and empower all women and girls

1. **SDG 5: Contextual Factors**

SDG 5: Achieve gender equality and empower all women and girls		
Factor affecting		**Existing Policy Ministry/Frameworks Organizations**
Social Development	**Economic Liabilities**	
5.1 End all forms of discrimination against all women and girls everywhere		
Lack of concerted attention to gender discrimination in HRH research, policy, and practice; Vertical and horizontal occupational gender segregation; Sexual harassment or unwanted hostile, or humiliating work environment; Hostility or a discriminatory animus toward women in the workforce; Women cast in a traditional house bound and inferior role in the workforce; Socio-cultural preference for boys	Low social and economic status of women Lack of women empowerment – especially pertaining to financial decision making Women employment in informal sector Wage discrimination Lack of infrastructure accessible to women Lack of laws and regulations supportive for women's financial independence	Pakistan's National Assembly and Senate – rules and regulations for women representation; Civil Society Organizations & International Organizations – quota seats for women; Ministry of Women Empowerment; Provincial women development departments; UN Agencies and NGOs working on Gender and Women empowerment; Family planning association of Pakistan; Gender Reforms Action Plans (GRAPs); The Convention on Elimination of all forms of Discrimination against Women (CEDAW); MISP in the SOPs of National Disaster Management Plans and Provincial Disaster Management Plans; National Parliamentary Caucus; Rahnuma-Youth Helpline (YHL) Fifty Youth Resource Centres (YRCs)
5.2 Eliminate all forms of violence against all women and girls in the public and private		
Low perception of women's status, perception of man's right to control his wife behavior; Lack of institutional support from police and judicial system; General tolerance of sexual assault within the community; Weak community sanctions against perpetrators of sexual violence; Societal norms supportive of sexual violence and harassment; Societal norms supportive of male superiority and sexual entitlement; Weak laws and policies related to sexual violence and gender equality		
5.3 Eliminate all harmful practices, such as child, early and forced marriage and female		
Inadequate legislative framework with an accompanying enforcement mechanism to address cases of child marriage; Existence of customary or religious laws supportive of practice; Marriage considered necessary for social protection of girls, family stability during unstable social periods and poverty		
5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences		

Women's empowerment, urban/rural disparities in women's socio-economic status; Lack of advocacy for Family Planning and Reproductive Health Rights, Adolescent and Women Empowerment; Lack of access to comprehensive, gender-sensitive, rights- based sexuality education		

2. SDG 5: Available Data and Historical Trends

SDG 5: Achieve gender equality and empower all women and girls			
5.2 Eliminate all forms of violence against all women and girls in the public and private			
5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age			
Baseline	**Expected**	**Required**	**Data Source**
38.5	Tbd	Tbd	PDHS 2012
5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence			
• 772 FIRs registered for sexual assaults nationally; • 370 medical exams were conducted in sexual assault cases and 109 FIRs registered in Karachi; • 1,172 women were raped between January and September, with 1,090 cases in Punjab, 73 in Sindh, five in KP, and four in Balochistan; • 2,576 cases of rape were registered in Punjab (2013)			NGO War Against Rape (2013) Pakistan Human Rights Report (2014) Aurat Foundation Report (2013)
5. 3 Eliminate all harmful practices, such as child, early and forced marriage and female			
5.3.1 Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18			
2.8 (15 – 19 yrs) 21.1 (20 – 24 yrs)	**<1** **<15**	**≤ 10**	PDHS 2012
Punjab: 5.2% of women age 15-49 years (Married before 15 years of age); 21% of women age 20-49 years (Married before age 18)			MICS 2014
Sind: 5572 women (15 to 19 years ever Married); 10% aged 20 to 24 had live birth before age 18			MICS 2014
Balochistan: 6.7% (Marriage before age 15); 34.6% (Marriage before age 18); 6.9% (Age 15 to 19 currently married)			MICS 2011
5.3.2 Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age			
In WHO's regional report, data related to genital mutilation was not present for Pakistan as this is not a common issue in the country			WHO 2015
5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences			
5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care			
Own healthcare decisions – 47%	**70**	**100**	PDHS 2012-13

ANC from skilled provider – 73% Delivery from SBA – 55.2% PNC from skilled provider – 57.7% Use of modern contraceptives – 26.1%		

SDG 6: ENSURE AVAILABILITY AND SUSTAINABLE MANAGEMENT OF WATER AND SANITATION FOR ALL

1. SDG 6: Available Data and Proposed Targets

SDG 6: Ensure availability and sustainable management of water and sanitation for all																	
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2030	Gaps
6.1 By 2030, achieve universal and equitable access to safe and affordable drinking water for all[18]																	
6.1.1 Proportion of population using safely managed drinking water services (% of population with access)																**Expected** / **Required**	**Lack of awareness; poor waste managements**
National	88.5	88.7	88.9	89.1	89.3	89.5	89.7	89.9	90.1	90.3	90.5	90.7	90.9	91.1	91.3	**100** / **100**	**Data Sources: WHO/UNICEF Joint Monitoring Program (JMP) for Water Supply and Sanitation; PIHS, PSLM, MICS**
Rural	85.0	85.4	85.7	86.0	86.3	86.7	87.0	87.3	87.6	88.0	88.3	88.6	88.9	89.3	89.6		
Urban	95.4	95.3	95.2	95.1	95.0	94.9	94.8	94.7	94.6	94.5	94.4	94.3	94.2	94.1	94.0		
6.2 By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations 5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age																	
6.2.1 Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water[27](% of population with access)																**Expected** / **Required**	**Lack of awareness**
National	36.9	38.7	40.5	42.3	44.1	45.9	47.6	49.4	51.2	53.0	54.8	56.5	58.3	60.0	73	**> 90** / **100**	**Data Sources: WHO/UNICEF Joint Monitoring Program (JMP) for Water Supply and Sanitation; PIHS, PSLM, MICS**
Rural	19.6	21.7	23.8	25.9	28.0	30.1	32.2	34.3	36.4	38.5	40.6	42.7	44.8	46.9	49.0		
Urban	71.6	72.4	73.1	73.9	74.7	75.4	76.2	77.0	77.7	78.5	79.3	80.0	80.8	81.6	82.3		
Proportion of population practicing open defecation[27](% of population)																	
National	41.5	39.4	37.3	35.3	33.2	31.2	29.2	27.2	25.2	23.2	21.2	19.2	17.3	15.4	13.4		
Rural	58.9	56.2	53.6	50.9	48.2	45.5	42.9	40.2	37.5	34.9	32.2	29.5	26.9	24.2	21.5		
Urban	6.3	5.9	5.5	5.1	4.6	4.2	3.8	3.4	3.0	2.5	2.1	1.7	1.3	0.8	0.4		

[18]WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation

SDG 11: MAKE CITIES AND HUMAN SETTLEMENTS INCLUSIVE, SAFE, RESILIENT AND SUSTAINABLE

11.7 By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, in particular for women and children, older persons and persons with disabilities

11.7.2 Proportion of persons victim of physical or sexual harassment, by sex, age, disability status and place of occurrence, in the previous 12 months

SDG 11: Make cities and human settlements inclusive, safe, resilient and sustainable		
11.7 By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, in particular for women and children, older persons and persons with disabilities		
11.7.2 Proportion of persons victim of physical or sexual harassment, by sex, age, disability status and place of occurrence, in the previous 12 months		
2011/2012	**2017**	**Data Source**
32.2% (physical violence only reported by married women under domestic violence chapter)	Not available	PDHS 2012

SDG 16: PROMOTE PEACEFUL AND INCLUSIVE SOCIETIES FOR SUSTAINABLE DEVELOPMENT, PROVIDE ACCESS TO JUSTICE FOR ALL AND BUILD EFFECTIVE, ACCOUNTABLE AND INCLUSIVE INSTITUTIONS AT ALL LEVELS

SDG 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels		
16.1 Significantly reduce all forms of violence and related death rates everywhere		
16.1.3 Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months		
2011/2012	**2017**	**Data Source**
32.2% (physical violence only – women, domestic violence)	Not available	PDHS 2012 (table 14.1)
16.1.4 Proportion of population that feel safe walking alone around the area they live		
2011/2012	**2017**	**Data Source**
Not available	Not available	
16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children		
16.2.1 Proportion of children aged 1-17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month		
2011/2012	**2017**	**Data Source**
Violent discipline – Proportion of children age ***1-14 years*** who experienced psychological aggression or physical punishment during last one month Punjab - 80.7% (MICS 2014) Sindh – 81.3% (MICS 2014)	Not available	MICS (different years)

3. STAKEHOLDER ANALYSIS AND SWOT

STAKEHOLDER ANALYSIS

In depth interviews of relevant personnel at Federal and Provincial level were undertaken to explore the issues pertaining to localization of SDGs.

Overall, a high level of policy coherence is present, with UNDP taking a lead role in providing technical assistance, expertise and cost sharing in setting up SDG Support Units within Planning and Development departments, at Federal and Provincial level. Punjab unit is fully functional and committed, Sindh is set up but at initial stage, KP is in process, and Balochistan has yet to establish its unit. Parliamentary resolution on SDGs with political commitment exists at all levels.

For instance, Punjab has its Primary and Secondary Health department as well as specialized healthcare and medical departments. There is a Provincial Health Policy and Strategic Framework for Punjab 2012-2020, the FP 2020 and the PSPU (Policy and Strategic Planning Unit) is playing a lead role in the SDG agenda alignment. Budget realignment and reallocation is kept in consideration within the SDG agenda. KP's SDG Unit is in process of being established in the Health Sector Reform Unit (HSRU).

Potential barriers to implementation of SDGs are common across the provinces. These include lack of clarity on roles and responsibilities of focal persons (ToRs), delays in setting targets and milestones, and a lack of ownership despite knowledge and awareness of SDGs. A sense of overburdened workload with a view that the SDGs are a 'separate' entity that would be difficult to integrate into the current programs and system are additional factors. Additionally, not involving all stakeholders and a lack of operationalization of targets and indicators can act as barriers to effective implementation.

Gaps and weaknesses in the existing systems typically relate to data sources and collection of quality data that is reliable, relevant and timely. Budgetary recommendations regarding resource allocations whether financial or personnel or infrastructure is another area of deficiency. The need for a robust M&E system was emphasized. Indicators need to be identified and operationalized according to the breadth of all the SDG targets. Environment and Gender mainstreaming and inclusiveness can be improved. Delays in implementation exist as consultations and discussions do not get translated into policy or actions in a timely manner.

More specifically in Punjab, health care access inequalities persist, with lack of investment in prevention and treatment of substance abuse, RTA, tobacco control, air, water, soil pollution. There is a lack of focus on trade distortions, agriculture markets, and food commodities. Only 1% budget allocation is on stunting reduction compared to agriculture and livestock productivity.

However, opportunities for localization include the prioritization and sequencing activities carried out by departments to identify areas for enhanced coverage using the MDPI (Multi-dimensional Poverty Index) – pilot project undertaken in two of the ten districts of Punjab. The SDGs are viewed by many as the unfinished agenda of the MDGs, so integration and alignment of targets is possible in vertical programs e.g. Punjab Multi Sectoral Nutrition Strategy. Best practices are shared at national and regional meetings. The development of integrated MIS system to capture reporting on the additional targets and indicators; along with strengthening the M&E frameworks can be capitalized on.

The existing capacity to achieve SDGs localization is present in the functional SDG Units in Punjab and Sindh (focal persons identified), with KP in process but Balochistan has yet to

establish a unit. Technical assistance is being provided by P&D department with SDG Advisory Council under UNDP lead. Data sources have been identified and there is collation of data feeding into federal dashboard. Four clusters of SDGs have been identified giving clarity and direction. In Punjab, several initiatives aligned with SDGs are underway focusing on improved service delivery, reducing maternal and infant mortality, capacity building of healthcare personnel, gender equality amongst others. KP also has multiple reforms and initiatives that include improving governance, healthcare financing, HRH and Health Information System. There is sufficient knowledge and awareness on SDGs and it can be deepened by emphasizing an integrated multi stakeholder approach.

A thematic content analysis of interviews conducted at federal and provincial level, i.e. SWOT analysis follows in section below.

SDG 3 LOCALIZATION - SWOT ANALYSIS

STRENGTHS

FEDERAL:

1. There is a general awareness of SDGs among the senior policy makers and planning officials and for resources required for implementation. This is evident through existence of dedicated, functional federal and provincial departments, which include:
    a. Parliamentary Standing Committee on SDGs, with 29 elected members representing all ministries and political parties
    b. SDG Cell in the Planning Commission of Pakistan
2. SDG Support Unit in the Planning commission developed to
    a. Assist all concerned departments in aligning policy and plans with SDGs agenda
    b. Provide technical support to provincial planning and development departments in aligning development plans and activities with the SDGs, research, monitoring and evaluation
3. Planning Commission's Public-Sector Development Program (PSDP)aligned with development objectives enunciated in the seven pillars of the Vision 2025 and for achieving SDGs
4. Planning Commission in process of reviewing SDGs targets and indicators to identify, localize and internalize relevant indicators for the country
5. Allocations made in Federal PSDP 2016-17 for
    a. National Initiative for SDGs/Nutrition: PKR 10 billion allocated in 2016-17; PKR 100 million spent by end of fiscal year with a throw forward of PKR 900 million for 2017-18. This program is managed by the Cabinet Division; information on initiatives is not public
    b. PM's Global SDGs Achievement Program: PKR 20 billion allocated in 2016-17, increased to PKR 30 billion in PSDP 2017-18. This program is managed by the Cabinet Division; information on initiatives is not public
6. National Health Vision 2025: designed with overarching values of transformation and change, equity, and resilience and accountability is to be a comprehensive, long term agenda for sustainable growth and inclusive development. NHV aims to improve health through universal access to affordable quality essential health services, and delivered through resilient and responsive health system, ready to attain Sustainable Development Goals and fulfil its other global health responsibilities.
7. SDG Unit in the MoNHSRC developed to
    a. Collect and collate data for consolidated reporting on SDG 3
    b. Provide policy guidance to the provincial health departments for alignment of policy and programs with SGD 3 and National Health 2025
    c. Collaborate with the SDG units at federal and provincial levels
8. Pakistan HIS Dashboard, hosted on the MoNHSRC, integrated and interactive system providing health managers access to information from provincial vertical health programs and DHIS
    a. Review of DHIS with reference to SDG3 conducted to align with SDG and WHO indicators
    b. EMRO mission to Pakistan to review HIS in Pakistan (report pending)

PROVINCIAL

1. Key officials, including policy makers and technocrats, are aware of the SDGs agenda, resources required for achieving targets. SDG 3 indicators and targets referred to in development of provincial programs and plans.
2. Senior bureaucratic officials notified as focal persons for some of the 17 SDG related line departments, in Punjab. The process is underway in other provinces
3. Alignment of key health program strategies with SDGs agenda (Punjab and Sind)
    a. Based on the Multidimensional Poverty Index, developed by UNDP, development plans of 10 of the lowest performing districts in Punjab being realigned to improve indicators related to health, education and standard of living.
    b. Development of Sindh Sustainable Development Strategy in progress; plan aims to highlight baseline values and indicators for the local context.
4. Provinces have the technical and financial resources to initiate process of alignment of SDG-3 interventions implementation at district level

WEAKNESSES

FEDERAL:

1. National level targets and indicators from the proposed list of SDGs yet to be finalized, with participation of provincial representatives (to ensure targets identified are not unrealistic – regions with low technical capacity will bring down the gains made by regions with good progress)
2. SDG Support Unit is under the Economic wing of Planning Commission, which coordinates only with their counterpart from Provincial Planning and Department and not with the line ministries.
    a. Input from Planning Commission's departments on Health and other related sections such as Nutrition, Population is limited
    b. Similarly, the Planning Commission's section on Health do not interact regularly with the MoNHSRC and Provincial health departments
3. Lack of functional inter-departmental coordination mechanisms between Planning Commission, UNDP, MoNHSRC and other line departments; resulting in development of plans and strategies which are unrealistic, overambitious, lack ownership and cannot be fully funded by the resources available to the health department
4. SDG 3 relevant indicators and milestones have not yet been decided for national and provincial level implementation.
    a. There is a discord between research institutes on definition of key indicators – e.g. For the Pakistan Demographic and Health Survey (PDHS), NIPS include Doctor/Nurse/LHV and CMW as Skilled Birth Attendant; in the PSLM, Bureau of Statistics does not include CMW as skilled birth attendant.
5. Contributions of existing resources (infrastructure, human resources), by the MoNHSRC and Health Departments directly are not reported, on a single platform.
6. Federal government lacks the fiscal capacity to generate funds for financing and sustaining proposed SDGs initiatives
7. DHIS and health program information systems provide service utilization figures (numbers only) for the primary and secondary level public sector facilities
    a. Data available is missing information from public sector tertiary level facilities, and private health sector users, which is 70% of the population
8. Inefficient allocation and utilization of financial resources at Federal level – DHIS and program level service use information is currently not being utilized; information available does not represent the entire population and is not aligned with SDGs yet. National level surveys are irregular and not done simultaneously in all provinces
9. Lack of planning on involving the civil society (NGOs, INGOs) and private sector in achieving SDGs
    a. Partnerships with public sector are not regulated or documented routinely

PROVINCIAL

1. Provincial level contributions to indicators cannot be finalized without a national figure
2. Sensitization of parliamentarians, through active advocacy, needed at provincial level
3. Elaborate strategy and plans not yet transferred from paper to real time implementation steps
    a. All concerned line ministries not yet notified of roles and responsibilities
    b. In some places, focal persons yet to be notified; while in others 'charge' for the SDGs keeps shifting from one person to the next
    c. Data collection and reporting mechanisms for SDGs yet to be developed, especially from the private sector

4. Although senior provincial bureaucrats notified as focal persons from relevant department, awareness about the SDGs agenda is low and hence engagement with other departments, activities and initiatives is minimal
5. Lack of a comprehensive awareness and understanding of the SDGs agenda lacking at the district level. Although some activities have been conducted for sensitization at District level, an understanding of how SDGs are to be implemented and aligned with existing initiatives and programs is missing
    a. District Health Management Teams (DHMTs), DHOs and Town Health officials need to be sensitized and trained to ensure implementation
6. Low financial absorptive capacity at district level – funds released are not utilized in the defined period
    a. Procedural delays also contribute to inefficient utilization of financial resources
7. Provider performance and population health needs are not used for making allocations. Lack of a strategic approach in utilization of available resources – DHIS and program level data not used for workforce and service management.
8. Focal persons for Provincial DG Health office yet to be appointed in Sind, Balochistan
9. DHIS reporting is not regular from all Districts in provinces –
    a. Incomplete data from districts where monitoring is weak
    b. Missing data, especially from conflict areas
    c. Delayed reporting from some regions
10. District level health managers
    a. Lack capacity to understand inherent implications for implementation of SDGs related interventions
    b. Unable to link existing initiatives with SDGs targets and indicators
    c. Lack resources to implement new initiatives designed as part of the joint NHV 2025 and SDGs agenda
11. Lack of an effective coordination between relevant sectors of the provincial governments (Health, Water, Sanitation and Hygiene (WASH), Food, Social Protection, Population, Agriculture, Labor, Women Development and Education, P&DD etc.), non-governmental organizations, Community Support Organizations (CSOs) and development partners

OPPORTUNITIES

1. International interest in the SDGs related agenda, especially poverty reduction, promotion of education and gender equality can be capitalized on to generate support for local initiatives. This support can be capacity development for designing and implementing innovative solutions, research endeavors and resource generation.
2. National commitments envisaged in the National Vision and National Health Vision provide an ideal opportunity for ensuring adequate resource allocations for SDG 3 related programs and interventions
3. Global interest in cross cutting issues of action on climate change, environmental protection and sustainable development provide a lucrative opportunity for the country to invite international research and development on local and regional issues. This could lead to improvements in agricultural developments, new evidence for increasing agricultural yield, thus paving way for improvement in country strategy for improved nutrition and eliminating hunger
4. Infrastructure development investments for the China Pakistan Economic Corridor (CPEC) can also be harnessed for promoting social development, especially for health and reducing inequalities

THREATS

1. The overall SDGs agenda is over ambitious, with some targets unachievable for most countries (e.g. drastic reductions promulgated for maternal mortality and neonatal mortality). Considering the contextual factors and limited resources, envisaged targets cannot be achieved, within the stipulated time
2. Some of the defined targets and indicators are not relevant to the local context and commitment to measuring them would require extensive financial and technical resources
3. The CPEC agenda is over shadowing the momentum/drive needed for steering the SDGs. Senior political and civil leadership was seen to be more invested in the allied infrastructure development, paying minimal attention to the SDGs agenda

4. PROPOSED FRAMEWORK FOR IMPLEMENTATION

Building on the results from qualitative inquiry, a framework with a road map for implementing SDG3 and other health related indicators has been developed. Using a systematic line of inquiry, major areas that require specific policy responses, including whether standards and regulations need to be revised or new ones introduced to provide a more supportive institutional context for action, have been included in the framework. The framework is also cognizant of the relevant aspects of SDGs-linked local development strategy, as given in the National Vision 2025.

The framework identifies steps and actions needed at the three levels of implementation, i.e. National, Provincial and District health departments. The core actions needed, as highlighted by the key stakeholders, have been included. This can ensure greater cohesion between the concerned departments through better integration at national and provincial level.

AIMS AND OBJECTIVES

The core aim of the framework is to guide development of an action plan, which can assist the national and provincial governments in achieving SDG3 specific targets and associated indicators.

OUTCOMES

The desired outcomes have been highlighted, with broad targets identified, each of which can be a driver for an action plan and assist with the process of localizing and monitoring progress of implementation of SDG3.[5]

These outcomes are

1. Mainstreaming the interventions for SDG3 by inclusion of selected indicators in each district's budget and implementation plan
2. Develop a list of localized indicators for implementation, prioritized according to provincial situation and needs
3. Strengthen the District Health Management Teams
    a. To ensure implementation of initiatives for achieving selected indicators
    b. Assist the district management with operational and allocative planning using the district budget
    c. To support health services programs with implementation, monitoring and routine reporting
4. Develop mechanisms to initiate and institutionalize inter-sectoral collaboration, coordination and public-private partnerships in health sector, at district level.
5. Monitor the implementation process diligently to ensure progress is on track to meet SDG3 implementation by 2030; be mindful of the barriers to implementation; and identify efficient processes
6. Ensure technical and financial resources for replicating successful action plans, as identified through the step above

It is expected that these outcomes maybe used as intermediate steps which contribute to the longer-term plans for achieving SDG3 target indicators.

KEY ACTIONS AND POLICY REQUIREMENTS

The implementation of this framework will require key policy changes at the National level, to initiate required activities in Provincial and District health and allied departments.

[55]*This will be further specified after the provincial and federal level consultations

1. Develop organizational coordination mechanism and plan between SDG Cell, Provincial and District level health and allied departments
2. Define targets and indicators for national level adoption
3. Develop an interactive platform for monitoring progress on SDG 3 indicators
4. Develop a capacity building plan for national and provincial health managers
5. Develop a comprehensive advocacy strategy for raising awareness among key policy makers, academia, community support organizations and solicit their support
6. Develop a set of national guidelines for initiating and institutionalizing SDG3 localization process in Provincial Health departments

KEY ACTORS AND INSTITUTIONS

Implementing the interventions for and achieving the SDG3 targets and indicators would require cross sectoral collaborative participation of the health department with departments of food and nutrition, women development, water supply, sanitation, social protection and education, besides financial and developmental investments. Following the initiation of departmental collaborations, focal persons should be identified, assigned with specific roles and responsibilities, responsible for ensuring continuity of interdepartmental coordination and reporting on agreed upon indicators and milestones to be achieved.

Considering that the Planning and Development Departments at Federal level, Punjab and Sind have established SDG support units, with the core function of facilitating inter-sectoral collaborations and coordination, it is recommended that the process be replicated in other provinces as well. There is however, a need to

- Initiate collaboration with relevant sectors and departments at national and provincial level
- Undertake a consensus building exercise on identifying roles and responsibilities,
- Identify practical timeframes for implementation and completion of identified activities

The MoNHSRC should take the role of providing oversight and assume the leadership to ensure implementation of proposed framework for implementation and progress on achieving the localized SDG 3 indicators.

TIMEFRAME

The required implementation plans for main activities at provincial and district levels should also identify whether they need to be carried out in the short, medium or long term. Short term priorities will need more detailed action plans. They should specify monthly and even weekly activities and resources required to achieve the desired outcomes. Sufficient time needs to be allocated to allow for capacity and resource development, especially since the lack of skills or finances may become a major barrier to progress.

FINANCIAL FORECAST

Considering the current situation of SDG3 localization in Pakistan, developing a financial forecast to depict the resources required for work to be carried out is not feasible at this stage. However, considering the financial resource allocation steps taken by the Planning and Development Departments in Federal, Punjab and Sind governments, it is recommended that similar process be replicated in other regions. Alongside, timely release of allocated funds needs to be ensured to enable the provinces to achieve timely implementation of localized SDG3 indicators.

ACCESSING RESOURCES

Local and international sources of funding need to be identified and utilized for ensuring continuity in implementation of developed plans. The implications of different sources would also need to be assessed for their potential impacts on implementation and coverage of interventions. Considering the all-encompassing agenda of the SDGs, Public-Private, Public-NGO and Public-Public Partnerships can all help to bring additional resources for implementing provincial and district plans.

MONITORING AND REVIEW

A crucial part of implementing the developed action plans will be the periodic assessment of each plan, which should be applied as standard practice to ensure that the plan is moving towards its desired objectives as well as to assess whether it is having any unforeseen outcomes or impacts.

The production of a logical framework, inclusive of initiatives under SDGs agenda (such as UHC, Infection and non-infectious diseases programs), can be a useful tool throughout planning, implementation and monitoring processes of an action plan. It encourages planners to be clear about the main elements of a plan, as well as how these will be verified and monitored. It also provides a useful means to present a plan to policy-makers and other stakeholders.

FRAMEWORK

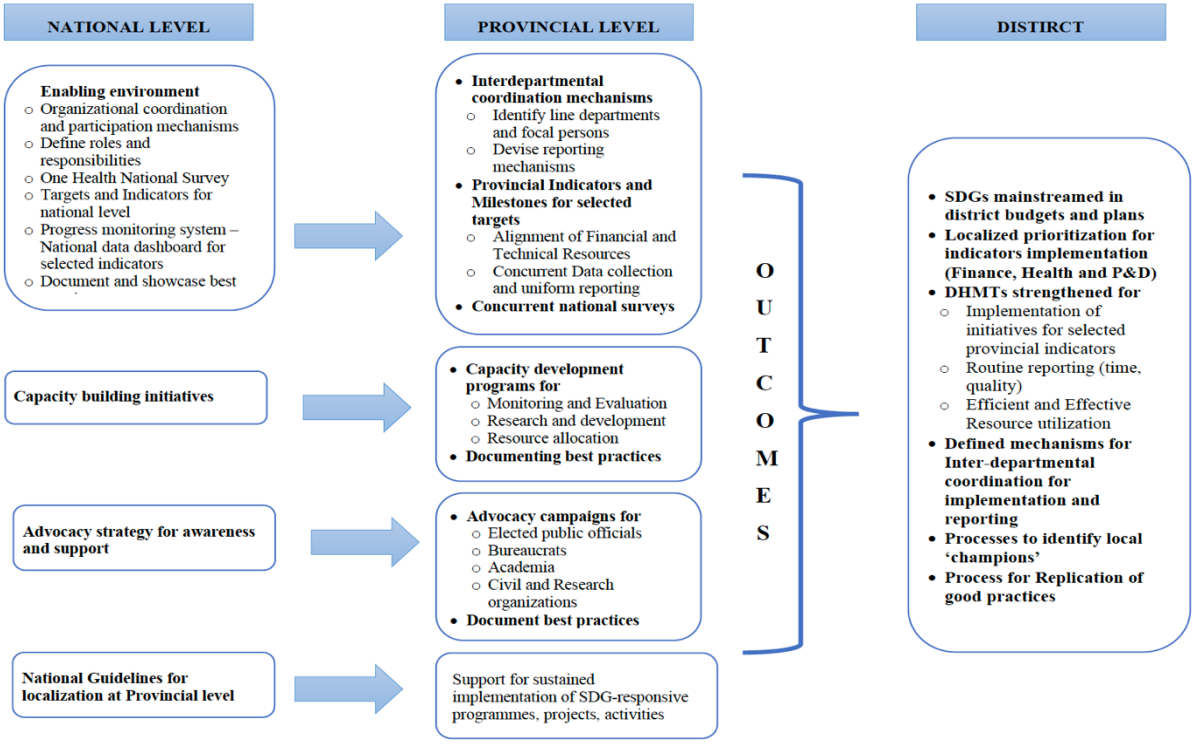


Figure 20 - Framework (proposed)

CHAPTER 4: RECOMMENDATIONS

Issues in SDG3 Localization, and Recommendations

Improving the institutional arrangements for SDG 3 coordination and monitoring

The Planning Commission's national and provincial SDG Support Units have assumed the primary responsibility for monitoring and reporting on SDG implementation, but this should be done in a participatory and transparent manner.

Setting National and Provincial targets and indicators

The SDG 3 adaptation process requires setting national targets, as explicit policy commitments, adopting indicators for the purpose of monitoring and assessing the achievement of these targets. Based on the results of this report, consultative process, under the stewardship of MoNHSRC, was initiated an SDG 3 localization consultations were conducted at provincial level. The Federal and Provincial ministries have engaged in a localization exercise to agree on national targets and milestones (Annex 9). There are a number of areas of NHV where there are no or very few established and approved provincial targets. The SDGs therefore present Pakistan with the opportunity to trigger a process to negotiate and set national development targets and define indicators, but it should be noted that the process to define national level targets may not suffice to account for provincial variation

The overall responsibility for SDG monitoring should continue to be vested in the Planning Commission, to ensure implementation of agreed upon interventions, milestones and uniformity in reporting. Given the wider scope of the SDGs strengthening of inter-sectoral collaboration and coordination within health at the national, provincial and district health levels can yield exponential gains in health.

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ANNEXURES

ANNEX 1 – DATA EXTRACTION FORMS

Following format of data tables were used for review of documents, trends in indicators and target projections

1. Review of documents

SDG	Target/ Indicator	Factors affecting		
		Social Context	Economic Liabilities	Policy/Action frameworks

2. SDG Indicators – historical trends

SDG Description	
Year (2001 to 2015)	Data Sources
Indicator Description	
Indicator values	

3. SDG Indicators – projected trends and proposed targets

SDG Description												
Year (2001 – 2030)												Gaps to achieving proposed
Indicator Description									Proposed Targets			
Indicator Values												

ANNEX 2 – CHECKLIST OF INDICATORS

Target Description	Indicator Description
Goal 2: End hunger, achieve food security and improved nutrition, and promote sustainable agriculture	
2.1 By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round	2.1.1 Prevalence of undernourishment
2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons	2.2.1 Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age
	2.2.2 Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)
Goal 3: Ensure healthy lives and promote well-being for all at all ages	
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1 Maternal mortality ratio
	3.1.2 Proportion of births attended by skilled health personnel
3.2 By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	3.2.1 Under-five mortality rate
	3.2.2 Neonatal mortality rate
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations
	3.3.2 Tuberculosis incidence per 100,000 population
	3.3.3 Malaria incidence per 1,000 population
	3.3.4 Hepatitis B incidence per 100,000 population

	3.3.5 Number of people requiring interventions against neglected tropical diseases
3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease
	3.4.2 Suicide mortality rate
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders
	3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol
3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents	3.6.1 Death rate due to road traffic injuries
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods
	3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group
3.8 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	3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, new-born and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)
	3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income
	3.9.1 Mortality rate attributed to household and ambient air pollution

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)
	3.9.3 Mortality rate attributed to unintentional poisoning
3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older
3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all	3.b.1 Proportion of the target population covered by all vaccines included in their national programme
	3.b.2 Total net official development assistance to medical research and basic health sectors
	3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis
3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	3.c.1 Health worker density and distribution
3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness

ANNEX 3 –FEDERAL AND PROVINCIAL RESPONDENTS

Region	Respondents	Contact details
Federal	Dr. Sabeen Afzal	MoNHSRC
	Mr. Hassan Hamza	MoNHSRC
	Mr. Ali Kemal,	SDG Support Unit, Planning Commission, UNDP
	Mr. Adeel Ahmed	UNDP, Islamabad
	Ms.Romina Khurshid Alam,	MNA, Member Parliamentary Committee on SDGs
Punjab	Dr. Amanullah,	Chief Economist, P&D
	Dr. Shabana Haider	Member Health, P&D Punjab
	Mr. Shahzad Khalil	SDG Cell (P&D project, supported by UNDP)
	Nadir Khalique,	Additional Secretary, Women Development department, Punjab NIPA, 184 Upper Mall Scheme
	Dr. Nadeem Zaka	HPRU, Punjab
	Dr. Shabnum Sarfraz	
Sind	Dr. Mobeen Memon	Aditional Secretary Health
	Ms. Mobeen Ajaib	SDG Unit, P&D
	Ms. Sara Salman	Focal Person, WHO
Khyber Pakhtunkhwa	Dr. Tahir Nadeem	DG, Provincial Health Services Academy
	Dr. Akhtar Saeed	Focal Person, WHO
	Dr. Shahid Younis	Chief Health Sector Reform Unit
	Dr. Khalil UR Rehman	Health Sector Reform Unit
	Dr. Muhammad Faheem	Provincial Program for PHC and FP in KP
	Dr. Aqeel Bangash	DOH KP
	Dr. Israrullah Khan	DOH KP
	Dr. Sahab Gul	MNCH Deptt. KP
	Dr. Syed Irfan	Director Public Health KP
Balochistan	Dr. Hayat Ronjho	DOH, Focal person SDGs (notification awaited)
	Dr. Ghulam Rasool Zehri	Chief Plannoing Health, Balochistan
	Dr. Babar Alam	Focal Person, WHO
	Amin Mandokhel	DGHS

ANNEX 4 – IDI GUIDE

Introduction

Thank you very much for coming to this meeting. I welcome you on behalf of the Health Services Academy and the WHO. This study is being undertaken to learn about how different stakeholders understand the SDG localization calls for the adaptation & integration of global goals into the local development processes of the country. Through our discussions, we hope to understand the context, current situation, and needs of different departments for enhancing their ownership (both duty bearers and right holders) and dialogue on their localization i.e. setting up local/country specific milestones to achieve global targets; standards to follow and to be maintained including country specific indicators to measure the progress on set milestones according to the context, needs and mapping of identified gaps in development. We will also inquire about your views on how after localization step, agreed milestones, standards and indicators can be integrated into planning, policies & strategies (or has been), systems to deliver services for population for implementation and national data sets to measure progress on achievement of goals.

Your participation will help us understand the context in developing a framework for implementation and monitoring of localized SDG 3 and health related targets.

If you agree to participate in this study, please indicate so and if not then please state the reason for refusal.

___ Agreed _____ Reused

Reason for refusal

Respondent Name:

Date:

Location:

(For respondents from National/Provincial Governments)
After consent and addressing queries begin with the questions as below:

- How is your department identifying gaps in existing system for adaptation and implementation of the SGDs?
  (probes)
  - Focal persons and their roles and responsibilities
  - Progress to date
- What, if any, policy development steps have been taken to pursue integration of the SDGs at National/Provincial level
  - What are the barriers to implementation
  - Does the department have sufficient capacity and resources to implement and monitor SDGs?
- Is there sufficient awareness among the key program personnel regarding SDGs?
  - If not, what is needed to fill this gap
  - If yes, how was this achieved, what steps were taken
- Considering the health-related SDGs (2, 3, 5, 6, 10), which of the targets (list to be shared with respondent) are
  - Significant, considering the local situation
  - Required standards and milestones for integration
- Are there any existing activities related to SGDs underway in (this) region?
  - What are the activities
  - Key expected outcomes

(For respondents from development organizations)
After consent and addressing queries begin with the questions as below:

1. What, if any, policy development steps have been taken by National/Provincial governments to pursue integration of the SDGs at National/Provincial level
    a. What are the barriers to implementation
    b. Does the department have sufficient capacity and resources to implement and monitor SDGs?
2. Is there sufficient awareness among the key program personnel regarding SDGs?
    a. If not, what is needed to fill this gap
    b. If yes, how was this achieved, what steps were taken
3. Are there any existing activities related to SGDs underway in (this) region?
    a. What are the activities
    b. Key expected outcomes
4. How is your organization identifying gaps in existing system for adaptation and implementation of the SGDs?
   (probes)
    a. Focal persons and their roles and responsibilities
    b. Progress to date
5. Considering the health-related SDGs (2, 3, 5, 6, 10), which of the targets are
    a. Significant, considering the local situation; and
    b. What are the required standards and milestones for integration

ANNEX 5 – THEMATIC CONTENT ANALYSIS

Development Partners

Themes	Concepts explored
Policy coherence	High level of coherence, UNDP/SDG Support Units + P&D In Punjab, Sindh government committed at all levels KP is in process of establishing a mechanism and Balochistan is considering development of a similar unit
Barriers to implementation of SDGs	Knowledge & awareness present but understanding and operationalization lacking. Not all stakeholders involved. Delays in setting up advisory groups, lack of ToRs. Lack of integration of policies in some departments. Lack of ownership. Sense of overburdened. Poor M&E, poor quality data. Outsourcing of PC1 to private sector.
Gaps and weaknesses in existing systems	Balochistan not on board. Poor understanding of SDGs. identifying resources. Data collection and recording poor. Indicators specified and operationalized. Policy alignment in some areas. Multiple data sources – alignment and use. Budget reallocation/ realignment. Lack of uniformity in resource acquisition and allocation. Slow progress in implementation due to lack of formalizing activities, prioritizing, sequencing etc. consultations and discussions are not translated into actions or policies.
Opportunities for localization	All the SDGs addressed at all levels. SDGs viewed as unfinished agenda of MDGs. Focal persons and SDG units at provincial and district level, with expertise from multi stakeholders. Best practices shared. Prioritization activities undertaken. Pilot project in Punjab in 10 districts. Development of MDPI. Realignment of budgets. Identification of lead departments that would identify targets and indicators. Regular consultative workshops. Monitoring and reporting frameworks, with integrated MIS systems. Setting of milestones. Availability of technical expertise and assistance.
Existing capacity to achieve SDGs	Functional units in Punjab and Sindh. Provincial cells and task forces working with different departments. Technical assistance by P&D with SDG Advisory Council. Data sources and collation of data feeding into federal dashboard. Four clusters of SDGs giving clarity and direction. Integration of PFC award. Focal persons present. Knowledge & awareness good. Punjab piloting 10 districts.

Punjab Health and Allied Department

Themes	Concepts to be explored
Policy coherence	High level of commitment and policy coherence in Punjab. P&D dept. – health related SDGs. Primary & Secondary health dept., specialized healthcare and medical dept. Provincial Health Policy and Strategic Framework for Punjab. PSPU. FP 2020
Barriers to implementation of SDGs	Lack of technical institutionalization, ToRs. Lack of alignment of SDGs with gender program
Gaps and weaknesses in existing systems	Operationalization of targets/ indicators. Not all targets identified e.g. suicide mortality. Lack of defined roles and responsibilities. Effective monitoring. Data quality assurance. Health care access inequalities. Lack of investment in prevention and treatment of substance abuse, RTA, tobacco control, air, water, soil pollution. Lack of focus on trade distortions, agriculture markets, food commodities. Only 1% budget allocation on stunting reduction of agriculture and livestock productivity. Budget realignment/allocation issues. Gender and environment not fully integrated or aligned. Technical knowledge/ capacity gaps. Lack of resources e.g. vehicles. Non -functional dashboard. Designated posts vacant. Lack of staff in some areas.
Opportunities for localization	SDG support units. Strong and functional women empowerment program and quotas. Transparent mechanisms in place. Involvement of all stakeholders in committees and feedback. Robust data collection and analysis. Needs assessment analyses. Inter department, and vertical program alignment and integration. E.g. MSNS Multi Sectoral Nutrition Strategy had all stakeholders on board, budget realignment and reallocation.
Existing capacity to achieve SDGs	Strong Provincial Health Policy and Strategic framework in place. Pilot in 10 districts underway. PC1 takes into account SDG targets. Service delivery improvements. PHFM, MSDS, IRMNCH, vertical program alignment. Punjab Growth Strategy. M&E strengthened. HISDU, HFA, LHW and CMW evaluation and retention. Integrated MIS under Punjab DHIS with PITB and PSPU. Punjab population innovation fund to reduce maternal and infant mortality. Clustering of SDGs. Gender specific programs – Akhuwati, domestic workers, harassment, underage marriage etc.

Sindh Health and Allied Departments

Themes	Concepts to be explored
Policy coherence	With UNDP, Sindh SDG Support Unit in Sindh P& D Board set up. At initial stages of developing inter-departmental linkages
Barriers to implementation of SDGs	Too soon to assess – will need a structured and integrated approach.
Gaps and weaknesses in existing systems	Too soon to assess
Opportunities for localization	Awareness better than with MDGs. Identifying targets and indicators in progress. Integration of departmental activities in process.
Existing capacity to achieve SDGs	Consultative workshops with stakeholders have sensitized district governments. Still in initial stage. Will need UNDP support.

Khyber Pakhtunkhwa Health and Allied Departments

Themes	Concepts to be explored
Policy coherence	KP health department has established SDG Unit in the Health Sector Reform Unit (HSRU), with several health reforms underway. Sufficient awareness among key health personnel
Barriers to implementation of SDGs	Roles and responsibilities yet to be assigned for Unit's plan of action and interdepartmental collaborations. Focal persons for other health allied departments are yet to be identified.
Gaps and weaknesses in existing systems	Pathways to alignment of existing initiatives with SDGs agenda. Localization efforts have not started yet.
Opportunities for localization	Awareness better than with MDGs. Several initiatives already underway, which can be aligned with the SDG agenda
Existing capacity to achieve SDGs	Consultative workshops with stakeholders have sensitized provincial health department officials. Still in initial stage.

Balochistan Health and Allied Departments

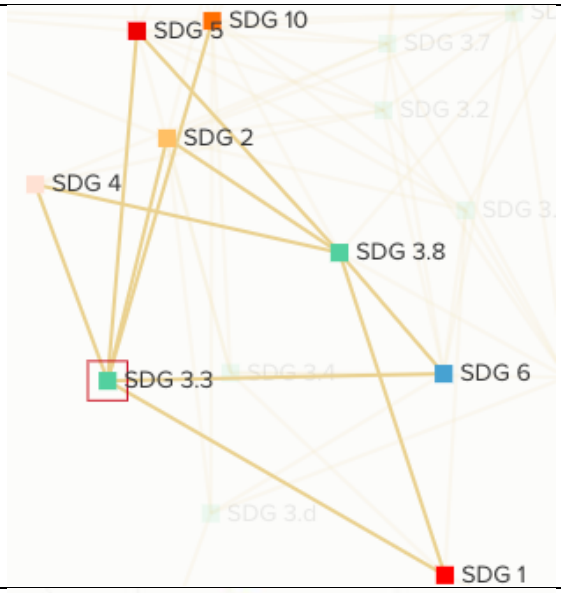
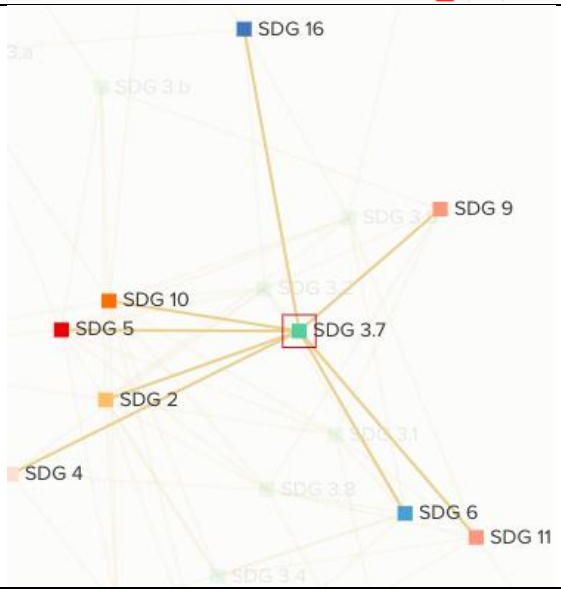
Themes	Concepts to be explored
Policy coherence	P&D and UNDP in initial stages of establishing a provincial support unit. Initiatives related to health (MNCH, Nutrition, LHW program) have milestones which can be aligned with the SDGs agenda
Barriers to implementation of SDGs	There is a need for a structured and integrated approach. Key personnel at provincial health and planning department do not have a coherent understanding of the
Gaps and weaknesses in existing systems	Delays and disruptions in appointment of SDGs focal person for health. Sensitization of other allied departments has not yet been initiated Inefficient resource utilization
Opportunities for localization	Awareness better than with MDGs and focal person aware of link between existing initiatives and SDGs agenda. Financial resources available to initiate interdepartmental collaborations for integration of SDGs
Existing capacity to achieve SDGs	Still in initial stage. Sensitization and awareness raising activities needed at provincial and district level

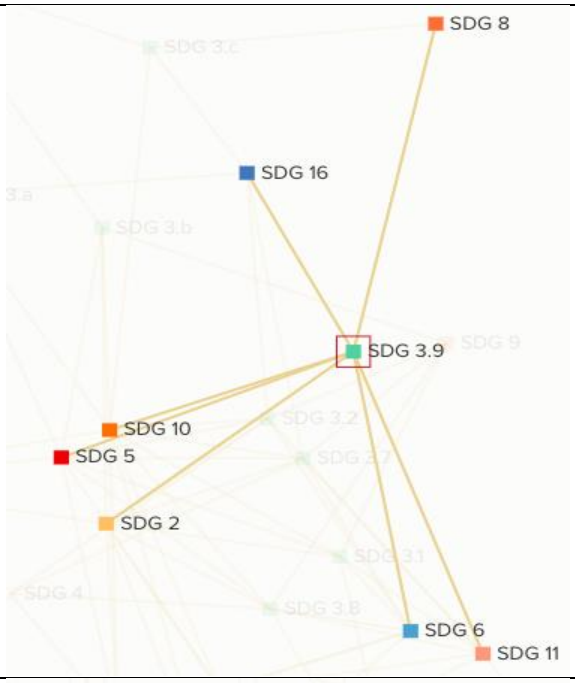
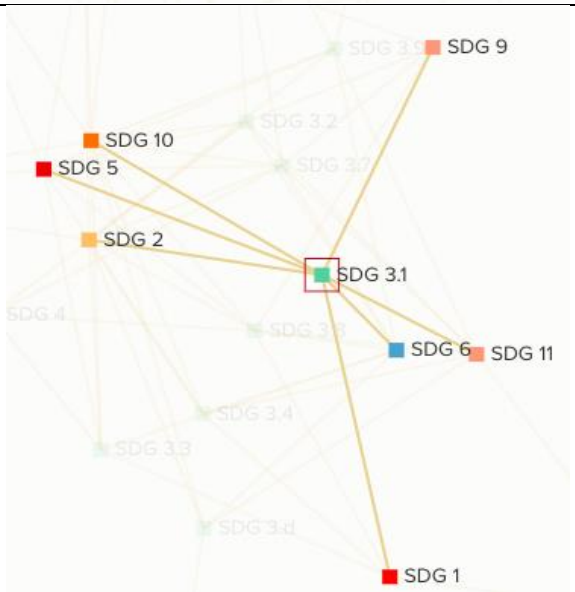
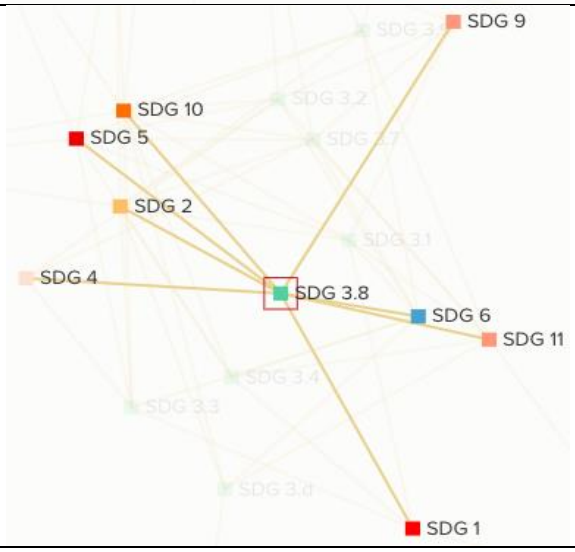
ANNEX 6 – SDG NETWORK ANALYSIS MATRIX

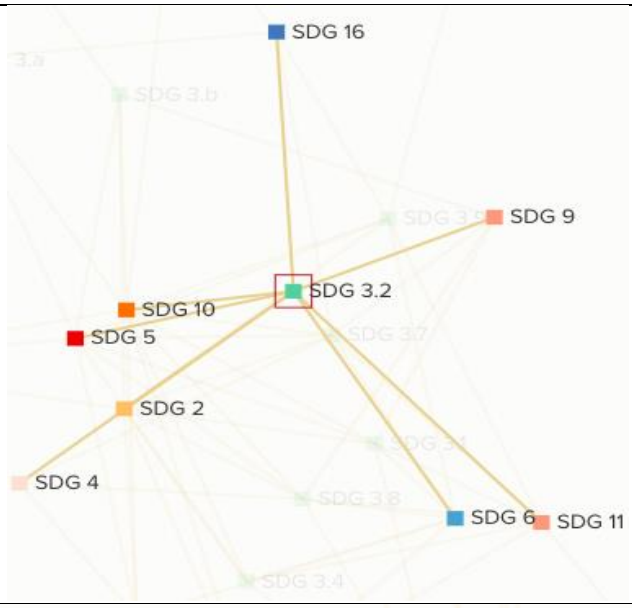
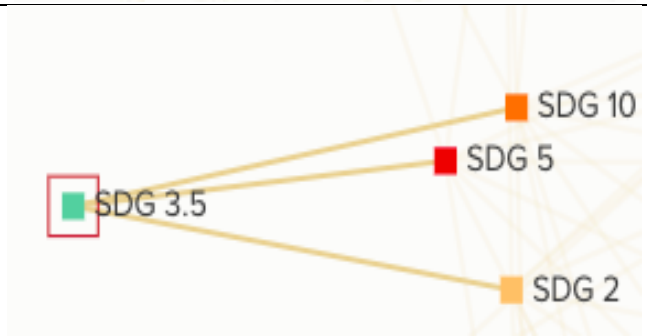
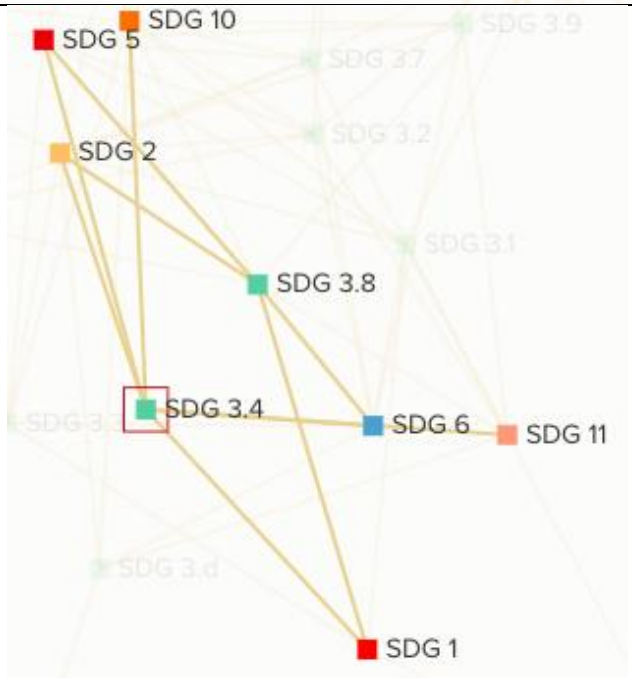
From	To	Weight	Connected targets
SDG 3.1	SDG 5	6	2.2; 5.1; 5.2;5.3;5.6;6.1;6.2; 1.2, 1.1, 1.3, 9.1, 10.2, 10.1, 11.1, 11.2; 1.2, 1.1, 1.3, 9.1, 10.2, 10.1, 11.1, 11.2
SDG 3.1	SDG 2	3	
SDG 3.1	SDG 6	3	
SDG 3.1	SDG 1	3	
SDG 3.1	SDG 9	1	
SDG 3.1	SDG 10	2	
SDG 3.1	SDG 11	2	
SDG 3.2	SDG 5	2	2.1; 2.2;2.1,2.2,5.3 5.6, 6.1, 6.2; 4.2, 10.1, 9.1, 11.1, 11.2, 16.2, 16.9
SDG 3.2	SDG 2	4	
SDG 3.2	SDG 6	2	
SDG 3.2	SDG 4	1	
SDG 3.2	SDG 9	1	
SDG 3.2	SDG 10	1	
SDG 3.2	SDG 11	2	
SDG 3.2	SDG 16	2	
SDG 3.3	SDG 5	8	2.1; 5.1;5.6;6.1;6.2;6.3; 2.1, 2.2,5.2, 6.1, 6.2, 6.3; 2.1, 2.2, 5.1, 6.1, 6.2, 6.3; 2.1, 5.1, 5.2, 6.1, 6.3; 2.1, 2.2, 6.1, 6.2, 6.3; 1.4, 4a, 10.1, 10.2
SDG 3.3	SDG 2	8	
SDG 3.3	SDG 6	14	
SDG 3.3	SDG 1	1	
SDG 3.3	SDG 4	1	
SDG 3.3	SDG 10	2	
SDG 3.4	SDG 5	4	2.1, 2.2, 6.1, 6.2, 6.3; 5.1, 5.2, 10.2; 1.4, 11.7
SDG 3.4	SDG 2	2	
SDG 3.4	SDG 10	1	
SDG 3.4	SDG 11	1	
SDG 3.4	SDG 1	1	
SDG 3.4	SDG 6	3	
SDG 3.5	SDG 2	4	2.1; 2.2; 5.1, 5.2; 10.1,10.2, 10.4; 2.1, 2.2, 10.1, 10.2, 10.4;
SDG 3.5	SDG 5	2	
SDG 3.5	SDG 10	6	
SDG 3.6	SDG 1	1	11.2; 1.5
SDG 3.6	SDG 11	1	
SDG 3.7	SDG 2	4	2.1; 2.2; 5.1; 5.2;5.3;5.6; 5.b ;6.1;6.2;6.3; 2.1; 2.2; 5.1;5.2;5.3;5.6;5.b;6.1;6.2; 4.1, 9.1, 11.1, 11.2, 16.2, 16.9, 16b
SDG 3.7	SDG 5	10	
SDG 3.7	SDG 6	5	
SDG 3.7	SDG 4	1	
SDG 3.7	SDG 9	1	
SDG 3.7	SDG 10	2	
SDG 3.7	SDG 11	2	
SDG 3.7	SDG 16	3	
SDG 3.8	SDG 1	1	2.1; 2.2; 5.1; 5.2;5.3;5.6;5.b; 6.1;6.2;6.3;10.2; 10.1, 10.2; 1a, 1.3, 4.2, 4a. 9.1, 10.1, 10.2, 11.1, 11.2
SDG 3.8	SDG 2	2	
SDG 3.8	SDG 4	2	
SDG 3.8	SDG 5	5	
SDG 3.8	SDG 6	2	
SDG 3.8	SDG 9	1	
SDG 3.8	SDG 10	2	
SDG 3.8	SDG 11	2	
SDG 3.9	SDG 2	2	5.1; 6.1;6.2;6.3;6.a; 6;b;10.2;11.6; 2.1, 2.2, 6.1, 6.2, 6.3, 6.a, 6.b; 8.8, 10.1, 10.2, 11.5, 11.6, 11.7, 16.1
SDG 3.9	SDG 5	1	
SDG 3.9	SDG 6	10	
SDG 3.9	SDG 8	1	
SDG 3.9	SDG 10	2	
SDG 3.9	SDG 11	3	
SDG 3.9	SDG 16	1	
SDG 3.a	SDG 5	1	5.1;10.2; 16.3, 16.6, 17.14, 17.17
SDG 3.a	SDG 10	1	
SDG 3.a	SDG 16	2	
SDG 3.a	SDG 17	2	
SDG 3.b	SDG 2	2	5.1; 6.1;6.2;6.3;6.a; 6;b;10.2;11.6; 2.1, 2.2, 6.1, 6.2, 6.3, 6.a, 6.b; 8.8, 10.1, 10.2, 11.5, 11.6, 11.7, 16.1
SDG 3.b	SDG 5	1	
SDG 3.b	SDG 9	1	
SDG 3.b	SDG 10	4	
SDG 3.b	SDG 17	4	
SDG 3.c	SDG 8	1	10.1, 10.2; 8.5, 16.6, 17.1, 17.17
SDG 3.c	SDG 10	2	
SDG 3.c	SDG 16	1	
SDG 3.c	SDG 17	2	
SDG 3.d	SDG 2	2	2.1, 2.2, 6.1, 6.2, 6.3; 11.3, 10b, 11c, 13.1
SDG 3.d	SDG 6	3	
SDG 3.d	SDG 10	1	
SDG 3.d	SDG 11	2	
SDG 3.d	SDG 13	1	

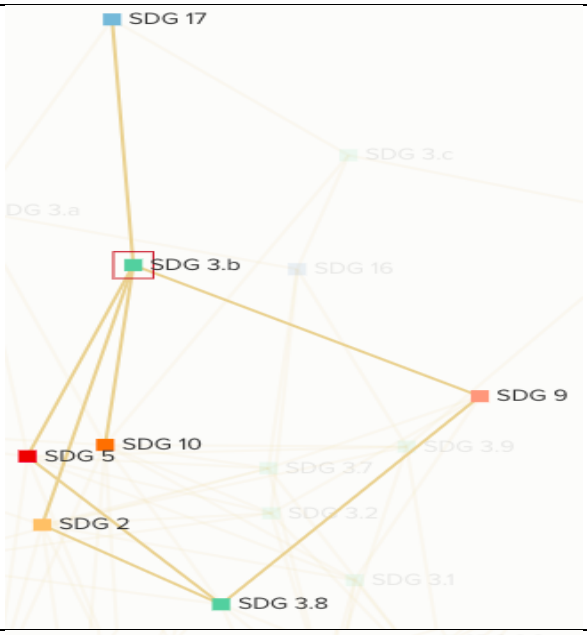
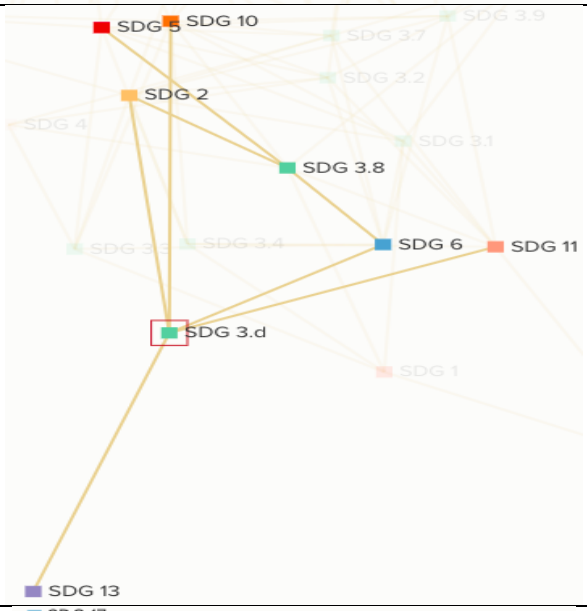
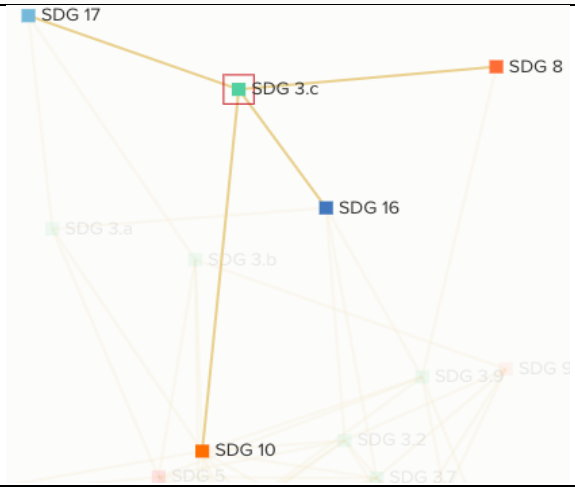
Cumulative (SDG 3)	Weight
SDG 1	7
SDG 2	33
SDG 4	5
SDG 5	40
SDG 6	42
SDG 7	-
SDG 8	2
SDG 9	5
SDG 10	26
SDG 11	15
SDG 12	-
SDG 13	1
SDG 14	-
SDG 15	-
SDG 16	9
SDG 17	8

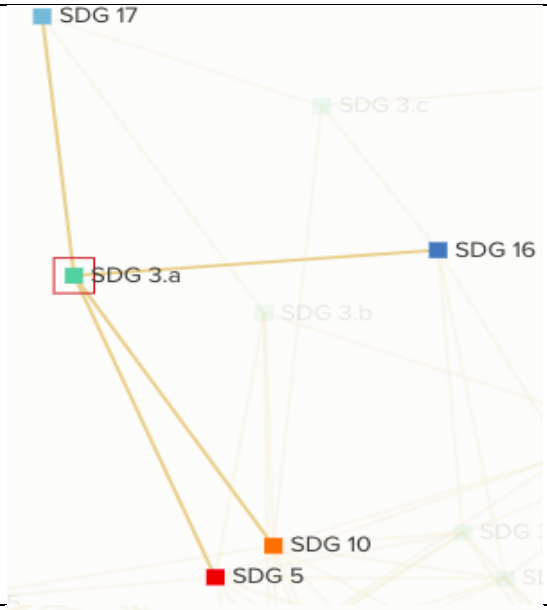
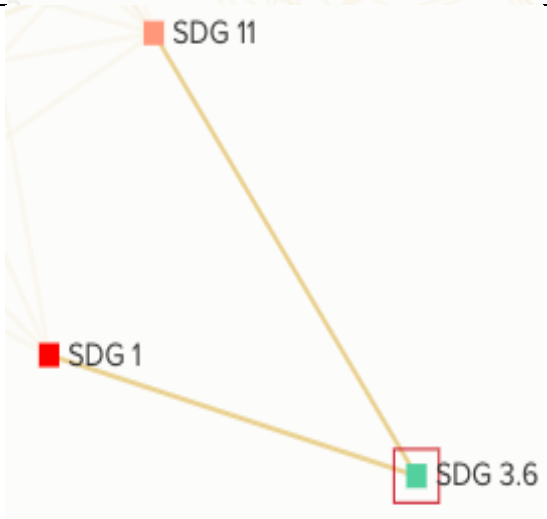
Table 9 - SDG Network analysis matrix - connections and number of ties

SDG 3 – Targets leverage points	Connections	
SDG 3.3	34	
SDG 3.7	28	

SDG 3.9	20	
SDG 3.1	20	
SDG 3.8	17	

SDG 3.2	15	
SDG 3.5	12	
SDG 3.4	12	

SDG 3 b	12	
SDG 3 d	9	
SDG 3 c	6	

SDG 3 a	6	
SDG 3.6	2	

ANNEX 7 – ODA FOR HEALTH, PAKISTAN

Funding Organizations	Year	Commitments (USD 2014)	Title	Sector
World Bank	2006	104,250,203	NWFP First Development Policy Credit	Government and civil society, general
World Bank	2005	59,230,691	NWFP SAC II - Supplemental Financing	General Budget Support
World Bank	2002	151,182,232	Sindh Structural Adjustment Credit Project	General Budget Support
ASDB Group	2005	5,923,069	Balochistan Devolved Social Services - HIV/AIDs and Infectious Diseases Control	Health
ASDB Group	2005	153,999,796	Balochistan Devolved Social Services - Program Loan	Other Social Infrastructure and Services
Canada	2011	1,693,628	Mother Care and Child Survival in Underserved Regions of Mali, Mozambique and Pakistan / Soins de la mère et survie de l'enfant dans régions mal desservies du Mali, Mozambique et Pakistan	Health, general, Basic health, Population Policies/ Programmes and Reproductive Health
Canada	2011	989,817	Improving Community Health / Améliorer la santé communautaire	Health, general, Basic health, Population Policies/ Programmes and Reproductive Health, Other Social Infrastructure and Services
United States	2010	58,140,433	Maternal and Child Health	Health
United States	2010	1,074,111	Maternal and Child Health	Health
United States	2011	210,713,640	Social Assistance	Other Social Infrastructure and Services, Health
Australia	2013	4,520,328	Citizen Engagement for Social Service Delivery III	Basic education, Education, level unspecified, Multisector, Health, Administrative Costs of Donors
Canada	2011	760,901	Mother Care and Child Survival in Underserved Regions of Mali, Mozambique and Pakistan / Soins de la mère et survie de l'enfant dans régions mal desservies du Mali, Mozambique et Pakistan	Health, general, Basic health, Population Policies/ Programmes and Reproductive Health
Canada	2011	1,339,158	Improving Community Health / Améliorer la santé communautaire	Health, general, Basic health, Population Policies/ Programmes and Reproductive Health, Other Social Infrastructure and Services
United Kingdom	2004	417,938	Social Assistance	Government and civil society, general
United States	2010	6,911,902	Maternal and Child Health	Health
Greece	2011	6,268	Medical Education & Training	Post-secondary education
United States	2010	2,148,221	Maternal and Child Health	Health
United Nations Children`s Fund (UNICEF)	2011	32,650	Disease and Nutritional surveillance	Basic health
United Nations Children`s Fund (UNICEF)	2012	29,056	Support to C4D interventions for multiple OTs within FA2	Health

Spain	2012	126,652	Aid for universities, research centres and hospital trusts to hire early-stage research staff-	Education, level unspecified, Post-secondary education, Health
World Health Organization (WHO)	2013	8,388	AC Pakistan Health systems and services	Health, general, Basic health, Health
World Health Organization (WHO)	2013	293,782	AC Pakistan Health systems and services	Health, general, Basic health, Health

ANNEX 8 - PROVINCIAL CONSULTATIVE MEETINGS - GUIDELINES

Most of the data for the SDG 3 indicators is available from periodic national surveys, such as PDHS, MICS, NNS. However, even these surveys are not done
regularly, and time of survey is also variable, especially for provincial surveys (e.g. MICS). Routine reporting from the DHIS is only on the number of clients using the public-sector health services, missing information from the private health facilities.
Considering the deficiencies in available data, realistic and achievable Provincial targets and milestones can only be defined with technocrats of health departments, using disaggregated data from their respective provincial health departments.
Participants are requested to bring the annual/quarterly reports to progress on the following, in a focused group work

1. Fill in the missing/false information in attached template
2. Deliberate on the proposed targets, milestones and timelines; keeping in view existing situation (technical, financial, political) of their health department
3. Identify gaps which need to be filled to enable the health department in achieving the agreed targets

Group work will be followed by

1. Group presentations on the above exercise
2. Identification of key issues which are likely to affect SDG 3 agenda
3. Proposed actions for a way forward

Template to be filled

Goal	Indicator	Current value	Source	Year	Proposed targets by 2030	Milestones		
						2020	2025	2030
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1 Maternal mortality ratio							
	3.1.2 Proportion of births attended by skilled health personnel							
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	3.2.1 Under-five mortality rate							
	3.2.2 Neonatal mortality rate							
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations							
	3.3.2 Tuberculosis incidence per 100,000 population							
	3.3.3 Malaria incidence per 1,000 population							
	3.3.4 Hepatitis B incidence per 100,000 population							
	3.3.5 Number of people requiring interventions against neglected tropical diseases							
3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease							
	3.4.2 Suicide mortality rate							
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders							
	3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within							

	a calendar year in litres of pure alcohol					
3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents	3.6.1 Death rate due to road traffic injuries					
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods					
	3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group					
3.8 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	3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborns and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)					
	3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income					
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.9.1 Mortality rate attributed to household and ambient air pollution					
	3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)					
	3.9.3 Mortality rate attributed to unintentional poisoning					
3.a Strengthen the implementation of the World Health Organization	3.a.1 Age-standardized prevalence of current tobacco use among					

Framework Convention on Tobacco Control in all countries, as appropriate	persons aged 15 years and older					
3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all	3.b.1 Proportion of the target population covered by all vaccines included in their national programme					
	3.b.2 Total net official development assistance to medical research and basic health sectors					
	3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis					
3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	3.c.1 Health worker density and distribution					
3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness					

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