

# **12<sup>th</sup> FIVE YEAR PLAN (2018-2023)**

## **HEALTH**

In Pakistan, breaking the vicious circle of poverty and ill health is an essential condition for economic development. Health is now higher on the agenda of the government than ever before, and concern for the health of poor people is becoming a central issue in development.

The human and economic rationale for investing in health is mirrored by a growing consensus on the importance of a broad agenda of improving the health of the poor. This 12<sup>th</sup> Five Year Plan identifies the essential components of a pro-poor health approach and provides a framework for action within the health system – and beyond it, through policies in other sectors. The Vision 2025 and the Sustainable Development Goals (SDGs) also call for a renewed commitment for comprehensive health improvements by ensuring universal access to affordable, quality, essential health services to all, delivered through a resilient and responsive health system.

Unfinished agenda of the Millennium Development Goals (MDGs) along with more ambitious but comprehensive health related SDGs, rapidly changing pattern of the burden of disease with major share of non-communicable diseases, increasing frequency and intensity of health emergencies and disease outbreaks with emerging / re-emerging diseases, high population growth rate, hidden burden of under-nutrition, governance concerns, crises in human resources for health and poor quality primary & secondary healthcare infrastructure are some of the major health sector challenges in Pakistan.

The task is further challenging particularly for those who are poor or vulnerable, women and children, youth, persons with disabilities, people living with diseases, older people, refugees, internally displaced persons and migrants.

### **Situational analysis**

The country has faced formidable social, economic, security, political and governance challenges during the last decade. This was also an era of unprecedented change, confusion and complexity in the health sector, especially soon after the 18th constitutional amendment in 2011 with abolishment of the concurrent list and Ministry of Health (MoH).

Total Health Expenditure (THE) ratio to Gross Domestic Product (GDP) has increased from 2.8% in 2011-12 to 3.1% in 2015-16, out of which share of the public sector is only one third. Similarly, per capita health expenditure has increased from US\$ 34.7 in 2011-12 to US\$ 45 in 2015-16 with public sector share of US\$15.3 per person.<sup>1</sup>

- Population of Pakistan is approximately 218.3 million (including AJK and GB) in 2018 with an additional 1.4 million registered Afghan refugees. Of the total population, 64 percent is below the age of 30 years, while 29 percent is between 15 and 29 years old, and proportion wise the second youngest in the South Asian region after Afghanistan.<sup>2</sup>
- Burden of the communicable, maternal, child and nutritional group, which was more than 60 percent (36,033 DALYs lost per 100,000 population) of the total burden of diseases in the year 2000, has gone down to 43.3 percent (17,063 DALYs lost per 100,000 population) in 2017. However, the burden of non-communicable disease group which was 31.7 percent (18,802 DALYs lost per 100,000 population) of the total burden in the year 2000 has increased its share to 47.5 percent (18,709 DALYs lost per 100,000 population) in 2017. The share of burden of injuries increased from 7.38 percent (4,371 DALYs lost per 100,000 population) to 9 percent (3,577 DALYs lost per 100,000 population) over the same period.<sup>3</sup>
- The BoD is rendered worse by an increasing population, with Pakistan now the fifth most populous country in the world and with contraceptive prevalence of only 25% for modern methods, while unmet need for birth spacing is around 17%.
- In 2017, top ten causes of death (all ages) in Pakistan included: 1) Ischemic Heart Disease; 2) Neonatal disorders; 3) Stroke; 4) Diarrheal Diseases; 5) Lower Respiratory Infections; 6) Road injuries; 7) COPD; 8) Cirrhosis; 9) TB; and 10) Diabetes.
- In 2017, the death rate was 6.6 deaths per 1,000 population (approximately 1.4 million deaths) and 60.3 percent of all deaths were because of non-communicable diseases, while communicable, maternal, neonatal and

---

<sup>1</sup> Pakistan Bureau of Statistics, 2018; National Health Accounts 2015-16

<sup>2</sup> UNDP, 2017; National Human Development Report (NHDR)

<sup>3</sup> Institute of Health Metrics & Evaluation, 2018; BOD data for Pakistan 2017: <https://vizhub.healthdata.org/gbd-compare/>

nutritional group contributed to 31.5 percent of total deaths and the share of injuries was 8.16 percent.<sup>3</sup>

- The birth rate was estimated at 27.3 per 1,000 population in 2016 and a population growth rate of 2.04.<sup>4</sup> Pakistan still has a very high fertility rate of 3.6 children per woman in 2017-18.<sup>5</sup> Life expectancy at birth for both sexes has improved to 68 years (66 years for males and 70.1 years for females) in 2017.<sup>4</sup>
- Declines in neonatal, infant and child mortality rates have been slow. One of the major reasons for slow decline in under 5 mortality rate (at 74 per 1,000 live births in 2017-18<sup>6</sup>) is exceptionally high neonatal mortality rate coupled with high still births, which has been estimated at 42 per 1,000 live births<sup>6</sup>. Major causes of deaths among new-borns are neonatal encephalopathy due to birth asphyxia or trauma, pre-term birth, haemolytic disease and jaundice, neonatal sepsis and other neonatal conditions. Communicable diseases among children include diarrhoea and acute respiratory infections. Pakistan is one of the three remaining countries where Polio is still endemic.
- Pakistan's maternal mortality ratio (MMR) is also higher than those of other countries in the region and estimated to be 165.6 for the year 2017<sup>4</sup>, with a lifetime risk of maternal death equivalent to 1 in 140.<sup>7</sup> Maternal deaths due to preventable causes are haemorrhage, sepsis and hypertension. The percentage of mothers attended by skilled birth attendant during childbirth has improved significantly to 69% in 2017-18, majority of which are institutional deliveries.<sup>6</sup>
- Pakistan has an endemicity of Hepatitis B and C in the general population with 7.6% affected individuals; the 5th highest tuberculosis burden in the world, has focal geographical areas of malaria endemicity, and an established HIV concentration among high risk groups. Other vaccine preventable diseases and new emerging infections call for strengthening and putting in place a real time disease surveillance and response system, uniformly across the country.

---

<sup>4</sup> Planning Commission and National Institute of Population Studies, 2017: <https://www.pc.gov.pk/uploads/annualplan2018/Annual.pdf> and NIPS: "Updating the Population Projections for Pakistan, Provinces, FATA & ICT (2016)"

<sup>5</sup> National Institute of Population Studies (NIPS), 2013; Pakistan Demographic & Health Survey, 2017-18

<sup>6</sup> National Institute of Population Studies, 2018; Pakistan Demographic & Health Survey 2017-18

<sup>7</sup> UN Interagency Group, 2015, Trends in Maternal Mortality 1990-2015

- Non-Communicable Diseases (which include cardiovascular diseases, diabetes mellitus, cancers and chronic pulmonary diseases) along with mental health illnesses (depression, psychosis, substance abuse (drugs & alcohol), dementia) and others, now constitute more than half of the BoD, causing far more premature deaths and disabilities among an economically productive adult age group. Overall, 46.2 percent of the population (20 years and above) is hypertensive in Pakistan and 26.3 percent are diabetic, which are unacceptably very high rates and demand immediate actions.<sup>8</sup>The common underlying factors for non-communicable diseases including sedentary lifestyle, nutrition and smoking which has not been addressed adequately.
- Multiple other factors like social determinants of health, such as access to improved drinking water, food and sanitation contribute to the health of the people. In Pakistan, 37.6% of children under the age of five suffer from chronic malnutrition (stunting) and 7.1% of children suffer from acute malnutrition (wasting).<sup>6</sup> Sixteen million people in the country are without access to safe water, including drinking water. In 2014-15, 91 percent of the population was having access to safe drinking water and only 73 percent of the population was using an improved sanitation facility.<sup>9</sup>
- Particularly, rural populations suffer from numerous health issues due to multiple reasons, e.g. poverty, lack of education (especially female literacy), awareness, poor infrastructure and health facilities. Statistics show that there is a significant gap between health facilities and awareness in urban and rural Pakistan.
- Poverty, low literacy, unemployment, gender discrimination, and huge treatment gap have led to an invisible burden of mental health problems in the society. Disability due to blindness, hearing loss and other causes is also high, and services for disabled population are limited, including poor provision of assistive devices to improve their quality of life.
- Pakistan has seen progress in access to health care services; however, the gains are uneven across different service areas as out of pocket expenditure is still more than 57% despite having network of (primary, secondary and

---

<sup>8</sup> Pakistan Health Research Council, 2018; Pakistan Diabetic Survey 2016-17

<sup>9</sup> Pakistan Bureau of Statistics, 2015; Pakistan Social & Living Standard Measurement Survey, 2014-15

tertiary) public health care system in place. Though skilled birth attendance (SBA) has improved from 18% in late 1990s' to 69% in 2017-18, but quality of services varies significantly among provinces and districts. Despite improvement in immunization coverage, rates of routine immunization remain unacceptably low at 65.6% in 2017-18, leading to high expenditure on immunization campaigns. Access to and affordability of essential medicines is low and hospitals beds are only one third of the minimum threshold for Pakistan. Moreover, there are geographical disparities in coverage between provinces, districts and rural-urban areas.

- Pakistan has one of the lowest doctors, dentists and nurses to population ratios. Nurses, lady health visitors and midwives play a vital role in keeping a population healthy, their number is currently around 100,000 against the need of >900,000 by 2030 to meet the SDG-3 target. The public sector is inadequately staffed and job satisfaction and work environment needs improvement. The overall health sector also faces an imbalance in the number, skill mix and deployment of health workforce, and inadequate resource allocation across different levels of health care i.e. primary, secondary and tertiary. In order to produce quality workforce for health sector, the quality of medical and allied education both in public and private sector needs to be looked into.

Despite devolution, health system faces challenges of low performance accountability within the government, creating inefficiency and quality issues. Largely unregulated for quality care and pricing, there is also duplication of services with the private sector, along with an issue of dual practice. Although having the potential, private sector contributes least towards primary, preventive and promotive health services. A range of actions is needed, acting upon the social determinants within the health and social sectors, if a wider impact is to be achieved.

### **Performance Review of 11th Five Year Plan (2013-18)**

The 11<sup>th</sup> National Five Year Plan (2013-18) has shown some promising results for prevention and control of communicable and non-communicable diseases due to investment in quality human resource production, ownership of the provinces for devolved vertical programmes and improvements in hospital infrastructure

and some increase in hospital beds. Enhanced political ownership resulted in launching of social health insurance nationwide to provide quality healthcare to most vulnerable and marginalized segment of the population.

Many targets are off-track due to dissociation in national strategic objectives and provincial implementation plans. This can be visualized in lack of integration of mental health into primary healthcare, establishment of dedicated mental health facilities, their access and utilization. Targets of 11<sup>th</sup> Five Year Plan (2013-18) along with baseline and achievements are at [Annexure-A](#).

There were a number of reforms and policy initiative undertaken during 11<sup>th</sup> Plan which include:

- Increased focus on revamping and strengthening of primary and secondary healthcare facilities with significant prioritization on maternal health
- Placement of tertiary healthcare facilities under autonomous board of governors for administrative and functional efficacy
- Introduction of social health protection and insurance
- Indigenous vaccine production
- Accreditation and standardization of health facilities, medical ethics, including patient safety
- Establishment of District Health Authorities
- School health services.
- Provision of free of cost medicines for Hepatitis B and C
- Initiation of Safe Mother Ambulance Service for pregnant ladies
- Establishment of drug testing labs at provincial levels

### **Critical Issues**

Key sectoral **challenges** are:

- Government spending on health has been less than optimal (0.9% of GDP in 2016-17). Most part of the allocations to health is consumed by the secondary and tertiary care, leaving merely 15% for the preventive and primary health care.
- There were inefficiencies in the public health spending due to weak management systems, resulting in low utilization and eventual lapse of funds. Payments are not linked to performance.

- There was no uniform approach for managing the governance of health institutions and the capacity for contracting in and contracting out of services was not optimal.
- There was stagnancy in the coverage of community health workers, and their numbers, coverage and quality are worsening from the required standards.
- Polio virus transmission has not been interrupted so far
- Burden of non-communicable diseases including mental health, is increasing rapidly augmented by high population growth.
- Poor regulation of private health sector
- Linking National Health Management Information System (HMIS) with Civil Registration and Vital Statistics System (CRVS)
- Deficient Public Health Laboratory Network System in the context of disease surveillance and response.
- Lack of occupational health and safety particularly in labour force
- Pharmaco-economics, Pharmaco-epidemiology and Pharmaco-vigilance remained ignored areas with no health technology assessment and approaches.
- There were issues related to quality and price of drugs and their prescriptions. Medicines pricing remained a contentious issue between the regulators and the industry.

### **Approach and Strategic Lines of 12th Five Year Plan (2018-23) Health Sector**

With a renewed dedication to a progressive health sector, the federal and provincial governments are committed to address the challenges in the sector by setting out a realistic but ambitious five-year plan.

In health sector, the 12th Five Year Plan is aligned to the Vision 2025 and Sustainable Development Goals to set the strategic direction in Pakistan and outlines how the federal, provincial and districts governments in partnership with the private sector and other stakeholders will proceed with the implementation. Vision in the health sector will be on progressing towards universal health coverage, thereby all people and communities have equitable access to comprehensive and guaranteed quality health services they need throughout the life course without financial hardship, by providing equitable

access to key primary, promotive, preventive, curative and rehabilitative health interventions for all particularly for women and children. This will be complemented by health system strengthening interventions for promotion of human capital for health, ensuring health supplies and availability of reliable and accurate health information to manage and evaluate health services.

The 12th Five Year Plan will act as a platform to address social determinants of health by emphasizing on groups in conditions of poverty and vulnerability, and also in particular for health governance and accountability & developing core capacity building for global health obligations like International Health Regulations (IHR), Global Health Security Agenda and other such treaties and international commitments.

The Plan has four simultaneous and interdependent strategic lines in accordance with internationally accepted and adopted approach:

**Strategic Line 1:** Advancing Universal Health Coverage

**Strategic Line 2:** Addressing Health Emergencies and Disease Epidemics

**Strategic Line 3:** Promoting Healthier Populations

**Strategic Line 4:** More effective and efficient health organizations at national, provincial, district and autonomous bodies level and better supporting the health system in the country

## **Objectives**

A core overarching objective of increased functional synergy between Planning Commission/ Ministry of Planning, Development and Reform and Provincial Planning & Development Departments, M/o National Health Services, Regulations and Coordination and Health Departments for ensuring smooth and effective translation of Vision 2025, Sustainable Development Goals and 12th Five Year Plan (2018-23) to Implementation Strategies and Plans, that will be enforced and ensured.

The 12th Five Year Plan (2018-23) describe Government's efforts within the context of Vision 2025 and **Sustainable Development Goals focusing on 11 strategic objectives:**

**Objective 1:** Strengthened Health Governance, Leadership and Accountability

**Objective 2:** Improved Universal Health Coverage

**Objective 3:** Improved Hospital Care and Health Access

**Objective 4:** Optimal and Sustainable Health Budgets, Alternate modes of Healthcare Financing including Social safety nets and Health micro-insurance for the poor and vulnerable

**Objective 5:** Availability of quality health Supplies, Diagnostics, Drugs, Vaccines/ Sera, Reagents and Equipment along with functional Logistic System and effective Regulations

**Objective 6:** Advance Human Capital for Health along with effective Regulations

**Objective 7:** Availability of reliable and accurate Health Information, Research to facilitate Policy planning, Healthcare management and Innovations

**Objective 8:** Emergence of high-threat infectious hazards prevented, detected and responded

**Objective 9:** Strengthened Health Emergency Preparedness

**Objective 10:** Determinants of health addressed leaving no one behind

**Objective 11:** Improved Financial, Human, Administrative resources management towards transparency and efficient use of resources

Annexure-B enlists baseline and targets to be achieved by 2020, 2025 and 2030.

### **Action plan**

The following measures will be taken for ensuring improvement in the healthcare system at all levels.

#### **1: Health Governance**

- Health system governance, health policies, strategies & plans, and regulatory frameworks will be strengthened along with their implementation and monitoring.
- Development of Provincial Health Strategies, e-Health Strategy, Disease Specific Strategic Plans, National Action Plan/ Provincial Strategies for

Non-Communicable Diseases, Action Plan for UHC, Provincial/Area strategies for HRH, etc. will be top priority.

- Further devolution of powers in health to district governments will be implemented with appropriate reviews.
- Integration of healthcare with the academic institutions will be instituted.
- Performance of regulatory bodies will be reviewed for further reforms and to ensure their effectiveness and efficiency.
- Pricing and quality of drugs will be ensured by enforcement of drug regulations at all levels of manufacturing, testing and sale. Issues related to Pharmaco-economics, Pharmaco-epidemiology and Pharmaco-vigilance will be addressed.
- Healthcare commissions will be further strengthened, established and made functional in all provinces and areas.

## **2: Universal Health Coverage**

- A generic Essential Package of Health Services (EPHS) for ensuring UHC will be developed through a consultative process and based on Disease Control Priorities – Edition III. The package will be implemented through five platforms:
  - i) Population based;
  - ii) Community level;
  - iii) Primary healthcare centre level;
  - iv) First level hospital;
  - v) Tertiary hospital level.

Development of quality standards and costing will be an integral part of the exercise to make rational decisions. The package will be applicable both for the public and private sector.

- The **EPHS** will have **four sub-packages** of services:
  - a: Reproductive, maternal, new-born and child health services and nutrition;
  - b: Communicable diseases with a priority to tuberculosis, Hepatitis, HIV&AIDS, Malaria and other WASH related interventions;

c: Non-communicable diseases including mental health with a priority to hypertension, diabetes, cancer screening and tobacco control measures;

d: Services access and quality with a focus on essential health workforce, meeting threshold for hospital beds, essential medicines and equipment and international health regulations

- Public and private health facilities meeting the quality standards of EPHS will be involved in the implementation of 'Family Practice Approach'. Medical records of all families will be kept in a nearby health facility (public or private) and Smart cards will be issued to the families to access health services and referral services.
- Public sector doctors, general practitioners and nurses will be trained on 'Family Medicine' with option for e-courses.
- Community mobilization will be ensured through lady health workers and their number will be increased from 93,000 to >160,000 along with measures for provision of quality services.
- Referral linkages will be developed between Primary Health Care (PHC) facilities (public and private) and referral hospitals to reduce unnecessary PHC workload on hospitals and to serve as gatekeepers for accessing health insurance services.

### **3: Specialized Hospital Care**

- Bed capacity in current hospitals will be increased along with construction of new hospitals to ensure hospital bed threshold of 18 beds per 10,000 population is achieved along with private sector.
- Private sector and charity organizations will be encouraged to open new hospitals (especially in socio-economically poor districts) and meeting the standards for linkage with health insurance programme.
- Equipment and services in hospitals will be modernized with development and implementation of essential equipment lists.
- Services for care of disabled and old age people will be a priority. Availability of free essential assistive devices will be launched in phased manner.

#### **4: Health Financing**

- Overall government expenditure on healthcare will be increased from a level of 0.91% in 2016-17 to 5% of GDP (by 2023). Efficiency, effectiveness and economy in health care spending will be improved especially at all levels.
- Pro-poor social protection initiatives including the Health Insurance Programme will be financed and scaled up to all districts in Pakistan by 2020 covering the poorest segment of society and the ceiling per family will be enhanced to a maximum of Rs. 720,000 per year.
- Alternate mode of financing e.g. 'Sin Tax' on harmful substances like cigarette, fizzy sugary drinks etc. will be introduced, with dedication of the collected amount only for health sector. Corporate sector e.g. oil companies, vehicle manufacturers etc. will be involved to perform corporate social responsibilities in tackling the burden of non-communicable diseases and health issues related to ambient air, noise pollution etc.
- Financing initiatives (conditional cash transfers, vouchers) will be launched to facilitate access to essential primary and secondary health services and priority diseases with a focus for coverage for the entire population, and protected through necessary legislation.
- Private sector participation in provision of publically provided health services will be increased by outsourcing through transparent competitive process. Health services reforms like contracting out of primary health care facilities and hospitals that are already underway will focus on strengthening of services. Innovative management models that align with preventive primary health targets will be tested.
- Public private partnerships will be explored for joint ventures including health financing.

#### **5: Medicines and Health Technologies**

- Capacity of procurement, logistic and supply chain management system will be enhanced for regular, uninterrupted and adequate availability of essential drugs and other health commodities at all levels of health care.

- Zero tolerance for availability of spurious and low quality medicines in public or private sector with a system of strict penalties in all districts.
- Essential drugs list will be regularly reviewed conforming it to burden of various diseases in different provinces/ areas. Staff will be trained on rational use of drugs while considering the challenge of antimicrobial resistance.
- Essential equipment list for different level of healthcare system will be developed based on evidence and the same will be implemented.
- Irrational procurement of medicines and other technologies will be addressed by identifying in the essential health service delivery packages, the quantity and type of equipment, supplies, and medicines needed to deliver the defined services for each of health facility at different levels of governance.
- Proper and sufficient storage of essential medicines will be ensured. Pricing and quality of drugs will be ensured by enforcement of drug regulations at all levels of manufacturing, testing and sale.

## **6: Human Resources for Health**

- Production capacity of nurses and LHVs will be doubled in the current nursing schools. New nursing schools will be opened both in the public sector and in the private sector.
- Decent job opportunities for health workforce will be increased both in the public and private sector. Healthcare commission and authorities will strictly regulate the minimum number and standards of HRH in health facilities and hospitals.
- Quality of medical education will be improved through enforcement of standards and accreditation to enhance health workforce productivity. For this purpose, structural reforms of regulatory bodies, review of their terms of references, enforcement of accreditation rules and regulations, and review of standards and curricula will be undertaken.
- Pre-service and in service training facilities will be established for different cadres of health workers. Medical education curriculum will be revised and updated with a focus on community-oriented medical education at

all levels. Faculty positions will be filled in all educational institutions with trained and qualified faculty. Continuous Medical Education for health professionals will be institutionalized and made mandatory for continuation of practice.

- Human Resource for Health Registries at provincial and national levels will be maintained electronically to facilitate forecasting, planning and monitoring of workforce deployment and development, along with National Health Workforce Accounts at national level.

## **7: Health Information System**

- Scope and content of health data system will be broadened to monitor Vision 2025, SDGs and 12th Five Year Plan health target progress and vital statistics like births and deaths. This will also link to an effective real time integrated disease surveillance, emergency preparedness and response system.
- Community based information collection will be strengthened and integrated along with rest of vertical programmes MIS with DHIS and further with DHIS II software platform. Tertiary healthcare information system will be established along with linkages with the provincial health information system initially and later on with the private healthcare facilities. Quality of information collected will be validated through appropriate quality assurance mechanisms.
- Capacity of health management staff will be enhanced on use of health information and organize an information database containing research studies, reports, literature and relevant documentation pertaining to health sector and its dissemination.
- Institutional set-ups for health sector data and implementation progress at different tiers of health governance will be established and synchronized. Culture of Evidence to Policy conduits will be strengthened.
- 'One Health Survey' will be designed and conducted to monitor health related SDGs at national, provincial and district/ constituency level on a regular basis, in collaboration with different partners.
- Research organizations will promote commissioned research in the country.

## **8. High-threat infectious outbreaks prevented, detected and responded**

- Real time Integrated Disease Surveillance and Response System will be scaled up after initial piloting and assessment. And will also be linked up with One Health across the country.
- Skilled health workforce to tackle the challenges will be produced to build the required capacity to establish integrated disease surveillance and response system in all districts and key points.
- High quality Public Health laboratory networks will be scaled up for immediate diagnosis of outbreaks and decision making / response across the country.
- Linkages will be developed with other line ministries and departments for an effective response (One Health).
- The Ministry of NHR&C will ensure strengthening and functional health establishments at 19 Points of Entry (POEs) along with quarantine facilities to ensure safe travel and trade.
- Contingency plans for POEs will be readily available and will be immediately activated in case of epidemic or health hazards.

## **9. Health Emergency Preparedness**

- Country core capacities related to International Health Regulations and Global Health Security and monitoring the same will be strengthened through continuous reforms and preparation. National Institute of Health as National focal point for IHR will be strengthened to perform essential public health function as a National Public Health Institute.
- Capacity will be developed to assess and report on hazard emergency preparedness.
- Minimum core capacities for emergency preparedness and disaster risk reduction will be developed in collaboration with Disaster Management Authorities.
- Operational readiness will be ensured to manage identified risks and vulnerabilities related to health.

- Work will be carried out on regulatory and operational preparedness for public health emergencies.

#### **10: Determinants of Health**

- There will be focus on developing inter-sectoral linkages and cross sectoral actions adopting 'One Health' and 'Health in All Policies' particularly in the area of communicable and non-communicable diseases to prevent deaths and disabilities especially for which actions lies beyond the scope and mandate of health sector.
- Provincial governments will work with stakeholders across sectors on health related priorities including advocacy, behavioral change communication, information exchange etc. in pursuit of Vision 2025 and SDGs.
- Efforts will be geared towards recognition of community involvement.
- Women empowerment, and local/ rural development will be the key channels for cross-sectoral action.
- Strengthening monitoring highlighting equity and gender issues

#### **11: Financial, Human, Administrative resources management**

- Capacity on financial, human, administrative resources management will be built at all national, provincial and district level.
- Transparency, efficient use of resources and effective delivery of results at all levels will be ensured
- E-office will be introduced in the health sector.

**Targets and Achievements of 11<sup>th</sup> Five Year Plan**

	Goals		Benchmark	Targets	Achievements
		Units	2012-13	2018	2017-18
1	Infant Mortality Rate (IMR)	per 1000 lb	74	40	62 <sup>13</sup>
2	Child Mortality Rate (CMR)	per 1000 lb	89	52	74 <sup>13</sup>
3	Immunization (i) Infants 12- 23 months	percent	54	>90	66 <sup>13</sup>
	(ii) Measles Coverage	percent	81	>90	73 <sup>13</sup>
4	National Program for Family Planning & Primary Healthcare				
	1. Lady Health Workers	No	98,000	130,000	92,949 <sup>10</sup>
	2. Coverage of population	percent	83	100	60 (with new population estimates)
5	Control of HIV/AIDS				
	1. HIV prevalence among pregnant women	percent	0.041	To be reduced by 50%	0.09
	2. HIV prevalence among vulnerable groups	percent	0.2	To be reduced by 50%	0.1
6	T.B/ Malaria Control Program				
	1. Population in Malaria high risk areas using effective treatment/Bed nets	percent	40	75	50% 3.3 Million LLIN
	2. Incidence of Tuberculosis	per 100,000	230	45	270 <sup>11</sup>
	3. Proportion of TB cases detected and cured under DOTS	percent	Detected=69% Cured= 90 %	Detected=76% Cured= 95 %	69% and cure rate 93%
7	Maternal Mortality Ratio	per 100,000	260	140	165.6 <sup>12</sup>
8	Skilled personnel attending deliveries	percent	52	>90	69 <sup>13</sup>
9	Pregnant women having at least 3 antenatal consultation	percent	62	100	73 <sup>14</sup>

<sup>10</sup> LHWP database, December 2017<sup>11</sup> WHO TB Country Profile Pakistan 2015<sup>12</sup> NIPS PDHS estimates<sup>13</sup> Pakistan Demographic Health Survey 2017-18<sup>14</sup> UNICEF (<https://data.unicef.org/country/pak/>)

## Annexure B

Baseline and Target Setting: Ministry of National Health Services, Regulations and Coordination											
Indicator		National Baseline	Source/ Year	Milestone 2020	Milestone 2025	Target 2030	Global Target 2030	Disaggregation Available	Preferred Source	Lead Ministry	Reporting Agency
2.2.1	Prevalence of Stunting (height for age <-2 SD from the median of the WHO Child Growth Standards) among children under 5 years of age (%)	Stunting: 44.8	PDHS 2012-13	35	30	22	<1	Province	One Health Survey / PDHS	Minsistry of NHR&C	National Institute of Population Studies
2.2.2	Prevalence of Malnutrition (weight for height >+2 or <-2 SD from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight) (%)	Wasting: 10.8 Overweight: 3.2	PDHS 2012-13	7 3	5 3	3 3	<1	Province	One Health Survey / PDHS	Minsistry of NHR&C	National Institute of Population Studies
3.1.1	Maternal Mortality Ratio ( per 100,000 live births)	276 178	PDHS 2006-07 UNIA 2014-15	148	120	<95	<70	Province	One Health Survey / PDHS/UNIA	Minsistry of NHR&C	National Institute of Population Studies
3.1.2	Proportion of births attended by skilled health personnels (%)	58	PSLM 2014-15	72	80	>85	>90	District	One Health Survey / PDHS/PSLM	Minsistry of NHR&C	National Institute of Population Studies
3.2.1	Under 5 mortality rate (per 1,000 live births)	89 81.9	PDHS 2012-13, UNIA 2014-15	70	59	49	<25	Province	One Health Survey / PDHS/ UNIA	Minsistry of NHR&C	National Institute of Population Studies
3.2.2	Neonatal mortality rate (per 1,000 live births)	55 47.3	PDHS 2012-13, UNIA 2014-15	40	35	30	<12	Province	One Health Survey / PDHS/ UNIA	Minsistry of NHR&C	National Institute of Population Studies
3.3.1	Number of new HIV infections per 1000 uninfected population by sex,age and key population	0.09	UNAIDS 2014-15	<0.12	<0.15	<0.19	<0.1	National	UNAIDS	Minsistry of NHR&C	National AIDS Control Program
3.3.2	Tuberculosis incidence per 100,000 population	270	TB Survey 2011-12 PDHS 2012-13	267	230-264	212-261	<54	Province	PHRC	Minsistry of NHR&C	Pakistan Health Research Council
3.3.3	Malaria Incidence per 1,000 population	8.56	Malaria Survey 2013-14 / PHRC	3.9	2	<1	<1	Province	PHRC	Minsistry of NHR&C	Pakistan Health Research Council
3.3.4	Hepatitis B incidence per 100,000 population	72	Hepatitis Survey 2007-08 / PHRC	64	54	45	<1	Province	PHRC	Minsistry of NHR&C	Pakistan Health Research Council
3.3.5	Number of people requiring interventions against neglected tropical diseases	31,056	NIH,WHO Estimates 2015		<20,000	<10,000	<1	Province	WHO Estimates	Minsistry of NHR&C	National Institute of Health (NIH)
3.4.1	Mortality rate attributed to Cardiovascular disease, cancer, diabetes or chronic respiratory	24.7	Global Health Estimates 2015	24.7	23	20	17	National	WHO	Minsistry of NHR&C	Minsistry of NHR&C
3.4.2	Suicide mortality rate (per 100,000 population)	2.1	WHO 2015		1.9	1.8	<1	National	One Health Survey / PDHS	Minsistry of NHR&C	National Institute of Population Studies
3.5.1	Coverage of prevention / treatment of substance abuse (%)	10	UNODC, WHO 2015	10	15	35	>80	National	WHO	Minsistry of NHR&C	National AIDS Control Program
3.5.2	Total alcohol per capita (>15 years) consumptions (litres of pure alcohol)	0.2	WHO GISAH 2017		0.2	0.2	-	National	WHO	Minsistry of NHR&C	National AID Control Program
3.7.1	Proportion of women of reproductive age (aged 15-49 yrs) who have their need for family planning satisfied with modern method (%)	47	PDHS 2012-13	54	60	70	>95	Province	One Health Survey / PDHS	Minsistry of NHR&C	National Institute of Population Studies
3.7.2	Adolescent birth rate (aged 10-14 yrs, aged 15-19 yrs) per 1000 women in that age group	38.3	PDHS 2012-13	35	32	29	<10	National	One Health Survey / PDHS	Minsistry of NHR&C	National Institute of Population Studies
3.8.1	Coverage of essential health services defined as UHC Index (%)	40	WHO & WB 2015	53	58	65	>80	Province	One Health Survey / PSLM	Minsistry of NHR&C	Pakistan Bureau of Statistics

Indicator		National Baseline	Source/ Year	Milestone 2020	Milestone 2025	Target 2030	Global Target 2030	Disaggregation Available	Preferred Source	Lead Ministry	Reporting Agency
3.8.2	Number of families covered by health insurance program	3.22 million	PM NHP 2018		14 million	20 million		District	WHO	Minsitry of NHR&C	PM's National Health Program
3.9.1	Mortality rate attributed to household and ambient air pollution (per 100,000 population)	87.2	WHO/ Global Health Observatory 2014-15			Tbd		National	WHO	Minsitry of NHR&C	Minsitry of NHR&C
3.9.2	Mortality attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe water, sanitation and Hygiene for All (WASH) services) (per 100,000 population)	20.7	WHO, Global Assessment environmental risks 2012			Tbd		National	WHO	Minsitry of NHR&C	Minsitry of NHR&C
3.9.3	Mortality rate attributed to unintentional poisoning (per 100,000 population)	1.5	WHO, Global Health Estimates 2014-15			Tbd		National	WHO	Minsitry of NHR&C	Minsitry of NHR&C
3.a.1	Age standardized prevalence of current tobacco use among persons aged 15 yrs and older (%)	12.4	PBS/ GATS 2014	12.2	12	Tbd		Province	PBS	Minsitry of NHR&C	Pakistan Bureau of Statistics
3.b.1	DPT3/Penta3 Immunization coverage (%)	65.2	PSLM 2014-15	76	79	>80	>95	District	One Health Survey / PSLM	Minsitry of NHR&C	Pakistan Bureau of Statistics
3.b.3	Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis (%)	65	HFA 2012	75	80	>95	>95	District	HFA	Minsitry of NHR&C	Departments of Health
3.c.1	Healthworker density and distribution (per 10,000 population)	14.1	PMDC, PNC 2015	16	20	34.4	44.5	Province	PMDC, PNC	Minsitry of NHR&C	PMDC, PNC
3.d.1	International Health Regulation (IHR) capacity and health emergency preparedness (%)-19 capacities -13 capacities	48 53	WHO JEE 2015	55 60	63 68	>75	>90	Province	JEE WHO	Minsitry of NHR&C	National Institute of Health (NIH)
5.2.1	Proportion of ever partnered women and girls aged 15 yrs and older subjected to physical, sexual or psychological violence by a current or a	38.5	PDHS 2012-13			Tbd		Province	One Health Survey / PDHS	Minsitry of NHR&C	National Institute of Population Studies
5.2.2	Proportion of ever partnered women and girls aged 15 yrs and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence (%)	NA							One Health Survey / PDHS	Minsitry of NHR&C	National Institute of Population Studies
5.3.2	proportion of girls and women aged 15-49 yrs who have undergone female genital mutilation/cutting by age (%)	<0.1	WHO 2015	<0.1	<0.1	<0.1	<0.1	National	WHO	Minsitry of NHR&C	Minsitry of NHR&C
5.6.1	Proportion of women aged 15-49 yrs who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (%)	47	PDHS 2012-13	54	60	70	>95	Province	One Health Survey / PDHS	Minsitry of NHR&C	National Institute of Population Studies
6.2.1	Proportion of population using improved sanitation (%)	73	PSLM 2014-15	75	78	82	100	District	One Health Survey / PSLM	Minsitry of NHR&C	Pakistan Bureau of Statistics
11.7.2	Proportion of persons victim of physical or sexual harrasment, by age, sex, disability status place of occurrence in the previous 12 months (%)	NA							One Health Survey / PDHS	Minsitry of NHR&C	National Institute of Population Studies
16.1.3	Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months (%)	NA							One Health Survey / PDHS	Minsitry of NHR&C	National Institute of Population Studies
16.1.4	Proportion of population that feel safe walking alone around the area they live (%)	NA							One Health Survey / PDHS	Minsitry of NHR&C	National Institute of Population Studies
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	NA							One Health Survey / PDHS	Minsitry of NHR&C	National Institute of Population Studies

Indicator		National Baseline	Source/Year	Milestone 2020	Milestone 2025	Target 2030	Global Target 2030	Disaggregation Available	Preferred Source	Lead Ministry	Reporting Agency
	<b>NT.1. Population growth rate</b>	2.4 2.04	Intercensal 1998-2017 NIPS 2017	2	1.9	1.8	-	Provincial	PDS	Minsitry of NHSR&C	Pakistan Bureau of Statistics
	<b>NT.2. Total fertility rate</b>	3.8	PDHS 2012-13	3.5	3.2	2.9	-	National	One Health Survey / PDHS	Minsitry of NHSR&C	National Institute of Population Studies
	<b>NT.3. Hospital bed per 1,000 population (public sector only; private sector data partially available)</b>	0.62	PBS 2016					Provincial	PBS	Minsitry of NHSR&C	Pakistan Bureau of Statistics
	<b>NT.4. Physicians per 1,000 population</b>	0.8	PMDC 2015					Provincial	PMDC	Minsitry of NHSR&C	PMDC
	<b>NT.5. Dentist per 1,000 population</b>	0.1	PMDC 2015					Provincial	PMDC	Minsitry of NHSR&C	PMDC
	<b>NT.6. Paramedics per 1,000 population</b>	NA	-					NA	Paramedic Council (legislation in process)	Minsitry of NHSR&C	Paramedic Council (legislation in process)
	<b>NT.7. LHV per 1,000 female population</b>	0.12	PNC 2017					Provincial	PNC	Minsitry of NHSR&C	PNC