"Well and Healthy Balochistan"

Health Sector Strategy
2018 - 2025

ACKNOWLEDGEMENT

I highly appreciate the efforts made by the Health Department Team in developing the Health Sector Strategy for Balochistan Province. Undeniably, this strategy will support the Health Department to follow the road map in achieving the targets focusing SDGs-3.

I also appreciate the initiative taken by the Health Department Team to embark on the arduous task of developing the Health Strategy for the province of Balochistan through holding series of consultations with all the Program Managers and experts enabling to bring out the final product of immense importance which was essentially required as a guiding document for carrying out specific activities under various programs to achieve the desired objectives efficiently in stipulated time frame.

I owe my candid thanks to the following for their kind consultation, hard work, devotion and valuable contribution in developing the Health Sector Strategy.

- **Mr. Syed Skindar Shah, Special Secretary Health, Balochistan**
- **Dr. Muhammad Tariq Jafar, Divisional Director Health Services, Quetta Division**
- **Dr. Shakir Ali Baloch, Provincial Coordinator EPI / MNCH Balochistan**
- **Mr. Shah Jehan Chief of Section (Health & Nutrition), P&DD, Balochistan**
- **Dr. Muhammad Hayat Roonjha, Director Health Services (Public Health) PHD, Quetta**
- **Dr. Tahira Kamal Baloch , Chief Health Sector Reform Unit (HSRU) , Balochistan**
- **Dr. Saeedullah Khan, Team Leader (Mercy Corps) Quetta**
- **Dr. Farooq Azam Jan, Ex-Director General Health Services, Balochistan**

I would like to pay special thanks to TRF consultants for their worthwhile input in configuring the basic outline of the Health Sector Strategy, which helped enormously to further amplify and develop the final document. Not the least the generous support provided by UNICEF for printing of this strategy document is much appreciated.

I earnestly hope that the spirit of partnership will continue and will be intensified to put this strategy in to implementation for the betterment of the people of Balochistan and also congregate the National and international commitment in the context of Sustainable Development Goals (SDG-3)

(Dr. Masood Qadir Nousherwani)
Director General Health Services
Balochistan

Department of Health Government of Balochistan (GoB) developed its Health Policy 2018-30 with the support of World Health Organization (WHO). The policy goal is to achieve Universal Health Coverage and the targets as set forth for Sustainable Development Goal (SGD) -3. The policy will provide vision, direction and guidelines for different components of health system and services as a long-term plan for Health System Strengthening. Balochistan Health Sector Strategy (2017–2022) has been revised and aligned with the Health Policy 2018-30 to serve as a vehicle for investment in the health sector. The strategy (2018 – 2025) has an action plan and monitoring mechanism to measure the progress of achievements of the provincial targets.

On behalf of Health System Strengthening Unit (HSSU) Government of Balochistan, I would like to express my gratitude to WHO for its generous support. I am particularly grateful to Dr. Assai Adakai, WHO Country Director Pakistan for his visionary leadership, dedication, technical inputs and positive attitude. I would like to acknowledge the valuable contribution of Dr Jamal Nasheer WHO Country office. I am highly grateful to Dr. Ehsanullah Tarin (Consultant) for his technical support and kind cooperation. Last but not least I would like to extend special thanks to Dr. Babar Alam WHO Provincial Head Balochistan and his dynamic team including Mir Beberg Mengal, Dr Asfand yar Sherani, Dr Dawood Riaz Baloch and Mr Younus Baloch for providing the overall technical, financial and logistic support to achieve the task of completing the policy and strategy documents

Dr. Tahira Kamal Baloch
Chief Coordinator
HSS – Unit Balochistan

Table of Contents

Balochistan health sector strategy, 2018-25

1. Background

Health department, government of Balochistan framed its health policy 2018-30. Aiming to achieve universal health coverage and targets as set forth for SDG-3, it will provide direction and guidelines for different components of health system and serve as a long term plan for health system strengthening.

Aligned with the provisions of the health policy, the Balochistan Health Sector Strategy (2018-23) has been developed to serve as a vehicle for investment in health sector. Essentially, it builds on Balochistan Health Sector Strategy (2017-22) and provides a medium term plan for health system development. The last year (2023-24) in the life of the strategy will mark its evaluation, coinciding with mid-term evaluation of Balochistan Health Policy. Lessons learnt from evaluation will be used in revising and updating both documents: Balochistan Health Policy (2018-30) and Health Sector Strategy (2018-23).

A system wide approach to health system development has been envisaged: all building blocks of the health system are therefore addressed in Balochistan Health Sector Strategy (2018-23). Because, health in humanitarian emergencies and compliance to IHR, 2005 are relatively neglected areas, a separate section is assigned. Likewise, capacity of Health Sector Strengthening Unit will be built in order to coordinate implementation of Balochistan Health Policy (2018-30) and Health Sector Strategy (2018-23). The directorates in health department will implement relevant components of health sector strategy; and for that purpose in each of these directorates a project implementation unit will be established.

Balochistan Health Sector Strategy (2018-23) is presented as a set of eight log frames: one each for six building blocks of health system; one for health in humanitarian emergencies and compliance to IHR, 2005; and another for capacity building for implementation and management of strategy. These log frames are however preceded by sections on planning process and monitoring and evaluation, but firstly the vision and objectives of Balochistan Health Sector Strategy (2018-25) are presented.

2. Vision

Well and healthy individuals, families and communities in all over Balochistan, whose health needs especially of the poor, underserved and vulnerable receive attention without facing financial hardship and that health is in all policies of other sectors in the province.

3. Objectives

Within the ambit of the vision, the objectives of the Balochistan Health Sector Strategy (2018-23), are framed in the wake of the health challenges facing the province and in an effort to achieve targets defined under SDG-3 enunciated in Balochistan Health Policy (2018-30). These objectives, which are translated into the outcomes of Balochistan Health Sector Strategy (2018-23), are as below:

1. Address the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases;
2. Achieve universal health coverage, including financial risk protection and access to quality health-care services with a focus on primary health care;
3. Ensure universal access through life course to integrated reproductive (including family planning) maternal, neonatal, child health-care and nutrition services across province;
4. Reduce premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being;
5. Introduce reforms with a particular attention to system design for ensuring effective oversight, regulation, accountability, health in all policies, inter-sectoral collaboration and partnership;
6. Substantially increase investment in the health sector and enhance recruitment, development, training (pre and in-service) and retention of health workforce particularly in rural areas;
7. Ensure access by all to essential medicines and vaccines, which are safe, effective, good quality and affordable;
8. Build information system and ensure the availability of high-quality, timely and reliable data and reports for decision making
9. Enhance capacity in health emergency preparedness and compliance to International Health Regulations (IHR, 2005) and reduce deaths and injuries from road traffic accidents; and
10. Improve implementation capacity by enhancing managerial support, financing the envisaged interventions and tracking and evaluating the progress.

4. The context: situational analysis

The process for the framing of Balochistan Health Sector Strategy (2018-25) benefitted from that developed for Balochistan Health Policy (2018-30). But, it relies mainly on that developed for Balochistan Health Sector Strategy (2017-22)[1]. Following health system"s building block, it is summarized as below and may be read together with the context developed for Balochistan Health Policy (2018-30):

4.1. Service delivery

- There is absence of a pro-poor integrated essential package of services and medicines;
- Lifeline programs are facing shortage of resources, infrastructure and staff;
- The performance of TB-DOTS programs is very low; and likewise diagnosis and treatment services for malaria cases below district level are highly inadequate;
- The immunization program is historically performing sub-optimally; and with weak supportive supervision of PHC basic EmONC services is non-existent at PHC facilities level.
- Secondary care hospitals are not well equipped and staffed to effectively provide quality services, especially comprehensive EmONC services are not available in districts resulting in the Tertiary care hospitals are overburdened.
- Tertiary care hospitals are not providing services according to capacity; The Medical Superintendents lack even minimal autonomy to manage services.

[1] Health Department, Government of Balochistan, Balochistan Health Sector Strategy, 2017-22 pp 4-6

- NGOs have a potential of providing healthcare to citizens, especially poor and marginalized, but need to be coordinated and regulated in accordance with policy of the Government; this is an untapped potential, which can be used for expanding healthcare for poor and needy.

4.2. Governance and leadership

- The governance and accountability processes have been weak, reflected in poorly planned and maintained healthcare network in the province;
- The development planning has not been able to address health inequalities within and between districts and performance of public sector health institutions is sub-optimal;
- Public health planning is concentrated around infectious diseases, while non-communicable diseases remain almost outside the mainstream agenda.
- The Public Private Partnership under Peoples Primary Healthcare Initiative (PPHI) and other Organizations lacks an institutional framework for establishing key elements of contracting and setting targets for the organizations" performance evaluation;
- The regulation of „for-profit" private health sector is weak; and likewise drug and medicine regulation has been poor in the province;

4.3. Health financing

- The government general expenditure on health as percent of total government general expenditure is too small to cope with health needs of the population, resulting in high out- of-pocket health expenditure;
- Government of Balochistan has not fully taken over the financing and management of preventive programs and community based PHC services after 18th Amendment.
- There are capacity gaps in managing the financial systems and procedures, resulting in major inefficiencies in public sector spending.
- The audit systems are functioning, but sub-optimally. The PIFRA/SAP system is partially functional, while New Accounting Model (NAM) Chart of Account is partially used for the preparation of budget.
- Households in the lowest income quintile spend much higher proportion of their total expenditure on health seeking than those in the richest quintile.

4.4. Health workforce

- Minimum essential staff and infrastructure requirements are not fully met in a large proportion of primary and secondary health care facilities;
- There is inequity in the availability of doctors, paramedics and LHWs amongst districts and the levels of health facilities;
- Human resource production capacity, deployment, staff mix and skill mix, and gender balance is inadequate, especially in rural health services;
- The health sector is facing shortage in all female health cadres and specialists;
- The policy for continuing medical education (CME) is virtually non-existent;
- While supportive supervision of primary health care services is lacking, the reward system for certain staff categories needs to be rationalized.

4.5. Medical products

- Expenditure on medicine and vaccine as percent of total health expenditure exceed 52%, yet there is shortage and stock outs at health facilities;
- The lack of essential drugs programme combined with freedom to prescribe in the absence of clinical practice guidelines contributes to irrational prescription;
- The inventory management system is weak; and distribution is not equity based, without a distribution plan and rationalization; and there is no system for repair and maintenance.
- The Logistics Management System is almost non-existence;
- The expenditure on medicines at the PHC facilities is low at 7% of the total expenditure; and there is no provincial essential drugs list and facilities" specific formularies
- Medical equipment is not equitably available across health facilities and is not being utilized optimally due to lack of the required human resource.

4.6. Health information

- The health information system is built on DHIS. Data generated at primary health care facilities (MCH centers, civil dispensaries, basic health units, and rural health centers) is collected manually. It is digitized and consolidated at district level, where the information from secondary health care (tehsil and district headquarter hospitals) consolidates for generating a district report, but no analysis is done.
- Tertiary care hospitals report direct to the provincial health Information center. The data from districts and tertiary care is received online and analyzed (cumulative data of province, divisions, district and health center) only at provincial level.
- There is no empirical study done to assess health information system, but there is anecdotal evidence that reporting from districts and tertiary care is regular, but within districts the regularity is 80%, while there are issues in completeness and correctness. LQAS conducted (2017) in two districts found correctness is 50 to 60%. Data and reports generated by vertical programmes do not integrate with DHIS.
- The monitoring and accountability mechanisms are not well routed for ensuring results based management. Logistic information of district health facility is missing, and no working mechanism for repair of equipment.

4.7. Health in humanitarian emergencies

- Balochistan is a disaster prone province. There have been droughts, floods, landslides and mudslides, earthquake and large scale epidemics affecting the health of the populations and disrupting the public health system. In addition, there are man-made emergencies. A

provincial disaster management authority (PDMA) has been established to deal with emergencies both natural and man-made.

- Health is represented and is part of the PDMA. However, in order to effectively deal with emergencies, there is a need to institute measures aiming at mitigation, preparedness and response. Implementing international health regulations is a related issue; and it may be prudent to establish in health department an entity, "emergency risk management and international health regulations (ERM&IHR)".

5. Balochistan Health Sector Strategy (2018 -25): planning process

5.1. Developing Logframes

The issues were prioritized in the given context or situation analysis (section-4), and strategic directions were defined, aligning those essentially with the health system building blocks and SDG-3 targets. Accordingly, as the basis of operational planning, logframes are developed and presented in section 6.

5.2. Operational plans

The priorities and strategic directions envisaged in Balochistan Health Sector Strategy (2018-23) are used in guiding the development of PC-II forms or concept papers. Upon approval of PC-II forms by the Planning and Development Board, Government of Balochistan, operational plans, i.e. PC-I forms are developed. These plans serve to seek funding and defining detailed modalities for their implementation.

5.3. Resource implications of Balochistan health sector strategy

For the implementation of health sector strategy over five years a total of RS 62,710 million as capital is required. Under the new development schemes consequent to implementing the strategy, new posts will be created and institutions will be established. The recurrent cost of these new posts and institutions is estimated @ 20% of the capital cost in respective year or a total of RS 12,542 million for five years. Thus, in order to implement health strategy, a total of RS 75,252 million will be required over five years. During 2023-24, the health policy will be reviewed for its financial and physical progress on implementation; and accordingly financial projections for the remaining life of policy will be made. This exercise will feed into framing health sector strategy for 2024-2030.

During 2017-18 RS 6,107 million is available under provincial social sector development programme (PSDP). Considering a yearly increase @5% using 2017-18 allocation as base, a total of RS 35,432 million will be available, leaving a total deficit of Rs 39,820 million. It is expected that the government of Balochistan will continue providing recurrent budget with a projected yearly increase @ 5.41% with allocation of RS 18,306 million during 2017-18 taken as base year.

Table-1: financial layout of Balochistan health sector strategy during 2018-23 (PKRs in million)						
Description	Yr1 (2018-19)	Yr2 (2019-20)	Yr3 (2020-21)	Yr4 (2021-22)	Yr5 (2022-23)	Total for 5 years
Capital cost for implementing Health sector strategy	3,023.7	11,885.95	16,181.45	18,286.45	13,332.45	62,710
Recurrent cost (estimated @ 20% of capital cost) due to new posts and institutions	604.74	2,377.19	3,236.29	3,657.29	2,666.49	12,542
Total financial needs of the health sector strategy	**3,628.44**	**14,263.14**	**19,417.74**	**21,943.74**	**15,998.94**	**75,252**
PSDP funds with yearly increase @5% with 2017-18 allocation of RS 6,107 million as the base year	6,412	6,732.97	7,070	7,423.10	7,794	35,432
Funding gap for implementing health sector strategy	**(2,784)**	**7,530**	**12,348**	**14,521**	**8,205**	**39,820**
Recurrent cost with projected yearly increase @ 5.41% with 2017-18 as the base year (which is RS 18,306 million)	19,296	20,339	21,439	22,598	23,820	107,492

5.4. Resources and flow of funds

Given the task of achieving universal health coverage, especially in the context of Balochistan health system, substantial funding will be required as indicated in table-1 above. In addition to the existing health sector allocations, development as well as non-development, following could be explored to finance the health strategy:

1. **Improve efficiency** in utilising the available resources: For example, at national level, the percentage share of Medicine/Vaccine in private and public sector are 49% and 66.67% respectively. Balochistan specific data on public sector expenditure on Medicine/Vaccine as percentage share is not available. At national level, it forms 52.22% of the total out of pocket health expenditure (PDHS, 2013-14).

   That is, roughly the public sector expenditure on Medicine/Vaccine is around 50% of the total health expenditure. If generic procurement and rational prescription is introduced, the expenditure of medicine/vaccine could be reduced to half or 25% of total public sector health expenditure, sparing funds for use in important areas, for example, for revamping the

Table-2: share of health expenditure		
Expenditure type	**Amount (Rs. million)**	**% of total**
Military	987	2.3
Provincial Government	13,979	33.1
Cantonment Board	10	0.0
Employment Social Security Institution	64	0.2
Zakat	34	0.1
PBM	73	0.2
Prov Abs/C	29	0.1
Out of pocket	23,702	56.2
NGOs	3,261	7.7
Donor	63	0.1
Total	**42,202**	**100**
Source: Pakistan NHA, 2013-14		

health care delivery network. That is, since the total public sector spending on health was RS 13,979 million during 2013-14, about RS 3,495 million can be made available (NHA, 2013-14).

2. **Unify financing sources**

   a. ***Establish a common funding platform:*** As in table-2, there are a number of entities in public sector involved in financing health. In addition to donors and NGOs that are discussed below, a total of RS. 1,197 million is contributed by a variety of parastatal agencies. A mechanism can be devised to unify these channels of resources and bring harmonisation in utilisation under a common funding platform. The coherence and harmonisation created in this manner will add to the value for the available money.

   b. ***Harnessing donors' support***: IHP+ (international partnership+) aims to improve aid effectiveness under Paris Declaration (2005) and Pakistan is its member. Most development partners, being member of IHP+ have moral binding to support health sector strategy, which already been drafted and will be aligned to health policy.

      During 2013-14, the donors contributed RS 63 million to health expenditure; and channeled to fund activities planned in the health sector strategy (NHA, 2013-14). The health department being proactive with partners in this manner could raise more funds. It is expected that health department by being proactive with partners could raise funds @RS 100 million that could be used as per preference of the particular donor and channeled to fund activities planned in the health sector policy/strategy.

      In addition, sources like Global Fund and HIV/AIDS, Tuberculosis and Malaria, GAVI Alliance, Bill and Melinda Gates foundation, USAID, JICA etc. could be explored to generate resources for funding the health sector strategy.

   c. ***Mainstreaming NGOs' contribution***: according to NHA, 2013-14, NGOs expenditure or contribution to the health sector during 2013-14 was RS 3,261 million. However, given the improved law and order situation, the NGOs" input has fallen. Actual figures are not available, but it is estimated to be around 500 million yearly. These funds can be streamlined and used for funding health sector as per preference of the particular NGO.

3. **Enhance public sector funding** : Total out of pock health expenditure, according to NHA, 2013-14, is RS 23,702 million or 56.2% of the total health expenditure. In order to reduce out of pocket expenditure and increasingly invest in revamping and expanding the health care infrastructure and education and training institutions for improving health workforce density, additional allocation by public sector will be required. In this regard, following options can be explored.

a. ***Re*-appropriation *of provincial general government allocation***: Provincial government contributes RS 13, 979 million or 33.1% of the total health expenditure

(NHA, 2013-14). Compared to that, the main bulk of health expenditure i.e. RS 23,702 million or 56.2% is out of pocket. As in table 3, total general government allocation for health (current and development) in 2016-17 was 7.34% of total general government allocation, which increased to 7.43% in 2017-18. **NB**: data on expenditure is not available; therefore allocation was used in computing the financial figures. As in table 3, compared to 2016-17, the recurrent allocation during 2017-18 increased by 5.41%. This increment in recurrent budget is also projected through life of strategy (table-1).

Table -3: Total general government allocation v/s Total general government allocation for health

Budget category	**2016 -17**	**2017 -18**
Total General Government Budget (current)	218,173,357,410	242,556,746,170
Total General Government Budget for Health (Current)	17,367,697,000	18,306,590,400
% General Government Budget (current) for health	**7.96%**	**7.55%**
Total General Government Budget (Dev.)	68,058,193,000	86,011,170,000
Total General Government Budget for Health (Dev.)	3,635,831,000	6,107,040,000
% General Government Budget (Dev.) for health	**5.34%**	**7.10%**
Total General Government Budget (Dev. + current)	286,231,550,410	328,567,916,170
Total General Government Budget (Dev. + current) for Health	21,003,528,000	24,413,630,400
% of Total General Government Budget (Dev. + current) for health	**7.34%**	**7.43%**
15% of Total General Government Budget (Dev. + current)		49,285,187,426
% increase in 2017 -18 compared to 2016 -17 for current budget		5.41%
% increase in 2017 -18 compared to 2016 -17 for development budget		68%
% increase in 2017 -18 compared to 2016 -17 for total allocation for health		16.2%

Source: Planning and development department, government of Balochistan

b. ***Enhancing allocation for health***: Drawing on the recommendations of Abuja Declaration (2001), the total general government health expenditure should be 15% of the total general government expenditure. Considering that 100% allocation is utilized, enhancing current allocation to 15% of total general government budget mean doubling the allocation for health to RS 49,285 billion per year.

While government of Balochistan may consider enhancing PSDP allocation, like in 2017-18, there is 16.2% increase compared to in 2016-17. However, in table 1, projection has been made for PSDP allocation considering there will be 5% yearly increase with 2017-18 allocation of RS 18,306 as base.

c. ***Grant from Federal government***: Government of Balochistan can request grant from federal government for meeting its social sector development programmes, especially in the health sector.

d. ***Loan (soft)***: the plans prepared for strengthening health system can be presented to the World Bank, Asian Development Bank etc. for funding.

5.5. Implementation

The Health System Strengthening Unit (HSSU) will be the custodian, responsible to coordinate the implementation of Balochistan health sector strategy. The health department will translate the priorities and strategic directions, enunciated in the strategy, into PC-IIs or concept papers. After PC-IIs are approved, detailed plans or PC-1 forms will be prepared and submitted the competent forum for their approval. It is envisaged that eight PC-1s will be prepared.

In order to accomplish this task, HSSU will be strengthened. Furthermore, for different PC-Is, the concerned sections and directorates within the department of health will be the implementation agencies. Also, a Project Implementation Unit or similar structures within the responsible directorates will be established. The Baluchistan health sector strategy will also serve as a platform to rally partners" support in health development not only to finance but also provide technical assistance for the envisaged interventions. In this regard, Pakistan being a member of WHO/IHP+ is eligible to use this forum as catalyst for seeking support of development partners.

Furthermore, in order to build the implementation and management capacity, the managers and key project staff will be trained, both in country and abroad. Major technical areas for training may include, project management, monitoring and evaluation, financial management, accounting and fiduciary control etc. In addition, standard operating procedures and guidelines for development projects will be developed and provided to the project staff for using as reference.

5.6. Monitoring and evaluation

5.6.1 M&E framework

The core indicators, drawn from log frames for each component of Balochistan health sector strategy, constitute the framework for monitoring and evaluation, as in figure-1.

According to the above framework, inputs introduced in the building blocks of health system will lead to the improved delivery of health services package with efficiency, equity and quality. Concurrent inputs to address social determinants of health like education, water and sanitation, food and nutrition are likely to substantiate the effect of inputs in the health system. Resultantly, the strategic objectives, enunciated as outcomes in the logframes, essentially aligned with SDG-3 targets, will be achieved. The overall impact of implementing the strategy will be the improved health status.

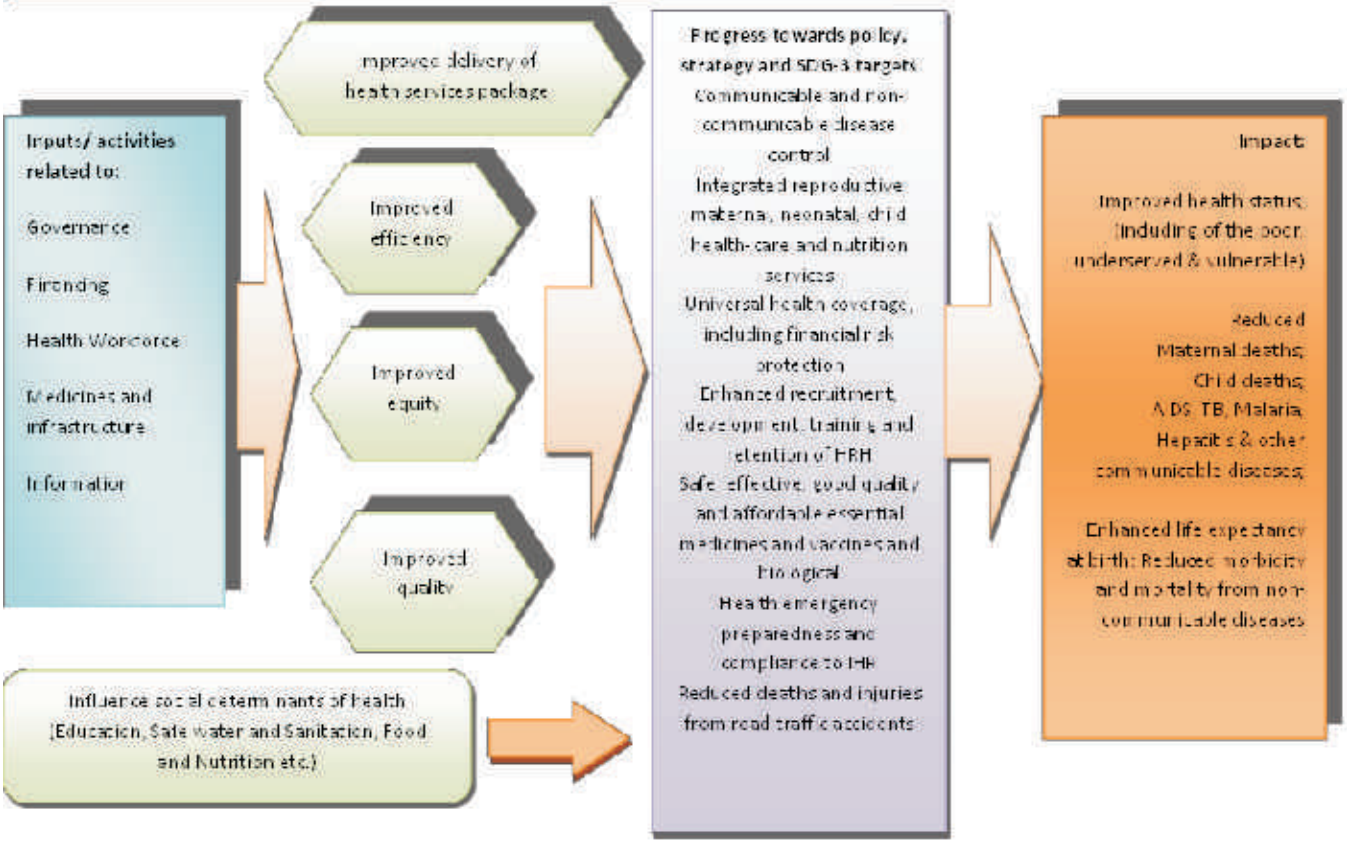
5.6.2 Data collection and analysis

The data sources for indicators are indicated in logframes (section 6 below). The major sources include:

- Routine health information system (DHIS) based on health facility reporting;
- Administrative sources, like government budgets, financial reports and human resources data;
- Population surveys like MICS, PDHS and household health services utilization and health expenditure surveys or joint comprehensive survey as proposed by National Ministry of Health Services, Regulation andCoordinaiton;

- Birth and death registration systems; and
- Project monitoring reports.

Figure 1: M&E framework (adapted from WHO building block model)



5.6.3 Review processes

The health department, while undertakes periodic reviews to monitor progress on implementation, a cross sectoral steering body will be constituted to:

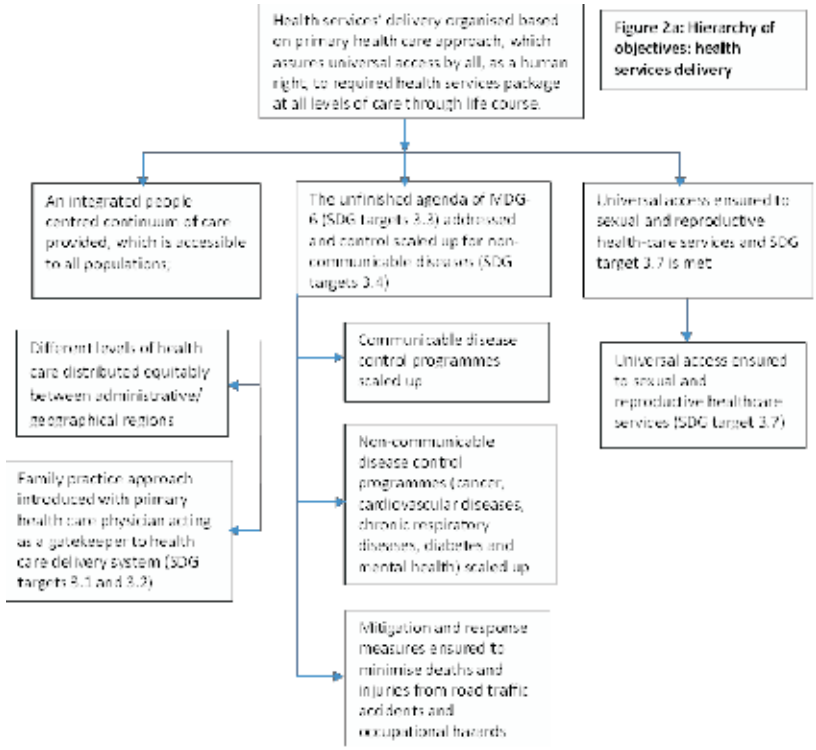
- Review progress against targets as set out in the strategy;
- Discuss key issues and barriers and emerging threats, requiring a response and opportunities;
- Highlight issues for next round of review and operational planning; and
- Share lessons and successful stories and draw attention to the least performing programmes and directorates and plan for support.

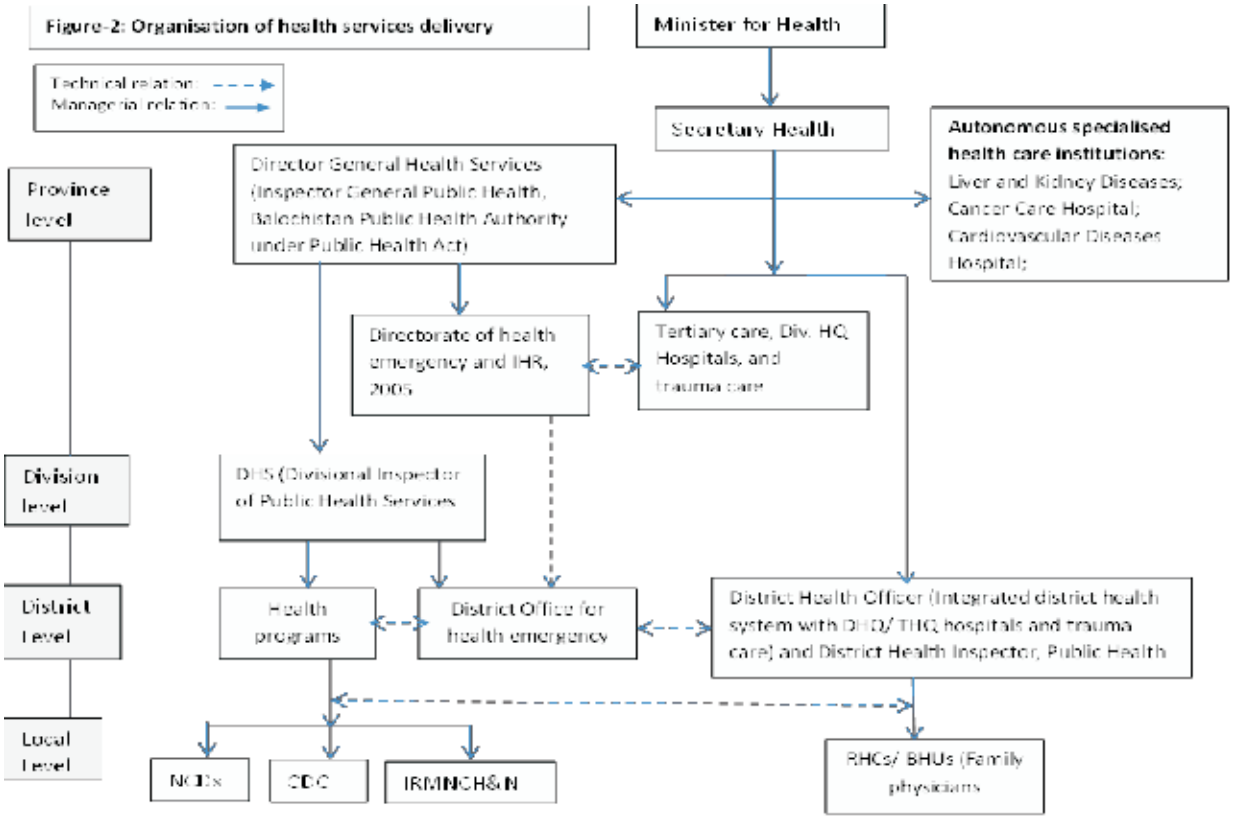
6. Log frames : strategic interventions

6.1. Health service delivery

the health services delivery in accordance with hierarchy of objectives in figure 2a and log frame will be revamped and reorganized as in figure-2.

Autonomous specialized health care institutions: Liver and Kidney Diseases; Cancer Care Hospital; Cardiovascular Diseases Hospital etc. will be established. Autonomy will be extended to tertiary care hospitals and health districts. At each divisional headquarter, including Quetta, there will be a tertiary care hospital with a trauma care center. Likewise, in each DHQ/secondary care hospital, a trauma care unit will be established. In districts the curative services, together with DHQ/ THQ/ secondary care hospitals, will be reorganized as (autonomous) integrated





District health system with a network of family physicians for providing people centered integrated health care through life course.

The Directorate General of Health Services (DGHS) will be restructured under Public Health Law, as the Balochistan Public Health Authority with hierarchical control over the divisional (DHS) and district (DHO) health services for health promotion and prevention programs (CDC, NCD, IRMNCH, Nutrition, National Program for FP&PHC, etc.). Under DGHS, a directorate of emergency and IHR, 2005 with branches in all districts will be established. These will interact laterally with tertiary care and DHQ/secondary care hospitals. Medico-legal services will be provided by the attending physician at trauma units and at different levels of care (THQ and RHC) with DHO heading the District Medico-legal board and DGHS as Provincial Medico-legal Appellant Board.

In the following, a detailed plan for reorganizing health service delivery is given.

Hierarchy of objectives	**Indicators**			**Means of verification**
Goal: Well and healthy people, whose health needs, especially of the poor, underserved and vulnerable, are effectively addressed. **NB:** The target for MMR, IMR and U5 years' mortality is to reduce by 50% of the baseline.	**Indicator** Life expectancy at birth (years): Maternal mortality per 100,000 live births Infant mortality per 1,000 live births Under 5 years mortality per 1,000 live births	**Baseline** 64.6 M; 62.2 F 785 97 111	**Target** 67.6 M; 65.2 F 393 48 56	Population survey reports
Purpose Reform and build a responsive health system that ensures access to the needed health services without facing financial hardship. **NB: health services** connote the provision through life course of promotive, preventive, curative, rehabilitative and palliative care. **Financial protection** means saving from paying for health, be it by government as in tax based system of health financing or through insurance.	By 2030, all population has access to quality health services By 2030, everyone has financial protection from out-of-pocket payments for health	NA NA	80% 100%	Health services utilization and expenditure survey (health accounts)

Hierarchy of objectives	**Indicators**	**Baseline (2017-18)**	**Target (2023-24)**	**Means of verification**
Outcome: **1. Health service delivery:**				

Health services" delivery organized based on the primary health care approach, which assures universal access by all, as a human right, to the required health services package at all levels of care through life course.	health care delivery network is revamped health care delivery network is expanded to meet the target in 2030 health services package available to the population	NA One health care facility for 7,923 people NA	All existing network One health care facility for 5,000 people > 40% of population	Health facility assessment Health services utilization survey
Outputs/deliverables (strategic interventions): 1.1 an integrated people centered continuum of care provided, which is accessible to all populations; 1.2. the unfinished agenda of MDG-6 (SDG targets 3.3) addressed and control scaled up for non-communicable diseases (SDG targets 3.4) **NB**: NCDs include cancer, cardiovascular diseases, chronic respiratory diseases, diabetes, injuries (including due to occupational hazards) and mental health	1.1 % of deliveries by SBAs 1.2 % of children < 23 months fully immunized 1.3 % of children U5 years who are stunted 1.2.1 Number of new HIV infections per 1,000 uninfected population, 1.2.2 Tuberculosis incidence per 100,000 population 1.2.3 Malaria incidence per 1,000 population at risk 1.2.4 Number of people requiring interventions against neglected tropical diseases 1.2.5 Hepatitis B incidence per	17.8% 16.4% 52.2% 0.76% 270 4.9 NA 72	>45% >45%	Population survey (MICS, PDHS) Surveillance/ programme data Household survey (history of illness) Surveillance/ programme data Population survey Household

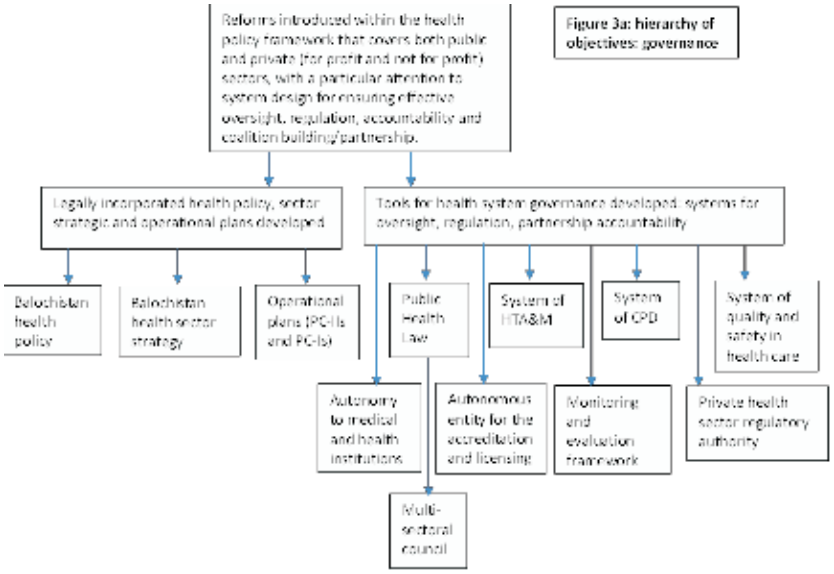
	100,000 population			survey (verbal autopsy)
	1.2.6 Mortality rate attributed to CDs	39% (National)		
1.3. universal access ensured to sexual and reproductive health-care services and SDG target 3.7 is met	1.2.7 Mortality rate attributed to NCDs	51% (National)	> 45%	Population survey (MICS, PDHS)
	1.3.1 % of women of reproductive age using modern methods of FP	16.3%	< 4%	
	1.3.2 adolescent birth rate per 1,000 women	7.8%		

Component 1.1: Provision of integrated people centered continuum of care	**Inputs (activities):**	**Resource estimates (RS in million)**
1.1.1 different levels of health care distributed equitably between administrative/geographical regions of the province **NB**: currently facilities/hospitals for different levels of care are inequitably distributed across the province. It is intended to scale up and expand/establish new health care facilities keeping in view epidemiological and demographical needs of regions and population. **NB**: The primary health care network include also the community level health outlets like CMWs birth station and LHWs Health houses.	1.1.1.1 Define health services" package for all levels (tertiary, secondary, primary) of care 1.1.1.2 Map health care network (tertiary, secondary, primary) across the province 1.1.1.3 Identify gaps and revamp health care network, ensuring it is equitably distributed 1.1.1.4 Identify gaps, geographical and demographic, and expand health care network, ensuring it is equitably distributed	25,018
1.1.2 family practice approach introduced with primary health care physician acting as a gatekeeper to health care delivery system (SDG targets 3.1 and 3.2) **NB**: through family practice approach it is possible to provide integrated people centered health care through life course. The family physician acts in such system as gatekeeper to refer the patients to the level of care required by the people.	1.1.2.1 Define and register catchment population for health care network 1.1.2.2 Strengthen integrated reproductive maternal, neonatal, child health and nutrition services 1.1.2.3 Strengthen referral system (bi-directional), including provision of transport 1.2.4 Integrate traditional and complementary medicine practitioners into PHC network and regulate their practice	4,010

Component 1.1: Provision of integrated people centered continuum of care	**Inputs (activities):**	**Resource estimates (RS in million)**
Component 1.2: Address unfinished MDG-6 agenda (carried over as SDG targets 3.3) and meet SDG targets 3.4	**Inputs (activities):**	
1.2.1 communicable disease control (CDC) programmes scaled up	1.2.1.1 Strengthen communicable disease programmes to end epidemic of HIV/AIDS, control tuberculosis, and eradicate malaria 1.2.1.2 Collaborate with Livestock Department and development partners to control Zoonotic diseases like Congo fever (CCHF) 1.2.1.3 Establish partners" network and scale up programme for controlling Leishmaniasis, blinding trachoma, and other neglected tropical diseases (NTDs) 1.2.1.4 Strengthen programme for combating hepatitis, educate communities to improve WASH and control water-borne diseases 1.2.1.5 Integrate CDC programmes with primary health care and establish an integrated surveillance system with in DHIS2	14,050
1.2.2 Non-communicable disease control programmes (cancer, cardiovascular diseases, chronic respiratory diseases, diabetes and mental health) scaled up	1.2.2.1 Establish surveillance system for NCDs integrated with CDC, feeding into DHIS2 1.2.2.2 Integrate NCD control programmes within primary health care services and referral for specialist care 1.2.2.3 Develop and introduce clinical practice guidelines for effective treatment of NCDs 1.2.2.4 Scale up health education and advocacy for healthy lifestyle 1.2.2.5 Establish collaborative network with local bodies at different levels for providing parks, gyms and spaces for exercise	730
1.2.3 mitigation and response measures ensured to minimize deaths and injuries from road traffic accidents and occupational hazards	See under outcome, "Health in humanitarian emergencies and IHR, 2005"	

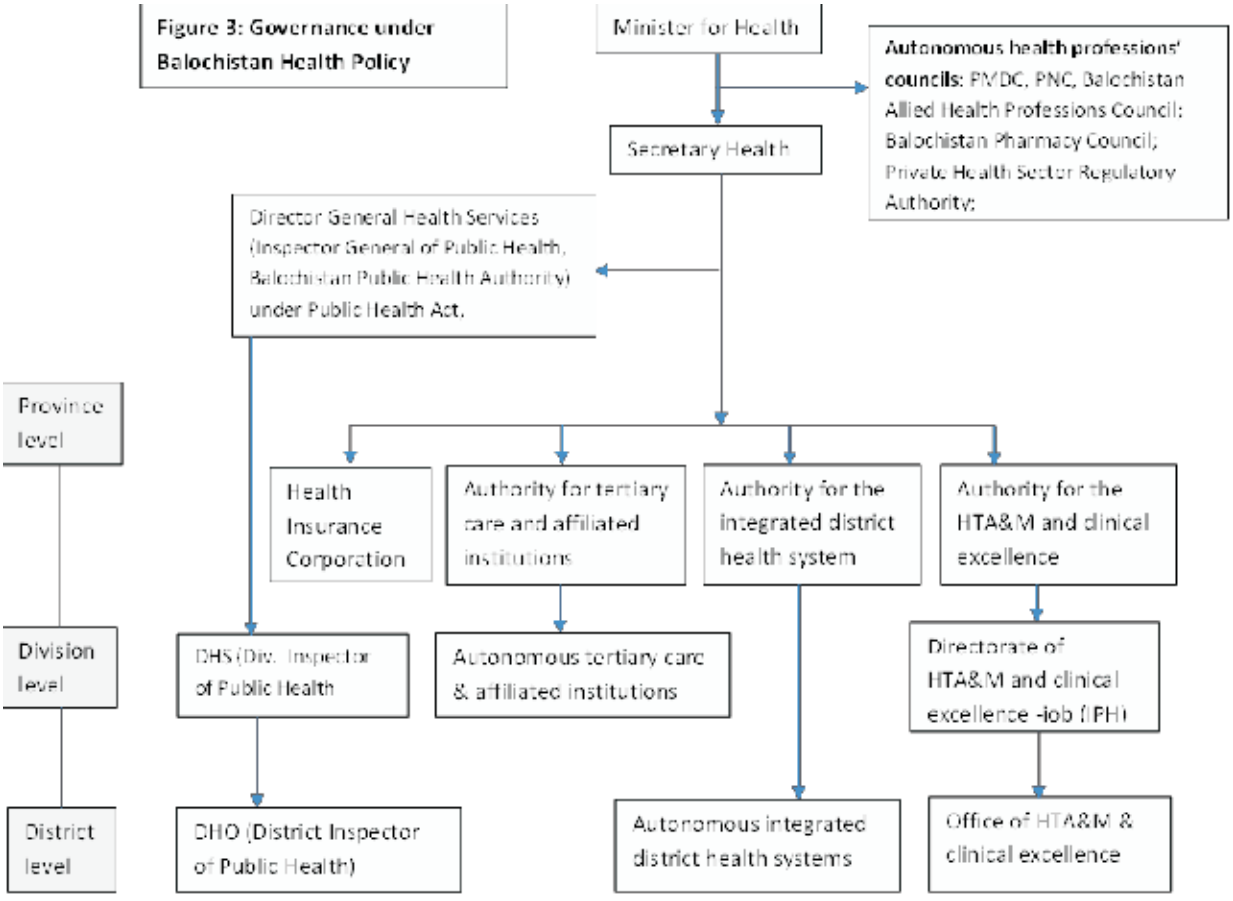
Component 1.1: Provision of integrated people centered continuum of care	**Inputs (activities):**	**Resource estimates (RS in million)**
Component 1.3: Universal access to sexual and reproductive health-care services	**Inputs (activities):**	
1.3.1 universal access ensured to sexual and reproductive healthcare services (SDG target 3.7) NB: sexual health concerns the sexual development and sexuality (including puberty), sexually transmitted diseases/ HIV/AIDS, and unwanted and unsafe pregnancies. **NB**: reproductive health comprise, family planning and safe motherhood beginning before conception and continuing with proper nutrition and healthy lifestyle through to pregnancy by providing antenatal care, prevention of complications, safe delivery and natal care, treatment of complications if any, healthy postpartum, and anti-tetanus coverage of mother and the neonate.	1.3.1.1 Collaborate with Population Welfare Department for meeting community"s demand for family planning commodities 1.3.1.2 Introduce interventions like, information and education, and integrate reproductive health services into provincial strategies and programmes	175

6.2. Health system governance



Health system governance deals with policy development and planning processes, information for oversight, monitoring and evaluation, regulation, accountability and coalition building or partnership. In order to improve governance, a hierarchy of objectives is defined in figure 3a.

In the proposed system, to achieve objectives the system of governance will be restructured as in figure-3. The governance in the new scenario will shape to focus on the regulatory functions, instead of provision and financing of health services. Balochistan Public Health Authority (BPHA) with the DGHS assuming the role of Inspector General of Public Health will be established under



Public Health Law. While a number of autonomous professional councils already exist, law will be promulgated to establish Allied Health Professions Council and Balochistan Pharmacy Council, while Private Health Sector Regulatory Authority will be strengthened. The detailed strategic plan is as below:

Hierarchy of objectives	Indicators	Baseline	Target	Means of verification
Outcome: **2. Governance in health system**: reforms introduced within the health policy framework that covers both public and private (for profit and not for profit) sectors, with a particular attention to system design for ensuring effective oversight, regulation, accountability and coalition building/partnership.	By end of 2018, legally incorporated framework for health planning is available By end of 2025, tools for health system governance are available and functional	NA NA	Health policy, sector strategic and operational plans; Systems of oversight, regulation, coalition building, and accountability	Documents Documents
Output (2.1): legally incorporated health policy, sector strategic and operational plans developed				
2.1.1 Balochistan health policy (Well and Healthy Balochistan) framed and approved by province	By April, 2018 Balochistan health policy is available	NA	Balochistan health policy	Documents
2.1.2 Balochistan health sector strategy framed and approved by P&D department/Board	By end of April 2018, Balochistan health sector strategy is available	NA	Balochistan health sector strategy	Documents
2.1.3 Operational plans (PC-IIs and PC-Is) within the remits of health sector strategy framed and approved by P&D department/Board	By end of 2018, PC-1s available within the remits of health sector strategy	NA	Approved PC-1s for addressing all remits of health sector strategy	
Output (2.2): tools for health system governance developed: systems for the oversight, regulation, coalition building, and accountability 2.2.1 Public Health Law promulgated;	By end of 2019, a public health law is promulgated	NA	Public health Act, 2019	Documents
2.2.2 a multisectoral body/council established for disease prevention, health promotion and population health at provincial/district levels	By 2020, tertiary care hospitals made autonomous	NA	Autonomous medical & health institutions, teaching and training institutes Act, 2020	Documents
2.2.3 Autonomy granted to the medical and health institutions;	By 2020, Undergraduate and postgraduate medical institutes made autonomous	NA		
2.2.4 Autonomous entity established for the accreditation and licensing of health facilities;	By 2020, a law enacted to accredit and license health	NA	Organization for the accreditation and licensing of health	Documents

Hierarchy of objectives	Indicators	Baseline	Target	Means of verification
	facilities established		care institutions	
2.2.5 System of quality and safety in health care strengthened (clinical excellence);	By 2020, a robust system of quality and safety set up	NA	Directorate of clinical excellence	Documents
2.2.6 A system of continuous professional development (CPD) designed and introduced	By 2020, a robust system of CPD established	NA	Organization of CPD	Documents
2.2.7 a private health sector regulatory authority established/strengthened	By 2020, a law enacted to regulate private health sector	NA	Private health sector regulatory authority	Documents
2.2.8 a system of health technology assessment and management (HTA&M) established to also oversee the new health establishments in public and private sector (certificate of need)	By 2020, a system of HTA&M set up	NA	Directorate of HTA&M with branches in division Reorganized health secretariat and subordinate offices at divisions and districts	Documents
2.2.9 Monitoring and evaluation framework developed to strengthen regulatory functions of the government, with provider and financing functions delegated	By 2020, an M&E framework for health system	Partially available		Documents

Component 2.1: Balochistan health policy and planning	**Inputs (activities):**	**Resource estimates (RS in million)**
2.1.1 Balochistan health policy (Well and Healthy Balochistan) framed and approved **NB:** health policy provides broad directions and agenda for health development and aligning it with sustainable development goals.	2.1.1.1 Conduct situational analysis, using inter-alia the literature review, to develop health policy context; 2.1.1.2 Involve stakeholders in policy process through field visits, individual and group meetings, and FGDs 2.1.1.3 Share draft policy with stakeholders and conduct dissemination meetings to seek feedback; 2.1.1.4 Finalize draft Balochistan health policy	**0**
2.1.2 Balochistan health sector strategy approved by planning and development department/board **NB:** aligned with the ideals envisaged in health policy, health sector strategy is developed as a tool for prioritizing interventions and allocating resources for the medium term.	2.1.2.1 Use context for health policy and define priority interventions within remits of Balochistan health policy; 2.1.2.2 Involve stakeholders for consultation and drafting Balochistan health sector strategy, building on the already developed health sector strategy; 2.1.2.3 Share draft Balochistan health sector strategy with stakeholders and conduct dissemination meetings	0

This strategy however being aligned with health policy is for the period 2018-25. Last year will see evaluation and framing strategy 2025-30	to seek feedback; 2.1.2.4 Finalize draft Balochistan health sector strategy	
2.1.3 Operational plans (PC-1s) within remits of health sector strategy framed and approved **NB**: The operational plans or PC-1s are for 3-5 years period and tools to allocate resources and provide detailed plan for implementation.	2.1.3.1 Agree on priority interventions defined within remits of Balochistan health policy; 2.1.3.2 Develop PC-2s (concept papers) for the agreed priority interventions for approval of P&D department; 2.1.3.3 Develop PC-1s (operational plans) for approved PC-2s and submit to P&D department for approval	258
Component 2.2: systems for the oversight, regulation, coalition building, and accountability	**Inputs (activities):**	**Resource estimates**
2.2.1 Public Health Law promulgated; **NB**: Such legal provisions are meant to organize and regulate activities both in the public and private sectors for the prevention of diseases, promotion of health, and prolonging healthy life in the population as a whole.	2.2.1.1 Draft Public Health Law in consultation with stakeholders 2.2.1.2 Share draft Public Health Law with stakeholders and conduct dissemination meetings to seek feedback; 2.2.1.3 Finalize draft Public Health Law and submit for the approval of cabinet and assembly 2.2.1.4 Frame public health rules and establish institutions, including a multisectoral body/council for disease prevention, health promotion and population health to oversee the implementation of rules 2.2.1.5 Establish a public health laboratory at district and a reference laboratory at provincial level	**755**
2.2.2 a multisectoral body/council established for disease prevention, health promotion and population health at provincial/district levels	2.2.2.1 Drawing on the public health rules (2.2.1.4) a multisectoral body/council[2] established; 2.2.2.2 The council will, inter-alia: a. Define standards for the quality and adequacy of essential public health services[3];	**50**

[2] the said **council**, for each governance level, shall comprise of focal points (organizational entities) at least from:

(1) Agriculture; (2) Bureau of statistics; (3) Education; (4) Food - safety; (5) Health (as the secretariat); (6) Housing and urban development; (7) Justice and law enforcement (e.g. police, ministry of home affairs); (8) Labour and industry; (9) Social welfare; (10) Transport – accidents and injuries; (11) Water, environment and sanitation (WES); [3] **Essential public health services** means "the structure and arrangement for delivering essential public health functions as an integral part of primary health care as pronounced in Alma-Ata (WHO, 1978) and reiterated (WHO, 2008)" - and include: (1) monitor health status to identify community health problems; (2) diagnose and investigate health problems and health hazards in the community; (3) inform, educate, and empower people about health

issues; (4) mobilize community partnerships to identify and solve health problems; (5) develop policies and plans that support individual and community health efforts; (6) enforce laws and regulations that protect health and ensure safety; (7) link people to needed personal health services and assure the provision of health care when otherwise unavailable; (8) assure a competent public and personal health care workforce; (9) evaluate effectiveness, accessibility and quality of

personal and population-based health services; (10) research for new insights and innovative solutions to health problems.

	b. Oversee functioning, quality and performance of the organisations in health and other sectors engaged in providing essential public health services c. Ensure the provision of clean environment, clean drinking water, and proper sanitation; d. Ensure occupational health at places of work (factories, offices etc.) and living (homes, hotels and guest houses etc.)	
2.2.3 Autonomy granted to medical and health institutions; **NB**: all primary health care facilities and the preventive and promotive functions associated with DHO and secondary health care will be organised as "integrated district health system" is termed as a body "health institution", which will be granted autonomy. The tertiary care hospital together with its associated institutions (e.g. nursing school /college, paramedic school/college) is termed as "medical institution", to be granted autonomy.	2.2.3.1 Draft in consultation with stakeholders the law for granting autonomy 2.2.3.2 Share draft Law with stakeholders and conduct dissemination meetings to seek feedback; 2.2.3.3 Finalize draft Law and submit for the approval of cabinet and assembly; 2.2.3.4 Frame rules under Autonomous medical & health institutions, teaching and training institutes Act, 2020 and establish institutions to implement rules	**5**
2.2.4 Autonomous entity established for the accreditation and licensing of health facilities; **NB**: Establishing autonomous organization for accreditation and licensing is a tool to ensure the health care facilities are capable to provide quality health services.	2.2.4.1 Draft in consultation with stakeholders the law for establishing an autonomous entity for accreditation and licensing of health care facilities 2.2.4.2 Share draft Law with stakeholders and conduct dissemination meetings to seek feedback; 2.2.4.3 Finalize draft Law for establishing autonomous organization for accreditation and licensing of health care facilities, Act, 2020 and submit for the approval of cabinet and assembly; 2.2.4.4 Frame rules under Autonomous organization for accreditation and licensing of health care facilities, Act, 2020 and establish institutions to implement rules 2.2.4.5 Establish standards and devise mechanisms for inspection of health care facilities for maintaining on list	**255**
2.2.5 System of quality and safety in health care strengthened (clinical excellence); **NB**: The directorate of quality and safety in health care will expand to collaborate with the Centre of health technology assessment and include structures like a unit for clinical audit, a unit for clinical practice guidelines development and a unit for evidence based medicine.	2.2.5.1 Design a system, including SOPs and guidelines, of clinical excellence in consultation of stakeholders; 2.2.5.2 Establish a provincial „directorate of quality and safety in health care" with branches in all districts (in district health office) and tertiary health care institutions 2.2.5.3 Within health and medical institutions develop and introduce a system of adverse event reporting, morbidity and mortality reviews 2.2.5.4 Build capacity as part of CPD programme to	**1,030**

	improve quality and safety in health care	
2.2.6 System of continuous professional development (CPD) designed and introduced **NB:** Provincial and District Health Development Centers could be transformed to work as the autonomous provincial and divisional directorates of CPD to organize accredited regular short courses for medics, pharmacists, nurses and paramedics. In the provincial directorate of CPD, a CPD board comprising academics from various disciplines will form a body to accredit trainers and training material for the short courses and assorted academic activities and assign credit hours	2.2.6.1 Design a system, including SOPs and guidelines, of CPD in consultation of stakeholders; 2.2.6.2 Establish an autonomous provincial „directorate of CPD" with branches in all divisional headquarters (in director health office) and tertiary care institutions; 2.2.6.3 Organize accredited regular short courses at directorates of CPD and assorted academic activities with assigned credit hours 2.2.6.4 Maintain a CPD register at provincial directorate of CPD; and provide credentials of different staff categories to the licensing bodies	758
2.2.7 a private health sector regulatory authority established and strengthened **NB:** Such a body is meant to accredit and ensure the health care establishments in private sector meet standards and are capable to provide quality health services. In addition, the law (refer to HTA&M) will ensure that health care establishments are launched only after a certificate of need is issued and inspection is carried out to ensure those meet a set of standards.	2.2.7.1 Draft, in consultation with stakeholders, the law for establishing an autonomous entity "private health sector regulatory authority"; 2.2.7.2 Share draft Law with stakeholders and conduct dissemination meetings to seek feedback; 2.2.7.3 Finalize draft Law for establishing private health sector regulatory authority, Act, 2020 and submit for the approval of cabinet and assembly; 2.2.7.4 Frame rules under the private health sector regulatory authority, Act, 2020 and establish institutions to implement such rules	153
2.2.8 a system of health technology assessment and management (HTA&M) established **NB:** HTA is a multidisciplinary activity that systematically examines technical performance; safety; clinical efficacy and effectiveness; cost effectiveness; organizational implications; social consequences; legal; and ethical considerations of the application of technology. **NB:** The HTA&M also oversees the new health establishments in public and private sector and meet requirements of "certificate of need".	2.2.8.1 Develop master plan for Balochistan health technology assessment/management (HTA&M); 2.2.8.2 Establish a permanent structure for HTA&M like Centre for Health Technology Assessment in DoH; and will conduct/outsource researches to eligible institutions and or experts for answering specific HTA questions; 2.2.8.3 Strengthen systems, structures and mechanisms for HTA/equipment management; and the structure to include a multidisciplinary technical advisory group; 2.2.8.4 Build capacity in health technology assessment and healthcare technology/equipment management;	453
2.2.9 Monitoring and evaluation framework developed to strengthen regulatory functions of government, with provider and financing functions delegated **NB:** Through reforms suggested in health policy, health department will exercise only regulatory	2.2.9.1 Define and agree on a set of indicators, essentially focusing on regulatory bodies/functions for performance monitoring and evaluation; 2.2.9.2 Develop monitoring checklist and reporting format for different regulatory functions and train	10

functions, parastatal entities will be established to manage provision of services (e.g. autonomous hospital) and financing of services (e.g. health insurance organization). The health department, in this scenario, will be responsible to monitor and exercise its regulatory functions.	supervisors in using these tools and produce reports;	

6.3. Financing of health system

It is how the health system is financed that no one faces financial hardship due to illness. Prepayment schemes are considered a better option than the currently in vogue tax based system. Such a system is considered commensurate with the state limiting its role to its regulatory function, while delegating financing and provision functions to the quasi state or parastatal organizations.

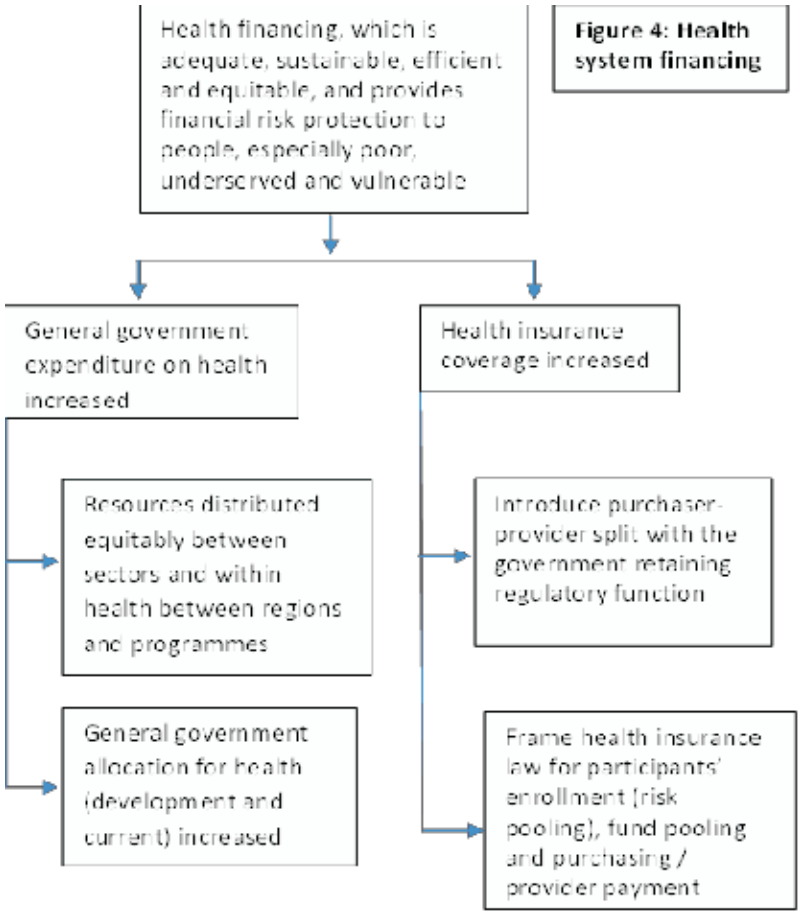


Figure 4: Health system financing

In the proposed system, the financing of health will be reformed to address the hierarchy of objectives given in figure-4, which is translated into a logframe as below.

Achieving the hierarchy of objectives, as in logframe, is likely to ensure a system of health financing, which is adequate, sustainable, efficient and equitable, and provides financial risk protection to people, especially poor, underserved and vulnerable.

Hierarchy of objectives	Indicators	Baseline	Target	Means of verification
Outcome:				
3. Financingof health system Ensure health financing, which is adequate, sustainable, efficient and equitable, and provides financial risk protection to people, especially poor, underserved and vulnerable.	By 2020, general government expenditure on health is increased	7.55%	General government health expenditure is enhanced to 10% of total general government expenditure	Documents/ budget book
	By 2025, % of people covered by health insurance is increased	299930 in 5 districts	50% of population is covered by health insurance , which by 2030 becomes 100%	Documents
Output (3.1 strategic interventions): General government expenditure on health increased				

Hierarchy of objectives	Indicators	Baseline	Target	Means of verification
3.1.1 Resources (financial) distributed equitably between sectors (health v/s other sectors) and within health between regions and programmes	By 2020, a formula to equalize transfers between sectors is defined	NA	Resources are equitably transferred from province to sectors	Documents
	By 2021, a formula to equalize transfers between regions and programmes defined/ approved	NA	Resources are transferred from province to regions and programs equitably	Documents
3.1.2 General government allocation for health (development and current) increased	By 2025, % increase in (current) general government funds allocated for health	7.55%	15% of total (current) general government fund allocated for health and maintained beyond	Documents
	By 2025, % increase in general government Dev. funds for health	7.10%	15% % of general government Dev. funds allocated for health and maintained beyond	Documents
Output (3.2 strategic interventions): health insurance coverage increased				
3.2.1 purchaser-provider split introduced with government retaining regulatory function	By 2019, reforms are introduced	Government is provider, fancier and regulator	Government retains only regulatory function, while delegating provider and financing function to quasi government entities	Documents
3.2.2 health insurance law framed for participants" enrollment (risk pooling), fund pooling and purchasing/ provider payment	By 2019, health insurance law is enacted	NA	Legal cover provided to health insurance activities	Documents
	By 2020, health insurance rules framed	NA	Health insurance activities are regulated as per Rules	Documents

Component 3.1: general government health expenditure is increased	**Inputs (activities):**	**Resource estimates (RS in million)**
3.1.1 A formula defined, approved and implemented for equitable distribution of resources	3.1.1.1 conduct public expenditure tracking study (PETS) and establish a micro dataset 3.1.1.2 collect data from medical statistics to evaluate	55

Component 3.1: general government health expenditure is increased	**Inputs (activities):**	**Resource estimates (RS in million)**
	the impact of factors on service utilization 3.1.1.3 Develop formula that could be used at provincial level to equalize transfers for different sectors	
3.1.2 Balochistan provincial health accounts developed to monitor flow of funds in the health sector	3.1.2.1 conduct household health services utilization and health expenditure survey 3.1.2.2 conduct survey of entities financing the health system"s functions 3.1.2.3 develop provincial health accounts; and define resource flow and identify inequalities in financing health system	80
3.1.3 efficiency improved in utilizing the available resources	3.1.3.1 Introduce generic pharmaceuticals (procurement and rational prescription) in public sector 3.1.3.2 Introduce strategic procurement for ensuring economical and timely supply of goods and/or services in the health system 3.1.3.2 Introduce performance audit and system of pay for performance	75
3.1.4 financial sources unified by integrating existing financial silos	3.1.4.1 map existing financing sources (NHA, 2013-14) 3.1.4.2 develop a common funding platform to coordinate, mobilize, and channel flow of existing and new resources to support health sector strategy	50
3.1.5 more funds allocated for general government health (development and current) expenditure	3.1.5.1 Advocate (using the evidence from NHA) for the enhanced funding of health by re-appropriation of the provincial general government expenditure 3.1.5.2 Introduce, using provincial authority, to generate resources from e.g. tax on tobacco and unhealthy foods like sugar, junk foods etc. 3.1.5.3 Develop plans (concept papers or PC-IIs, as indicated in logframe) for health system strengthening and seek funds/ loans from donors and development partners 3.1.5.4 Seek grant funds from federal government and other provincial governments to fund specific projects.	50
Component3.2: Population coverage by health insurance is increased	**Inputs (activities):**	**Resource estimates**
3.2.1 purchaser-provider split	Refer to section on governance for detailed activities	0

Component 3.1: general government health expenditure is increased	**Inputs (activities):**	**Resource estimates (RS in million)**
introduced with government retaining regulatory function		
3.2.2 health insurance law framed for the participants‟ enrollment (risk pooling), fund pooling and purchasing/ provider payment	3.2.2.1 draft health insurance law, essentially covering for example the following: a. fund pooling – establishing health insurance as an entity to pool funds b. define eligibility for participants‟ enrollment (risk pooling) – making it mandatory for the public and private sectors to enroll for health insurance, c. devise mechanisms for defining benefit or service package or services that are eligible for reimbursement against a defined amount of premium d. entity like a Tariff Committee for costing of benefit or service package e. devise mechanisms for purchasing services, like contracting with providers f. devise system for regulating provider payments, like salaries, fee for- service, diagnosis related groups, capitation or per-diem, or budget for a set of pre-defined health-related activities in a lump-sum fashion g. level of copayments, audit and verification of claims and reimbursement procedures 3.2.2.2 draft health insurance law is shared with wider stakeholder forum and discussed for inputs 3.2.2.3 draft health insurance law is finalized and enacted for promulgation by the provincial assembly 3.2.2.4 health insurance rules under the authority of “Health Insurance Act, 2019” are framed and required institutions are established	**7.5**

6.4. Health workforce

A health workforce of adequate size and skills is critical to the attainment of any population health goal (WHO, 2016 - Health workforce requirements for universal health coverage and the Sustainable Development Goals). However, in Balochistan at all levels of health care, there is, to varying degrees, issues in education and training, deployment, retention and the performance of health workforce. In order to address these issues and ensure health workforce in adequate number with required competencies and performance level, is available across the health system and there is an appropriate skill mix in health services, strategic objectives are defined as in figure 5a.

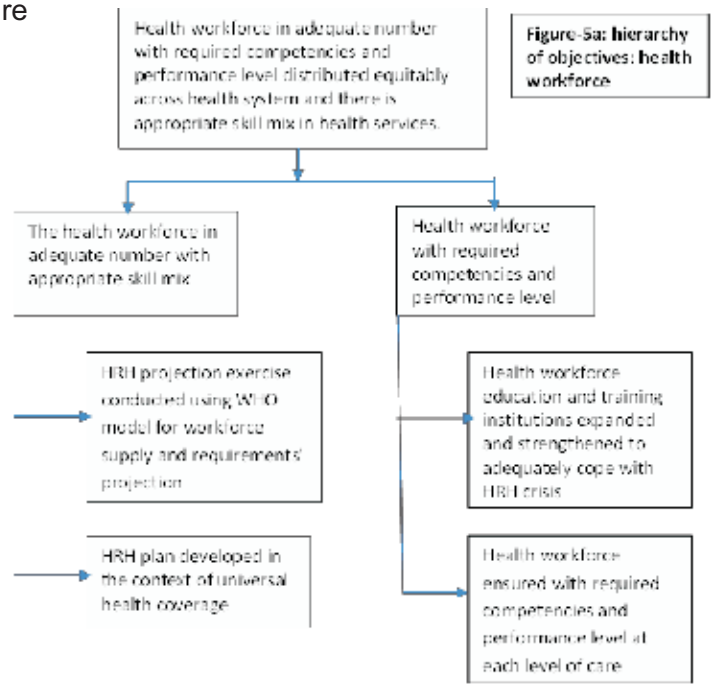
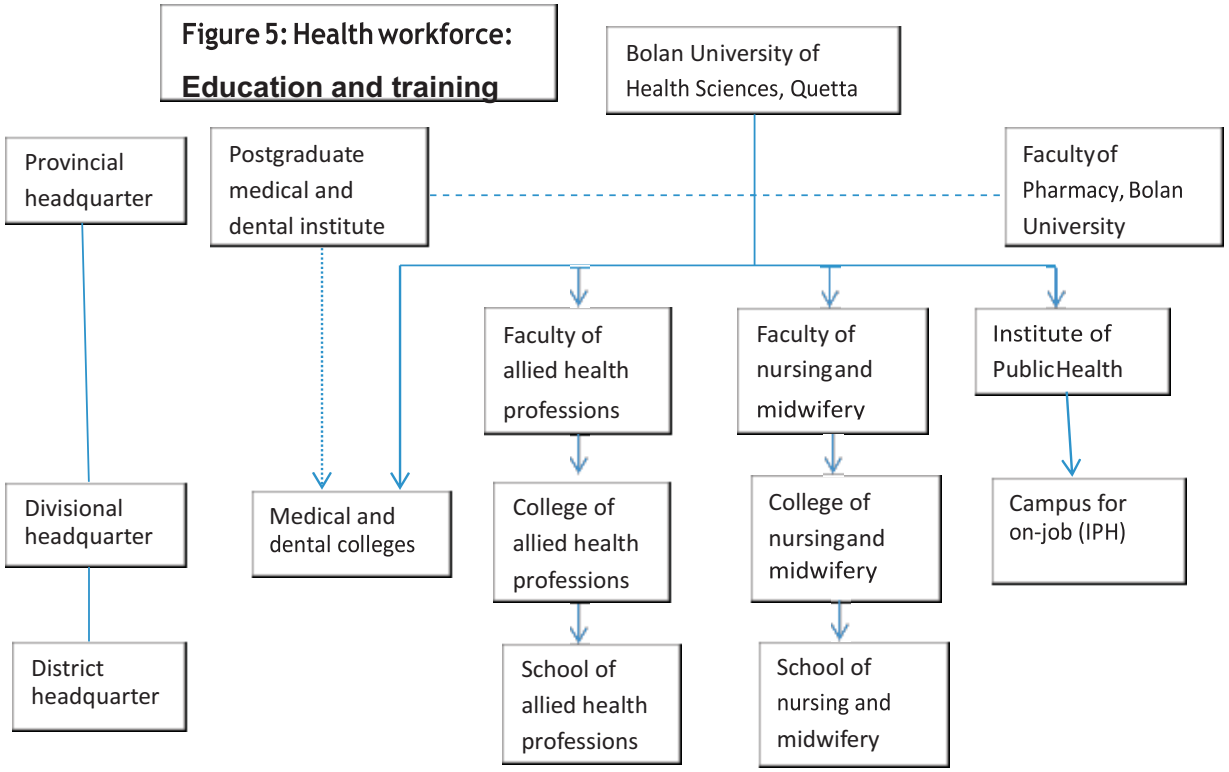


Figure-5a: hierarchy of objectives: health workforce

As to how the health workforce education and training institutions, which are the mainstay in health workforce availability, are distributed equitably is in figure-5.

That is, at provincial level, a postgraduate medical institute with branches in divisions (embedded in medical and dental colleges) and a faculty of pharmacy in Bolan University has technical link with Bolan

Figure 5: Health workforce: Education and training



University of Health Sciences. The Bolan University of Health Sciences will have faculties of allied health professions, nursing and midwifery and an institute of public health. At divisional level, there will be a college each of allied health professions, and nursing and midwifery, while in each district a school of allied health professions, nurse auxiliaries and midwifery will be established. The Institute of Public Health will have campuses in each division to coordinate on-job training of health managers. A strategic plan to realize the aforesaid visualizations is defined in matrix below.

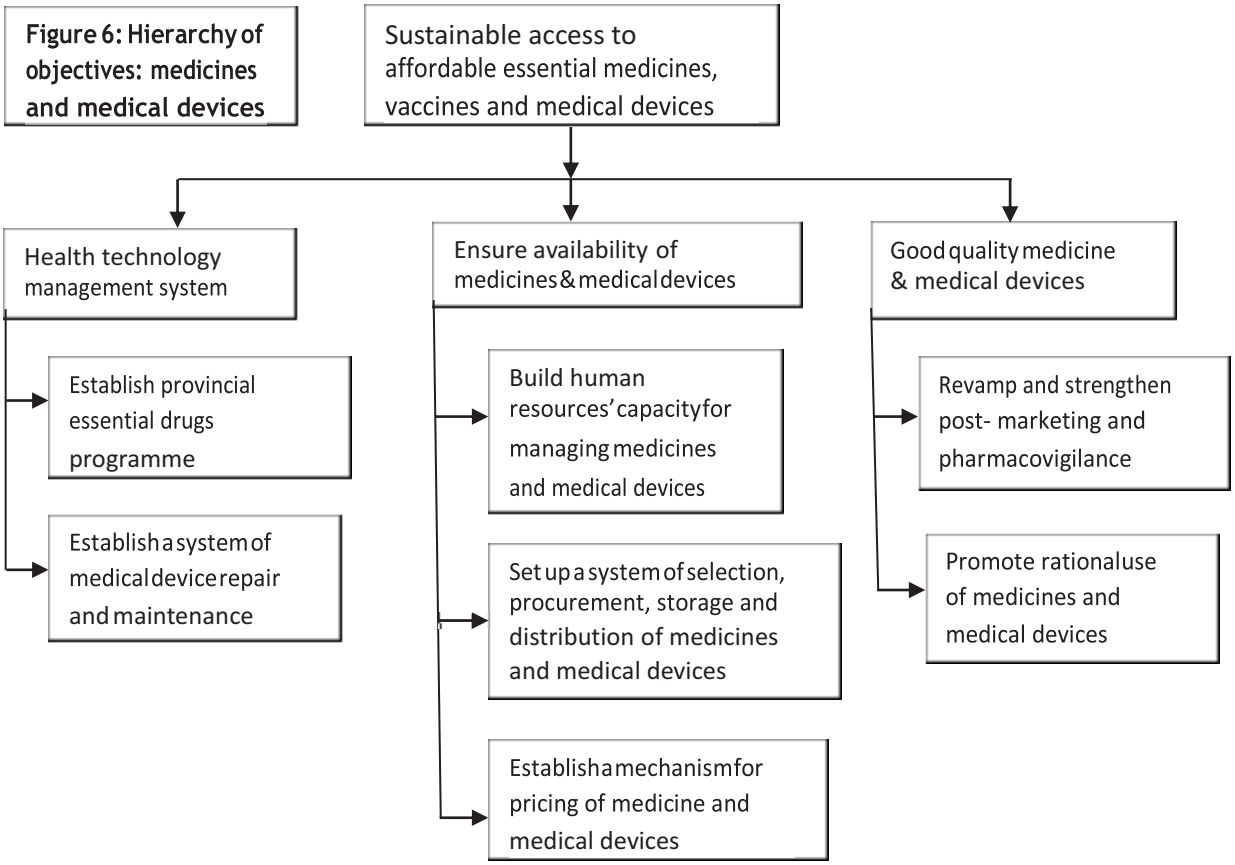
Hierarchy of objectives	Indicators	Baseline	Target	Means of verification
Outcome: **4. Health workforce**: Health workforce in adequate number with required competencies and performance level distributed equitably across health system and there is appropriate skill mix in health services.	By 2030, health workforce in adequate number and competencies is available	NA	a. At least three skilled workers per 1,000 population, equitably distributed (SDG-3c-1) b. Health workforce with required competencies and performance level	Documents/ health workforce profile
Output (4.1 strategic interventions): the health workforce in adequate number with appropriate skill mix				
4.1.1 HRH projection exercise conducted using WHO model for workforce supply and requirements" projection	By 2018, HRH projection exercise conducted	NA	HRH projection of workforce supply and requirements	Documents/
4.1.2 HRH plan developed in the context of universal health coverage	By 2019, a plan to address health workforce crisis developed and approved (PC-1)	NA	A comprehensive plan (PC-1) to address health workforce crisis, including rural retention	Documents/
Output (4.2 strategic interventions): Health workforce with required competencies and performance level				
4.2.1 health workforce education and training institutions expanded and strengthened to adequately cope with HRH crisis	By 2019, a plan prepared to expand HRH education and training	NA	Scheme in figure-5, is designed to transform and scale up health professionals" education and training	Documents/
4.2.2 health workforce ensured with required competencies and performance level at all levels of care	By 2020, a system developed to ensure good performing health workers	NA / DHDC not functional	An accreditation system for ensuring quality of health workforce education and training institutions, and continuous professional development (CPD)	Documents

Component (4.1): health workforce in adequate number with appropriate skill mix in health service	**Inputs (activities):**	**Resource estimates (RS in million)**
4.1.1 provincial health workforce profile, including those in the education pipeline developed **NB:** Given that data on health workforce both in practice and that under training is deficient, it is proposed to conduct a census survey and develop a profile of health workforce.	4.1.1.1 Design a tool and train team for collecting data 4.1.1.2 Conduct a census survey of health workforce 4.1.1.3 Develop provincial health workforce profile, including in the education pipeline	155
4.1.2 HRH projection made of the supply and requirements **NB:** WHO has developed models e.g. WHO, 2001, Human Resources For Health: Models for projecting workforce supply and requirements. This is an important exercise for long term planning of HRH.	4.1.2.1 Select a WHO model for the workforce supply and requirements" projection 4.1.2.2 Train team, acquire software and conduct exercise to project health workforce supply and requirements 4.1.2.3 Project health workforce (of different categories to ensure good skill mix) and pre-service education and training positions till 2030	2.5
4.1.3 A comprehensive plan (PC-1) prepared to address HRH crisis, including rural retention in the context of universal health coverage **NB:** DCE is an exercise, wherein the preferences of health workers for accepting rural posting are identified objectively. These are factored in plan (PC-1) for securing funding. WHO, 2012, How to conduct a discrete choice experiment for health workforce recruitment and retention in remote and rural areas: a user guide with case studies, Gva	4.1.3.1 Conduct discrete choice experiment (DCE) to define job characteristics that can influence health workers" decision to take up rural postings. 4.1.3.2 Use numbers and categories of the required health workforce derived from projection exercise and findings of DCE and draft PC-1 for creating and filling in positions 4.1.3.3 Put the PC-1 in the approval process and funding of positions; and upon approval recruit, select and deploy health workforce ensuring equitable distribution.	2,505
Component (4.2): Health workforce with required competencies and performance level	**Inputs (activities):**	**Resource estimates**
4.2.1 PC-1 prepared for transforming and scaling up health professionals" education and training **NB:** In Balochistan, the health professionals" education and training institutions fall short of standards for providing quality education and training and are too few to meet HRH requirements and are inequitably distributed.	4.2.1.1 Design a tool and train team for collecting data about health professional"s education and training institutions 4.2.1.2 Conduct a census survey of health professional"s education and training institutions 4.2.1.3 Develop inventory and status of the education and training institutions; and identify gap against the scheme in figure-5 to meet projected supply and requirements. **NB:** Scheme for transforming and scaling up health professionals" education and training: The Bolan University	2,521

An exercise will be conducted to map the existing education and training institutions against scheme envisaged in figure- and explained. The shortfall will be identified vis-à-vis the projection; and accordingly PC-1 will be developed for upgrading and scaling up health professionals" education and training institutions.	of Health Sciences will have faculties of allied health professions, nursing and midwifery and an institute of public health. At divisional level, there will be a college each of allied health professions, and nursing and midwifery, while in each district a school of allied health professions, nurse auxiliaries and midwifery will be established. The institute of public health will have campus in each divisional level to coordinate on-job training of health managers. 4.2.1.4 Develop draft PC-1 for transforming and scaling up health professionals"education and training institutions 4.2.1.5 Put PC-1 in approval process and funding; and upon approval, develop health workforce education and training institutions ensuring equitable distribution across province	
4.2.2 An accreditation system developed and enforced for ensuring the quality of health workforce education and training institutions, and continuous professional development (CPD)	Refer to section 2.2.5 in logframe for governance in health system. **NB**: CPD is a tool to help health professionals keeping abreast with the knowledge and skills up to date.	0

6.5. Medicine and other health technologies

In Balochistan, there are issues related to medicine and health technologies. While, the public sector funding for health is about 33% of total health expenditure, more than 50% of this budget is utilized for medicine and vaccines. But, given the irrational use and high prices of branded medicinal items, the available resources are too less and that too are used inefficiently.



Therefore, Balochistan Health Sector Strategy envisages a set of reforms presented in figure-6, as hierarchy of objectives. These aim at a well-functioning health system which ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use. In order to achieve this objective a set of strategic interventions, presented as a logframe in the following, will be implemented.

Hierarchy of objectives	Indicators	Baseline	Target	Means of verification
Outcome: **5. Medicine and other health technologies:** Population in the province has sustainable access to affordable essential medicines, vaccines, blood and blood products and medical devices	By 2022, a system for the selection, procurement, storage, distribution, rational prescription and use of generic medicines is established and operative	Partial/ unspecified	Zero stock out for essential medicine and medical devices at public sector health facilities	Document; and reports of periodic reviews
Output (5.1: strategic interventions) health technology management (excluding physical assets at facilities) system				
5.1.1 provincial essential drugs programme established	By 2020, a provincial essential drugs programme is designed and implemented	NA	A provincial EDL and formularies for health care facilities	Document; and reports of periodic reviews
5.1.2 a system of medical device repair and maintenance established	By 2020, a system of medical device repair & maintenance is designed and implemented	Ineffective	Medical devices are in good state of repair at health care facilities	Document; and reports of periodic reviews
Output (5.2: strategic interventions) Improved availability of medicines and medical devices				
5.2.1 human resources" capacity built for managing medicines and medical devices	By 2020, HRH involved in managing medicines and medical devices is trained	Inadequate	Efficient management of medicines and medical devices	Reports of periodic reviews
5.2.2 a system of selection, procurement, storage and distribution of medicines and medical devices is set up	By 2020, a system is set up for selection, procurement, storage and distribution of medicines & medical devices	Ineffective	Zero stock out for medicines and medical devices at public sector health facilities	Reports of periodic reviews
5.2.3 A mechanism established for the pricing of medicine and medical devices	By 2020, a mechanism devised and implemented for the pricing of medicine and medical devices	Federal/ DRAP control	Medicine and medical devices are available at affordable prices	Reports of periodic reviews
Output (5.3: strategic				

Hierarchy of objectives	Indicators	Baseline	Target	Means of verification
interventions) good quality medicine & medical devices				
5.3.1 post- marketing surveillance and pharmacovigilance revamped and strengthened	By 2020, post- marketing and pharmacovigilance system is strengthened	Inadequate and Ineffective	Quality medicines in the market Adverse reactions reported	Reports of periodic reviews Reports of periodic reviews
5.3.2 rational use of medicines and medical devices promoted	By 2020, prescription of medicines and medical devices	Irrational prescription	Misuse of injections and antibiotics prevented	Reports of periodic reviews

Component(5.1): health technology management (excluding physical assets at facilities) system	**Inputs (activities):**	**Resource estimates (RS in million)**
5.1.1 provincial essential drugs programme established **NB:** a standing committee on EDL and formularies will be assigned to keep the list updated according to the developments in knowledge	5.1.1.1 Set up a task force/standing committee for deliberating on provincial essential drugs programme 5.1.1.2 Define a provincial Essential Drugs List (EDL) and health care facilities" specific formularies 5.1.1.3 Share and discuss in a broader stakeholder forum the EDL and health care facilities" specific formularies 5.1.1.14 Finalize and notify for implanting EDL and health care facilities" specificformularies	25
5.1.2 a system of medical device repair and maintenance established **NB:** whereas, the selection and procurement of medical devices is important, keeping those operational is equally essential for the continuous provision of service and their efficient use.	5.1.2.1 Design a system of medical device repair and maintenance, including contracting out, training of technicians on operation and preventive maintenance, setting up workshops in public sector etc. 5.1.2.2 Get agreement on the preferred system and develop PC-1 to seek funding and establishing the organization for medical device repair and maintenance. 5.1.2.3 Put the PC-1 in process and upon approval establish the organization and institutionalize repair and maintenance	505
Component (5.2): availability of medicines and medical devices improved	**Inputs (activities):**	
5.2.1 human resources" capacity built for managing medicines and medical	5.2.1.1 Develop human resources" register involved in	179

devices	managing medicines and medical devices (selection, procurement, storage and distribution of medicines, and medical devices" repair and maintenance etc.) 5.2.1.2 Design a short course in collaboration with stakeholders and train trainers and develop training material 5.2.1.3 Organize periodic courses in PHDC and DHDC for HRH involved in managing medicines and medical devices	
5.2.2 a system set up for selection, procurement, storage and distribution of medicines and medical devices **NB**: WHO/AMDS and GFATM have development systems and technical knowledge and skills in various areas of the procurement and supply management (PSM) cycle. These are available to countries free.	**NB**: for the system of selection of medicines and medical devices – see section on health technology assessment. 5.2.2.1 Install Logistics Management and Information System, as part of DHIS-2 5.2.2.2 Train logistics staff involved in procurement and supply management (PSM) cycle 5.2.2.3 Manage medicine supply chain, ensuring there is zero stock out of essential medicine	1,528
5.2.3 A mechanism set up for pricing of medicine and medical devices **NB**: medicine and vaccines form over 50% of health expenditure, mainly through out-of-pocket. In order to reduce household expenditure on health, it is imperative to introduce pricing policies to make medicine and vaccine affordable.	5.2.3.1 Establish a provincial standing committee on drugs" prices, comprising drug regulatory authority, manufacturers, distributers, pharmacists and patient welfare associations to periodically review and fix essential drugs prices that are affordable for all. 5.2.3.2 The standing committee on drugs prices makes use of the WHO medicine price information; and WHO guideline on country pharmaceutical pricing policies.	10
Component (5.3): good quality medicine & medical devices	**Inputs (activities):**	
5.3.1 post- marketing surveillance and pharmacovigilance revamped and strengthened NB: **Post-marketing surveillance** is monitoring the safety of a pharmaceutical drug or medical device after it has been released on the market; **Pharmacovigilance** is the pharmacological science relating to collection, detection, assessment, monitoring, and prevention of adverse effects due to pharmaceutical products	5.3.1.1 Update and promulgate Balochistan drugs rules, 2018; and strengthen post-marketing inspection and set up drugs courts in divisions (permanent or rotatory benches); 5.3.1.2 Strengthen the Drugs Regulatory Authority (in terms of its functions for registration and market authorization, oversight for good manufacturing and laboratory practices, licensing etc.) through provincial legislation; 5.3.1.3 Include in the jurisdiction of Drugs Regulatory Authority vaccines and biological, cosmetics, animal drugs and pesticides, and quality assurance of medical devices; 5.3.1.4 Revamp drug testing laboratory, expanding its functions and infrastructure to include /upgrade biological laboratory and managing lab waste; 5.3.1.5 Strengthen the Drugs Regulatory Authority function of post-marketing surveillance and pharmacovigilance,	335

	especially in order to identify and evaluate previously unreported adverse reactions	
5.3.2 rational use of medicines and medical devices promoted **NB**: "Irrational use of medicines is a major problem worldwide. WHO estimates that more than half of all medicines are prescribed, dispensed or sold inappropriately, and that half of all patients fail to take them correctly. The overuse, underuse or misuse of medicines results in wastage of scarce resources and widespread health hazards, including multidrug resistance".	5.3.2.1 Develop clinical practice guidelines (CPGs) for different clinical conditions; 5.3.2.2 Establish drug and therapeutics committees in districts (to oversee/audit prescription pattern in PHC facilities) and hospitals (secondary and tertiary care); 5.3.2.3 Include problem-based pharmacotherapy training in undergraduate curricula and continuing medical education as a requirement to keep license to practice; 5.3.2.4 Promulgate and enforce regulation to curb incentives/advertisement by pharmaceutical industry; 5.3.2.5 Public education programme about medicines and medical devices to curb patients" influence on physicians for prescription	80

6.6. Health information

The Health Information System (HIS) is largely fragmented, due to the parallel reporting structures and information sub-systems implemented by vertical disease-specific programs, which seldom get consolidated due to the poor coordination mechanisms. Balochistan health information system is built on DHIS. Data generated at primary health care facilities (MCH centers, civil dispensaries, basic health units, and rural health centers) is collected manually. It is digitized and consolidated at district level, where the information from secondary health care (tehsil and district headquarter hospitals) consolidates for generating a district report, but no analysis is done. Tertiary care hospitals report direct to the provincial health Information center. The data from districts and tertiary care is received online and analyzed (cumulative data of province, divisions, district and health center) only at provincial level.

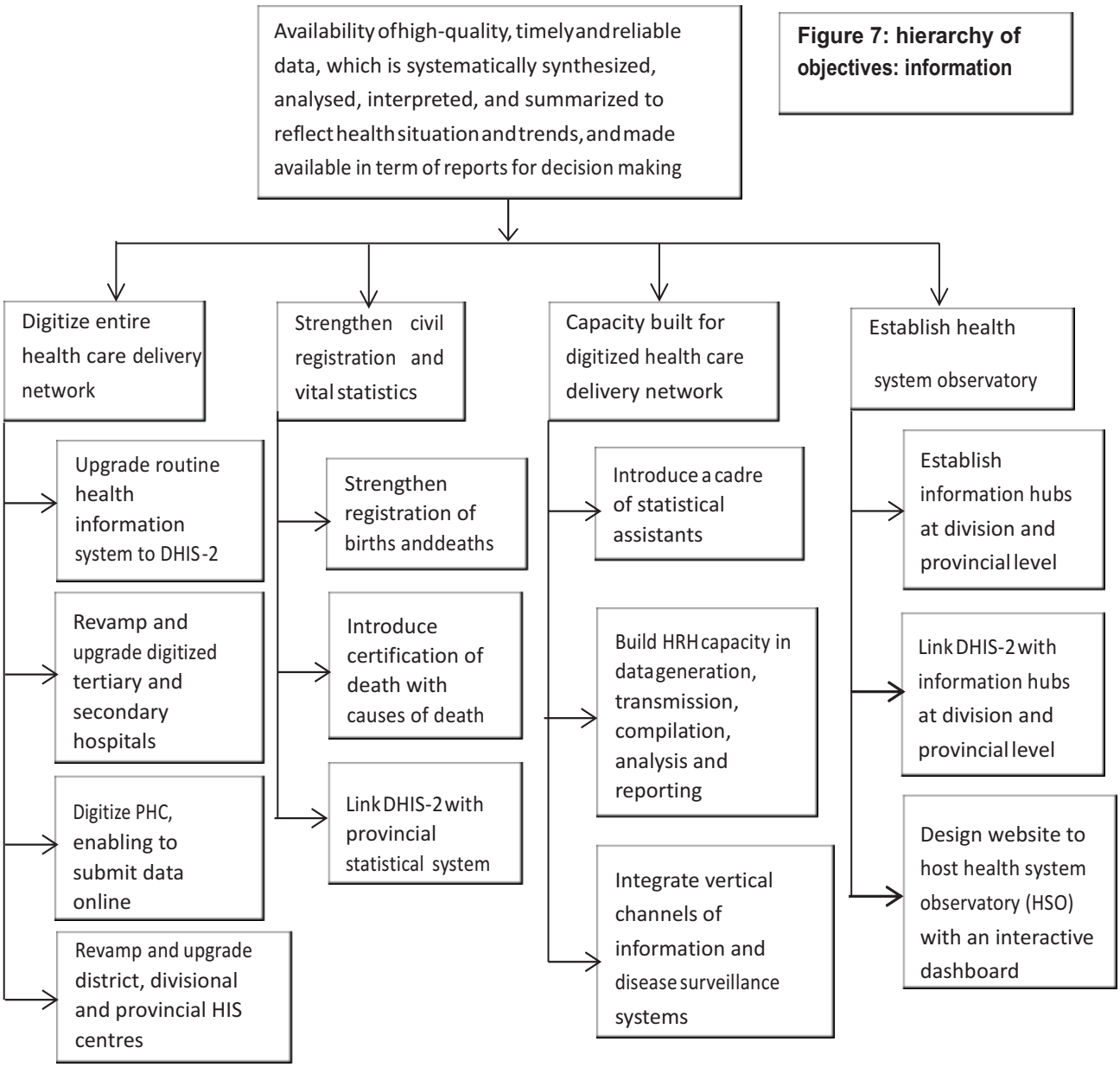


Figure 7: hierarchy of objectives: information

The Balochistan health sector strategy aims at developing Health information system with the availability of high-quality, timely and reliable data, which is systematically synthesized, analysed, interpreted, and summarized to reflect health situation and trends, and made available in term of reports for decision making. To achieve this, the hierarchy of objectives is in figure -7, while based on this the logframe is developed as below:

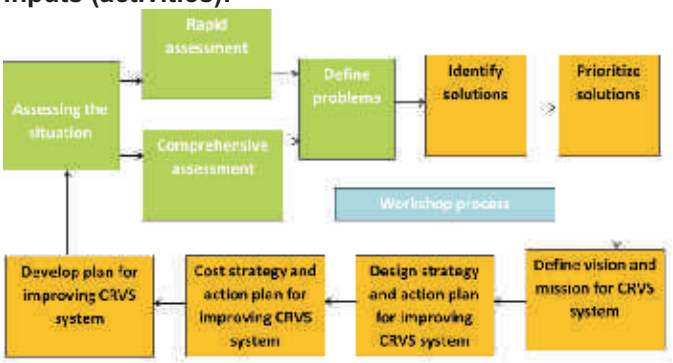
Hierarchy of objectives	Indicators	Baseline	Target	Means of verification
Outcome **6. Health information** : Health information system with the availability of high-quality, timely and reliable data, which is systematically synthesized, analysed, interpreted, and summarized to reflect health situation and trends, and made available in term of reports for decision making.	By 2020, RHCs and BHUs are digitized and submit data online to district and provincial HIS	Tertiary and secondary hospitals digitized	RHCs and BHUs are digitized and submit data online	Documents/ periodic HIS reports
	By 2022, entire health care delivery system is digitized to submits data online regularly and correctly	All facilities except MCH and CDs digitized	MCH and CDs digitized and submit data online	Documents/ periodic HIS reports
	By 2022, an integrated online health system observatory is established	NA	An online dashboard generates regular reports	Website and interactive reports

Output (6.1 strategic intervention): Digitized entire health care delivery network				
6.1.1 Upgraded routine health information system to DHIS-2	By 2020, routine health information system upgraded to DHIS-2	DHIS	HIS tailored to integrated health information management activities available	Documents/ periodic HIS reports
6.1.2 Revamped and upgraded digitized tertiary and secondary hospitals	By 2020, tertiary and secondary hospitals linked to DHIS-2	DHIS	Aggregate and patient-based statistical data	Documents/ periodic HIS reports
6.1.3 Digitized primary health care, enabling to submit online data	By 2022, primary health care network linked to DHIS-2	NA	Aggregate and patient-based statistical data collected, validated, analysed, and used for decision making,	Documents/ periodic HIS reports
6.1.4 Revamped and upgraded		DHIS, only at	Information hubs at	Documents/

Hierarchy of objectives	Indicators	Baseline	Target	Means of verification
district, divisional and provincial HIS centers	By 2022, district, divisional and provincial HIS centers revamped and upgraded	provincial HIS centers	three levels compile, analyze and present reports for local decision making	periodic HIS reports
Output (6.2 strategic intervention): strengthen civil registration and vital statistics (CRVS)				
6.2.1 registration of births and deaths strengthened	By 2025, a system to register births and deaths established	7.7% of < 5 years registered	All births and deaths registered and issued certificates	Documents/ population survey
6.2.2 certification of death with causes of death introduced	By 2025, a system of vital statistics established	NA	All deaths registered and certificates with cause of death issued	Documents/ population survey
6.2.3 DHIS-2 linked with provincial statistical system	By 2022, DHIS-2 is linked with provincial statistical system	NA	Health data integrated with other sectors data	Documents/ periodic HIS reports
Output (6.3 strategic intervention): Capacity built for digitized health care delivery network				
6.3.1 a cadre of statistical assistants introduced	By 2022, statistical assistants and statisticians in hospitals, RHCs, districts, divisions and province	Partially – in some facilities	Good quality data are produced timely and processed	Documents/ periodic HIS reports
6.3.2 HRH capacity built in data generation, transmission, compilation, analysis and reporting	By 2022, a short course established and organized regularly	NA	Good quality analytical reports generated and used for decision making	Documents/ periodic HIS reports
6.3.3 information channels and disease surveillance systems integrated	By 2022, program specific information and disease surveillance systems are integrated	All vertical programs have information channels and surveillance systems	Comprehensive and integrated information and disease surveillance system	Documents/ periodic HIS reports
Output (6.4 strategic				

Hierarchy of objectives	Indicators	Baseline	Target	Means of verification
intervention): Establish health system observatory				
6.4.1 information hubs at division and provincial level established	Refer to 6.1.4	NA	07	
6.4.2 DHIS-2 linked with information hubs at division and provincial level	By 2022, from periphery information integrates first at divisions and then at province	Information from periphery integrates at provincial level	Aggregate and patient-based statistical data is available near to the points of action	Documents/ periodic HIS reports
6.4.3 website designed to host health system observatory (HSO) with an interactive dashboard	By 2022, an interactive HSO hosted at web is available	NA	Health managers have access to information required for on-spot decision making	Documents/ periodic HIS reports

Component (6.1): Digitize entire health care delivery network	**Inputs (activities):**	**Resource estimates (RS in million)**
6.1.1 routine health information system upgraded to DHIS-2	6.1.1.1 Procure and install software DHIS-2 6.1.1.2 Adapt training material 6.1.1.3 Train health workers responsible for data collection, validation, transmission, analysis, and presentation 6.1.1.4 Operate DHIS-2 and generate periodic reports	515
6.1.2 digitized tertiary and secondary hospitals revamped and upgraded	6.1.2.1 Review current situation and identify gap in digitizing at tertiary and secondary hospitals; 6.1.2.2 Procure hardware, software and technical assistance for upgrading/digitization of tertiary and secondary hospitals 6.1.2.3 Revamp and upgrade the digitized tertiary and secondary hospitals, and train staff for operating the system	520
6.1.3 Digitized primary health care, enabling to submit online data	6.1.3.1 Review current situation and identify gap in digitizing primary health care facilities (RHC, BHU, CDs, MCH Centers) 6.1.3.2 Procure hardware, software and technical assistance	555

	for upgrading/digitization of primary health care facilities; 6.1.3.3 Revamp and upgrade digitization of primary health care facilities; and train staff for operating the system	
6.1.4 district, divisional and provincial HIS centers revamped and upgraded	6.1.4.1 Review current situation and identify gap in digitizing the district, divisional and provincial HIS centers; 6.1.4.2 Procure hardware, software and technical assistance for upgrading/digitization 6.1.4.3 Revamp and upgrade district, divisional and provincial HIS centers; and train staff for operating system	253
Component (6.2): civil registration and vital statistics (CRVS) system strengthened **NB**: in order to strengthen CRVS system, WHO defined methodology, comprising: assessment; planning; and Implementation. The process for assessment and planning for strengthening CRVS is presented in figure.	**Inputs (activities):**  	
6.2.1 registration of births and deaths strengthened	6.2.1.1 Review and update legal basis and identify resources for births and deaths registration 6.2.1.2 Review and update forms used for birth and death registration and certification; 6.2.1.3 Train health (and local council/municipal) staff in birth and death registration and certification;	160
6.2.2 certification of death with causes of death introduced	6.2.2.1 Review current practice for death certification and cause of death with regard to: " ICD-compliant practices for death certification " Hospital death certification " Deaths occurring outside hospital " Practices affecting quality of cause-of-death data 6.2.2.2 Develop comprehensive plan for introducing certification of deaths with causes of death 6.2.2.3 Supply printed material (death certificates) and train medical staff in: " Verbal autopsy for deaths outside hospitals; " Mortality reviews for hospital deaths; " Certification of deaths with causes of death	140
6.2.3 DHIS-2 linked with provincial statistical system	6.2.3.1 Design system (software) to link DHIS-2 output into	25

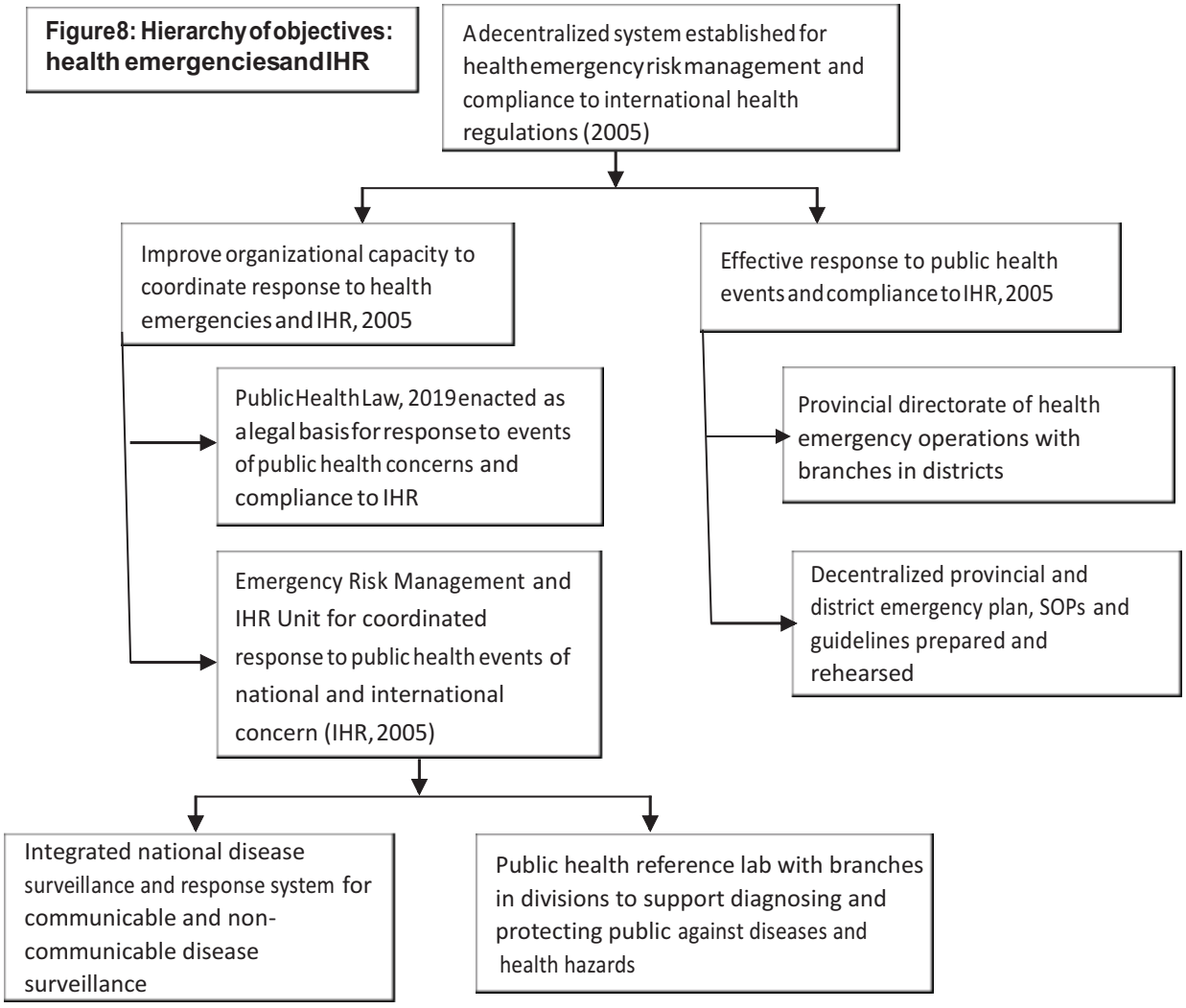
	the provincial statistical system; 6.2.3.2 Design summary tabulation of vital statistics on causes of death and template annual reports 6.2.3.3 Generate reports on vital statistics for placing in public domain	
Component (6.3): Capacity built of digitized healthcare delivery network	**Inputs (activities):**	
6.3.1 a cadre of statistical assistants /statisticians introduced	6.3.1.1 Review statistical assistants /statisticians workforce available vis-à-vis requirements; 6.3.1.2 Include new positions in the PC-I for strengthening health information system; 6.3.1.3 Negotiate with academic institutions for producing statistical workforce and to conduct in-service trainings; 6.3.1.4 Select, deploy and retain the statistical workforce to operate vital statistical system	205
6.3.2 HRH capacity built in data generation, transmission, compilation, analysis and reporting	6.3.2.1 Design short courses with the objective to build capacity of health workforce in data generation, transmission, compilation, analysis and reporting; 6.3.2.2 Organize short courses in PHDC/DHDCs regularly for the relevant health workforce;	65
6.3.3 information channels and disease surveillance systems integrated	6.3.3.1 Design a system (software) to integrate the hitherto vertical information channels and disease specific surveillance systems; 6.3.3.2 Install the integrated information and disease surveillance system; and provide access to programmes; 6.3.3.3 Orient and train relevant staff in data generation, transmission, compilation, analysis and reporting	203
Component (6.4): Establish health system observatory	**Inputs (activities):**	
6.4.1 information hubs established at division and provincial level	Refer to inputs under output 6.1.4	
6.4.2 DHIS-2 linked with information hubs at division and provincial level	Refer to inputs under output 6.2.3	
6.4.3 website designed and launched to host health system observatory (HSO) with an interactive dashboard	6.4.3.1 Constitute governance structure or Steering Committee to oversee data management, content management, web development and HSO design; 6.4.3.2 Invest in building DHIS-2 and synergies with initiatives like eHealth to enrich HSO contents; 6.4.3.3 Develop database for HSO including GIS 6.4.3.4 Develop Knowledgebase of HSO including e-documents library and research database; 6.4.3.5 Develop Health Intelligence of HSO, including trend analyses, policy briefs and health profiles;	65

	6.4.3.6 Website and web applications design and development; and 6.4.3.7 Acquire hardware to support HSO.	

6.7. Health in humanitarian emergencies and IHR, 2005

With the aim to establish a decentralized system for health emergency risk management and compliance to international health regulations (2005), in figure below as hierarchy of objectives has been developed. Using this hierarchy, a logframe (see below) is developed to outline Balochistan strategy for combating and protecting health in humanitarian emergencies and complying IHR, 2005.

Figure8: Hierarchy of objectives: health emergencies and IHR



This is necessitated because Balochistan is a disaster prone province. There have been droughts, floods, landslides and mudslides, earthquake and large scale epidemics affecting health of the populations and disrupting the public health system. In addition, there are man-made emergencies. A provincial disaster management authority (PDMA) is established to deal with emergencies both natural and man-made.

Health is represented and part of PDMA. However, in order to effectively deal with emergencies, there is a need to institute measures aiming at mitigation, preparedness and response. Implementing international health regulations is a related issue; and it may be prudent to establish in health department an entity, "emergency risk management and international health regulations (ERM&IHR)".

Hierarchy of objectives	Indicators	Baseline	Target	Means of verification
7. Health in humanitarian emergencies and IHR, 2005: A decentralized system established for health emergency risk management and compliance to international health regulations (2005)	By 2020, directorate of health emergency operations established at provincial level with branches in district	NA	Organizational capacity to coordinate response to emergencies	Documents/ periodic reports
	By 2021, decentralized provincial and district plan, SOPs and guidelines rehearsed and required paraphernalia is put in place	NA	Adequate preparedness for a response to health emergencies	Documents/ periodic reports
	By 2022, under Public Health Law a network of public health laboratories and integrated disease surveillance system established and operative	NA- PHA PH Lab in Quetta Disease specific surveillance systems	Preparedness for a response to events of public health concerns and compliance to IHR, 2005	Documents/ periodic reports
Output (7.1 strategic intervention): Organizational capacity to coordinate response to health emergencies				
7.1.1 organization of health emergencies and compliance to IHR, 2005 developed	By 2019, organizational structure of health emergencies and compliance to IHR, 2005 developed	NA	A body established to respond emergencies and comply IHR, 2005	Documents/ periodic reports
7.1.2 Decentralized provincial and district emergency plan, SOPs and guidelines prepared	By 2020, the provincial and district emergency plan tested and rehearsed	NA	A feasible emergency mitigation, preparedness, response and recovery plan is	Documents/ periodic reports

Hierarchy of objectives	Indicators	Baseline	Target	Means of verification
			available	
Output (7.2 strategic intervention): response to public health events and compliance to IHR, 2005				
7.2.1 A legal basis available for response to events of public health concerns and compliance to IHR, 2005	By 2019, Public Health Law, 2019 enacted	NA	There is effective response to events of public health concerns and compliance to IHR	Documents/ periodic reports
7.2.2 a coordinated response to public health events of national and international concern ensured	By 2019, Emergency Risk Management and IHR" Unit established	NA	A coordinated response to public health events of national and international concern	Documents/ periodic reports

Component (7.1): organizational capacity to coordinate response to health emergencies	**Inputs (activities):**	**Resource estimates (RS in million)**
7.1.1 An organization established for response to emergencies and comply with IHR, 2005	7.1.1.1 Cluster functions related to health emergency risk management and international health regulations, 2005 7.1.1.2 Design a provincial directorate of health emergency operations with branches in districts 7.1.1.3 Define human resource and material needs for the organization; and accordingly develop and approve PC-I 7.1.1.4 Organize and manage the directorate of health emergencies" operations and compliance to IHR, 2005 at provincial level with branches in districts	503
7.1.2 Decentralized provincial and district emergency plan, SOPs and guidelines prepared and rehearsed	7.1.2.1 Provincial and district emergency plan, standard operating procedures and guidelines prepared 7.1.2.2 Human resources and buffer stock as per SOPs and guidelines acquired as per standard operating procedures and guidelines 7.2.3 Decentralized provincial and district emergency plan tested and rehearsed to ensure a full state of preparedness and response to health emergency	**553**
Component (7.2): effective response to events of public health concerns and compliance to IHR, 2005	**Inputs (activities):**	

7.2.1 A legal basis provided for response to events of public health concerns and compliance to IHR, 2005	7.2.1.1 Draft Public Health Law in consultation with stakeholders; 7.2.1.2 Discuss in a broader stakeholders‟ forum to seek consensus and finalizing the Draft Public Health Law 7.2.1.3 Enact Public Health Law, 2019 7.2.1.4 Establish Field Epidemiology and Laboratory Training Programmes to support implementing Public Health Law	**53**
7.2.2 a coordinated response ensured to public health events of national and international concern	7.2.2.1 Establish Emergency Risk Management and IHR‟Unit as part of directorate of health emergency operations for coordinating response to public health events of national and international concern 7.2.2.2 Establish an integrated national disease surveillance and response system for communicable disease surveillance, prevention, control and response 7.2.2.3 Establish public health reference lab with branches in the divisions to support diagnosing and protecting public against diseases and other health hazards	**2,550**

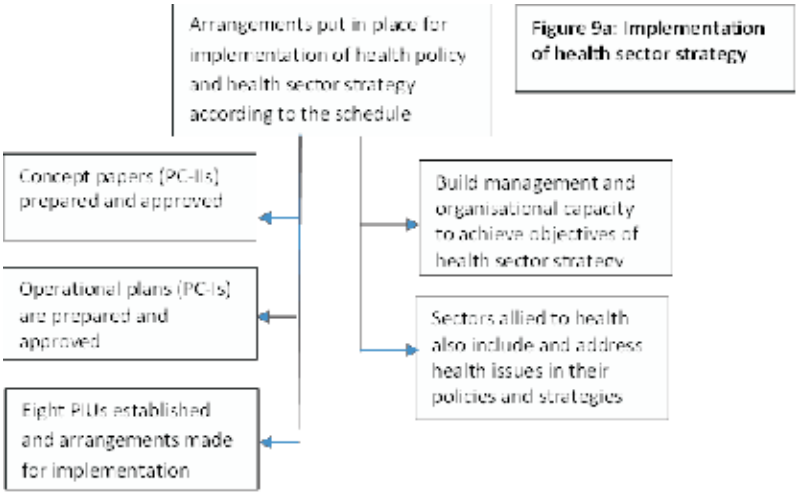


Figure 9a: Implementation of health sector strategy

6.8. Implementation of Balochistan health policy and health sector strategy

After having developed health policy and health sector strategy, it is imperative for the Health Department, Government of Balochistan to take measures for implementation, as in figure 9a.

Health Sector Strengthening Unit (HSSU) will coordinate, while concerned directorates will be the implementation agencies through project implementation units (PIU). A multisectoral steering committee, with HSSU acting as secretariat and Secretary Health acting as chairperson, will be formed to oversee the progress and to resolve issues in implementation, including assuring smooth flow of funds.

The DGHS will oversee, through respective directors, the PIUs in health services delivery, health workforce, medicine and medical devices, health information, health in humanitarian emergencies and IHR, 2005. Activities, especially concerning health services delivery component will be in through field formations, i.e. divisional directors and district health officers. The Health Governance PIU will be located in HSSU, while Additional Secretary (Development) will manage PIU for health financing. The procurement section in Health Department will be

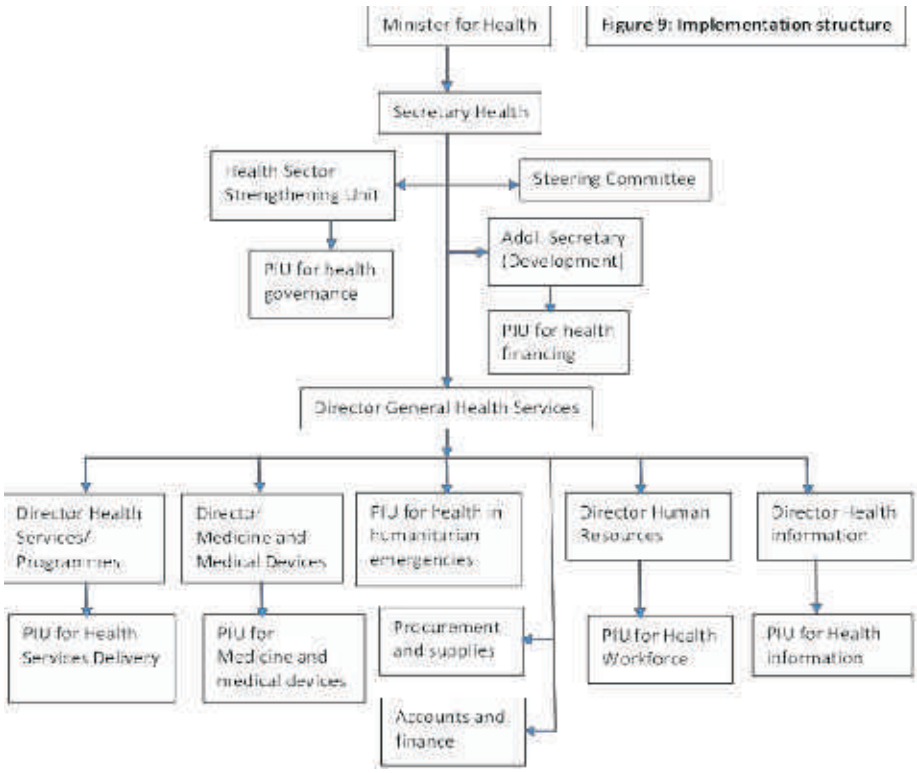


Figure 9: Implementation structure

reinforced to ensure timely procurement of civil works, goods and services. Likewise, the accounts section will be strengthened for assuring timely disbursements and fiduciary control. A suggested implementation structure is in figure-9, while the strategic plan is as below:

Hierarchy of objectives	Indicators	Baseline	Target	Means of verification
8. Implementation: Arrangements put in place for implementation of health policy and health sector strategy according to the schedule	By June 2018, concept papers (PC-IIs) are approved	NA	Nine	Documents
	By June 2019, operational plans (PC-Is) are approved	NA	Nine	Documents
	By the end of 2019, PIUs established and arrangements made for implementation	HSSU	7 PIUs and HSSU	Documents
	By the end of 2018, sectors allied to health include health in their policies and strategies	Not explicit	Education, agriculture, industry, road	Documents

Output/component 8.1 operational plans are developed	Inputs/activities	Resources required (RS in million)
8.1.1 concept papers (PC-IIs) prepared and approved **NB**: The HSSU working with Addl. Secretary (Dev.) will organize activity for preparing, submission and approval of PC-IIs by P&D Board	8.1.1.1 Decision is made on the scope of PC-IIs, i.e. whether at outcome level (one for each building block) or at output/ component level (more than one for each building block); 8.1.1.2 Technical assistance to support developing concept papers (PC-IIs) through a consultative process; 8.1.1.3 Draft PC-IIs working with relevant directorate/ section in the health department; 8.1.1.4 Submit and present PC-IIs in Departmental Development Working Party and finalize the draft; 8.1.1.5 Submit and present PC-IIs in Planning and development Board and complete the approval process	2.5
8.1.2 operational plans (PC-Is) are prepared and approved **NB**: implementing agencies for different PC-Is will be respective sections and directorates in health department.	8.1.2.1 Technical assistance to support developing operational plans (PC-Is) through a consultative process; 8.1.2.2 Define and collect required data and Draft PC-Is working with relevant directorate/ section in the health department; 8.1.2.3 Submit and present PC-Is in Departmental Development Working Party and finalize the draft;	25

	8.1.2.4 Submit and present PC-Is in Planning and development Board and complete the approval process 8.1.2.5 Prepare and get audit copy of PC-1s signed by the Finance Department and seek release of funds and staff positions as approved in PC-Is	
Component: (8.2) Operational plans are implemented effectively	**Inputs (activities):**	
8.2.1 eight PIUs established and arrangements made for implementation **NB:** the caretaker of PC-I for PIUs will be HSSU and will include resources for supporting HSSU	8.2.1.1 Technical assistance to support development of PC -I, through a consultative process, for PIUs in different sections and directorates of health department; 8.2.1.2 Submit and present draft PC-I in Departmental Development Working Party and finalize the draft; 8.2.1.3 Submit and present PC-Is in Planning and Development Board and complete the approval process; 8.2.1.4 Prepare and get audit copy of PC-1 signed by Finance Department and seek release of funds and staff positions as approved in PC-I for different PIUs 8.2.1.5 Recruit, select and orient/train staff to take up positions in different PIUs; and provide goods and services required for smooth implementation	102
8.2.2 sectors allied to health also include and address health issues in their policies and strategies	8.2.2.1 Technical assistance to support development of agenda for „health in all policies"; 8.2.2.2 Under the authority of Public Health Law, establish a multisectral Council for Disease Prevention, Health Promotion and Population Health at provincial and local level; 8.2.2.3 With health officials (DGHS at provincial level, DHS at divisional level, and DHO at district level) acting as secretariat of the multisectoral Council and ensure provision of essential public health services by all sectors;	6.5
8.2.3 management and organizational capacity built in health department to achieve objectives of the health sector strategy	8.2.3.1 Revamp and strengthen PHDC and DHDC to offer short courses in health planning and management; 8.2.3.2 establish partnership with universities/institutions local and abroad for master level training of health managers; 8.2.3.3 support through scholarships the training of health managers at master level in health planning and management	385