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Country Cooperation Strategy for WHO and Pakistan 2005–2009

Pakistan

World Health Organization
Regional Office for the Eastern Mediterranean

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Contents

Abbreviations

ADB	Asian Development Bank
AusAID	Australian Agency of International Development
BDN	Basic development needs
CCA	Common country assessment
CCS	Country cooperation strategy
CIDA	Canadian International Development Agency
DFID	Department for International Development, United Kingdom
DOTS	Directly-observed treatment, short-course
DPT	Diphtheria, pertussis, tetanus
EPI	Expanded Programme on Immunization
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Agency for Technical Cooperation)
HDI	Human development index
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HMIS	Health management information system
IFI	International financial institution
JICA	Japanese International Cooperation Agency
NGO	Nongovernmental organisation
NHPU	National Health Policy Unit
ODA	Official development assistance
PHC	Primary health care
PRSP	Poverty reduction strategy paper
STD	Sexually transmitted disease
TCDC	Technical cooperation between developing countries
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development

Executive Summary

The Country Cooperation Strategy (CCS) reflects a medium-term (6 year) vision and a strategic framework for WHO technical cooperation with a Member State. It serves as a medium-term basis for key periodic planning and also aims at improving WHO's support to the Member States for achieving the Millennium Development Goals (MDGs). The CCS for Pakistan has been developed through an intense process of analysis and consultation. First an exhaustive health sector situation analysis was undertaken by the WHO country team in close collaboration with the Federal Ministry of Health, examining major national and provincial health and related policies, strategies, plans, assessments and evaluations. Then, in October 2004, a mission, composed of senior staff from the Regional Office and WHO headquarters visited Pakistan. The CCS team, including senior country office staff and the mission, held discussions with senior decision-makers and key technical staff at federal, provincial and district levels of the Ministry of Health, donors and UN agencies.

Pakistan is the most populous country in the Eastern Mediterranean Region, accounting for 30% of the regional population. It is a federal state with four provinces, and is in the midst of a devolution process towards establishment of district governments. The level of socioeconomic development is still low: GDP per capita is US$ 580, HDI rank is 142 in the world and 32% of the population live below the poverty line. Geopolitical changes, such as the Afghan war and the situation after 11 September 2001, have affected the country significantly. Pakistan suffers from high child and adult mortality and a double burden of communicable and noncommunicable diseases. Slow progress in improving the indicators related to maternal health, child health, and morbidity and mortality caused by communicable diseases are major concerns in the progress towards the MDGs.

The health sector is in need of major strengthening. The level of investment in health, in spite of recent rapid increases in resource allocation by government, is still low. More than 75% of health financing is out-of-pocket. The private health sector, catering for 80% of health care delivery, is not regulated.

Improving the performance of the health system is essential for efficient implementation of priority health programmes. With devolution being the main focus of governance, the most critical challenge is building the capacity of the health sector at all levels to respond to the requirements of a devolved health system. The other priority challenges are control of communicable diseases, improving child and maternal health, and prevention and control of noncommunicable diseases. Poverty, globalization and trade, gender mainstreaming, unhealthy lifestyles and behaviour, and environment health challenges are important determinants of health that require coordination among various sectors and stakeholders.

The CCS team identified the priority strategic directions for WHO collaboration

for the period 2005–2010 based on the health sector analysis and discussions with national officials and key partners. The findings of the CCS team were in agreement with the articulation of priorities by H.E the Federal Minister of Health. The priorities are: capacity-building at all levels, focusing on preventive measures and improving health care services at the local level. Seven strategic directions were identified to guide WHO support to the country in the next 6 years. In addition to supporting the Federal Ministry of Health, the directions are selected to be sensitive and support other key health partners.

The seven strategic directions are:

Health policy and system development: improving the policy-making basis and governance, developing and managing human resources for health, improving service delivery, access and equity, improving health financing, regulating medicines and biotechnologies, developing an integrated health information system, and promoting and supporting applied research.

Communicable disease control: eradication of poliomyelitis, improving immunization, prevention and control of tuberculosis, malaria, HIV/AIDS, leishmaniasis, hepatitis and zoonotic diseases, and improvement of surveillance and the disease early warning system.

Health of women and children: capacity-building at local and referral levels, training and placement of skilled personnel, promoting safe motherhood and pregnancy, family planning, prevention and control of sexually transmitted infections, reducing neonatal and perinatal mortality, provision of emergency obstetric care and strengthening of the child survival programme.

Noncommunicable diseases: strengthening the new tripartite initiative on noncommunicable diseases by the Federal Ministry of Health, WHO and World Bank, focusing on lifestyles and nutrition, with high priority to road traffic accidents and drug abuse.

Social determinants of health: healthy environment, health awareness raising and healthy lifestyles, expanding community-based initiatives, strengthening linkages with health-related ministries and gender mainstreaming.

Emergency preparedness and response: strengthening the role of the Federal Ministry of Health in the Country Disaster Management Team and in provincial units of States and Frontier Regions, enhancing training and human resources development and maintaining a close link with UN agencies, NGOs and other relief and rehabilitation partners.

Partnerships, resource mobilization and coordination: Strengthening the capacity of the Federal Ministry of Health and district health offices for coordination of donors' support, assisting in resource mobilization and fostering coordination and partnership at all levels.

In order to effectively play its role and translate the CCS strategic agenda into cooperation activities, WHO needs to strengthen its country office and provide integrated and efficient backstopping from the regional and headquarters levels.

Section 1

Introduction

Section 1. Introduction

The Country Cooperation Strategy (CCS) provides a medium-term, 6-year vision of WHO's technical cooperation with Pakistan and serves as the basis for periodic key planning, such as the biennial joint programme review and planning missions (JPRM). It is also a framework for WHO's support to country efforts aimed at achieving the Millennium Development Goals (MDGs).

The objective of the CCS process is to direct the strength of WHO support at country, Regional Office and headquarters levels to addressing each country's health priorities and challenges in a focused manner. The CCS process examines the health situation in the country within a holistic approach that is based on the principles of Health for All (HFA) and primary health care (PHC) and that encompasses the health sector, socioeconomic status, determinants of health, and national policies and strategies that have a major bearing on health. The CCS focuses on selected priorities and puts greater emphasis on WHO's role as policy adviser. The CCS aims at fostering greater partnership with other national and international partners in health, and complementary work with other development agencies based on WHO's comparative advantage.

In 2001, a draft CCS was developed that defined the broad framework for WHO collaboration with Pakistan for a 6-year period. The changing global scenario since 2001, which brought Pakistan into the limelight as a frontline state, had far reaching impact on the country's policies in all sectors. The Government of Pakistan is also in the process of updating and revising its plans for the next 5 years. Furthermore, the country is in the midst of devolution of authorities and administration, which demands major capacity-building for all development sectors, including health, at the district level. These conditions and the changing role of development partners, political forces and others, necessitated revision of the 2001 draft CCS.

For preparation of this revised and updated CCS, the WHO country office undertook a rigorous analysis of the health sector. In October 2004, a CCS team, composed of senior staff from WHO headquarters and the Regional Office together with the country office, consulted with senior officials of the Federal Ministry of Health at federal, provincial and district levels, key UN agencies, the World Bank and major donors. The critical challenges for health development were identified. Based on the health priorities of the country, a strategic agenda for WHO collaboration was developed. Also, the implications for the implementation of the CCS for all three levels of the Organization, i.e. country office, Regional Office and headquarters, have been articulated. The formulation of the CCS is the beginning of a long and demanding process for the necessary shifts and fine tuning of approaches and more consolidated efforts both by government and WHO. Major challenges lie ahead and major achievements are there to gain.

Section 2

Country Health and Development Challenges

2.1 Socioeconomic and geopolitical profile

Pakistan is the most populous country in the Eastern Mediterranean Region with a population of 149.5 million spread over four provinces (Punjab, Sindh, North West Frontier Province and Baluchistan) and four federally administered areas. These are further divided into 126 districts, which have 8575 union councils and 50 568 villages.[1] The population is expected to reach 168 million by the year 2010 with the current growth rate of 1.9%.[2] The average adult literacy rate is just above 50% with an urban bias and significantly lower female literacy (32%).[3] Pakistan's ranking is 142 in the human development index (HDI).[4] The GDP per capita of the country was US$ 580 in 2003.[5]

Pakistan is an Islamic republic with a parliamentary system of democracy. The Prime Minister is executive head of the government, with provincial governments in the four provinces. The present parliament took oath in October 2002. The geopolitical situation in Pakistan has been affecting the economy of the country for the past two decades. The fallout of the Afghan war and the situation after 11 September 2001 have had significant impact on all the social sectors in Pakistan. Large-scale, unregulated internal and international migration poses the threat of epidemics and outbreaks of disease.

In 2001, the Government of Pakistan announced a plan to devolve financial and administrative authority to the district level with the aim of scaling up investment in the social sector and enhancing rational utilization of services in pursuit of poverty reduction and the MDGs. Since the devolution plan has been in place, performance has been mixed, with some improvements in the health sector.[6]

The Pakistan Poverty Assessment Survey (2000–2001)[7] estimates that 32% of the Pakistani population lives below the poverty line, of whom two-thirds are transitory poor.[8] The country has had variable periods of economic growth since independence. Periods of low growth rate (1990s) have alternated with periods of high growth (1980s) and for the last 2–3 years the country has shown an impressive growth trajectory, although the social indicators have yet to catch up.[5]

[1] *Annual Report of the Director-General*, Islamabad, Ministry of Health, 2001.
[2] Population Census Organization, 2003.
[3] Pakistan Integrated Health Survey, 2001.
[4] *Human development report 2004, Cultural liberty in today's diverse world*. New York, UNDP, 2004.
[5] Pakistan Economic Survey 2003–2004.
[6] Devolution in Pakistan, ADB/DFID/WB study 2004.
[7] *Pakistan poverty assessment: poverty, vulnerability, social gaps and rural dynamics*, Islamabad, World Bank, 2002.
[8] Centre for Research of Poverty Reduction and Income Distribution, Pakistan, 2003.

2.2 Health profile

The health profile of Pakistan is characterized by high population growth rate, high infant and child mortality rate, high maternal mortality ratio and high burden of communicable diseases. The infant mortality rate and under-5 mortality rate are respectively 77 and 103 per 1000 live births.[9] The major causes of these high rates of mortality include malnutrition, diarrhoea, acute respiratory illness and other communicable and vaccine-preventable diseases. Twenty-five per cent (25%) of babies are born with low birth weight. Over 35% of children below 5 years of age are short for their age, over 10% are under weight for their height and over half are anaemic.[10] The maternal mortality rate is also high at 350 per 100 000 live births. This is mostly attributed to a high fertility rate, low rate of skilled birth attendance, illiteracy, malnutrition and insufficient access to emergency obstetric care services.

Communicable diseases account for around half of deaths in Pakistan. Vaccine-preventable diseases, such as measles, hepatitis B and neonatal tetanus, have high prevalence. Other communicable diseases, such as tuberculosis, malaria, hepatitis C, typhoid and meningitis, also contribute significantly to the burden of disease. The incidence of tuberculosis is extremely high in the country, being estimated at 177 cases per 100 000 population per year. Pakistan has the sixth highest burden of tuberculosis in the world.

The incidence of malaria cases ranges from 2 to 5 cases per 1000 population.[11] Malaria remains a major public health problem in many areas of Pakistan. Since 2000, the annual number of cases has oscillated between 82 526 and 104 603. However, it is acknowledged by the authorities that not more than 20% of the actual number of cases is recorded. Although malaria is contained in general, the quality of malaria control is not the same in all provinces, which run their programmes with a considerable degree of autonomy. The programme is notably weaker in Baluchistan and North-West Frontier Province (NWFP). There are signs of substantial deterioration of the situation in these provinces.

With regard to the HIV/AIDS problem, Pakistan is placed in the low prevalence but high-risk category. There are indications of a concentrated HIV epidemic among intravenous drug users, which has become a major concern.

The burden of noncommunicable diseases is also on the rise. Diabetes, hypertension, cardiovascular diseases and cancer are growing rapidly due to changing lifestyles. It is estimated that noncommunicable diseases account for 25% of total deaths in Pakistan.[9] However, accurate information on the burden of noncommunicable diseases is often not available. The number of injuries due to road traffic accidents is high, being estimated at 6.7 per 100 000 population, and is expected to increase with growing traffic congestion.[12]

[9] *Annual Report of the Director-General, Islamabad*, Ministry of Health, 2000–2001.
[10] *Millennium Development Goals, Progress Report 2003*, Islamabad, Government of Pakistan, 2004.
[11] National Health Survey of Pakistan, 1998.
[12] *Estimating global road fatalities*, DFID, 2000.

Around 1.8% of the population is blind, mainly due to cataract. Al-Shifa Trust Eye Hospital, the Layton Rahmatullah Benevolent Trust, Pakistan Institute of Community Ophthalmology (PICO) and many more NGOs are working closely with WHO to develop district eye care and train human resources. The country signed the Vision 2020 declaration of support, and a national plan has been developed, but still more expansion and support are needed. Disease control strategies, human resource development for eye care, strengthening of infrastructure and human resources, as well as extra funds, are needed.

Poverty is an important factor in the health profile of Pakistan. Those living in absolute poverty are five times more likely to die before reaching the age of 5 years, and 2.5 times more likely to die between the ages of 15 and 59.[11] The major problems in health are due to poverty-related communicable diseases, childhood illnesses, reproductive health problems and malnutrition.[13]

2.3 Health systems development

2.3.1 Governance

The Federal Ministry of Health and provincial health departments are the principal organizations for ensuring a well-governed health system. However, their capacity for policy analysis and formulation is limited and they are institutionally unequipped to make use of some of the new policy analysis tools developed by the WHO, such as burden of disease estimation, national health accounts and cost–effectiveness analysis. As a consequence, institutions (such as hospitals, and academic and research institutes) and priority programmes managed by the Federal Ministry of Health and provincial health departments are functioning below their potential capacity.

The recognition of the role of the private health sector, and the ability of the Federal Ministry of Health and provincial health departments to regulate, support and build partnerships with the private sector is limited. At the level of programme implementation, the expected benefits of devolution in strengthening the district health system have yet to emerge.

2.3.2 Health care financing

The estimated total health expenditure in Pakistan is US$ 18 per capita of which public expenditure on health is US$ 4 per capita.[14] This compares unfavourably with the figure of US$ 34 per capita recommended by the Commission on Macroeconomics and Health.[15] During 2003–2004, public health expenditure was estimated at Rs 32.80 billion (US$ 565 million) of which Rs 8.5 billion (US$ 146 million) was development and Rs 24.30 billion (US$ 418 million) recurring, which is 0.84% of GNP, registering an increase of 13.8% in absolute terms over the past year.[16] While the government has been spending progressively more on health, it has yet to reach the target of 1% of

[13] *National agenda for health reform,* Islamabad, Ministry of Health, 2004.
[14] *The world health report: changing history*, Geneva, World Health Organization, 2004.
[15] *Macroeconomics and health: investing in health for economic development. Report of the Commission on Macroeconomics and Health*, Geneva, World Health Organization, 2001.
[16] *Pakistan Economic Survey 2003–2004*, Islamabad, Ministry of Finance, Government of Pakistan, 2004.

GNP. Out-of-pocket payment continues to be a significant source of financing of health care in Pakistan, accounting for over 75% of total health spending. There is limited experience with social health insurance, except for the employees' social security insurance (ESSI) scheme under the Social Welfare Department, for the almost 1 million formal sector workers. A national health account study has yet to be undertaken in Pakistan.

2.3.3 Human resources development

A major challenge is the imbalance in the health workforce and the lack of nurses, paramedics, skilled birth attendants and health system managers (Table 1). Currently, for every three physicians there is one nurse and almost 70% of deliveries are not conducted by a skilled birth attendant. The rapid increase in the number of medical colleges, mostly in the private sector, from 20 to 56 over the last 10 years has led to an overproduction of physicians and compromised the quality of medical education. An accreditation system is needed to monitor the quality of educational programmes, especially in the newly established colleges.

In the area of in-service training and continuing medical education, the Health Services Academy in Islamabad and the elaborate infrastructure of provincial and district health development centres are not functioning to their potential and require considerable technical assistance to achieve their mandate. Preliminary estimates indicate that almost 2000 health system managers are required to manage the 126 health districts and 900 public sector hospitals. Recently, emphasis has been placed on community-oriented medical education (COME) but it needs further strengthening. A large number of trained human resources migrate to other countries, leaving a vacuum in the required fields. Currently, there is no federal level unit on health human resource planning in the Federal Ministry of Health to forecast the requirement in various spheres of human resource.

2.3.4 Health service provision

There is an elaborate public sector health care delivery system, which consists of about 10 000 first level care facilities, more than 900 secondary and tertiary care hospitals, and almost 70 000 health houses run by lady health workers (LHWs) (Table 2).

Table 1. Human resources for health

Health personnel	1990	2000	2003
Registered doctors	52 794	92 734	108 062
Registered nurses	16 948	37 623	46 331
Registered lady health workers (LHWs)*	—	43 000	71 600
Population per doctor	2 082	1 529	1 404
Population per nurse	6 374	3 732	3 296

** LHW Programme started in 1993*

The LHWs currently cover almost 50% of the population, providing access to basic primary health care. The utilization of the public sector health care delivery system is low with only 24% of the population using government health services. Almost a third use non-qualified service providers.[17] The private sector provides 80% of curative health care.[18] Despite the large private health sector, formal and informal, for-profit and non-profit, there is inadequate understanding of the role of various private health care providers, its financing, coverage, quality and cost, and regulatory mechanisms. A concerted effort is required to develop an informed policy on the private health sector before regulatory mechanisms are put in place. There is also a need to document some of the successful experiences in public–private partnership in the country, such as the contracting out of the 104 basic health units in the district of Rahim Yar Khan to the Punjab Rural Support Programme (PRSP).

A substantial proportion of the population lacks regular access to essential medicines. Commercial interests sometimes conflict with public health priorities on the rational use, quality and safety of drugs, leading to wastage through irrational use. It has been estimated almost 15% of the health budget of the government is allocated to medicines. Pakistan also lacks a fully functional drug regulatory authority to guard the quality of imported and local products. In the area of vaccine production, Pakistan possesses the economic characteristics that could lead to adequate supplies of EPI vaccines through various forms of local production. However, the overall decline of vaccine production at the Biological Production Division, National Institute of Health, Islamabad stems in large part from a long-term failure to reinvest in staff, management systems, physical infrastructure, technology development, quality assurance and quality control.[19]

There are insufficient laboratory and diagnostic services at the rural primary and secondary levels, while services are oversupplied in urban areas. The regulatory and technical capacity of the Federal Ministry of Health needs to be strengthened

Table 2. Health infrastructure

Health infrastructure	1990	2000	2003
Hospitals	756	876	906
Basic health units	4 213	5 171	5 290
Total beds	72 997	93 907	98 684
Population per bed	1 480	1 495	1 536

[17] National Reconstruction Bureau and Canadian International Development Agency (CIDA). *Social audit of governance and delivery of public services: baseline survey report,* 2002.
[18] *National health survey of Pakistan*, Islamabad, Pakistan Medical Research Council, 1998.
[19] Harjee N. *History, strategic considerations and road map for the MOH, for the manufacture of EPI vaccines at the National Institute of Health*, Islamabad, (unpublished 2003).

and tools like health technology assessment can be used to evaluate technologies in health.

2.3.5 Health information and research

There has been insufficient development of an information culture and use of evidence in informing decisions by policy-makers and programme managers, and information systems are not geared to monitoring progress including that of the MDGs. The health management information system (HMIS) established in the 1990s suffers from inaccuracy of data reported and infrequent reporting by health facilities. The HMIS needs updating to cover the hospital sector and additional resources to sustain its operational costs. The Federal Ministry of Health has initiated a project to establish a national health information resource centre. Once fully functional, the health information system can serve as a useful monitoring and evaluation tool at all levels of the health system—federal, provincial and district. The Federal Ministry of Health and provincial departments lack capacity in the area of knowledge management and health information technology that would assist in improving institutional memory and the overall efficiency of the organization.

Health research in Pakistan has generally remained compromised due to lack of resources, supportive research environments, research management and political commitment. The Pakistan Medical Research Council (PMRC), the principal organization for promoting research, needs support to improve its performance. At present, the PMRC has limited human resource capacity, and financial resources, and does not have the institutional autonomy necessary for a research institute.

2.3.6 Key players

Although health is a provincial matter, the federal government has the overall responsibility of providing leadership and direction to stakeholders. The policies are formalized at federal level and implemented by provinces. The private sector provides a major chunk of curative care whereas the government provides a major share of preventive care, mainly through its vertical programmes. The devolution process has resulted in district government becoming a key player in provision of both preventive and curative health services. In the context of the health sector, the distribution of authority (and responsibility) between the district Nazim, the district coordination officer and the executive district officer for health (especially the latter two) has yet to be clearly delineated. Civil society organizations and philanthropy play a role in service delivery at micro level. Lately, some NGOs have been involved in policy formation as well. Donors and international development agencies have also been important stakeholders in the health sector in Pakistan, especially in recent years.

2.4 Health determinants

Poor health in Pakistan, as elsewhere, is in large measure a consequence of poverty, reflecting low income, poor sanitation, inadequate water supplies and a low level of education, all compounded by the fact that in each category women are worse off than men. The poverty–disease nexus causes underdevelopment and constrains economic growth. Other determinants that also exert a powerful influence on health outcomes include the environment, unhealthy lifestyles, lack of empowerment for women, gender imbalance in the health workforce and individual risk factors, such as tobacco, obesity and sexual behaviour. Indoor air pollution levels are very high due to the high percentage of the population using solid fuels for cooking (76%). In addition, globalization and international trade agreements, such as Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the General Agreement on Trade in Services (GATS), have implications for public health in the areas of access to essential medicines and provision of health services, respectively.

2.5 Health sector response

The overall vision for the health sector response is based on the Health for All approach. The Poverty Reduction Strategy Paper (PRSP) for Pakistan was adopted in 2002 and it terms the current health status of the nation as very poor with serious governance deficiencies, inequity in access to health and inadequate budgetary spending. The PRSP's vision is based on the priorities identified in the National Health Policy (NHP) of 2001, which emphasizes preventive care. The PRSP echoes the commitment towards achieving the MDGs. There is a high degree of continuity between the NHP, PRSP and the proposed 5-year development plan 2005–2010.

The NHP aims at implementing a strategy of protecting people against hazardous diseases, promoting public health and upgrading curative care facilities. Priority attention is accorded to the primary health care sector and good governance is seen as the basis of health sector reform to achieve quality health care. The policy targets ten key areas for specific reforms:

1. Reducing the widespread prevalence of communicable diseases.

2. Addressing inadequacies in primary/secondary health care services.

3. Promoting gender equity.

4. Correcting urban biases.

5. Bridging basic nutritional gaps.

6. Improved regulation of the private health sector.

7. Removal of professional and managerial deficiencies in the district health system.

8. Capacity-building for health policy monitoring.

9. Creating mass awareness in public health matters.

10. Improving the drug sector to ensure availability, affordability and quality of drugs.

The government has initiated a number of programmes and projects to improve the health status of the people emphasizing the above issues. These include national programmes for family planning and primary health care, malaria control, tuberculosis control, HIV/AIDS, poliomyelitis and EPI, and noncommunicable diseases.

Several donor-assisted initiatives like the National Health Facility, National Health Policy Unit and National Health Information Resource Centre are being implemented to support priority programmes, policy input and information management within the Federal Ministry of Health.

Section 3

Development Assistance and Partnership: Aid Flow, Instruments and Coordination

Section 3. Development Assistance and Partnership: Aid Flow, Instruments and Coordination

The flow of development assistance is aimed at poverty alleviation by contributing to growth and development, and improving people's quality of life through basic services, including health, education, and nutrition. Development assistance excludes resources provided for relief, emergency and humanitarian purposes. Only a small proportion of resources applied in the health and related sectors originate from external donors. The Federal Ministry of Health and the Ministry of Population and Welfare will be allocating about US$ 750 million for development and nondevelopment expenses for the fiscal year 2004–2005. The two largest donors of external financing are the World Bank and DFID.

3.1 Partners and donors

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

- ADB: Main areas of contribution are women's health and reproductive health.
- DFID: Major budgetary allocation for NHF. Other spheres of collaboration are reproductive health, PHC and consumer protection.
- GTZ: GTZ is working in three main areas which include supporting tuberculosis control, human resources development and health structure reform.
- JICA: Major areas of support are communicable diseases control including tuberculosis, HMIS, and maternal and child health. A large amount of vaccine has been provided as grant aid.
- UNICEF: The main area of work is maternal and child health.
- USAID: Contributes budgetary support for NHF. Other areas of support are reproductive health, communicable diseases and maternal health.
- World Bank: Supports maternal and child health (main support is for LHW programme), HIV/AIDS programme and public health surveillance.

UNFPA, GTZ, EU, Save the Children US and the Agha Khan Foundation contribute towards maternal and reproductive health. GFATM and GAVI have major contributions in communicable diseases. UNDP, WFP, UNAIDS, UNFPA and FAO are also contributing under the UN umbrella. CIDA, JICA and AusAID are bilateral organizations working in the health sector.

3.2 Flow of assistance

Table 3 gives a summary of available information on assistance in 2003.

3.3 Opportunities and challenges

There has always been a clear recognition of the importance of donor contributions to the health sector, however, coordination of development assistance between government and donors is weak. In this regard, WHO's role is to assist the government as a catalyst. Various approaches suggested for this purpose include an inter-agency coordination

Table 3. Summary of development assistance to Pakistan, 2003

Source	US$ (million)	%
Multilateral (breakdown)		
UN system (excluding the IFIs)	64.3	7.8
Grants	209.9	25.5
Loans	381.3	46.3
Bilateral		
Grants	69.2	8.4
Loans	98.6	12.0
Sub-total ODA	823.3	99.96
NGOs	0.36	0.04
Total development assistance	823.66	100

committee, a comprehensive development framework or most importantly a cell for coordination in the Federal Ministry of Health. The experience with the establishment of the Inter-Agency Coordination Committee (IACC) for improving coordination among various partners has been encouraging in recent years. Some of the critical challenges in donor coordination include aligning the donors behind the national health reform strategy, establishing clear priorities for funding areas of responsibility and benchmarks for each donor, and establishing a mechanism for sharing information.

The Federal Ministry of Health, Economic Affairs Division and Planning Division, have been playing a role in their own capacities in regulating aid flow but it needs to be strengthened and a common interface for more effective coordination is required. UN agencies, including WHO, UNICEF and UNFPA, undertake the CCA in collaboration with the government and have developed a tool for coordination, the United Nations Development Assistance Framework (UNDAF). CCA and UNDAF clearly define WHO's lead role in health among UN agencies.

The government has taken a step towards improving donor coordination by developing and adopting the PRSP as a basic document for all efforts, including health. It provides an opportunity for the donors and aid organizations to channel their resources coherently for common identified objectives. The National Health Policy Unit (NHPU) has the potential and mandate to further strengthen coordination of aid flow. The WHO country office can substantiate this harmonization by mobilizing the necessary technical and managerial resources required for this purpose.

Section 4

Current WHO Cooperation

Section 4. Current WHO Cooperation

4.1 Background

The World Health Organization has been working with the Government of Pakistan since the inception of the Organization with the joint aspiration of realizing the highest attainable standard of health for the people of Pakistan. In this partnership, the Health for All approach has remained the central vision. The best known accomplishments of the joint collaboration are the eradication of smallpox and guineaworm disease (dracunculiasis) with the last cases being reported in 1974 and 1993, respectively. The main thrust of WHO-Pakistan partnership has focused on national priorities and programme areas that will make a difference. Collaboration has been mainly directed as follows:

- essential health interventions with a focus on child and maternal health care, and control of communicable and noncommunicable diseases;
- health system and policies, aimed at improvement of access and universal coverage, and improving national capacity to improve delivery and performance;
- addressing the determinants of health, among which poverty is recognized as the most important contributor to ill health.

The WHO country office in Islamabad is headed by a WHO Representative and there are five suboffices, one in each province and one for Azad Janmu and Kashmir (AJK). The main country office is manned by a core of international and national professionals (see Annex 2), along with a variable number of consultants to assist the technical operations of the poliomyelitis eradication initiative.

4.2 Key areas of WHO technical support

During the past two biennia of joint technical collaboration, WHO has supported interventions in the areas of health policy and strategic planning, health systems and community development, health promotion and protection, and prevention and control of communicable diseases. The holistic approach to health sector and socioeconomic development has been applied. In addition, a number of essential health interventions have been implemented to reduce maternal, infant and child mortality rates and improve the quality of life. The four programme areas are summarized below.

4.2.1 Health policy and strategic planning support

WHO health policy and strategic planning support relates to the development of national policies, emergency preparedness and response strategies, accreditation of hospitals and health facilities. It is also concerned with the use of macroeconomics to place health at the centre of the development agenda, supporting operational research and developing partnerships for health. Through its technical assistance, WHO has supported the development of national operational guidelines for major public health programmatic interventions,

and has assisted in the formulation of health policies. Salient strategic policies that WHO has supported include the enactment of the prohibition on smoking in public places and protection of non-smokers, promotion of breastfeeding, transfusion of safe blood, and the Mental Health Act. WHO also provided technical support for the development of programme-based strategic policies in important fields, such as traditional medicines, national EPI, tuberculosis, HIV/AIDS and malaria control, child survival and home health care. Furthermore, as part of its support for capacity-building, WHO assisted in the creation of the NHPU in the Federal Ministry of Health and the establishment of a National Health Information Resource Center (NHIRC).

4.2.2 Health systems and community development

This area encompasses the expansion of primary health care (PHC), the development of human resources for health, the promotion of healthy lifestyle and sustainable development approaches such as the basic development needs (BDN) initiative. Assistance is provided for the promotion of healthy lifestyle interventions with focus on smoking prevention, promotion of physical activity and healthy diet. WHO technical assistance in the field of PHC has facilitated the scaling-up of the lady health workers programme. Lastly, WHO has supported the establishment of the devolved district health care system.

4.2.3 Health promotion and protection

The health promotion measures substantiated in health education, health protection and disease prevention are implemented as cross-cutting interventions through the different programmes, such as disease control, nutrition promotion and reduction of risk factors such as tobacco. WHO collaboration in health promotion also includes environmental health and chemical safety, food fortification, community-based rehabilitation and lifestyle changes leading to noncommunicable diseases.

4.2.4 Prevention and control of communicable diseases

Communicable disease control has been a major focus of the WHO support. WHO technical assistance has covered several national disease control programmes such as poliomyelitis eradication and EPI, tuberculosis (DOTS), malaria (RBM) and HIV/AIDS and viral hepatitis infection control. WHO capacity-building support is also directed at infectious disease surveillance with special attention to laboratory diagnosis at national and provincial levels and the development of disease early warning systems. The current support covers 24 health programmes and areas. In addition to the above, these include reproductive and family health care, child and adolescent health, emergency preparedness, health of the elderly, mental health and substance abuse, national drug policy, traditional medicine, vaccine production and control of rabies.

4.3 Financial resources

WHO contributed about US$ 70 million for priority health programmes and capacity-building over the 10 years from 1994 to 2003. The scale of support has increased considerably in the past few years. The current biennium (2004–2005) financial input for WHO technical assistance is US$ 5.5 million. In addition, an amount of US$ 22 million, mainly from extrabudgetary sources, has been earmarked for the poliomyelitis eradication programme, primarily, and for a few other priority areas, such as tuberculosis control, research activities and initiation of activities of the National Commission of Macroeconomics and Health (NCMH). Furthermore, WHO facilitates resource mobilization through partnership development, e.g. GAVI, GFATM and the Global Drug Facility (GDF).

4.4 WHO staff

The WHO Representative is currently assisted by five long-term international staff: two for poliomyelitis eradication and EPI, one for disease surveillance, one for emergency preparedness and response, and one on tuberculosis control. One post for PHC is vacant. In addition, a large number of international consultants are supporting poliomyelitis eradication. There are also some 15 national professional officers on SSA contracts assisting various programmes at the national level including PHC, environmental healthy, healthy lifestyles, tuberculosis, malaria and health management information system (HMIS). At the provincial level, four WHO national provincial officers, one for each province, facilitate WHO activities. In addition to these professional staff members, WHO general staff assist the implementation of WHO activities at the WHO Representatives' office, provincial offices and technical programmes.

Due to the very large scope of the work, there is need for a deputy WHO Representative at the national level. Also, additional international staff are needed to help with health systems, disease control, coordination and resource mobilization, and health promotion. Strengthening of the general support staff in provincial operation offices is also needed.

4.5 WHO partnership with other UN agencies

Besides its function of providing technical support to the government, WHO supports the country under the broader UN umbrella. WHO assisted in the preparation of the Common Country Assessment (CCA), which is an overview of national development priorities and programmes, and the UN Development Assistance Framework (UNDAF), designed in partnership with the government. All these strategic documents guide WHO collaboration in Pakistan.

4.6 Support from WHO headquarters and the Regional Office

The WHO country office continued to receive technical as well as financial support from the Regional Office and headquarters. The support included visits of experts including WHO staff and provision of extrabudgetary resources. The support facilitated the activities of the WHO country office in influencing health sector development and coordination among national and international partners.

The Regional Office also supports a range of intercountry activities such as consultations and training. The Pakistan country office has actively participated in these events. These intercountry activities facilitate exchange of information and experience and also support important programmes, such as vaccine development, essential drugs and operational research activities.

4.7 Resource mobilization

Resource mobilization within Pakistan is becoming more important for the WHO country office, and in this regard, it has made a good start by raising US$ 500 000 to support the programmes on HIV/AIDS, emergency preparedness and BDN. In order to continue and improve fund-raising, the country office needs to have, through the Regional Office and headquarters support, access to specialists who could strengthen resource mobilization capacity. Recently the country office constituted a resource mobilization promoting team to explore the needs and opportunities. Many bilateral donors have revealed that they are often uncertain as to where to invest their resources, and appreciated the effort of the WHO country office to bridge the gap through its technical inputs and consultations.

4.8 Strengths and weaknesses of WHO collaborative activities

To achieve its mandated goal, the WHO country office has the following comparative advantages and strengths to accomplish its tasks effectively.

- The WHO presence in all the four provinces and Azad Jammu and Kashmir (AJK), provides a valuable opportunity for the Organization to closely interact with local health institutions and district health systems, and assist public health interventions at the operational level.
- The strong and close relationship that exist between and the WHO country office and the Federal Ministry of Health is allowing the full engagement of WHO in all national dialogues for setting health reform policies, strategies and programmatic interventions. WHO can also interact with other health-related public sector departments at both provincial and district levels.
- The presence of a strong UN country team and their active engagement in health activities through their thematic working groups provides WHO with opportunity to mobilize the UN system in support of the health sector and build broader alliances with other international partners.
- The direct association of health with three of the MDGs and its relevance to many other MDGs offers WHO the legitimacy of interacting with a large number of stakeholders and promotes the central role of health in national socioeconomic development and poverty reduction.
- WHO engagement in the BDN programme provides the unique opportunity of directly interacting with civil society organizations and local communities at the district and grassroot levels. The latter provides the organization with the opportunity to participate actively in community-based integrated development interventions to address community priority needs, i.e. education, water and sanitation, nutrition, income generation, etc. This initiative has the power of catalysing and sustaining partnerships for health and community development.
- The strong potential of the country office to bring in prompt specialized technical support from the Regional Office and headquarters bestows on WHO a leadership role in all health reform debates as well as so-called programme-based support, and provides the government with the confidence of obtaining, whenever required, impartial and trustworthy health advice.

While enjoying the above strengths and opportunities, the WHO country office recognizes that the following challenges may constrain its public health performance in the country:

- Insufficient WHO professional staff in the country, especially in the critical areas of health systems and health promotion, for the effective involvement of WHO in critical health policy reform dialogue, led by the government and with participation of international development partners.
- Although WHO has its suboffices in all the four provinces and AJK, the technical capacities of these provincial offices are insufficient to respond to the growing demand for technical expertise where the health delivery system is fully decentralized. The evolving devolution makes a WHO robust technical presence at the district level a real necessity.
- WHO has had difficulty in retaining locally recruited, highly qualified national professionals because of poor remuneration and lack of career development opportunities. This creates high staff turnover and limits the medium and long-term technical capacity-building of the country team. The current efforts of the Regional Office and headquarters to recruit national programme officers (NPOs) at a competitive salary and promising career development would resolve this crucial difficulty.
- The capacities of the country office to effectively participate in resource mobilization efforts are still limited. The country office needs specifically trained and skilled human resources to address this important activity.
- Although the country office is supporting the establishment of a technical database in the country and is offering substantial input to the Federal Ministry of Health to enhance its HMIS, the health sector capacity for knowledge management in Pakistan still needs significant improvement. WHO needs therefore to assign greater focus to enhancing this technical expertise at the country office to improve evidence-based decision-making at all levels of the national health system.

Section 5

WHO Policy Framework: Global and Regional Directions

5.1 Operating framework

Health systems in developing countries are becoming more complex. The role of the state in provision of health care is diminishing rapidly, with the private sector and civil society becoming active and important players. Also, globally, a number of development organizations and financial institutions have become heavily involved with health development activities in developing countries. It was, therefore, timely for WHO to respond to this changing environment by calling for new ways of working with its Member States.

WHO has adopted a broad approach to health within the context of human development with a particular focus on the links between health and poverty reduction. It is assuming a greater role in establishing wider national and international consensus on health policies, strategies and standards, through managing the generation and application of research, knowledge and expertise. At the country level, through the CCS process, it is envisaged that:

- WHO collaboration will be more strategic and focused on fewer priority areas, which will be an amalgam of global, regional and national priorities;
- increased emphasis will be given to WHO's role as a policy adviser and broker;
- opportunities will be sought for increasing and strengthening partnerships with other international and national agencies, including nongovernmental organizations working in the field of health;
- innovative approaches will be sought to increase the effectiveness of WHO support;
- attempts will be made to ensure the utilization of the knowledge and skills present in the country for WHO's normative work.

5.2 Country level functions

To carry out WHO operations at the country level four WHO functions have been identified:

- catalysing the adoption and adaptation of technical strategies; seeding large-scale implementation;
- supporting research and development; monitoring health sector performance;
- information and knowledge sharing; providing generic policy options; standards; advocacy;
- providing specific policy advice; serving as broker; influencing policy, action and spending.

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

5.3 WHO-wide strategic directions

WHO's current (2002–2005) General Programme of Work lists the following four inter-related strategic directions to provide a broad framework for focusing WHO's technical work.

- Strategic direction 1: reducing excess mortality, morbidity and disability, especially in the poor and marginalized populations.
- Strategic direction 2: promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioural causes.
- Strategic direction 3: developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair.
- Strategic direction 4: framing an enabling policy and creating an institutional environment for the health sector and promoting an effective health dimension to social, economic, environmental and developmental policy.

5.4 WHO global priorities

Based on the analysis of major challenges in international health, WHO has established a set of global priorities. The selected global priorities as stated in the General Programme of Work for 2002–2005 are as follows:

1. Malaria, tuberculosis and HIV/AIDS: these three major communicable diseases pose a serious threat to health and economic development and have a disproportionate impact on the lives of the poor.
2. Cancer, cardiovascular diseases and diabetes: there is a growing epidemic of these diseases in the poor and in transitional economies.
3. Tobacco: is a major killer in all societies and rapidly growing problem in developing countries.
4. Maternal health: the most marked difference in health outcomes between developed and developing countries show up in maternal mortality data and it is difficult to reduce maternal mortality without a well-functioning health system.
5. Food safety: poses a growing public health concern with potentially serious economic consequences.
6. Mental health: five of the ten leading causes of disability are mental health problems; major depression is the fifth contributor to the global burden of disease and may be second by 2020.
7. Safe blood: is both a potential source of infection and a major component of treatment, and crucial in the fight against hepatitis and HIV/AIDS.
8. Health systems: development of effective and sustainable health systems underpins all the other priorities; demand is substantial from Member States for support and advice on health sector reform.
9. Investing in change in WHO: is a prerequisite for WHO to become a more efficient and productive organization and one capable of response within an increasingly complex environment. The development of new skills, systems and process is central to the effective management of WHO's core functions.

5.5 WHO regional priorities

The Eastern Mediterranean Region has the demographic profile of a developing region. It is a low–middle income region. Poverty and unemployment affect a large number of people. Communicable diseases are still prevalent in the least developed countries and tuberculosis, malaria and HIV/AIDS are major killers. A number of countries in the Region are in a state of conflict and emergency. Malnutrition is still a significant problem in some countries. Water scarcity is a region-wide challenge. Also, the lack of adequate safe water supply and proper sanitation are major health hindrances in the least developed countries, which constitute a large percentage of the population in the Region. Similarly, rapid urbanization and increase in car ownership have resulted in severe air pollution in major cities of the Region. Solid waste management, particularly of hazardous and medical wastes, is particularly weak in a significant number of countries of the Region.

An epidemiological shift is being witnessed in the Region. Currently, due to changes in lifestyles, noncommunicable diseases constitute 40% of the disease burden. It is projected that by 2020 the share of the burden for noncommunicable diseases will increase to 60%. This is creating a double burden of both communicable and noncommunicable diseases. Maternal mortality is still unacceptably high in some countries. The average maternal mortality ratio for the Region in 2001 was as high as 330 per 100 000 live births, while over 60% of infant deaths occur in the neonatal period in most countries. Foodborne diseases are also on the rise and represent a major public health challenge. The rapid change in lifestyles in many countries is having a clear impact in terms of stress and mental health-related conditions.

The health system, including governance, quality assurance, service delivery, health regulation, and medical technologies and medicine, needs major strengthening in almost all countries. Health financing is a major emerging issue in the Region. In lower income countries most health expenses are borne by people. The middle-income countries have a mix of private and public sector. In these countries, in some instances, there is a surplus of trained human resources, such as physicians. In high-income countries the major share of health expenditure is borne by governments. The health information system in almost all countries needs to be strengthened. The nursing picture is rather gloomy, both in terms of adequate numbers in poor countries and career structure.

In light of the above situation, the Regional Office has identified certain priority areas for its collaboration with Member States. These were spelled out in the programme budget for the period 2004–2005 which was endorsed by the Regional Committee for the Eastern Mediterranean at its Forty-ninth session held in October 2002 (EM/RC/49/R.2). The priorities include the following:

Health protection and promotion

- Promotion and development of healthy lifestyles through programmes such as the Tobacco Free Initiative, healthy communities, villages and cities, action-oriented school health activities, health of special groups and health education.
- Strengthening of national and regional initiatives to improve nutritional status through raising awareness of individuals and the community and control of micronutrient deficiencies.
- Integration of health promotion aspects with clinical approaches at all levels of the health care system, such as in the example of the regional initiatives to integrate at the primary health care level maternal, child and adolescent health, prevention and control of noncommunicable diseases and mental health activities.
- Promotion and strengthening of environmental health initiatives, particularly those relating to water safety and security, environmental health impact assessment, food safety and healthy environments for children and development of intersectoral activities in this respect.

Community development

- Addressing the underlying determinants of health and poverty as essential to ensuring sustainable development and sustained health improvements in the long term. Community-based initiatives such as basic development needs (BDN), healthy cities, healthy villages and women in health and development are among the priorities adopted by countries. In all these initiatives special emphasis is given to strengthening and enhancing the role of women as major stakeholders in achieving and sustaining the desired health and development goals.
- Efforts to facilitate achievement of the Millennium Development Goals, aiming to halve the number of people living in absolute poverty by the year 2015. This will include the development of various policies and plans such as Poverty Reduction Strategy Papers, to create supportive political, physical and economic conditions for all segments of the population to produce a positive impact on the overall quality of life. Concerted efforts are being made to make health systems better oriented to the needs of the poor by giving greater attention to promoting health throughout the life span, and reducing inequities in health status.

Disease control

- Improvement of epidemiological profiles using quantitative methods, such as burden of disease assessment and forecasting techniques. Efforts should be made to strengthen national and regional capabilities in epidemiology and national information systems through developing national and subnational registries for priority health problems. Efforts should also be made to benefit from epidemiological research studies in designing health policies and strategies. Priority diseases that are the main contributors to the disease burden and at the same time are amenable to intervention strategies will be identified.
- An integrated approach in communicable disease control programmes through ensuring political commitment, integrating cross-cutting control activities, scaling-up disease-specific control activities, and developing synergy of managerial processes.
  - Essential packages of services for prevention and control of priority diseases and indicators to monitor and evaluate these programmes will be developed.
  - Integration of cross-cutting control activities will cover at least communicable disease surveillance, epidemic preparedness and response including developing early warning and surveillance systems, infection control and containment of antimicrobial resistance, integrated human resource development, health education and advocacy, and operational research.
  - Scaling-up of disease-specific activities includes immunization programmes, tuberculosis control, malaria control, HIV/AIDS/STD prevention and control, elimination and eradication of specific diseases.
- Immunization programmes maintained and strengthened, with particular focus on countries that have lower immunization coverage and problems in certification of poliomyelitis eradication. The Regional Office will pursue its policy aimed at achieving self-sufficiency in vaccine production.
- Integrated management in control of noncommunicable diseases. Particularly attention will be paid to quality assurance programmes and to emerging needs, such as palliative care for cancer patients and health of the elderly.

Health systems and services development

- Promotion of a culture of strategic thinking in decision-making, using evidence-based policies and strategies, and development of important components of the stewardship function, such as regulation, public–private mix management, coordination, etc.
- Strengthening decentralization of health systems through capacity-building and technical expertise, and supporting district health systems through institutionalization of the district team problem-solving approach and development of sustainable management through national management effectiveness programmes.
- Improving quality in health service delivery through implementation of a programme of continuous quality improvement based on quality standards for individuals, departments and organizations against which performance will be measured.
- Support to accreditation initiatives, such as multidisciplinary assessments of health care functions, organizations and networks, as an important approach for improving the quality of health care structures.

- Enhancing national information systems in order to provide necessary data on spending on health, particularly on private services, making use of household expenditure and utilization surveys and national health accounts analysis.
- Testing of the WHO framework and tools for health system performance assessment and development of an observatory in the Regional Office to assess, manage and monitor health sector reforms.
- Development and decentralization of laboratory activities, health imaging technology, blood safety and blood transfusion.
- Strengthening of the essential drugs programme and ensuring use of essential drugs lists by most countries while promoting rational drug use and traditional medicine.
- Improvement of coordination for human resources development and promotion of continuing education for health personnel at the various levels of the system. Efforts will focus on developing innovative approaches for human resources development, including community-oriented health personnel education.

Section 6

Strategic Agenda: Priorities Jointly Agreed for WHO Cooperation in and with Pakistan for 2005–2009

Section 6. Strategic Agenda: Priorities Jointly Agreed for WHO Cooperation in and with Pakistan for 2005–2009

The priority directions for WHO's technical cooperation with the Government of Pakistan were identified through an intense process of analysis and consultation. An exhaustive health sector situation analysis was undertaken by examining major national and provincial health and related policies, strategies, plans, assessments and evaluations. The CCS team held discussions with senior health decision-makers and key technical staff at federal, provincial and district levels of the Federal Ministry of Health, donors and UN agencies.

The strategic directions for the WHO cooperation strategy for the next 6 years have been framed to support Pakistan in moving towards achieving the Millennium Development Goals. The strategic directions take into account: the national goal of the Government of Pakistan to provide adequate health coverage to all people, the desire of the senior leadership for rapid strengthening of the health sector and the ongoing devolution of governance and administration in the country. The strategic directions are guided by the spirit and essence of primary health care and Health for All. They also take into consideration that a large share of health care delivery is provided by the private sector. In addition to the Federal Ministry of Health, the directions are selected to be sensitive and support other key health partners in government, civil society, and programmes and activities that are supported by UN agencies, development banks and donors. Lastly, the strategic directions are cognizant of the WHO mandate, means and technical domain.

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

- health policy and system development
- communicable disease control
- improving the health of women and children
- noncommunicable diseases
- addressing the social determinants of health
- emergency preparedness and response
- enhancing partnerships, resource mobilization and coordination.

The strategic directions are elaborated below.

6.1 Health policy and system development

The overall objective of WHO's strategy will be to improve the development of health policy, planning, regulation and financing, leading to more equitable, responsive and fair financing of a decentralized health system. This will be accomplished by broadening support for a more equitable health system in the overall development agenda by building a consensus on health policy at national, provincial and district levels where WHO can help also in definition of the roles and responsibilities of different levels of the health system in Pakistan. In specific terms, WHO support for health policy and system development will be focused on the following.

6.1.1 Improving governance

- Policy analysis and development: undertaking assessment and policy analysis, and assisting in implementation of the burden of diseases study, to streamline and redefine the policies, role and functions of the health system at different levels and to provide clear direction for health development in the light of devolution.
- Capacity-building: supporting the Federal Ministry of Health in building managerial and technical capacity, especially in strategic planning, legislation and regulation, a system for accountability in implementation of plans and programmes, management, administration and utilization of resources, strengthening the new health policy and coordination unit in the Federal Ministry of Health, developing district and provincial health strategies and local level health plans, and effective backstopping by the provincial and federal levels.
- Strengthening institutional criteria: developing norms, standards for quality assurance, and accreditation of health facilities at all levels, promoting evidence-based policy formulation and decision-making to strengthen the technical and professional approaches.
- Special care will be given to strengthening the national capacities in monitoring, supervision and evaluation functions of the national health systems and programmes.

6.1.2 Human resources for health

- Developing policy and strategies: assessment, production and management (working conditions, performance, distribution and utilization), and defining the categories and the core competencies for different health personnel.
- Developing health managers: training a core group of health managers to run the district health programme, hospitals, and national and provincial health programmes.
- Strengthening medical and allied health personnel education: reviewing/updating of medical schools' and teaching institutes' curricula, including bio-ethics in education and training curricula, accreditation of medical education and rationalization of medical colleges' establishment, supporting community medical education and continuing medical education, and collaborating with the Federal Ministry of Health higher education institutes.
- Supporting training of personnel and institutions: training of nurses, other allied personnel, lady health workers and traditional medicine practitioners, and strengthening the Health Science Academy at federal and provincial levels for training of health managers through working with all partners in this area, including NGOs and the private sector.

6.1.3 Improving service delivery and equity

- Capacity-building: developing the PHC system and a package of basic health services to increase access to health care facilities, enhance the district health system, and strengthening the Federal Ministry of Health institutional capacities for implementation of priority health programmes at all levels for better management and utilization of available infrastructure and ability to respond to devolution.
- Facilitating intersectoral collaboration at all levels, particularly at the district level.
- Supporting equity: conducting comparative case studies and research in access, availability of health personnel, quality assurance and expenditure in different areas of the country with the aim of improving equity in health.

6.1.4 Achieving equitable and fair health financing

- National health accounts (NHA): establishing NHA and developing policies and strategies for health financing.
- Financing: testing community financing through applied pilot schemes and initiating schemes for health coverage through social security schemes, health insurance and community financing.
- Advocating for more resources: supporting the Federal Ministry of Health, in close collaboration with other partners, to increase resources for health from government and international sources.

6.1.5 Developing public–private sector partnership

- Assessing the situation and role of the private health sector and taking steps for public–private partnership, in collaboration with other partners.
- Evaluating and applying innovative approaches that have been initiated by other partners in health privatization.
- Assisting the Federal Ministry of Health to facilitate private sector participation in preventive health.

6.1.6 Medicine and biotechnology

- Capacity-building: supporting the ongoing establishment of the independent national drug regulatory authority, strengthening the independent national vaccine production and monitoring authority, and developing a strong legislative and regulatory basis for medicines and biotechnologies.
- Supporting the production of vaccines through the ongoing intercountry agreement.
- Enhancing the rational use of medicines and biotechnologies, including promotion of essential drugs.
- Strengthening the documentation and information base of the Federal Ministry of Health on international trade, to protect the interests of the country concerning the health aspects of globalization (WTO, TRIPS).

6.1.7 Health information

- Strengthening of the health management information system (HMIS) through restructuring of HMIS tools, the development of a hospital management information system, the inclusion of the private health sector, and incorporation of noncommunicable diseases, including mental health.
- Strengthening of the cancer, diabetes and cardiovascular diseases registries.
- Supporting the newly established National Health Information Resource Centre (NHIRC) in developing a comprehensive and integrated National Health Information System (NHIS).
- Giving critical priority to strengthening the use of information and data for development of policies, plans and management.
- Strengthening the knowledge management base of the Federal Ministry of Health for utilization of the results of existing studies and research for policy development, programming and management as well as improving advocacy, information/communication for health and use of up-to-date health technologies.

6.1.8 Promoting research

- Promoting and supporting the implementation of operational and applied research to strengthen policy formulation, planning, human resources development, monitoring and management at all levels, with special reference to improvement of access and equity.
- Supporting research and studies on utilization of health services, health care costs, efficacy and efficiency of different health programmes and, as a priority, on the impact of devolution on health services.

6.2 Communicable disease control

6.2.1 Improving immunization

- Giving the highest priority to poliomyelitis eradication and disease surveillance.
- Strengthening elimination initiatives for maternal and neonatal tetanus and measles, and routine immunization coverage for measles, DPT, BCG, hepatitis B and other immunizable diseases, in collaboration with UNICEF and other key partners.

6.2.2 Disease control

- Capacity-building for the implementation of communicable disease control programmes under a devolved health system and the monitoring of districts' performance.
- Strengthening of tuberculosis (Stop TB), malaria (Roll Back Malaria) and leishmaniasis control programmes, so that the programmes can achieve the globally set targets on time.
- Strengthening of the HIV/AIDS programme in collaboration with other partners, especially UNAIDS and the World Bank, as part of the 3 by 5 Initiative: anti-retroviral drugs for eligible people living with HIV/AIDS (PLWHA), blood safety, risk assessments, surveillance, community awareness, compassionate social care, and harm reduction, particularly for injecting drug users.
- Assisting the control of different types of hepatitis through preventive measures.
- Improving injection safety and infection control programmes.
- Strengthening of prevention and control of zoonotic diseases: Crimean-Congo haemorrhagic fever, especially in Baluchistan, and rabies control in collaboration with FAO.

6.2.3 Improving surveillance

- Strengthening of health laboratories for quality control and surveillance.
- Enhancing communicable diseases surveillance and the disease early warning system (DEWS) through HMIS, with special focus on strengthening the surveillance and reporting systems at district level.

6.3 Improving the health of women and children

- Promoting and assisting safe motherhood, making pregnancy safer, family planning and child spacing, and prevention and control of sexually transmitted infections, in collaboration with UNFPA and other key partners.
- Focusing on greater use of evidence as a basis for policy-making, increased priority for nutrition programmes to reduce neonatal and perinatal mortality (especially those to reduce anaemia and to increase birth weight), and provision of emergency obstetric care.
- Capacity-building for training and placement of skilled birth attendants and midwives, and improving the referral system as part of the essential district health services package.
- Supporting policy level and advocacy action to generate support for maternal and neonatal health among local decision-makers and health professionals.
- Focusing on technical support for the expansion of the child survival programme, with special attention to acute respiratory infections and diarrhoeal diseases control.

6.4 Noncommunicable diseases

- Giving a high priority to advancing and strengthening the new tripartite initiative on noncommunicable diseases being launched by the Federal Ministry of Health, WHO and World Bank.
- Supporting advocacy for multisectoral efforts to address lifestyle and nutrition-related causes of poor health.
- Giving special focus to road traffic accidents, drug abuse and development of a sustainable mental heath programme. This would also involve piloting and testing interventions and subsequently preparing for scaling-up and introduction of appropriate legislation.
- Supporting prevention and control of nutrition-related conditions leading to chronic diseases.

6.5 Addressing the social determinants of health

6.5.1 Healthy environment

- Capacity-building: supporting the Federal Ministry of Health to establish an environmental health unit at the federal and provincial levels, monitor environmental health, develop and implement a hygiene education programme, and create a systematic linkage between communicable disease control and environmental health.
- Water quality: supporting the preparing of water quality policy, strengthening of monitoring and developing community-based water purification, such as solar disinfection.
- Advancing the ongoing and effective initiative for hospital waste management.
- Supporting the implementation of community-based water supply, sanitation and other environmental health activities, through community-based initiatives (BDN).

6.5.2 Health awareness raising and healthy lifestyles

- Developing country-wide concerted efforts to raise people's awareness of health issues.
- Strengthening programmes on healthy lifestyles and tobacco control.
- Strengthening the capabilities of the Federal Ministry of Health for nutrition.
- Expanding community-based initiatives such as BDN and Healthy Cities to combat poverty and empower communities to improve their health.

6.5.3 Gender mainstreaming

- Developing a gender perspective and gender streamlining as a cross-cutting strategy for all health programmes and activities, particularly for gender disaggregated health data and information.

6.6 Emergency preparedness and response

- Capacity-building: strengthening of the Federal Ministry of Health field capacity, reinforcing the Federal Ministry of Health's role in the Country Disaster Management Team and strengthening health activities being implemented under the States and Frontier Regions units in provinces.
- Enhancing training and human resources development
- Maintaining a close link with key UN agencies, NGOs and other partners.

6.7 Partnerships, resource mobilization and coordination

- Supporting the Federal Ministry of Health capacity for utilization and coordination of donors' support through the new policy and coordination unit in the Ministry, especially for developing norms, criteria and priority areas for donor support.
- Supporting the preparation of case studies, evaluations, and necessary data and information for a donors' inventory, and a directory of projects and programmes needing external assistance.
- Giving high priority to resource mobilization, assisting in developing project proposals for donors' support and acting as a supporter and mediator between donors and the Federal Ministry of Health.
- Assisting in creation of coordination and partnership between concerned health programmes, related sectors, and UN and external support agencies at local, district, provincial and national level.

Country Cooperation Strategy for WHO and Pakistan

Section 7

Implementing the Strategic Agenda: Implications for WHO Secretariat, Follow-up and Next Steps at Each Level

Section 7. Implementing the Strategic Agenda: Implications for WHO Secretariat, Follow-up and Next Steps at Each Level

The Country Cooperation Strategy (2005–2010) will be a significant step in the collaborative work of WHO and the Government of the Pakistan. It will streamline and strengthen WHO's contribution to national health development. Implementation of this strategy will have considerable implications on the working of WHO at various levels.

7.1 Implications for the country office

In order to meet the strategic requirements during the years 2005–2010, the WHO country office in Pakistan and its suboffices will have to be strengthened technically and administratively. The growing shift from the role of programme implementation to one of an effective advocate and catalyst for strategic development of the health sector has immediate implications for the WHO Representative's Office in Pakistan. The necessary changes need to be made as soon as possible. The strengthening of the capacities of the country office to fulfil its essential functions in technical areas, management, advocacy, representation and partnerships, needs to be facilitated by all levels of the Organization.

7.1.1 Technical functions

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

7.1.2 Management and administrative functions

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

- Ensuring that the CCS is used to inform strategic planning as well as the biennial programme budgeting.
- Implementation of the new expanded delegation of authority to the WHO Representative from the Regional Office, commensurate with his responsibilities, including flexibility to allocate, re-allocate and spend resources within the strategic framework.
- Redefinition, revision and assessing of the staffing needs at the country office to fulfil the expected functions of the office. This has to include revision of the terms of reference of the existing WHO country staff to incorporate the new strategic directions. The

assignment of a deputy WHO Representative in the country needs to be given higher consideration.

- Strengthening the roles and functions of the WHO sub-offices at provincial level. Appropriate staffing and adequate logistics have to be secured for these sub-offices to improve their performance, including recruitment of at least one national programme officer at each sub-office.
- Making the necessary arrangements for staff development and improving the attitude and skills of all members of the WHO country team including the general services staff.
- Improving the physical work environment inside the office. This includes providing more space and a better communications system.

7.1.3 Advocacy, representation and partnership functions

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

7.2 Implications for the Regional Office and headquarters

The Country Cooperation Strategy for Pakistan will require the country office to assume the lead role in decision-making and programme planning and implementation, at country level. The performance of this changed function and the minimal requirements stated above will depend to a large extent on the increasing transformation from decisive to supportive management at the Regional Office and headquarters.

The staff at these levels of the Organization have to be willing to accept this change for a proactive response to the needs and requests of the country offices. It will involve new ways of thinking, enhanced operating procedures and more effective mobilization of resources to fill gaps in the health programmes of Pakistan.

The Regional Office and headquarters will have to work closely to identify and track technical resources in a more coordinated manner to support the country office activities by sharing global and regional experiences, developing standards, guidelines and protocols, and providing documents and publications. Traditional and modern communications and information technology should be utilized for the dissemination of the technical resources between the different levels of WHO.

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

More specifically, the Regional Office will continue to:

- provide technical support and more systematic response to urgent technical requirements of the Pakistan country office;
- share regional experiences (TCDC), resources (WHO Collaborating Centres, regional centres of excellence) and development of guidelines and protocols especially in the priority areas in the CCS;
- strengthen monitoring and evaluation;
- mobilize and allocate additional resources to the country office;
- build technical as well as administrative capacities of staff at country level, by involving them in regional and intercountry meetings and training.

Similarly, headquarters will provide the necessary backstopping, and technical and financial, support to the country office in close coordination with the Regional Office.

Annexes

Annex 1
CCS Pakistan team members

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Annex 2
WHO Pakistan organigram