

NATIONAL **HEALTH**

VISION

PAKISTAN

2016-
2025



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LIST OF ACRONYMS

BOD	burden of disease
CBO	community-based organisation
CSO	civil society organization
HR	human resource
HTA	Health Technology Assessment
IHR	International Health Regulations
M&E	monitoring and evaluation
MDG	Millennium Development Goal
M/ONHSR&C	Ministry of National Health Services, Regulation & Coordination
NGO	nongovernmental organisation
SDG	Sustainable Development Goal

FOREWARD

THIS VISION
WILL SERVE AS
INSPIRATION
AND GUIDING
ROADMAP
FOR ALL THOSE
IMPLEMENTING
REFORMS BY
STRENGTHENING
HEALTH
SYSTEMS.

Pakistan undertook a major constitutional reform in 2011 with the 18th amendment, which resulted in abolishment of Ministry of Health and subsequent devolution of powers, notably strategy development and program implementation. It also led to the establishment of Federal Legislative Lists I & II, indicating the federal functions in the devolved system.

To execute the federal functions, Ministry of National Health Services, Regulation, and Coordination (M/ONHSR&C) was recreated in 2013 with the mandate to provide a common strategic vision to guide the health sector according to the Government of Pakistan's National Health Vision, which is to achieve universal health coverage by 2025 through efficient, equitable, accessible, and affordable health services to its entire populace; to coordinate public health and population welfare at national and international levels; fulfil international obligations and commitments; provide oversight for provincial and national health regulatory bodies; enforce drug regulations including medical profession and education.

The National Health Vision is a significant achievement of the current government. It is my pleasure and privilege as the Minister for State M/ONHSR&C to launch the National Health Vision (2016–2025) for the Islamic Republic of Pakistan. This vision will serve as inspiration and guiding roadmap for all those implementing reforms by strengthening health systems. It has been prepared in accordance with the needs of a devolved and decentralized system, and I strongly believe that, with the help of this vision document, the federation of Pakistan and its provinces will be able to achieve the targets set in SDGs.

I acknowledge the dedication and effort of all staff under the leadership of the Secretary and the DG, M/ONHSR&C.

The Government of Pakistan is committed to ensuring equity and quality through the delivery of essential preventive and curative care services to every citizen of Pakistan. I pray that we see this vision fulfilled by 2025.

— *Saira Afzal Tarar, Minister for State*



DECLARATION BY FEDERAL AND PROVINCIAL MINISTERS OF HEALTH

National Health Vision 2016-2025 Consultative Meeting

30th August, 2016

Marriot Hotel Islamabad

The National Health Vision Document (2016-2025) is unified National Common Health Vision with agreed priorities covering eight thematic areas. We pledge to work together for better health of all especially for women and children of Pakistan and therefore we endorse this document.

S.#	Name & Designation	Province/Region	Signatures
1.	Saira Afzal	M/ONHSREC	Saira
2.	M. Najeeb Nagi Khan	AT&K	M. Najeeb Nagi Khan
3.	RAHMAT Sakh	Baluchistan	RAHMAT Sakh
4.	Sikandar Maqsood	Sindh	Sikandar Maqsood
5.	sheram Khan	Tarakai KP	sheram Khan
6.	KH. SALMAN RAFI	Punjab	KH. SALMAN RAFI

MESSAGE

THE
GOVERNMENT
OF PAKISTAN
HAS PLEDGED
TO **INCREASE**
HEALTH SECTOR
ALLOCATION
TO 3 PERCENT
OF GDP
BY THE NEXT
DECADE.

The Government of Pakistan is cognizant of the fact that investment in the health sector is of utmost importance, and would like to ensure that its population is healthy and has equitable access to quality health services. With the 18th Constitutional Amendment and devolution of health as a subject to the provincial governments, the federal government being the main interface with international community, required a National Health Vision encompassing medium-term goals aligned with Pakistan's Vision 2025, and global commitments and instruments for conduct constitutional federal functions.

The Government of Pakistan has pledged to increase health sector allocation to 3 percent of GDP by the next decade. Further, the Government of Pakistan is open to exploring avenues of mutual interest with development partners to mobilize more resources by adopting a plan that will allow the health sector to fulfil its role in economic development and global security.

Since the re-creation of the Ministry of National Health Services, Regulation & Coordination in 2013, we have reviewed our priorities and capacity. We have examined our structure through a functional alignment process, and as we work to consolidate these changes by improving our skills, systems, and structures, we will enhance our ability to deliver improved outcomes.

The National Health Vision (2016–25) defines our purpose and priorities. It takes its guidance from in-depth consultations with the line ministries, provinces/regions, development partners, nongovernmental organisations, civil and private sector entities, and evolves from national priorities in tandem with regional/global reforms and initiatives.

Finally, I would like to acknowledge and thank all those who have contributed to the creation of this vision.

—*Muhammad Ayub Shaikh, Secretary*

ACKNOWLEDGEMENTS

The National Health Vision 2016–25 is a result of the Pakistan Vision 2025 that was developed by the Ministry of Planning, Development & Reforms. It solidifies the intent for placing financial resources and is roadmap for the development of a prosperous and healthy Pakistan.

This vision document is the result of many meetings, discussions, and debates over a year, under the aegis of the Ministry of National Health Services, Regulation & Coordination, with eventual consensus involving every section of the society. This vision is owned by both the political and administrative leadership of the health sector and the overall political and administrative arena of the country.

It is worth noting the coordination efforts of the Health Planning, Systems Strengthening and Information Analysis Unit of the Ministry under the able leadership of director programs and the assistance from development partners, among them JSI/USAID, WHO, and World Bank. I would like to give my special thanks to the provincial health ministers, secretaries of health, director generals' health services, and colleagues from all health and line departments for contributing to the process.

The making of Pakistan National Health Vision 2016–2025 is indebted to Ms. Saira Afzal Tarar, Minister for State for Health, who initiated the political dialogue with provincial leadership and articulated the importance of such a vision to the Prime Minister of Pakistan. The Federal Minister for Planning & Development Prof. Ahsan Iqbal's encouragement was a key factor in initiating the process. I am also grateful to the trust and confidence that the Federal Secretary Health placed in the team during the development process.

My special gratitude is due to lead consultants Dr. Shehla Zaidi from Aga Khan University and Dr. Babar Tasneem Shaikh from Health Services Academy, who painstakingly helped with various drafts of the document. The vision could not have materialized without their input.

I am also grateful to the contribution of Dr. Nasir Idrees, Dr. Syed Mursalin, Dr. Adnan Khan, Mr Ayaz Kiani, and Dr. Shahzad Ali Khan, who worked on the thematic areas of the vision. Many more individuals and institutions gave their time and feedback to create this forward-looking document.

In the end, I pray for the achievement of the targets set in the National Health Vision 2016–2025.

— *Dr. Assad Hafeez, Director General*

1. VISION STATEMENT

The vision of the Office is to improve the health of all Pakistanis, particularly women and children by providing universal access to affordable, quality, essential health services which are delivered through a resilient and responsive health system, capable of attaining the Sustainable Development Goals and fulfilling its other global health responsibilities.

1. BACKGROUND¹

- 1) The 2011 devolution of health to the provinces created challenges as well as opportunities. It is expected that the health benefits gained from federal support will lead to more equitable health system coverage, in line with provincial priorities. The provincial health departments and the re-established Ministry of National Health Services, Regulation and Coordination (M/ONHSR&C) are taking their new roles as indicated in the federal legislative list parts I & II.
- 2) Political devolution within Pakistan charged provincial health care systems with planning health care delivery structures, programs, and services. This responsibility and leadership is important because the targets of health-related Millennium Development Goals (MDGs) were not completely achieved, and far more effort is required to work toward the even more challenging targets of the Sustainable Development Goals (SDGs).
- 3) Since July 2011, there has been a lack of consensus on a national vision that reflects aspirations for better health of the people of the country as a whole. A national vision document on health that is aligned with the country's vision 2025 and international health priorities, and is based on provincial realities, is needed. This is within the framework of post-18th Amendment Constitutional roles/responsibilities.

¹ All references used to cite facts and figures are available on request from the HPSIU-M/o NHSR&C.

3. PAKISTAN AT THE CROSSROADS FOR HEALTH: CHALLENGES

- 4) Despite several social, economic, political, and cross-border challenges compounded by successive natural catastrophes, the health indicators of Pakistan have shown improvement in the last 25 years. However it still lags behind some regional countries.
- 5) The average life expectancy has increased from 59 years in 1990 to 67 years in 2015. The last maternal mortality ratio recorded (2006-2007) was 276 per 100,000 live births, but this has improved significantly in the past decade, due to wide outreach of the national lady health worker program, and skilled birth attendance availability. Infant and under 5 mortality rates have also improved (from 72/1000 to 66/1000 live births). However, the neonatal mortality rate has remained stagnant, and stillbirth rates have increased (43/1000 live births).
- 6) Pakistan is facing high rates of communicable and non-communicable diseases, resulting in a double **burden of disease** (BOD), which is disproportionately higher among the poor. **Communicable diseases**, pregnancy related health conditions, and malnutrition constitute about half of the BOD. In young children, diarrhoea and respiratory illness remain the major killers. Maternal deaths due to preventable causes like sepsis, haemorrhage, and hypertensive crises are common. Pakistan is one of three remaining countries where polio is endemic. Moreover, Pakistan has endemic rates of hepatitis B and C in the general population, with 7.6% affected individuals—the fifth-highest tuberculosis burden in the world. The country has a focal geographical area of malaria endemicity, and an established HIV concentration among high-risk groups. Other vaccine-preventable diseases and emerging infections call for strengthened disease surveillance and response systems uniformly across the country. Pakistan has one of the highest prevalence of under-weight children in South Asia. Stunting, micro nutrient deficiencies, and low birth-weight babies contribute to already high levels of child mortality. Many of these conditions could be controlled by relatively low-cost interventions and clinical best practices utilized at primary and secondary care levels.
- 7) **Non-communicable diseases**, along with injuries and mental health, constitute the other half of the BOD. These, unlike communicable diseases, affect adults of (otherwise) economically productive age. Yet the common underlying factors for non-communicable diseases, including lifestyle, nutrition, and smoking, have not been addressed adequately. Pakistan is ranked seventh-highest in the world for diabetes prevalence. One-in-four adults over 18 years of age is hypertensive, and smoking levels are high (38% among men and 7% among women). Rising but still under-estimated rates of cancer and cardiopulmonary disease remain largely ignored. Poverty, low literacy, unemployment, gender discrimination, and a huge treatment gap have led to an invisible burden of mental health problems. Disability due to blindness and other causes is also high, and services for disabled people, including provision of devices to improve their quality of life, are limited. Injuries, which account for more than 11% of the total BOD, are likely to rise with increasing road traffic, urbanization, and conflict.

- 8) **Population Growth:** The BOD is rendered worse by an increasing population, and Pakistan is now the sixth-most populous country in the world. A decline in the population growth rate has been slow. The current growth rate of 1.9% per annum is driven by an increasing age at first marriage in urban areas; yet contraceptive prevalence, at only 35%, is far below that of other countries in the region. Unmet need for birth spacing is around 25%, and the health system must develop strategies to close this gap.
- 9) **Health Access and Inequities:** Pakistan has seen progress in access to health care services through contracting primary health care facilities. However, gains are uneven across service areas because out-of-pocket expenditures is still approximately 70% despite the primary, secondary, and tertiary health care network. Though skilled birth attendance has improved from 18% in late 1990s to 58% in 2015, only one-third of women make the required minimum number of antenatal visits, and only 2% attend the recommended postnatal (after 1–2 days of delivery) visit. Despite an overall reduction in polio cases due to high vertical accountability, rates of routine immunization remain unacceptably low at 54%. Access to and affordability of essential medicines is low. Moreover, there are geographical disparities in coverage between provinces, districts, and rural-urban areas. Evidence shows that low-income groups are likely to have lower levels of health, nutrition, immunization, and family planning coverage.
- 10) **Health Systems:** Pakistan has a **mixed health system** that includes the government or public sector, private sector, civil society, and philanthropic donors. A major strength of the government's health care system in Pakistan is primary health care outreach, which is delivered at the community level by 100,000 lady health workers, a growing number of community midwives, and other community-based health workers who have earned community trust. Complementary, alternative, and traditional healing is also popular in Pakistan.

Pakistan's health system faces **challenges** of vertical service delivery structures and low performance accountability within the government, creating efficiency and quality issues. Largely unregulated for quality of care or pricing, there is duplication of service delivery by the private sector, which contributes little towards preventive and promotive health services. The public sector is inadequately staffed and both job satisfaction and work environment need improvement. The overall health sector also faces an imbalance in the number, skill mix, and deployment of its workforce, and inadequate resource allocation across different levels (i.e., primary, secondary, and tertiary). The quality of medical and related education in the public and private sector needs to be improved, and actions to neutralize social determinants within the health and social sectors must be taken to overcome these challenges.

4. PURPOSE

- 11) The purpose of this document is to provide an **overarching national vision** and a common direction that harmonizes provincial and federal efforts, and inter-provincial/sectoral efforts to achieve desired health outcomes. This document is a jointly developed account of **strategic actions** to achieve the common vision, and is a guideline for best practices for the provinces/areas to develop their respective policies and initiatives.
- 12) The word “national” depicts common political aspirations of the provincial and the federal governments. This document concurs with federal vision, provincial strategies, and international commitments to which Pakistan is a signatory.
- 13) Beyond the health sector, this document builds convergence with important national programs and policy such as the Pakistan Vision 2025, Poverty Reduction Strategy, and pro-poor social protection initiatives.

5. GUIDING VALUES

- 14) The National Health Vision strives to provide unified direction overcome various health challenges, while ensuring adherence to universal health coverage as the ultimate goal. The principle values include:
 - a) Good governance
 - b) Innovation and transformation
 - c) Equity and pro-poor approach
 - d) Responsiveness
 - e) Transparency and accountability
 - f) Integration and cross-sectoral synergies
- 15) The delivery of high-quality health care services is a provincial responsibility and the actions indicated in this document are in concert with the provincial needs, expectations, and priorities. The national health vision aims to resonate with the ideals and expectations of provinces. The federal government will support and facilitate the provinces in developing and implementing their strategies by providing the overall vision and facilitating/advocating financial and technical resource mobilization to ensure that essential health services are accessible to all citizens.

6. OBJECTIVES

- 16) The National Health Vision 2016–2025 has adopted the following objectives to improve the health and well-being of the Pakistanis:
- a) Provide a **unified vision** to improve health while ensuring provincial autonomy and diversity;
 - b) Build **coherence** between federal and provincial efforts by consolidating progress, learning from experience, and moving towards universal health coverage;
 - c) Facilitate **synchronization** across international reporting and treaties;
 - d) Facilitate **coordination** for regulation, information collection, surveillance, and research on improved health systems;
 - e) Provide a **foundational basis** for charting and implementing SDGs in partnership with other sectors.

7. THEMATIC PILLARS

PILLAR #1: Governance

The National Health Vision builds its narrative on eight thematic pillars to ensure access, coverage, quality, and safety— essential requisites for achieving the ultimate goal of universal health coverage in Pakistan. The challenges and strategic vision for each thematic pillar or domain are itemized below. These will form the basis of the over-arching technical support that the federal government will offer and coordinate for the provinces.

Challenges

- 17) Governance has been a constant challenge, undermining service delivery and budgetary investments. As in other sectors, **patronage** often has a significant role in determining the agenda for health policies and administration in Pakistan.
- 18) The capacity to **regulate public and the private sector** health market (i.e., medical practice, pharmaceutical, and diagnostics) is weak.
- 19) There is no uniform approach for managing the governance of health institutions, and capacity for contracting services is not optimal.

Strategic Direction

- 20) Federal and provincial health authorities must rebuild their **stewardship of the health system** through professional independent advice and technical governance of health services planning. They must strive to become the providers of essential health services provision and delivery.
- 21) A steady and purposeful **stewardship role** of the provinces should bring structural changes to the health system. It is expected that **sector-wide strategic planning**, regulation, purchasing, financing, and separating service provision from stewardship.
- 22) **Health services reforms** that are already underway should focus on strengthening government-provided services. **Innovative management models** that align with preventive primary health targets should be tested.
- 23) **Private sector** should be seen as a partner in healthcare delivery and should be engaged and regulated through appropriate mechanisms. It should strive to meet national SDG targets.
- 24) Increase share of public sector **budgets commitment** to governance strengthening, and establishing dedicated structures within provincial and federal ministries. Both government and private service providers will be involved in performance accountability and targeted service delivery.
- 25) **Accountability mechanisms** must be put in place at all levels. Development of key performance indicators and output-based measures facilitate progression to performance-based models.

PILLAR #2: Health Financing

Challenges

- 26) Government spending on health has always been suboptimal (0.6% of GDP). Most health allocations are consumed by secondary and tertiary care, leaving a scant 15% for preventive and primary care.
- 27) There are inefficiencies in the public health spending due to weak management systems, resulting in low utilization and eventual lapse of funds. Payments are not linked to performance.
- 28) **Donor funding** has been minimal (<2% of total national health expenditure). The official donor assistance is far less than that committed in the Paris declaration, and should better align with government strategies.
- 29) Many population sub-groups lack **financial protection** and are at risk of catastrophic health expenditures.

Strategic Direction

- 30) Government is cognizant that **adequate, responsive, and efficient health financing** is the cornerstone of a country's well-functioning health systems. Spending on health will be presented as an **"investment"** to the line ministries, finance departments, and international development partners.
- 31) Federal and provincial governments will increase **health allocations** as pledged in Pakistan Vision 2025 to 3% of GDP, to maximize the pay-offs from investing in health.
- 32) **Priorities for health allocations** will be revisited, and a higher share for essential health service delivery, preventive programs, communication, capacity building of frontline health workers, and governance ensured.
- 33) **Pro-poor social protection initiatives** (including the recent Prime Minister National Health Program) will continue to be financed and new initiatives (conditional cash transfers, vouchers) launched to facilitate access to essential primary and secondary health services and priority diseases, with a vision for coverage and protection for the entire population through necessary legislation.
- 34) There will be progressive movement toward **universal health coverage**. Reproductive, maternal, new-born, child and adolescent health and nutrition investments will be increased in phases.
- 35) Governments will develop mechanisms to build capacity to implement **fiscal discipline, revisit formulae for district allocations** to maintain parity, and grant financial autonomy to health institutions.
- 36) Federal and provincial governments will develop joint strategies to **enhance resource mobilization** for health from official development assistance/ international development partners, private sector engagement, and taxes, such as 'sin' taxes.

PILLAR #3: Packaging Health Services

Challenges

- 37) There is now an established and increasing **double burden** of disease comprising non-communicable diseases, mental health, and injuries, and communicable and infectious diseases such as TB, HIV, and hepatitis B and C. Additionally, the health needs of elderly and aging populations will become a major problem in the next few years.
- 38) **Inadequate infrastructure** and standards, along with poor-quality services have weakened public trust, resulting in just 20% of the population using public-sector first-level health care services.
- 39) Progress has been constrained by **fragmented service delivery**, inadequate resource commitment to preventive and promotive care, and lack of human resource (HR) skill mix.
- 40) **Inequitable access**, urban-rural disparities, lack of private sector regulation, and non-conformity of essential services packages have affected the quality of health care service delivery.

Strategic Direction

- 41) Governments will improve **coverage and functionality** of primary and promotive health services (especially in peri-urban, urban slums, and rural areas), while ensuring the widening of **essential service packages** by introducing services in family medicine, new-born survival, birth spacing and contraceptives, non-communicable disease, mental health, under-nutrition, disability, gerontology, and other areas. Service quality will be ensured by implementing **minimum service delivery standards** at all levels.
- 42) Government will encourage and support the **integration of vertical programmes** at the provincial level for optimal use of resources and better performance.
- 43) Governments will enforce **public health laws** related to smoking, drug safety, organ donation and transplant, blood transfusion, environmental protection, food safety, etc.
- 44) Efforts to build **synergy with the private sector** in essential health services delivery (preventive and curative), report key indicators, and for understanding its functioning, composition and possible outreach to the under-served.
- 45) The entire health care system will be made **resilient to disasters** (climate change, disease outbreak, etc.) through disaster mitigation responses and continued provision of services during acute crises/emergencies.

PILLAR #4: Human Resources for Health

Challenges

- 46) Human resources in health are critical to the provision of high-quality preventive, promotive, and curative services. Pakistan has one of the world's lowest ratios of doctors, dentists, nurses, and paramedics to **people**. Other pressing issues include maldistribution of HR, retention, and low work-place satisfaction levels. This results in significant staff turnover and loss at all levels.
- 47) **Professional education** in health is sub-optimal and curricula do not reflect modern pedagogic techniques, international standards, or local requirements.
- 48) Health practitioner **licensing** and renewal is rare and not linked to improved qualification, competence, performance, or continuous professional development. Institutional levers for gauging the **performance of health staff** are weak.
- 49) **Coverage by community health workers is stagnant**, and their numbers and quality are below required standards.

Strategic Direction

- 50) Medical and related health education will be tailored to the health needs of the population, and will focus on social determinants of health, ethics, and public health law. Continuous professional development will be institutionalized across both public and private sectors in conjunction with associations, as will health professional re-licensing.
- 51) Owing to the rapidly growing population, disease patterns, and health needs, the workforce will be expanded and strengthened.
- 52) Government will focus on appropriate and adequate HR **skill mix** and task shifting. Public, family medicine, and allied health institutions will be nurtured and institutionalized to increase the cadre of managers, regulators, administrators, specialized allied health staff, and family physicians.
- 53) **Responsive management** will be introduced at health departments, and incentives to boost performance and make rural appointments attractive given.
- 54) **A HR database** at provincial and national levels will be created to facilitate forecasting workforce development.
- 55) Comprehensive **national HR, nursing, and allied health work force strategies** based on the National Health Vision may be considered.

PILLAR #5: Health Information System and Research

Challenges

- 56) Health information systems in Pakistan are **fragmented and vertical**. They respond to or serve primarily the vertical health programmes and District Health Information. Consequently, health indicator data collected by various systems may show conflicting results.
- 57) Demographic health and social and living measurement surveys cannot fully compensate for the lack of reliable ongoing monitoring data. And these surveys too require analytical capacity, which has been limited to date.
- 58) Although information systems are critical for planning, resource allocation, and health care delivery, in Pakistan it is impractical because the information systems **lack accuracy, quality, reliability, and links to decision makers**.
- 59) Though research is conducted in Pakistan, it is performed in silos, is not relevant to local issues, and is often of poor quality because of limited capacity and resources. Compounding this is the lack of collaboration between researchers, implementers, and policy makers.

Strategic Direction

- 60) **Innovative technologies** will be incorporated into district health information systems to facilitate evidence-based decision making. Provincial and national platforms for **transforming evidence into policy** will also be encouraged.
- 61) Governments will **build coherence** across health information systems, and will invest in systems to monitor SDG and national health target progress and vital statistics such as births and deaths.
- 62) The national health vision calls for a transition from medical to **national health research** that prioritizes areas according to local requirements. A **central hub for information repository**, standardization, and quality will be developed with assistance from provinces. This hub will promote evidence-based decision making, policy formulation, and health systems research.
- 63) Strengthened information systems at national, provincial, and district levels will lead to an effective, **integrated disease surveillance and response system**, with a particular focus on early warning.
- 64) Government will establish a collaborative mechanism for high-quality research on national priority areas, and will help regulate the research environment.

PILLAR #6: Essential Medicines and Technology

Challenges

- 65) Health sector technologies have not been introduced through a needs assessment process, leading to misuse of such equipment/technologies. The current mechanisms to determine the appropriateness of health supplies, diagnostics, medicines, and laboratory reagents are not evidence-based.
- 66) The essential services package does not identify the type or number of equipment, supplies, or medicines needed to deliver the defined services for a specific health facility. This encourages **irrational procurement**, use, and spending on technology and results in the loss of precious resources.
- 67) Problems related to **quality and price** of drugs and prescriptions: medicine pricing is a contentious issue between regulators and the industry.
- 68) **Plans for a health technology assessment** through the use of pharmacoecomics, pharmacoepidemiology, and pharmacovigilance have not advanced.

Strategic Direction

- 69) Create health technology assessment capacity at federal, provincial, and district levels. Governments will **vigilantly monitor** the selection, quality, price, and use of technology, equipment, and medicine according to international standards.
- 70) Collect **evidence and best practices** on medicine-related policy, legislation, and operative guidelines to develop standard treatment guidelines. Establish **an entity** (e.g., NICE-UK) to oversee adherence to standard treatment guidelines and best practices.
- 71) The federal and provincial governments will ensure that appropriate **regulations for the control of drugs, devices, diagnostics, and biological reagents** across the country are established to ensure quality control and patient safety.
- 72) Encourage the pharmaceutical industry to provide **innovative and affordable solutions** to patients. Introduce a **pharmacovigilance program** at the federal level and at provincial collection centres.
- 73) Implement **drug pricing policy** to protect the public interest by regulating prices of essential medicines. Appropriate policies for **orphan drugs, alternative medicines, and medical devices** will also be put in place.
- 74) **Revisit, strengthen, and implement the Drug Regulatory Authority of Pakistan and legislation** to regulate drugs, human organ donations, blood transfusions, and all therapeutic goods.

PILLAR #7: Cross-Sectoral Linkages

Challenges

- 75) Public health professionals are becoming increasingly aware that their field is affected by the political, **social, economic, and developmental context** in which they operate.
- 76) Illiteracy, unemployment, gender inequality, food insecurity, rapid urbanization, environmental degradation, natural disasters and the lack of access to safe drinking water and sanitation all have **negative effects on the health** of individuals and communities.
- 77) A large number of **preventable deaths** and disabilities among children, pregnant/ lactating women, young adults, and the aging population could be averted but action lies beyond the scope and mandate of the health sector.
- 78) **Population growth** calls for concrete steps to increase the contraceptive prevalence rate and reduce the total fertility rate.

Strategic Direction

- 79) Renew and synergize focus on **cross-sectoral actions** to advance health, with a particular focus on communicable and non-communicable disease including mental health and malnutrition. Promote the concepts of “**One Health**” and “**Health in all Policies.**”
- 80) Government will strive to develop a common vision, framework, and platform with **stakeholders** from across sectors to work on health-related priorities such as population, education, food security, agriculture and livestock, housing, sanitation, water, environment, and disaster management.
- 81) Government will embark upon advocacy, planning, legislation, regulation, behavioural change communication, information exchange, and evidence-based decision making through **joint efforts with various sectors** in pursuit of the **SDGs**.
- 82) Efforts will be geared towards **recognition of community involvement**. Women empowerment, and local/ rural development being the key channels for cross-sectoral action.

PILLAR #8: Global Health Responsibilities

Challenges

- 83) **SDGs** and the broader sustainability agenda demand much more effort than the MDGs, and must include addressing the root causes of poverty and investments in development that benefits all people.
- 84) Achieving **international public health security** is one of the main challenges arising from the new and complex landscape of public health. Treaties like the International Health Regulations (IHR-2005) and Global Health Security Agenda (GHSA) require core capacities that have not been developed at federal or provincial levels.
- 85) Progress on other **treaties and commitments** like the Framework Convention on Tobacco Control (FCTC), Mental Health Gap Action Programme (mH-GAP) reproductive, maternal, new-born, child, and adolescent health, Family Planning 2020, etc. are hindered by a lack of coordination.

Strategic Direction

- 86) The new global **sustainable development agenda** will be reflected in all health strategies and plans, and the government will be provided appropriate technical support and technical expertise.
- 87) Mechanisms for **coordination** across sectors and between provinces and federal ministries, including **integrated disease surveillance and response** indicated in the IHR 2005 and GHSA, will be established to prevent, detect, and respond to events that may constitute a public health emergency.
- 88) Adapt best practices for polio eradication and apply to other priorities, particularly expanded programme for immunization and vaccine-preventable disease surveillance.
- 89) Develop a strategic and **coordinated approach** to facilitate adherence to SDGs and other international treaties.

8. MONITORING AND EVALUATION

- 90) The M/o NHR&C will develop a monitoring and evaluation (M&E) framework for the National Health Vision 2016–2025. It will link and coordinate with the planning commission for SDG reporting, provincial/area/regional health departments for alignment with strategies.
- 91) The M&E plan will detail the specific roles of various facets of the health system including processes of data acquisition, flow, analysis, use, and feedback; resource requirements; institutional/organizational infrastructure needs; analysis of available competency and capacity; and specific indicators and their timelines for gauging performance and results. It will also define how different levels of government might use data and information from the system and suggest corrective actions where needed.
- 92) The M&E framework and its operational plan will focus on progress toward outcomes by developing a mix of tools and approaches relevant to the proposed objectives, activities, and targets. Monitoring data will be verified independently (via third parties). Provincial health systems strengthening units (or equivalent entities) will track the nation's health progress.
- 93) A high-level interprovincial health and population forum will oversee implementation of the National Health Vision 2016–2025 and will endorse reports for presentation to Parliament.

9. ANNEXURE

Process: Realizing a Shared National Vision

1. The need for a common binding national health vision was articulated and endorsed during a series of meetings in 2013–14 between federal and provincial ministries of health and respective provincial chief ministers. The process was led by the federal M/ONHSR&C.
2. An inter-ministerial forum for the coordination and accountability of the National Health Vision health was established. Each province identified technical focal points.
3. In May 2015, M/ONHSR&C held a preparatory meeting with key resource persons to initiate the process of discussion/deliberation, and prepare recommendations on how to proceed with each thematic pillar, and to develop a national policy framework for health.
4. The M/ONHSR&C hired a consultant to develop a concept note for each thematic pillar to present to participants at the larger technical meeting.
5. This was followed by a series of technical consultative meetings with all stakeholders. Meetings on each thematic pillar were held from January to February 2016 to determine the roles and responsibilities and enhance coordination between the federal Ministry and provincial health departments and regional and special areas. Approximately 300 experts representing the planning commission, line ministries, provincial departments of health and population, UN agencies, health development partners, community service/ community-based organizations, nongovernmental organizations, experts, academics, etc.² participated in the consultative process, which led to a draft of the health vision document.
6. A series of meetings with the minister of state for M/ONHSR&C and provincial chief ministers, health ministers, chief secretaries, and their teams were held to get their views and comments on the framework of National Health Vision document.³ Recommendations supported by scientific evidence and global best practices were collated for feedback from provinces. The meetings were held in Punjab (6th July, 2015); Khyber Pakhtunkhwa (19th August, 2015); Sindh (30th November, 2015); and Baluchistan (10th December, 2015). The meetings were also an opportunity to visit each province in a post-devolved setup with provincial health sector strategies in place.
7. The final draft of the document was shared with all stakeholders in August 2015, and comments and views were incorporated.
8. On 30th August 2016, the final National Health Vision 2016–2025 was unveiled and endorsed by all federal and provincial ministers.

² List of participants of all meetings are available on request from the HPSIU-M/O NHSR&C.

³ Minutes of all the meetings are available on request from the HPSIU-M/ONHSR&C.

