PAKISTAN:

2021 Monitoring Report

UNIVERSAL HEALTH COVERAGE


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MOVING TOGETHER
TO BUILD A HEALTHIER PAKISTAN

UNIVERSAL HEALTH COVERAGE: EVERYONE, EVERYWHERE

UNIVERSAL HEALTH COVERAGE

2021 Monitoring Report
UNIVERSAL HEALTH COVERAGE

PAKISTAN

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Regulations & Coordination

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2021 Monitoring Report - Universal Health Coverage

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MESSAGE

Investing in health is not just good for the individuals who directly benefit, but is also worthy for their families, communities, country' growth and political stability. Universal Health Coverage recognizes that health is a 'public good' with externalities, and that the state has a responsibility to invest in provision of essential health services while ensuring equity.

No goal is real unless measured against a time-bound target. We need to make our policies and interventions accountable and measurable, to track progress and make adjustments as the process of implementation moves ahead. In order to learn and to benchmark progress, we need a measurement framework that can provide a common, and comparable, set of metrics. That is why the Ministry of National Health Services, Regulations & Coordination and Health Departments have localized health-related Sustainable Development Goals (SDGs) with support of World Health Organization and using that as a joint framework for monitoring progress in health.

Universal Health Coverage is the main outcome of health-related SDGs and is measured with two targets, one for essential service delivery (3.8.1) and other for financial protection (3.8.2).

For service delivery, the global target is that more than 80 percent of the people and especially the poor have access to essential health services, such as delivering babies in a safe environment, vaccinating children, successful treatment of tuberculosis, high blood pressure, diabetes etc. At the national level, we aim that by 2030, more than 65 percent of the population will have access to quality essential health services.

For financial protection, the proposed target is to reduce by half the number of people by 2030 who are impoverished due to out-of-pocket health care expenses. By 2030, no one should fall into poverty because of out-of-pocket health care expenses.

We are now working with the provincial and federating areas' health departments and a wide array of partners to track these targets on a regular basis. This tracking exercise is gradually being trickled down to the district level. However, we still need to work hard to ensure quality and timely availability of data for right decision making. The Government of Pakistan is committed to ensuring equity and quality through the delivery of essential preventive, promotive, curative, palliative and rehabilitative health services to every citizen.

Dr Faisal Sultan
SAPM/ Federal Health Minister

FOREWORD

Development commitments through the Sustainable Development Goals, government's policy interests, and health security concerns are the primary drivers of health service delivery in Pakistan. Now the health sector leadership in Pakistan is pursuing expanded efforts to address other health challenges, such as inequity and Universal Health Coverage.

To assess the progress in public health development in Pakistan, it is critical to see how we are doing in achieving our goals and targets. Together, we must learn from the mistakes of the past, embrace the opportunities of the present and shape the future we all want.

We must make UHC a reality. While UHC is ambitious, it is affordable. There is a need to increase domestic health expenditure, raising revenue equitably through progressive taxation and removing out-of-pocket payments. We must prioritise primary healthcare as the first step towards achieving UHC, making sure the most deprived and marginalised have access to essential health services. Donors and development partners must make sure their aid is transformative, in line with national and provincial UHC plans, priorities and domestic resource mobilisation.

Monitoring progress towards UHC should focus on both provision of essential package of health services and ensuring social health protection. Measuring equity is also critical to understand who is being left behind—where and why. Each province and district in Pakistan is unique, and each province may focus on different areas, or develop their own ways of measuring progress towards UHC. But there is also value in a global approach that uses standardized measures that are internationally recognized so that they are comparable across borders and over time.

Ministry of National Health Services, Regulations & Coordination is supporting provincial/area health departments to develop their health systems to move towards and sustain UHC, and to monitor progress. But we are not alone: we are working with many different partners in different situations and for different purposes to advance UHC in Pakistan.

I am especially thankful to WHO, UNICEF, FCDO and USAID for contributing to develop UHC benefit packages and supporting UHC monitoring system in Pakistan.

Aamir Ashraf Khawaja
Secretary (NHSR&C)

ACKNOWLEDGEMENTS

Pakistan: 2021 Monitoring report of Universal Health Coverage is the second annual report to assess and monitor the progress at national, provincial and district levels. It solidifies the intent for investing in the roadmap for the health sector development, while ensuring regular monitoring on what progress has been made and what are the challenges.

Universal health coverage is building political momentum around a shared vision for strengthening of health systems, advocating for sufficient, appropriate and well-coordinated investments, facilitating accountability for progress and promoting coordination and partnerships.

I would like to give my special thanks to the SAPM/ Federal Minister of Health, Provincial/ Area Health Ministers, Secretaries Health, Directors General Health Services and other colleagues from the ministry and health departments for contributing to the process of universal health coverage.

I hereby acknowledge the efforts of the Health Planning, Systems Strengthening and Information Analysis Unit (HPISU) of the Ministry under the leadership of Dr Malik Muhammad Safi and Dr Syed Raza Zaidi and technical inputs of Javeria Yousaf, Usman Bashir, Wahaj Zulfiqar and Mishal Javed. It is also worth mentioning the active role of Dr Atiya Aabroo, Dr Samra Mazhar and Dr Sabeen Afzal from the Ministry and Provincial/ Area UHC focal points and UHC coordinators from Health Departments.

I would like to convey my special thanks to the development partners and more specifically UK's Foreign, Commonwealth & Development Office, US Agency for International Development, Bill & Melinda Gates Foundation, Disease Control Priorities-3 secretariat, UNICEF, UNFPA, Global Alliance for Vaccine & Immunizations, Global Fund to fight against AIDS, TB & Malaria, World Bank and others.

My special gratitude is due to Dr Mahipala Palitha, Head of WHO Country Office in Pakistan and his team, as this report could not have materialized without their inputs.

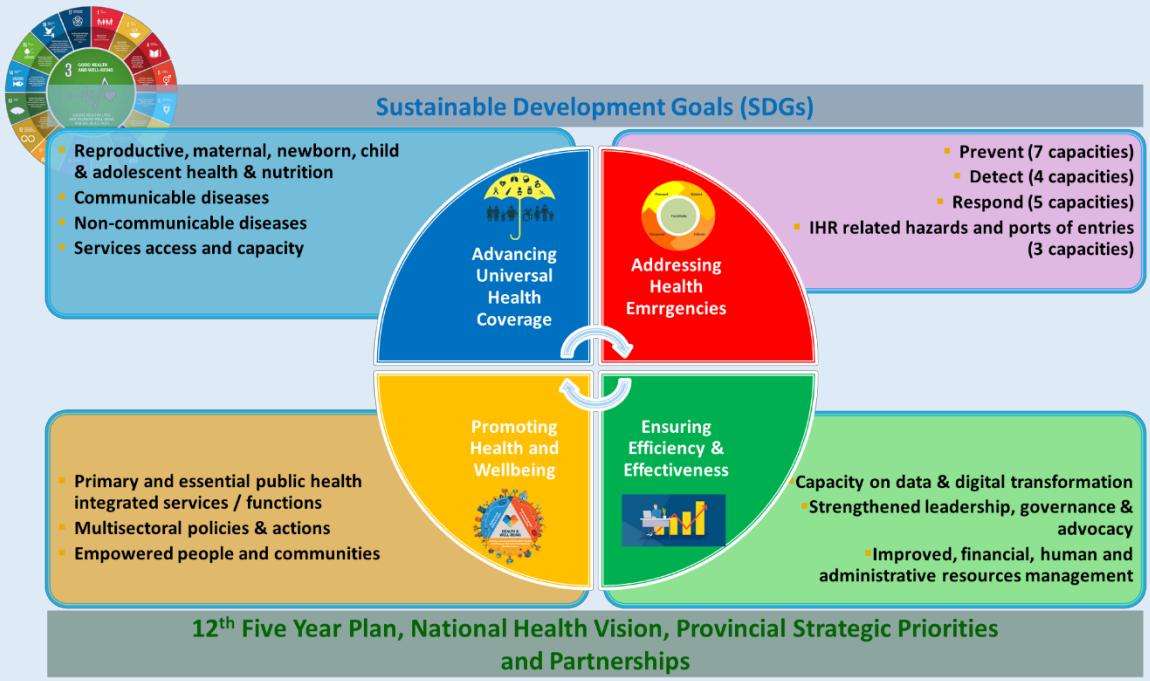
In the end, I pray for the achievement of health-related sustainable development goals and more specifically universal health coverage targets in Pakistan.

Dr. Rana Muhammad Safdar
Director General Health

NATIONAL HEALTH VISION

*'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'*

FRAMEWORK



EXECUTIVE SUMMARY

The 2021 UHC Monitoring Report relates directly to one of the defining characteristics of the SDGs: promoting accountability by encouraging the health sector and academic institutions to commit to reporting on UHC progress on a regular basis. Most of the data provided in the following pages have been derived from national and provincial surveys and administrative data of the regulatory bodies and programmes. The report also provides district level Universal Health Coverage Service Coverage Index, albeit with a challenge of significant data gaps and quality issues.

National and provincial/ federating area ownership is key to the success of achieving the SDGs. The process of monitoring through this report takes account of national and potentially subnational priorities. This report intends to contribute to regional and global SDG monitoring frameworks. It is envisaged that by developing metrics and reporting, this report will encourage provinces/ federating areas and districts to refine and tailor them to their local circumstances. As the data show in this report, the process is fraught with challenges, not just in reaching the targets themselves, but also in terms of measuring progress towards them. The road to universal health coverage is long, but the commitment to achieving and measuring it is underway.

This year's monitoring report is being published at a crucial moment. Never before has there been as much political momentum for universal health coverage as there is right now. And never before has there been greater need for commitment to health to be enjoyed by all, rather than a privilege for the wealthy few. Further, the government and development partners are planning to significantly enhance financial resources for universal health coverage and this report can act as a baseline for the efforts in coming years.

Universal Health Coverage is the main outcome of health-related SDGs and is measured with two targets, one for coverage of essential service delivery (3.8.1) and other for financial protection (3.8.2).

The analysis reveals that only half the population in Pakistan has access to essential health services/ universal health coverage and that we are far behind reaching the global UHC Service Coverage Index target of 80+ by 2030. Though there is considerable improvement in the UHC service coverage index from 40 in 2015 to 50 in 2020, the real challenge still lies ahead. With expected enhanced investment for provision of essential health services at community and primary health care level, there would be a need to ensure efficiency and effectiveness, while building the capacity of districts and private sector to deliver these essential services. There is also a need to address serious equity issues as

Balochistan and Gilgit-Baltistan have a lower score in comparison to the other provinces/ federating areas.

Furthermore, the indicator to monitor catastrophic health expenditure is also critical and has shown a worsening trend during 2010 and 2015. As the government is currently scaling up *Sehat Sahulat* Programme, the results in the future should indicate the effectiveness of this investment. In 2015, 4.5 percent of the people in Pakistan spent more than 10 per cent of their household budget on health care, which is alarming considering the already high poverty index, a reported 51.9 percent out-of-pocket expenditure and a worsening economic situation in the country.

Although the burden of disease has declined from 70,086 DALYs lost per 100,000 population in 1990 to 42,059 DALYs lost per 100,000 population in 2019, with improved performance in maternal and child health sectors, the report also highlights the forthcoming challenge of tackling non-communicable diseases and mental health issues.

The categories of Infectious diseases and Services access and capacity also demand immediate attention, while the recent health emergency of COVID-19 pandemic has diverted huge resources for emergency response. So far, the government has spent more than US$ 1.6 billion only on the COVID-19 vaccine and enhancing diagnostic services. This is exceptional commitment on the part of the government.

More than half of the burden of disease in Pakistan could be tackled through inter-sectoral policies and interventions. However, that would require a very strong commitment from health and other sectors to work in a unified manner.

Ideally, UHC monitoring at the district level should leverage existing health management information system data, but at the same time the information system has infrastructure limitations, serious quality challenges along with incompleteness of data. Further information from private sector is not available. Additional data collection at district level for UHC monitoring should focus on processes and use of low-cost techniques.

Health Information System Technical Working Groups (TWGs) at national and provincial level need to develop and implement robust monitoring and evaluation frameworks to rapidly assess the performance of health sector on UHC and suggest remedial measures.

What gives us hope is that health departments and district health offices are leading and driving progress towards UHC, recognizing that it is both the right and smart thing to do. Although data availability and analysis are still a challenge – provinces/ federating areas are generating some of the most credible and comparable data on health coverage. However, we all need to be far more ambitious. There is a need for stronger commitment towards -working with provinces, federating areas and districts, -increasing access to essential health services, -ensuring people don't fall into poverty because of health expenses, and -moving closer to our goal of Universal Health Coverage by 2030. That won't be easy, but it's possible.

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CONTENTS

ACRONYMS

BHU	Basic Health Unit
BMGF	Bill & Malinda Gates Foundation
BoD	Burden of Disease
CMW	Community Midwife
COPD	Chronic Obstructive Pulmonary Disease
CPR	Contraceptive Prevalence Rate
CVD	Cardiovascular Disease
CKD	Chronic Kidney Disease
DALY	Disability Adjusted Life Years
DCP3	Disease Control Priorities – 3rd Edition
EPHS	Essential Package of Health Services
FCDO	UK's Foreign, Commonwealth and Development Office
GATS	Global Adult Tobacco Survey
GB	Gilgit Baltistan
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GYTS	Global Youth Tobacco Survey
HDI	Human Development Index
HMIS	Health Management Information System
HPSIU	Health Planning, System Strengthening & Information Analysis Unit
HRH	Human Resource for Health
ICT	Islamabad Capital Territory
IHD	Ischemic Heart Disease
IHME	Institute of Health Metrics & Evaluation
IHR	International Health Regulations
IMR	Infant Mortality Rate
KP	Khyber Pakhtunkhwa
LHW	Lady Health Worker
MCH	Maternal and Child Health
mhGAP	Mental Health Global Action Programme
MICS	Multiple Indicators Cluster Survey
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
M/o NHSR&C	Ministry of National Health Services, Regulations & Coordination
M/o PDSi	Ministry of Planning, Development and Special Initiatives
NAPHS	National Action Plan on Health Security
NCD	Non-Communicable Disease
OOP	Out of Pocket Expenditure
PAEC	Pakistan Atomic Energy Commission
PDHS	Pakistan Demographic Health Survey
PHC	Primary Health Care
PMC	Pakistan Medical Commission
PMMS	Pakistan Maternal Mortality Survey
PNC	Pakistan Nursing Council
PSLM	Pakistan Social and Living Standards Measurement Survey
RMNCH	Reproductive, Maternal, Newborn & Child Health
RHC	Rural Health Centre
SDG	Sustainable Development Goal
STEPS	STEPwise Approach to NCD Risk Factor Surveillance
TFR	Total Fertility Rate
THE	Total Health Expenditure
UHC	Universal Health Coverage
UHC-BP	Universal Health Coverage - Benefit Package
UHC SCI	UHC Service Coverage Index
YLD	Years Lived with Disability
YLL	Years of Life Lost
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
WPV	Wild Polio Virus

LEAVE NO ONE'S HEALTH BEHIND:

Invest in Health Systems for All


Health is an investment, not a cost.
Let's invest in systems that leave no one behind.

INTRODUCTION

Even after 74 years of independence, healthcare is one of the sectors, which is still underserved in Pakistan and the surface has barely been scratched. Pakistan has embarked on an ambitious target of **achieving Universal Health Coverage (UHC) for all citizens by 2030** with a vision that everybody should have access to affordable and quality essential health services in the country.

Health is centrally positioned within the 2030 sustainable development agenda, with one comprehensive goal of 'Good Health' (SDG 3) and its 13 targets (and more than 27 indicators) covering major health priorities, and links to targets in many of the other goals.

Ministry of Planning, Development and Special Initiative (PDSi) is coordinating the overall agenda of the sustainable development goals (SDGs) at the national level, whereas responsibilities for sectoral SDGs has been assigned to line ministries. For Health, the Ministry of National Health Services, Regulations & Coordination (NHSR&C) in collaboration with Provincial/ Federating Areas Health Departments has been assigned 36 SDG indicators.

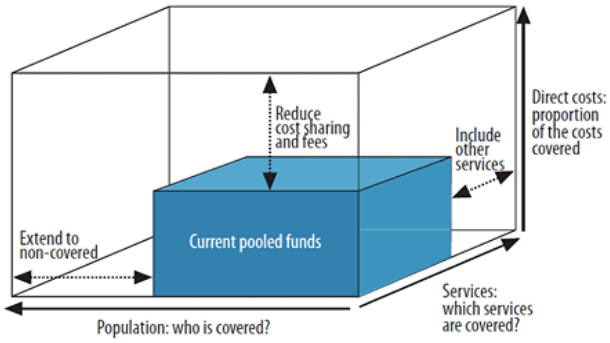
UHC underpins, and is key to attaining the entire SDG3, as well as the health-related targets and the development of strong resilient health systems. Achieving the UHC requires an integrated approach to the provision of health services that minimizes fragmentation and competing agendas.

The **UHC framework embodies three related objectives**:

a) Equity in access to essential healthcare services - everyone who needs services should get them, not only those who can pay;

b) The quality of health services should be good enough to improve the health of those receiving services; and

c) People should be protected against financial risk, ensuring that the cost of using services does not put people at risk of financial harm.



UHC ensures that all people and communities have access to needed promotive, preventive, curative, rehabilitative and palliative health services of optimum quality without risk of financial hardships, cuts across the health targets and contributes to promoting health security and equity. Progress towards UHC also ensures positive change in other health-related targets across different sectors. Good health allows children to learn and adults to earn, helps lift people from poverty, addresses social and gender inequities and provides the basis for well-being, social cohesion, health security and long-term economic development.

To achieve UHC, the following **principles** guide the actions:

- Leaving no one behind: a commitment to equity, non-discrimination and a rights-based approach
- Transparency and accountability for results
- Evidence-based strategies and leadership, with government stewardship to ensure availability,

accessibility, acceptability and quality of service delivery

- Making health systems everybody's business – with engagement of people, communities, civil society and private sector
- International and national cooperation based on mutual learning in achieving and sustaining UHC and development

The **National Health Vision (NHV) 2016-25** and the **National Action Plan (2019-23)** along with **Provincial Health Strategies** provides an overarching vision and agreed upon common direction, harmonizing federal and provincial efforts for achieving the desired SDG3 outcomes and impact. These documents were developed to represent aspirational priority actions and to set ambitious targets to achieve SDGs including universal access to health services.

To assess the progress of UHC in Pakistan, it is critical to see how we are doing in achieving our targets. Together, we must learn from the mistakes of the past, embrace the opportunities of the present and shape the future of good health and well-being.

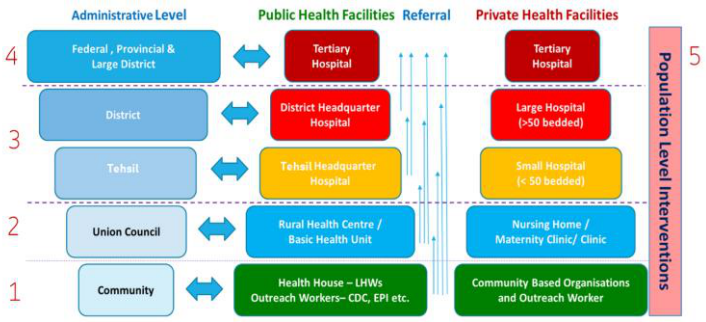
SDG target for UHC 3.8 has two indicators:

- 3.8.1 on **coverage of essential health services** measured through UHC Service Coverage Index (SCI); and
- 3.8.2 on the **proportion of a country's population with catastrophic spending on health**, defined as large household expenditure on health as a share of household total consumption or income

Both must be measured together to obtain a clear picture of those who are unable to access health care and those who face financial hardship due to spending on health care.

3.8.1 UHC Service Coverage Index (SCI) is a composite indicator and is defined as the average coverage of essential health services based on sixteen tracer interventions in four groups that include reproductive, maternal, newborn and child health; infectious diseases; non-communicable diseases; and services capacity and access.

The UHC prioritizes four groups of integrated essential health care services at all five levels of health care delivery system (i.e., community, primary healthcare centre, first level hospital, tertiary hospital and population levels) and through both public and private sectors, to address the burden of diseases in an effective and efficient way.



As defined by World Bank (WB) and World Health Organization (WHO), four groups and sixteen proxy interventions for UHC SCI monitoring are as following:

a: Reproductive, maternal, new-born, child and adolescent health & nutrition

- Family Planning;
- Antenatal and Delivery care;
- Child Immunization;
- Health Seeking behaviours for Child Illness (Pneumonia)

b: Infectious diseases

- Tuberculosis Effective Treatment;
- HIV & AIDS Anti-Retroviral Treatment;
- Insecticide Treated Nets Coverage for Malaria;
- Adequate Water and Sanitation

c: Non-communicable diseases

- Blood Pressure;
- Diabetes Mellitus;
- Cervical Cancer Screening;
- Tobacco Control

d: Service capacity and access

- Hospital Beds Density;
- Essential Health Workforce Density;
- Access to Essential Medicines, Vaccines and Commodities;
- Capacities for International Health Regulations (IHR)

According to WB and WHO[1] , the baseline UHC SCI for Pakistan in 2015 was very low at 40 percent, indicative of poor access / use of essential health services and data issues/ challenges.

The year wise (2015-20) UHC SCI at country and provincial/ federating area level is showing a positive

[1] World Bank and WHO, 2017; Global UHC Monitoring Report

trajectory with country's UHC SCI of 49.9 in 2020, with a target of 55 in 2023 and 65 in 2030.

Year wise UHC Index						
Province/Area	2015	2016	2017	2018	2019	2020
Islamabad	44.7	47.7	48.9	48.5	51.3	**56.0**
Punjab	40.6	42.8	45.6	47.3	48.2	**52.0**
Khyber Pakhtunkhwa	36.2	40.7	45.8	47.3	47.6	**50.3**
Azad Jammu & Kashmir	39.0	40.7	43.6	46.2	47.9	**49.8**
Sindh	37.6	40.6	43.9	45.0	46.7	**48.6**
Gilgit Baltistan	35.8	39.3	41.0	42.6	43.5	**45.2**
Balochistan	27.1	29.3	32.3	33.5	35.0	**35.2**
National	**39.7**	**42.1**	**45.3**	**46.3**	**47.1**	**49.9**

3.8.2 Financial risk protection is another dimension of the UHC. The affordability of healthcare is a key issue especially in low- and middle-income countries, where a large number of people lack sufficient financial means to access health care services. Worldwide, millions of people are pushed into vicious cycle of poverty every year due to compelling needs to pay for health care services. Financial risks are measured by the following two indicators:

- Population with household expenditures on health >10% of total household expenditure or income (%) – Value for Pakistan is 4.5 in 2015 compared to 1.03 in 2010
- Population with household expenditures on health >25% of total household expenditure or income (%) – Value for Pakistan is 0.5 in 2015 compared to 0.02 in 2010

Source: WHO Global UHC Reports

There are multiple ways, by which the government is making efforts to protect its citizens from financial risks. The top priority is to enhance government health expenditures on health, which have reached to a level of PKR 477 billion in 2019-20 and are still around 1.2 percent of the Gross domestic product (GDP).

In an attempt to reform the health sector, the federal and provincial governments introduced social health protection programmes in their constituencies, such as the *Sehat Sahulat* Programme (SSP), and the Social Health Protection Initiative (SHPI). The target population of these programmes is the poorest population. SSP uses the benchmark of defining poverty as families/ households having daily income of less than $2.00, while Gilgit Baltistan SHPI uses the benchmark of $1.00 per day.

In total, these programmes have expanded to 65 districts across the country and have enrolled over 81 million individuals.

At present, these initiatives provide coverage for inpatient care, and the benefits package for each social protection programme includes secondary care up to a limit which differs by each initiative. SSP has also defined the list of priority diseases and services to be covered under tertiary care, while SHPI does not currently cover tertiary care. The beneficiaries of these programmes can access services from a combination of public and private sector facilities empanelled with the insurance companies.

Other than these major initiatives, the poor population also has access to 'Zakat' and 'Bait ul mal' funds to pay for health care.

'Bait ul mal' is a publicly funded social protection initiative created for the welfare of vulnerable populations such as the disabled, orphans and widows.

Zakat, on the other hand, is a 2.5 percent zakat paid by Muslims on their annual savings, which is collected and allocated by the Ministry of Religious Affairs for each province. Health care is one of six programmes administered under the Zakat fund. These initiatives are important reforms to reduce catastrophic expenditures of the poorest families. However, these need to be expanded both in terms of breadth of services and coverage of people.

There are also separate health service delivery programmes for armed forces and employees of autonomous institutions, private and commercial establishments.

Employers of private and commercial institutions, which employ 10 or more persons, must provide insurance to employees under the Employees' Social Security Institution (ESSI). The revenue for insurance is collected and distributed by the provincial ESSIs using a mandatory deduction of 7 percent, which is used to provide outpatient and inpatient services.

This report presents the detailed results of the latest efforts to monitor Pakistan's path towards UHC.


PAKISTAN
POLITICAL
CHINA
GILGIT-BALTISTAN
KHYBER PAKHTUNKHWA
AFGHANISTAN
PUNJAB
INDIA
BALOCHISTAN
IRAN
SINDH
ARABIAN SEA
LEGEND
SIR CREEK
JUNAGADH & MANAVADAR
INDIA
ARABIAN SEA

CONTEXT

Pakistan is the site of several ancient cultures, including the 8,500-year-old Neolithic site of Mehrgarh in Balochistan, and the Indus Valley Civilisation of the Bronze Age, the most extensive of the civilisations of the Old World. The region that comprises the modern state of Pakistan was the realm of multiple empires and dynasties, including the Achaemenid; briefly that of Alexander the Great; the Seleucid, the Maurya, the Kushan, the Gupta; the Umayyad Caliphate in its southern regions, the Hindu Shahi, the Ghaznavids, the Delhi Sultanate, the Mughals, the Durranis, the Sikh Empire, British East India Company rule, and the British Indian Empire from 1858 to 1947.

Spurred by the Pakistan Movement, Pakistan gained independence on 14th of August, 1947 and was accompanied by an unparalleled mass migration and loss of life.

Pakistan has more than 1,000 kilometres coastline along the Arabian sea and Gulf of Oman in the south and is bordered by India to the east, Afghanistan to the west, Iran to the southwest, and China in the northeast. It is separated narrowly from Tajikistan by Afghanistan's Wakhan Corridor in the northwest, and also shares a maritime border with Oman.

Pakistan (including Gilgit-Baltistan and Azad Jammu & Kashmir) is characterized as the 5th most populous country on the globe with 232 million people (2021)[2] with an additional 1.435 million registered Afghan refugees, with more than 58 percent residing in Khyber Pakhtunkhwa (KP) province, 22.8 percent in Balochistan and remaining in other provinces.[3] The inter-censual population growth has come down slowly at an average of 2.4 percent (1998-2017), while the current population growth rate is estimated at 2.1.

Area-wise, Pakistan is the 33rd largest country, spanning 881,913 square kilometres. The country is divided into provinces of Punjab, Sindh, KP and Balochistan and three federating areas of Gilgit Baltistan (GB), Azad Jammu & Kashmir (AJK) and Islamabad Capital Territory (ICT). Federally Administered Tribal Area (FATA) has been merged with the KP province, through a constitutional amendment in 2018.

Province/ Area wise Population and Population Density[2]

Province/Area	Population in 2017	Projected Population 2021	Area (Km²)	Density/ Km² 2021
Punjab	110,012,422	118.5 M	205,344	577
Sindh	47,886,051	52.2 M	140,914	370
Khyber Pakhtunkhwa	35,525,047	39.3 M	101,741	387
Balochistan	12,344,408	13.9 M	347,190	40
Islamabad	2,006,572	2.4 M	906	2,657
Gilgit Baltistan	1,492,000	2.0 M	72,971	28
Azad Jammu & Kashmir	4,045,366	4.5 M	13,297	331
PAKISTAN	**213,311,886**	**232 million**	**881,913**	**264**
Urban	36.43%			
Rural	63.57%			

It is projected that population of Pakistan will be around 253 million in 2025 and 281 million in 2030.

In Pakistan, 63.57 percent of the population lives in rural areas, while 36.43 percent of the population is in

[2] Pakistan Bureau of Statistics (PBS), 2017; The Population Census (2017) and projected populations in 2021

[3] https://data2.unhcr.org/en/country/pak

urban areas in 2017. Only Sindh and Islamabad Capital Territory have more than 50 percent of the population residing in urban areas. As per 2017 Census, sex ratio in the country is 106 males:100 females (103.7 in rural areas and 107.4 in urban areas).

The provinces/ areas are subdivided into administrative 'divisions' - 10 in Punjab, 7 in Sindh, 7 in KP, 6 in Balochistan, 3 in GB and 3 in AJK. Divisions are further subdivided into districts, tehsils/ talukas and union councils. The divisions do not include the ICT, which is counted at the same level as a province.

Pakistan is home to more than 74 languages spoken as first languages. Five languages have more than 10 million speakers each in Pakistan – Punjabi, Pashto, Sindhi, Saraiki and Urdu. Pakistan's national language is Urdu, which, along with English, is the official language.

Pakistan currently has the fifth largest number of youth population in the world. Of the total population, 64 percent is below the age of 30 years, while 29 percent is between 15 and 29 years old, and proportion wise the second youngest in the South Asian region after Afghanistan. Pakistan's gradually declining but high fertility rate will further contribute to an increase in the youth population in the years to come.

Despite challenges, the economy of Pakistan was able to maintain its growth momentum above 4.0 percent every year since 2013-18, with highest growth in 10 years at 5.79 percent recorded in 2017.[4] The rate declined to 1.9 percent in 2018-19. In 2019-20 the rate declined to (-)0.38 percent as a result of COVID-19 pandemic; and improved to 3.94 percent in 2020-21.

Per capita income is an indicator of economic well-being and has increased from US$ 586 in 2002-03 to US$925 in 2006-07 and to US$1,641 in FY 2017. However, a decline to a level of US$1,388 is observed in 2019-20, since the economic situation is under stress mainly due to fiscal crisis and then as a result of COVID-19 pandemic. In 2020-21, per capita income increased to a level of US$1,544.

Economic activity in Pakistan is expected to regain momentum and benefit from an improved business sentiment, China-Pakistan Economic Corridor (CPEC) and other infrastructure initiatives. However, rising oil prices, very high inflation rate and Afghanistan's dependency on Pakistan for foreign exchange are serious economic challenges.

According to Pakistan's Social Policy and Development Centre report on Updating Pakistan's Poverty Number on multidimensional poverty released in 2019, nearly 37 percent of Pakistanis live in multidimensional poverty, with the highest rates of poverty in Balochistan.[5]

Pakistan's Multidimensional Poverty Index (MPI) showed a slight decline, with national poverty rates falling from 39 percent in 2016 to 37 percent in 2019. However, progress across different provinces/ federating areas of Pakistan is uneven. Poverty incidence in urban areas is 32.1 percent, while rural areas display 39.3 percent of poverty levels. Disparities also exist across provinces. Poverty in KP stands at 36.1 percent, Sindh at 43.7 percent, Punjab at 31.6 percent, and Balochistan at 56.8 percent.

Pakistan is a lower-middle income country, having primarily an agrarian economy. Cotton, wheat, rice, sugarcane, fruits, vegetables, and tobacco are the chief crops, and cattle, sheep and poultry make up husbandry. There is also a fishing industry. Most of Pakistan's agricultural output comes from the Indus basin. The country is self-sufficient in food, as vast irrigation schemes have extended farming into arid areas. Unfortunately, the food import bill rose significantly during 2020-21 leading to food insecurity and rising in prices. Use of fertilisers and new varieties of crops are likely to increase yields in future.

The annual cost of Pakistan's imports usually exceeds its earnings from exports, and is responsible for the increasing current account deficit. The chief imports are petroleum, machinery, plastics, transportation equipment, edible oils, paper, iron and steel, and tea. Exports include textiles and clothing, rice, leather and sporting goods, chemicals, and carpets. The chief trading partners are the United States, the United Arab Emirates, Saudi Arabia, and China.

With the passage of time, urbanization (Immigration, from both within and outside the country, is regarded as one of the main factors contributing to urbanisation in Pakistan) is increasing rapidly. Market driven factors have resulted in diversification of occupations and services sector has recently surpassed other sectors. Share of the agriculture sector in the 2017-18 GDP was only 19 percent, industrial sector 21 percent and that of services sector 60 percent. Share of the agriculture sector in the 2020-21 GDP slightly improved to 19.2 percent, declined in industrial sector to 19.1 percent and improved that of services sector to 61.7 percent.

[4] Ministry of Finance, 2013-20; Pakistan Economic Surveys

[5] PSPD Report "Updating Pakistan's Poverty Numbers for the Year 2019"

The political climate is currently stable but un-predictable. Pakistan's last thirteen years of continuation of democratic process is a very positive sign, while considering the fact that country faced multiple security, economic and political challenges over the period. Current parliament, provincial assemblies and governments are based on elections held in July 2018, have around two years before holding the next elections. Successful elections were also held in GB and AJK recently. Local government elections are also expected in near future.

Both Pakistani and international experts see the period (2018-23) as the best chance in a generation for sustainable peace and development with some risks. There are signs of more stability in the provincial governments and more positive reforms are expected to strengthen the local/district governments.

Considering coalition governments at national and provincial levels and expected formation of new provinces/ administrative areas, there is a risk that the governments may face political challenges which may have a negative impact on a credible long-term approach to the development objectives including the health sector. Pakistan is located in a very sensitive geo-political area. Regional and global politics also need to be monitored carefully, as this can have a significant impact on development opportunities including health.

The Bertelsmann Stiftung's Transformation Index (BTI) measures successes and setbacks on the path toward a democracy based on the rule of law and a socially responsible market economy. With a worsening score of 3.75/10, Pakistan ranks 102 among the 137 countries in the 2020 BTI. In 2016, Pakistan score was 3.90/10 with a ranking of 106, thus indicating a current negative trajectory.

The internal security situation has improved significantly over the last few years. There was a significant decrease in the number of terrorist attacks in Pakistan since 2017. However, many challenges remain to be addressed on the front of internal as well as border security. The northern border with the Indian held Kashmir, is an area of long-lasting security tension between the two countries.

The humanitarian situation has also improved significantly in recent past but still the country has to take care of more than 1.4 million Afghan refugees, requiring lifesaving support, food assistance and health care. The number may increase significantly in near future with transition in Afghan government.

The risk of internal conflict also exists and needs to be monitored carefully in the context of health. COVID-19 may also lead to security risk as a result of protest against lockdowns and inflation.

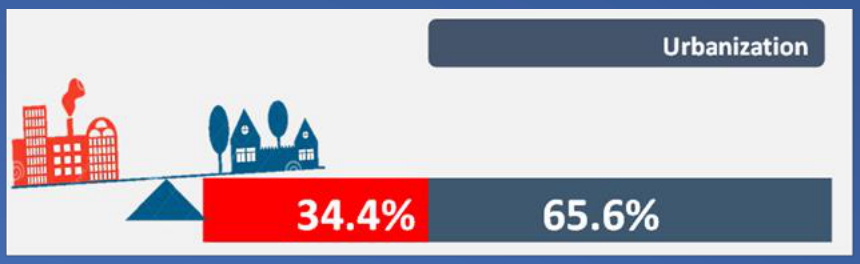
Education lays the foundation of a developed and progressive society. It empowers and creates ability among individuals and societies to utilize their human capabilities and builds a strong correlation with socio-economic development. The constitution of Pakistan commits to provide free primary and secondary education. Unfortunately, the literacy rate (10 years and older) is stagnant at 60 percent in 2019-20 compared to 2014-15 (in male it is 70 percent and in female it is 49 percent).[6]

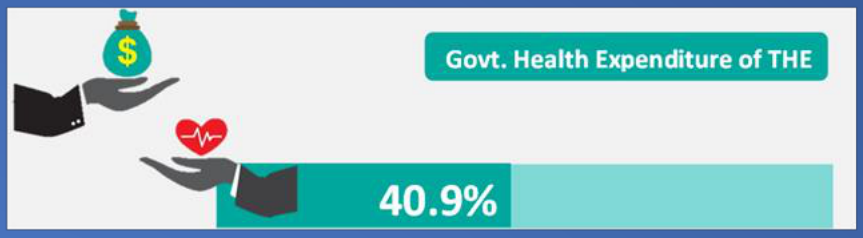
Pakistan Human Development Index (HDI) for 2015 was 0.681, which according to the thresholds used for the national report categorises Pakistan as a country with a medium level of development.[7] This figure differs from the global HDI 0.557 calculated for Pakistan in the HDR Indices 2019[8], that accordingly ranked Pakistan 154th out of 189 countries and classified it as a country with medium human development. This difference in score was due to use of different methodology and data, as well as different cut-offs in the estimation at national vs international level.

Corruption is a major risk for health sector as it destroys lives and communities, and undermines countries and institutions. It generates popular anger that threatens to further destabilise societies and exacerbate violent conflicts. The Transparency International (TI) indicates that the perceived level of public sector corruption (on a scale of 0 - 100, where 0 means that a country is perceived as highly corrupt and 100 means it is perceived as very clean) is low (31) for Pakistan and it ranks on the 124/180 countries in 2020. Pakistan has made little or no progress towards tackling the menace of financial misconduct.

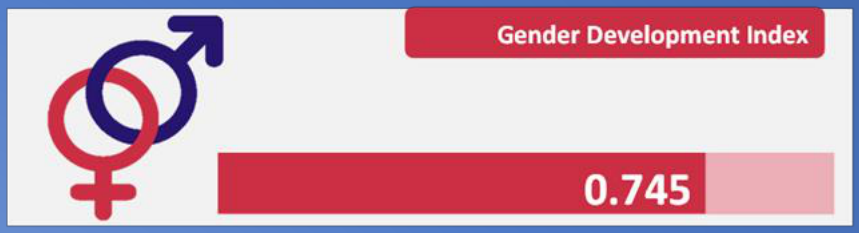
With weak financial institutions, low tax collection and distribution system, weak accounting & audit system and weak budgeting processes the fiduciary risks are high. This also leads to risk of material irregularities resulting in losses of all kinds, over charging (procurement), theft or misuse of assets (computers and cars), losses of cash due to fraudulent activities etc.

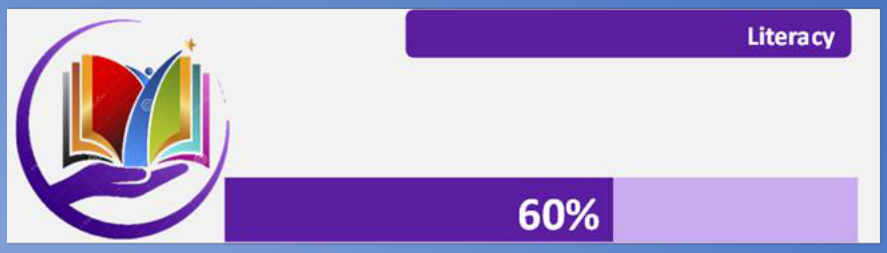
[6] PSLM, 2014-15 & 2019-20
[7] UNDP, 2017; National Human Development Report (NHDR)
[8] UNDP, 2020; Human Development Indices and Indicators 2019 - Statistical Update


Urbanization
34.4%
65.6%


Govt. Health Expenditure of THE
40.9%


Human Development Index
0.557


Gender Development Index
0.745


Literacy
60%

HEALTH SITUATION

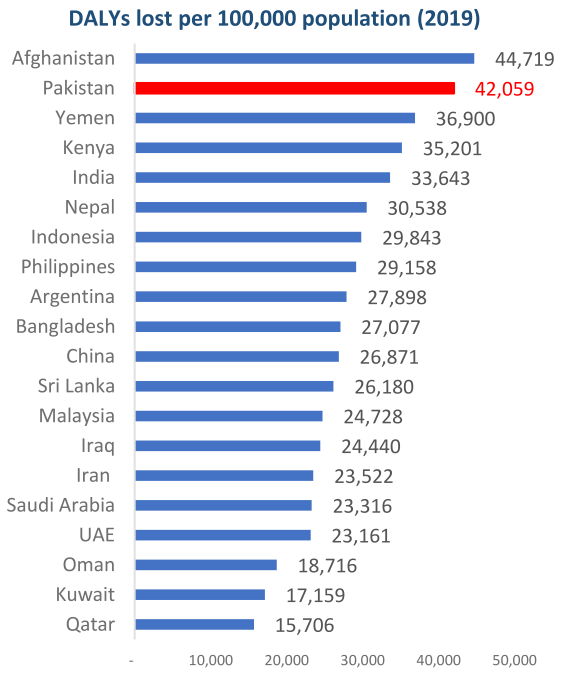
Investment in health improves health outcomes, reduces poverty and contributes in promoting economic growth. Better health and improved health systems also enable a country to tackle health emergencies and ensure national security. With poor health status in Pakistan, another major challenge during 2021 was the continuing negative impact of COVID-19 epidemic, particularly for those who are poor or vulnerable, women and children, youth, persons with disabilities, people living with diseases, older people, refugees, internally displaced persons and migrants.

Pakistan is currently going through epidemiological and demographic transitions. However, both transitions in Pakistan are slow compared to other countries in the region. **Epidemiological transition** considers patterns of mortality change and causes of death (and sometimes ill health) from patterns dominated by maternal & child health and infectious diseases to those in which chronic, degenerative physical ailments predominate with increasingly non-communicable and mental ill-health conditions.

Demographic transition refers to the shift in vital rates within population groups at various geographical scales from a pattern of high birth (fertility) and death (mortality) rates to one of low rates. Paralleling both these transitions are recognized related changes such as "**nutrition transition**" and "**ageing transition**". [9] All these patterns are evident in Pakistan and it is recognized that they may not be unidirectional. Indeed, different "speeds" of transition may occur in different places and sometimes reverses or mixed patterns are observed.

Burden of Disease (BoD) is "A systematic, scientific effort to quantify the comparative magnitude of health loss from all major diseases, injuries, and risk factors by age, sex, and population and over time". The preferable unit for quantification of BoD is Disability-Adjusted Life Years (DALYs), which measures the number of years of healthy life lost to premature death and disability. Hence, DALYs are the sum of years of life lost due to premature death (YLLs) and years lived with disability (YLDs).

According to Institute of Health Metrics & Evaluation (IHME)[10], the annual rate of DALYs lost per 100,000 population indicates that Pakistan has very high BoD



among the regional countries i.e., 42,059 DALYs/ 100,000 population in 2019.

[9] https://doi.org/10.1002/9781118786352.wbieg0063

[10] https://vizhub.healthdata.org/gbd-compare/

Median age is 22.8 years in Pakistan, compared to global median age of 29.6 years, indicating a very young population in Pakistan. Life expectancy at birth in 2019 was 66 years (65 years for males and 67 years for females) and is much lower than the global average life expectancy of 73.5 years.

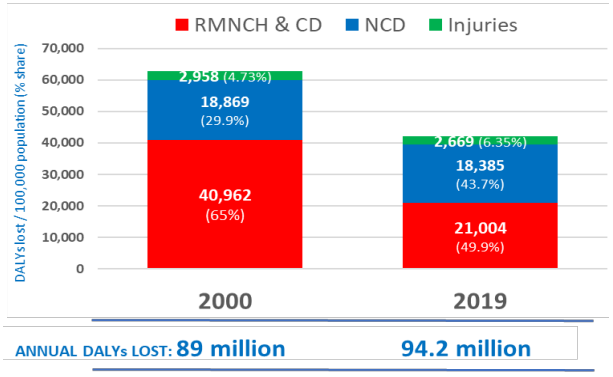
Since 1990, life expectancy of the Pakistani population has increased from 61 years to a life expectancy of 66 years with a total change in expectancy of just +4.8 years. In comparison, Japan's life expectancy was 79 years, which increased to 85 years in 2019 with a total change in life expectancy of +5.4 years.

The IHME classifies the BoD into three major components:

i. Reproductive, Maternal, Neonatal, Child Health & Nutrition + Communicable Diseases
ii. Non-Communicable diseases and
iii. Injuries.

Burden of the communicable, maternal, child and nutritional group in Pakistan, which was more than 65 percent (40,962 DALYs lost per 100,000 population) of the total burden of diseases in the year 2000, has gone down to 49.9 percent (21,004 DALYs lost per 100,000 population) in 2019. However, the burden of non-communicable disease group which was 29.9 percent (18,698 DALYs lost per 100,000 population) of the total burden in the year 2000 has increased its share to 43.7 percent (18,385 DALYs lost per 100,000 population) in 2019. The share of burden of injuries increased from 4.73 percent (2,958 DALYs lost per 100,000 population) to 6.35 percent (2,669 DALYs lost per 100,000 population) over the same period. These facts illustrate the reduction in the BoD of RMNCH-N and communicable diseases with a concomitant increase in the BoD share of NCDs and Injuries.

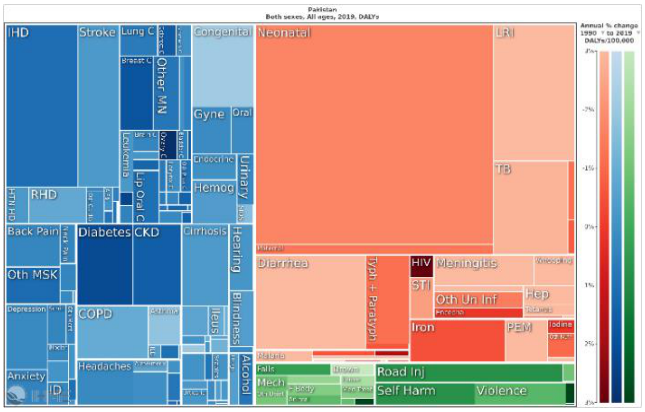
Trend of BoD in Pakistan during 2000-19



Pakistan is dealing with a double burden of diseases as it is not only confronting a huge burden of MNCH & infectious diseases but also an epidemic of non-communicable disease & Injury burden. The following figure indicates that burden of MNCH and communicable disease (red) is still very high, while the non-communicable diseases (blue) and injuries (green) are now occupying more than half of the box.

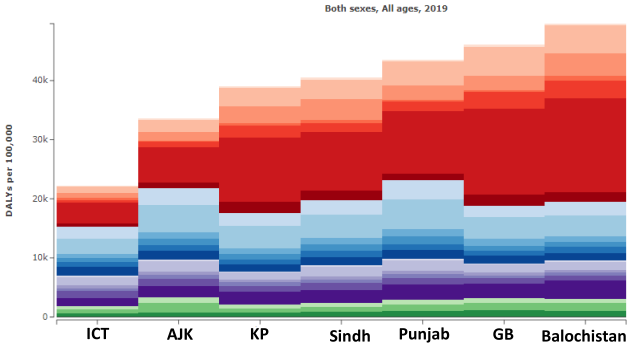
The BoD breakdown by disease groups indicates that neonatal issues in Pakistan still constitute the highest component of the BoD. Early Neonatal disorders (0-6 days of age) account for the highest BoD among the age groups (198,034 DALYs/100,000) while late neonatal disorders (7-27 days of age) account for 39,457 DALYs/100,000 population.

BoD Breakdown by disease groups in Pakistan (2019)



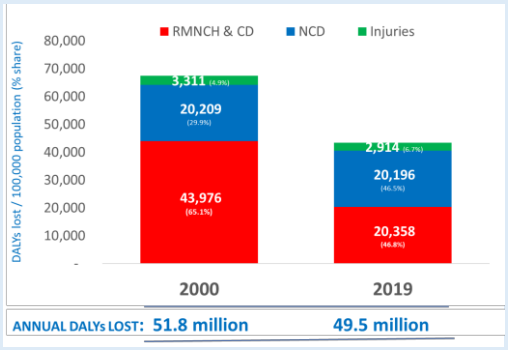
There is also a serious equity issue among provinces/ federating areas, as rate of DALYs lost/100,000 population varies from 22,226 to 49,620 between Islamabad and Balochistan respectively. Compared to the national BoD of 42,059 DALYs lost per 100,000 population in 2019, Balochistan followed by GB and Punjab have higher BoD than the national average, while Sindh, Khyber Pakhtunkhwa, Azad Jammu & Kashmir and Islamabad have lesser burden of disease rate than the national average.

BoD by Province/ area (2019)

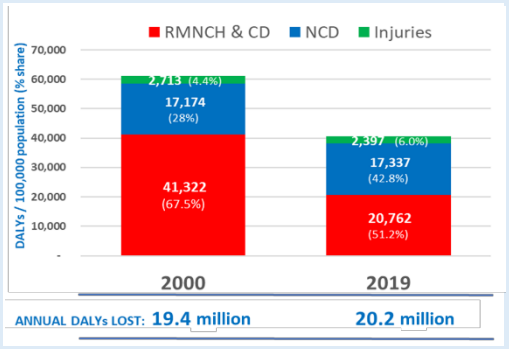


TRENDS IN PROVINCIAL/ FEDERATING AREA BoD (Annual DALYs Lost) in 2000 and 2019

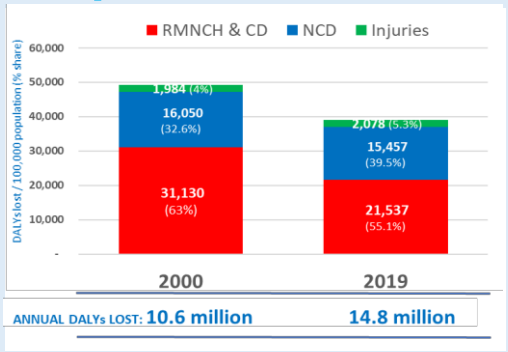
Punjab



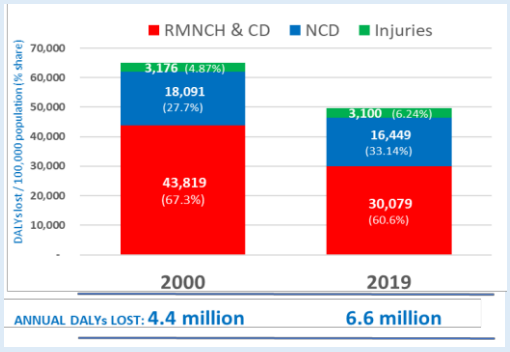
Sindh



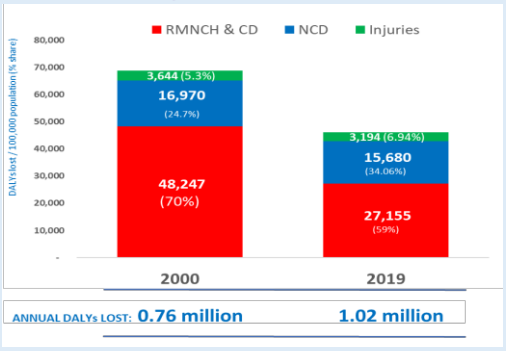
Khyber Pakhtunkhwa



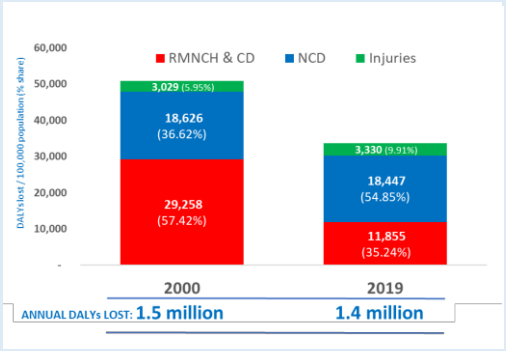
Balochistan



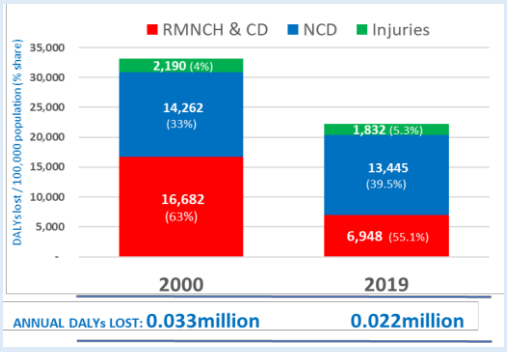
Gilgit Baltistan



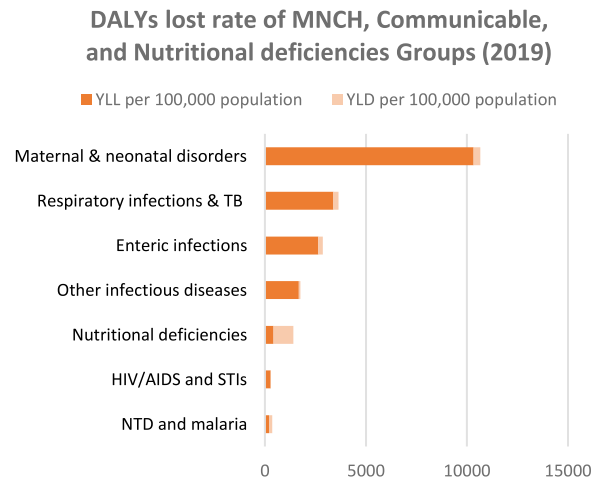
Azad Jammu & Kashmir

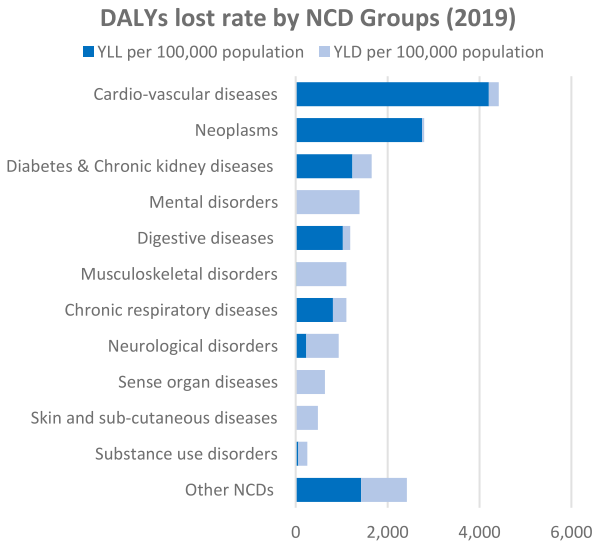


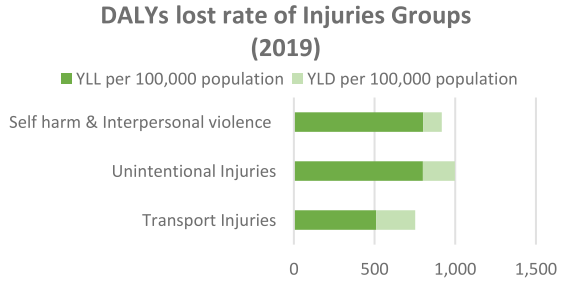
Islamabad



Neonatal and maternal disorders constitute the largest disease group of disease burden, followed by cardio-vascular diseases and then respiratory infections & TB. A summary of DALYs lost/100,000 population of the three groups of diseases is shown in the following graphs.

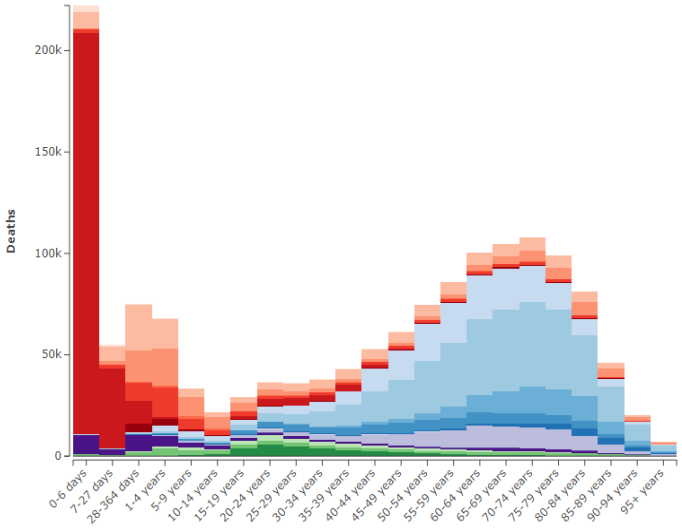






The disease pattern also changes with the age groups, as neonatal disorders are more common in the early age of life, followed by respiratory infections and diarrheal diseases among children and cardio-vascular and neoplasms in the older age.

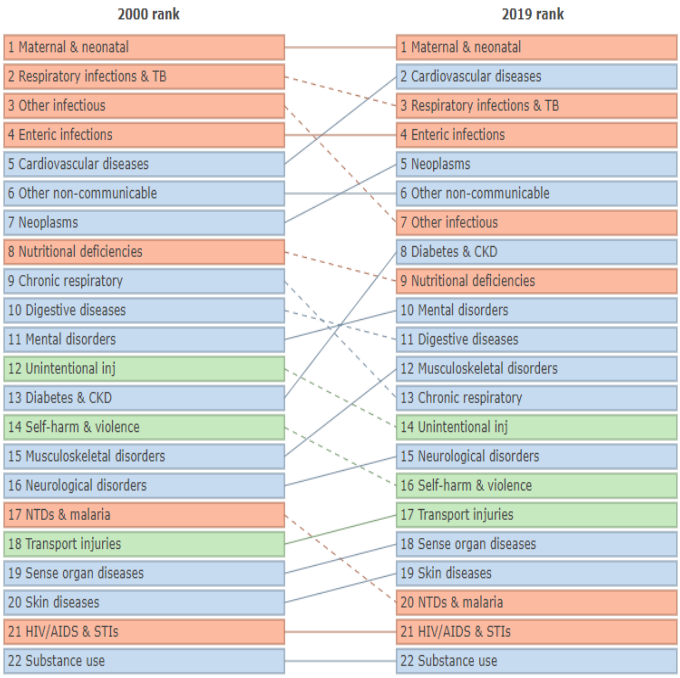
Variation in BoD in Pakistan by age (2019)



In 2019, the death rate was 6.7 deaths per 1,000 population (approximately 1.49 million annual deaths). 55.3 percent of all these deaths were because of non-communicable diseases, while communicable, maternal, neonatal and nutritional group contributed to 38.9 percent of total deaths and the share of injuries was 5.69 percent.

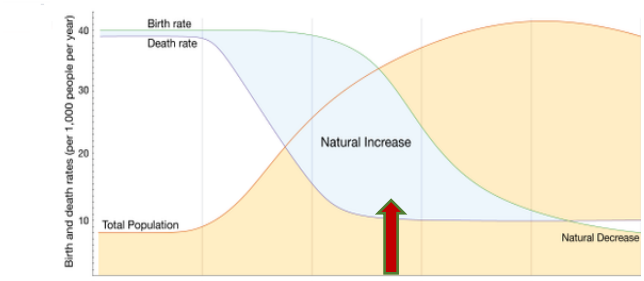
Maternal and neonatal disorders are one of the top disorders in Pakistan, followed by cardiovascular diseases. Disease ranking have changed significantly since 2000 as shown below.

Change is disease ranking from 2000 to 2019



Demographic Transition in Pakistan started in the 1950s, with a gradual decline in the mortality rate which improved significantly during the first two decades after independence. Life expectancy at birth for both sexes improved from 33.8 years in 1951 to 66 years (65 years for males and 67 years for females) in 2019. Infant Mortality Rate (IMR) declined significantly from 177 in 1950-55 to 62 deaths per 1000 live births in PDHS 2017-18.[11] Death rate in 2019 is estimated at 6.7 per 1,000 population, while birth rate is estimated at 28 per 1,000 population.[12]

The fertility transition did not keep pace with the mortality decline in the past. The targets for reducing fertility were not accomplished, even until recently. Thus, fertility level in the decades of 1970s and 1980s in Pakistan remained exceptionally high and fluctuating between six and seven children per woman. It is a well-accepted fact that fertility decline in Pakistan started only in the late 1980s and later gained momentum in the 1990s and specially at the start of new millennium. Pakistan still has a very high fertility rate, which was 3.8 children per woman in 2012-13 and 3.6 children per woman in 2017-18, with higher rates in rural areas.[13]



	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Birth rate	High	High	Falling	Low	Very low
Death rate	High	Falls rapidly	Falls more slowly	Low	Low
Natural increase	Stable or slow increase	Very rapid increase	Increase slows down	Stable or slow increase	Stable or slow decrease

Over the last decade, fertility rate appears to be stagnant again leading to delayed demographic transition. This is related to less investment in and declining services for family planning. Considering high unmet demand for family planning services, there is still a chance for rapid decline in fertility rate by ensuring availability of contraceptive commodities and increasing trained workforce for provision of family planning services through primary healthcare approach. Without any further delay, this is a critical reform for improved health status of people of Pakistan and also for demographic dividend.

COVID-19 pandemic and health emergencies also determine the health status of a country. The novel coronavirus, COVID-19 (or SARS-COV-2) is a highly communicable disease, labelled as a modern-era pandemic and a public health emergency by the World Health Organization. Spreading throughout the world, it has infected millions, and claimed the lives of more than 5.27 million people, as of December 2021. Countries all over the world are faced with the unenviable challenge of balancing the health of their citizens — with stay-at-home orders, closure of industries, etc — and the need to ensure that social safety nets to maintain the livelihoods of the poorest demographics also remain functional.

In Pakistan, COVID-19 cases were reported from Islamabad and Karachi on February 26, 2020. Pakistan being one of the densely populated countries in Asia, with a population of 232 million, and Karachi being the largest metropolitan city in Pakistan, has been greatly vulnerable to this outbreak.

The administration had a huge responsibility to constrain the spread through a timely response and the adoption of appropriate measures to avoid any major catastrophe. The disease was initially difficult to contain, especially because of noncompliance of the general population to the necessary measures and timely reporting of symptoms. Within 45 days, on April 10, 2020, Pakistan reported 4,601 confirmed cases with a death toll approaching 66 individuals.

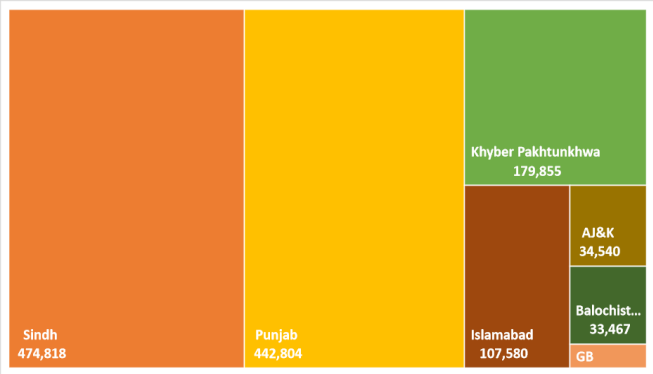
The government of Pakistan has been lauded by international organizations including the WHO (and rightly so) for taking the necessary precautions and measures against the COVID-19 pandemic early on to guarantee not only the containment of disease spread but also to fulfil its responsibility as a state toward its people and their safety

One of the first steps taken by the government was to develop a functional National Command and Control Centre (NCOC) and to detect the route of disease spread in Pakistan. The origin of the virus was the first question; hence, detailed history-taking of patients was crucial not only in understanding the outbreak but also in determining the contacts of patients with other people in the community. This helped in cordoning off areas or home-bounding people who came in close contact with a patient with COVID-19. In addition to this, patients with a recent international travel history were monitored

[11] UN Interagency Group, 2015-20; Levels & Trends in Child Mortality
[12] https://data.worldbank.org/indicator/SP.DYN.CDRT.IN?locations=PK
[13] National Institute of Population Studies, 2012-13 and 2017-18; Pakistan Demographic & Health Surveys

closely because many cases and massive spread was reported in the countries neighbouring Pakistan

As of mid-December, 2021, Pakistan is reporting 300 new infections on average each day. There have been more than 1.28 million infections and more than 28,770 coronavirus-related deaths reported in the country since the pandemic began. Sindh and Punjab reported higher number of cases 474,818 and 442,804 followed by KP, Islamabad, AJK, and GB.



Pakistan faced shortages of essential materials necessary to combat the spread of COVID-19, with Personal Protective Equipment (PPE) remaining scarce and exorbitantly expensive. This poses significant challenges not just for the population at large, but specifically for healthcare professionals, who risk becoming vectors of the disease, creating the conditions for a potentially catastrophic situation.

Pakistan has passed the 76 million mark for total COVID-19 vaccine doses administered of which 49 million persons are fully vaccinated, 27 million have been administered the first dose. The government has announced booster shots for overseas travellers to be administered at a cost of PKR 1,270. Whereas free booster vaccination is now offered to people above 50 years of age, health care providers and immune-compromised patients.

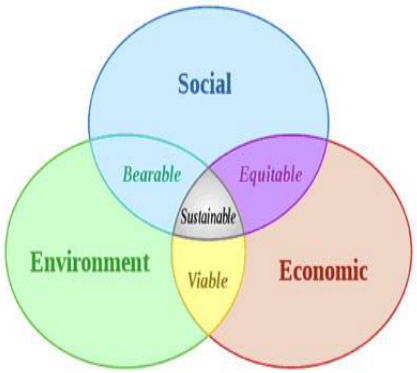
So far, the government has spent more than US$ 1.6 billion on vaccine and diagnostic services, which is an extra-ordinary response considering difficult economic situation and high inflation rate. Partners have also supported Pakistan to mitigate the risks related to COVID-19 pandemic.

Credit disbursement to the agriculture sector increased by 12% on year-on-year basis to PKR 1.37 trillion in FY21. According to the State Bank of Pakistan, 49 financial institutions managed to achieve 91% of their assigned credit target of PKR 1.5 trillion for the year.

For those who survived the virus, COVID-19 may have lingering health effects, including long-term disability due to lung scarring and heart damage, along with mental health issues that could affect individuals for a prolonged period. Indiscriminate use of antibiotics during the pandemic could further increase antimicrobial resistance. Although it is still too early for existing data to reflect this impact, the COVID-19 pandemic threatens to reverse years of progress towards improved country health and reflects the actual picture of our health system.

HEALTH RELATED SUSTAINABLE DEVELOPMENT GOALS

The Millennium Development Goals and subsequent Sustainable Development Goals (SDGs) ushered in new opportunities to significantly improve health status and well-being globally. The seventeen Sustainable Development Goals (SDGs), 169 targets and 244 indicators of the 2030 Agenda integrate all three dimensions of sustainable development (economic, social and environmental) recognizing that eradicating poverty and inequality, creating inclusive economic growth and preserving the planet are inextricably linked.



SDG 3 specifically focuses on health, with the aim to "Ensure healthy lives and promote well-being for all at all ages" based on the definition of health in the WHO Constitution. Health is positioned within the 2030 Agenda, with one comprehensive goal (SDG 3) and its 13 targets (and more than 27 indicators) covering major health priorities, and links to targets in many of the other goals.

The Government of Pakistan, with the signing and ratification of the UN SDG 2030 Agenda in 2015, expressed its clear resolve and commitment to work in partnership with the international community for improving the health of the people. By adhering to the 2030 Agenda of SDGs, the country aims to bring about transformational change in 17 domains covering multiple sectors to improve the lives of not only the citizens of Pakistan but also contribute towards the betterment of the entire humanity.

The Government of Pakistan aims to successfully implement the health-related sustainable development agenda in collaboration with provinces, private sector, civil society organizations and other line ministries. The National Health Vision (NHV) 2016-25 and National Action Plan (2019-23) provide an overarching national vision and agreed upon common direction, harmonizing provincial and federal efforts for achieving the desired SDG 3 outcomes and impact. They were designed to represent an aspirational priority action and to set ambitious targets to achieve SDGs including universal access to health services

The commitment to "leave no one behind" is a cornerstone of the 2030 Agenda for Sustainable Development. But high and rising inequalities act as both visible and concealed impediments to progress in population health and human, social and economic development. Major challenges remain in terms of reducing maternal and child mortality and control of communicable and non-communicable diseases.

Priorities for the health service delivery are provision of quality family planning services, tackling under-nutrition, addressing the high burden on neo-natal deaths and reducing the numbers of tuberculosis and hepatitis cases.

The health agenda in Pakistan also highlights the importance of addressing non-communicable diseases and their risk factors such as tobacco use, poor diet, mental health problems, road traffic injuries, and environmental health issues. Weak health systems are a major obstacle, resulting in major deficiencies in UHC for even the most basic health services and inadequate preparedness for health emergencies.

Localization of SDG 3 targets and indicators has established the leadership role of the health sector in implementation and monitoring of SDG 3 in Pakistan and contributed to multisectoral linkages for achievement of the health-related SDGs. Pakistan is one of the first countries in the Region to reach this milestone and launched SDG 3 localization report in 2018.

Timely, reliable, disaggregated and actionable data is the dire need of the present era for driving strategic policy changes. Assessable information is essential to monitor and accelerate progress towards the health-related SDGs. In view of the above, Pakistan has developed an SDG 3 web based and mobile application, that provides the information at the national and provincial level for each health-related indicator. The application serves as a mechanism to easily access updated SDG 3 targets for each indicator for Pakistan and check the status of progress.

SDG 3 has strong interconnections with other SDGs on poverty, hunger, education, gender equality, water and sanitation, economic growth, inequality, safe cities, climate change and partnerships. The bi-directional relationship between health and these other areas makes advancement of each one beneficial to the others.

COVID-19 poses major challenges to population health and well-being globally and thwarts the progress in meeting SDGs and the WHO Triple Billion targets. Disruptions of essential health services due to COVID-19 have been widespread due to the shortage of medicines, staff, diagnostics and public transport services. Prior to the COVID-19 pandemic, positive progress in health was being made. However, the progress is inadequate for attaining the Triple Billion targets and health-related SDGs, calling for more effective disease and injury prevention and control programmes.

SDG 3: Good Health and Well Being

3.1.1 Maternal Mortality Ratio per 100,000 live births

2030	2025	2020	2015
95	115	186/140	178

3.1.2 Proportion of births attended by skilled health personnel

2015	2020	2025	2030
59	71	80	>85

3.2.1 Under-Five Mortality Rate per 1000 live Births

2030	2025	2020	2015
49	60	74/67	81

3.2.2 Neonatal Mortality Rate per 1000 live Births

2015	2020	2025	2030
46	42/41	35	30

3.2.1.A Infant Mortality Rate per 1000 live births

2030	2025	2020	2015
45	51	62/56	66

3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations

2015	2020	2025	2030
0.09	0.12	115	0.19

3.3.2 Tuberculosis incidence per 1,000 population

2030	2025	2020	2015
212-261	240	263	270

3.3.3 Malaria incidence per 1,000 population

2015	2020	2025	2030
8.56	1.7	1	<1

3.3.4 Hepatitis B incidence per 100,000 population

2030	2025	2020	2015
45	54	NA	900

3.3.5 Number of people requiring interventions against neglected tropical diseases

2015	2020	2025	2030
30,418,380	55,298,514	<20,000	<10,000

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

2030	2025	2020	2015
20	24	29.4	24.7

3.4.2 Suicide mortality rate

2015	2020	2025	2030
2.1	8.9	1.9	≤1.6

3.5.1 Coverage of treatment interventions for substance use disorders

2030	2025	2020	2015
35	15	NA	10

3.5.2 Total Alcohol per capita (≥ 15 years consumption (litres of pure alcohol)

2015	2020	2025	2030
0.2	0.3	0.2	<0.2

3.6.1 Death rate due to road traffic injuries per 100,000 population

2030	2025	2020	2015
<13	14.5	13	14.2

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

2015	2020	2025	2030
47	49	60	>70

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

2030	2025	2020	2015
29	32	46	38.3

3.8.1 Universal Health Coverage Index

2015	2020	2025	2030
40	49.9	58	65

3.8.2 Incidence of catastrophic expenditure (%) at 10% of household total consumption or income

2030	2025	2020	2015
NA	NA	4.5	1.03

3.9.1 Mortality rate attributed to household and ambient air pollution (per 100,000 population)

2015	2020	2025	2030
87.2	173.6	NA	70

3.9.2 Mortality rate attributed to exposure to unsafe WASH services (per 100,000 population)

2030	2025	2020	2015
NA	NA	19.6	20.7

3.9.3 Mortality rate attributed to unintentional poisoning (per 100,000 population)

2015	2020	2025	2030
1.5	1.6	NA	NA

3.a Age-standardized prevalence of tobacco smoking among persons 15 years and older

2030	2025	2020	2015
10	11	20	12.4

3.b.1 DPT3/Penta3 Immunization coverage (%)

2015	2020	2025	2030
65.2	83.5	79	80

3.b.2 Total ODA to medical research and basic health (%)

2030	2025	2020	2015
NA	NA	0.6	1.7

3.b.3 Proportion of health facilities with essential medicines (%)

2015	2020	2025	2030
NA	NA	NA	NA

3.c Skilled health professionals' density (per 10,000 population)

2030	2025	2020	2015
34.4	24	16.9	14.1

3.d.1 IHR Index (13 core competencies) (%)

2015	2020	2025	2030
43	53	NA	>75

Other Health Related SDGs

Goal 1: No Poverty

	2015	2020
Population living below the poverty line (%)	38	37
Urban	32	32
Rural	41	39

Source: HIES 2015-16 and 2018-19 estimates

	2015	2020
Children U5 who are		
Stunted (%)	44.8	37.6
Wasted (%)	10.8	7.1
Overweight (%)	3.2	2.5

Source: PDHS 2012-13 and 17-18

Goal 4: Quality Education

	2015	2020
Literacy Rate (10 years and older) (%)	60	60
Net Primary School Enrolment Ratio (NER) (%)	67	64
Literacy Rate (15-24 yrs) (%)	NA	72

Source: PSLM 2014-15 and 2019-20

Goal 6: Clean Water and Sanitation

	2015	2020
Access to improved Drinking water (%)	93	94
Access to improved Sanitation Facilities (%)	73	83

Source: PSLM 2014-15 and 2019-20

Goal 7: Affordable and Clean Energy

	2015	2020
Population with primary reliance on clean fuels and technologies at the household level (%)	45	49

Source: World Health Statistics Report 2016 and 2021

Goal 8: Decent Work and Economic Growth

	2015	2020
Unemployment Rate (%)	5.9	6.9
Male	5	5.9
Female	9	10

Source: Pakistan Labor Force Survey 2014-15 and 2018-19

Goal 11: Sustainable Cities and Communities

	2015	2020
Annual mean concentrations of fine particulate matter (PM 2.5) in urban area (µg/m^3)	68.7	56.2

Source: World Health Statistics Report 2016 and 2021

Goal 16: Peace, Justice and Strong Institutions

	2015	2020
Estimated direct deaths from major conflicts per 100,000 population	4.2	NA
Mortality rate due to homicide per 100,000 population	9.5	6

Source: World Health Statistics Report 2016 and 2021


3
GOOD HEALTH AND WELL-BEING
ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES
1 NO POVERTY
PRIORITIZING THE HEALTH NEEDS OF THE POOR
2 ZERO HUNGER
ADDRESSING THE CAUSES AND CONSEQUENCES OF ALL FORMS OF MALNUTRITION
4 QUALITY EDUCATION
SUPPORTING HIGH-QUALITY EDUCATION FOR ALL TO IMPROVE HEALTH AND HEALTH EQUITY
5 GENDER EQUALITY
FIGHTING GENDER INEQUITIES, INCLUDING VIOLENCE AGAINST WOMEN
6 CLEAN WATER AND SANITATION
PREVENTING DISEASE THROUGH SAFE WATER AND SANITATION FOR ALL
7 AFFORDABLE AND CLEAN ENERGY
PROMOTING SUSTAINABLE ENERGY FOR HEALTHY HOMES AND LIVES
8 DECENT WORK AND ECONOMIC GROWTH
PROMOTING HEALTH EMPLOYMENT AS A DRIVER OF INCLUSIVE ECONOMIC GROWTH
9 INDUSTRY, INNOVATION AND INFRASTRUCTURE
PROMOTING NATIONAL R&D CAPACITY AND MANUFACTURING OF AFFORDABLE ESSENTIAL MEDICAL PRODUCTS
10 REDUCED INEQUALITIES
ENSURING EQUITABLE ACCESS TO HEALTH SERVICES THROUGH UNIVERSAL HEALTH COVERAGE BASED ON STRONGER PRIMARY CARE
11 SUSTAINABLE CITIES AND COMMUNITIES
FOSTERING HEALTHIER CITIES THROUGH URBAN PLANNING FOR CLEANER AIR AND SAFER AND MORE ACTIVE LIVING
12 RESPONSIBLE CONSUMPTION AND PRODUCTION
PROMOTING RESPONSIBLE CONSUMPTION OF MEDICINES TO COMBAT ANTIBIOTIC RESISTANCE
13 CLIMATE ACTION
PROTECTING HEALTH FROM CLIMATE RISKS, AND PROMOTING HEALTH THROUGH LOW-CARBON DEVELOPMENT
14 LIFE BELOW WATER
SUPPORTING THE RESTORATION OF FISH STOCKS TO IMPROVE SAFE AND DIVERSIFIED HEALTHY DIETS
15 LIFE ON LAND
PROMOTING HEALTH AND PREVENTING DISEASE THROUGH HEALTHY NATURAL ENVIRONMENTS
16 PEACE, JUSTICE AND STRONG INSTITUTIONS
EMPOWERING STRONG LOCAL INSTITUTIONS TO DEVELOP, IMPLEMENT, MONITOR AND ACCOUNT FOR AMBITIOUS NATIONAL SDG RESPONSES
17 PARTNERSHIPS FOR THE GOALS
MOBILIZING PARTNERS TO MONITOR AND ATTAIN THE HEALTH-RELATED SDGs

STATUS OF UNIVERSAL HEALTH COVERAGE

Universal Health Coverage (UHC) means that all people receive the health services they need. These services include public health services designed to promote better health (such as anti-tobacco information campaigns and taxes), prevent illness (such as vaccinations), and provide treatment (such as pneumonia and tuberculosis), rehabilitation (such as rehabilitation of drug users or injury cases) as well as palliative care (such as end-of-life care) of sufficient quality to be effective. Ensuring at the same time that the use of these services does not expose the user to financial hardship.

UHC (3.8) is a composite of two indicators – 3.8.1 on coverage of essential health services and 3.8.2 on the proportion of a country's population with catastrophic spending on health, defined as large household expenditure on health as a share of household total consumption or income.

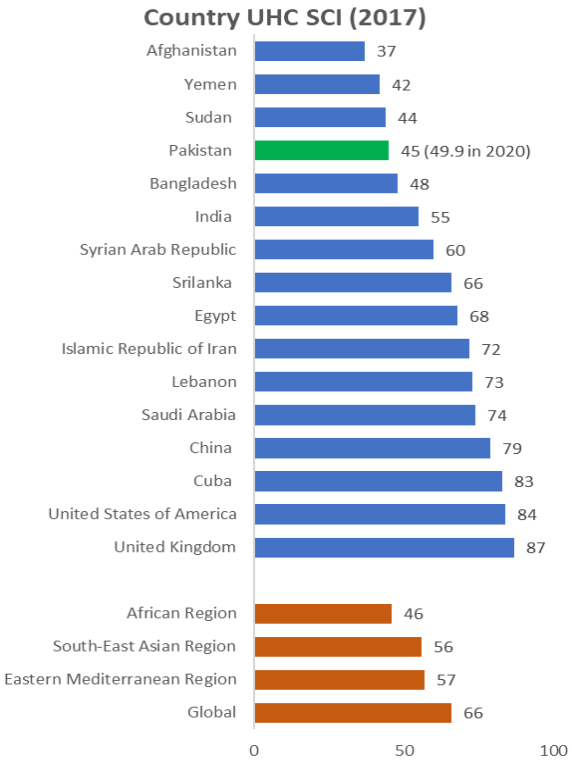
Both must be measured together to obtain a clear picture of those who are unable to access health care and those who face financial hardship due to spending on health care.

UHC Service Coverage Index (3.8.1)

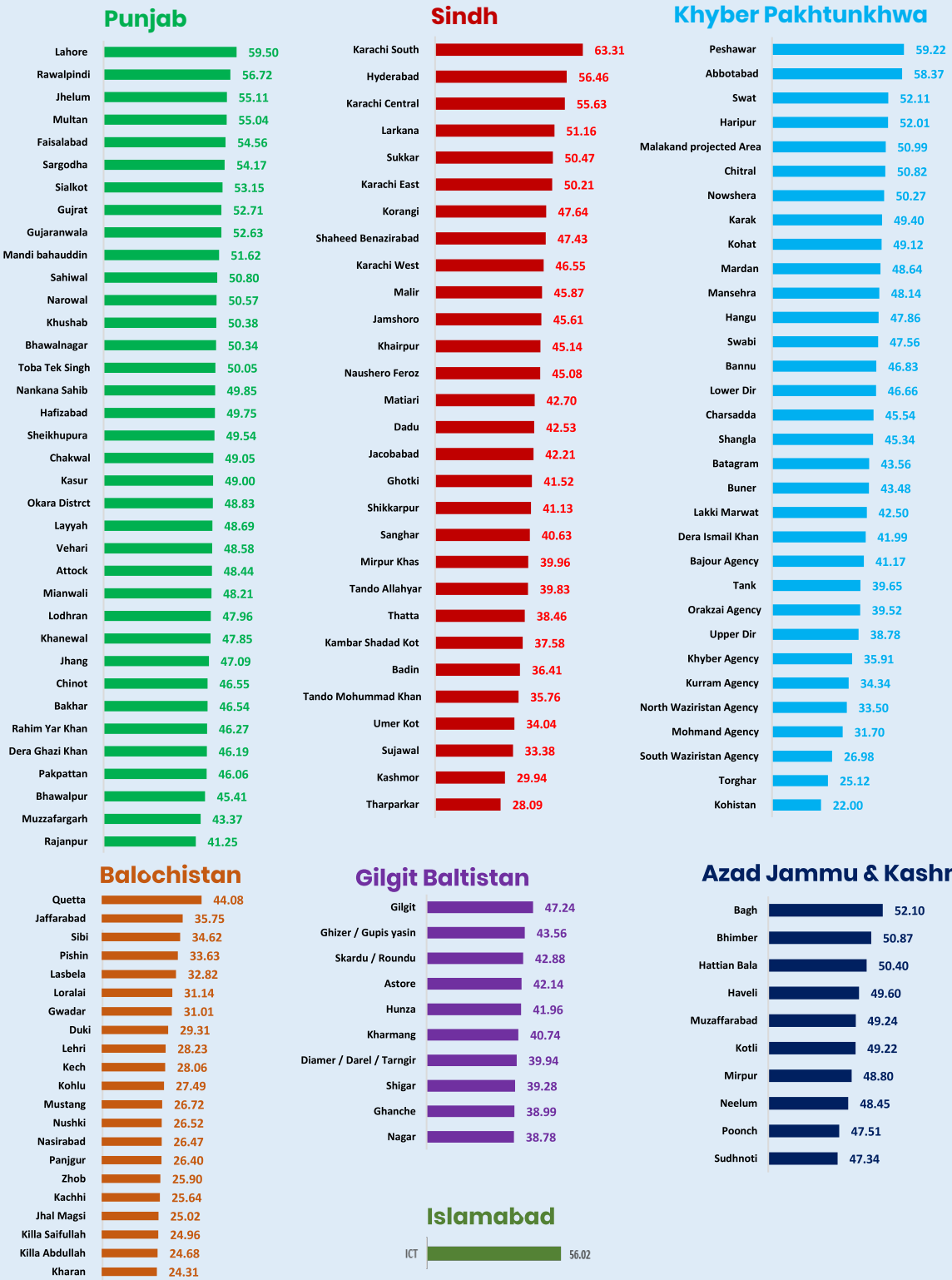
A UHC Service Coverage Index – a single indicator computed from tracer indicators of coverage of essential services (that include reproductive, maternal, new-born and child health; infectious diseases; non-communicable diseases; and service capacity & access; among the general population) – was developed by WB and WHO. The index is correlated with under-five mortality rates, life expectancy and the Human Development Index (HDI).

Because of the lack of data, it is not yet possible to compare the UHC service coverage index across key dimensions of inequality. Until these data gaps are addressed, inequalities can be assessed by looking at a narrower range of service coverage indicators, in particular for maternal and child health interventions.

Pakistan's UHC service coverage index is improving but the pace of improvement is very slow and much low compared to other countries and regions.[14]



[14] WHO, 2021; World health statistics 2021, monitoring health for SDGs

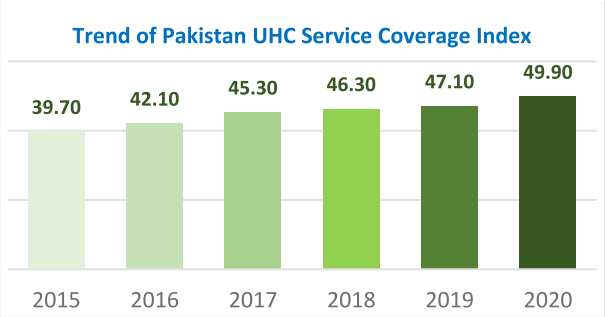


DISTRICT WISE
UHC SERVICE COVERAGE INDEX (2020)

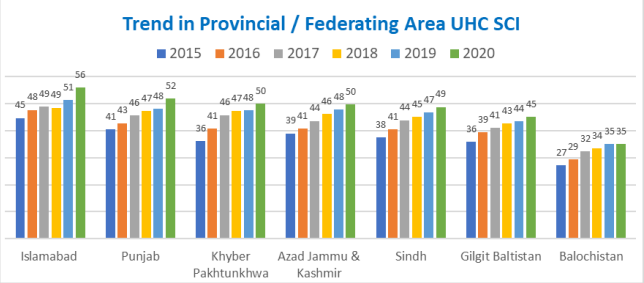
For more details, please refer to Annexure

MOVING TOGETHER TO BUILD A HEALTHIER PAKISTAN
UNIVERSAL HEALTH COVERAGE

Trend in UHC SCI of Pakistan is positive but improvement is slow as shown below in the annual trend.



Further, there are also noteworthy variations in the UHC SCI among provinces and districts.

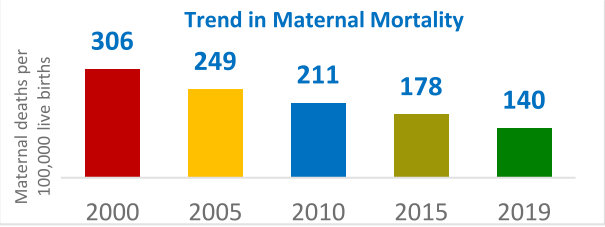


Sixteen tracer indicators were selected, four for each of the four categories specified for service coverage index. Data availability was a major consideration and so far, thirteen indicators are being used to monitor the service coverage index at global, regional and national level.

Category 1: Reproductive, Maternal, New-born and Child Health

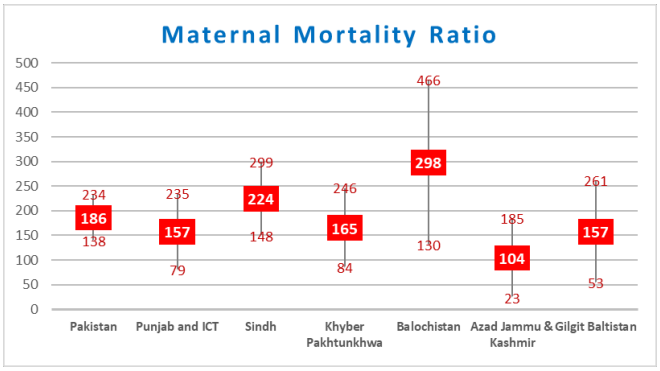
An analysis of the overall reproductive, maternal, newborn, child health (RMNCH) status of the population of Pakistan indicates a positive trajectory at **impact level indicators** and is critical towards realistic and effective implementation of the roadmap for UHC.

The estimates from the Pakistan Maternal Mortality Survey (PMMS) 2019, indicate that maternal mortality ratio (MMR) for Pakistan was 186/ 100,000 live births (199 in rural areas and 158 in urban areas) during three years preceding the survey. A positive declining trend was also estimated by the UN Inter-Agency group as shown below:



With the current pace, Pakistan has good probability of reaching the desired SDG 3.1 target of less than 70 maternal deaths/100,000 live births by 2030, provided commitments and efforts are not only sustained but further enhanced especially in hard-to-reach areas.

Geographical and equity considerations were also evident in the PMMS 2019 results for MMR estimation, by province and federating area.



Four most common complications that women report that they experienced during delivery are prolonged labour pains, laceration in vagina, the baby didn't breathe and the baby's presentation was breech. Prolonged labour pains were twice as common as in Balochistan than in the other provinces.

Around one quarter of maternal deaths could be averted if unmet need of contraceptives is made available. Improvement in antenatal care, postnatal care, skilled birth attendance along with other determinants such as poverty, illiteracy (especially of women) and nutrition also contributes greatly in determining maternal health outcomes. The early marriages and repeated pregnancies negatively impact the adolescent health leading to increased teenage pregnancies. In Pakistan, 8 percent of pregnancies are among adolescent girls of age 15-19 years.

In the last few decades, though significant advancements have been made in curtailing infant and child mortality rates, however these are still far higher than the targets set under SDG 3.2.

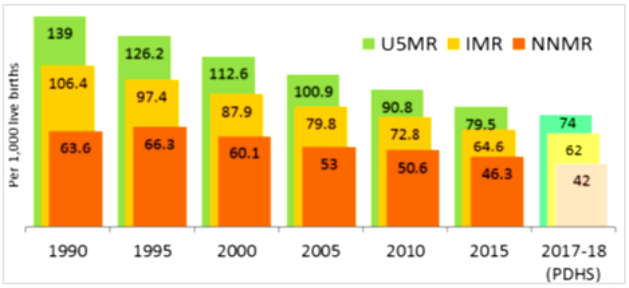
Maternal health has a direct impact on the newborns. In PDHS 2017-18, neonatal mortality has been reported as 42 deaths per 1000 live births which means that 1 in 22 children born in Pakistan die during the first month of birth. Data from Pakistan also demonstrate that neonatal mortality is mostly caused by prematurity, birth asphyxia, sepsis, acute respiratory infections, and congenital anomalies followed by other factors.

Newborn deaths account for greatest share in under-five mortality i.e., 74 deaths per 1000 live births whereas

infant mortality is as high as 62 deaths per 1000 live births. Almost 80 percent of these mortalities are preventable through provision of basic essential healthcare services to all at community and PHC centre level.

Among children under 5 years of age, diarrhoea and acute respiratory infections are the main cause of death and illness and can be prevented through integrated management of childhood illness. One of the life-saving interventions is ensuring availability of Oral Rehydration Therapy (ORT). Despite being affordable and easily available the use of ORS is reported to be only 38 percent.[15]

Trends in Child Mortality and Comparison with Infant and Neonatal Mortality

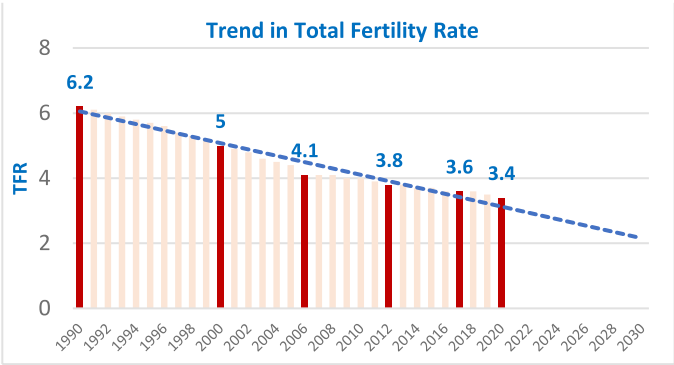


Child mortality is skewed by gender and place of residence (rural/ urban). Boys are more likely to die than girls in the first month of their lives (Boys: 52 deaths and Girls: 33 deaths per 1,000 live births).

Similarly, under-5 mortality rate is 80 deaths per 1,000 live births among boys and 68 deaths per1,000 live births among girls. Childhood mortality rate is higher in rural areas than in urban areas by 10 deaths per 1,000 live births. Neonatal, infant, and under-5 mortality rates are 45, 68, and 83 deaths per 1,000 live births, respectively, in rural areas, as compared with 37, 50, and 56 deaths per 1,000 live births in urban areas.

Another critical impact level indicator for SDGs is Total Fertility Rate (TFR), which is showing a gradual but positive decline. TFR was estimated to be 6.2 in 1990 for Pakistan, which declined to 5 at the start of this millennium, followed by a rapid decline and reaching to a level of 4.1 in 2006-07. After that the pace of decline slowed down and TFR reached a level of 3.8 in 2012-13 and 3.6 in 2017-18. For 2020, TFR is estimated by World Atlas Data to be 3.4 for Pakistan.

Over last five years, the decline in TFR is very slow and Pakistan may not reach replacement level fertility of 2.1 by 2030, provided extra-ordinary efforts are made not only to increase availability of contraceptive commodities but also increasing the number of community health workers (declining since 2011) offering family planning services through an integrated approach.



Among provinces, TFR was the lowest in Punjab at 3.4 and the highest in Khyber Pakhtunkhwa and Balochistan at 4 in 2017-18 (PDHS).

For UHC SCI, the RMNCH category consists of four proxy and priority indicators related to: i) Family planning; ii) Antenatal care (4+) visits; iii) Child immunization (Penta 3); and iv) Care- seeking behaviour for childhood pneumonia.

RMNCH aggregate score for Pakistan is estimated to be 64.7 in 2020 and has improved significantly from a baseline of 51.8 in 2015. With continued efforts, universal access to RMNCH services can easily be assured. The worst performance is in the indicator for family planning. Performance for ANC 4+ visits is still much below the desired level but has shown good progress over last five years.

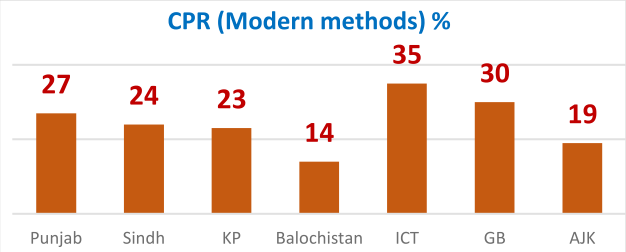
Further description of the status of RMNCH category is as following:

UHC Indicators	Punjab	Sindh	KP	Balochistan	ICT	GB	AJK	National
1. Family Planning demand satisfied with modern methods (%)	50.3	50.2	45.1	33.8	55.1	46.4	38.5	**48.6**
2. Antenatal care - 4+ visits	56.2	54.1	44.6	23.1	80.2	34.9	46.5	**51.4**
3. Child immunization (Penta 3) (%)	94.9	73.2	74.3	42.2	86.3	82.2	95.4	**83.5**
4. Care-seeking behaviour for child pneumonia (%)	86.1	85.4	84.3	62.2	83.6	76.3	80.8	**84.2**
RMNCH Aggregate Score in 2020	**69.33**	**64.19**	**59.58**	**37.84**	**75.14**	**56.45**	**60.95**	**64.74**

[15] Situation Analysis, Country Cooperation Strategy for WHO and Pakistan 2019-23

Family Planning: In Pakistan, average births per woman are estimated to be 3.4 in 2020. In PDHS 2017-18, TFR was reported 3.4 for Punjab, 3.6 for Sindh and 4 for Khyber Pakhtunkhwa (4.8 for ex-FATA) and Balochistan. Moreover, 14.8 percent of teenagers in Khyber Pakhtunkhwa had begun childbearing as compared with 6.2 percent in Punjab, 9.9 percent Sindh and 11.6 percent Balochistan.[16]

Unfortunately, there is decline in the contraceptive prevalence rate (CPR) at national level with only 25 percent of couples using modern contraceptive methods (PDHS 2017-18) compared to 26 percent in 2012-13.



The use of contraceptive methods, both modern as well as traditional, increases with education and prosperity. For instance, 22 percent of currently married women with no education used a modern method of contraception compared with 30 percent of women with secondary or higher level of education. Similarly, 7 percent of married women with no education used a traditional method compared to 14 percent with a higher level of education who used a traditional method.

The lack of family planning services leads to unintended pregnancies, more than half of which result in induced abortions whereas one third result in unplanned childbirth. Around one quarter of maternal deaths could be averted if unmet need of contraceptives is made available.

Maternal Care: Frequent and regular antenatal care (ANC) is essential to monitor pregnancy and reduce mortality risks for both the child and the mother. Antenatal care, postnatal care, skilled birth attendance along with other determinants such as poverty, illiteracy (especially of women) and nutrition also contribute greatly in determining maternal health outcomes. The early marriages and repeated pregnancies negatively impact the adolescent health leading to nutritionally deficient offspring and perpetuating a vicious life cycle.

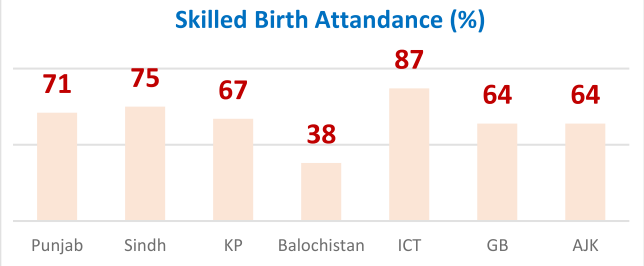
According to the PDHS 2017-18, ANC by skilled providers was 94 percent in ICT, followed by 92 percent in Punjab, 90 percent in Azad Jammu & Kashmir, 86 percent in Sindh, and 80 percent both in Gilgit-Baltistan and Khyber Pakhtunkhwa. The coverage was the worst in Balochistan at only 56 percent.

Moreover, there is correlation between the level of education and the choice of ANC from a skilled provider. For example, 99 percent of mothers with higher education received ANC from skilled providers compared to 76 percent of mothers with no education.

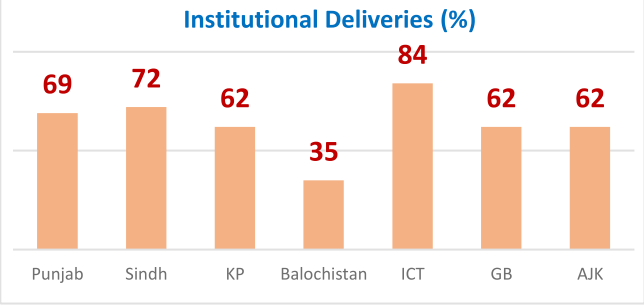
ANC by skilled providers was higher in urban areas (76.8 percent) as compared to rural areas (46.6 percent). 82 percent of the mothers received ANC from a doctor.

The uptake of ANC from a skilled provider also depended on wealth. 67 percent of mothers living in households falling in the lowest wealth quintile received ANC from any skilled provider; the proportion increased to 98 percent for women living in the highest wealth quintile.

At national level, percentage of births attended by a skilled provider is 69 percent, mother education was positively related to delivery with skilled attendant for example, 94 percent of the mothers with at least secondary education delivered with the assistance of a skilled attendant as compared to 56 percent of the mothers with no education/preschool.



Percentage of births occurring in a health facility was 66 percent compared to 34 percent delivered at home. Mothers from urban areas are more likely to deliver at a health facility (81 percent) compared to rural areas (59 percent).

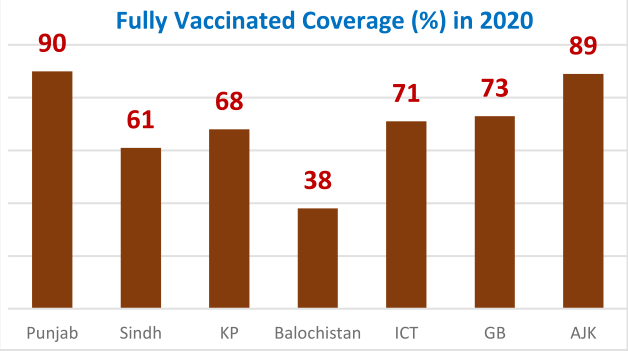


[16] NIPS, 2018; Pakistan Demographic Health Survey 2017-2018

Immunization: Over the years, immunization coverage has shown positive progress with variation among provinces and districts. Full vaccination among children of age 12-23 months shows an increase from 54 percent in 2012-13 (PDHS) to 65 in 2017-2018 (PDHS) and 76 percent in 2020 (TPVICS)[17].

A child is considered fully vaccinated if s/he received BCG, Polio3, Penta3, Pneumo3 and Measles 1 as per the vaccination schedule.

Approximately 93 percent children received the BCG vaccination in 2020. Overall, 93 percent received polio zero (at birth), 91 percent Polio-1, 88 percent Polio-2 and 84 percent received Polio-3 vaccine any time before the 2020 survey. In addition, 80 percent received the measles 1 vaccine in 2020.



In 2020, all the districts in Punjab reported more than 80 percent coverage of Penta 3 immunization, while 40 percent of the districts in Khyber Pakhtunkhwa achieved 80 percent of the Penta 3 coverage. Only 24 percent of the districts in Sindh and 6 percent districts in Balochistan reported at 80 percent of Penta 3 coverage. Gilgit-Baltistan with 70 percent and Azad Jammu & Kashmir with 100 percent of their districts had at least 80 percent of Penta 3 coverage.

In 2020, 81 percent of vaccination card retention was found in Punjab, 50 percent in Sindh, 57 percent in Khyber Pakhtunkhwa, 19 percent in Balochistan, 62 percent in Islamabad, 53 percent in Gilgit-Baltistan and 76 percent in Azad Jammu & Kashmir.

The districts of Mianwali and Mandi Bahuddin from Punjab, Badin and Tharparker in Sindh, Chitral and Haripur in Khyber Pakhtunkhwa, Khyber in ex-FATA, Harnai and Washuk in Balochistan, Shigar and Hunza in Gilgit Baltistan and Bhimber and Mirpur in Azad Jammu & Kashmir reported the highest coverage for fully vaccinated in 2020 survey.

Polio: Pakistan is one of the last two polio-endemic countries in the world, alongside Afghanistan.[18]

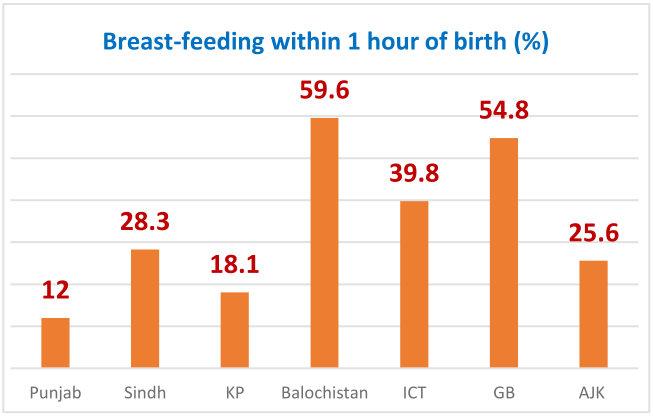
As of 31st November 2021, only one Wild Poliovirus (WPV) case has been reported in Pakistan (from Balochistan in January 2021) as compared to 84 cases in 2020.

Similarly, as of 31st November, only 8 cases of Circulating Vaccine-Derived Poliovirus (cVDPV) have been reported in 2021, as compared to 135 cases in 2020.

So far, 12 percent of the environmental samples were found positive compared to 56 percent in 2020. This year, number of districts for positive environmental samples was 22 compared to 56 in 2022.

Breast Feeding: Results from the PHDS 2017-18 show that only 48 percent of infants under the age of 6 months were on exclusive breastfeeding, compared to 38 percent in 2012-13. Thirty-seven percent of infants under the age of 6 months were fed using a bottle in 2017-18. Among children 6-23 months, only 12 percent were fed in accordance with the criteria for a minimum acceptable diet.

In Pakistan, 20 percent of newborns started breast-feeding within one hour of birth.



[17] Aga Khan University; 2020; Third Party Verification Immunization Coverage Survey (TPVICS)

[18] Polio Eradication Initiative https://polioeradication.org/where-we-work/polio-endemic-countries/

Acute Respiratory Infections: According to the World Health Organization (WHO) reports, acute respiratory infection (ARI), fever, and dehydration from diarrhoea are some of the main contributing causes of childhood mortality in developing countries. Timely medical intervention for children experiencing any symptoms of the diseases can significantly reduce child deaths.

According to PDHS 2017-18, for each child under age 5, mothers were asked if the child had experienced a cough accompanied by short, rapid breathing, or difficulty in breathing as a result of a chest-related problem (symptoms of ARI); a fever; or an episode of diarrhoea in the 2 weeks preceding the survey. Respondents were also asked if treatment was sought when the child was ill. Results showed that 14 percent of children under age 5 showed symptoms of ARI while treatment from a health facility or provider was sought for 84 percent of children with ARI symptoms.[16]

Moreover, according to the survey results, antibiotic treatment for children with ARI symptoms was sought for only 46.4 percent of the children. Furthermore, there was a correlation between wealth, education and the place of living with awareness about ARIs. Both men and women in urban areas were found to be more aware than their rural counterparts and better-educated respondents and those in the highest wealth quintile were considerably more knowledgeable of ARI prevention methods than other respondents.

Diarrhoea: Diarrhoea accounts for 7.7 percent of all deaths among children in Pakistan. To assess the incidence of diarrhoea, in PDHS 2017-2018 report, for each child under age 5, mothers were asked if the child had experienced an episode of diarrhoea in the 2 weeks preceding the survey. Results showed that treatment was sought from a health facility or health provider for 59.7 percent of children with diarrhoea.

Moreover, according to the survey results, children who experienced diarrhoea were 19 percent, care-seeking for diarrhoea was for 71 percent, diarrhoea treatment with oral rehydration salts (ORS) and zinc were available for 8 percent and diarrhoea treatment with oral rehydration therapy (ORT) and continued feeding were present for 34.9 percent of the children.[16]

Category 2: Infectious Diseases

For UHC service coverage index, the infectious diseases category consists of four proxy and priority indicators related to: i) Tuberculosis; ii) HIV & AIDS; iii) Malaria prevention; and iv) Water and Sanitation. Malaria prevention indicator is currently not monitored at the global or national level for UHC reporting.

Infectious diseases aggregate score for Pakistan is 34.7 as shown below. Among provinces, Khyber Pakhtunkhwa has the highest score of 41.77 while ICT has the lowest score of 25.01. The efforts to control infectious diseases are weak nationwide and more political commitment is required specially to tackle tuberculosis and HIV & AIDS. Malaria prevention interventions needs to be prioritized specially in high prevalence areas of Balochistan and newly merged districts of KP.

Tuberculosis: Pakistan ranks fifth among the 30 high TB burden countries in the world, sharing approximately 67 percent of the TB burden of Eastern Mediterranean Region (EMR) area of the WHO. Pakistan is also one of the countries with highest multi drug resistant tuberculosis (MDR-TB). Even today, TB is one of the major causes of deaths in the country.

In Pakistan, the TB incidence was estimated to be 227/100,000 population in 2019, while the incidence rate of the multi drug resistance cases have been 12.45/100,000 population. IHME data shows a decline in the number of prevalent cases of TB from 34,131,175 in 2015 to 32,578,730 in 2019, which is still alarming.

Although TB is curable, its early detection is necessary for an effective treatment and curtailing its spread. **TB Case detection in Pakistan** is declining at 45 percent in 2020, which is well below the standard of 70 percent, and this is exactly where the problem lies.

Province/Area	2015	2016	2017	2018	2019	2020
Punjab	205,036	221,739	223,218	220,775	189,712	154,241
Sindh	61,878	72,830	77,392	80,061	78,705	66,645
KP + FATA	47,205	49,836	47,149	48,350	45,542	39,250
Balochistan	8,575	10,462	10,608	10,331	11,205	9,539
Islamabad	1,653	2,368	2,212	1,898	1,905	1,001
Gilgit-Baltistan	1,795	2,995	2,679	2,918	2,619	2,113
AJK	5,638	5,831	5,639	5,215	5,158	3,947
PAKISTAN	331,780	366,061	368,897	369,548	334,846	276,736

UHC Indicators	Punjab	Sindh	KP	Balochistan	ICT	GB	AJK	National
5. Tuberculosis effective treatment (%)	46.3	43.5	38.2	22.5	12.6	49.7	32.9	**42.0**
6. HIV treatment (%)	12.5	10.5	22.7	17.1	12.5	12.5	12.5	**12.0**
7. Insecticide-treated nets for malaria prevention (%) **	NA	NA	NA	NA	NA	NA	NA	**NA**
8. At least basic sanitation (%)	89.0	76.0	84.0	44.0	99.0	83.0	83.0	**83.0**
Infectious Diseases Aggregate Score 2020	37.24	32.58	41.77	25.66	25.01	37.25	32.47	34.71

A large number of TB patients in Pakistan consult private practitioners for treatment for which there is no record/ partial reporting. These cases are neither notified nor are their outcomes recorded. National TB Control Program started TB case notification pilot project in five districts of Pakistan. Mandatory TB Case Notification Acts have been approved by Sindh, Khyber Pakhtunkhwa, & Punjab. The Public Private Mix (PPM) Model pilot project will be implemented in five districts of Sindh and Khyber Pakhtunkhwa with the support of Global Fund and in collaboration with partners. The Project is being implemented in Hyderabad, Matari and Jamshoro in Sindh province and Peshawar and Mardan in Khyber Pakhtunkhwa. Involvement of private practitioners in the provinces has gradually increased the case notification rate. Online TB case notification system through helpline is also being established.

Provincial health departments are providing free of cost diagnostic and treatment services (Anti-TB drugs, Laboratory consumables & non-consumables) to the population of the provinces.

TB Outcomes in 2020

Indicator	Punjab	Sindh	KP+ ex-FATA	Balochistan	ICT	GB	AJK
TB Cases Notified	154,241	66,645	35,210 +4,040	9,539	1,001	2,113	3,947
Case Detection Rate (%)	49.5	47.8	40.1 +27.1	25.9	16.1	50.1	35.0
Treatment Success Rate (%)	93.4	91.1	95.3 +95.4	86.7	76.8	99.2	94.0

Source: National TB Control Programme 2020

HIV & AIDS: Pakistan is among few countries in the world with a rising number of HIV & AIDS cases. Over years, the country has moved from a low prevalence to concentrated epidemic with HIV prevalence of 38.4 percent among persons with injecting drug users (PWID), 7.2 percent among transgender persons, and 5.6 percent among men who have sex with men.

With an estimated HIV prevalence rate of 0.1 percent in the general population, approximately 183,705 People living with HIV (PLHIV) in the country. As of December 2020, the National AIDS Control Programme (NACP) has registered 44,758 (24 percent) people in 49 antiretroviral therapy (ART) centres throughout the country and out of those only 24,362 (54 percent) were receiving ART which is far below the UNAIDS target of 90 percent receiving ART.[19]

The HIV incidence rate is high in Sindh at 6.67 per 100,000 population and lowest in KP at 4.64 per 100,000 population. Whereas, the registered number of HIV cases are highest in Punjab 23,583.

According to PDHS 2017-18, men are more aware than women that HIV can be transmitted during pregnancy (39 percent versus 21 percent), during delivery (32 percent versus 20 percent), and through breastfeeding (37 percent versus 19 percent) and that the risk of transmission can be reduced by the mother taking special drugs (23 percent versus 9 percent).

Sixth round of the Integrated Biological & Behavioural Surveillance (IBBS) is planned to be conducted in 2022.

Hepatitis: All the five types of viral hepatitis (A, B, C, D and E) are prevalent in Pakistan. Hepatitis A and E produce the highest morbidity while hepatitis B and C infections contribute the highest morbidity and mortality towards disease burden in the country.[20] Hepatitis B is considered to be the most dangerous amongst the five types of hepatitis because it is clinically asymptomatic. Hepatitis B is endemic in Pakistan with a prevalence rate of 3 percent and is more prevalent in people with low socio-economic status.[21]

The HCV prevalence is highest in Punjab (6.7 percent), Sindh (5 percent), Balochistan (1.5 percent) and Khyber Pakhtunkhwa (1.1 percent).[22]

According to PDHS 2017-2018 results, 88 percent of women and 94 percent of men age 15-49 have heard of hepatitis B or C. Among those who reported having heard of hepatitis, 18 percent of women and 34 percent of men mentioned that avoiding contaminated food/water will prevent them from getting, hepatitis; 13 percent of women and 23 percent of men mentioned that using a disposable syringe will help prevent hepatitis. Moreover, education was positively correlated with knowledge concerning hepatitis B or C, as was wealth quintile. People living in urban areas were generally more aware about hepatitis compared to people living in rural areas.

[19] Systematic Review of Reported HIV Outbreaks, Pakistan, 2000–2019; https://wwwnc.cdc.gov/eid/article/27/4/pdfs/20-4205-combined.pdf

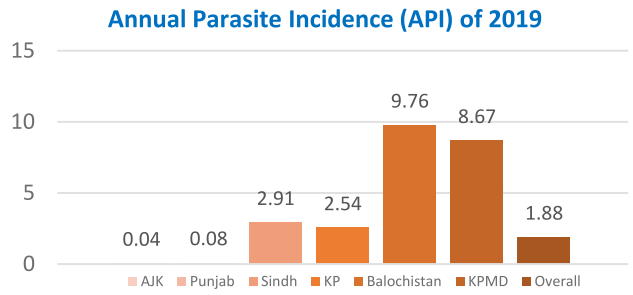
[20] PHRC, 2008; National Survey on Prevalence of Hepatitis B & C in General Population of Pakistan,
Pakistan Medical & Dental Council, 2014; Unpublished data: http://www.pmdc.org.pk/Home/tabid/36/Default.aspx

[21] Hepatitis B virus in Pakistan: a systematic review of prevalence, risk factors, awareness status and genotypes. Ali M, Idrees M, Ali L, Hussain A, Ur Rehman I, Saleem S, Afzal S, Butt S, Virol J. 2011 Mar 6; 8:102.

[22] Qureshi H. Bile KM. Jooma R. Alam SE. and Afridi HU. Prevalence of hepatitis B and C viral infections in Pakistan: findings of a national survey appealing for effective prevention and control measures. Eastern Mediterranean Health J.2010; 16: S15-S23
http://www.emro.who.int/emhj-volume-16-2010/volume-16-supplement/article-02.html

Malaria: Pakistan is one of the most malaria affected country in the WHO EM Region, sharing 98 percent of the total regional burden of malaria. With an estimated 1 million new cases and 300,000 confirmed reported cases each year it is one of the major causes of mortality and morbidity in the country.

In Pakistan, the annual parasitic incidence is 1.88 per 100,000 in 2019. The total number of 413,533 confirmed malaria cases have been reported from across the country with highest number of cases from Sindh (146,477), Balochistan (129,787) followed by KP (82,207), FATA (45,560), Punjab (9,344) and AJK (158).[23]



Source: Pakistan Malaria Annual Report 2019

The annual parasitic incidence rates are higher in Balochistan and newly merged districts of KP. The challenges in Balochistan and Khyber Pakhtunkhwa are huge as more than 80 percent of its population lives in rural areas with inadequate healthcare services and structures. According to PDHS 2017-18, only 16 percent households in KP and 18.8 percent households in Balochistan have been found to have at least one mosquito net in their possession and a very small number of 0.1 percent in KP and 0.2 percent in Balochistan had slept under any mosquito net the previous night when asked.

While malaria is declining in the country, the challenge of dengue has emerged as a major public health issue especially in urban areas of Punjab, Islamabad, Khyber Pakhtunkhwa and Sindh.

Antimicrobial resistance (AMR): has become a major public health challenge for the country and has spread to almost all the provinces/ areas of the country because of the indiscriminate use of antibiotics and poor infection control practices. Furthermore, the "misuse and overuse" of antimicrobials, contribute to the increasing burden of infections due to resistant bacteria, viruses, parasites and fungi, while limiting the treatment options for managing such infections.[24]

In Pakistan, a number of contributory factors have been identified in the spread of AMR. These include unnecessary large number of registered products (approximately 50,000); unjustified or misleading advertisements with only about 15 percent promotional brochures meeting WHO criteria; self-medication in more than 50 percent of the population according to different studies/surveys; and, a high number of quacks in the country.

The highest numbers of drugs are prescribed with more than 3 drugs per patient, and 70 percent of patients are prescribed antibiotics. This irrational and indiscriminate use is more common among General Physicians (GPs) and public sector hospitals with a bias towards costly broad-spectrum antibiotics. Availability of over the counter (OTC) without prescription medications, especially antibiotics is a common practice throughout the country contributing towards increase in AMR.[24]

In Pakistan, resistance in gram negative organisms have been recognized in several studies. An alarmingly highly resistant Enterobacteriaceae against third generation Cephalosporins has also been reported. Typhoid continues to be an important public health threat across the country due to drug resistance and associated treatment failure. Studies across the country have also revealed high rates of multi-resistant staphylococcus aureus resistance, commonly associated with hospital acquired infections. Similarly, MDR TB and chloroquine resistant falciparum is another obstacle in achieving targets of the respective national/ provincial programmes which has grave implications for the population at large.

Category 3: Non-Communicable Diseases

For UHC service coverage index, the non-communicable diseases (NCD) category consists of four proxy and priority indicators related to: i) Hypertension; ii) Diabetes; iii) Cervical cancer screening; and iv) Tobacco control. Cervical cancer screening is not currently monitored at global or national level for UHC reporting.

NCD diseases aggregate score for Pakistan is 54.15. Disaggregated data for NCD by provinces is currently not available as available surveys estimated the situation only at country level.

There is need to carry out STEPwise approach to Surveillance (STEPS) and Global Adult Tobacco Survey (GATS) not only at the country level but also at provincial / federating area level. NCD aggregate score for Pakistan

[23] Directorate of Malaria Control, Government of Pakistan: Pakistan Malaria Report, 2019.

[24] National AMR Action Plan for Pakistan, 2017; Ministry of National Health Services Regulations and Coordination Pakistan

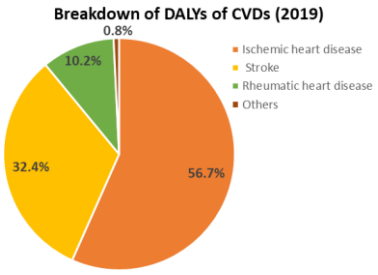
(and the same is at provincial level considering data limitation) is shown below in the table.

Non-communicable diseases (NCD) are classified into twelve disease groups with DALYs rate for each group in Pakistan in 2019 as shown in the graph. Overall, Years of life lost (YLL) per 100,000 population were 11,777 whereas Years lived with disability (YLD) were 6,608.

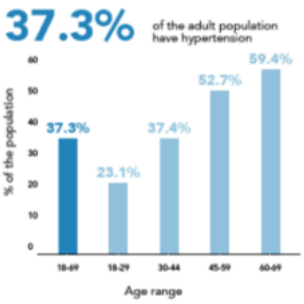
NCD related DALYs rates in Pakistan are primarily driven by five main disease groups:

- Cardio-vascular diseases (CVDs)
- Neoplasms/ Cancers
- Diabetes & Chronic kidney diseases
- Chronic respiratory diseases, and
- Mental disorders

Cardio-vascular diseases: The magnitude of increase, in NCD related death and disability from 2009 to 2019, is alarming. The GBD/ IHME data for Pakistan reports that ischemic heart disease (IHD) related death and disability increased by 29 percent between 2009 and 2019.[25] Stroke related death and disability increased by 20 percent, while diabetes related death and disability increased by 87 percent in the same time period. These numbers indicate that the burden on the future health service delivery in Pakistan is going to be exceptionally challenging as not only the diseases are leading to an overwhelming loss of DALYs on the one hand, while on the other economic losses are also substantial, first due to the loss of economic activity and second due to the phenomenal cost associated with treating these lifelong conditions. In Pakistan, 55 percent of NCD mortality is due to CVDs, which is expected to rapidly rise in coming years. DALYs lost attributable to CVDs include IHD, stroke, rheumatic heart disease, cardiomyopathy & myocarditis, peripheral artery disease and other cardio vascular disorders.



Hypertension is one of the world's silent killers, with more than 1.1 billion people living with hypertension. According to the WHO Hypertension fact sheet for Pakistan, 37.3 percent of the adult population and around 20.2 percent of the total population have hypertension. Around 11.6 percent of the total population are aware of (diagnosed) hypertension; 4.5 percent of the total population are under treatment and only 1.4 percent of the total population have controlled this. It is estimated that there are around 46 million hypertension cases in Pakistan in 2019.



Cancers (Neoplasms): are the second leading group of morbidity and mortality among NCD in Pakistan. GBD 2019 estimated that there were more than 4.1 million cancer cases in Pakistan, whereas new cases were more than 2.77 million. Around 179,773 cancer related patients' deaths were estimated in the same year.

Cancers accounted for 6.7 percent of the total DALYs lost and 12 percent of total deaths in Pakistan in 2019. GBD 2019 estimated prevalence of cancers in Pakistan was 1,834/100,000 population, while incidence rate was 1,236/ 100,000 population.

The most prevalent and frequently diagnosed cause of cancer death in female population of Pakistan is breast cancer, having an estimated prevalence rate of 165/ 100,000 population. Annually approximately fifty-one thousand newly diagnosed cases of breast cancer are reported.

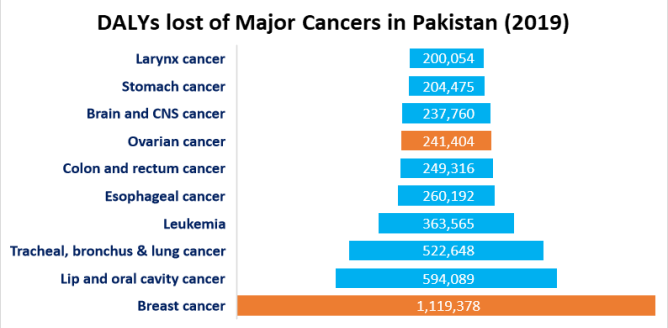
Cancers like breast, lung, liver, colorectal, prostate, head and neck carcinoma are most commonly diagnosed in Pakistan. Hepatocellular cancer is a common tumour in Pakistan, linked to the high background prevalence of hepatitis C and B. Cancer may be caused by different factors like gene mutations, carcinogens and some

UHC Indicators	Punjab	Sindh	KP	Balochistan	ICT	GB	AJK	National
9. Prevalence of Normal blood pressure (%)	69.0	69.0	69.0	69.0	69.0	69.0	69.0	**69.0**
10. Normal blood sugar (%)	39.0	39.0	39.0	39.0	39.0	39.0	39.0	**39.0**
11. Cervical cancer screening among women 30-49 years (%) **	NA	NA	NA	NA	NA	NA	NA	**NA**
12. Tobacco non-smoking (%)	59.0	59.0	59.0	59.0	59.0	59.0	59.0	**59.0**
Non-communicable Diseases Aggregate Score in 2020	**54.15**	**54.15**	**54.15**	**54.15**	**54.15**	**54.15**	**54.15**	**54.15**

[25] Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: A systematic analysis for the Global Burden of Disease Study 2019. Global Health Metrics| Volume 396, Issue 10258, P1204-1222, October 17, 2020

medical factors that harm the immune system of the body.

Symptoms of cancer are relatively varied and classified according to location, progression pattern and size of tumours as well. Cancer management and chemo protocols also depend on the progression and site where

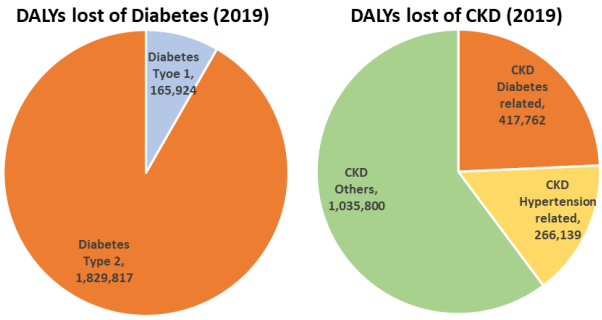


it develops. Tumours that reside only in a specified location and show restricted growth are commonly characterized as benign tumours. In 2019, more than 3.37 million out of total of 4.1 million cancer cases were estimated as benign in Pakistan.

Pakistan Atomic Energy Commission (PAEC) gives high priority to the application of nuclear technology in health sector. Through its 18 medical centres spread all over the country, patients receive state-of-the-art diagnostic and treatment facilities either free of charge or at subsidized rates.

Small- and large-scale private sector hospitals are also offering chemotherapy services. Whereas Lady health workers (LHWs) and PHC centres are engaged for early screening of cancers, especially breast cancer.

Diabetes and Chronic kidney diseases: Another 'Silent Killer' in the NCD group is Diabetes - a major public health issue in Pakistan. Diabetes has a significant lifelong catastrophic health expenditure on person, family and society. Further, complications of diabetes include



stroke, cardiovascular diseases, chronic kidney disease (CKD)/ renal failure, cataract and others.

GBD 2019 estimated that there were more than 19 million diabetes and CKD cases in Pakistan, whereas new cases were more than 795,706. Prevalence rate of diabetes was 3,975 per 100,000 population whereas prevalence of CKD was 5,585 per 100,000 population. Around 92,000 diabetes and CKD related patients' deaths were estimated in the same year.

According to a systematic review[26] on Type 2 diabetes in Pakistan, in males the prevalence is 11.2 percent and in females value is 9.19 percent. The mean prevalence in Sindh province is 16.2 percent in males and 11.7 percent in females; in Punjab province it is 12.14 percent in males and 9.83 percent in females. In Balochistan province 13.3 percent among males, 8.9 percent in females; while in Khyber Pakhtunkhwa (KP) it is 9.2 percent in males and 11.60 percent in females. The prevalence of type 2 diabetes mellitus in urban areas is 14.81 percent and 10.34 percent in rural areas of Pakistan.

Another systematic review[27] in 2019 which identified a total of 635 studies, only 14 studies were considered for meta-analysis. The prevalence of diabetes in Pakistan was revealed at 14.62 percent (10.651 –19.094 percent) based on 49,418 people using the inverse–variance random–effects model. The prevalence of prediabetes was 11.43 percent (8.26 percent–15.03 percent) based on a total sample of 26,999 people.

While it is important to ensure availability of diagnostic and treatment services in all PHC centres, diabetes can be prevented, as many studies have shown. It can be done through lifestyle changes such as healthier diets and increased physical activities. Weight management and physical activity are the true foundation of diabetes prevention. Public awareness of the risk factors is an important step toward diabetes prevention.

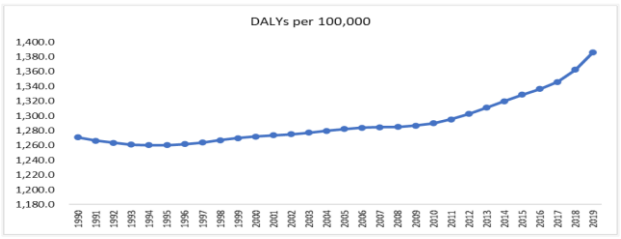
With rampant lack of awareness in Pakistan, there is under detection of earlier stages of CKD, leading to lack of preventive measures, which inevitably facilitates progression of mild, potentially treatable CKD to full-blown kidney failure. Where the annual cost of dialysis of a single patient is over $3000, annual per capita income is $1560, and public spending on health is a meagre 1 percent of the gross national product, it is not surprising that only 10 percent receive any renal replacement therapy. *Sehat Sahulat* Programme is currently supporting the poorest families to reduce catastrophic indoor expenditure.

26 Sultan Ayoub Meo, Inam Zia, Ishfaq A Bukhari, Shoukat Ali Arain, 2016; Type 2 diabetes mellitus in Pakistan: Current prevalence and future forecast

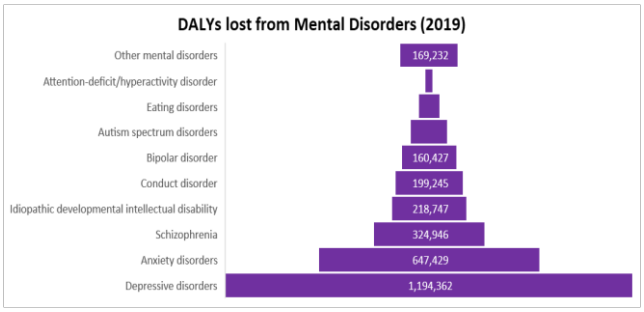
27 Sohail Akhtar, Jamal Abdul Nasir, Tahir Abbas and Aqsa Sarwar, 2019; Diabetes in Pakistan: A systematic review and meta-analysis

Mental disorders: Historically, mental health has been a neglected area in Pakistan, where loss of DALYs due to mental health disorders is also on the rise. Between 1999 and 2009 the country recorded only a 1 percent increase in the loss of mental health disorder related DALYs while between 2009 and 2019 the increase was 8 percent as shown in the figure.

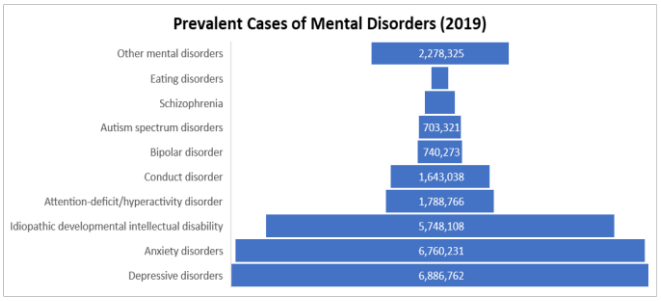
Trend of Burden of Mental Health Disorders in Pakistan



Mental disorders include a wide range of conditions. GBD 2019 data for Pakistan indicate DALYs loss as a result of mental disorders of around 3.1 million, with three major conditions including depressive disorders, anxiety disorders and schizophrenia.



On the other hand, prevalent cases of mental disorders were around 25.7 million, with three major conditions including depressive disorders, anxiety disorders and idiopathic developmental/ intellectual disabilities.



Neurological disorders and substance abuse disorders are not included in the mental disorders group but are closely associated. Total DALYs lost in 2019 as a result of neurological disorders was around 2.1 million, whereas that of substance abuse disorder was 0.57 million. Prevalent cases of neurological disorders were around 72.5 million, whereas those of substance abuse disorders were 3.4 million in 2019.

Mental disorders are usually not considered a direct cause of death and most of the deaths are categorized under injuries including self-harm etc. More than 85,000 deaths were estimated as a result of injuries in 2019, out of which one third were as a result of self-harm.

While it is socially acceptable to seek help from a health professional for physical disorders, seeking help for psychological disorders is problematic in Pakistan. Mental illness is often associated with supernatural forces such as witchcraft, possession, and black magic. Families often hide mental illness to prevent the patient from adverse stereotyping.

The psychological health care system is deficient in Pakistan, and the way it is mainly managed explains why accessing psychological help is a taboo subject. At the time of independence in 1947, there were three mental asylum-like hospitals, one each at Hyderabad, Lahore, and Peshawar, with a total of 2000 beds. These were in a miserable shape with no psychiatrists and managed by medical officers only. These hospitals were called mad-houses or “pagal khanay” and patients were often brought there in chains.

Seven decades after independence, the health care system is still not adequate. Whereas the median number of mental health beds per 100,000 population is above 50 in high-income countries, and 11.3 in the more developed countries of the Eastern Mediterranean Region, this figure is around 1.7 for Pakistan. A recent survey showed that nearly a third of the respondents believed that people fail to access mental health services because mental health professionals are not accessible.

Given the limited fiscal space available for mental health, it should at least sensitize the people that mental disorders are just like physical disorders.

Chronic respiratory diseases: In this NCD group, major diseases include chronic obstructive pulmonary disease (COPD), pneumoconiosis, asthma, interstitial lung disease and pulmonary sarcoidosis and other chronic respiratory diseases. COPD and asthma form the major burden in this group with annual DALYs loss of 1.7 million and 0.56 million respectively in 2019. Number of cases of the two diseases were 3 million and 3.2 million respectively in 2019.

Chronic respiratory diseases contribute to more than 82,000 annual deaths and the number is rising with increasing environmental pollution/ smoke. Asthmatics were more likely to report history of allergies. The rate of asthma increases as communities become more

urbanized. On-going pandemic of COVID-19 may have late complications of increasing chronic respiratory diseases.

Risk Factors: In the context of NCD diseases in Pakistan, key risks factors prioritized include: 1) Unhealthy diets, 2) **Tobacco use**; 3) Air pollution; and 4) Physical inactivity - also contributing to high plasma glucose and high low-density lipoproteins. Out of these, Tobacco use is also one of the UHC indicators for NCD.

The STEPwise approach to Surveillance (STEPS) survey of 2013-2014[28] shows that prevalence of current tobacco smokers in Pakistan are 13.9 percent in both genders combined. Smoking is more prevalent among males (27.8 percent) while 4.2 percent of the females are smokers, average age to start smoking is 22.1 (21.4-22.9).

According to GATS 2014, in Pakistan, the prevalence of tobacco product use is very high (19.1 percent) particularly among men (31.8 percent) and women (5.8 percent). Exposure to second-hand smoke was observed in 86 percent of restaurants while it was 76 percent on public transportation, indicating that ban on tobacco use in public places is not being followed.[29] Tobacco use in Pakistan is also on the rise with the advent of novel products. Overall, 19.1 percent adults were currently using tobacco products bifurcated into 12.4 percent who smoked tobacco, and 7.7 percent who use smokeless tobacco.

According to Global Youth Tobacco Survey (GYTS 2013), among the youth (13-15 years of age students), 10.7 percent of school students (13.3 percent boys and 6.6 percent girls) currently use tobacco. Overall, 21.0 percent of students are exposed to second-hand smoke in their homes and 37.8 percent were exposed to smoke inside enclosed public places.

Despite having a comprehensive law, the enforcement has been an issue. A recent WHO study implemented by the Pakistan Bureau of Statistics (PBS) in collaboration with the Ministry of NHSR&C to monitor the compliance to smoke free laws and tobacco advertising, promotion and sponsorship (TAPS) suggested high levels of non-compliance which was around 36 percent.

Category 4: Services Access and Capacity

For UHC service coverage index, the services access and capacity (SAC) category consists of four proxy and priority indicators related to: i) Hospital Beds density; ii) Essential Health Workforce density; iii) Access to Essential Medicines, Vaccines and Commodities; and iv) Capacities for International Health Regulations (IHR). Information on 'Access to Essential Medicines, Vaccines and Commodities' is not currently monitored at global or national level for UHC reporting.

SAC aggregate score for Pakistan is 50.98 as shown in the table below. Islamabad has the highest score for this category whereas Balochistan has the lowest.

Hospital beds density: Required threshold for hospital bed density for Pakistan is 18 beds per 10,000 population. Against this need, only 8.9 hospital beds per 10,000 population were available in 2020 in the public and private sector of country.

Hospital beds (public & private) density is the highest in Islamabad, followed by Azad Jammu & Kashmir and then Punjab. Total hospital beds in public & private sector were 112,606 in Punjab; 36,104 in Sindh; 33,344 in Khyber Pakhtunkhwa; 6,182 in Balochistan; 6,684 in Islamabad; 1,341 in Gilgit-Baltistan; and 5,810 in Azad Jammu & Kashmir.

Out of total **202,071 hospital beds** in Pakistan, 108,111 were in public sector whereas 93,960 were in private sector in 2020. Private hospital beds information was compiled for the first time for UHC SCI estimation in 2020.

In the public sector of Pakistan, health services are provided through a tiered network of health care facilities – PHC centres, First level hospitals and Tertiary hospitals. PHC centres include 670 RHCs, 5,472 BHUs/

UHC Indicators	Punjab	Sindh	KP	Balochistan	ICT	GB	AJK	National
13. Hospital beds per 10,000 population against threshold (%)	53.7	39.3	49.2	25.0	161.4	36.7	74.8	**49.4**
14. (Physicians*Psychiatrist*Surgeon) density against threshold (%)	47.4	61.3	45.7	31.1	82.7	33.3	44.9	**50.6**
15. Availability of essential medicines in PHC (%) **	NA	NA	NA	NA	NA	NA	NA	**NA**
16. International Health Regulations core capacity index (%)	56.9	49.8	48.8	32.7	68.0	40.7	57.1	**53.0**
Services Access & Capacity (SAC) Aggregate Score in 2020	52.51	49.32	47.85	29.40	96.80	36.76	57.69	50.98

[28] PHRC, WHO and M/o NHSR&C, 2016; NCD Risk factors survey (STEPS) - Pakistan

[29] Burden of Tobacco in Pakistan: Findings from Global Adult Tobacco Survey 2014

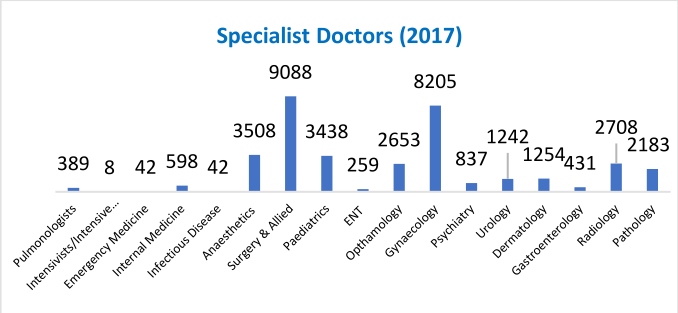
Sub Health Centres and other Primary Health Centres, including Dispensaries (5,743), MCH (752), TB Centres (412). Number of hospitals in public sector include 1,282 in 2020. [30]

For-profit private sector constitutes a diverse group of doctors, nurses, pharmacists, traditional healers, drug vendors, as well as laboratory technicians, shopkeepers and unqualified practitioners. The facilities they provide services at include: private hospitals, nursing homes, maternity clinics; clinics run by doctors, nurses, midwives, paramedical workers, diagnostic facilities and the sale of drugs from pharmacies and unqualified sellers. However, in some cases, the distinction between public and private sectors is not very clear as many public sector practitioners also practice privately.

Not-for-profit private sector is relatively sizeable with more than 80,000 not-for-profit non-governmental organizations (NGOs) registered under various Acts in Pakistan. More than 45,000 were included in the database of Pakistan Centre for Philanthropy and six percent of these NGOs are working in health sector.

Essential Health Workforce: Human Resource for Health is the most critical factor in provision of quality preventive, promotive and curative services. Minimum threshold to achieve UHC/ SDG-3 is 4.45/1,000 population for essential health workforce (physicians, nurses, LHVs and midwives) with a break up of 1.11/1,000 population and 3.34/ 1,000 population.

For UHC Service Coverage Index, the HRH density is estimated by estimating three types of specialists i.e., Physicians, Psychiatrists and Surgeons. According to Pakistan Medical Commission (PMC), there were 250,085 (registered since 1962) physicians including 837 Psychiatrists and 9,088 surgeons.



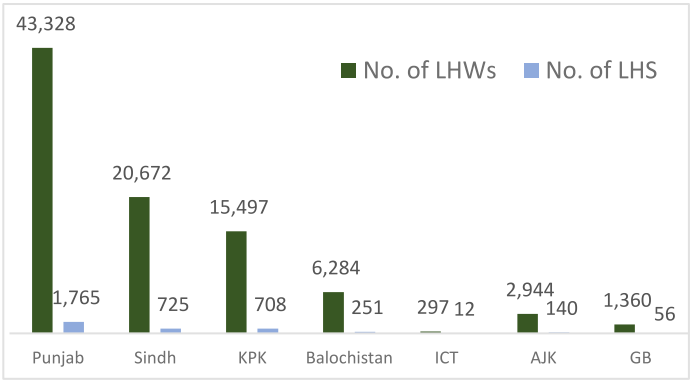
For UHC it is also critical to ensure the threshold for availability of minimum numbers of physicians (0.9 per 1,000 people), psychiatrists (1 per 100,000 people) and surgeons (14 per 100,000 people). The HRH score against the threshold was highest in Islamabad (82.7), followed by Sindh (61.3) and Punjab (47.4).

In Pakistan doctor population ratio is 1.09/1,000 population and Nurse/Midwife/LHV ratio is 0.59/1,000 population in 2021 according to Pakistan Medical Commission (PMC) and Pakistan Nursing Council (PNC) data. Breakdown of numbers and HRH densities by provinces in 2021 is shown below.

Province	Registered	Density required	Density/ 1,000 population
PHYSICIANS (including Specialists)			
Punjab +AJK + GB + ICT	123,344	**1.11**	0.97
Sindh	83,943	**1.11**	**1.61**
KP + FATA	34,637	**1.11**	0.88
Balochistan	7,447	**1.11**	0.53
NURSES (Nurse, LHV, MW, CMW, FWW)			
Punjab +AJK + GB + ICT	80,140	**3.33**	0.63
Sindh	29,637	**3.33**	0.57
KP+ FATA	16,851	**3.33**	0.43
Balochistan	2,116	**3.33**	0.15

Note: Residential status of additional 4,610 doctors and 9,363 nurses in not known.

In addition, there were 29,580 Dentists & Specialists and 47,531 Pharmacists have also been registered by the end of 2021. By the end of 2020, there were 90,382 LHWs and 3,675 LHSs.



Further there were 69,038 *Tabib /Hakeem*, 168,036 Homoeopaths and 400 Certified Nursing Assistant by the end of 2020.

In 2021, registered medical institutes in the country were 117 (45 in public sector and 72 in private sector). This

[30] Pakistan Bureau of Statistics data for 2020 published in Pakistan Economic Survey 2020-21

number excludes 59 dental colleges (17 in public sector and 42 in private sector) in the country.

According to the PMC, 117 medical institutes 62 were in Punjab & ICT, 29 in Sindh, 20 in Khyber Pakhtunkhwa, 2 in Balochistan and 4 in Balochistan. There are 49 institutes offering post graduate medical courses in the country.

According to PMC, current **production capacity of medical graduates in public and private sector registered institutions** is as following:

Province/ Federating Area	Public	Private	Total
Punjab and ICT	3,783	4,900	**8,683**
Sindh	2,300	1,650	**3,950**
Khyber Pakhtunkhwa	1,330	1,050	**2,380**
Balochistan	220	100	**320**
AJ&K	300	100	**400**
Total	**7,933**	**7,800**	**15,733**

Pakistan is facing extreme shortage of nurses, LHVs and midwives. According to PNC, **province-wise number of nursing institutes** are as following:

Province/ Federating Area		Post GBSN	RNBSN	BSM	MSN	PHD
Federal/ AJ&K/GB	Govt	5	2	0	0	0
	Armed Forces	0	0	0	0	0
	Private	7	5	0	1	0
	Total:	12	7	0	1	0
Punjab	Govt	16	8	0	1	0
	Armed Forces	5	2	0	0	0
	Private	31	27	0	3	0
	Total:	52	37	0	4	0
Sindh	Govt	19	5	1	3	0
	Armed Forces	1	0	0	0	0
	Private	23	25	0	2	0
	Total:	43	30	1	5	0
Khyber Pakhtunkhwa	Govt	3	3	0	2	0
	Private	12	10	0	0	0
	Total:	15	13	0	2	0
Balochistan	Govt	11	1	0	0	0
	Armed Forces	1	0	0	0	0
	Private	1	0	0	0	0
	Total:	13	1	0	0	0
Grand Total:		**135**	**88**	**1**	**12**	**0**

Current **production capacity of nurses** from these nursing institutes is as following:

Province/ Federating Area		Post GBSN	RNBSN	BSM	MSN	PHD
Federal/ AJ&K/GB	Govt	250	100	0	0	0
	Private	305	255	0	15	0
	Total:	**555**	**355**	**0**	**15**	**0**
Punjab	Govt	1390	295	0	30	0
	Armed Forces	270	90	0	0	0
	Private	1425	1155	0	52	0
	Total:	**3085**	**1540**	**0**	**82**	**0**
Sindh	Govt	1005	340	20	50	0
	Armed Forces	150	0	0	0	0
	Private	1170	1185	30	50	0
	Total:	**2325**	**1525**	**50**	**100**	**0**
Khyber Pakhtunkhwa	Govt	250	250	0	50	0
	Private	2255	2010	0	0	0
	Total:	**2505**	**2260**	**0**	**50**	**0**
Balochistan	Govt	375	70	0	0	0
	Armed Forces	50	0	0	0	0
	Private	1	0	0	0	0
	Total:	**426**	**70**	0	**0**	**0**
Grand Total:		**8896**	**5750**	**50**	**247**	**0**

In addition to nurses, the cadre of midwives, community midwives and LHVs plays a critical role in provision of primary healthcare services. According to PNC, province-wise number of midwifery, community midwifery and LHV institutes are as following:

Province/ Federating Area		Midwife	CMW	LHV
Punjab	Govt	48	45	13
	Armed Forces	6	0	0
	Missionary	2	2	2
	Private	4	5	1
	Total:	**60**	**50**	**14**
Sindh	Govt	16	27	6
	Armed Forces	12	20	0
	Private	1	0	0
	Total:	**29**	**47**	**6**
Khyber Pakhtunkhwa	Govt	10	12	5
	Armed Forces	2	3	4
	Total:	**12**	**15**	**9**
Balochistan	Govt/Semi government	4	16	6
	Armed Forces	0	1	0
	Private	1	0	0
	Total:	**5**	**17**	**6**
Grand Total:		**106**	**129**	**35**

Current **production capacity of midwives, community midwives and LHVs** from these nursing institutes is as following:

Province/ Federating Area		Midwife	CMW	LHV
Punjab	Govt	1466	1589	1291
	Armed Forces	135	0	0
	Missionary	60	0	0
	Private	150	145	50
	Total:	**1811**	**1734**	**1341**
Sindh	Govt	530	868	245
	Armed Forces	100	0	0
	Private	440	575	0
	Total:	**1070**	**1443**	**245**
Khyber Pakhtunkhwa	Govt	185	601	220
	Armed Forces	70	105	145
	Total:	**255**	**706**	**365**
Balochistan	Govt/Semi government	45	503	185
	Armed Forces	0	30	0
	Private	15	0	0
	Total:	**60**	**533**	**185**
Grand Total:		**3196**	**4416**	**2136**

Although there have been attempts by the provincial government in scaling up of health professional's production (especially nurses, midwives and LHVs) but that has not been sufficient to keep pace with the increasing population of the province. Furthermore, there has always been an imbalance in the production of various health professions such as – doctors : nurses. The meagre production capacity of nurse/midwives is a major challenge in achieving the minimum recommended essential HRH for UHC in the country.

Imbalance within the professionals e.g., shortage of anaesthetists, psychiatrist, intensivists etc is another major challenge. The aforementioned essential HRH capacity compounded by high attrition rate among the graduates (as a result of out-migration for jobs and more production of female physicians not willing to perform duties in rural areas etc.) is another major issue that needs to be further investigated with mitigation measures.

Out migration of doctors and nurses is on the rise and only in 2020, 1,130 physicians and 148 nurses emigrated for jobs, whereas 932 physicians and 328 nurses emigrated for jobs till August in 2021. Major migration of doctors and nurses is to United Kingdom, United States, Canada and Gulf countries.

Capacities for International Health Regulations: Pakistan is a signatory to the International Health Regulations – IHR (2005). However, despite multiple efforts, it has yet to meet the required core capacities, which could jeopardize the country's travel and trade. Even more important, it means the country is not fully prepared to prevent, detect and respond to health threats to protect its population, irrespective of whether the threats arise internally or externally.

The WHO with input from partners, including the Global Health Security Agenda, subsequently developed a Joint External Evaluation (JEE) tool as one of four components of a new framework for IHR monitoring and evaluation. In response to resolution EM/RC62/R.3 of the WHO Eastern Mediterranean Regional Committee which required countries to assess and monitor the implementation of the IHR (2005), Pakistan was the first country in the WHO Eastern Mediterranean Region, and the fourth globally, to volunteer for a JEE, which was carried out in 2016.

The geographic location and topography of Pakistan predisposes the country to many natural disasters, notably earthquakes and floods. The country also experiences the adverse effects of climate change – especially extreme temperatures, melting glaciers, landslides, heavy monsoon downpours, river erosions, etc.

These disasters trigger outbreaks of communicable diseases (mainly waterborne diseases, skin infections and pneumonia), as well as malnutrition and injuries. They also seriously affect peoples' health and overall economic development.

Disasters have a disproportionate impact on women and children, who comprise 70 percent of disaster-affected populations. Due to cultural norms, women and children – particularly girls – face greater risks of ill-health in the wake of disasters. They are also less likely to safely access assistance. As women are not sufficiently included in community consultations and decision-making processes – both before and after disasters – their needs are often not met, and their concerns are not adequately addressed.

Human induced hazards that threaten the country relate to transport, industry, oil spills, forest fires, city fires, civil conflicts and internal displacements of communities as a result of multiple factors. Increasing urbanization means larger urban populations inhabiting peri-urban, marginal and at-risk areas. Vulnerability to disasters is growing in both urban and rural areas, placing ever more lives at risk.

The country (especially provinces of Khyber Pakhtunkhwa and Balochistan) has continued to host the largest number of refugees in the world over the last three decades. Most recent figures from 2021 show that there are 1.4 million Afghan refugees registered in the country. Of the total registered refugees, 40 percent live in refugee villages and 60 percent live in urban areas in Balochistan, Khyber Pakhtunkhwa, and Punjab provinces. The most pressing health need is access to emergency and basic health care services such as vaccination, treatment for infectious diseases, malnutrition, psychosocial support, safe maternity care, and safe drinking water and sanitation to prevent the spread of water-borne diseases.

Change in the Afghan government possess a threat of another wave of migration to Pakistan. Already Pakistan has to invest heavily to build capacities to control the COVID-19 pandemic. Multiple emergencies at the same time led to heavy burden on already weak economy of the country.

To address these issues, Pakistan must continue to improve preparedness, response and recovery in relation to all types of emergencies with health consequences. A joint external evaluation of the Country's International Health Regulations (IHR) Core Capacities was carried out in 2016.

Review of **19 technical areas** to fulfil the IHR requirements to prevent, detect and mount a comprehensive public health response to health threats indicated that preparedness level in Pakistan was at **48 percent**.[31] While considering 13 core capacities for international comparison, the IHR index is reported to be 53.[14] IHR index at provincial level was not estimated in the JEE of 2016. However, values at provincial/ federating areas levels have been estimated by applying weightage of HDI on the JEE score.

COVID-19 pandemic has made the Governments realize the need to strengthen core capacities for IHR at national and provincial level. Five major cross-cutting themes include: 1: Continued and expanded multi-sectoral communication and coordination; 2: Sufficiently funded, widely supported country 5-year plan / roadmap; 3: establish a strong active surveillance and tiered public health laboratory system; 4: develop and enhance regulations, standards and coordination mechanisms for food safety; and 5: National cross-sectoral approach.

As a result of the COVID-19 epidemic, significant investment has been made on some key strategic areas related to IHR and the index related to IHR is expected to improve over last few years. There is an urgent need for the next round of JEE not only at national level but also at provincial / federating area level.

[31] WHO, 2020; Country Cooperation Strategy 2020-25


SEHAT
SAHULAT PROGRAM

Financial Protection (3.8.2)

The affordability of healthcare is a key dimension for achieving UHC. In low- and middle-income countries, a large number of people lack sufficient financial means to access health care services. Millions of people are pushed into vicious cycle of poverty every year due to compelling needs to pay for health care services. Financial risks are measured by following two indicators:

- **Population with household expenditures on health >10% of total household expenditure or income (%)**
  – Value for Pakistan is 4.5 in 2015 compared to 1.03 in 2010
- **Population with household expenditures on health >25% of total household expenditure or income (%)**
  – Value for Pakistan is 0.5 in 2015 compared to 0.02 in 2010

The two values indicate that Pakistan was already having a rising trend of household expenditure on health from 2010 to 2015, whereas population was already negatively affected by high level of poverty. Current COVID-19 pandemic, very high inflation rate and worsening economic situation in the country are expected to have serious financial risks on the population / rising household expenditures on health.

Globally more than 100 million people are pushed into extreme poverty due to health-related expenditures. In Pakistan major portion of all new entrants in poverty are also because of catastrophic health expenditure. Having Out-of-Pocket (OOP) expenditure on health of more than 51.9 percent and one out of every three living in extreme poverty, Pakistan has been ranked as one of the most exposed nations to poverty risk among 43 countries of Asia-Pacific region.

Government has taken a number of steps to protect its citizens from financial risks. The top priority of the government is to enhance **government health expenditures on health**, which have reached to a level of PKR 477 billion in 2019-20 and are around 1.2 percent of the Gross Domestic Product (GDP).

In an attempt to reform the health sector, the federal and provincial governments introduced social health protection programmes in their constituencies, such as the ***Sehat Sahulat* Programme (SSP)**, and the **Social Health Protection Initiative (SHPI)**. The target beneficiary of these programmes is the poorest population.

Sehat Sahulat Programme uses the benchmark of defining poverty as families/ households having daily income of less than $2.00, while Gilgit Baltistan SHPI uses the benchmark of $1.00 per day.

Sehat Sahulat Programme is a public sector funded social health protection initiative of Federal and participating provincial and federating area governments working to provide financial health protection to targeted families against catastrophic (extra-ordinary) health care expenditure. *Sehat Sahulat* Programme is being implemented in a phased manner, starting from below poverty families and eventually targeting universal families and providing coverage eventually to all people across Pakistan.

In total, these social protection programs have expanded to 65 districts across the country and have enrolled over 81 million individuals. The program is providing services to more than 18 million families.

Province/ Federating Area	Current Status	Families Covered
Islamabad	Below poverty	65,157
Azad Jammu & Kashmir	Universal	763,807
Gilgit-Baltistan	Below poverty	72,678
Punjab	Below poverty and Universal in 7 districts	8,592,745
Khyber Pakhtunkhwa	Universal	7,469,666
Tribal districts	Universal	1,213,159
Balochistan	Nil	Nil
Tharparker (Sindh)	Universal	314,666
Sindh	Nil	Nil
TOTAL		**18 million**

The program will be expanded to approximately 39 million families during fiscal year of 2021- 2022. So far, the program has not been implemented for the families of Balochistan and Sindh (other than District - Tharparkar).

Sehat Sahulat Programme only provides services to families which requires indoor health care services. The services include, but are not limited to, cardiac treatments (stents, open heart, valvular replacement etc), oncological (cancer) management, burn management, organ failure management (dialysis etc), complication of diabetes mellitus, accident / trauma management, neurosurgical procedures, abdominal surgeries, fracture management and other medical & surgical interventions.

The programme so far does not offer facility for transplant (kidney or liver) or implants (cochlear and other) and other general exclusions list for health insurance such as self-inflicted injuries, cosmetic surgeries, out-patient services, take home medicines, sports injuries etc.

Package	Priority Disease Treatment Package	Secondary Care Treatment Package
Only Indoor/ Day care procedures	**Initial Financial Limits:** Rs: 300,000 / family / year **Additional Financial Limit (If required):** Rs: 300,000 / family / year	**Initial Financial Limits:** Rs: 60,000 / family / year **Additional Financial Limit (if required):** Rs: 60,000 / family / year
Additional coverage	▪ Transportation cost of Rs 1,000 per discharge 3 times in any given year ▪ Burial support expense of Rs 10,000 per death in empaneled hospitals ▪ One free post discharge follow-up	

For the identifying families living below poverty line, the *Sehat Sahulat* Programme is using National Socio-Economic Registry (NSER) of Benazir Income Support Programme. The families are those having threshold of PMT 32.5 and below. The data is verified using NADRA support. For the identification of universal, vulnerable and marginalized families, *Sehat Sahulat* Programme is using NADRA database. Permanent resident families are identified using permanent address on National Identity Card, while families are identified using B form information. Transgender and Disabled information is also extracted using NADRA database.

Sehat Sahulat Programme has a wide network of more than 500 panelled hospitals – both in public and private sector - across Pakistan. Beneficiary from any districts can avail treatment from any of these panelled hospitals.

Other than these social protection programs, poor population also has access to Zakat and 'Bait-ul-Mal' funds to pay for health care.

Bait-ul-Mal is a publicly funded social protection initiative created for the welfare of vulnerable populations such as the poor, widows, destitute women, orphans and disabled persons. This vulnerable group is supported through general assistance, education, medical treatment and rehabilitation.

Any individual can apply for general finance assistance once a year only. Any of the two services i.e. (i) Medical treatment (ii) General financial assistance (iii) Education stipend (iv) Individual rehabilitation may be granted simultaneously within a period of one year to the same applicant. However, general financial assistance and rehabilitation cannot be combined. For IFA (General) preference will be given to widows, the infirm and disabled every year. Other categories of individuals would be catered only twice in the entire life. Preference is given to accommodate them in other dispensations i.e., IFA (Medical), IFA (Education), IFA (Rehabilitation) as per requirement.

First time a family that consists of 02 or more disabled person has been given status of Special Friend of Pakistan Bait-ul-Mal. Which means, Pakistan Bait-ul-Mal, provides financial assistance to these special friends amounting to Rs.10,000/- to a family having one special person and Rs. 25000 to a family having two or more special persons.

Zakat, on the other hand, is a 2.5 percent zakat paid by Muslims on their unused annual savings, which is collected and allocated by the Ministry of Religious Affairs for each province. Health care is one of six programmes administered under the Zakat fund. These initiatives are important reforms to reduce catastrophic expenditures of the poorest families. However, these need to be expanded both in terms of breadth of services and coverage of people.

There are also **separate health service delivery programmes** for armed forces and employees of autonomous institutions, private and commercial establishments.

Employers of private and commercial institutions, which employ 10 or more persons, must provide insurance to employees under the **Employees' Social Security Institution (ESSI)**. The revenue for insurance is collected and distributed by the provincial ESSIs using a mandatory deduction of 7 percent, which is used to provide outpatient and inpatient services. ESSI provides medical care facilities and different cash benefits to secured workers and their dependents. ESSI has their own network of hospitals and clinics where free services are offered to the employees and their families.

CROSS-SECTORAL AND INTER-SECTROAL

Health is an interdisciplinary subject encapsulating a broad range of factors covered within and beyond the realm of the health sector. Population health outcomes are not confined to health sector rather are determined by the economic status, education, housing, nutrition, sanitation, population dynamics, human development and improvements at a governance level. Therefore, health is viewed in a health care systems context through a holistic lens. There is growing awareness amongst public health professionals that their universe is impacted by the political, social, economic and developmental milieu in which they operate. Factors such as illiteracy, unemployment, gender inequality, food insecurity, rapid urbanization, environmental degradation, natural disasters and the lack of access to safe water and sanitation all have the potential to aggravate the state of health of individuals and communities.

A large number of preventable deaths and disabilities among children, pregnant/ lactating women, young adults and aging population can be averted by adopting inter-sectoral approach to health. It underscores the need for developing alternative policy approaches, considering the inter-sectoral scope, with careful attention to the social determinants of health and several contemporary considerations that influence health status. The redefining of targets within the health sector is essential to garner support from across various sectors and to incorporate these targets in an explicit policy framework to foster inter-sectoral action. National Health Vision of Pakistan (2016-2025) has been developed on the same principle for achieving the desired health outcomes and to create an impact on health.

The concept of inter-sectoral linkages is not simplistic; it requires careful planning using an inclusive and participatory approach. More importantly, it requires the support of not only the line ministries but the other social sectors as well. Thus, forging effective collaborative partnerships and coordination mechanisms, engaging local community, national and international stakeholders, and pursuing the aid effectiveness approaches will be the most rewarding.

To conclude, as is evident, UHC will not be easy to accomplish in a huge and diverse country like Pakistan unless all governments and their respective partners will need to work in close harmony and at a pace of efforts never witnessed before.

Equity

Equity refers to the fact that 'no discrimination is made on the basis of a person's characteristics such as gender, race, caste, religion, geographic location, and socio-economic status. According to the WHO Commission on Social Determinants of Health 'health equity is about equitable distribution of health services in the society and that means distribution in conformity with where the needs are greatest'. Health equity gaps are growing today, despite unprecedented wealth and technological progress. Tackling the underlying causes of poor health can contribute to improving health by reducing health inequity.

The health sector is pivotal to driving equity, prosperity and inclusive economies but many other sectors, such as finance, housing, employment and education, also have important roles to play. Efforts to reduce health inequities are core investments for achieving inclusive growth and vice versa. There is strong support from the

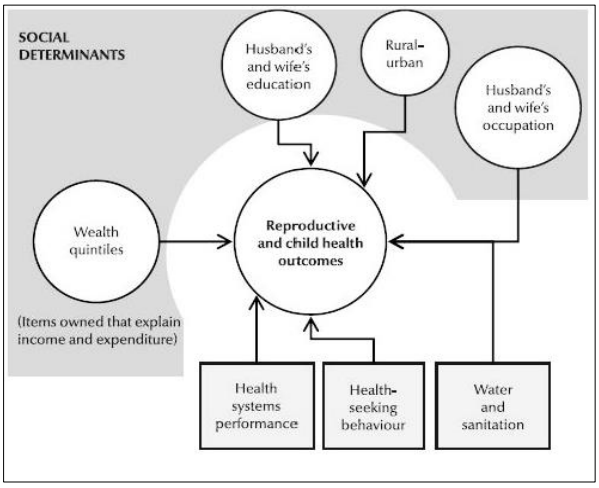
public for a more equal society and to invest in the necessary conditions to enable all people to prosper and flourish in life and health.

In Pakistan, living in the rural areas would lend itself to a greater risk for mortality and morbidity than living in an urban area. As evident from PDHS 2017-18, childhood mortality rates are higher in rural areas than in urban areas by 10 deaths per 1,000 live births. Neonatal, infant, and under-5 mortality rates are 45, 68, and 83 deaths per 1,000 live births, respectively, in rural areas, as compared to 37, 50, and 56 deaths per 1,000 live births in urban areas. Similarly, being poor makes one more vulnerable to diseases. Mortality rates decrease with increasing wealth. For instance, under-5 mortality rates are 100 deaths per 1,000 live births among children born to women in the lowest wealth quintile but 56 deaths per 1,000 live births among those born to women from the highest quintile, which means that the risk of under-5 mortality is almost twice for the poor.

In context of antenatal coverage, urban women are more likely than rural women to receive ANC from a skilled provider (94 percent and 82 percent respectively). Disparities according to socioeconomic characteristics persist; women in the highest wealth quintile (98 percent) and the highest education category (99 percent) are more likely to receive ANC services from a skilled provider than their counterparts in the lowest wealth quintile (67 percent) and with no education (76 percent).

The following figure illustrates the framework of social determinants of health and other factors affecting RMNCH outcomes. Among the social determinants of health, level of education, occupation, income, wealth and rural–urban status is important. Outside of the social determinants, health systems performance, health-seeking behaviour and several factors in the inter-sectoral domain also influence health outcomes.

Framework of Social Determinant of Health



As Pakistan is shaping the UHC agenda and has defined its UHC Benefit Package including essential health services, there is a need that inter-sectoral interventions are seen by parliamentarians, policy makers from different ministries, service providers, leaders, media, civil society, partners and people as an essential element of UHC and well-being. Accelerated progress, more commitments, better aligned action across sectors and among all partners and stronger mutual accountability mechanisms are needed.

Government of Pakistan is committed to ensure health equity across population stratums by offering the financial protection through the implementation of the policy and programmatic reforms, envisioning a 'health system that is efficient, equitable and effective to ensure acceptable, accessible and affordable health services. It will support people and communities to improve their health status while it will focus on addressing social inequities and inequities in health and is fair, responsive and pro-poor, thereby contributing to poverty reduction'.

Gender

Pakistan has significant gender disparities that serve as a major impediment to economic and social development, as well as to upholding human rights in general. As per the 2021 Global Gender Gap Index (GGGI) Pakistan ranks 153 out of 156 countries assessed on the index. Pakistan features among the bottom 10 countries in two of the four subindexes: 152 in economic participation and opportunity, 144 in educational attainment. The scorecard places Pakistan at 153 in Health and Survival and 98 in Political Empowerment. A comparison of previous rankings shows that the overall ranking for Pakistan has drastically slipped from 112 in 2006 to 153 in 2021[32].

Global Gender Gap Index

Economic participation and opportunity
Educational attainment
Health and survival
Political empowerment

2006 score		2021 score	
112	0.543	153	0.556
112	0.369	152	0.316
110	0.706	144	0.811
112	0.951	153	0.944
37	0.148	98	0.154

[32] World Economic Forum (WEF) Report on 2021 Global Gender Gap Index (GGGI)

The report by World Economic Forum stated that only 5 percent of senior and leadership roles are held by women, whereas only 22.6 percent of Pakistan's labour income goes to women. Further, women do not have equal access to justice, ownership of land and non-financial assets or inheritance rights. On a more positive note, there are signs of improvement in the share of women who are in professional and technical roles (25.3 percent, up from 23.4 percent in the previous edition of the index).

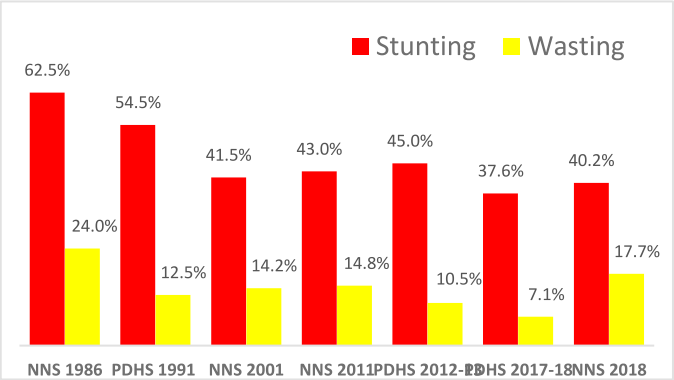
Just 81.1 percent of Pakistan's Educational Attainment gap has been closed, with gender gaps as large as 13 percent or more across all levels of education. These gaps are the widest at lower education levels (84.1 percent primary enrolment gap closed) and are somewhat narrower for higher education levels (84.7 percent gap closed in secondary enrolment and 87.1 percent closed in tertiary enrolment). Further, only 46.5 percent of women are literate, 61.6 percent attend primary school, 34.2 percent attend high school and 8.3 percent are enrolled in tertiary education courses. Pakistan has closed 94.4 percent of its Health and Survival gender gap, negatively impacted by wide sex ratio at birth (92 percent) due to gender-based sex-selective practices, and 85 percent of women have suffered intimate partner violence.

In health, the gap widened to 94.6 percent which means that women in the country do not have the same access to healthcare as men[28]. To bridge the gap in access to UHC, the issue of gender disparity needs to be tackled to ensure equitable health services provision.

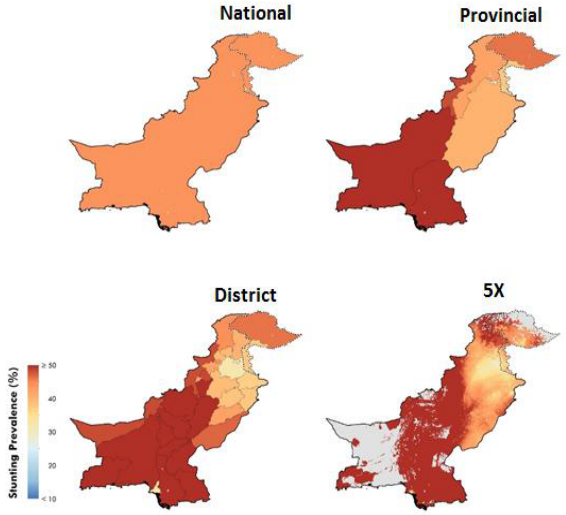
Nutritional disparities

Nutritional disparity is related to deep-rooted patriarchal norms and practices. These foment gender-based discrimination in food consumption. They also affect the knowledge, attitudes and practices of women, in particular, and of caregivers in general, in terms of child and adolescent food intake and well-being. Maternal nutritional status is inextricably linked to the nutritional status of children.

Some parts of Pakistan experience droughts that took the lives of many people and their livestock. Herd sizes become smaller than normal owing to drought and usually take several years to recover, leaving households with insufficient assets for food purchases. According to National Nutrition survey 2018 and PDHS 2017-18 the prevalence of stunting under 5 years is static for last two years indicating chronic under-nutrition problem in the country.

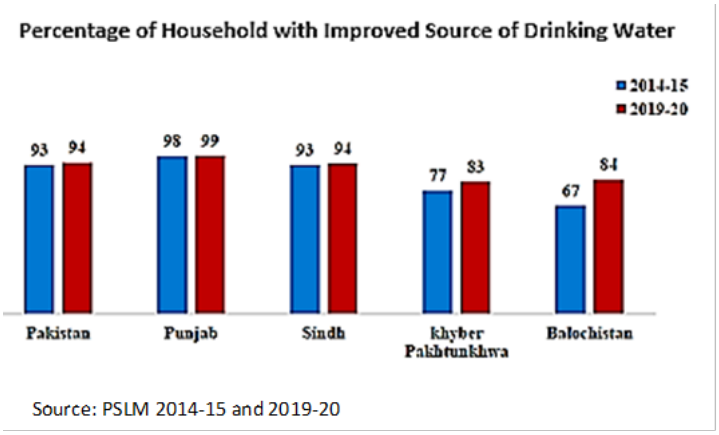


Geographically disagregated data for stunting is important to understand the seriouness of stunting in specific areas as shown below and accordingly need for appropriate response.



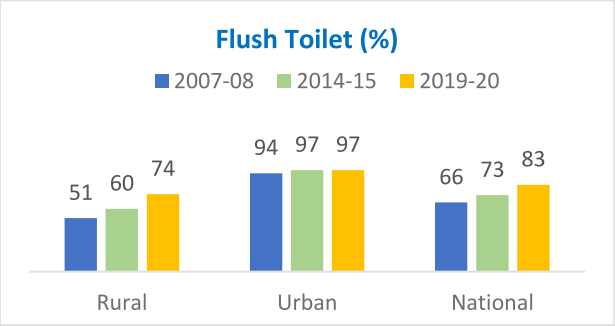
Safe Water and Adequate Sanitation

Safe drinking-water, sanitation and hygiene are crucial to human health and well-being. Safe WASH is not only a prerequisite to health, but contributes to livelihoods, school attendance and dignity and helps to create resilient communities living in healthy environments.



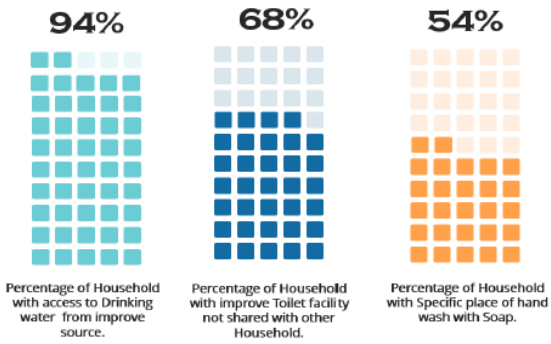
Drinking unsafe water impairs health through illnesses such as diarrhoea, and untreated excreta contaminates groundwaters and surface waters used for drinking-water, irrigation, bathing and household purposes. In addition, chemical contamination of water continues to pose a health burden, whether natural in origin such as arsenic and fluoride, or anthropogenic such as nitrate. In actuality quality of water has worsened especially in urban areas and this has increased the risk of outbreaks of waterborne diseases. Increasing access to safe water must also be accompanied by efforts to ensure the quality of drinking water. Acute Watery Diarrhoea, Typhoid etc are endemic and claims hundreds of lives annually, particularly in densely populated areas. Water quality monitoring and house water treatment and safe storage are critical interventions that aim to reduce the risk of contamination of water supplies. Environmental factors pose an increasing threat to the availability of water. Lack of an effective solid waste management system means that the environment is absorbing untreated waste, with dire consequences.

Status of Adequate Sanitation is even worse as the prevalence of open defecation in rural areas is still very high. Empowering communities to take action for their own sanitation needs, as well as supporting schools and health facilities to provide essential sanitary facilities, are priority WASH interventions.



Women are especially vulnerable to harassment and violence in the absence of adequate WASH facilities, especially when travelling long distances to fetch water, using shared toilets, or practicing open defecation. Women and girls often wait until nightfall to defecate, which increases the risk of assault. The shame and indignity of defecating in the open also affects women's self-esteem, as does a lack of water for washing clothes and personal hygiene.

Pakistan's vulnerability to disasters including earthquakes, floods, droughts, and internal displacement due to conflict, often leaves hundreds of thousands of affected people in need of emergency water and sanitation support. Sustainable access to water, sanitation and hygiene in health centres and schools also remains a challenge especially for girls who lack adequate facilities to manage their menstruation. The effects of climate change and rapid urbanisation also contribute to challenges of improving access to safe water and sanitation. An estimated 70 percent of households still drink bacterially contaminated water.



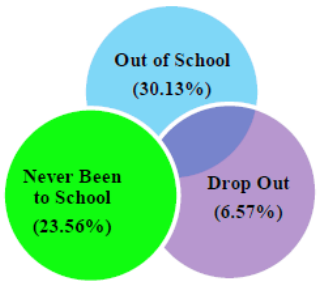
Education

High rates of poverty in communities across Pakistan make it difficult for parents to afford school fees and poverty remains the main reason for not sending their children to school. Government has declared free primary public education but has had great difficulty in retaining teachers at the salaries the government can afford to pay. Children especially in rural communities are often denied their rights for education.

The studies link education with reduced child and maternal deaths, improved child health, and lower fertility. Women with at least some formal education are more likely than uneducated women to use contraception, marry later, have fewer children, and be better informed on the nutritional and other needs of children.

Knowledge based society is an essential factor for economic and social growth of a country. Formal, non-formal and informal education systems are the basic pillars for knowledge-based society. With the advancements of technology in the modern era with

significant change adoption in education system have created new opportunities for developing countries to enhance literacy rate as well as inculcate intellectual capability in the society. Furthermore, Creativity, Critical Thinking, Communication and Collaboration are five necessary educational skills that need to be developed in 21st century generation. Therefore, the policy makers are required to reform their policies and restructure the existing infrastructure to accommodate the challenges. Access to Secondary Education is highly uneven, particularly for girls. There is limited access to secondary schools because there are very few schools, and they are mostly located in the urban areas. According to PSLM 2018-19, out of school children are more than 30 percent with a high drop-out rate.



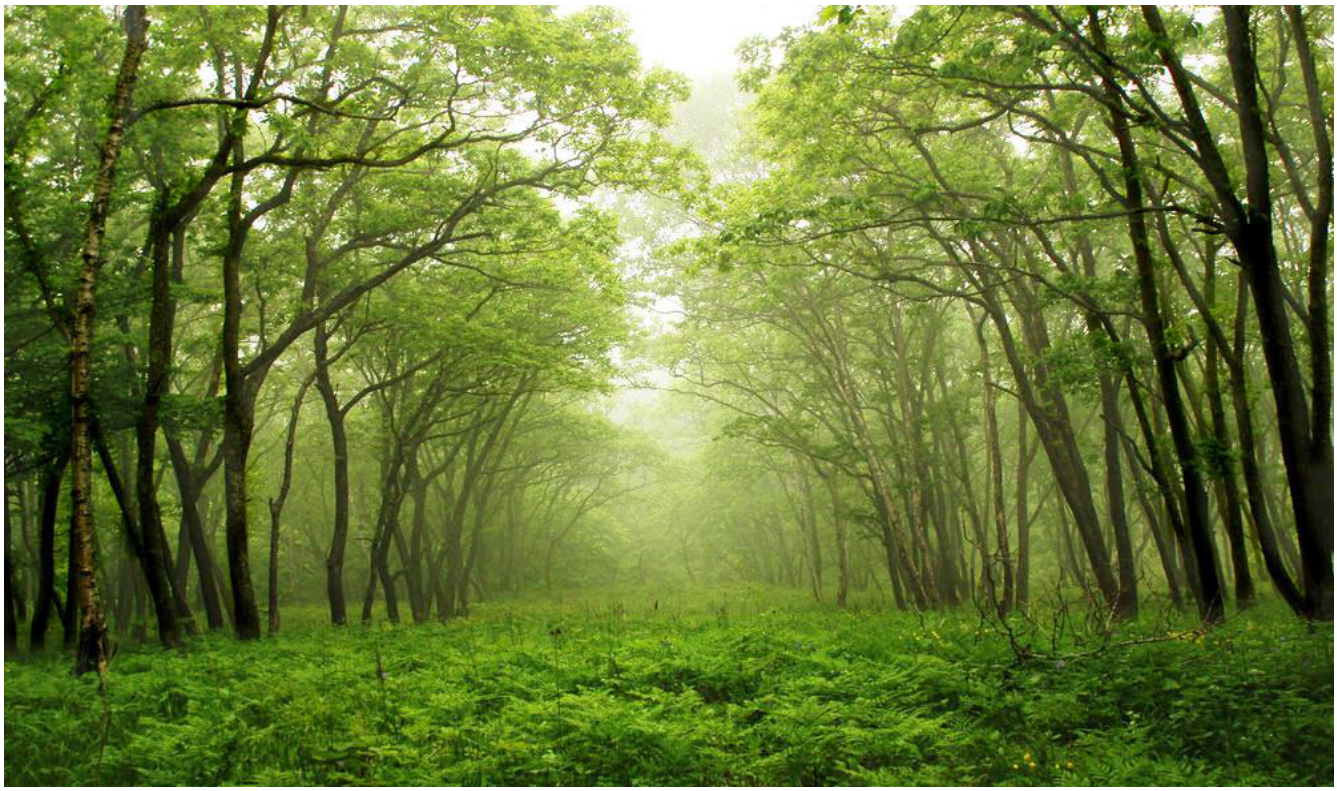
Urbanization

Pakistan's population has been documented to be predominantly rural. However, for better economic opportunities, people from rural areas are migrating to urban areas leading to significant rise in the urbanization. Urbanisation has been very rapid in recent years, with the population of major cities jumping to some of the world's largest cities with poor civil amenities.

Disasters and Climate Change

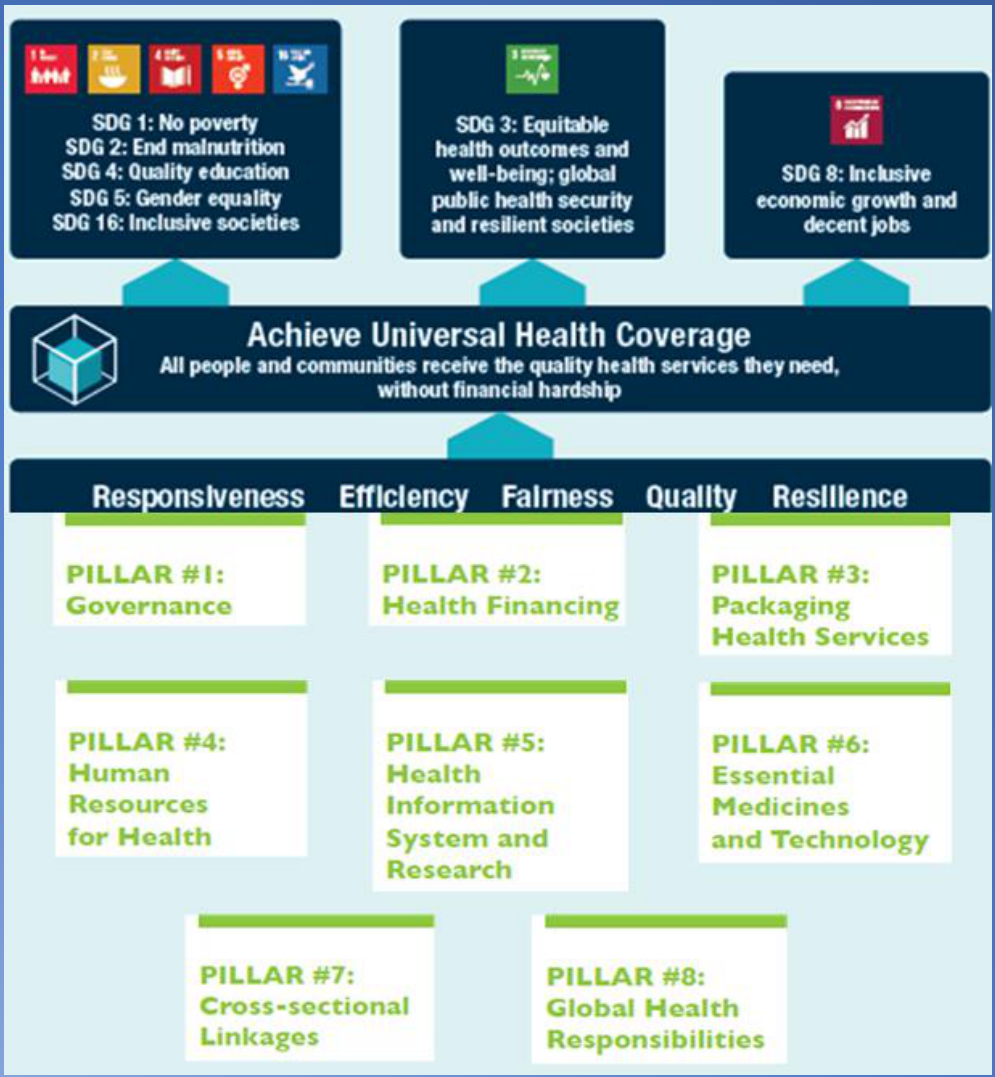
Pakistan is among the countries most vulnerable to Disasters - including droughts, storms, epidemics, floods, pest attacks, river erosion etc. Human induced hazards that threaten the country relate to conflicts, terrorist activities, transport, fires and internal displacements of communities as a result of multiple factors. Climate change has already brought about a considerable increase in the frequency and intensity of extreme weather. Pakistan is also a severely water stressed with depleting water resources. Increasing urbanisation means larger urban populations inhabiting peri-urban, marginal and at-risk areas. Vulnerability to drought and disasters is growing in both urban and rural areas, placing ever more lives at risk.

Government of Pakistan is committed to meeting the SDGs and institutional arrangements for most of national goals and targets are in place. Greater efforts are needed to institutionalize the SDGs within the health agenda, since all goals are important for health.



THEORY OF CHANGE

National Health Vision



POLICY RESPONSE

The National Health Vision (NHV) 2016–2025[33] and National Action Plan, NHSR&C (2019-23)[34] strives to provide a responsive unified direction to overcome various health challenges, while ensuring adherence to UHC as the ultimate goal. The principle values include Good governance, Innovation and transformation, Equity and pro-poor approach, Responsiveness, Transparency and accountability, Integration and cross-sectoral synergies.

The Government's National Health **Vision** 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"*

The NHV and its eight thematic pillars have been agreed by all provincial governments and they are in process of developing the next generation of health sector strategies aligned to NHV. Balochistan[35] was the first province followed by Islamabad[36] to finalize its health strategy, aligned with NHV.

NHV is translated in the **Twelfth Five Year Development Plan (2019–2023)**. Given the epidemiological and demographic changes, a revised integrated package of wider preventive and curative interventions aligned to Disease Control Priorities (DCP-3)[37] needs to be considered, with an emphasis on cost effective and feasible RMNCAH, communicable diseases, non-communicable diseases and service access and quality interventions.

Detailed explanation of NHV is available in relevant sub-sectoral strategies and action plans. Following are the brief descriptions of some of these strategies:

1: The **National Vision (2016-25) for Coordinated Priority Actions to address Challenges of Reproductive, Maternal, New-born, Child, Adolescent Health (RMNCAH) and Nutrition**[38]
A dynamic document leading to a mechanism for national consensus on important issues around RMNCAH and nutrition and is in line with global commitments on the subject.

The vision reflects the commitment of government to accelerate progress in ten priority areas including: i) Improving the access and quality of MNCH community based PHC services ensuring continuum of care; ii) Improved quality of care at primary and secondary level care facilities; iii) Overcoming financial barriers to care seeking and uptake of interventions; iv) Increased funding and allocation for MNCH; v) Reproductive health including family planning; vi) Investing in nutrition of adolescent girls, mothers and children; vii) Investing in addressing social determinants of health; viii) Measurement and action at district level; ix) National accountability and oversight; x) Generation of the political will to support MNCH as a key priority within SDGs.

2: **Action Plan 2019-24 regrading Population growth in Pakistan**[39] frame clear, specific and actionable

[33] Ministry of NHSR&C, 2016; National Health Vision 2016-25
[34] Ministry of NHSR&C, 2016; Action Plan NHSR&C 2019-23
[35] Health Department, Balochistan, 2018; Well and Healthy Balochistan's Health Sector Strategy 2018-23
[36] Ministry of NHSR&C, 2018; Islamabad Health Strategy 2018-23
[37] Disease Control Priorities secretariat, 2017; Disease Control Priorities Edition III (9 volumes)

[38] Ministry of NHSR&C, 2016; National Vision (2016-25) for Coordinated Priority Actions to address Challenges of Reproductive, Maternal, New-born, Child, Adolescent Health (RMNCAH) and Nutrition
[39] Government of Pakistan, 2019; Action Plan (2019-24) regarding Population growth in Pakistan

recommendations to address matters relating to alarming population growth. The Action Plan frames a set of recommendations aiming at enhancing Contraceptive Prevalence Rate to 50% thereby lowering the total fertility rate to 2.8 children per woman by 2025 and; to further raising CPR to 60% and reaching a total fertility rate of 2.2 children per woman by 2030. The action plan was placed before the Council of Common Interest (CCI) chaired by the Prime Minister and represented by Chief Ministers of the provinces for immediate consideration for approval on 19th November, 2018. Action Plan is a set of interventions in eight focused areas and the recommendations are to be implemented by the federal and provincial governments with active support from the private sector, civil society organizations and international development partners.

3: Pakistan National Action Plan for Health Security[40]
Pakistan is a signatory to the International Health Regulations – IHR (2005). However, despite multiple efforts, it has yet to meet the required core capacities, which could jeopardize the country's travel and trade. Even more important, it means the country is not fully prepared to prevent, detect and respond to health threats to protect its population, irrespective of whether the threats arise internally or externally.

The WHO Secretariat, with input from partners, including the Global Health Security Agenda, subsequently developed a Joint External Evaluation (JEE) tool as one of four components of a new framework for IHR monitoring and evaluation. In response to resolution EM/RC62/R.3 of the WHO Eastern Mediterranean Regional Committee which required countries to assess and monitor the implementation of the IHR (2005), Pakistan was the first country in the WHO Eastern Mediterranean Region, and the fourth globally, to volunteer for a Joint External Evaluation (JEE)[41], which was carried out in 2016.

Considering the findings of JEE for 19 IHR related capacities in the country, the first "National Action Plan for Health Security (NAPHS)" was developed in 2018 through an all-inclusive, fully consultative and participatory approach. The NAPHS has drawn expertise from various sectors and reflects a shared commitment to enhanced collaboration for addressing national health security. The NAPHS aims to create and maintain active collaboration between the Federal and Provincial entities working in Pakistan for addressing health security through the "One Health" approach to ensure timely preparedness, consistent and coordinated response in the event of occurrence of an event of public health concern.

4: Pakistan Human Resources for Health Vision 2018-30[42]
Pakistan has one of the lowest densities of health workers in the region and globally, with an essential /skilled health professional (physicians including specialists, nurses, lady health visitors (LHVs) and midwives) density of 1.4 per 1,000 population (2018), which is much below the indicative minimum threshold of 4.45 physicians, nurses and midwives per 1,000 population necessary to achieve universal health coverage. For sustainable development, it is not only the adequate numbers, which is needed but also a well distributed workforce with appropriate skills mix to provide quality services. HRH Vision 2018-20 focuses on four strategic objectives:

i) To establish a national and provincial health workforce planning and development capability that provides the necessary tools (strategies, governance mechanism, legislation) and resources to deliver a health workforce of sufficient size, composition, capability and distribution to meet the health needs of the population;
ii) To align investment in human resources for health labour market with the current and future needs of the people and health system to address shortages and improve distribution of quality health workforce, so as to enable maximum improvements in health outcomes and poverty reduction;
iii) To build the capacity of institutions at district, area/ province and national levels for effective and quality pre-service & in-service training and leadership of actions on human resources for health;
iv) To strengthen data collection, processing and dissemination of information related to human resources for health for monitoring and ensuring accountability at different levels.

5: National Action Plan for the Implementation of Bangkok Principles on Health Aspects of the Sendai Framework for Disaster Risk Reduction[43]
Pakistan is vulnerable to a wide range of natural and human induced disasters that have caused a substantial loss of life and property. The devastating earthquake of October 2005 and floods of 2010 took thousands of precious lives and rendered millions homeless. As a result of this lesson learning, the National Disaster Management Act was enacted in the country during 2010. However, the aspects of health in reducing disaster

[40] Ministry of NHSR&C, 2018; National Action Plan for Health Security (NAPHS)
[41] WHO, 2016; Joint External Evaluation (JEE) of Capacities on International Health Regulations
[42] Ministry of NHSR&C, 2018; Pakistan: Human Resources for Health Vision 2018-30
[43] Ministry of NHSR&C and NDMA: National Action Plan for the Implementation of Bangkok Principles on Health Aspects of the Sendai Framework for Disaster Risk Reduction

risk reduction were felt not to be addressed especially in the context of Disaster Risk Management.

Accordingly, a National Action Plan to strengthen the existing systems was developed, setting strategic priorities to achieve a robust health system in Pakistan by aligning with the National Disaster Management Plan and National DRR Policy. The plan has seven strategic objectives to be achieved over short, medium and long term:

i) Promote systematic integration of health into national and sub-national disaster risk reduction policies and plans and the inclusion of emergency and disaster risk management programs in national and sub-national health strategies;
ii) Enhance cooperation between health authorities and other relevant stakeholders to strengthen country capacity for disaster risk management for health, the implementation of the International Health Regulations (2005) and building of resilient health systems;
iii) Stimulate people-centred public and private investment in emergency and disaster risk reduction, including in health facilities and infrastructure;
iv) Integrate disaster risk reduction into health education and training and strengthen capacity building of health workers in disaster risk reduction;
v) Incorporate disaster-related mortality, morbidity and disability data into multi-hazards early warning system, health core indicators and national risk assessments;
vi) Advocate for, and support cross-sectoral, trans-boundary collaboration including information sharing, and science and technology for all hazards, including biological hazards;
vii) Promote coherence and further development of local and national policies and strategies, legal frameworks, regulations, and institutional arrangements.

6: **Other National Strategies/ Plans**:
In addition to the above-mentioned strategies, the Ministry and Provincial Health Departments have produced following disease specific polices, strategies and plans:

1: National EPI Policy and Strategic Guidelines 2015[44]

2: National End TB Strategic Plan 2017-20[45]

3: Pakistan AIDS Strategy III 2015-21 (2017 Revision)[46] Another revision is in progress in 2021-22

4: National Malaria-Strategic Plan-2015-2020[47]

5: Hepatitis Strategic Framework 2017-21[48]

6: National Blood Policy and National Strategic Framework-2014-20[49]

7: National Strategic Framework for containment of Antimicrobial resistance[50]

8: National Action Framework on Non-communicable diseases and Mental health (2022-30) has been recently endorsed by the Inter-Ministerial Health & Population Council in November 2021[51]

7: **Essential Package of Health Services/ UHC Benefit Package of Pakistan**
For making progress towards achieving UHC target, an opportunity emerged in Pakistan when an international workshop of the Eastern Mediterranean Region was jointly organized by the Government of Pakistan, Disease Control Priorities (DCP3) secretariat and WHO EMRO in Islamabad in August 2018, with participation of the Federal Ministries, Provincial Health Departments, UN agencies and other partners. Participants were sensitized on the concept and evidence described in the nine DCP3 volumes and model packages.

Soon after, the Inter-Ministerial Health & Population Forum, held on 14 September 2018, decided to endorse the DCP3 recommendations for the purpose of developing a UHC Benefit Package of Pakistan/ Essential Package of Health Services (EPHS). Accordingly, a joint federal and provincial request was sent to the DCP3 Secretariat to select Pakistan as the first country adapting DCP3 evidence to develop the EPHS/ UHC benefit package for Pakistan.

The provision of essential health services towards achieving UHC and health-related SDGs was underscored in the draft 12th Five-Year Plan (health chapter), and National Action Plan (2019-23). To translate the government commitment into action, the Ministry established a formal collaboration in July 2019 with the DCP3 Secretariat and the World Health Organization (WHO) under a memorandum of understanding and financial support of the Bill & Melinda Gates Foundation (BMGF).

A series of consultations were held with stakeholders leading to agreement on the objectives, expected outcomes and methods of work. The scientific evidence (burden of disease, targeted population, unit cost, cost-

[44] Ministry of NHSR&C, 2015; National EPI Policy and Strategic Guidelines 2015
[45] Ministry of NHSR&C, 2017; National End TB Strategic Plan 2017-20
[46] Ministry of NHSR&C, 2017; Pakistan AIDS Strategy III 2015-21 (2017 Revision)
[47] Ministry of NHSR&C, 2015; National Malaria-Strategic Plan-2015-2020
[48] Ministry of NHSR&C, 2017; Hepatitis Strategic Framework 2017-21
[49] Ministry of NHSR&C, 2014; National Blood Policy and National Strategic Framework-2014-20
[50] Ministry of NHSR&C, 2016; National Strategic Framework for containment of Antimicrobial resistance
[51] Ministry of NHSR&C and Provincial/ Area Health Departments, 2020; National Action Framework on Non-communicable diseases and Mental health (2022-30)

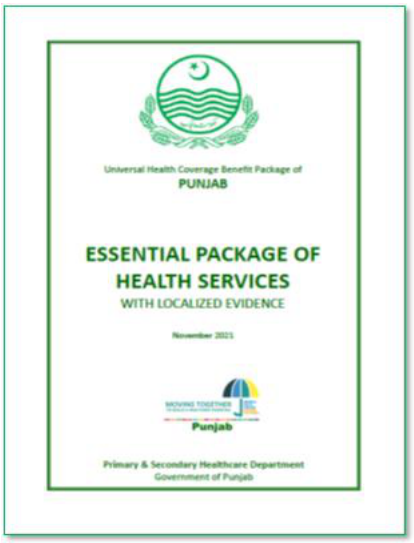
effectiveness, budgetary impact, expected health gains, health plans, health system capacity and fiscal space etc.) was localized and the process of dialogue and deliberation was ensured on setting priorities and services. The UHC Benefit Package of Pakistan/ Essential Package of Health Services was finalized and endorsed by the Inter-Ministerial Health & Population Council on 22 October 2020.[52] In the same meeting, all Health & Population ministers decided to localize scientific evidence at provincial/ federating area level and accordingly develop Provincial / Federating Area EPHS.

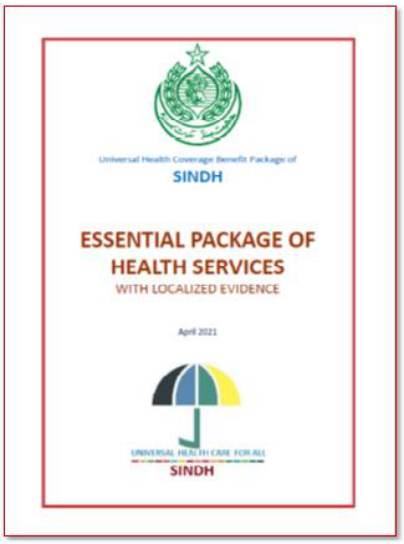
During 2021, provincial/ federating area level consultations were held not only to localize scientific evidence but also develop costed EPHS documents. Following provincial/ federating area costed EPHS documents were developed during 2021:

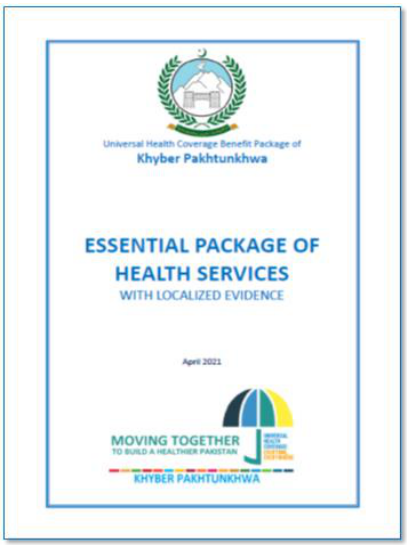
1: Punjab EPHS with localized evidence
2: Sindh EPHS with localized evidence
3: Khyber Pakhtunkhwa EPHS with localized evidence
4: Balochistan EPHS with localized evidence
5: Gilgit-Baltistan EPHS with localized evidence
6: Azad Jammu & Kashmir EPHS with localized evidence

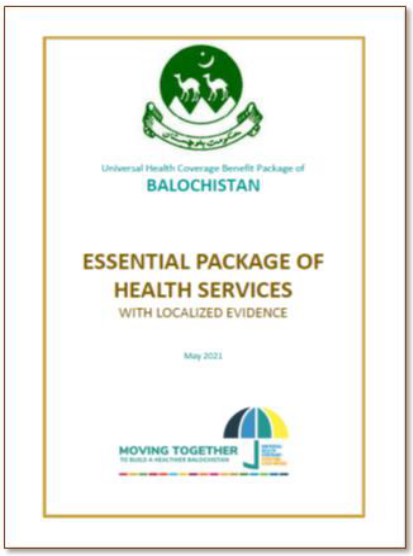
Sindh was the first province to finalize its EPHS document and getting endorsement from its UHC Steering Committee, followed by AJK and Gilgit- Baltistan.

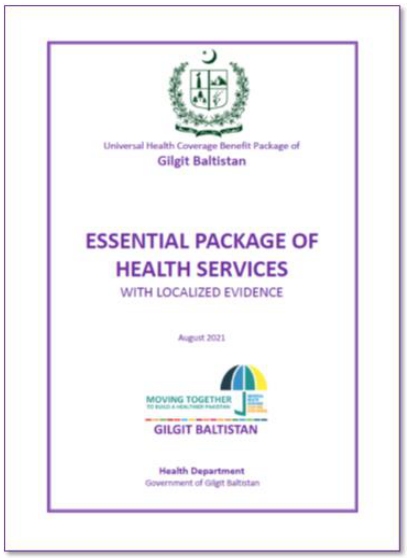
Based on the DCP3 recommendations, work on Inter-sectoral National Action Framework is also under process.

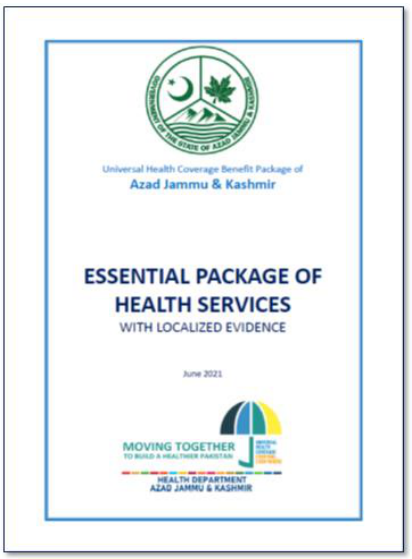












[52] Ministry of NHSR&C and Provincial/ Federating Areas Health Departments. 2020; National Essential Package of Health Services with localized evidence

HEALTH FINANCING

Health financing is a strategic approach to generate, pool, allocate and use financial resources in the health sector including UHC and health system. Apart from revenues that originate from abroad (e.g., external funds from donors), and revenues deriving from natural resources owned by the state, the population is the ultimate source of most of the funds for the system, whether in the form of direct out-of-pocket (OOP) payments for services, insurance contributions, or taxes that people and firms pay to their governments. These funds are pooled by a wide variety of public and private agencies.

In Pakistan, prepaid and pooled funds for health remain relatively small and fragmented. Un-pooled, private OOP expenditures comprise the greatest share of resources for the national health sector. Non-government health budget sources of pooled funds for the health sector include private health insurance, and social security funds (which include Zakat, Bait-ul-Mal, ESSI). The de facto pool for most of the population is the government health budget.

Government health budgets determine allocations for health down to the district and local government levels. Health care providers and patients/ clients are the end recipients of the health care funds. The three broad categories of the health care providers are public provider, private provider, and non-government organization providers/ non-profit Institutions, and include public and private hospitals, clinics, community health centres in the public and private sectors, private practitioners, traditional health care providers, dispensaries, pharmacies, laboratories, etc.

Total health expenditure (THE) is an aggregate of current health expenditure and development expenditure, and for FY 2017-18, it is estimated as Rs, 1,206,332 million by the National Health Account. Compared to FY 2015-16, current, development and total health expenditures show increase of 31.8 percent, 26.4 percent and 31.3 percent respectively. It is illustrated in the diagram below.

A. Current expenditure

- Rs. 1,108,464 million (31.8% increase)

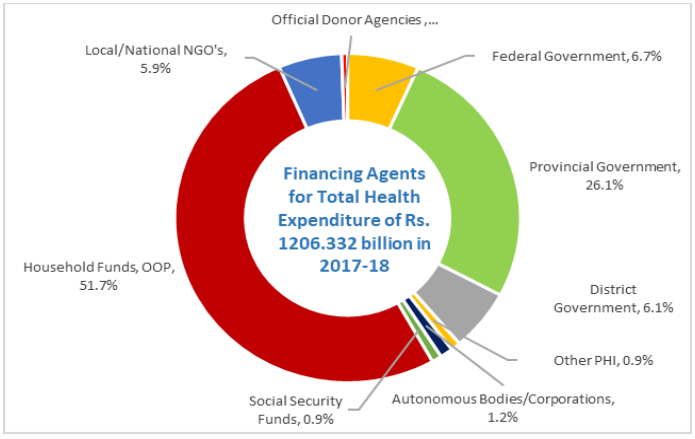
B. Development expenditure

- Rs. 97,868 million (26.4% increase)

Total health expenditure = A + B

- Rs. 1,206,332 million (31.3% increase)

Out of THE in Pakistan, 40.9 percent is made by general government agents which include the expenditures by territorial governments (federal and provincial governments, and district/tehsil bodies); social security funds; and autonomous bodies/ corporations health expenditures. The private expenditures constitute the 58.5 percent of THE in Pakistan, out of which 88 percent are households OOP health expenditures. The share of development partners/donors' organizations in THE is almost 0.6 percent in 2017-18.



During the financial year 2019-20, the cumulative health-related expenditure by federal and provincial governments increased to Rs 482.3 billion from Rs 421.8 billion of the previous financial year, recording an increase of 14.3 percent. The current expenditure increased by 11.8 percent from Rs 363.2 billion to Rs 406.0 billion, while the development expenditure increased by 30.2 percent from Rs 58.6 billion to Rs 76.3 billion. Public sector expenditure on health was estimated at 1.2 percent of GDP in 2019-20, compared to 1.1 percent in 2018-19.

Federal and Provincial Government Health Expenditure

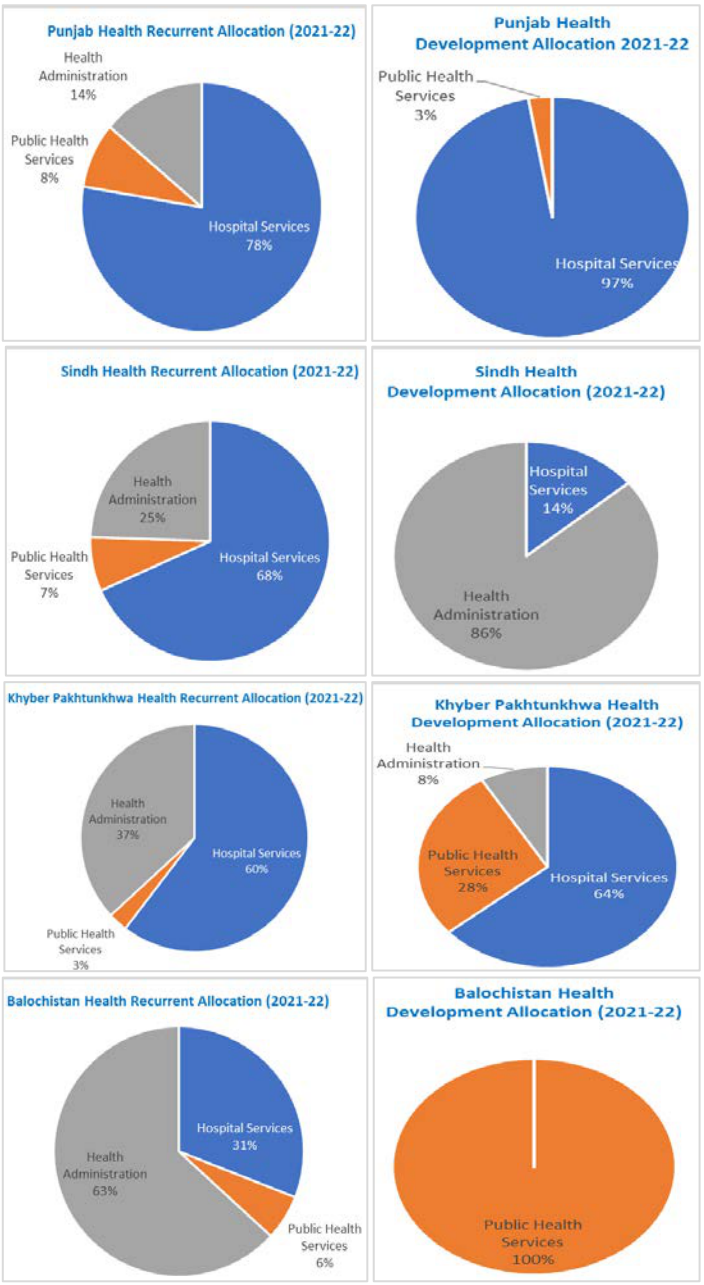
Fiscal years	Public Sector Expenditure (Federal and Provincial) in Rs Million			Health Expenditure as percent of GDP
	Current Expenditure	Development Expenditure	Total Health Expenditure	
2011-12	104,284	29,898	134,182	1
2012-13	129,421	31,781	161,202	0.6
2013-14	146,082	55,904	201,986	0.7
2014-15	165,959	65,213	231,172	0.7
2015-16	192,704	75,249	267,953	0.9
2016-17	229,957	99,005	328,962	1
2017-18	329,033	87,434	416,467	1.2
2018-19	363,154	58,624	421,778	1.1
2019-20 (P)	406,011	76,254	482,265	1.2

P: Provisional

Source: Pakistan Economic Survey 2020-21

Devolution of the health sector from the federal to the provincial level in 2011 has shaped the current architecture of the health financing system, and resulted in gradual and enhanced spending on health care due to the increased fiscal space available to the provinces. A disaggregation of budget allocations by purpose shows a concerning trend, whereby a disproportionately higher allocation has been reserved for hospital expenses, a significant proportion is devoted to health administration, and public health services have the least share of budget allocation.

Punjab had the highest allocation of current expenditures for health, and spent 78 percent of its total budget on hospital services; while Balochistan had the lowest allocation for current health expenditures, and spent only 31 percent on hospital services. Salaries and administrative costs are lowest for Punjab (14 percent) and are the highest for Balochistan (63 percent). Public health services have been given the least priority in budget and allocation ranges from 3 percent in Khyber Pakhtunkhwa to 8 percent in Punjab. A large portion of the public spending on health has been consumed in salaries and administrative costs varying across provinces. However, Punjab has the most efficient distribution of resources, with more focus on hospital and public health services.

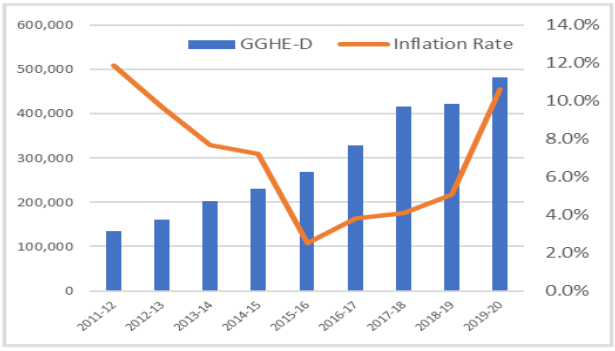


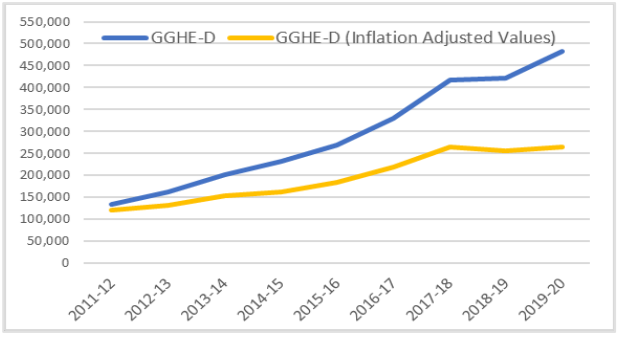
According to the National Health Accounts 20017-18, the annual per capita THE (Recurrent and Development) is Rs 5,749.9 (US$ 52.3), and is 3.2 percent of the GDP. OOP per capita for Pakistan as per NHA 2017-18 is (27.2 US$) Rs. 2984, which translates to OOP as percent of THE of 51.7 percent.

For 2018, the total spending by Pakistan's government as a share of the economy as measured by GDP (GGE as percent of GDP) stands at 21.6 percent, and of the general government expenditures, the share of government

expenditures devoted to health (GGHE-D as percent of GGE), is 5.26 percent.

While Pakistan's economy has grown in the recent years, the country continues to suffer from several macroeconomic imbalances, such as inflation. Although the figures indicate increase in health expenditures over the years, but taking inflation into account, the general government expenditures devoted for health sector have remained stagnant over the last few years.





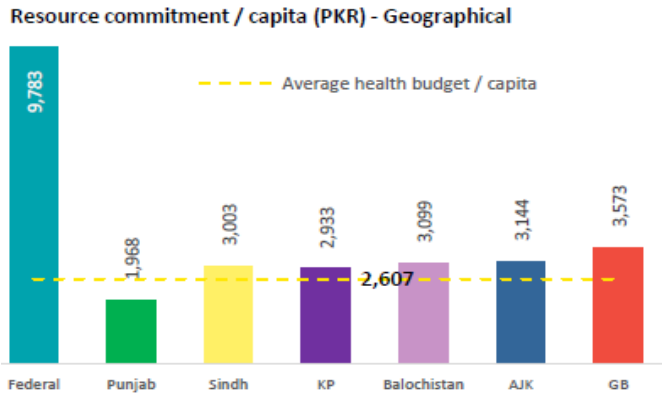
Overall public health expenditure looks to be static in real term over last few years, while considering inflation rate. However, more recently the government has so far spent more than $1.6 billion on COVID-19 response especially on vaccine and testing. Considering this expenditure, a rapid boost in the public health expenditure is expected now.

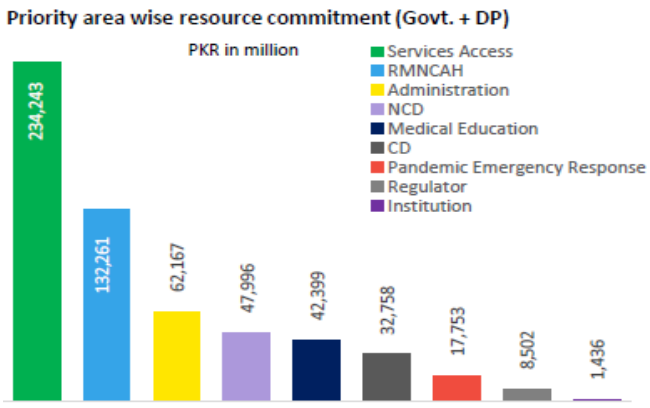
UHC is based on the principle that all individuals and communities have equitable access to their needed health care, in good quality, without suffering financial hardship. In order to achieve UHC, Pakistan has adapted a set of costed priority interventions referred to as UHC-BP based on the DCP-3. To achieve UHC, increase access to quality health care services and protect against catastrophic health expenditure, an amount of Rs. 1.28 trillion is required as per resource gap analysis (2019-20) supported by the World Bank/ Global Financing Facility. The government commitment is Rs. 477 billion and donors' support is Rs. 102 billion. The gap is of Rs. 841 billion which is required to be spent on health sector to progress towards achieving UHC.

Pakistan needs to invest more in the health sector to improve social protection and the health of population, preferably through public sector. Policy makers should encourage stable and flexible financial plans along with an increase in budget allocation considering the priorities of the health sector. In order to progress towards the goal of UHC and health emergencies, Pakistan needs to avoid fragmentation, reduce inequity, and maximize purchasing power.

PKR in million

Government of Pakistan (GoP) commitment – Current	401,091
GoP commitment- Development	76,499
Total – GoP commitment	477,590
IDP – commitment	102,025
Total commitment	579,615
(Less): Commitment for non-prioritized interventions*	(132,257)
Prioritized commitments**	447,358
Cost of UHC interventions***	1,288,589
Financing Gap	841,231






3
GOOD HEALTH
AND WELL-BEING
ENSURE HEALTHY LIVES
AND PROMOTE WELL-BEING
FOR ALL AT ALL AGES

CHALLENGES

Some of the key challenges in the health sector and more specifically to achieve UHC in Pakistan include the following:

Health Governance

- Limited institutional capacity
  - Provincial/ Area level - policy analysis, planning, coordination, outsourcing, regulation
  - District level - monitoring, supervision, operational planning
- Weak culture of accountability and transparency
- Inadequate engagement of the private sector
- Limited capacity for ensuring effective decentralization – central, provincial, district levels
- Weak health sector and inter-sectoral coordination
- Need to regularly review implementation of policy documents
- Need to strengthen regulatory bodies and implementation of legislations

Service Delivery

- Availability: Shortage of health facilities, inequity, limited availability of essential health services; Weak engagement with the Private sector/ General physicians for delivery of EPHS
- Accessibility: Physical, financial, social barriers
- Quality: Quality standards and regulatory systems
- Demand: Low awareness and demand
- Coverage: Limited coverage of essential services, biased towards rich and well-off areas – equity issues
- Utilization: Low utilization of PHC health services leading to burden on hospitals; poor referral system
- Humanitarian - Development Nexus to be developed for effective response during emergencies while ensuring sustainability

Human Resources for Health

- Acute shortage - 1.69 essential health force /1000 pop (Target- 4.45 by 2030)
- Inequitable distribution- Urban/Rural and declining number of LHWs
- Inadequate skill mix
- Weak HRH management: inadequate incentives, disparities, weak supervision, limited employment capacity
- Weak technical capacity: No proper system of In-service training
- Weak HRH information: HRH registry needs to be standardized and integrate for appropriate planning and HRH management
- Growth of private sector health educational institutions with weak regulation

Health Financing

- Data constraints on health financing, including out-of-pocket expenditure and delayed mechanism to update
- Predictable and adequate financing for health
- Health emergencies and epidemics needing huge investments
- No health financing strategy with limited allocation & expenditure
- Need to close financing gap to ensure provision of services, along with a pre-payment mechanism to reduce catastrophic/out-of-pocket health expenditure
- Public financial management reforms in health sector, aligned to cross-sectoral public financial management reforms
- Need to strengthen rules/procedures for purchase of goods and services in public sector while ensuring efficiencies
- Need to ensure strong accountability system in public sector

Health Information

- Accessibility to information – Infrequent availability of survey results at national, provincial and district level
- Poor comparability of different surveys' results
- HIS of vertical programs, surveillance systems to be integrated fully in Pakistan Health Information System (PHIS) Dashboard
- Questionable quality of data reported through Health Management Information System (HMIS)
- Limited use of information for decision making
- System of Civil Registration and Vital Statistics not in place
- Limited use of technology and innovation

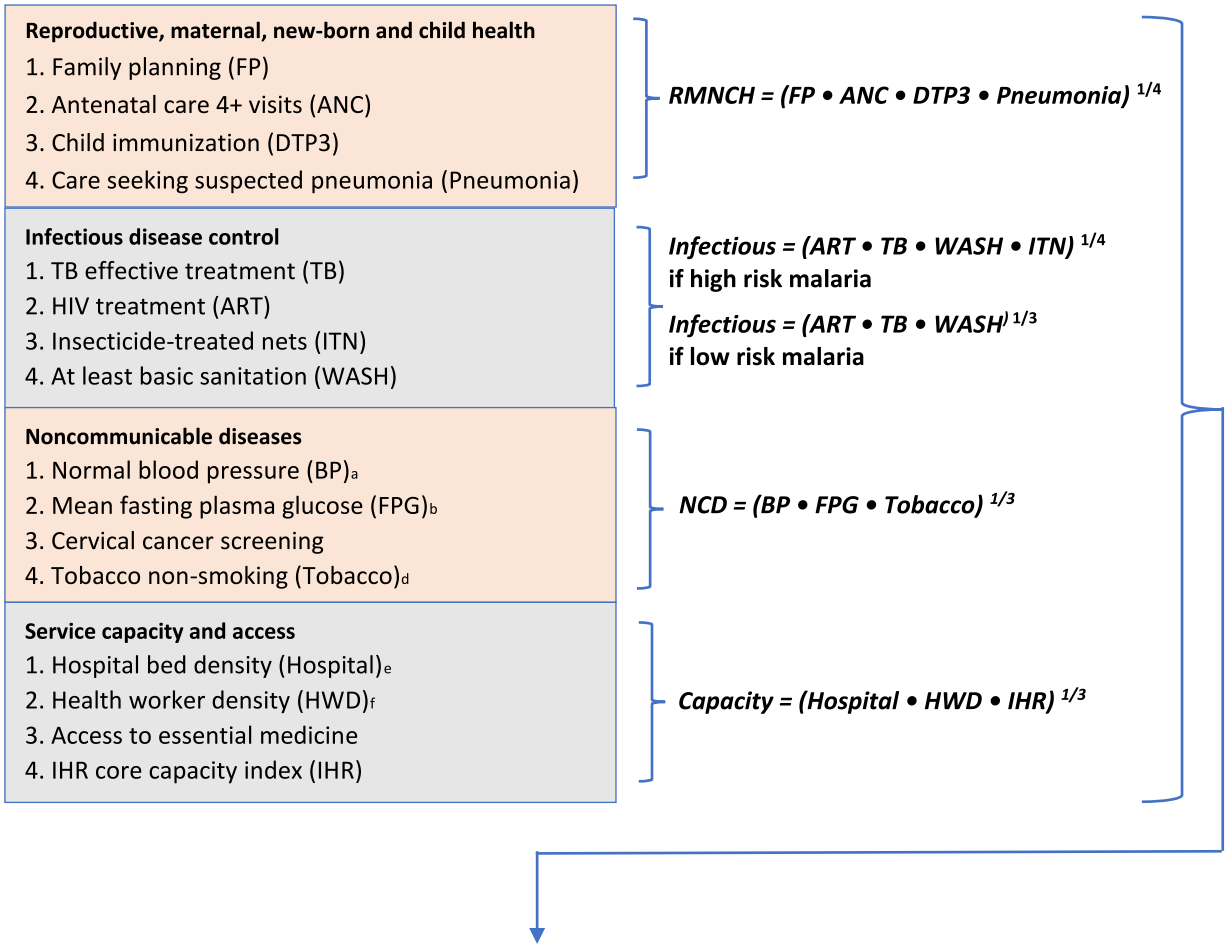
Essential Medicines and Health Technologies

- Need to have a robust mechanism to monitor availability of quality essential medicines, commodities and supplies - with regular consumption analysis to check frequent stock-out
- Unused equipment/technologies to be disposed of regularly
- Inappropriate stock management should be addressed at all levels
- Strengthening of national, provincial and district procurement system, including regulation
- Check on inflow of counterfeit drugs
- Improved regulation of pharmaceutical sector

Annexure

UHC Service Coverage Index at National, Provincial, Federating Area and District level in 2020

UHC Service Coverage Index Calculation



a. The percentage of the adult population with ***normal blood pressure*** is based on age-standardized estimates. These distributions are rescaled to provide finer resolution for the index, based on the observed minima across countries. The rescaled indicator = (X–50)/ (100–50) *100, where X is the prevalence of normal blood pressure.

b. ***Mean fasting plasma glucose (FPG)*** is not measured on a scale bounded between 0 and 100%. To account for this range, estimates of national mean FPG were rescaled using a minimum of 5.1 mmol/L (the midpoint of minimum theoretical risk) and a maximum of 7.1 mmol/L (the maximum across national means). The rescaled indicator for mean FPG = (7.1–X)/(7.1–5.1), where X is mean FPG.

c. ***Cervical cancer screening*** and access to essential medicines are excluded due to low data availability.

d. As in (a), ***tobacco non-smoking*** is also based on age-standardized estimates, and is rescaled to provide finer resolution based on a minimum bound of 50%, so that the rescaled indicator = (X–50)/ (100–50)*100, where X is prevalence of tobacco non-smoking.

e. ***Hospital bed density*** values were rescaled and capped based on a threshold of 18 per 10 000, based on minimum rates observed in high income OECD countries. Values below 18 per 10 000 are rescaled as X/18*100, where X is hospital beds per 10 000, and values above 18 per 10 000 are set to 100.

f. as in (e), ***health worker density (HWD***) is rescaled and capped based on threshold values. Physician density has a threshold of 0.9 per 1000, psychiatrists have a threshold of 1 per 100 000, and surgeons have a threshold of 14 per 100 000. After rescaling these values (i.e., minimum (100, X/threshold*100), where X is the cadre-specific density, they are combined into a HWD composite variable for entry into the above index calculations, computed as (physicians * psychiatrists * surgeons). $^{1/3}$

National and Provincial/Areas UHC Service Coverage Index from 2015 to 2020:

Year wise UHC Index						
Province/Area	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Islamabad (ICT)	44.7	47.7	48.9	48.5	51.3	56.0
Punjab	40.6	42.8	45.6	47.3	48.2	52.0
Khyber Pakhtunkhwa (KP)	36.2	40.7	45.8	47.3	47.6	50.3
Azad Jammu & Kashmir (AJK)	39.0	40.7	43.6	46.2	47.9	49.8
Sindh	37.6	40.6	43.9	45.0	46.7	48.6
Gilgit Baltistan (GB)	35.8	39.3	41.0	42.6	43.5	45.2
Balochistan	27.1	29.3	32.3	33.5	35.0	35.2
National	**39.7**	**42.1**	**45.3**	**46.3**	**47.1**	**49.9**

Detailed breakdown of the UHC Index at provincial/area level for 2020 is as following:

UHC Indicators	Punjab	Sindh	KP	Balochistan	ICT	GB	AJK	National
1. Family Planning demand satisfied with modern methods (%)	50.3	50.2	45.1	33.8	55.1	46.4	38.5	48.6
2. Antenatal care -4+ visits	56.2	54.1	44.6	23.1	80.2	34.9	46.5	51.4
3. Child immunization (Penta 3) (%)	94.9	73.2	74.3	42.2	86.3	82.2	95.4	83.5
4. Care-seeking behaviour for child pneumonia (%)	86.1	85.4	84.3	62.2	83.6	76.3	80.8	84.2
RMNCH Aggregate Score	69.33	64.19	59.58	37.84	75.14	56.45	60.95	64.74
5. Tuberculosis effective treatment (%)	46.3	43.5	38.2	22.5	12.6	49.7	32.9	42.0
6. HIV treatment (%)	12.5	10.5	22.7	17.1	12.5	12.5	12.5	12.0
7. Insecticide-treated nets for malaria prevention (%) **	NA	NA	NA	NA	NA	NA	NA	NA
8. At least basic sanitation (%)	89.0	76.0	84.0	44.0	99.0	83.0	83.0	83.0
CD Aggregate Score	37.24	32.58	41.77	25.66	25.01	37.25	32.47	34.71
9. Normal blood pressure (%)	69.0	69.0	69.0	69.0	69.0	69.0	69.0	69.0
10. Normal mean plasma blood sugar (%)	39.0	39.0	39.0	39.0	39.0	39.0	39.0	39.0
11. Cervical cancer screening among women 30-49 years (%) **	NA	NA	NA	NA	NA	NA	NA	NA
12. Tobacco non-smoking (%)	59.0	59.0	59.0	59.0	59.0	59.0	59.0	59.0
NCD Aggregate Score	54.15	54.15	54.15	54.15	54.15	54.15	54.15	54.15
13. Hospital beds per 10,000 population against threshold (%)	53.7	39.3	49.2	25.0	161.4	36.7	74.8	49.4
14. (Physicians*Psychiatrist*Surgeon) density against threshold (%)	47.4	61.3	45.7	31.1	82.7	33.3	44.9	50.6
15. Availability of essential medicines in PHC (%) **	NA	NA	NA	NA	NA	NA	NA	NA
16. International Health Regulations core capacity index (%)	56.9	49.8	48.8	32.7	68.0	40.7	57.1	53.0
SAC Aggregate Score	52.51	49.32	47.85	29.40	96.80	36.76	57.69	50.98
UHC Index	**52.05**	**48.61**	**50.39**	**35.26**	**56.02**	**45.23**	**49.85**	**49.91**

UHC Service Coverage Index at District Level (2020)

District/ Province/ Area	Population	National UHC Index Ranking	Provincial UHC Index Ranking	FP demand satisfied with modern method (%)	ANC – 4+ visits (%)	Child immunization (Penta 3) (%)	Care-seeking behavior for child pneumonia (%)	RMNCH Score	TB effective treatment (%)	HIV treatment (%)	Insecticide-treated nets for malaria prevention (%)	At least basic sanitation (%)	Infectious Diseases Score
Attock	1,988,694	49	24	46.40	60.30	92.30	78.30	67.06	26.43	12.54	NA	96.40	31.73
Bakhar	1,757,645	66	30	57.90	34.30	92.40	67.80	59.39	41.61	12.54	NA	60.60	31.62
Bhawalnagar	3,139,369	29	14	66.70	40.30	92.90	69.40	64.52	46.39	12.54	NA	75.50	35.28
Bhawalpur	3,883,944	73	34	68.40	35.50	96.50	69.60	63.55	62.09	12.54	NA	82.80	40.10
Chakwal	1,564,746	41	19	54.10	72.20	93.50	78.40	73.15	20.28	12.54	NA	97.30	29.14
Chinot	1,438,314	65	29	52.70	48.80	92.60	58.10	60.99	49.69	12.54	NA	68.40	34.93
Dera Ghazi Khan	3,104,851	68	32	46.40	36.30	97.80	77.40	59.76	71.19	12.54	NA	74.90	40.59
Faisalabad	8,291,823	11	5	63.50	64.70	90.70	82.70	74.51	44.62	12.54	NA	93.40	37.39
Gujaranwala	5,292,706	15	9	34.80	58.70	97.60	79.60	63.12	63.48	12.54	NA	99.10	42.89
Gujrat	2,872,282	14	8	53.20	70.00	98.00	86.80	75.02	28.34	12.54	NA	98.60	32.72
Hafizabad	1,211,085	34	17	46.20	43.00	98.80	87.60	64.39	55.20	12.54	NA	92.40	39.99
Jhang	2,894,291	61	28	46.50	42.80	98.70	62.10	59.10	54.63	12.54	NA	73.80	36.98
Jhelum	1,268,868	9	3	55.80	81.30	98.50	86.80	78.92	52.09	12.54	NA	96.20	39.76
Kasur	3,644,057	42	20	62.20	42.30	98.70	62.60	63.50	48.16	12.54	NA	96.20	38.73
Khanewal	3,065,874	54	27	63.30	45.30	97.50	80.40	68.86	47.24	12.54	NA	86.40	37.13
Khushab	1,344,745	28	13	50.70	38.70	99.70	77.70	62.44	63.21	12.54	NA	83.40	40.43
Lahore	12,033,729	2	1	60.50	75.40	84.40	90.30	76.79	42.01	12.54	NA	99.23	37.39
Layyah	1,952,218	45	22	65.80	44.50	96.50	78.20	68.56	32.36	12.54	NA	84.70	32.52
Lodhran	1,790,882	52	26	63.30	36.50	97.60	76.20	64.38	39.69	12.54	NA	91.80	35.75
Mandi bahauddin	1,665,225	19	10	39.90	58.60	99.70	88.20	67.34	75.46	12.54	NA	91.10	44.18
Mianwali	1,630,274	50	25	48.80	53.60	99.70	71.60	65.74	40.11	12.54	NA	81.30	34.45
Multan	5,030,849	10	4	71.10	56.80	98.50	77.80	74.59	52.51	12.54	NA	91.20	39.16
Muzzafargarh	4,630,032	81	35	48.10	37.50	98.30	65.30	58.33	43.57	12.54	NA	72.90	34.15
Nankana Sahib	1,406,543	33	16	53.60	63.10	99.70	69.80	69.65	41.55	12.54	NA	98.70	37.19
Narowal	1,782,755	25	12	47.60	60.60	99.20	83.60	69.94	39.42	12.54	NA	96.20	36.23
Okara Distrct	3,172,206	43	21	56.60	46.70	99.70	63.60	63.98	47.09	12.54	NA	95.90	38.40
Pakpattan	1,914,489	69	33	60.20	38.30	99.00	64.50	61.94	45.11	12.54	NA	86.80	36.62
Rahim Yar Khan	5,109,198	67	31	63.40	30.80	92.90	80.80	61.88	37.65	12.54	NA	78.60	33.36
Rajanpur	2,167,668	91	36	46.00	27.20	98.60	66.30	53.48	46.12	12.54	NA	69.10	34.19
Rawalpindi	5,774,416	5	2	55.80	75.30	92.90	82.70	75.38	42.60	12.54	NA	97.40	37.33
Sahiwal	2,629,162	24	11	68.90	59.30	99.40	63.00	71.12	40.17	12.54	NA	94.50	36.24
Sargodha	3,876,858	12	6	54.80	49.30	99.50	81.90	68.50	63.38	12.54	NA	87.00	41.04
Sheikhupura	3,667,852	36	18	52.00	62.00	83.50	87.10	69.59	35.48	12.54	NA	99.00	35.32
Sialkot	4,091,800	13	7	49.60	63.40	96.90	83.60	71.04	32.45	12.54	NA	98.90	34.27
Toba Tek Singh	2,283,518	32	15	58.60	51.50	98.10	83.00	70.41	46.58	12.54	NA	90.90	37.58
Vehari	3,032,211	47	23	67.80	44.80	93.00	92.20	71.44	48.68	12.54	NA	66.30	34.33
Punjab	**116,334,523**			**50.30**	**56.20**	**94.90**	**86.10**	**69.33**	**46.26**	**12.54**	NA	**89.00**	**37.24**
Badin	1,933,630	107	24	64.20	19.20	82.50	42.80	45.68	45.97	10.45	NA	41.60	27.14
Dadu	1,626,083	84	15	34.00	29.40	81.70	77.70	50.19	44.75	10.45	NA	74.40	32.64
Ghotki	1,774,330	90	17	43.50	42.60	64.90	73.70	54.56	34.55	10.45	NA	63.80	28.45
Hyderabad	2,322,939	6	2	62.30	67.40	77.00	64.90	67.68	61.45	10.45	NA	90.00	38.66
Jacobabad	1,053,557	86	16	51.70	28.60	45.50	83.40	48.67	45.05	10.45	NA	79.40	33.44
Jamshoro	1,071,208	71	11	41.90	26.00	75.20	49.90	44.97	97.95	10.45	NA	70.40	41.61
K. Shadad Kot	1,413,338	106	23	35.00	38.50	58.70	59.90	46.66	35.82	10.45	NA	78.70	30.88
Karachi Central	3,085,716	8	3	50.30	89.90	84.10	90.60	76.61	41.91	10.45	NA	98.40	35.06
Karachi East	3,201,412	31	6	41.40	64.80	78.60	76.60	63.40	28.47	10.45	NA	99.80	30.97
Karachi South	1,841,342	1	1	46.40	82.30	86.60	78.10	71.29	61.96	10.45	NA	99.60	40.10
Karachi West	4,278,071	64	9	39.30	66.10	72.40	58.30	57.54	21.52	10.45	NA	98.40	28.08
Kashmor	1,164,954	121	28	15.90	7.50	26.00	94.40	23.26	32.15	10.45	NA	68.00	28.37

Normal blood pressure	Normal blood sugar	Cervical cancer screening among women 30-49 years (%)	Tobacco non-smoking	Non-Communicable Diseases Score	Hospital beds per 10,000 population	(Physicians* Psychiatrist *Surgeon) density against threshold (%)	Availability of essential medicines in PHC (%)	International Health Regulations core capacity index (%)	Services Access & Capacity Score	UHC Index 2020	Provincial UHC Index Ranking	National UHC Index Ranking	District/ Province/Area
69.00	39.00	NA	59.00	54.15	35.03	50.98	NA	61.17	47.80	48.44	24	49	Attock
69.00	39.00	NA	59.00	54.15	49.37	40.73	NA	48.88	46.15	46.54	30	66	Bakhar
69.00	39.00	NA	59.00	54.15	70.57	40.86	NA	49.03	52.10	50.34	14	29	Bhawalnagar
69.00	39.00	NA	59.00	54.15	13.92	41.83	NA	50.20	30.80	45.41	34	73	Bhawalpur
69.00	39.00	NA	59.00	54.15	39.80	51.37	NA	61.64	50.14	49.05	19	41	Chakwal
69.00	39.00	NA	59.00	54.15	30.94	42.61	NA	51.13	40.70	46.55	29	65	Chinot
69.00	39.00	NA	59.00	54.15	28.79	34.70	NA	41.64	34.65	46.19	32	68	Dera Ghazi Khan
69.00	39.00	NA	59.00	54.15	65.73	50.72	NA	60.86	58.76	54.56	5	11	Faisalabad
69.00	39.00	NA	59.00	54.15	48.06	49.88	NA	59.85	52.35	52.63	9	15	Gujaranwala
69.00	39.00	NA	59.00	54.15	61.31	51.56	NA	61.87	58.05	52.71	8	14	Gujrat
69.00	39.00	NA	59.00	54.15	33.81	45.73	NA	54.87	43.94	49.75	17	34	Hafizabad
69.00	39.00	NA	59.00	54.15	30.54	44.23	NA	53.08	41.54	47.09	28	61	Jhang
69.00	39.00	NA	59.00	54.15	46.10	53.77	NA	64.52	54.28	55.11	3	9	Jhelum
69.00	39.00	NA	59.00	54.15	31.56	46.31	NA	55.57	43.30	49.00	20	42	Kasur
69.00	39.00	NA	59.00	54.15	22.02	45.34	NA	54.40	37.87	47.85	27	54	Khanewal
69.00	39.00	NA	59.00	54.15	41.60	45.79	NA	54.95	47.13	50.38	13	28	Khushab
69.00	39.00	NA	59.00	54.15	135.01	56.88	NA	68.25	80.63	59.50	1	2	Lahore
69.00	39.00	NA	59.00	54.15	37.62	47.28	NA	56.74	46.56	48.69	22	45	Layyah
69.00	39.00	NA	59.00	54.15	34.90	42.74	NA	51.29	42.45	47.96	26	52	Lodhran
69.00	39.00	NA	59.00	54.15	33.06	46.44	NA	55.72	44.06	51.62	10	19	M. Bahauddin
69.00	39.00	NA	59.00	54.15	40.72	41.83	NA	50.20	44.06	48.21	25	50	Mianwali
69.00	39.00	NA	59.00	54.15	75.04	46.57	NA	55.88	58.02	55.04	4	10	Multan
69.00	39.00	NA	59.00	54.15	20.52	37.88	NA	45.45	32.81	43.37	35	81	Muzzafargarh
69.00	39.00	NA	59.00	54.15	30.89	48.00	NA	57.59	44.03	49.85	16	33	Nankana Sahib
69.00	39.00	NA	59.00	54.15	38.33	48.51	NA	58.21	47.66	50.57	12	25	Narowal
69.00	39.00	NA	59.00	54.15	31.10	45.73	NA	54.87	42.73	48.83	21	43	Okara Distrct
69.00	39.00	NA	59.00	54.15	22.37	42.81	NA	51.37	36.64	46.06	33	69	Pakpattan
69.00	39.00	NA	59.00	54.15	34.98	40.54	NA	48.64	41.01	46.27	31	67	Rahim Yar Khan
69.00	39.00	NA	59.00	54.15	19.32	32.82	NA	39.38	29.23	41.25	36	91	Rajanpur
69.00	39.00	NA	59.00	54.15	81.77	56.49	NA	67.79	67.91	56.72	2	5	Rawalpindi
69.00	39.00	NA	59.00	54.15	42.66	46.05	NA	55.26	47.70	50.80	11	24	Sahiwal
69.00	39.00	NA	59.00	54.15	67.68	47.22	NA	56.66	56.57	54.17	6	12	Sargodha
69.00	39.00	NA	59.00	54.15	33.75	47.87	NA	57.44	45.27	49.54	18	36	Sheikhupura
69.00	39.00	NA	59.00	54.15	63.12	54.09	NA	64.91	60.52	53.15	7	13	Sialkot
69.00	39.00	NA	59.00	54.15	28.59	49.49	NA	59.38	43.80	50.05	15	32	Toba Tek Singh
69.00	39.00	NA	59.00	54.15	34.06	42.48	NA	50.98	41.94	48.58	23	47	Vehari
69.00	**39.00**	NA	59.00	**54.15**	**53.72**	**47.36**	NA	**56.90**	**52.51**	**52.05**			**Punjab**
69.00	39.00	NA	59.00	54.15	14.19	39.51	NA	32.06	26.20	36.41	24	107	Badin
69.00	39.00	NA	59.00	54.15	16.84	60.61	NA	49.19	36.89	42.53	15	84	Dadu
69.00	39.00	NA	59.00	54.15	22.42	49.30	NA	40.00	35.36	41.52	17	90	Ghotki
69.00	39.00	NA	59.00	54.15	96.41	68.67	NA	55.72	71.72	56.46	2	6	Hyderabad
69.00	39.00	NA	59.00	54.15	32.32	42.20	NA	34.24	36.01	42.21	16	86	Jacobabad
69.00	39.00	NA	59.00	54.15	31.95	54.86	NA	44.52	42.73	45.61	11	71	Jamshoro
69.00	39.00	NA	59.00	54.15	10.77	43.73	NA	35.49	25.57	37.58	23	106	K Shadad Kot
69.00	39.00	NA	59.00	54.15	52.45	81.91	NA	66.46	65.85	55.63	3	8	Karachi Central
69.00	39.00	NA	59.00	54.15	39.31	81.91	NA	66.46	59.81	50.21	6	31	Karachi East
69.00	39.00	NA	59.00	54.15	205.53	81.91	NA	66.46	103.81	63.31	1	1	Karachi South
69.00	39.00	NA	59.00	54.15	28.41	81.91	NA	66.46	53.68	46.55	9	64	Karachi West
69.00	39.00	NA	59.00	54.15	6.87	45.17	NA	36.66	22.49	29.94	28	121	Kashmor

UHC Service Coverage Index at District Level (2020)

District/ Province/Area	Population	National UHC Index Ranking	Provincial UHC Index Ranking	FP demand satisfied with modern method (%)	ANC – 4+ visits (%)	Child immunization (Penta 3) (%)	Care-seeking behavior for child pneumonia (%)	RMNCH Score	TB effective treatment (%)	HIV treatment (%)	Insecticide-treated nets for malaria prevention (%)	At least basic sanitation (%)	Infectious Diseases Score
Khairpur	2,558,804	75	12	49.70	44.90	84.50	69.10	60.08	48.57	10.45	NA	51.90	29.75
Korangi	2,619,698	55	7	44.70	78.60	84.00	76.60	68.95	39.73	10.45	NA	100.00	34.63
Larkana	1,617,633	20	4	52.60	44.70	72.40	59.90	56.51	56.40	10.45	NA	78.00	35.82
Malir	2,224,696	70	10	60.90	64.20	71.00	66.00	65.42	31.07	10.45	NA	97.60	31.64
Matiari	818,993	83	14	46.60	52.90	70.60	70.60	59.21	36.70	10.45	NA	60.50	28.52
Mirpur Khas	1,614,470	96	20	32.60	28.40	78.20	74.70	48.22	55.28	10.45	NA	47.10	30.08
Naushero Feroz	1,704,690	76	13	42.40	42.90	72.20	77.70	56.52	42.04	10.45	NA	89.50	34.00
Sanghar	2,190,369	95	19	49.80	21.60	63.40	79.30	48.22	50.33	10.45	NA	52.30	30.19
S. Benazirabad	1,702,042	58	8	44.90	35.10	73.70	88.90	56.69	61.47	10.45	NA	56.90	33.19
Shikkarpur	1,291,366	93	18	39.10	24.90	68.40	57.00	44.14	38.85	10.45	NA	58.30	28.71
Sujawal	829,797	116	27	31.70	29.80	36.90	59.10	37.89	33.74	10.45	NA	33.90	22.86
Sukkar	1,589,759	26	5	51.60	54.10	63.80	75.50	60.56	63.46	10.45	NA	76.20	36.97
Tando Allahyar	901,724	98	21	38.10	44.20	77.30	63.80	53.68	24.80	10.45	NA	59.90	24.95
TM Khan	720,168	109	25	29.30	41.40	77.70	48.30	46.19	38.91	10.45	NA	48.90	27.09
Tharparkar	1,793,364	124	29	13.10	19.30	64.60	83.90	34.21	28.11	10.45	NA	21.10	18.37
Thatta	1,050,199	105	22	44.20	46.60	84.80	100.00	64.65	19.44	10.45	NA	50.20	21.69
Umer Kot	1,148,420	113	26	33.20	6.30	74.20	83.90	33.78	87.53	10.45	NA	33.00	31.14
Sindh	**51,056,575**			**50.20**	**54.10**	**73.20**	**85.40**	**64.19**	**43.53**	**10.45**	NA	**76.00**	**32.58**
Abbotabad	1,414,900	4	2	54.65	60.00	92.10	67.60	67.22	35.54	22.71	NA	96.20	42.66
Bajour District	1,194,014	92	22	49.55	26.30	64.30	69.50	49.13	16.25	22.71	NA	45.50	25.61
Bannu	1,310,521	62	14	44.02	26.30	52.30	69.50	45.29	48.47	22.71	NA	74.50	43.45
Batagram	507,698	78	18	36.27	27.70	53.90	53.80	41.31	47.71	22.71	NA	79.30	44.13
Buner	974,430	80	19	37.92	44.30	69.70	85.70	56.28	28.00	22.71	NA	67.00	34.93
Charsadda	1,726,696	72	16	47.83	39.10	76.70	59.60	54.07	22.98	22.71	NA	89.70	36.04
Chitral	469,795	23	6	48.40	48.20	96.50	47.20	57.10	34.24	22.71	NA	96.40	42.17
Dera Ismail Khan	1,861,115	88	21	35.62	17.30	61.00	65.60	39.63	35.54	22.71	NA	83.80	40.75
Hangu	557,543	53	12	42.66	47.70	53.80	71.70	52.93	57.66	22.71	NA	95.60	50.02
Haripur	1,058,163	18	4	52.57	50.10	94.20	65.50	63.49	23.83	22.71	NA	93.90	37.04
Karak	758,438	37	8	44.17	50.40	55.10	52.20	50.30	48.72	22.71	NA	92.10	46.71
Khyber District	1,074,649	108	26	15.51	46.30	73.00	70.10	43.78	27.05	22.71	NA	66.20	34.39
Kohat	1,207,407	40	9	46.68	46.30	76.00	70.10	58.25	42.41	22.71	NA	88.00	43.93
Kohistan	844,218	144	32	16.45	2.00	40.20	35.60	14.73	25.72	22.71	NA	61.40	32.98
Kurram District	649,043	112	27	15.51	46.30	65.00	70.10	42.53	14.49	22.71	NA	65.90	27.89
Lakki Marwat	981,408	85	20	41.44	16.60	32.30	51.90	32.77	55.87	22.71	NA	85.10	47.62
Lower Dir	1,586,913	63	15	43.09	59.30	80.40	45.30	55.23	26.84	22.71	NA	84.00	37.13
Malakand	770,160	21	5	49.55	42.30	84.70	59.30	56.96	41.34	22.71	NA	93.90	44.51
Mansehra	1,664,212	51	11	48.55	38.30	83.90	63.20	56.04	29.04	22.71	NA	90.90	39.14
Mardan	2,544,833	46	10	50.49	50.10	72.30	53.30	55.88	30.10	22.71	NA	90.80	39.59
Mohmand District	490,004	118	29	15.51	61.50	55.30	62.30	42.58	16.59	22.71	NA	32.20	22.98
North Waziristan	576,205	115	28	15.51	26.30	26.30	69.50	29.39	30.85	22.71	NA	56.60	34.10
Nowshera	1,644,204	30	7	50.06	62.80	86.20	60.50	63.63	28.09	22.71	NA	92.60	38.95
Orakzai District	258,843	100	24	15.51	46.30	59.10	70.10	41.53	49.53	22.71	NA	79.70	44.76
Peshawar	4,825,129	3	1	54.29	61.50	77.30	62.30	63.32	63.37	22.71	NA	94.60	51.44
Shangla	820,959	74	17	31.46	42.30	81.80	59.30	50.40	50.54	22.71	NA	72.60	43.68
S Waziristan	725,426	127	30	15.51	17.30	4.80	65.60	17.05	16.44	22.71	NA	50.20	26.57
Swabi	1,735,690	56	13	46.97	50.60	81.00	66.90	59.91	21.74	22.71	NA	94.20	35.96
Swat	2,520,770	16	3	44.38	57.80	92.40	57.50	60.76	38.56	22.71	NA	89.60	42.81
Tank	460,135	99	23	32.96	11.40	61.60	50.10	32.82	48.25	22.71	NA	74.50	43.38

Normal blood pressure	Normal blood sugar	Cervical cancer screening among women 30-49 years (%)	Tobacco non-smoking	Non-Communicable Diseases Score	Hospital beds per 10,000 population	(Physicians *Psychiatrist*Surgeon) density against threshold (%)	Availability of essential medicines in PHC (%)	International Health Regulations core capacity index (%)	Services Access & Capacity Score	UHC Index 2020	Provincial UHC Index Ranking	National UHC Index Ranking	District/ Province/Area
69.00	39.00	NA	59.00	54.15	34.22	53.32	NA	43.27	42.90	45.14	12	75	Khairpur
69.00	39.00	NA	59.00	54.15	11.62	81.91	NA	66.46	39.85	47.64	7	55	Korangi
69.00	39.00	NA	59.00	54.15	85.58	59.27	NA	48.10	62.49	51.16	4	20	Larkana
69.00	39.00	NA	59.00	54.15	11.31	81.91	NA	66.46	39.49	45.87	10	70	Malir
69.00	39.00	NA	59.00	54.15	19.88	54.57	NA	44.28	36.35	42.70	14	83	Matiari
69.00	39.00	NA	59.00	54.15	24.81	41.24	NA	33.47	32.47	39.96	20	96	Mirpur Khas
69.00	39.00	NA	59.00	54.15	18.93	63.78	NA	51.75	39.69	45.08	13	76	Naushero Feroz
69.00	39.00	NA	59.00	54.15	22.98	47.09	NA	38.21	34.58	40.63	19	95	Sanghar
69.00	39.00	NA	59.00	54.15	50.20	54.86	NA	44.52	49.68	47.43	8	58	S. Benazirabad
69.00	39.00	NA	59.00	54.15	35.97	49.87	NA	40.47	41.71	41.13	18	93	Shikkarpur
69.00	39.00	NA	59.00	54.15	23.37	31.27	NA	25.37	26.46	33.38	27	116	Sujawal
69.00	39.00	NA	59.00	54.15	47.35	63.20	NA	51.29	53.54	50.47	5	26	Sukkar
69.00	39.00	NA	59.00	54.15	20.08	50.64	NA	41.09	34.70	39.83	21	98	Tando Allahyar
69.00	39.00	NA	59.00	54.15	13.27	36.16	NA	29.34	24.15	35.76	25	109	TM Khan
69.00	39.00	NA	59.00	54.15	15.89	21.77	NA	17.67	18.28	28.09	29	124	Tharparkar
69.00	39.00	NA	59.00	54.15	22.54	36.16	NA	29.34	28.81	38.46	22	105	Thatta
69.00	39.00	NA	59.00	54.15	16.93	30.88	NA	25.06	23.58	34.04	26	113	Umer Kot
69.00	39.00	NA	59.00	54.15	**39.28**	**61.33**	NA	**49.80**	**49.32**	**48.61**			**Sindh**
69.00	39.00	NA	59.00	54.15	126.98	55.57	NA	59.23	74.77	58.37	2	4	Abbotabad
69.00	39.00	NA	59.00	54.15	27.73	50.39	NA	53.70	42.18	41.17	22	92	Bajour District
69.00	39.00	NA	59.00	54.15	43.07	44.77	NA	47.71	45.14	46.83	14	62	Bannu
69.00	39.00	NA	59.00	54.15	33.48	36.88	NA	39.30	36.48	43.56	18	78	Batagram
69.00	39.00	NA	59.00	54.15	23.89	38.56	NA	41.09	33.58	43.48	19	80	Buner
69.00	39.00	NA	59.00	54.15	26.87	48.64	NA	51.83	40.76	45.54	16	72	Charsadda
69.00	39.00	NA	59.00	54.15	51.91	49.22	NA	52.46	51.18	50.82	6	23	Chitral
69.00	39.00	NA	59.00	54.15	32.18	36.22	NA	38.60	35.57	41.99	21	88	Dera Ismail Khan
69.00	39.00	NA	59.00	54.15	24.41	43.38	NA	46.23	36.58	47.86	12	53	Hangu
69.00	39.00	NA	59.00	54.15	62.37	53.46	NA	56.97	57.48	52.01	4	18	Haripur
69.00	39.00	NA	59.00	54.15	47.69	44.91	NA	47.86	46.80	49.40	8	37	Karak
69.00	39.00	NA	59.00	54.15	32.05	15.77	NA	16.81	20.41	35.91	26	108	Khyber District
69.00	39.00	NA	59.00	54.15	30.87	47.47	NA	50.59	42.01	49.12	9	40	Kohat
69.00	39.00	NA	59.00	54.15	2.37	16.72	NA	17.82	8.90	22.00	32	144	Kohistan
69.00	39.00	NA	59.00	54.15	38.35	15.77	NA	16.81	21.66	34.34	27	112	Kurram District
69.00	39.00	NA	59.00	54.15	30.40	42.14	NA	44.91	38.60	42.50	20	85	Lakki Marwat
69.00	39.00	NA	59.00	54.15	38.05	43.82	NA	46.70	42.70	46.66	15	63	Lower Dir
69.00	39.00	NA	59.00	54.15	44.15	50.39	NA	53.70	49.25	50.99	5	21	Malakand
69.00	39.00	NA	59.00	54.15	35.59	49.37	NA	52.61	45.21	48.14	11	51	Mansehra
69.00	39.00	NA	59.00	54.15	36.33	51.34	NA	54.71	46.73	48.64	10	46	Mardan
69.00	39.00	NA	59.00	54.15	26.08	15.77	NA	16.81	19.05	31.70	29	118	Mohmand District
69.00	39.00	NA	59.00	54.15	47.24	15.77	NA	16.81	23.23	33.50	28	115	North Waziristan
69.00	39.00	NA	59.00	54.15	38.99	50.90	NA	54.25	47.57	50.27	7	30	Nowshera
69.00	39.00	NA	59.00	54.15	53.66	15.77	NA	16.81	24.23	39.52	24	100	Orakzai District
69.00	39.00	NA	59.00	54.15	104.40	55.21	NA	58.84	69.73	59.22	1	3	Peshawar
69.00	39.00	NA	59.00	54.15	40.81	31.99	NA	34.09	35.43	45.34	17	74	Shangla
69.00	39.00	NA	59.00	54.15	38.06	15.77	NA	16.81	21.61	26.98	30	127	S Waziristan
69.00	39.00	NA	59.00	54.15	34.70	47.76	NA	50.90	43.85	47.56	13	56	Swabi
69.00	39.00	NA	59.00	54.15	66.16	45.13	NA	48.10	52.37	52.11	3	16	Swat
69.00	39.00	NA	59.00	54.15	27.53	33.52	NA	35.72	32.06	39.65	23	99	Tank

UHC Service Coverage Index at District Level (2020)

District/ Province/Area	Population	National UHC Index Ranking	Provincial UHC Index Ranking	FP demand satisfied with modern method (%)	ANC – 4+ visits (%)	Child immunization (Penta 3) (%)	Care-seeking behavior for child pneumonia (%)	RMNCH Score	TB effective treatment (%)	HIV treatment (%)	Insecticide-treated nets for malaria prevention (%)	At least basic sanitation (%)	Infectious Diseases Score
Torghar	170,926	134	31	17.24	11.40	46.10	48.40	25.73	25.72	22.71	NA	51.50	31.10
Upper Dir	1,016,558	103	25	26.93	39.10	56.30	51.80	41.86	19.97	22.71	NA	88.40	34.23
Khyber Pakhtunkhwa	**38,338,040**			**45.10**	**44.60**	**74.30**	**84.30**	**59.58**	**38.20**	**22.71**	**NA**	**84.00**	**41.77**
Awaran	122,188	149	31	13.89	7.50	45.40	53.20	22.40	26.44	17.10	NA	2.52	10.45
Barkhan	184,695	150	32	19.03	2.20	52.90	39.40	17.19	7.16	17.10	NA	22.70	14.06
Chaghi	252,937	141	24	16.86	16.70	41.40	40.10	26.15	8.05	17.10	NA	12.20	11.89
Dera Bhugti	338,464	142	25	21.76	12.30	8.80	63.20	19.64	6.03	17.10	NA	24.00	13.53
Duki	252,176	122	8	30.59	2.20	29.90	39.40	16.78	13.97	17.10	NA	89.90	27.79
Gwadar	277,363	120	7	35.57	11.80	63.60	63.60	36.10	7.02	17.10	NA	62.10	19.54
Harnai	100,397	145	27	14.77	12.30	89.90	63.20	31.88	3.16	17.10	NA	12.30	8.72
Jaffarabad	558,127	110	2	27.70	11.40	52.60	84.30	34.40	54.82	17.10	NA	55.80	37.40
Jhal Magsi	156,041	135	18	14.69	11.40	15.80	84.30	21.73	117.91	17.10	NA	12.20	29.08
Kachhi	243,071	133	17	27.70	11.40	11.50	84.30	23.52	13.97	17.10	NA	13.80	14.88
Kalat	446,697	151	33	32.52	7.50	33.10	53.20	25.60	2.23	17.10	NA	1.64	3.97
Kech	1,020,162	125	10	33.56	11.80	62.50	63.60	35.42	9.07	17.10	NA	15.50	13.39
Kharan	167,429	138	21	23.28	7.50	78.00	53.20	29.18	18.15	17.10	NA	2.29	8.92
Khuzdar	882,507	148	30	33.08	7.50	16.80	53.20	21.70	13.44	17.10	NA	0.92	5.96
Killa Abdullah	844,220	137	20	19.11	16.70	57.60	40.10	29.30	18.29	17.10	NA	35.50	22.31
Killa Saifullah	372,682	136	19	33.88	2.20	25.20	39.40	16.49	48.54	17.10	NA	9.30	19.76
Kohlu	239,633	126	11	21.44	12.30	56.90	63.20	31.20	7.22	17.10	NA	94.20	22.66
Lasbela	627,538	117	5	33.40	7.50	48.20	53.20	28.31	23.15	17.10	NA	63.70	29.33
Lehri	123,100	123	9	35.40	12.30	21.40	63.20	27.70	4.66	17.10	NA	72.80	17.97
Loralai	425,176	119	6	30.59	2.20	26.90	39.40	16.34	38.53	17.10	NA	72.80	36.33
Musakhel	172,456	143	26	29.54	2.20	13.50	39.40	13.64	4.18	17.10	NA	72.80	17.33
Mustang	289,599	128	12	36.85	7.50	9.60	53.20	19.38	13.94	17.10	NA	29.60	19.18
Nasirabad	542,549	130	14	24.97	11.40	28.30	84.30	28.71	29.97	17.10	NA	54.10	30.27
Nushki	195,215	129	13	35.41	16.70	9.80	40.10	21.96	25.18	17.10	NA	7.02	14.46
Panjgur	330,654	131	15	35.56	11.80	68.80	63.60	36.81	7.34	17.10	NA	12.20	11.52
Pishin	812,165	114	4	38.70	16.70	55.40	40.10	34.61	27.01	17.10	NA	65.20	31.11
Quetta	2,664,439	77	1	53.31	16.70	43.10	40.10	35.22	30.95	17.10	NA	75.20	34.14
Sherani	167,809	140	23	23.68	2.20	22.70	39.40	14.69	16.14	17.10	NA	20.60	17.85
Sibi	140,951	111	3	35.41	12.30	21.40	63.20	27.70	33.75	17.10	NA	34.60	27.13
Sohbatput	211,020	139	22	24.96	11.40	63.10	84.30	35.08	8.02	17.10	NA	36.00	17.03
Washuk	188,726	147	29	15.09	7.50	86.60	53.20	26.87	11.22	17.10	NA	12.20	13.28
Zhob	332,791	132	16	23.68	2.20	28.80	39.40	15.59	49.62	17.10	NA	20.60	25.95
Ziarat	177,336	146	28	24.17	12.30	33.30	63.20	28.12	8.56	17.10	NA	5.23	9.15
Balochistan	**13,536,269**			**33.80**	**23.10**	**42.20**	**62.20**	**37.84**	**22.45**	**17.10**	NA	**44.00**	**25.66**
Bagh	396,427	17	1	38.50	38.70	96.30	72.30	56.75	60.29	12.54	NA	83.00	39.74
Bhimber	-	22	2	38.50	38.70	98.30	72.30	57.04	44.60	12.54	NA	83.00	35.94
Hattian Bala	245,720	27	3	38.50	38.70	91.00	72.30	55.95	42.22	12.54	NA	83.00	35.29
Haveli	251,816	35	4	38.50	38.70	92.20	72.30	56.14	34.47	12.54	NA	83.00	32.98
Kotli	914,878	39	6	38.50	38.70	97.20	72.30	56.88	30.23	12.54	NA	83.00	31.57
Mirpur	575,930	44	7	38.50	38.70	97.80	72.30	56.97	27.18	12.54	NA	83.00	30.47
Muzaffarabad	782,895	38	5	38.50	38.70	93.10	72.30	56.27	31.43	12.54	NA	83.00	31.98
Neelum	203,858	48	8	38.50	38.70	87.20	72.30	55.36	27.16	12.54	NA	83.00	30.46
Poonch	533,557	57	9	38.50	38.70	95.50	72.30	56.63	20.04	12.54	NA	83.00	27.53
Sudhnoti	406,861	59	10	38.50	38.70	98.00	72.30	57.00	18.82	12.54	NA	83.00	26.96
Azad Jammu and Kashmir	**4,311,942**			**38.50**	**46.50**	**95.40**	**80.80**	**60.95**	**32.90**	**12.54**	**NA**	**83.00**	**32.47**

Normal blood pressure	Normal blood sugar	Cervical cancer screening among women 30-49 years (%)	Tobacco non-smoking	Non-Communicable Diseases Score	Hospital beds per 10,000 population	(Physicians* Psychiatrist *Surgeon) density against threshold (%)	Availability of essential medicines in PHC (%)	International Health Regulations core capacity index (%)	Services Access & Capacity Score	UHC Index 2020	Provincial UHC Index Ranking	National UHC Index Ranking	District/ Province/Area
69.00	39.00	NA	59.00	54.15	2.37	17.53	NA	18.68	9.19	25.12	31	133	Torghar
69.00	39.00	NA	59.00	54.15	31.04	27.39	NA	29.19	29.17	38.78	25	102	Upper Dir
69.00	39.00	NA	59.00	54.15	**49.17**	**45.67**	NA	**48.80**	**47.85**	**50.39**			**Khyber Pakhtunkhwa**
69.00	39.00	NA	59.00	54.15	6.37	12.73	NA	13.46	10.30	19.00	31	149	Awaran
69.00	39.00	NA	59.00	54.15	3.01	17.45	NA	18.44	9.89	18.97	32	150	Bolan
69.00	39.00	NA	59.00	54.15	17.57	15.46	NA	16.34	16.43	22.93	24	141	Barkhan
69.00	39.00	NA	59.00	54.15	14.12	19.95	NA	21.09	18.11	22.59	25	142	Chaghi
69.00	39.00	NA	59.00	54.15	30.05	28.04	NA	29.65	29.24	29.31	8	122	Dera Bhugti
69.00	39.00	NA	59.00	54.15	12.62	32.61	NA	34.48	24.21	31.01	7	120	Gwadar
69.00	39.00	NA	59.00	54.15	16.60	13.54	NA	14.32	14.77	21.72	27	145	Harnai
69.00	39.00	NA	59.00	54.15	18.91	25.39	NA	26.85	23.45	35.75	2	110	Jaffarabad
69.00	39.00	NA	59.00	54.15	7.83	13.47	NA	14.24	11.45	25.02	18	135	Jhal Magsi
69.00	39.00	NA	59.00	54.15	17.37	25.39	NA	26.85	22.79	25.64	17	133	Kachhi
69.00	39.00	NA	59.00	54.15	11.19	29.81	NA	31.52	21.91	18.63	33	151	Kalat
69.00	39.00	NA	59.00	54.15	12.47	32.61	NA	34.48	24.11	28.06	10	125	Kech
69.00	39.00	NA	59.00	54.15	31.52	21.35	NA	22.57	24.76	24.31	21	138	Kharan
69.00	39.00	NA	59.00	54.15	14.16	30.33	NA	32.06	23.97	20.24	30	148	Khuzdar
69.00	39.00	NA	59.00	54.15	3.55	17.52	NA	18.52	10.49	24.68	20	137	Killa Abdullah
69.00	39.00	NA	59.00	54.15	10.43	31.06	NA	32.84	22.00	24.96	19	136	Killa Saifullah
69.00	39.00	NA	59.00	54.15	8.11	19.65	NA	20.78	14.91	27.49	11	126	Kohlu
69.00	39.00	NA	59.00	54.15	17.35	30.62	NA	32.38	25.81	32.82	5	117	Lasbela
69.00	39.00	NA	59.00	54.15	11.73	32.46	NA	34.32	23.56	28.23	9	123	Lehri
69.00	39.00	NA	59.00	54.15	30.05	28.04	NA	29.65	29.24	31.14	6	119	Loralai
69.00	39.00	NA	59.00	54.15	8.05	27.09	NA	28.64	18.42	22.03	26	143	Musakhel
69.00	39.00	NA	59.00	54.15	13.43	33.79	NA	35.72	25.31	26.72	12	128	Mustang
69.00	39.00	NA	59.00	54.15	2.05	22.89	NA	24.20	10.43	26.47	14	130	Nasirabad
69.00	39.00	NA	59.00	54.15	21.34	32.46	NA	34.32	28.76	26.52	13	129	Nushki
69.00	39.00	NA	59.00	54.15	19.83	13.84	NA	34.48	21.15	26.40	15	131	Panjgur
69.00	39.00	NA	59.00	54.15	7.93	35.48	NA	37.51	21.94	33.63	4	114	Pishin
69.00	39.00	NA	59.00	54.15	77.13	48.88	NA	51.68	57.97	44.08	1	77	Quetta
69.00	39.00	NA	59.00	54.15	17.36	21.71	NA	22.96	20.53	23.24	23	140	Sherani
69.00	39.00	NA	59.00	54.15	39.41	32.46	NA	34.32	35.28	34.62	3	111	Sibi
69.00	39.00	NA	59.00	54.15	2.05	22.89	NA	24.20	10.43	24.10	22	139	Sohbatpur
69.00	39.00	NA	59.00	54.15	7.06	13.84	NA	14.63	11.27	21.60	29	147	Washuk
69.00	39.00	NA	59.00	54.15	17.36	21.71	NA	22.96	20.53	25.90	16	132	Zhob
69.00	39.00	NA	59.00	54.15	7.52	22.16	NA	23.43	15.74	21.64	28	146	Ziarat
69.00	39.00	NA	59.00	54.15	**25.00**	**31.08**	**NA**	**32.70**	**29.40**	**35.26**			**Balochistan**
69.00	39.00	NA	59.00	54.15	74.83	44.81	NA	57.10	57.64	52.10	1	17	Bagh
69.00	39.00	NA	59.00	54.15	74.83	44.81	NA	57.10	57.64	50.87	2	22	Bhimber
69.00	39.00	NA	59.00	54.15	74.83	44.81	NA	57.10	57.64	50.40	3	27	Hattian Bala
69.00	39.00	NA	59.00	54.15	74.83	44.81	NA	57.10	57.64	49.60	4	35	Haveli
69.00	39.00	NA	59.00	54.15	74.83	44.81	NA	57.10	57.64	49.22	6	39	Kotli
69.00	39.00	NA	59.00	54.15	74.83	44.81	NA	57.10	57.64	48.80	7	44	Mirpur
69.00	39.00	NA	59.00	54.15	74.83	44.81	NA	57.10	57.64	49.24	5	38	Muzaffarabad
69.00	39.00	NA	59.00	54.15	74.83	44.81	NA	57.10	57.64	48.45	8	48	Neelum
69.00	39.00	NA	59.00	54.15	74.83	44.81	NA	57.10	57.64	47.51	9	57	Poonch
69.00	39.00	NA	59.00	54.15	74.83	44.81	NA	57.10	57.64	47.34	10	59	Sudhnoti
69.00	39.00	NA	59.00	54.15	**74.83**	**44.81**	**NA**	**57.10**	**57.64**	**49.85**			**Azad Jammu and Kashmir**

UHC Service Coverage Index at District Level (2020)

District/ Province/Area	Population	National UHC Index Ranking	Provincial UHC Index Ranking	FP demand satisfied with modern method (%)	ANC – 4+ visits (%)	Child immunization (Penta 3) (%)	Care-seeking behavior for child pneumonia (%)	RMNCH Score	TB effective treatment (%)	HIV treatment (%)	Insecticide-treated nets for malaria prevention (%)	At least basic sanitation (%)	Infectious Diseases Score
Astore	97,591	87	4	46.40	14.50	69.60	51.40	39.39	62.45	12.54	NA	83.00	40.21
Diamer/Diarel/Tangir	305,069	97	7	46.40	5.20	39.50	46.30	25.77	117.11	12.54	NA	83.00	49.58
Ghanche	178,846	102	9	46.40	11.70	98.30	72.60	44.37	17.21	12.54	NA	83.00	26.16
Ghizer/ Gupis Yasin	254,568	79	2	46.40	68.30	96.00	79.10	70.04	16.55	12.54	NA	83.00	25.83
Gilgit	235,762	60	1	46.40	53.60	79.10	72.30	61.41	65.02	12.54	NA	83.00	40.75
Hunza	74,613	89	5	46.40	92.20	98.10	87.20	77.78	7.71	12.54	NA	83.00	20.02
Kharmang	100,402	94	6	46.40	8.50	95.00	75.20	40.97	37.02	12.54	NA	83.00	33.78
Nagar	74,613	104	10	46.40	30.10	96.90	79.30	57.24	7.51	12.54	NA	83.00	19.85
Shigar	182,492	101	8	46.40	11.00	99.20	69.50	43.31	20.21	12.54	NA	83.00	27.60
Skardu/Roundu	507,856	82	3	46.40	24.80	99.20	56.10	50.30	37.02	12.54	NA	83.00	33.78
Gilgit Baltistan	**2,011,813**			**46.40**	**34.90**	**82.20**	**76.30**	**56.45**	**49.66**	**12.54**	**NA**	**83.00**	**37.25**
Islamabad Capital Territory	**2,300,366**	7	1	**55.10**	**80.20**	**86.30**	**83.60**	**75.14**	**12.60**	**12.54**	**NA**	**99.00**	**25.01**

Methodology Used for District level estimation of UHC Service Coverage Index

Methodology used for estimation is on the approach described in the 2017-Global UHC Monitoring Report (World Bank and WHO). The primary data sources used for indicators of service coverage include Pakistan Demographic & Health Survey (PDHS), Pakistan Social & Living Standards Measurement Surveys, Multiple Indicator Cluster Surveys, National and Provincial Bureau of statistics reports, JEE Report 2016, WHO Global Monitoring Reports and administrative data of the Ministry and Departments of Health.

A. Reproductive, maternal, new-born and child health (RMNCH)/ Age related cluster

1: Family Planning demand satisfied with modern method (%)- The data source used for 2015 and 2016 is PDHS 2012-13 and from 2017 to 2020, PDHS 2017-18 is used. The district level information is referenced from the respective provincial Multiple Indicator Cluster Surveys. However, for KP and Balochistan, the data is estimated using human development index as weightage. In case of AJK and GB, PDHS 2017-18 data is replicated at the district level.

2: Antenatal Care – 4+ visits (%)- At the National and provincial level, the data is referenced from Pakistan demographic and Health surveys. At the district level, Punjab-MICS 2014 is used for the year 2015 and 2016, and MICS 2017-18 is used from 2017-2020, Sindh-MICS 2014 is used for 2015 to 2019 and MICS 2018-19 for the year 2020. However, Khyber Pakhtunkhwa MICS 2016-17 is used from the years 2015 to 2020. For Balochistan, MICS 2010 is used for 2015-2020. AJK DHS 2010 is used for the year 2015 and 2016. However, for the year 2017-2020, PDHS 2017-18 is used. GB MICS 2016-17 used for all the years (2015-2020)

3: Child immunization (Penta 3) (%)- At the National and provincial level, the data is referenced from Pakistan demographic and Health surveys from the years 2015-2019, However, for the year 2020, EPI third Party evaluation survey 2020 is referenced at the national, provincial and the district level. Punjab MICS 2014 is used for the year 2015 and 2016, and MICS 2017-18 for the years 2017 to 2019. Sindh MICS 2014 is used for the years 2015- 2019. For Khyber Pakhtunkhwa, PSLM 2014-15 is used for the year 2015 and MICS 2016-17 is used for the years 2016-2019. For Balochistan, PSLM 2014-2015 is considered from 2015 to 2019. AJK DHS 2010 is used for 2015 & 2016 and PDHS 2017-18 from 2017 to 2019. GB MICS 2016-17 used for the years 2015-2019.

4: Care-seeking behaviour for child pneumonia (%)- Pakistan demographic and health survey is referenced at the national and the provincial level for the years 2015-2020.For Punjab, the district level information for the year 2015 and 2016 is calculated based on PDHS 2012-13 provincial information and weightage of district human development index. However, from the years 2017 to 2020, Punjab MICS 2017-18 is used. Sindh MICS 2014 is used for the years 2015-2019.For the year 2020, MICS 2018-19 is referenced. Khyber Pakhtunkhwa MICS 2016-17 is used from the years 2015 to 2020. For Balochistan, MICS 2010 is used as the referenced for 2015-2020. AJK

DHS 2010 is considered in 2015 and 2016 and from 2017 to 2020, PDHS 2017-18 is referenced and data is replicated at the district level. For Gilgit Baltistan, MICS 2016 is used for the years 2015-2020.

Normal blood pressure	Normal blood sugar	Cervical cancer screening among women 30-49 years (%)	Tobacco non-smoking	Non-Communicable Diseases Score	Hospital beds per 10,000 population	(Physicians* Psychiatrist* Surgeon) density against threshold (%)	Availability of essential medicines in PHC (%)	International Health Regulations core capacity index (%)	Services Access & Capacity Score	UHC Index 2020	Provincial UHC Index Ranking	National UHC Index Ranking	District/ Province/Area
69.00	39.00	NA	59.00	54.15	36.67	33.28	NA	40.70	36.76	42.14	4	87	Astore
69.00	39.00	NA	59.00	54.15	36.67	33.28	NA	40.70	36.76	39.94	7	97	Diamer/Diarel/Tangir
69.00	39.00	NA	59.00	54.15	36.67	33.28	NA	40.70	36.76	38.99	9	102	Ghanche
69.00	39.00	NA	59.00	54.15	36.67	33.28	NA	40.70	36.76	43.56	2	79	Ghizer/ Gupis Yasin
69.00	39.00	NA	59.00	54.15	36.67	33.28	NA	40.70	36.76	47.24	1	60	Gilgit
69.00	39.00	NA	59.00	54.15	36.67	33.28	NA	40.70	36.76	41.96	5	89	Hunza
69.00	39.00	NA	59.00	54.15	36.67	33.28	NA	40.70	36.76	40.74	6	94	Kharmang
69.00	39.00	NA	59.00	54.15	36.67	33.28	NA	40.70	36.76	38.78	10	104	Nagar
69.00	39.00	NA	59.00	54.15	36.67	33.28	NA	40.70	36.76	39.28	8	101	Shigar
69.00	39.00	NA	59.00	54.15	36.67	33.28	NA	40.70	36.76	42.88	3	82	Skardu/Roundu
69.00	39.00	NA	59.00	54.15	**36.67**	**33.28**	**NA**	**40.70**	**36.76**	**45.23**			**Gilgit Baltistan**
69.00	39.00	NA	59.00	54.15	**161.11**	**82.70**	**NA**	**68.00**	**96.76**	**56.02**	1	7	**Islamabad Capital Territory**

B. INFECTIOUS/ COMMUNICABLE DISEASES (CD)

1: Tuberculosis effective treatment (%)- It is calculated by considering two indicators; case detection rate and treatment success rate. The data is referenced from NTP TB (2015-20)

2: HIV treatment (%) – The data is provided by Nationals AIDS Control Program, considering estimates of people living with HIV in each province and then taking percentage of ART coverage. For AJK, GB and ICT, we assumed figures as their data is not separately mentioned but included in Punjab

3: Insecticide-treated nets for malaria prevention (%)- This indicator is not being used at international level

4: At least basic sanitation (%)- The data is taken from PSLM 2014-15 for 2015 to 2017 and PSLM 2018-19 for the years 2018 to 2020. For AJK & GB the data is not available and national figure is used.

C. NON-COMMUNICABLE DISEASES (NCD)

1: Prevalence of Normal blood pressure (%)- used data from WHO UHC Monitoring reports for Pakistan

2: Normal blood sugar (%)- used data from WHO UHC Monitoring reports for Pakistan

3: Cervical cancer screening among women 30-49 years (%)- This indicator is not being used at international level

4: Tobacco non-smoking (%)- used data from WHO UHC Monitoring reports for Pakistan

D. SERVICES ACCESS AND CAPACITY (SAC)

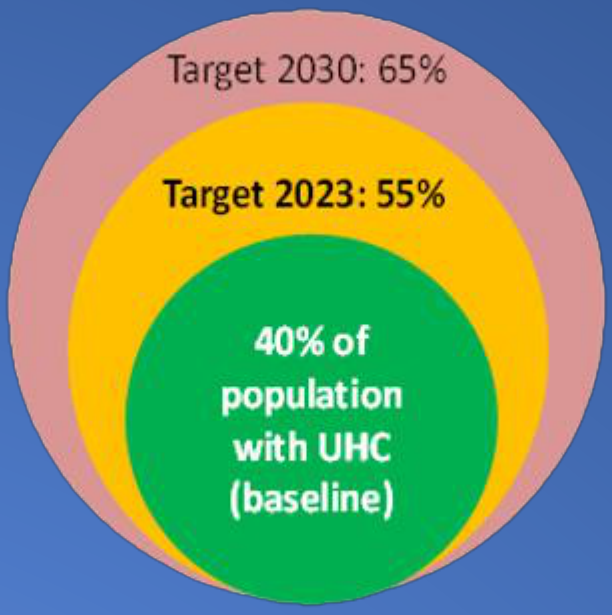
1: Hospital beds per 10,000 population against threshold (%)- For the year 2020, the hospital bed densities are calculated based on the data provided by the provincial/area health departments. The data included both the public and private hospital beds number at the provincial and the district level. For AJK and GB, beds densities are replicated at the district level. However, for the years 2015-2019, the hospital bed densities at the district level are calculated from provincial information using weightage of human development index from the year 2015-2019.For these years, provincial information is referenced from the Statistical Year book, whereas for Areas, reports of the respective Planning and Development department were used. For these years 2015-2019, data is only for public sector and private sector data is not available in all provinces/ areas.

2: (Physicians*Psychiatrist*Surgeon) density against threshold (%)-Data provided by Pakistan Medical Commission (PMC). For ICT, the densities of human resource were calculated based on ICT health facilities mapping data and subtract it from the Punjab data as ICT data provided by PMC was included in the Punjab data. For GB, PMC provided the figures with AJK, considered the HR percent distribution of 25% and 75% among GB and AJK respectively.

3: Availability of essential medicines in PHC (%)- This indicator is not being used at international level

4: International Health Regulations core capacity index (%)- the 13 Core capacities from JEE Report of 2016 were used and estimated the district level figures using weightage of HDI

PAKISTAN:
UHC Service Coverage Index Targets



GLOBAL:
UHC Service Coverage Index Target

80%+ by 2030

MOVING TOGETHER
TO BUILD A HEALTHIER PAKISTAN

UNIVERSAL HEALTH COVERAGE: EVERYONE, EVERYWHERE

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DCP3 Disease Control Priorities
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HPSIU Analyse | Strategize | Action
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**Ministry of National Health Services,
Regulations and Coordination**

Kohsar Block, Pak Secretariat, Islamabad.
Tel:051-9245576
website: www.nhsrc.gov.pk