Monitoring progress towards Universal Health Care District EPHS implementation

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Table of Contents

Introduction	1
Towards developing a comprehensive M&E framework for monitoring progress towards UHC implementation	3
Monitoring framework for District EPHS	9
Way forward	20
Annex - A: Summary report Zoom conference (February 23, 2021)	21
Annex - B: Summary report DCP3 UHC M&E Framework Workshop Pakistan (11 March 2021)	23
Annex - C: National Health Indicators and Targets on SDGs	27
Annex - D: Photo Gallery (Face to Face workshop March 11, 2021)	37

Introduction

Government of Pakistan committed to accelerate progress towards the health-related SDGs through its medium- and long-term health visions and related plans. Through these instruments, the government has reaffirmed its commitment to UHC and SDGs. Besides, Pakistan has adopted a people-centered approach to PHC as the cornerstone of its efforts to accelerate progress towards UHC and SDGs.

Following the recommendation of the Pakistani Inter-Ministerial Health and Population Forum in September 2018, Pakistan became the first country in the world to align its UHC Benefit Package with the DCP3 recommended high impact interventions. The package includes interventions selected for the community, Primary Health Care (PHC) and First Level Hospital (FLH). The selection criteria included the effectiveness, burden of disease, feasibility, cost-effectiveness, equity, budget impact, financial risk protection, and social and economic impact. By category, there are 42 interventions on RMNCH, 12 on Infectious Diseases, 13 on NCDs, and 21 on Health Services. By levels of the health system, there are 19, 32 and 37 interventions for the community, PHC and FLH levels, respectively.

DCP-3 has provided concrete set of priorities for universal health coverage (UHC), grounded in economic reality and intended to prove appropriate to the health needs and constraints of low- and middle-income countries (LMICs), by:

(1) developing a model benefits package referred to as essential UHC (EUHC)

(2) identifying a subset of interventions termed the highest-priority package (HPP); and

(3) presenting a case all countries—including low-income countries—could strive to fully implement the HPP interventions by the end of the Sustainable Development Goal (SDG) period (2030)

In November 2020, the National Advisory Committee (NAC) endorsed a package of 107 interventions for the district level UHC EPHS (Essential Package of Health Services) implementation in the long-term horizon. For immediate implementation and until the fiscal space is expanded to allow full implementation of the EPHS, the NAC recommended the endorsement of a more limited national generic package of 88 interventions for use as a model for provincial and district implementation. It is recommended that provinces adapt and tailor their package according to their disease burden, special needs and available resources. The NAC also endorsed its recommendation to the Government to conduct in collaboration with the relevant development partners, a fiscal space assessment, and consider an increase in the health allocation to accommodate the full implementation of the UHC EPHS.

The effective implementation of the district UHC EPHS will need greater provincial engagement, district leadership, inter-sectoral coordination, addressing health system bottlenecks and key implementation issues including strategic purchasing.

Multiple efforts are ongoing to define the implementation and M&E strategies for UHC implementation in Pakistan. The National Ministry of Health Services Regulation and Coordination (MHSR&C) has finalized the district EPHS package, developed a draft UHC investment case and has completed two rounds of provincial consultations for identifying health system strengthening priorities. The draft UHC investment case developed by UNICEF's support presents a theory of change and a suggested list of

indicators. World Bank has supported fiscal space analysis and a resource mapping exercise at the national and provincial/regional levels. MHSR&C and Health Services Academy (HSA) with support from the University of Manitoba have also recently completed a Health Report 2020 focusing on RMNCH issues. The report illustrates the need to use a holistic approach to measure effective coverage, inequalities, quality of care, resilience of health system in the wake of shocks such as Covid-19 pandemic and health and survival outcomes. Health Services Academy and the University of Manitoba team is also providing support for the baseline surveys and mapping of facility readiness using SARA approach in selected districts for implementation of the UHC EPHS.

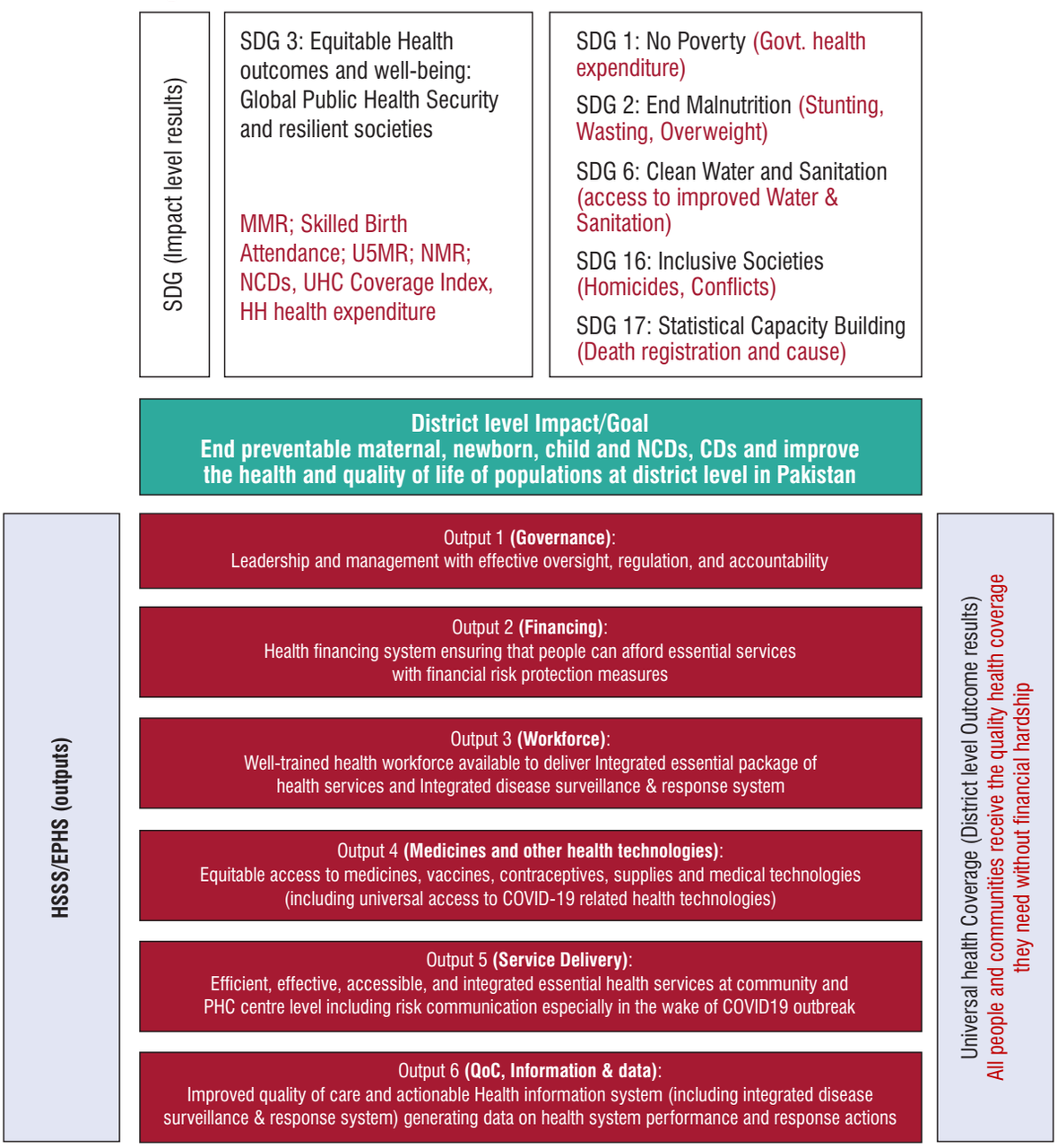
To embark upon development of a National M&E package, MHSR&C, DCP3 secretariat at WHO Geneva, Health Services Academy and the University of Manitoba partnered together to host a series of technical discussions. This report aims to present the key discussions and building blocks coming out of the technical discussions and expert consultations during February and March 2021. The report will also provide important recommendations while Pakistan is in the process of developing the National M&E framework, and monitoring of UHC indicators at the district level starting with 12 priority districts. Towards developing a comprehensive M&E framework for monitoring progress towards UHC implementation

Following the development of package of essential services, UHC investment case and province level adaptation that is currently underway, an M&E framework is needed to align with national, provincial and district priorities. The imperatives for a comprehensive M&E framework include its ability to report country's progress on global SDG-3 commitments for Universal Health Care; linkages with other SDGs particularly on reducing poverty, hunger and malnutrition and improving air quality. In Pakistan's context, it is important that this M&E framework aligns with the priorities defined in UHC investment case, measures the reduction in health system bottlenecks, tracks progress towards achieving the impact targets and assesses equitable effective coverage.

Towards developing a comprehensive M&E framework for monitoring progress towards UHC implementation

Following the development of package of essential services, UHC investment case and province level adaptation that is currently underway, an M&E framework is needed to align with national, provincial and district priorities. The imperatives for a comprehensive M&E framework include its ability to report country's progress on global SDG-3 commitments for Universal Health Care; linkages with other SDGs particularly on reducing poverty, hunger and malnutrition and improving air quality. In Pakistan's context, it is important that this M&E framework aligns with the priorities defined in UHC investment case, measures the reduction in health system bottlenecks, tracks progress towards achieving the impact targets and assesses equitable effective coverage.

Figure 1: M&E Framework for National/Provincial/District/PHC levels

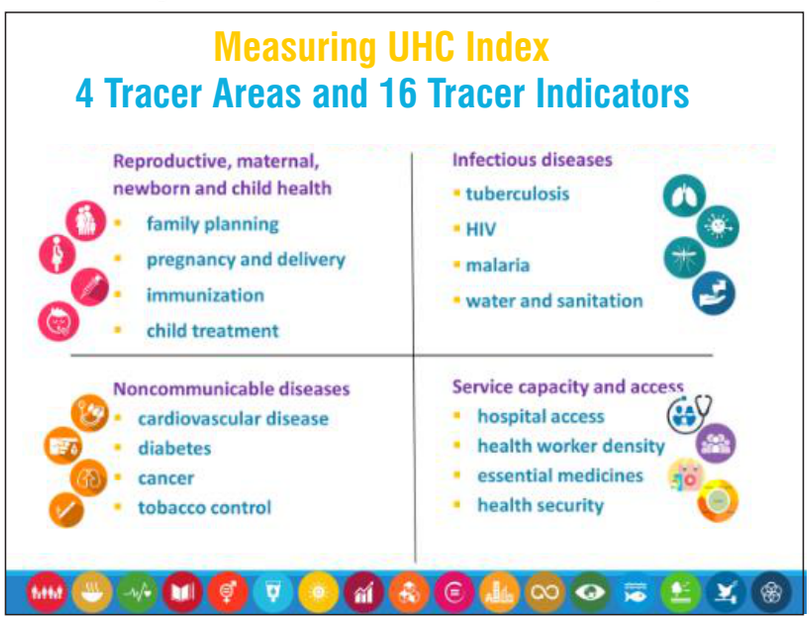


In order to provide a comprehensive country specific M&E package to monitor the UHC interventions, efforts are underway to streamline the various monitoring mechanisms as well as complement the mechanisms that exist. In this regard, the theory of change and resultant M&E framework presented in Pakistan Investment Case for 2021-2026 provides a comprehensive starting point. It had the limitation of having more than 100 indicators and a need was felt to discuss the proposed measures with district and provincial stakeholders for developing a shorter and a more focused set of indicators. The data portals that already exist at National and provincial reporting (e.g. PDHS, PSLM, National and Provincial MICSs, STEPS, NNS, Routine health system data, Facility assessments). Newly launched Health report 2020 focusing on RMNCH, provides an excellent data source and is a contributor to collection of critical information as well as highlighting the way forward by bringing limitation and challenges to the forefront.

The SDG3 commitments for Universal Health Care will be reported for target 3.8 defined as "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all". The concern is with all people and communities receiving the quality health services they need (including medicines and other health products), without financial hardship. Two indicators have been chosen to monitor target 3.8 within the SDG framework. Indicator 3.8.1 is for health service coverage and indicator 3.8.2 focuses on health expenditures in relation to a household's budget to identify financial hardship caused by direct health care payments. Taken together, indicators 3.8.1 and 3.8.2 are meant to capture the service coverage and financial protection dimensions, respectively, of target 3.8. These two indicators should be always monitored jointly.

Countries provide many essential services for health protection, promotion, prevention, treatment, and care. Indicators of service coverage – defined as people receiving the service they need – are recommended by the WHO to track progress in providing services under universal health coverage (UHC). Since a single health service indicator does not suffice for monitoring UHC, an index is constructed from 16 tracer indicators selected based on epidemiological and statistical criteria. This includes several indicators that are already included in other SDG targets, thereby minimizing the data collection and reporting burden. The index is reported on a unit less scale of 0 to 100, with 100 being

Figure 2: Global Universal Health Care Index Composition



Measurement of UHC service coverage primarily under SDG 3.8.1 is being done under the global UHC index of WHO through 16 tracer indicators under 4 thematic areas consisting of RMNCH, Infectious diseases, NCDs and service capacity and access. These tracer indicators are meant to be indicative of service coverage, not a complete or exhaustive list of health services and interventions that are required for universal health coverage. The 16 tracer indicators were selected globally because they are well-established, with available data widely reported by countries (or expected to become widely available soon). Therefore, the index can be computed with existing data sources and does not require initiating new data collection efforts solely to inform the index.

WHO's guidance on UHC monitoring recommends disaggregating tracer indicators by sub-national, household residence, socio-economic status and by sex etc. to map the disparities.

“Equity is central to the definition of UHC, and therefore the UHC service coverage index should be used to communicate information about inequalities in service coverage within countries. This can be done by presenting the index separately for the national population vs disadvantaged populations to highlight differences between them. For countries, geographic location is likely the most feasible dimension for sub-national disaggregation based on average coverage levels measured with existing data sources. To do this, the UHC index can be computed separately by, e.g., province or urban vs rural residence, which would allow for subnational comparisons of service coverage. Currently, the most readily available data for disaggregation on other dimensions of inequality, such as household wealth, is for indicators of coverage within the reproductive, maternal, newborn and child health services category. Inequality observed in this dimension can be used as a proxy to understand differences in service coverage across key inequality dimensions. This approach should be replaced with full disaggregation of all 16 tracer indicators once data are available to do so”.

In Pakistan, the current data availability at the national, provincial and district levels does not provide disaggregations to allow measuring disparity in UHC index. However the disparities in impact indicators and UHC index tracer indicators for RMNCH cluster can be used as a proxy. This is in line with the WHO guidance on monitoring equitable UHC coverage.

Many of the tracer indicators of health service coverage are measured by household surveys. However, administrative data, facility data, facility surveys, and sentinel surveillance systems can be utilized for certain indicators. There is currently very limited data on service coverage for non-communicable diseases. Service coverage data for high blood pressure and diabetes do not exist, so at present, instead, population prevalence of raised blood pressure and raised blood glucose are being used as proxies for service coverage.

Financial protection

The WHO-World Bank UHC framework uses two indicators of financial protection: 'catastrophic' health spending SDG target 3.8.2 and SDG target 1.1.1 on impoverishment due to health-care costs. Both generally decrease as public spending on health rises. In this report, the threshold for defining catastrophic health spending is the same as that used in the WHO World Health Statistics Report 2016: over 25% of a household's budget is spent on health care. Impoverishing out-of-pocket expenses (IMPOV) leave a household's nonmedical spending below the poverty line (e.g. $1.90-a-day).

Pakistan, like many other countries in South Asia, has data on out-of-pocket payments (OOP) as a share of total health expenditure. Countries which have a lower share of total health spending from OOP generally have fewer people experiencing financial hardship from health-care costs, so the OOP indicator is also recommended. Many people are pushed into poverty due to health-care costs globally and in Pakistan. Pakistan is well known to have the highest share of total health spending coming from out-of-pocket payments. The main causes are expenditure on medicines and use of private providers.[1] Hence the addition of monitoring out of pocket expenditures is proposed at national level.

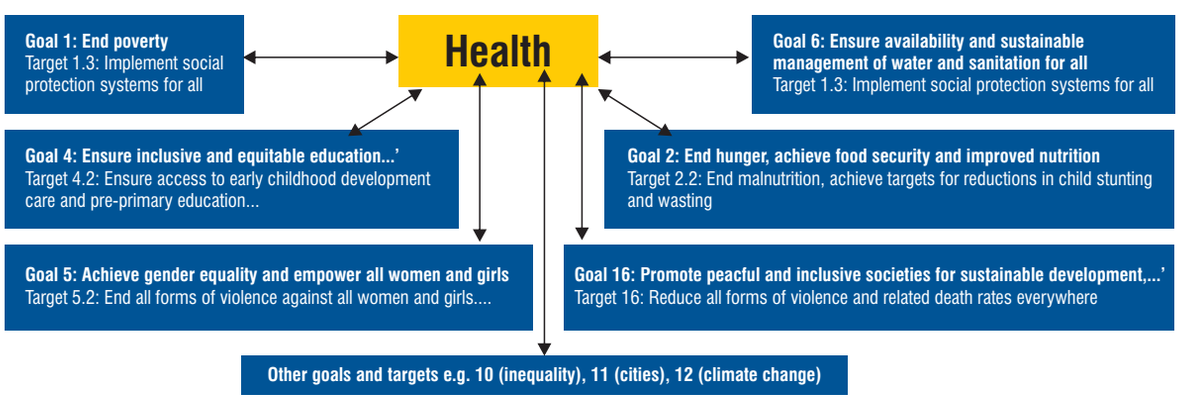
Linkages to other SDGs and improving inter-sectoral synergies:

Health is framed as a contributor to, and beneficiary of, progress in many other SDGs. Hence it is important to draw linkages at national and provincial levels with other SDGs and at district level where local data is available.

[1] *Health in the sustainable development goals: where are we now in the South-East Region? What next?, WHO, Regional Office for South-East Asia*

It is of utmost importance that effective linkages are created with other relevant M&E frameworks and systems so that these feed into a holistic national M&E package, both to avoid duplication and to allow efficiency. Such interlinkages will allow depth of analysis and may ensure the improvement of quality of various M&E elements in order to contribute to a high-quality national package. Some processes and systems that need to be considered for this includes SDG 3 monitoring, PHC MISs, Sehat Sahulat, Nutrition MIS, Hepatitis control, HIV (UNAIDS reporting), CRVS, Health Care Commissions, GPs, Parastatals, cancer registry, IDSR etc. As the Government of Pakistan has pledged to report on all SDGs, the UHC M&E framework can limit its reporting on a few selected impact indicators for SDG3 including MMR, NMR,U5MR, premature Mortality due to NCDs, UHC index for service coverage, household out of pocket expenditure and linkages with other SDGs as shown in figure on page 3.

Figure 3: Interlinkages to health interventions across SDGs



Source: Health in the sustainable development goals: where are we now in the South-East Region? what next? WHO, Regional Office for South-East Asia

'Leaving no one behind'

Estimates suggest that a large number of people are still being 'left behind' in terms of access to needed health care, as suggested by the evidence presented in Pakistan countdown 2030 equity profile. Disaggregated national, provincial and district data is needed to shed light on who these people are. The figures below shows inequalities in coverage by income group, and by urban versus rural populations. There is also the need for a focus on other significant groups of people often wholly or partially excluded from health care: ethnic minorities, migrants, mobile populations and refugees, the urban poor, women, and people whose behaviours, identities or health conditions are stigmatized. Data are scarce for these groups. Creative ways to improve information on who is being left behind that may not be captured through existing formal household surveys is required.

Figure 4: Variation in Urban and Rural Coverage - Pakistan

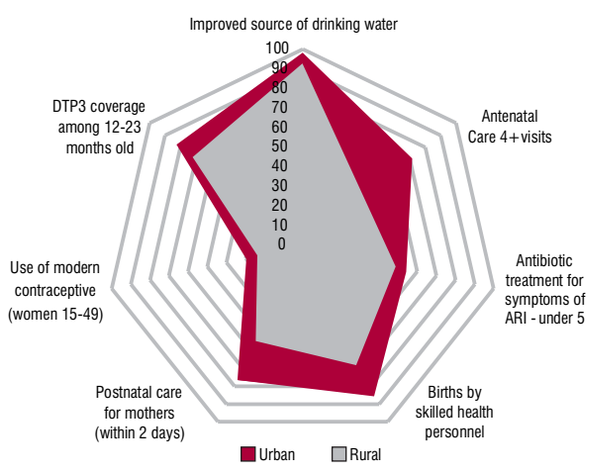
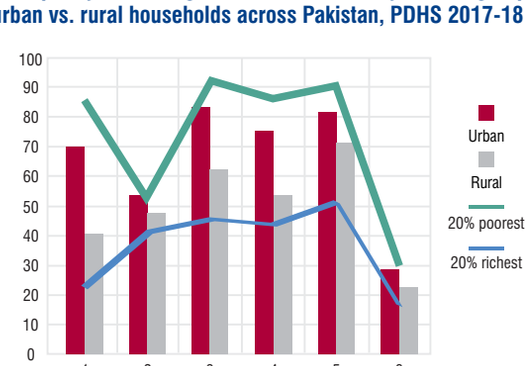


Figure 5: Inequality in coverage of health services by income group and by urban vs. rural households across Pakistan, PDHS 2017-18



1. Antenatal Care 4+ visits
2. Antibiotic treatment for symptoms of ARI - under 5
3. Births by skilled health personnel
4. Postnatal care for mothers (within 2 days)
5. DTP3 coverage among 12-23 months old
6. Use of modern contraceptive (women 15-49)

Source: Pakistan DHS 2017-18

Role of 'power'

It is important to keep in view that certain groups that may be at a risk of being missed out due to their position and visibility in the society. It is suggested to also assess how people and groups with less 'power' (knowing that power is not just manifested by financial resources) are consistently included. Researchers have increasingly drawn attention to the influence of power implicated throughout the global health field, noting that in failing to explicitly recognize the normative premises that undergird global health efforts, we overlook why and how actors holding power may steer health efforts in particular directions. Power, moreover, is relative and relational, and manifests at levels ranging from policy decision-making to the local implementation of interventions. Scholars have highlighted that the exercise of power occurs not only among actors typically considered powerful on the global stage, or actors at the national level, such as political parties whose ideologies can influence the equity and universality of public policy (Mackenbach, 2014; Navarro et al., 2006), but also actors across the health system who may be powerful in particular local contexts. Administration, bureaucratic agents, and frontline health workers may exercise power in the course of everyday health service delivery, with negative or positive consequences for the people they serve (Erasmus & Gilson, 2008; Gilson, Schneide, & Orgill, 2014). Ethnicity, language, belonging to transgender community and being religious minority are some of the grouping to be considered for Pakistan. More work is warranted in the regard to ensure a conscious minimization of power impacting decisions making and how it effects the population at the receiving end of health services.

Challenges for monitoring progress at district level

With its ambition to setup a monitoring system further down to the district level to align with the implementation of HPP (High-Priority Package) in 12 priority districts across the country, the focus and need for setting up a district level M&E package is gaining traction. The table below shows some analysis of the importance of district level monitoring as well as some challenges that are faced in this endeavor in Pakistan.

Figure 6: Importance of district level monitoring and some identified challenges

Why Measure UHC Index at District level	Challenges for Measuring UHC Index at District level in Pakistan
Important to measure UHC Index at district level to **monitor progress on the implementation of UHC Benefit Package / EPHS**	Stakeholders mostly **do not have full understanding** on the UHC and UHC index & What about interventions **beyond 16 proxy indicators**?
HPSIU has started an activity of measuring Year-wise UHC Index for all districts in Pakistan (already measuring at national & provincial level)	UHC Index is a composite indicator and its **disaggregation** by income quintile and gender would be quite complex
District Results and methodology would be shared with all stakeholders and data will be available on the website of the MNHSR&C	Source of data is mainly surveys but national/ provincial vs provincial/ district **results vary significantly** (definition, sampling and measuring issues e.g. modern methods for family planning)
Important level to collect data around **Equity and Quality of Services** at primary health	Some indicators are **only measured at national** level (e.g. IHR index) what value should be used at district level (proxy indicator-IDSR status?) or apply weightage of national value by district?

Source: HSPIU presentation at the UHC M&E Technical Discussion workshop held on 11th March, 2021

Key recommendations and steps for a sustainable M&E ambition in Pakistan

- **Financial Coverage**: M&E package will evolve as more and more interventions are rolled out and geographic spread increases, to ensure that comprehensive monitoring system is in place and remains largely localized in nature. Furthermore, as the fiscal space is created for the expansion in UHC interventions, it is also important that the financial requirements for undertaking the routine, mid-term and end-line monitoring and evaluation needs are built into such plans.

- **Quality of care and equitable access** are identified as one of the limitations of the global UHC monitoring. There has to be ways of setting specific targets for these two aspects as it is extremely important to know how well the UHC is reaching people of various socioeconomic groups get equal access to the quality UHC services. Disaggregation of data (e.g. rural/urban, by sex and income quintiles) is vital to monitor the equity at various levels. Equity indicators have been suggested in the National M&E framework. There is a need for deliberations on measuring the Equity (e.g. data desegregation, zooming in on priority groups especially in districts) and Quality of Care (e.g. quality dimensions for the 16 tracer indicators and well as district monitoring) through routine monitoring as well as specialized surveys and studies.

Figure 7: Key health system bottlenecks

Weak district level autonomy, leadership, and governance
Inadequate financing for health
Insufficient, underutilized, and underperforming health workforce
Shortage of essential medicines, contraceptives, and supplies
Inaccessibility to health services
Sub-optimal quality of health services

Source: Pakistan Investment Case for 2021-2026, Ministry of Health

- **Measuring reduction in health system bottlenecks** is important to monitor for reducing barriers to effective implementation of the UHC district EPHS package. The key health system bottlenecks identified from provincial consultations and highlighted in the draft UHC investment case are important parameters to monitor at all levels. Some indicators have been chosen under each output in this regard and hence categories are kept consistent with the investment case in the proposed M&E framework.

- **M&E Capacity Building:** Given that the limited capacity of M&E human resource is a known bottleneck in implementation of M&E systems effectively, it is recommended that institutional support is provided to building the capacity of district and provincial stakeholders on UHC and PHC M&E. Similarly, to institutionalize the M&E at sub-national levels, it is important to broker partnerships building on these initial steps to bring in the provincial stakeholders into M&E discussions. Health Services Academy has offered to develop and run short courses for UHC M&E in this regard in partnership with the Ministry of National Health Services regulation & coordination and University of Manitoba.

- **Learning exchange:** In order to make sure that effective improvements are made in the system with time, exchange of knowledge and learning between districts and provinces, annual meetings of M&E experts working on UHC, involvement of research institutions is recommended as frequently and realistically possible.

Monitoring framework for District EPHS

In order to kick start an evidence backed discussion, a district level monitoring and evaluation framework is presented as a generic guidance for implementing a monitoring system at the district level. The provincial adaptation of DCP3 package exercise can also include deliberations to localize the M&E framework.

The suggested framework tries to answer the challenges mentioned in the section above, as well as aiming to fulfill the need of the results planned for districts, and in turn linking it very closely to the theory of change in the Pakistan Investment Case. The six outputs in the district M&E framework are aligned to the priority areas being measured through the six Investment Case outcomes, ensuring a close link between the two.

A draft list of indicators was presented to the expert group on 11th March, 2021 at Health Services Academy Islamabad that deliberated on the sufficiency, completeness and relativity of the indicators as well as possible sources of data collection and frequency of collection of data. The initial framework also allowed the participants to think about the possibilities to bring various monitoring system under the umbrella of an overall monitoring package and provide linkages to make sure that the resultant monitoring system is most efficient.

The monitoring framework consists for high level impact indicators (SDGs), and district level including UHC tracer indicators to be monitored at district level. The indicators were developed and selected from the UHC investment case, as well as monitoring needs set out in the ICT project document for implementation of UHC in the district. In turn, the framework also links very closely with the baseline conducted using SARA methodology for ICT in recent months, and provides an initial basis for streamlining the M&E need as well as financial needs of the M&E of EPHS as part of UHC implementation in Pakistan.

Figure 8: Challenges in Measuring UHC Index at National & Provincial level

Three indicators not reported at global, national and provincial level:

- **Insecticide treated bed nets for malaria prevention (%)**
- **Cervical cancer screening (30-49 years) (%)**
- **Availability of essential medicines in PHC (%)**

Why not measured in Pakistan?

- **Bed nets intervention only in 72 districts (comparability issue)**
- **No formal cervical screening and vaccination (new intervention)**
- **No formal mechanism of measuring availability of essential (consensus on list and methodology)**

Better to use global approach at national and provincial level (consensus)

Source: MoH presentation in the 11th March 2021 meeting

The indicators presented were largely acceptable to the participants of the meeting and some additions and changes were proposed which are reflected in the updated framework. The proposed M&E framework will act as a prototype to design district level monitoring frameworks in other parts of the country especially 12 priority districts for early roll-out.

Collection of Data:

It was agreed that some indicators may not be possible to be monitored for now, as the system at districts does not support reporting on them, but if found critical, can contribute to expansion and improvising the monitoring mechanisms and capacity in districts. Similarly, such indicators may have core targets to aspire to gradually increasing the target as the information starts being collected over the next 5 years of the implementation in districts and as the fiscal space is expanded.

Baselines and Targets:

Realizing that the current situation varies greatly across districts in Pakistan and even within provinces, targets and baselines have not been presented in the proposed district EPHS monitoring framework. No targets and baselines have been agreed at the district level and it will take some deliberations to arrive at that. It is proposed that as the first step towards finalization of the framework for districts, a thorough review of indicators is done as well as best estimates for baselines and targets are made keeping in view the situation in districts and the planned change in situation given the resources and human capacity etc. This can be initially done as part of the provincial consultations, involving the right stakeholders from the districts.

Data Gaps:

Some critical suggestions made by the group were around exploring the quality and equity dimensions for the coverage indicators, linking with efforts for strengthening CRVS, addressing malnutrition, hepatitis control and cross sectoral inputs. Age disaggregation and relevance to adolescent and old age population was also raised. Some investments to try small scale demonstration were warranted for newer themes. Harnessing data from private sector, parastatal institutions and linkages to other relevant M&E frameworks were high/lighted. The framework has tried to address the issues and limitations as well, especially around quality of care as well as indicators around essential medicine availability, ITNs and cervical cancer screening.

Frequency of information:

It is important to continually update realistic timelines (e.g. monthly, quarterly, midline and endline) and appropriate data collection methods/portals (e.g. household survey, DHIS, routine data collection etc.) relevant to the indicators being monitored as the development of M&E package progresses.

The proposed monitoring framework is presented on following pages:

(a) M&E Framework for National/Provincial/District/PHC levels

SDG 3 Indicators	Baseline (2014-15)	Target 2030	Data Sources	Frequency	Reporting (Current sources)	Reporting (Emerging sources)
3.1.1 Maternal Mortality Ratio (per 100,000 live births)	178	<70	PDHS, UNIA	6 years	Nat Survey, UNIA	ONE Nat Survey with provincial estimates
3.1.2 Skilled Birth Attendance (%)	58	>90	PDHS, UNIA	Annual+ 3 Years	Nat survey	ONE Nat Survey with provincial & district/ constituency estimates
3.2.1 Under Five Mortality Rate (per 1,000 live births)	81.9	<25	PDHS, PSLM	3 Years	Nat Survey, UNIA	ONE Nat Survey with provincial & district/ constituency estimates
3.2.2 Neonatal Mortality Rate (per 1,000 live births)	47.3	<12	PDHS, UNIA	3 Years	Nat Survey, UNIA	ONE Nat Survey with provincial & district/ constituency estimates
3.4.1 Probability of dying from cardiovascular disease, cancer, diabetes, chronic respiratory disease between age 30 and 70 (%)	24.7	17	NH, WHO estimates	6 Years	WHO	NBoD study, WHO
3.8.1 Universal Health Coverage index (%)	40	>80	PDHS	Annual	National Survey	ONE Nat Survey with provincial, district / constituency estimates
3.8.2 Incidence of catastrophic expenditure (%) at 10% of household total consumption or income	1.03	Tbd	IHR Ext Eva	3 years	WHO/WB	HIES
3.8.2 Proportion of people who made direct payments to health care providers at the time of service use (Out of pocket expense)	TBC	TBC (income, sex, age, & Urban/Rural)	PSLM	Annual+ 3 Years	WHO/WB	National Survey
Other Health related SDGs						
1.a.2 General government health expenditure as % of general government expenditure	4.7	Tbd	WHO	3 Years	GHED	NHA
2.2.1 Prevalence of stunting among children < 5 years of age (%)	45	Tbd	Global Health Expenditure database	3 years	Nat survey UNICEF, WHO	ONE Nat Survey with provincial estimates
2.2.2 Prevalence of wasting in children < 5 years of age (%)	10.8	Tbd	NNS, UNIA	3 years	Nat survey UNICEF, WHO	ONE Nat Survey with provincial estimates
2.2.3 Prevalence of anaemia in women aged 15 to 49 years, by pregnancy status (%)	Tbd	Tbd	NNS	3 years	Nat survey UNICEF, WHO	ONE Nat Survey with provincial estimates
6.1.1 Proportion of population using improved drinking water sources (%)	91	Tbd	PDHS	Annual+ 3 years	Nat survey UNICEF, WHO	ONE Nat Survey with provincial, district / constituency estimates
6.2.1 Proportion of population using improved sanitation (%)	73	Tbd	PSLM	Annual+ 3 Years	Nat survey UNICEF, WHO	ONE Nat Survey with provincial, district / constituency estimates
16.9.1: Proportion of children under 5 years of age whose births have been registered	42 (2019)	Tbd	PDHS	Annual+ 3 Years	Nat survey UNICEF, WHO	ONE Nat Survey with provincial, district / constituency estimates

(b) Monitoring progress towards Universal Health Care (District EPHS Implementation)

INDICATOR	DEFINITION	BASELINE** (2019)	TARGET (2025)	DATA SOURCE	FREQUENCY	REPORTING	REMARKS
Goal: End preventable maternal, newborn, child and NCDs, CDs and improve the health and quality of life of populations at district level in Pakistan							
Institutional Maternal Mortality Ratio	Number of deaths per 100,000 health facility deliveries (by district) (Urban/ Rural, maternal age, cause of death)	TBC	TBC	DHIS (public facilities) and private sector hospitals and GP clinics	Six monthly and Annual	DHIS and private facility reports	Current DHIS reporting does not differentiate between facility deaths and LHW reported deaths from community & age below 15 years or above 45 years
Institutional Neonatal Mortality Rate	Number of deaths within 28 days of birth per 1,000 health facility live births (M/F, U/R, gestational age, birth weight, cause of death)	TBC	TBC	DHIS (public facilities) and private sector hospitals and GP clinics	Six monthly and Annual	DHIS and private facility reports	Current DHIS reporting does not have cause of death nor by sex, gestational age or weight
Institutional Still Birth Rate	Number of stillbirths per 1,000 live births per health facility live births (fresh/ macerated)	TBC	TBC	DHIS (public facilities) and private sector hospitals and GP clinics	Six monthly and Annual	DHIS and private facility reports	This is important indicator to monitor quality of care as 50% of all still births happen during labor
Institutional post-neonatal U5 Mortality Rate	Number of children (1 month to 5 years) in a calendar year per 1,000 health facility live births (M/F, U/R, cause of death, age of the child in completed months)	TBC	TBC	DHIS (public facilities) and private sector hospitals and GP clinics	Six monthly and Annual	DHIS and private facility reports	Current DHIS reporting does not provide cause of death nor by age categories
Proportion of deaths by cardiovascular diseases	Number of deaths among 30-70 years old due to cardiovascular diseases per 100,000 population (M/F, U/R, by age decides)	TBC	TBC	Public facilities and private sector hospitals and GP clinics; Civil registration with complete coverage and medical certification of cause of death	Annual	DHIS and private facility reports	Need addition in DHIS reporting
Output 1: Leadership and management with effective oversight, regulation, and accountability							
1.1 Department of Health with UHC management structures (%)	Provincial Technical committees are functional & District QoC Focal Person identified	TBC	TBC	DHO Office/Province Office/UHC Focal Point	Yearly	Annual Reports	
1.2 UHC performance report is available	District level report on key UCH indicators is compiled	TBC	TBC	UHC Focal Point	Yearly	Annual Reports	

1.3 Incremental budget secured	Percentage and amount of newly added and cumulative district budget	TBC	TBC	Provincial Finance Department	Yearly	Annual Financial Reports	
1.4 IDSR and emergency preparedness and response plan available	IDSR and EP plans are in place in District and Provincial Response Units	TBC	TBC	DHO Office/ Province Office	Yearly	Annual Reports	
1.5 Mechanism for joint planning process is established	Planning Meeting is organized at agreed frequency and meeting reports are available	TBC	TBC	Public Accounts Committee (PAC)	Yearly	PAC Reports	
1.6 Public health facilities accredited by the HCC (%)	% HCC accredited facilities in urban, rural, peri urban areas .	TBC	TBC	HCC	Monthly	Community-> Facility -> to DHO Office -> Province	
1.7 Private health facilities accredited by the HCC (%)	% HCC accredited facilities in urban, rural, peri urban areas	TBC	TBC	HCC	Monthly	Community-> Facility -> to DHO Office -> Province	
Output 2: Health financing system ensuring that people can afford essential services with financial risk protection measures							
2.1 Percentage of Poor families enrolled in social protection	Total Population in catchment area that is being covered by any SP programme/ mechanism (e.g. Sehat Sahulat/ PM Health Insurance Programme; Social welfare Department, Social Security, Bait-ul-Mal/Zakat also working in same area. Provinces have their own programs/mechanisms as well.)	TBC	TBC	Annual assessment through a comprehensive platform	Six monthly assessments	At departmental level	No single integrated platform to provide information, which is recommended in a gradual manner
2.2 Proportion of Population within 5 km of HCF covered (geospatial analysis needed)	% of catchment population of facilities as available in DHIS covered through Gps/ NGOs/mobile/outreach	TBC	TBC	DHIS	Quarterly	Quarterly reports	Routine information not collected and needs to be collected and assess available information for baseline
2.3 Increased budget allocations at community and PHC levels	Percentage and amount of newly added and cumulative community and PHC budgets	TBC	TBC	District Finance Officer	Yearly	Annual Financial reports	To be discussed with WB if resource mapping showed this possibility

Output 3: Well-trained health workforce available to deliver Integrated essential package of health services and Integrated disease surveillance & response system							
3.1 UHC: Hospital beds/10,000 pop against threshold (%)	beds per capita, relative to a maximum threshold of 18 per 10,000 population	TBC	TBC	DHQ/TERT/ EVERY THREE YEARS HF SURVEY	Every 2 Year		
3.2 UHC: Physicians *Psychiatrist *Surgeon) density/ threshold (%)	Health professionals (physicians, psychiatrists, and surgeons) per capita, relative to maximum thresholds for each cadre	TBC	TBC	DIHS/PMC	Yearly		(partial overlap with SDG indicator 3.c.1
3.3 UHC: IHR core capacity index (%)	International Health Regulations (IHR) core capacity index, which is the average percentage of attributes of 13 core capacities that have been attained	TBC	TBC	WHO	5 Years	Annual Report	Presently available for national level only
3.4 HCP filled positions increase secured (%)	Increase in number and type of position	TBC	TBC	DHIS	Yearly	Annual Report	
3.5 DHQ with ≥1 Neonatologist	Number of DHQs where one or more Neonatologist has been hired	TBC	TBC	HFS	Yearly	Annual Report	
3.6 DHQ with ≥3 neonatal nurses	Number of DHQs where three or more Neonatal nurses has been hired	TBC	TBC	HFS	Yearly	Annual Report	
3.6 RHCs with ≥2 Mos & 2 nurses trained in neonatology	Number of RHCs where two or more Neonatal MOs & at least 2 Neonatal nurses are available	TBC	TBC	HFS	Yearly	Annual Report	
3.8 24/7 BHUs with ≥1MO & 1 nurse trained in neonatology	Number of 24/7 BHUs where one or more Neonatal MO & at least 1 Neonatal nurse are available	TBC	TBC	HFS	Yearly	Annual Report	
3.9 RHCs with ≥1 school health & nutrition officer	Number of RHCs where one or more school health & nutrition officer is available	TBC	TBC	HFS	Yearly	Annual Report	
3.10 RHCs and 24/7 BHUs with ≥1 school health & nutrition officer	Number of RHCs and 24/7 BHUs where one or more school health & nutrition officer is available	TBC	TBC	HFS	Yearly	Annual Report	

3.11 LHWs trained on UHC (%)	Percentage of LHW in a district who are trained on UHC	TBC	TBC	HFS	Yearly	Annual Report	
3.12 MHPs trained on UHC (%)	Percentage of Medical Health professionals in a district who are trained on UHC	TBC	TBC	HFS	Yearly	Annual Report	
3.13 District HR development plan developed	Districts that have developed clearly identified HR needs and developed a plan based on these, including financial needs	TBC	TBC	HFS	Yearly	Annual Report	
3.14 District HR performance monitoring mechanisms developed	Number of districts where updated criteria and process for HR monitoring has been established and annual reviews are being done under that mechanism	TBC	TBC	HFS	Yearly	Annual Report	
3.15 HCFs with biannual UHC performance reviews (%)	Percentage of HCFs where UHC performance reviews are being carried out after every six months	TBC	TBC	HFS	Six Monthly	Annual Report	
Output 4: Equitable access to medicines, vaccines, contraceptives, supplies and medical technologies (including universal access to COVID19 related health technologies)							
4.1 Mean availability of obstetric signal functions offered in EmONC facilities (%)	Percentage of EmONC facilities that are providing Basic/Comprehensive signal functions (Public and Private)	TBC	TBC	SARA	Yearly	Community-> Facility -> to DHO Office -> Province	To be assessed on basis of signal functions for Basic and Comprehensive services
4.2 Mean availability of newborn signal functions offered in EmONC facilities (%)	Percentage of EmONC facilities that are providing Basic/Comprehensive newborn signal functions (Public and Private)	TBC	TBC	SARA	Yearly	Community-> Facility -> to DHO Office -> Province	To be assessed on basis of signal functions for Basic and Comprehensive services
4.3 Proportion of selected essential medicines, vaccine, commodities and supplies available	Percentage of selected supplies available according to the facility need (Community, BHU, RHC, FLH) public and private facilities	TBC	TBC	DHIS + Third party monitoring	Monthly	Community-> Facility -> to DHO Office -> Province	Essential medicines and supplies to be identified
4.4 Proportion of district facilities with at least 3 staff members trained on post-partum family planning	Percentage of facilities with staff that have completed post-partum training (Community, BHU, RHC, FLH) public and private facilities	TBC	TBC	DHO Office records	Monthly	Community-> Facility -> to DHO Office -> Province	Applicable to facilities conducting deliveries

4.5 Health facilities with no commodity stock-out of essential	Percentage of health facilities in a district that reported availability of all essential commodities with zero stock-out	TBC	TBC	DHIS/SARA + independent spot checking	Monthly	Community-> Facility -> to DHO Office -> Province	Essential package to be defined. Need to add zinc and neonatal commodities
Output 5: Efficient, effective, accessible, and integrated essential health services at community and PHC centre level including risk communication							
5.1 Demand for FP satisfied with modern method (UHC)	Percentage of women of reproductive age (15–49 years) who are married or in-union who have their need for family planning satisfied with modern methods	TBC	TBC	cLMIS, DHIS Private Sector (DHIS+ Tertiary Care) Health Care Commission Population Welfare - MIS Pharmacies - DRAP	Annual (One health Survey) + 3 years (Survey) Quarterly District Collation of Information DHIS	DHS, MICS, One Health Survey	At the District Household Survey. Regular monthly information from DHIS may have double counting through different departments. cLIMS data can help monitor the purchase through pharmacies and private sector, all of which needs to be complied to give a trend on usage
5.2 Percent of Public health facilities delivered integrated voluntary family planning services as a part of essential health care services.	Percent of BHUs, RHCs, THQHs, DHQHs, and Teaching Hospitals that are delivered integrated voluntary family planning services	TBC	TBC	DHIS	Quarterly		Increased collaboration with Population Welfare required to reallocate FWCs
5.3 Number of additional users of modern methods of contraceptives by public sector	Percent increase in the number of new users of modern method in a given time period	TBC	TBC	DHIS	Quarterly		
5.4 Percentage Increase in users of modern contraceptives served through LHWs/CMW	Percent increase in the number of new users of modern method in the LHW/CMW catchment population in a given time period	TBC	TBC	DHIS	Quarterly		
5.5 Number of public health facilities reporting stock out of modern contraceptive methods.	Number BHUs, RHCs, THQHs, DHQHs, and Teaching Hospitals that report stock out of modern contraceptive methods.	TBC	TBC	DHIS	Quarterly		
5.6 Percentage of Antenatal care with 4 visits (UHC)	4 visits at any time during the pregnancy; Measure Quality of Care at least once (B.P., Hb, Urine Test)	TBC	TBC	DHIS-2 Possibility for ANC Consult-ation (to check the number of exact visits)	5&3 years	DHS, MICS	If we want to measure every trimester? Link with SBA Coverage
5.7 UHC: Child immunization (Penta 3) (%)	Age appropriate penta-3 coverage of vaccination status	TBC	TBC	EPI MIS	5&3 years (Monthly at District Level)	DHS, MICS	

5.8 UHC: Care-seeking behaviour for child pneumonia within 48 hours	No of u5 consultations for ARI; No of child consultations for diarrhea	TBC	TBC	DHIS	5&3 years	DHS, MICS	For District Level we can take data from Child Consultation from ARI QoC: Within 48 hours to capture that?
5.9 UHC: Tuberculosis effective treatment (%)	Percentage of incident TB cases that are detected and successfully treated	TBC	TBC	ATM MIS	Quarterly	NTCP/PTCPs	
5.10 UHC: HIV antiretroviral treatment (%)	Percentage of people living with HIV currently receiving anti-retroviral therapy	TBC	TBC		Quarterly	NTCP/PTCPs	To be discussed further with UNAIDS for district level
5.11 UHC: ITNs for malaria prevention in endemic areas (%)	Number of ITNs distributed in high burden Districts	TBC	TBC	DOMC/VMCTs	5&3 years	DHS, MICS	
5.12 UHC: At least basic sanitation (%)	Percentage of households using at least basic sanitation facilities	TBC	TBC	PDHS	5&3 years	DHS, MICS	WASH Survey - at Health Care Facilities. (1/2 years)
5.13 Tetanus toxoid immuniz-ation school children and mothers	Percentage of TT vaccination coverage for school children and among women attending antenatal care	TBC	TBC		5&3 years	DHS, MICS	Link with MNTE monitoring and surveillance
5.14 Measles coverage among children under 2(%)	% of children aged 12–23 months old who have been vaccinated	TBC	TBC	EPI MIS	Monthly	DHS, MICS	
5.15 Vitamin A supplementation in children 6-59 (%)	Percentage of children 6-59 months who have given 2 doses of Vitamin A supplementation in a given year	TBC	TBC	EPI MIS Polio Campaigns)	5&3 years (Bi-Annually)	DHS, MICS NNS	
5.16 UHC: Normal blood pressure (%)	Age-standardized prevalence of non-raised blood pressure (systolic blood pressure <140 mm Hg or diastolic blood pressure <90 mm Hg) among adults aged 18 years and older	TBC	TBC	DIHS	5 years	STEPS	Link to DHIS Information on number of consultation
5.17 UHC: Normal blood sugar (%)	Age-standardized mean fasting plasma glucose (mmol/L) for adults aged 18 years and older	TBC	TBC	DIHS	5 years	STEPS	
5.18 UHC: Cervical cancer screening in women 30-49 years	Percentage of women screened through HCFs in the catchment area in a given year	TBC	TBC	DHIS Reporting should be done through Revitalized cancer registry system at district level	5 years	STEPS	Surveillance policy required for Cervical Cancer

5.19 UHC: Tobacco non-smoking (%)	Age-standardized prevalence of adults >=15 years not smoking tobacco in last 30 days	TBC	TBC		5 years	STEPS	Can be only done at National Level every 3 and 5 years
5.20 Minimum no. of EmONC facilities (1 C-EmONC & 4 B-EmONCs/ 500,000 population)	Districts with minimum number of EMoNC facilities for catchment population	TBC	TBC	EMONC Assessment Survey (SARA)	3 years	SARA	
5.21 RHCs and 24/7 BHUs with telemedicine (%)	Percentage of RHCs and 24/7 BHUs providing telemedicine services in catchment area	TBC	TBC	SARA	Annual	SARA	
5.22 Proportion of RHCs with functional ambulances	Percentage of RHCs in a district that have at least one functional ambulance available 24/7	TBC	TBC	SARA	Annual	Reports	Or districts with pooled ambulance systems
5.23 Proportion of 24/7 BHUs with functional ambulances	Percentage of BHUs in a district that have at least one functional ambulance available 24/7	TBC	TBC	SARA	Annual	Reports	
5.24 Proportion of population with increased information on UHC	Percentage of persons with information about UHC (M/F, children) Urban Rural	TBC	TBC	Telephonic Survey/Third party monitoring	Bi - Annual	Special Campaign Monitoring	
5.25 Proportion of facility maternal deaths audited (%)	Percentage of maternal deaths that occurred in previous month and were audited	TBC	TBC	DHIS/HMIS/ LHW MIS/ DHIS 2	Monthly	Facility -> to DHO Office -> Province	Link to MPDSR
5.26 Proportion of facility perinatal deaths audited (%)	Percentage of deaths between 28 completed weeks of gestation and seven completed days after birth, that occurred in the previous month and were audited	TBC	TBC	DHIS/HMIS/ LHW MIS	Monthly	Community -> Facility -> to DHO Office -> Province	WHO definition: 22 completed weeks of gestation to 7 completed days after birth however for viability age in Pakistan's context 28 weeks in proposed. Some provinces have a policy of auditing at least 10% of all the perinatal deaths
5.27 Proportion of DHQ and THQs with KMC and NICUs	Percentage of DHQ and THQs with KMC and NICUs	TBC	TBC	DIHS	Yearly	Annua Report	In first phase, only DHQs status will be monitored.

Output 6: Improved quality of care and actionable Health information system (including integrated disease generating data on health system performance and response actions							
6.1 Functional DHIS2	Number of districts with up to date DHIS2 reports available	TBC	TBC	DHIS / PHIS CELL	Yearly	Annual Report	
6.2 GPs with functional DHIS2 (%)	Number of GPs with up to date DHIS2 reports available	TBC	TBC	DHIS / PHIS CELL	Yearly	Six-monthly	Abbreviated DHIS 2 reporting for private sector
6.3 Departments of health with QoC units	Number of DOHs that have set up QoC units	TBC	TBC	SARA	Yearly	Annual Report	Provincial level indicator
6.4 Health facilities with QoC enhancement teams (%)	Percentage of health facilities that have nominated QoC teams	TBC	TBC	DHIS	Yearly	Annual Report	District level
6.5 Proportion of health facilities with availability of Healthcare quality standards and guidelines	Percentage of health facilities with available documents on standards of care and guidelines in both public and private sectors	TBC	TBC	SARA Third party monitoring	Yearly	Annual Report	
6.6 percentage of HCFs with improved WASH infrastructure and practices	Availability of sufficient clean water and improved sanitation in FLHs/RHCs/BHUs	TBC	TBC	Wash in HCF assessment / SARA	Yearly	Annual Report	See WASH in HCF guidance by WHO and UNICEF
6.7 Paper based medical records are converted to electronic system	FLHs and RHCs with electronic patient records (%) (district/FLH/RHCs)	TBC	TBC	First level hospital	Six monthly	Third party/ spot check reports	

Way forward

Based on the discussion with participants of the technical meetings and review of the situation around monitoring of UHC, a few key recommendations have been presented in this report to guide the work ahead.

- This work is a set of preliminary recommendations to inform the process of provincial and district level UHC monitoring and evaluation. Provincial consultations will be continued in coming months to allow for localization of the UHC package as well as further work on monitoring of critical aspects of implementation. It is envisaged that clarity around the implementation of M&E package at provinces and districts, and its linkages with the envisaged national framework/package will also be acquired through the process of provincial consultations and actions.

- HPSIU at MNHR&C has already computed UHC index for all provinces and regions from 2015-19. Progress is noted in all sub-national regions overtime. Plans are underway to compute district level UHC coverage indices. For the proposed M&E framework, some of the indicators can be gleaned for district level information from the planned SARA surveys in the first phase /12 priority districts. The proposed transition from DHIS to DHIS-2 and use of digital technologies will help more robust monitoring at the district level.

- The UHC investment case describes activities for mid-term and final evaluations including third party independent periodic monitoring on key indicators for course corrections and learning for scale-up. The investment case document prescribes tentative budget for these activities.

- We hope this document helps the readers to prioritize and plan monitoring and evaluation of UHC implementation at all levels in an integrated fashion. Provinces and regions can build on this to develop their localized M&E frameworks with a minimum set of core indicators to be reported by all for national computation.

Annexure

Annex A: Summary report Zoom conference (February 23, 2021)

1. Objectives:

- To review global UHC monitoring recommendations and lessons learnt from other countries.
- To discuss the relevance, feasibility, and special challenges for Pakistan

2. Key ideas, insights and discussions:

Some key insights and discussion points from the conference that helps in designing of a monitoring framework for UCH work in Pakistan have been summarized below.

- Main objectives of the DCP3 collaboration with pilot countries are: Supporting these countries in priority setting of health interventions under UHC (Pakistan being the first); building sustainable capacities; using country experience to update evidence on DCP3 and model package; Setting a sub-package focusing on top priority basic health services for polio high-risk areas for Pakistan and Afghanistan

- In addition to the High Priority Package (HPP), another area of partnership between DCP3 and Ministry of Health is the development of health promoting intersectoral policy interventions that are integral to UHC. Under this, a core package of 29 policies has been identified for early implementation in LMICs and an expanded list of 71 policies.

- Population coverage, essential set of service coverage and financial protection are key aspects of monitoring and measuring the UCH in a comprehensive manner. In the WHO global index, population coverage is being measured, but access to the breadth of interventions is not being measured. This is a key limitation in the global tool that can present skewed results in terms of UHC in the countries. This could be something Pakistan can aim to feature in its National M&E framework.

- Equity dimension is a critical gap in almost all monitoring systems globally, which needs more attention as UHC is all about equitable access to services. Therefore, there is need for specific target setting that should include levels and distribution according to key stratifiers (e.g. urban/rural; wealth; education; subnational areas etc.) In absence of specific targeting, equity will not be monitored effectively and very hard to determine for countries how effectively they are reaching the intended populations.

- Measuring District health system strengthening is critical as district is the primary unit of implementation, strengthening of system at the district level hold promise to implementation of PHC as well as a allows a primary unit for monitoring. Decentralization of health system to provinces in Pakistan, given the range of services offered at the district level makes it a natural step for the country. Most of the micro and meso level decision are undertaken at the district administration level. These reasons make the district level a very effective level to monitor the optimization of services.

- Suggestions for data sources and frequency were shared to monitor UHC at district level as well as some points to ponder about assessing the important elements of service content and quality.

More details around the subjects presented can be found in section 4 below.

3. List of participants:

Dr. Asad Hafeez, Vice Chancellor, HSA
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4. Expert Presentations from the conference can be found at the following links:

https://www.dropbox.com/sh/pvnip22nloq7w0e/AAAjUdEO_lJsy7-OOHqs8u3Ka?dl=0

Annex - B:
Summary of DCP3 UHC M&E Framework Workshop Pakistan (11 March 2021)

1. Objectives:

- To develop a national package of indicators and methodologies that can be adapted by the provinces and regions.

- To map the required investments for M&E district UHC package tailored to the progressive implementation of the district UHC package and the 2, 5 and 10 year benchmarks towards 80% coverage by 2030.

2. Key ideas, insights and discussions:

The face-to-face workshop was an opportunity for the participants especially from provincial health departments to [provide a refresher for the elements of UHC monitoring, how the country and provinces were performing on global UHC index as well as to understand the necessity and challenges in district level monitoring.

It also allowed for the participants from provinces and some districts to share initial ideas on how the district monitoring system will have to be setup and what kind of indicators will be monitored through that. The ICT monitoring framework provided a useful prototype of starting to visualize the district monitoring frameworks and think about the challenges that it might envisage once the district level roll-out starts after localization at the provincial levels.

It was immensely useful to have these health sector colleagues to review and provide inputs to the ICT framework as it provided opportunity for a peer review of the same.

More details on the session have been discussed in the sections starting from 'Towards developing a comprehensive M&E Framework' and sections following that.

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4. Presentations from the workshop can be accessed on the link below:

https://www.dropbox.com/sh/pvnip22nloq7w0e/AAAjUdEO_lJsy7-OOHqs8u3Ka?dl=0

Annex - C:
National Health Indicators and Targets on SDGs

(Endorsed by the Inter-Ministerial H&P Strategic Forum on 4 April 2018)

1. 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.

2. Health is centrally 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.

3. The National Health Vision (NHV) 2016-25 provides an overarching national vision and agreed upon common direction, harmonizing provincial and federal efforts for achieving the desired SDG3 outcomes and impact. It was designed to represent an aspirational direction and to set ambitious targets to achieve SDGs including universal access to health services.

4. The SDG3 follows the health-related Millennium Development Goals (MDGs) of the period 2000–15, as major challenges remain in terms of reducing maternal and child mortality and control of communicable diseases. The health agenda also highlights the importance of addressing non-communicable diseases and their risk factors such as tobacco use, mental health problems, road traffic injuries, and environmental health issues. Weak health systems are a major obstacle, resulting in major deficiencies in Universal Health Coverage (UHC) for even the most basic health services and inadequate preparedness for health emergencies.

5. M/o NHSR&C aims to successfully implement the health-related sustainable development agenda in collaboration with provinces and other sectors, through the development of national plans that are integrated with the National Health Vision 2016-2025.

6. The role of lead Ministries is vital to the SDGs since they form plans/policies based on the data reported on SDG indicators and targets. Ministry of Planning, Development and Reforms has given the responsibility monitoring the indicators to different line ministries. Ministry of Climate Change (with 50 indicators) has the maximum indicators they need to monitor, followed by Ministry of National Health Services, Regulations & Coordination (36 indicators) and Ministry of Finance (31 indicators).

7. The M/o NHSR&C has completed the process of localization of health-related SDG indicators. With support of WHO, the Ministry conducted a national level workshop in December 2017 to set baselines (for years 2000 and 2015) and targets for health-related SDGs at the national level, using trend analysis of available data for Pakistan. Following this the ministry and WHO supported the provincial /area DOHs to localize SDG3 indicators at provincial / area level.

8. Alongside, Health Services Academy with support of WHO completed a study in 2018 to gather and analyse data on health-related SDGs and make projections for future both at national/ provincial/ area level.

9. The National level health related SDG indicators were finalized and presented in the Inter-Ministerial Health & Population Strategic Forum held on 4 April 2018 and the same were endorsed. It was also discussed and agreed in the forum to hold ONE HEALTH SURVEY for health indicators by pooling all the available resources both domestic and external support.

Part 1: NHV/ SDG 3 and related Indicators at National level and Monitoring options:

SDG Indicators	Baseline		Current Data Sources	Target 2030		Comparable estimates required for monitoring at		Proposed Data Sources at		Disaggregation of data required
	2000	2014-15		Expected	Required	International	National	Inter-national	National/ Provincial/ District or Constituency wise	
3.1.1 Maternal Mortality Ratio (per 100,000 live births)	294	178	PDHS, UNIA	95	<70	Annual	6 years	Nat Survey, UNIA	ONE Nat Survey with provincial estimates	Yes
3.1.2 Skilled Birth Attendance (%)	23	58	PDHS, PSLM	>85	>90	Annual	Annual + 3 Years	Nat survey	ONE Nat Survey with provincial & district/ constituency estimates	Yes
3.2.1 Under Five Mortality Rate (per 1,000 live births)	112.6	81.9	PDHS, UNIA	49	<25	Annual	3 Years	Nat Survey, UNIA	ONE Nat Survey with provincial & district/ constituency estimates	Yes
3.2.2 Neonatal Mortality Rate (per 1,000 live births)	60.1	47.3	PDHS, UNIA	30	<12	Annual	3 Years	Nat Survey, UNIA	ONE Nat Survey with provincial & district/ constituency estimates	Yes
3.3.1 HIV Incidence among adults (per 1,000 uninfected population)	0.01	0.09	UNAIDS, WHO	0.19	≤0.01	Annual	6 Years	UNAIDS	Nat Health Examination Survey	Yes
3.3.2 TB Incidence (per 100,000 population)	275	270	TB Survey, WHO	212-261	≤54	Annual	6 Years	Nat Survey, WHO	Nat Health Examination Survey	Yes
3.3.3 Malaria Incidence (per 1,000 population at risk)	44.8	8.56	Malaria Survey, WHO	<1	<1	Annual	6 Years	Nat Survey, WHO	Nat Health Examination Survey	Yes
3.3.4 Hepatitis B incidence (per 100,000 population)	NA	72	PHRC	45	<1	Annual	6 Years	Nat Survey, WHO	Nat Health Examination Survey	Yes
3.3.5 Number of people requiring interventions against neglected tropical diseases	NA	31,056	NIH, WHO estimates	<10,000	<1	Annual	Annual	WHO	NIH, WHO	-
3.4.1 Probability of dying from cardiovascular disease, cancer, diabetes, chronic respiratory disease between age 30 and 70 (%)	24.8	24.7	WHO, Global Health Estimates	20*	17	5 years	6 Years	WHO	NBoD study, WHO	-
3.4.2 Suicide mortality rate (per 100,000 population)	2.6	2.1	PDHS, WHO, PDS	≤1.6*	≤1	2-3 years	6 Years	WHO	ONE Nat Survey with provincial estimates	-
3.5.1 Coverage of Prevention/ treatment of substance abuse	NA	10	UNODC, WHO	35*	>80	Annual	Annual	UNODC, WHO	NACP, UNODC, WHO	-

***: intuitive estimates based on consultations with stakeholders**

3.5.2 Total alcohol per capita (≥ 15 years) consumption (litres of pure alcohol)	NA	0.2	WHO, GISAH	≤0.2	Nil	Annual	Annual	WHO	WHO	-
3.6.1 Road traffic mortality rate (per 100 000 population)	15	14.2	WHO, Global Health Estimates, Police Data	<13	8	2-3 years	2-3 years	WHO	Police data	Yes
3.7.1 Proportion of eligible couples who have their need for family planning satisfied with modern methods (%)	35	47	PDHS	>70	>95	Annual	Annual+ 3 Years	Nat Survey	ONE Nat Survey with provincial & district/ constituency estimates	Yes
3.7.2 Adolescent birth rate (per 1,000 women aged 15–19 years)	49	38.3	PDHS	29*	≤10	Annual	Annual	Nat Survey	ONE Nat Survey with provincial estimates	Yes
3.8.1 Universal Health Coverage index (%)	NA	40	WHO /WB	65	>80	Annual	Annual	National Survey	ONE Nat Survey with provincial & district/ constituency estimates	Yes
3.8.2 Incidence of catastrophic expenditure (%) at 10% of household total consumption or income	-	1.03	WHO / WB	Tbd	Tbd	Annual	3 years	WHO / WB	HIES	-
3.9.1 Mortality rate attributed to household and ambient air pollution (per 100,000 population)	-	87.2	WHO, Global Health Observatory	Tbd	Tbd	2-3 years		WHO, Global Health Observatory	-	-
3.9.2 Mortality rate attributed to exposure to unsafe WASH services (per 100,000 population)	-	20.7	WHO, Global Assessment environmental risks, 2012	Tbd	Tbd	2-3 years	-	WHO	-	-
3.9.3 Mortality rate attributed to unintentional poisoning (per 100,000 population)	-	1.5	WHO, Global Health Estimates	Tbd	Tbd	2-3 years	-	WHO	-	-
3.a Age-standardized prevalence of tobacco smoking among persons 15 years and older	-	12.4	GATS	10	Tbd	Annual	3 years	Nat Survey, WHO	Health Examination survey	Yes
3.b.1 Measles - 2 Immunization coverage (%)	-	Introduced	WHO/WB, PDHS, PSLM	>80	>95	Annual		Nat survey, UNICEF, WHO	ONE Nat Survey with provincial & district/ constituency estimates	Yes
3.b.2 Total ODA to medical research and basic health (%)	-	<1	NHA, OECD database	Tbd	Tbd	Annual	3 years	OECD, WHO	NHA	-
3.b.3 Proportion of health facilities with essential medicines (%)	-	65	HFA 2012	>80	100	Annual	3 years	Nat Survey, WHO	HFA, Thrid Party Monitoring	Yes
3.c Skilled health professionals' density (per 10,000 population)	6.6	14.1	PMDC, PNC	34.4	44.5	Annual	Annual	PMDC, PNC WHO	PMDC, PNC National Dashboard	Yes
3.d.1 IHR Index (13 core competencies) (%)	-	53	WHO	>75	100	Annual	5 years	WHO	IHR Ext Eva	-

Breakdown of the UHC Index										
A: Reproductive, Maternal, New-born, Child and Adolescent Health and Nutrition (weight age: 25%)										
3.7.1 Proportion of eligible couples who have their need for family planning satisfied with modern methods (%)	35	47	PDHS	>70	>95	Annual	Annual+ 3 Years	Nat Survey	ONE Nat Survey with provincial & district/ constituency estimates	Yes
Antenatal care, 4+ visits (%)	22	73	WHO/WB, PDHS, PSLM	>55	>90	Annual	Annual+ 3 Years	Nat survey, WHO/WB	ONE Nat Survey with provincial & district/ constituency estimates	Yes
Child immunization (DPT III, Penta III) (%)	59	65.2	WHO/WB, PDHS, PSLM	>80	>95	Annual	Annual+ 3 Years	Nat survey, WHO/WB	ONE Nat Survey with provincial & district/ constituency estimates	Yes
Care-seeking behaviour for child pneumonia (%)	-	64	WHO/WB, PDHS,	>75	>90	Annual	Annual+ 3 Years	Nat survey, WHO/WB	ONE Nat Survey with provincial & district/ constituency estimates	Yes
B: Communicable diseases (weight age: 25%)										
Tuberculosis treatment coverage (%)	-	69	NTP-MIS	>90	>90	Annual	Annual	ATM MIS, WHO	ATM MIS	Yes
ARV Therapy coverage (%)	-	6	HIV-MIS	>25	>90	Annual	Annual	ATM MIS, UNAIDS, WHO/WB	ATM MIS	Yes
LLIN coverage for malaria (%)	-	13.4	MCP	>25	-	Annual	Annual	ATM MIS, WHO	ATM MIS	Yes
Population using safe sanitation (%)	-	64	WHO/WB, PSLM, PDHS	Tbd	100	Annual	Annual	Nat survey, WHO/WB	ONE Nat Survey with provincial & district/ constituency estimates	Yes
C: Non-Communicable diseases (weight age: 25%)										
Normal blood pressure (%)	-	53.8	PHRC, WHO/WB (70)	Tbd	Tbd	Annual	6 years	Nat Survey, WHO	Health Examination survey	Yes
Mean fasting plasma glucose (mmol/L) Population with normal glucose level (%)	-	5.84 73.7	WHO/WB, PHRC	Tbd	Tbd	Annual	6 years	Nat Survey, WHO	Health Examination survey	Yes
Cervical cancer screening (%)	-	0.9	Cancer Registry	Tbd	Tbd	Annual	6 years	Nat Survey, WHO	Health Examination survey	Yes
Tobacco non-smoking (%)	-	80	WHO/WB, GATS	Tbd	Tbd	Annual	6 years	Nat Survey, WHO	Health Examination survey	Yes
D: Service coverage and access (weight age: 25%)										
Hospital beds per 10,000 population; Hospital beds against the threshold (%)	-	6 33	WHO/WB FBS	12 66	18 100	Annual	Annual	FBS, WHO/WB	HFA	Yes
Access to essential medicine, vaccine and commodities (%)	-	65	HFA	>80	100	Annual	3 years	HFA, WHO	HFA, 3rd Party Monitoring	Yes
Physicians per 1,000 population Psychiatrists per 100,000 population Surgeons per 100,000 population	- - -	0.8 0.3 1.3	WHO/WB PMDC	1.11 0.7 2.2	1.11 - -	Annual	Annual	PMDC WHO/WB	National Dashboard	Yes
IHR Index -19 capacities (%)	-	48	IHR Ext Eva	>75	100	Annual	5 years	WHO	IHR Ext Eva	-
3.8.2 Incidence of catastrophic expenditure (%) at 10% of household total consumption or income	-	1.03	WHO/WB	Tbd	Tbd	Annual	3 years	WHO/WB	HIES	-

3.9.1 Mortality rate attributed to household and ambient air pollution (per 100,000 population)	-	87.2	WHO, Global Health Observatory	Tbd	Tbd	2-3 years	-	WHO, Global Health Observatory	ONE Nat Survey with provincial & district/ constituency estimates	-
3.9.2 Mortality rate attributed to exposure to unsafe WASH services (per 100,000 population)	-	20.7	WHO, Global Assessment environmental risks, 2012	Tbd	Tbd	2-3 years	-	WHO	-	-
3.9.3 Mortality rate attributed to unintentional poisoning (per 100,000 population)	-	1.5	WHO, Global Health Estimates	Tbd	Tbd	2-3 years	-	WHO	-	-
3.a Age-standardized prevalence of tobacco smoking among persons 15 years and older	-	12.4	GATS	10	Tbd	Annual	3 years	Nat Survey, WHO	Health Examination survey	Yes
3.b.1 Measles - 2 Immunization coverage (%)	-	Introduced	WHO/WB, PDHS, PSLM	>80	>95	Annual	3 years	Nat survey, UNICEF, WHO	ONE Nat Survey with provincial & district/ constituency estimates	Yes
3.b.2 Total ODA to medical research and basic health (%)	-	<1	NHA, OECD database	Tbd	Tbd	Annual	3 years	OECD, WHO	NHA	-
3.b.3 Proportion of health facilities with essential medicines (%)	-	65	HFA 2012	>80	100	Annual	3 years	Nat Survey, WHO	HFA, Third Party Monitoring	Yes
3.c Skilled health professionals' density (per 10,000 population)	6.6	14.1	PMDC, PNC	34.4	44.5	Annual	Annual	PMDC, PNC, WHO	PMDC, PNC National Dashboard	Yes
3.d.1 IHR Index (13 core competencies) (%)	-	53	WHO	>75	100	Annual	5 years	WHO	IHR Ext Eva	-
Other Health related SDGs										
1.a.2 General government health expenditure as % of general government expenditure	-	4.7	Global Health Expenditure database	Tbd	Tbd	Annual	3 years	GHED	NHA	-
2.2.1 Prevalence of stunting among children < 5 years of age (%)	36.8	45	NNS, UNIA	22	Tbd	Annual	3 years	Nat survey UNICEF, WHO	ONE Net Survey with provincial estimates	Yes
2.2.2 Prevalence of overweight in children < 5 years of age (%)	-	NA	NNS, UNIA	Tbd	Tbd	Annual	3 years	Nat survey UNICEF, WHO	ONE Net Survey with provincial estimates	Yes
5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	-	38.5	PDHS	Tbd	Tbd	Annual	3 years	Nat survey, UNW	ONE Net Survey with provincial estimates	Yes
5.3.1 Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18	-	2.8 21.0	PDHS	<1 <15	≤10	Annual	Annual	Nat Survey, UNPD	ONE Net Survey with provincial estimates	Yes
5.3.2 Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age	-	-	NA	-	-	-	-	-	-	-
5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	-	47	PDHS	70	100	Annual	3 Years	Nat Survey, UNW	ONE Net Survey with provincial estimates	Yes

6.1.1 Proportion of population using improved drinking-water sources (%)	86	91	PSLM	100	100	Annual	Annual+ 3 Years	Nat survey UNICEF, WHO	ONE Nat Survey with provincial & district/ constituency estimates	Yes
6.2.1 Proportion of population using improved sanitation (%)	57	73	PSLM	>90	100	Annual	Annual+ 3 Years	Nat survey UNICEF, WHO	ONE Nat Survey with provincial & district/ constituency estimates	Yes
7.1.2 Proportion of population with primary reliance on clean fuels (%)	-	45	WHO	Tbd	> 95	Annual	3 years	Nat survey WHO	ONE Nat Survey with provincial & district/ constituency estimates	Yes
11.6.2 Annual mean levels of fine particulate matter ($PM_{2.5}$) in urban areas (µg/m3)	-	67.7	WHO Global Assessment	Tbd	Tbd	Annual	-	-	-	-
13.1.1 Average death rate due to natural disasters (per 100,000 population)	-	0.4	WHO, Global Health Estimates	Tbd	Tbd	5 years	-	-	-	-
16.1.1 Mortality rate due to homicide (per 100,000 population)	-	9.5	WHO, Global Health Estimates	Tbd	Tbd	5 years	-	-	-	-
16.1.2 Estimated deaths from major conflicts (per 100,000 population)	-	-	WHO	Nil	Nil	5 years	-	-	-	-
17.19.2 Completeness (%) of cause-of-death data	-	NA	WHO, Global Health Estimates	Tbd	Tbd	5 years	-	-	-	-

Part 2: NHV/ SDG3 and related Indicators at National level with Milestones:

SDG Indicators	Baseline		Current Data sources	Milestone						Target 2030	
	2000	2014-15		2018	2020	2022	2024	2026	2028	Expected	Required
3.1.1 Maternal Mortality Ratio (per 100,000 live births)	294	178	PDHS, UNIA	160	148	137	126	115	105	95	<70
3.1.2 Skilled Birth Attendance (%)	23	58	PDHS, PSLM	69	72	75	78	82	85	>85	>90
3.2.1 Under Five Mortality Rate (per 1,000 live births)	112.6	81.9	PDHS, UNIA	75	70	66	62	57	53	49	<25
3.2.2 Neonatal Mortality Rate (per 1,000 live births)	60.1	47.3	PDHS, UNIA	42	40	38	36	34	32	30	<12
3.3.1 HIV Incidence among adults (per 1,000 uninfected population)	0.01	0.09	UNAIDS, WHO	0.11	0.12	0.14	0.15	0.16	0.17	0.19	≤0.01
3.3.2 TB Incidence (per 100,000 population)	275	270	TB Survey, WHO	269	267	260-266	250-265	230-264	220-263	212-261	≤54
3.3.3 Malaria Incidence (per 1,000 population at risk)	44.8	8.56	Malaria Survey, WHO	7	3.9	3	2	1	1	<1	<1
3.3.4 Hepatitis B incidence (per 100,000 population)	NA	72	PHRC	68	64	60	56	52	49	45	<1
3.3.5 Number of people requiring interventions against neglected tropical diseases	NA	31,056	NIH, WHO estimates				<20,000			<10,000	<1
3.4.1 Probability of dying from cardiovascular disease, cancer, diabetes, chronic respiratory disease between age 30 and 70 (%)	24.8	24.7	WHO, Global Health Estimates	24.7	24.7	24	23.5	22.5	21.5	20*	17
3.4.2 Suicide mortality rate (per 100,000 population)	2.6	2.1	PDHS, WHO, PDS				1.9			≤1.6*	≤1

3.5.1 Coverage of Prevention/ treatment of substance abuse	NA	10	UNODC, WHO				15			35*	>80
3.5.2 Total alcohol per capita (≥ 15 years) consumption (litres of pure alcohol)	NA	0.2	WHO GISAH				0.2			≤0.2	Nil
3.6.1 Road traffic mortality rate (per 100 000 population)	15	14.2	WHO, Global Health Estimates, Police Data	14.5	15.5	15	15	14	14	<13	8
3.7.1 Proportion of eligible couples who have their need for family planning satisfied with modern methods (%)	35	47	PDHS	50	54	56	58	62	66	>70	>95
3.7.2 Adolescent birth rate (per 1,000 women aged 15–19 years)	49	38.3	PDHS	36.3	35	34	32.7	31.6	30.4	29*	≤10
3.8.1 Universal Health Coverage index (%)	NA	40	WHO, WB	49	53	55	57	60	62	65	>80
Breakdown of the UHC Index											
A: Reproductive, Maternal, New-born, Child and Adolescent Health and Nutrition (weight age: 25%)											
3.7.1 Proportion of eligible couples who have their need for family planning satisfied with modern methods (%)	35	47	PDHS	50	54	56	58	62	66	>70	>95
Antenatal care, 4+ visits (%)	22	37	WHO/WB , PDHS, PSLM	40	42	45	47	50	53	>55	>90
Child immunization (DPT III, Penta III) (%)	59	65.2	WHO/WB PDHS, PSLM	75	76	77	78	79	80	>80	>95
Care-seeking behaviour for child pneumonia (%)	-	64	WHO/WB , PDHS,	66	67	69	71	72	74	>75	>90
B: Communicable diseases (weight age: 25%)											
Tuberculosis treatment coverage (%)	-	69	NTP-MIS	73	75	78	81	84	88	>90	>90
ARV Therapy coverage (%)	-	6	HIV-MIS	6	6	7	10	15	20	>25	>90
LLIN coverage for malaria (%)	-	13.4	MCP	15	17	19	21	23	24	>25	-
Population using safe sanitation (%)	-	64	WHO/WB, PSLM, PDHS							Tbd	100
C: Non-Communicable diseases (weight age: 25%)											
Normal blood pressure (%)	-	53.8	PHRC, WHO/WB (70)							Tbd	Tbd
Mean fasting plasma glucose (mmol/L) Population with normal glucose level (%)	-	5.84 73.7	WHO/WB, PHRC							Tbd	Tbd
Cervical cancer screening (%)	-	0.9	Cancer Registry							Tbd	Tbd
Tobacco non-smoking (%)	-	80	WHO/WB, GATS							Tbd	Tbd
D: Service coverage and access (weight age: 25%)											
Hospital beds per 10,000 population;	-	6	WHO/WB	9	10	10	11	12	12	12	18
Hospital beds against the threshold (%)		33	FBS							66	100
Access to essential medicine, vaccine and commodities (%)	-	65	HFA	67	70	74	78	80	80	>80	100
Physicians per 1,000 population	-	0.8	WHO/WB	0.9	0.9	1	1	1.1	1.11	1.11	1.11
Psychiatrists per 100,000 population	-	0.3	PMDC							0.7	-

Surgeons per 100,000 population	-	1.3								2.2	-
IHR Index - 19 capacities (%)	-	48	IHR Ext Eva	52	55	58	61	65	70	>75	100
3.8.2 Incidence of catastrophic expenditure (%) at 10% of household total consumption or income	-	1.03	WHO/WB							Tbd	Tbd
3.9.1 Mortality rate attributed to household and ambient air pollution (per 100,000 population)	-	87.2	WHO, Global Health Observatory							Tbd	Tbd
3.9.2 Mortality rate attributed to exposure to unsafe WASH services(per 100,000 population)	-	20.7	WHO, Global Assessment environmental risks, 2012							Tbd	Tbd
3.9.3 Mortality rate attributed to unintentional poisoning (per 100,000 population)	-	1.5	WHO, Global Health Estimates							Tbd	Tbd
3.a Age-standardized prevalence of tobacco smoking among persons 15 years and older	-	12.4	GATS				11			10	Tbd
3.b.1 DPT3/Penta3 Immunization coverage (%)	59	65.2	WHO/WB PDHS, PSLM	75	76	77	78	79	80	>80	>95
3.b.2 Total ODA to medical research and basic health (%)	-	<1	NHA, OECD database							Tbd	Tbd
3.b.3 Proportion of health facilities with essential medicines (%)	-	65	HFA 2012	67	70	74	78	80	80	>80	100
3.c Skilled health professionals' density (per 10,000 population)	6.6	14.1	PMDC, PNC	15	15.5	17	20	24	38	34.4	44.5
3.d.1 IHR Index (13 core competencies) (%)	-	53	WHO	57	60	63	66	70	74	>75	100
Other Health related SDGs											
1.a.2 General government health expenditure as % of general government expenditure	-	4.7	Global Health Expenditure database							Tbd	Tbd
2.2.1 Prevalence of stunting among children < 5 years of age (%)	36.8	45	NNS, UNIA	37.6						22	Tbd
2.2.2 Prevalence of wasting in children < 5 years of age (%)	13.1	10.8	NNS, UNIA	7.1						3	Tbd
5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	-	38.5	PDHS							Tbd	Tbd
5.3.1 Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18	-	2.8 21.0	PDHS							~~15~~ 18	≤10
5.3.2 Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age	-	-	NA							-	-

5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	35	47	PDHS	50	54	56	58	62	66	>70	>95
6.1.1 Proportion of population using improved drinking-water sources (%)	86	91	PSLM							100	100
6.2.1 Proportion of population using improved sanitation (%)	57	73	PSLM							>90	100
7.1.2 Proportion of population with primary reliance on clean fuels (%)	-	45	WHO							Tbd	>95
11.6.2 Annual mean levels of fine particulate matter ($PM_{2.5}$) in urban areas (µg/m3)	-	67.7	WHO, Global Assessment							Tbd	Tbd
13.1.1 Average death rate due to natural disasters (per 100,000 population)	-	0.4	WHO, Global Health Estimates							Tbd	Tbd
16.1.1 Mortality rate due to homicide (per 100,000 population)	-	9.5	WHO, Global Health Estimates							Tbd	Tbd
16.1.2 Estimated deaths from major conflicts (per 100,000 population)	-	-	WHO							Nil	Nil
17.19.2 Completeness (%) of cause-of-death data	-	NA	WHO, Global Health Estimates							Tbd	Tbd

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https://www.countdown2030.org/country-collaborations/pakistan-countdown-country-collaboration

Annex - D:
Photo Gallery (Face to Face workshop March 11, 2021)

Ministry of
National Health Services
Regulations & Coordination
Government of Pakistan

DCP3 Disease Control Priorites
Country Translation Phase

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

University of Manitoba