Strategy 2012–2020
Sindh Health Sector

1. BACKGROUND AND PURPOSE

INTRODUCTION

A major development in the constitutional history of Pakistan has taken place recently when, all functions related to the social sectors including health have been devolved to the provinces. The Constitutional (18th Amendment) Act, 2010 was passed in the Parliament and was promulgated on April 20, 2010. The 18th amendment has provided an opportunity for provincial governments among other important responsibilities to review among other important responsibilities policy-making address gaps in human, administrative, management and financial resources to be able to plan for the additional responsibilities.

As per the implementation plan, the federal Ministry of Health stand abolished with effect from July1, 2011. The provinces are now -responsible for providing stewardship to the health sector in addition to the earlier service delivery role. Discussion between the provinces and federal government has led to establishment of an Inter-Provincial Concurrent list for Health Sector which includes International Commitments, Drug Licensing, Registration and Pricing functions, Export/Import of goods and services, and professional bodies such as Pakistan Medical & Dental Council, Nursing Council and Pharmacy Council as federal functions to be collectively managed at the federal level. Important functions notably priority setting and strategy development, regulation, management of vertical programs and management of federally funded facilities and initiatives have been agreed as provincial responsibilities.

As the administrative and fiscal space of provinces has increased multi-fold with a simultaneously increase in their responsibilities, the need to adjust health care delivery systems, governance structures and financial allocations in the provinces to improve health outcomes while maintaining equity, quality and efficiency in health care.

The Government of Sindh requires that a Health Sector Strategy be developed by reviewing the current situation in the health sector and establishing priorities for services

to be delivered to the people in an integrated manner. The Strategy will support the Health Department to progress further with a sense of direction, purpose and urgency by prioritizing policy related interventions consistent with availability of financial resources. Technical support for this assignment is provided by Technical Resource Facility Islamabad, an international agency assisted by DFID and AusAID, and is part of similar assistance being extended to all provinces in the post devolution context. Discussions have been held by TRF at Federal and Provincial levels with lead Development Partners and UN Agencies involved with the Health Sector. With one of the key outcomes of their involvement being that the alignment of future development partner investment is -tailored with the Strategy to the greatest extent possible so as to minimize the transaction costs on Government of multiple reviews and reporting requirements from multiple sources.

SCOPE

The proposed strategic framework for 2012-2020 is expected to serve as an over-arching umbrella to guide the operational plans of medium and long term programs and projects. It also provides estimates of resource envelopes for the total budgetary outlays as well as costs of specific strategies requiring assistance. The document is expected to provide strategic directions for resource mobilization from the stakeholders including the public sector, international donors, corporate sector and philanthropic organizations. In the preparation of the strategic framework care will be taken to avoid overlaps and redundancies for achieving efficiency and coordination across the various sub strategies across the sector. A menu of strategic and commensurate financing options will be presented, would range from no costs policy actions to budgetary enhancements, efficient spending of existing resources, and harnessing spending from private sector and donors. An allied monitoring and evaluation (M&E) framework will provide the Key Performance Indicators (KPIs) and quantitative annual targets over 2012-2020.

The eight year strategic framework is also expected to guide the DOH in the development of its annual development plans (ADPs) and expenditure forecasting.

OVERALL PURPOSE

- The key purpose of developing the strategic framework is to identify as to what is required for health systems strengthening (HSS) in Sindh;
- Define a set of sub strategies for the major building blocks of the HSS including : service delivery; human resources; health management information; medical products, vaccines and technologies; financing; and leadership /governance/s
- Provide a strategic framework/roadmap aligned with evidence based prioritized needs identified in the situation analysis which will in turn be a basis for detailed operational planning.

VISION:

Maximizing efforts to improve health status of the people in Sindh in congruence with international and national commitments and in response to Sindh's contextual needs

APPROACH:

Action on evidence based priority needs of Sindh through joint efforts of all partners and related sectors following a result based, technically relevant, resource feasible and socially accountable approach.

GUIDING PRINCIPLES

- **Provincial-demand** driven and addressing **provincial context**
- Building on appropriate **existing provincial processes** and **experience**
- Improve **equity** by maximizing benefits to disadvantaged population
- **Sectoral-vision** encompassing both public and private sector
- **Inter sectoral-action** to enhance healthy public policy
- Strong element of **monitoring and accountability**

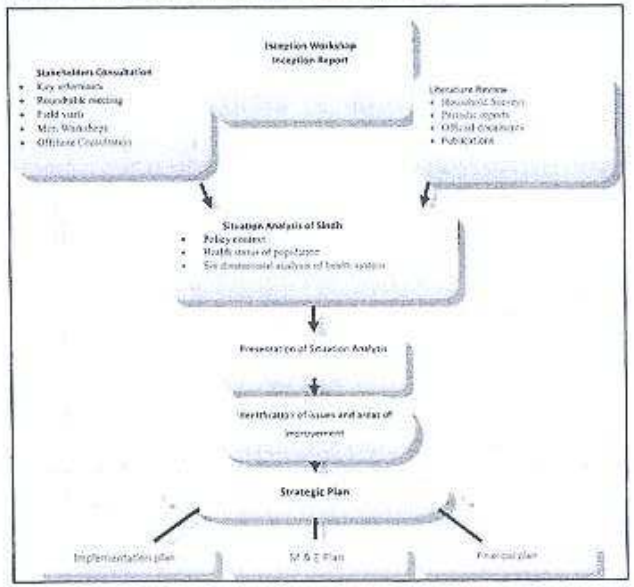
OBJECTIVE:

To provide a strategic direction aligned with evidence based prioritized needs which will in turn be a basis for detailed operational planning.

SPECIFIC OBJECTIVES

1. To enhance health outcomes in the province while improving cost efficiency and quality of service delivery.
2. To enhance stewardship role of DOH for steering the public and private sector towards desired health outcomes.
3. To harmonize the strategy plan with national policies and international commitments while maintaining strong contextual relevance for Sindh.
4. To provide a Financial Framework for investment by government, private sector, UN agencies and international partners
5. To provide a broad Monitoring and Evaluation Framework for monitoring of sector strategy by DOH and partners

PROCESS FOR STRATEGY DEVELOPMENT



A three tiered process was used for strategy development:

Inception framework development:

This inception framework was adapted from the World Health Organization's health systems strengthening (HSS) framework encompassing i) demographic and health needs, ii) health services delivery, iii) human resources' needs, iv) essential medicines, iv) management information system (MIS), v) health financing and vi) governance. - The Inception Framework was shared with DOH Sindh and international donors in consultative workshops and approved in September 2011 by GOS.

Situation Analysis:

An evidence based Situation Analysis was carried out during September to November 2011 and report submitted in November 2011. The approved report after incorporation of peer review feedback was shared with development partners in January 2012 and Steering Committee of DOH in February 2012. Feedback received was incorporated and finalized in February 2012. The approved report is available as reference document.

Strategy Development:

Strategy development was based on key areas and themes identified by the SA Report and feedback of consultative sharing with DOH Sindh and donors. The process involved listing and refining key thematic areas, developing strategic objectives, strategic actions, development of key performance indicators, annual targets and gross costing. The strategy is built on the existing strengths of the DOH systems, private sector strength in the province, reform experiences from South Asia and other low-middle income countries, and best practices on systems strengthening from HRDC-DFID, Partnership for Health Reform Plus, WHO and other internationally recognized sites. On advice of GOS a draft zero was developed, presented and shared with GOS and development partners. This version incorporates comments received from different development partners.

KEY CHALLENGES IDENTIFIED THROUGH SITUATION ANALYSIS

District Health Systems need strengthening more particularly in lower performing districts:

- Social indicators and health indicators are particularly poor in rural population of Sindh falling below the average for rural Pakistan and are closer to province of Baluchistan.
- Coverage of maternal and child health services, contraception, vaccination and communicable disease control is patchy due to poorly functional basic and emergency services.
- Only 27% of deliveries take place in health facilities, merely 70% of under 1 year children are immunized for measles, 11% of child bearing age couples practice contraception.
- Use of public sector is lower in Sindh at 22% compared to 29% in rest of the country.
- The LHW Program is the flagship program of DOH for community interventions but has coverage of only 20-43% in certain districts and technical knowledge and supervision is weaker than other provinces.

There are major gaps in PHC coverage in urban poor:

- Sindh has an unusual composition with 47% of population residing in urban areas and Karachi has the highest growth rate of 3.2%.

Key Health Indicators of Sindh

Indicator	Sindh	Pakistan
IMR	81	78
NMR	53	54
MMR	314	276
Female Education	46	46
Sex Ratio	112.2	108.5
flush toilet facility	62	66
Safe Water	89	87
Population Growth Delivery	2.8	2.69
Institutional Delivery	42	41
Polio 3	70	79
Measles	77 %	82
Undernourished Children	40.5	31.5
Child Anemia	73	62
Maternal Anemia	62	51
Food insecurity	72	58
Adult Hypertension	40	
Adult Depression	32	
HIV/AIDS cases	3936	7547
TB case detection	59	70
Malaria cases/ 1000	1.5	
Prevalence of Hepatitis B and C	7.5	7.6
Public Sector Utilization	22	29
LHW coverage	45	
T. Public Sector Expenditure	37.7	32
T. OOP Expenditure	66	64

- At present PHC spending is least in Karachi and tilt towards tertiary care level. As a result there is thin PHC infrastructure, sub-standard frontline facilities, poor MDG indicators and polio outbreaks in low income areas.
- Non Communicable Disease are endemic striking economically productive adults.

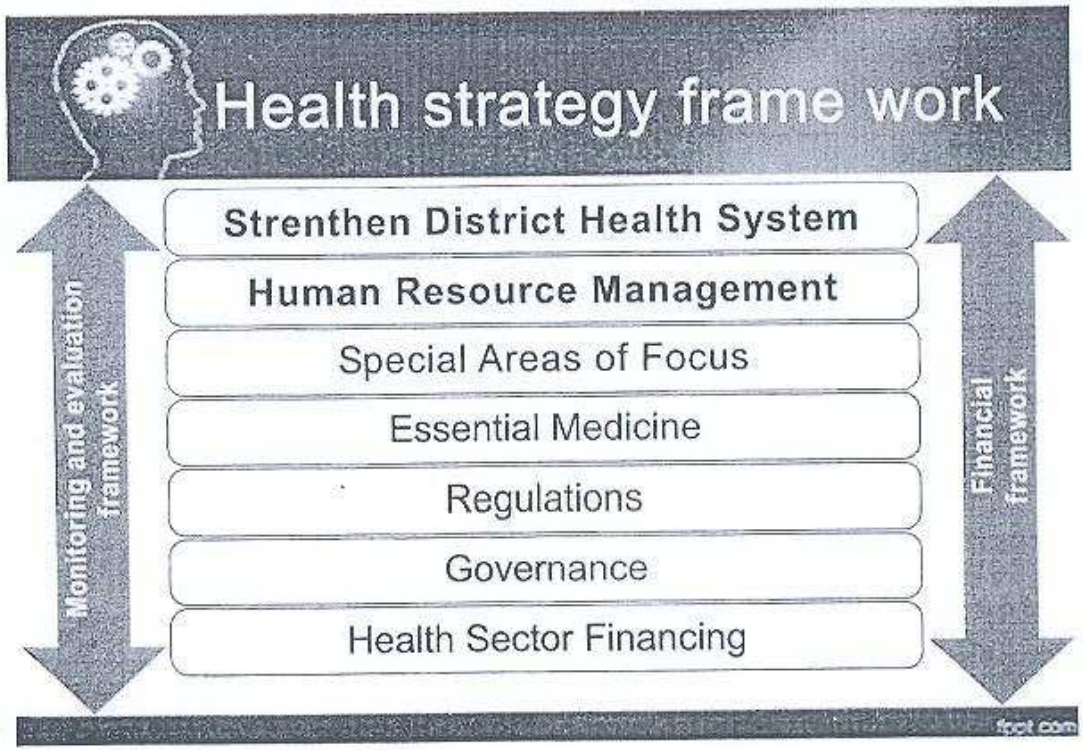
Special Areas of Focus:

- **Nutrition:** Sindh has the highest rate of child under-nutrition (40%), maternal (62%) and child anemia (73%) and food insecurity (72%) compared to rest of Pakistan. .
- **Polio:** Sindh has been reporting Polio cases from Karachi metropolis followed by at least 5 rural districts. Immunization coverage of Polio 3 in Sindh is only 70% and active immunity independently confirmed is nearly 20 percentage points lower than reported coverage.
- **NCDs:** Account for 56% of disease burden and are estimated to be higher in Sindh which has a higher urban population than other provinces. NCDs are endemic in the urban poor and have an earlier age of onset. Ischemic heart disease accounts for the largest share of disease burden, followed by mental health and trauma while chronic obstructive lung disease and cancers make up the remaining burden. Karachi has one of the highest global rates of particulate air pollution and breast cancer. Despite high prevalence levels, majority of patients are unaware of disease onset and inappropriately controlled.
- Communicable Diseases: TB case detection rate (CDR) has reached to 59% and is below national target of 70%. Hepatitis B and C levels are also major concerns. Vaccination levels are at best 14-7% in better performing districts and 6-0% in remaining district. HIV, in urban Sindh has of the total of 7547 reported HIV cases in Pakistan, 3936 are in Sindh, with 81% reported from Karachi metropolis majorly due to injectable drug users (IDUs), male sex workers (MSM), female sex workers, jail inmates, street children, fishermen, and long distance truck drivers.

- Human resource deployment, retention and capacity is sub-optimal in rural areas particularly for female staff
- Sindh has become probe to natural disasters but lacks disaster preparedness for health care.
- Essential Medicine availability is poor in public sector and compounded by high OOP expenses, irrational use and suspect quality across the sector.
- There is lack of regulation despite highest private health sector concentration in Sindh.
- Governance Issues
- Public sector spending is low in real terms, there are major inefficiencies and regressively high OOP expenditure.

Box 1: Key Themes identified through Stakeholder Consultation

- Concerted action is needed on MNCH, nutrition and polio eradication, as health indicators have either declined or at best remained stagnant while special focus is needed on control of key communicable diseases, occupational health and disaster management.
- Strengthening of district health systems are needed, particularly in the more disadvantaged rural districts providing integrated care and aggressive outreach.
- Shift needed in urban areas from heavy capital investment in hospitals to operational investment in primary health care and harnessing of private sector.
- NCDs are increasingly prevalent in urban poor and need cost effective primary and lifestyle interventions.
- Emergency care networks require strengthening rural districts with adequate links to major teaching hospitals.
- Skill enhancement of human resource needed for essential basic and secondary care, health management and drug dispensing.
- Comprehensive essential medicine strategy is missing and needed to address drug availability, quality, rational use and market quality assurance.
- Functional and structural changes needed across Department of Health to improve efficiency of the Health Department.
- Regulatory roadmap needed as Sindh has the highest concentration of private sector, including unlicensed providers.
- Strong and effective stewardship role needs to be built for DOH to steer entire health sector.
- Harnessing of private sector investment and services needs to be made for joint action on achieving desired health goals.
- Public sector investment in health needs significant increase and effective strategizing is needed of existing investment by philanthropic sector, corporate sector and international partners.


Health strategy frame work
Strenthen District Health System
Human Resource Management
Special Areas of Focus
Essential Medicine
Regulations
Governance
Health Sector Financing
Monitoring and evaluation framework
Financial framework

STRATEGY SUMMARY & IMPLEMENTATION

Strategic Outcome	Strategy
1: Strengthen district health systems with special emphasis on under developed districts and urban PHC	
1 a: Strengthen district health systems starting with most under-developed districts of Sindh	**1.1a:** Roll out of Minimum Service Delivery Package (MSDP) provision through FLCFs with at least one MSDP providing facility per Taluka . **1.2a:** Establish Essential Service of Health Package (EPHS) in DHQs for provision of essential secondary care provision linked to prioritized referrals from MSDP providing facilities **1.3a:** Contract out facilities in remote talukas of disadvantaged districts to qualified private sector entities for publically financed provision of MSDP. **1.4a:** Expanding community based outreach coverage with an integrated community health package involving community based education and behavioral change **1.5a:** Provision of supportive outreach measures including transport vouchers to increase facility utilization **1.6a** Intersectoral district based pilots on nutrition and social development through collaboration with BISP, water & sanitation, education and other sectors. **1.7a:** Strengthen district health governance for result based implementation of services in disadvantaged districts.
1b Implement an Urban PHC system built on public private partnerships and addressing contextual needs of low income urban population.	**1.1b:** Develop an integrated family health practice model of "one stop shop for health and population" in low income urban localities involving registering of households with practitioner **1.2b:** Roll out of urban adjusted Minimum Service Delivery Package through franchising with GPs and NPOs, and upgrading and standardizing services of existing urban FLCFs **1.3b:** Implementation of urban adjusted Essential Health Service Package at identified secondary care centers in public and private sector with prioritized referral links from MSDP centers, and onward linkage to tertiary hospitals.

	1.4b Deployment and training of LHWs and multi-purpose health workers linked to Family Practice model for community based health package targeted to entire household. **1.5b** Use of family health cards for free consultative services and drugs, and subsidized charges for diagnostic support **1.6b:** Support implementation of key lifestyle changes through behavioral change, regulatory and inter-sectoral action. **1.7b:** Strengthen governance for implementation of urban PHC systems, including integrated delivery from public sector, stewardship of private sector and implementation of viable financial models.
2: Streamline human resource production, retention and capacity to support priority heath needs.	**2.1:** Strengthen development, deployment and retention of female health staff in rural areas. **2.2:** Enhance coverage and technical supervision of LHWs, and deploy community male and female volunteers in under-covered remote areas using a modified package of services **2.3:** Fill vacancies of specialists at rural DHQs and Civil Hospitals through task shifting and telemedicine. **2.4:** Develop a trained administrative cadre to improve efficiency of health administration at district and provincial level. **2.5:** Develop a hospital pharmacy cadre to ensure rational use of drugs and quality management of inventory. **2.6:** Strengthen management of human resources in the province.
3: Special Areas of Focus	**3.1:** Aggressive coverage of Polio through implementation of community based Polio Plus Program **3.2:** Mainstreaming of evidence based action for under-nutrition in health packages and establishing linkages with other sectors for integrated pilots **3.3:** Functionalizing of MNCH services at EPHS, MSDP and community based level and enhancement of community based services building in evidence based interventions **3.4:** Re-defining links with DOPW with shift of contraceptive services through district and urban PHC systems and aimed at birth spacing in younger couples **3.5:** Mainstreaming of primary and secondary control of NCD interventions and lifestyle support in low income urban townships **3.6:** Establishing links between TB, Malaria and Hepatitis for integrated control at community based, MSDP and EPHS levels, and evidence based intervention enhancements. **3.7:** Implement focal action on HIV / AIDS and STIs in targeted risk groups through NGO government

	partnership **3.8:** Establish permanent structures at provincial and district levels for disaster management and enhance capacity. **3.9.** Establishment of medico-legal unit at provincial level for enhancing forensic medicine at DHQs and THQs **3.10** Incorporation of integrated health response to gender based violence **3.11:** Participation in inter-sectoral action on occupational Health for industrial, agricultural and informal sector workers
4: Enhance sector-wide access to essential drugs through improvement in quality assurance, affordability, supply management and rational prescriptions.	**4.1:** Enhance technical and budgetary support for market surveillance and quality assurance of drugs **4.2:** Strengthen management of supply side so as to improve availability of quality drugs and improve accountability checks **4.3:** Implement multi-stakeholder led action on rational use of drugs. **4.4:** Plug deficiencies in production, deployment and training of pharmacists. **4.5:** Promote multi-pronged strategies for rational use of drugs, including promotion of generics, reduction in poly pharmacy and improving drug dispensation practices. **4.6:** Develop a central body for pharmacy functions integrating and enhancing existing functions being undertaken by Drug inspectorate, quality Assurance and Training units.
5: Regulate the health sector in particular the extensive private sector towards licensed practice, standardization of care, minimal reporting requirements and address of medical negligence.	**5.1:** Establish a Regulatory Authority and develop systems for licensing and registration of private health proyiders and outlets. **5.2:** Provide incentives for self accreditation of private providers and implementation of standardized services in major urban areas. **5.3:** Enhance accountability for medical negligence and recourse for consumer redress. **5.4:** Implement a mechanism of minimal reporting from private for profit and NPO providers. **5.5:** Develop focal multi-sector strategies for ensuring healthier environment
6: To respond to the stewardship and governance needs of health sector in the post 18th amendment devolution context, and also improve	**6.1:** Establish stewardship function of Secretariat for strong and effective steering of public and private health sector. **6.2:** Enhance visibility of Directorate in Implementation and oversight of district health services **6.3:** Functional and structural integration of programs having common outcomes for increased efficiency

efficiency and transparency of existing functions	6.4: To establish a multi-stakeholder Provincial Health Commission on Non-Communicable Diseases focal body in the province for technical guidance on control of NCDs across the health sector in Sindh. 6.5:Establishing PPP Framework and re-working modalities for PPHI 6.6: Establishing a well designed and integrated functional Monitoring and Evaluation Mechanism 6.7: Establish hospital autonomy pilots for major tertiary hospitals / specialist while building in transparency, performance and pro-poor protection measures. 6.8: To improve accountability in health service delivery by enhancing internal controls and establishing social accountability mechanisms at district and provincial levels
7: Increase investment in health sector and shift towards innovative financing systems to reduce OOP expenditure in the poor.	7.1 Increase total investment in the health sector, increasing public sector expenditure and effectively harnessing funding from private sector and international organizations 7.2: Increase investment in provision of primary care and essential secondary referral care 7.3: Reduce OOP expenditure on medicines especially for chronic diseases through multi-dimensional initiatives 7.4: Reduce catastrophic OOP expenditure through introducing Health equity funds and Community Pre-Payment Schemes for the poor. 7.5: Increase efficiency and performance of government financial systems 7.6: Increase efficiency through reducing overlaps across programs, reducing overlaps with private sector and removal of redundancies

STRATEGY IMPLEMENTATION:

Translation of strategy into implementation will require oversight, operational planning and establishment of clear lines of funding and performance accountability.

It is recommended that a multi-stakeholder Sindh Health Task Force be established at the sectoral level, on the pattern of Punjab Task Force, comprising of DOH, related departments, private sector and development partners to steer strategy implementation and provide social accountability. The newly established HSRU Sindh would serve as the natural secretariat for technical streamlining, coordination of implementation and monitoring, and will require sustained technical assistance over the medium and long term.

Operational plans will be need to be developed in a number of areas with broad areas including I) programmatic areas such as MNCH-Family Planning; Nutrition, Communicable Diseases; Polio Plus, Non-Communicable Diseases, Disaster Management; Pharmaceutical II) systemic areas such as Human Resource; District Health System Strengthening; Urban PHC; and III) governance and financing areas such as Program Integration; Administrative Restructuring; Regulation, PPP; Social Accountability, Financing Systems. Effective coordination amongst development partners is needed for input into respective operational plans.

Clear funding lines for strategy investment will need to be established with careful balancing of pooled budgetary support versus and project specific financing. Donor Coordination Unit and PPP Coordination units need to be activated within the HSRU. Flow of funds internally and external sources need to be carefully aligned with the result based M&E framework outlined in the strategy.

Inter-sectoral action will be needed for implementation in the complex and challenging areas of promoting healthy lifestyles for NCD control, environmental health, occupational health, nutrition, gender violence, HIV and Tobacco control. This will involve making productive and sustained linkages with Departments of Local Government, Agriculture, Labor, SESSI, Education, and Police as well as with non-public sector entities such as media and CSOs.