NATIONAL HEALTH VISION

Pakistan

2016-2025

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1. Vision Statement

To improve the health of all Pakistanis, particularly women and children, through universal access to affordable quality essential health services, and delivered through resilient and responsive health system, ready to attain Sustainable Development Goals and fulfill its other global health responsibilities.

2. Background

1. The 2011 devolution of health to the provinces has created challenges as well as opportunities for action. It is envisaged that the health benefits gained through the federal support can lead to more equitable health system coverage, au milieu de provincial priorities[1]. The provincial health departments and the re-established Ministry of National Health Services, Regulation and Coordination [MoNHSRC] are taking up their new found roles as provided for in the federal legislative list part I & II[2].
2. Political devolution within Pakistan provides a formidable opportunity for healthcare systems to address issues related to systems, planning health care delivery structures, programmes, and services[3]. This assumes greater significance as the targets of health related MDGs were not completely achieved, and far more effortsare required to work towards the even more challenging targets of the Sustainable Development Goals (SDGs)[4].
3. A significant gap after July 2011 has been lack of a consensus national vision that reflects the shared aspirations for better health of the people of the country as a whole. A national vision document on health that is aligned with the country's vision 2025[5], international health priorities and based on provincial realities, is thus needed, which lies within the framework of post 18th Amendment Constitutional roles/responsibilities.
4. The purpose of this document is to provide an overarching national vision and agreed upon common direction, harmonizing provincial, federal, inter-provincial and inter-sectoral efforts for achieving the desired health outcomes and to create an impact on health..
5. The word "national" depicts common political aspirations of the provincial and the federal governments. It has consonance with federal vision, provincial strategies, and international commitments.

[1] Bossert T. Devolution In Pakistan. Pakistan Health Policy Forum. Heartfile, Islamabad. http:// www.heartfile. org/blog/207
[2] https://pakistanconstitutionlaw.com/4thschedule-legislative-lists/
[3] Ali N, Khan MS. Devolution and health challenges and opportunities- a year later. Pakistan Journal of Public Health 2012; 2(2)-62-5.
[4] United Nations. Sustainable Development Goals: 17 goals to transform our world. 20th January 2016
[5] Ministry of Planning, Development & reform. Pakistan 2025: one nation, one vision. Planning Commission, Islamabad: 2014.

6. Moving beyond the health sector, it builds convergence with important national programs and policy settings such as the Pakistan Vision 2025, Poverty Reduction Strategy, and pro-poor social protection initiatives.

3. Pakistan at the Cross Roads for Health: Challenges

7. Despite several social, economic, political and cross border challenges compounded by successive natural catastrophes, the health indicators of Pakistan have shown improvement in the last 25 years; however it still lags behind some regional countries.
8. The average life expectancy has increased from 59 years by 1990 to 67 years by 2015. The last maternal mortality ratio recorded was 276 per 100,000 live births [2006-07][6], but it has improved significantly in the past decade, owing to wide outreach of national LHW program, and better skilled birth attendance availability[7]. Similarly, infant and under 5 mortality rates have improved [from 72/1000 to 66/1000 live births]; but neonatal mortality rate has remained stagnant; and so has the rising toll of stillbirths [43/1000 live births][8].
9. Pakistan is facing a double **burden of disease** (BoD), the burden is higher in the poor, and many of these conditions can be controlled at relatively low cost interventions and best practices through primary and secondary care levels. **Communicable diseases**, maternal health issues and under-nutrition dominate and constitute about half of the BoD[9]. In young children, diarrhoea and respiratory illness remain as the major killers[10]. Maternal deaths due to preventable causes like sepsis, haemorrhage and hypertensive crises are common. Pakistan is one of the three remaining countries where Polio is still endemic[11]. Moreover, Pakistan has an endemicity of hepatitis B and C in the general population with 7.6% affected individuals[12]; the 5th highest tuberculosis burden in the world[13], has focal geographical area of malaria endemicity[14], and an established HIV concentration among high risk groups[15]. Other vaccine preventable diseases and new emerging infections call for strengthening disease surveillance and response system uniformly across the country. Pakistan has one of

[6] National Institute of Population Studies & Macro International. Pakistan Demographic & Health Survey 2006-7. Islamabad: 2008.
[7] Ministry of Finance. Economic Survey of Pakistan 2016-17. Government of Pakistan. Islamabad: 2016.
[8] National Institute of Population Studies & Macro International. Pakistan Demographic & Health Survey 2012-13. Islamabad: 2014.
[9] World Health Organization. Country Cooperation Strategy for WHO and Pakistan 2011–2017. Eastern Mediterranean Regional Office. Cairo: 2013.
[10] UNICEF. Child Survival: Under-Five Mortality. 2016. http://data.unicef.org/child-mortality/under-five.html
[11] Polio Global Eradication Initiative. http://www.polioeradication.org/Keycountries.aspx
[12] Qureshi H, Bile KM, Jooma R, Alam SE, Afridi HU. Prevalence of hepatitis B and C viral infections in Pakistan: findings of a national survey appealing for effective prevention and control measures. Eastern Mediterranean Health Journal 2010; 16 (Suppl): S15-S23.
[13] World Health Organization. Global TB Report. Geneva: 2014. 6 Pakistan 2014 Malaria Grant Concept Note
[14] Global Fund. Pakistan 2014 Malaria Grant Concept Note. Islamabad: 2014.
[15] UNAIDS. Global AIDS Response Progress Report. Geneva: 2014.

the highest prevalence of under-weight children in South Asia. Similarly stunting, micro nutrient deficiencies and low birth weight babies contribute to already high level of mortality in mothers and children[16].

10. **Non-Communicable Diseases** along with Injuries and Mental health issues, now constitute other half of the BoD, causing far more disabilities and premature deaths among an economically productive adult age group[17]. The common underlying factors for non-communicable diseases including lifestyle, nutrition and smoking have not been addressed adequately. Injuries account for more than 11% of the total BoD, and are likely to rise with increasing road traffic, urbanization and conflict[18]. Pakistan is ranked 7th highest in the world for diabetes prevalence[19]. One in four adults over 18 years of age is hypertensive, and smoking levels are high (38% among men and 7% among women). . Rising but still unestimated burden of cancers and COPD remain a largely unaddressed area. Poverty, low literacy, unemployment, gender discrimination, and huge treatment gap have led to an invisible burden of mental health problems in the society. Disability due to blindness or other causes is also high, and services for disabled population are limited, including provision of assist devices to improve their quality of life.
11. **Population Explosion**: The BoD is rendered worse by an increasing population, with Pakistan now the sixth most populous country in the world[20]. Decline in population growth rate has been slow, and the current population growth rate of 1.9% per annum is driven by increasing age at marriage in urban areas; while contraceptive prevalence of only 35% is far below than other regional countries. Unmet need for birth spacing is around 25%[21], and the health system has to strategize to address this gap.
12. **Health Access and Inequities:** Pakistan has seen progress in access to health care services; however, the gains are uneven across different service areas as out of pocket expenditure is still around 70% despite having network of (primary, secondary and tertiary) health care system in place. Though skilled birth attendance (SBA) has improved from 18% in late 1990s' to 58% in 2015, but only one third of women make the required minimum number of antenatal visits and the number decreases further for postnatal visits (2% after 1-2 days of delivery). Despite reduction in Polio cases due to high vertical accountability, the rates of

[16] Aga Khan University, Pakistan Medical Research Council, Nutrition Wing, Cabinet Division, Government of Pakistan. National Nutrition Survey 2011. Islamabad: 2011.
[17] World Health Organization. Country Cooperation Strategy for WHO and Pakistan 2011–2017. Eastern Mediterranean Regional Office. Cairo: 2013.
[18] National Institute of Population Studies & Macro International. Pakistan Demographic & Health Survey 2006-7. Islamabad: 2008.
[19] World Health Organization. Global report on diabetes. Geneva: 2016.
[20] Population Reference Bureau. World Population Data Sheet. New York: 2015.
[21] National Institute of Population Studies & Macro International. Pakistan Demographic & Health Survey 2012-13. Islamabad: 2014.

routine immunization remain unacceptably low at 54%[21]. Access to and affordability of essential medicines is low[22]. Moreover, there are geographical disparities in coverage between provinces, districts and rural-urban area[23]. Evidence shows that low income groups are likely to have lower levels of health, nutrition, immunization and family planning coverage[24].

13. **Health Systems**: Pakistan has a **mixed health system,** which includes government infrastructure, para-statal health system, private sector, civil society and philanthropic contributors[25]. A major strength of government's health care system in Pakistan is an outreach primary health care, delivered at the community level by 100,000 Lady Health Workers (LHWs) and an increasing number of community midwives (CMWs), and other community based workers who have earned success and trust in the communities[26]. Complementary, alternative and traditional system of healing is also quite popular in Pakistan.
14. Health system faces **challenges** of vertical service delivery structures and low performance accountability within the government, creating efficiency and quality issues. Largely unregulated for quality care and pricing, there is also duplication of services by the private sector[27]. Although having the potential, private sector contributes least towards preventive and promotive health services. The public sector is inadequately staffed and job satisfaction and work environment need improvement[28]. The overall health sector also faces an imbalance in the number, skill mix and deployment of health workforce, and inadequate resource allocation across different levels of health care i.e. primary, secondary and tertiary. In order to produce quality workforce for health sector, the quality of medical and allied education both in public and private sector needs to be looked into. A range of actions is needed, acting upon the social determinants within the health and social sectors, if a wider impact is to be achieved[29].

[22] Rehman A, Shaikh BT, Ronis KA. Health care seeking patterns and out of pocket payments for children under five years of age living in urban slums, Islamabad. International Journal for Equity in Health 2014; 13:30.
[23] Shaikh BT, Ejaz I, Khan D, Shafiq Y. Political and economic unfairness in health system of Pakistan: A hope with the recent reforms. Journal of Ayub Medical College Abbottabad 2013; 25(1-2):198-203.
[24] Hafeez M. Poverty and poor health in Pakistan: Exploring the effects of privatizing healthcare. Harvard International Review 35(4) Spring 2014.
[25] Shaikh BT**.** Health Care System in Pakistan. In: Himanshu Sekhar Rout (Ed.) Health Care Systems: A Global Survey. New Century Publications, New Delhi: 2011; pp. 434-454.
[26] Hafeez A, Mohamud BK, Shiekh MR, Shah SA, Jooma R. Lady health workers programme in Pakistan: challenges, achievements and the way forward. Journal of Pakistan Medical Association 2011; 61(3):210-5.
[27] World Health Organization. Analysis of the private health sector in countries of the Eastern Mediterranean: exploring unfamiliar territory. Regional Office for the Eastern Mediterranean, Cairo: 2014.
[28] Hafeez A, Bile KM, Khan Z, Sheikh M. Pakistan human resources for health assessment. Eastern Mediterranean Health Journal 2010; 16 Suppl: S145-51.
[29] Bhutta ZA, Hafeez A. What can Pakistan do to address maternal and child health over the next decade? Health Research Policy and Systems 2015; 13 (Suppl 1):49.

4. Purpose

15. The purpose of this document is to provide an **overarching national vision** an agreed upon common direction, harmonizing provincial &federal efforts, inter-provincial efforts and inter-sectoral efforts for achieving the desired health outcomes and to create an impact. It provides a jointly developed account of **strategic directions** to achieve the common vision, and which gives a guideline of best practices for the provinces/ areas to carve their respective policies and initiatives within their domains.
16. The word 'national' depicts **common political aspirations** of the provincial and the federal governments. It has consonance with provincial & federal health policy frameworks, post devolution health sector strategies, and with international health treaties, commitments and regulations to which Pakistan is a signatory.

5. Guiding Values

17. The National Health Vision strives to provide a responsive unified national direction to confront various health challenges, while ensuring adherence to Universal Health Coverage as its ultimate goal. The principle values include:
    a) Good governance
    b) Innovation and Transformation
    c) Equity and pro-poor approach
    d) Responsiveness
    e) Transparency and Accountability
    f) Integration and cross sectoral synergies
18. The delivery of quality health care services is a provincial responsibility and the priority actions emanating from this vision document would be in concert with the provincial needs, expectations and priorities. The national health vision aims to resonate with the ideals and expectations of provinces. The Federal government will support and facilitate the provinces in developing and implementing their strategies by providing the overall vision and by facilitating/advocating for financial and technical resource mobilization to ensure that essential health services are accessible to all citizens.

6. Objectives

19. The National Health Vision has adopted the following objectives in order to improve the health and well-being of the Pakistani society:
    a) Provide a **unified vision** to improve Health while ensuring provincial autonomy and diversity

b) Build **coherence** to Federal & Provincial efforts in consolidating the progress, learning from experiences and moving towards the universal health coverage.

c) Facilitate **synchronization** for commonality across international reporting and international treaties

d) Facilitate **coordination** for regulation, information collection, surveillance, and research for improved health systems

e) Provide a **foundational basis** for charting and implementing SDGs, in partnership with other sectors.

7. Thematic Pillars

20. National Health Vision builds its narrative on the following thematic pillars. These eight pillars will pave a way for ensuring access, coverage, quality and safety, which are essential requisites for achieving the ultimate goals of health system: **improved health, responsiveness, social protection, and efficiency**.

1. Health Financing

2. Health Service Delivery

3. Human Resource for Health

4. Health Information Systems

5. Governance

6. Essential Medicines & Technology

7. Cross-sectoral linkages

8. Global Health Responsibilities

21. Each thematic pillar or domain is critically analyzed for the challenges faced, and a strategic vision for which an over-arching technical support to the provinces will be offered and coordinated by the Federal government.

1. Health Financing

1a. Challenges

22. Government spending on health has always been less than optimal (0.6% of GDP). Most part of the allocations to health is consumed by the secondary and tertiary care, leaving merely 15% for the preventive and primary health care.
23. There are inefficiencies in the public health spending due to weak management systems, resulting in low utilization and eventual lapse of funds. Payments are not linked to performance.
24. **Donor funding** has been minimal (<2% of total national health expenditure). The official donor assistance (ODA) is far less than that committed in the Paris declaration, and that too could be better aligned and coordinated with governments' strategies.
25. Many population sub-groups **lack financial protection**, and face risk of catastrophic health expenditure.

1b. Strategic Vision

26. Government is cognizant that **adequate, responsive and efficient health financing** is the cornerstone of a country's well-functioning health systems. The spending on health will be advocated as "**investment**" with the line ministries, finance departments and international development partners.
27. Federal and Provincial governments will increase **allocation to health** as pledged in Pakistan vision 2025 to 3% of GDP, to maximize the pay-offs from investing in health.
28. **Priorities for health allocations** will be revisited, and a higher share for essential health service delivery, preventive programs, communication, capacity building of frontline health workers, and governance will be ensured.
29. **Pro-poor social protection initiatives** (including the recent national health insurance scheme) will continue to be financed and new initiatives (CCT, vouchers) will be launched, facilitating access to essential primary, secondary health services and priority diseases.
30. There will be a progressive movement towards **universal health coverage**. RMNCAH and nutrition investments will be increased in a phased manner.
31. Governments will develop mechanism to build capacity for implementing **fiscal discipline**, **revisit formulae for district allocations** to maintain parity, and grant financial autonomy to health institutions.
32. Federal and provincial governments will develop joint strategies aimed to **enhance resource mobilization** for health from official development assistance (ODA)/international development partners, private sectors' engagement, and through taxes such as sin tax.

2. Packaging Health Services

2a. Challenges

33. There is now an established and **increasing double burden** of disease including non-communicable diseases, mental health and injuries as well as communicable and infectious diseases such as TB, HIV/AIDS and Hepatitis B and C.
34. **Inadequate infrastructure** and standards along with poor quality of services have shaken the trust of the public, resulting in hardly 20% population utilizing the first level care in public sector.
35. Progress has been constrained by **fragmented delivery of services**, inadequate resource commitment to preventive and promotive care, human resource imbalance, and lack of skill mix.
36. **Inequitable access**, urban-rural disparities, lack of regulation of private sector, non-conformity of essential services packages have made the healthcare delivery being non -responsive.

2b. Strategic Vision

37. Governments will be working to improve the **coverage and functionality** of primary and promotive health services, while ensuring the widening of **essential service packages** by introducing family medicine, newborn survival, birth spacing and contraceptives supply, non-communicable diseases, mental health, under-nutrition, disabilities, problems of ageing population and other issues. Quality of services will be ensured by implementing **Minimal Standards for Delivery of Service** at all levels
38. Government will be encouraging and supporting the **integration of vertical programmes** at the provincial level for optimal and efficient utilization of resources and better performance.
39. Governments will be enforcing the **public health laws** promulgated, related to smoking, drug safety, organ donation and transplant, safe blood transfusion, environmental protection, food safety etc.
40. Efforts would be geared toward building **synergies with the private sector** in essential health services delivery (preventive and curative), reporting on key indicators and for understanding its functioning, composition and possible outreach for the under-privileged.
41. Entire health care system will be made **resilient** to disasters (climate change, natural disasters, disease outbreak etc) in terms of both disaster mitigation response and continued provision of services during acute crisis / emergencies.

3. Human Resource for Health

3a. Challenges

42. Human Resource in health is the most critical factor in provision of quality preventive, promotive and curative services. Pakistan has one of the **lowest** doctors, dentists, nurses and paramedics to **population ratios**. Other pressing issues in Human resource include maldistribution of HR, retention issues and low work-place satisfaction levels. This results in significant brain drain at all levels.
43. **Professional education** in health is run at sub-optimal level without synchronizing the curriculum with modern pedagogic techniques, international standards and the local requirements.
44. **Licensing** and renewal of licensing of health practitioners is weak, and is not linked with improved qualification, competence, performance and continuous professional development. There are weak institutional levers for gauging the **performance of health staff**.
45. There is an apparent stagnancy in the **coverage of community health workers,** and their numbers, coverage and quality are far from the required standards.

3b. Strategic Vision

46. Medical and allied health education will be tailored according to the health needs of the population, focusing on social determinants of health, ethics and public health laws. Continuous Professional Development will be institutionalized across both public and private sectors in conjunction with associations, and linking up with re-licensing of the health professionals.
47. Owing to the rapidly growing population, disease patterns and the health needs, further expansion and strengthening of existing workforce will be done.
48. Governments will focus towards appropriate and adequate **skill mix of human resource** production and task shifting where required. Fields of Public health, Allied health institutions and Family Medicine will be nurtured and institutionalized to increase the cadre of managers, regulators, administrators, specialized allied health staff and family physicians.
49. **Responsive management** will be brought in the health departments, and incentives will be given to boost the performance and to make the rural appointments attractive.
50. **HR database** at provincial and national level will be created for the sake of forecasting and developing workforce.
51. Developing a comprehensive **National HR strategy, Nursing strategy** and other allied health work force strategies may also be considered based on National Health Vision.

4. Health Information Systems and Research

4a. Challenges

52. Health information systems currently in use in Pakistan are **fragmented and vertical**. They respond to or serve primarily the health programmes that created them. Consequently, health indicator data collated through various systems sometimes give conflicting results.
53. Demographic Health or the Social and Living Measurement Surveys cannot fully compensate for the lack of reliable ongoing monitoring data. Furthermore, even these surveys require ability for analysis which has been limited to date.
54. It is critical to use the information systems for planning, resource allocation, and health care delivery system; however it is impractical because it **lacks accuracy, quality, reliability and absence of linkages with decision makers**.
55. Though research is conducted in Pakistan, it is carried out in silos, does not have relevance to local issues, and quality is often compromised because of capacity and resources. There is a **disconnect** between researchers, implementers and policy makers. Evidence to policy link hence is weak.

4b. Strategic Vision

56. **Innovative technologies** will be incorporated to provide speedy and reliant information to support evidence based decision making at the district level through District Health Information System (DHIS). Platforms at provincial and national level for **transforming evidence into policy** advice will be encouraged including dedicated units at federal and provincial levels (HPSIU and HSRUs/PSPU).
57. Governments will be **building coherence** across health information systems, and will be investing in key missing areas for monitoring the SDGs as well as national health targets, and information on vital events such as births and deaths.
58. The national health vision calls for a transition from medical research to **national health research** prioritizing areas as per local requirements. **Central hub for information repository**, standardization and quality will be developed at national level with the assistance of provinces. This will serve to promote evidence based decision making, policy formulation and health systems research.
59. Strengthening of information systems at national, provincial and district levels eventually leading to an effective, **integrated disease surveillance and response system**, with a particular focus on Early Warning System.

5. Governance

5a. Challenges

60. Governance has been a constant challenge undermining service delivery and budgetary investments. At times **patronage** plays a significant role in determining the agenda for health policies and administration in Pakistan, as in other sectors.
61. The capacity to **regulate public and the private sector** health market i.e. medical practice, pharmaceutical, and diagnostics is weak.
62. There is no uniform approach for managing the governance of health institutions and the capacity for contracting in and contracting out of services is not optimal.

5b. Strategic Vision

63. It appears necessary for federal and provincial health authorities to rebuild their **stewardship of the health system** through professional independent advice and technical governance of health services planning, and strive to become the forefront provider of essential health services provision and delivery.
64. A steady and purposeful **stewardship role** of the provinces should bring about structural changes in the health system. It is envisaged to have **sector wide strategic planning**, regulation, purchasing and financing and moving towards separation of service provision from its stewardship function.
65. **Health services reforms** which are already underway should focus more on performance strengthening of government provided services. **Innovative management models** of PHC are envisaged to be tried out with an emphasis for alignment with preventive health targets.
66. **Private sector** should be seen as a partner in healthcare delivery and should be engaged/regulated through appropriate mechanisms. They should also be engaged for meeting national SDG targets.
67. Increasing share of public sector **budgets commitment** for governance strengthening, and establishing dedicated structures within provincial and federal ministries. Both government and private service providers will be involved in performance accountability and target oriented service delivery arrangements.
68. **Accountability mechanisms** at all levels are envisaged to be put in place. Development of key performance indicators and output based measures would be helpful in gradual progression towards performance based models.

6. Essential Medicines & Technology

6a. Challenges

69. The current technologies being utilized in the health sector have not evolved through a rigorous needs assessment process, leading to misuse of such equipment/technologies. Current mechanisms to determine the appropriateness of supplies, diagnostics, medicines and laboratory reagents are not evidence based.
70. Package of essential services does not identify the type and quantum of equipment, supplies and medicines needed to deliver the defined services for a specific health facility. This encourages **irrational procurements**, use and spending on technologies resulting in loss of precious resources.
71. There are issues related to **quality and price** of drugs and their prescriptions. Medicines pricing is a contentious issue between the regulators and the industry.
72. **Health Technology Assessment** employing multidisciplinary approaches including Pharmaco-economics, Pharmaco-epidemiology and Pharmaco-vigilance remains as un-initiated concepts.

6b. Strategic Vision

73. Health Technology Assessment (HTA) capacity will be created at federal, provincial and district level. Governments will be **vigilantly monitoring** the selection, quality, price and use of technologies, equipment and medicine, as per international standards.
74. More **evidence and best practices** will be collected with regard to medicines related policies, legislations and operative guidelines; and to translate the same into standard treatment guidelines. **Setting up an entity** (e.g. NICE-UK) is another need to adherence to the standard treatment guidelines and best practices.
75. The federal and provincial governments will ensure that appropriate **regulations are in place for the control of drugs, devices, diagnostics and biological reagents** across the country, ensuring quality control and patient safety.
76. Pharmaceutical industry will be encouraged to provide **innovative and affordable solutions** to the patients. **Pharmaco-vigilance program** will be introduced at federal level and collection centers at provinces.
77. **Drug pricing policy** will be implemented, protecting public interest by regulating prices of essential medicines while allowing long term predictability. Appropriate policies for **Orphan Drugs, Alternative medicine and Medical Devices** will also be put in place.
78. **Strengthening of DRAP and effective Legislation** is required for efficient regulation of drugs, human organs donations, blood transfusions and all therapeutic goods will be revisited and implemented in spirit.

7. Cross-Sectoral Linkages

7a. Challenges

79. There is growing awareness amongst public health professionals that their universe is impacted by the political, **social, economic and developmental milieu** in which they operate.
80. Factors such as illiteracy, unemployment, gender inequality, food insecurity, rapid urbanization, environmental degradation, natural disasters and the lack of access to safe water and sanitation all have the **potential to aggravate the state of health** of individuals and communities.
81. A large number of **preventable deaths** and disabilities among children, pregnant/ lactating women, young adults and aging population can be averted but action lies beyond the scope of and mandate of health sector.

7b. Strategic Vision

82. There will be a renewed and synergistic focus on **cross-sectoral action** for advancing health, with a particular focus on communicable and non-communicable disease including mental health and under-nutrition. The concept of "**One Health**" and "**Health in all policies**" will be promoted.
83. Government will be striving to develop a common vision, framework and a platform with **multiple stakeholders** from across the sectors to work for health, for instance education, food security, agriculture and livestock, housing, sanitation, water, environment, IT, local government, social protection etc.
84. In order to gear up its efforts towards **SDGs**. Government will embark upon advocacy, planning, legislation, regulation, behavioral change communication, information exchange, and evidence based decision through **joint efforts of different sectors**.
85. Efforts will be geared towards **recognition of community involvement**, women empowerment, and local/ rural development being the key channels for cross-sectoral action, and health will be an inclusive partner.

8. Global Health Responsibilities

8a. Challenges

86. Sustainable Development Goals (**SDGs**) and the broader sustainability agenda, need far more efforts than employed in MDGs, addressing the root causes of poverty and the universal need for development that works for all people.
87. Achieving **international public health security** is one of the main challenges arising from the new and complex landscape of public health. Treaties like International Health Regulations (IHR-2005) and Global Health Security Agenda (GHSA) require certain core capacities that are not yet appropriately developed at federal and provincial levels.
88. Progress against other **treaties and commitments** like FCTC, mHGAP, RMNCAH, FP 2020 and others gets hindered because of a lack of coordination.

8b. Strategic vision

89. New global **sustainable development agenda** will be reflected in all health strategies and plans, for which governments will be provided technical support and appropriate expertise.
90. Mechanisms will be established for **coordination** across sectors and between provinces and federal ministry, to prevent, detect, and provide a coordinated response to events that may constitute a public health emergency of both national and international concern, including **integrated disease surveillance and response**, as laid down by the IHR 2005 and GHSA.
91. Determining systematically the assets and best practices of **polio eradication** to be transitioned and mainstreamed over time to support other priorities, particularly immunization and vaccine-preventable disease surveillance.
92. Adherence to other international treaties would warrant a strategic **and coordinated approach** to achieve the targets of newly adopted SDGs.

9. Monitoring and Evaluation

93. A monitoring and evaluation (M&E) mechanism will be developed for the National Health Vision 2016-2025. It would be in the shape of an M&E Framework and Plan, linked and coordinated with the Planning Commission for SDG reporting, provincial and area/region health departments for alignment with strategies, and other stake holders. . The MoNHSRC will coordinate for these functions.
94. The M&E plan would describe in detail the specific roles of different facets of the health system; the processes of data acquisition, flow, analysis, use and feedback; resource requirements; institutional/organizational infrastructure needs (at different levels); analysis of currently available competencies and capacities and specific indicators and their time-lines for gauging performance and results. It will also define how different levels of government can utilize the data and information from such a system and even suggest corrective actions where needed.
95. The M&E framework and its operational plan will focus on progress towards outcomes and impact, by developing an appropriate balance of M&E tools and approaches relevant to the proposed objectives, activities, and targets. Monitoring data will be verified independently (via third parties). Much of the monitoring will be executed by the provincial health systems strengthening units (or equivalent entities). Together these units will track the progress of the health of the nation.
96. A national body (high level Interprovincial health and population council) will have the responsibility of oversight of the implementation of the national health vision. It will endorse the reports for presentation to the parliament on annual basis.