SUSTAINABLE DEVELOPMENT GOAL 3: LEGISLATIVE, POLICY AND INSTITUTIONAL GAP ANALYSIS FOR BALOCHISTAN

“It is abundantly clear that a much deeper, faster and more ambitious response is needed to unleash the social and economic transformation needed to achieve our 2030 goals.”

António Guterres
United Nations Secretary General

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Message from the Provincial Minister for Health

The 2030 Agenda for Sustainable Development is a global commitment to end poverty and set the world on a sustainable path. The Sustainable Development Goals position health as a key feature of human development. After the 18th amendment and devolution of power from the Centre to the provinces, it is incumbent upon the provinces not only to align their policies with the SDGs but also to adopt policies which are well-grounded in local realities. The healthcare delivery system of Balochistan consists of the public and private sectors. The public health sector is governed by the provincial government with some support and guidance from the federal government. The range of health services which are being provided through Government includes promotive, preventive, curative, and rehabilitative health care services.

Balochistan's healthcare system has to go a long way to reach at a level where it is sufficient, effective, and efficient in the sense that it fulfills most of the health-related needs of the population. Currently, the situation of healthcare in the province portrays a gloomy picture. Infant and child health, maternal health, and nutrition statistics of the province vividly show that not only the province lags behind in almost all the national averages but also there is a great need for reforms in all the important dimensions of the health system, ranging from policy to programming and spending.

Government is aware of the limitations and budgetary challenges in the health sector. The health service delivery in rural areas lacks skilled health workers for a wide spread of population in small clusters. The development, operation, and maintenance costs of health facilities in Balochistan are very high compared to other provinces. Considering these challenges, the provincial government has passed a Public Private Partnership (PPP) law to encourage private sector in developing, operating, and maintaining health facilities. Government is committed to providing the right incentives and guarantees under the PPP framework. Government will still play its role in monitoring Key Performance Indicators (KPIs) and providing strategic guidance. It will mark the beginning of a new era in utilising private sector skills and resources.

Another major initiative of Government under SDG-3 is to provide Universal Health Coverage to its citizens. Government has taken concrete steps to achieve this objective and is in the advanced stage of providing Balochistan Health Card to 1.8 million families which will enable them to get treatment in public and private hospitals for up to 1 million rupees for each family. This programme will cover the entire province and would be funded by a regular budget in the future. This initiative will reduce disparity and inequality and provide quality health services in the province.

I am fully convinced that Government’s partnership with UNDP will bring the province on the path of progress and development. The institutional and legal gap analysis report is helpful for Government in identifying areas of improvement in the current processes in health service delivery and institutional and legal spheres. I am committed to and supportive of continuously pushing for and improving governance and introducing reform agenda for betterment of the province. I sincerely believe that the achievement of SDGs is our motto as they are fully aligned with government’s vision for the province.

Mr. Syed Ehsan Shah

Message from the Provincial Secretary Health

The Sustainable Development Goals (SDGs) offer a multifaceted approach to ponder upon and improve the current systems for betterment of the province. The collaborative efforts of the United Nations and global community have provided a comprehensive framework in terms of the SDGs for all member countries and especially underdeveloped regions within the countries such as Balochistan in case of Pakistan. I appreciate the UNDP efforts over the years with their technical input and continuous support for the province, particularly, for the Health Department.

The legal and institutional gap analysis on the SDG-3 sets a baseline for the department and will feed the system to overcome operational and legal gaps in the health sector and to identify overlapping mandates. The provincial government has already passed the Balochistan Healthcare Commission Act to improve healthcare landscape in the province and to govern different initiatives under one umbrella. This document will serve as a comprehensive action plan and a repository for the Commission to kick start its work to strengthen and enhance efforts to achieve SDG-3, align policies with the global development agenda, and provide a blueprint on the way forward for the province.

The provincial Health Department values the UNDP's efforts as a lead agency for the SDGs providing policy support to Government of Balochistan. I hope that the partnership can be leveraged to achieve the priority SDGs like SDG-3 with the aim to provide Universal Health Care 'Leaving No One Behind'.

Mr. Saleh Muhammad Nasar

Message from the Chief of Section (Planning & Development Department)

The Sustainable Development Goals (SDGs) framework is a manifesto of human development exhibiting the consciousness towards development needs of people. I am glad that the SDGs support unit at Planning and Development Department has partnered with the United Nations Development Programme (UNDP) to achieve this noble cause. The active support of the UNDP over the years has not only strengthened this partnership but has also achieved several milestones together. I hope the Health Department would benefit from the current study in identifying gaps in the provincial health system. The province has a long way to go before it achieves the vision laid down under the SDG's framework. I am confident that we are on the right track and together with UNDP, we will achieve the shared objective and vision.

Let me take this opportunity to thank the Resident Representative of the UNDP Pakistan and the team, and UNDP Head of Sub-Office, Balochistan for their extraordinary support not only for this study but for policy support for the province in other domains as well. This would not have been possible without their feedback, guidance, and support which will long be remembered.

Mr. Arif Hussain Shah

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Abbreviations and Acronyms

AHP	Allied Health Professional
AIDS	Acquired Immunodeficiency Syndrome
AMR	Antimicrobial Resistance
BACF	Balochistan AIDS Control Program
BAEF	Balochistan Awami Endowment Fund
BCPA	Balochistan Child Protection Act
BHF	Balochistan Health Foundation
BINUQ	Balochistan Institute of Nephro-Urology Quetta
BIPBS	Balochistan Institute of Psychiatry and Behavioral Sciences
BMCH	Bolan Medical College Hospital
CAREC	Central Asia Regional Economic Cooperation
CENAR	Center for Nuclear Medicine and Radiotherapy
CME	Continuous Medical Education
CMWs	Community Midwife Workers
CMYP	Comprehensive Multi-Year Plan
CR/VS	Civil Registration/Vital Statistics
CSW	Commission on the Status of Women
DEWS	Disease Early Warning System
DHDC	District Health Development Centers
DHIS	District Health Information System
DHQ	District Headquarter
EmONC	Emergency Obstetric and Neonatal Care
ENAP	Every Newborn Action Plan
EPA	Environmental Protection Agency
EPI	Expanded Program on Immunization
EPMM	Ending Preventable Maternal Mortality
FIGO	Federation of Gynecology and Obstetrics
FLCF	First Level Care Facility
HCAI	Healthcare Associated Infection
HMIS	Health Management Information System
HRH	Human Resources for Health
HWM	Hospital Waste Management
ICD-MM	International Classification of Diseases-Maternal Mortality
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICM	International Confederation of Midwives
ICN	International Council of Nurses

IRMNCAH&N	Integrated Reproductive, Maternal, Newborn, Child & Adolescent Health and Nutrition
LHWP	Lady Health Workers Programme
MARPs	Most at Risk People
MERC	Medical Emergency Response Centers
MNCH	Maternal, Newborn, Child & Health
MNHSR&C	Ministry of National Health Services, Regulation & Coordination
MPDSR	Maternal and Perinatal Death Surveillance and Response (MPDSR)
NCD	Non-Communicable Disease
NCRCA	National Commission on the Rights of Child Act
NEQS	National Environmental Quality Standards
NHR&C	National Health Services, Regulations and Coordination Division
NSER	National Socio-Economic Repository
NSPTC	National Strategic Plan for Tuberculosis Control
NTDs	Neglected Tropical Diseases
OPD	Outpatient Department
PCRWR	Pakistan Council for Research in Water Resources
PEPC	Pakistan Environmental Protection Council
PHC	Primary Health Care
PPHI	Peoples Primary Healthcare Initiative
RBC	Regional Blood Centre
SBAs	Skilled Birth Attendants
SROs	Statutory Regulation Orders
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UHC	Universal Health Coverage
UN	United Nations
UNCSW	United Nations Commission on the Status of Women
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNICEF	United Nations International Children's Emergency Fund
WHA	World Health Assembly
WHO	World Health Organization

Executive Summary

This report assesses the existing landscape of the legislative and policy framework of Balochistan on the Sustainable Development Goal (SDG) 3. The report reviews all 9 targets and 4 sub-targets of the SDG 3- achieving good health and wellbeing- in line with international treaties, federal and provincial laws. It identifies legislative and institutional gaps. The report gives some recommendations to achieve good health and wellbeing in the province.

The report spreads over 14 chapters; each chapter is dedicated to SDG 3 targets and sub-targets. The Chapter 1 provides introduction, scope of work, context to the topic, and elaborates methodology used for compiling this study. The Chapter 2 deals with Target 3.1 "Reduce Maternal Mortality Ratio". The provincial government had developed the Balochistan Integrated Reproductive, Maternal, Newborn, Child & Adolescent Health and Nutrition (IRMNCAH&N) Implementation Strategy & Action plan 2016-2020. This action plan needs to be extended and upgraded after its expiry in 2020. The federal government has issued the comprehensive National Guidelines on Maternal & Perinatal Death Surveillance and Response (MPDSR). The province needs to implement such guidelines in any future plans, policies and legislation. Two vertical programmes 'Maternal, Newborn and Child Healthcare' (MNCH) and 'Lady Health Worker' are currently providing services. Both programmes are understaffed and need massive support from the government. Government needs to devise a mechanism to provide continuous improvement training to enhance capacity of skilled birth attendants working in these programmes.

The Chapter 3 covers Target 3.2 "End Preventable Deaths of Newborns and Children under 5 years of age". In Balochistan, the key challenges in achieving this target come from lack of early initiation of breastfeeding, neonatal tetanus, low birth weight, lack of timely antenatal care and postnatal visits, home delivery practices, mothers' low literacy/education, maternal age at birth, short birth intervals, place and assistance at delivery, post-natal care and newborn care, the prevalence of diarrhea and pneumonia, under-nutrition, unhygienic conditions, incomplete immunisation and vaccination and discrimination towards a female child. Like the maternal mortality target, the challenges of reducing child mortality are taken up by Nutrition Programme, LHW Programmes, and MNCH Programmes which are severely understaffed. Although there is the Balochistan Breastfeeding Act 2014 but unfortunately it is non-functional. There is no institutional custodian of this Act within the health department. Similarly, there is no legislation protecting the rights of mothers and their children under 5 years of age. Although there is a Child Protection Act in the province, but it is more focused on child labour and related issues. It does not cover children under 5 years of age in terms of their health. The province does not have the child marriage restraint law to prevent adolescent age marriages which are a widespread custom in the province and poses health risk to adolescent mothers.

The Chapter 4 explains Target 3.3 "End Epidemics of Communicable Diseases". Major risk factors for infectious diseases (AIDS/HIV, Malaria, TB and Hepatitis) and mortality are due to unsafe blood transfusion, low vaccination, lack of safe water, sanitation and hygiene (WASH) services. The province has passed the Safe Blood Transfusion Authority Act in 2004 and the Clinical Laboratory Regulatory Authority Act in 2001. Both authorities are almost non-functional and there is no implementation mechanism developed yet. The charge of these authorities has been given to an official as an additional charge which seems to be non-productive. Although, there is mandatory vaccination law in the province but implementation is really very slow. There are seven vertical and other programmes dealing with epidemics, yet the vaccine coverage in the province is worryingly 29%, the lowest among all the provinces. There is a decent number of policies (non-mandatory) and programmes for epidemic diseases

in comparison with other SDG targets. However, there is no legislation covering epidemics' surveillance. True dispensation of vaccines and preventing epidemic diseases is yet to be seen.

The Chapter 5 discusses Target 3.4 "Reduce Premature Mortality from Non-communicable Diseases". Cardiovascular diseases, cancer, diabetes, mental health conditions, and chronic respiratory diseases are five main causes of the NCD burden in the province. Unfortunately, there is no mechanism for measuring and reporting the risk of dying from these five major diseases in the province. The provincial government needs to commission studies to assess the extent of the burden from premature mortality due to the NCDs in the province. The provision of essential drugs, knowledge about the NCDs, and capacity to deal with it is very poor especially at the primary health care level. Awareness and legislation related to food safety are nonexistent at the province level which is one of the major contributors towards the NCDs like cancer, cardiovascular and diabetes. The prevalence of poverty and weak social protection programmes exacerbate mental health issues. The implementation of recent initiatives of health insurance by the provincial government should be expedited and scaled to cover a larger population.

The Chapter 6 deals with Target 3.5 "Strengthen Prevention and Treatment of Substance Abuse". In absence of the appropriate provincial legal mechanism, the federal legal framework is being used in the province to control substance abuse. The Antinarcotic Force presence in the province has a limited capacity. The provincial police have been mandated to control the use of narcotics in Balochistan whereas, the Frontier Constabulary (FC) is given the powers of border control and customs. Both the provincial police and the FC personnel are largely semi trained on these issues and cannot enforce anti-narcotic laws in true spirit. The provincial social welfare department runs limited youth awareness programmes and has established some drug rehabilitation centers. The majority of these centers have limited financial and professional human resources. These rehabilitation centers are either non-functional or semi-functional with very limited positive results. There is the prohibition of Sheesha law at the provincial level but its scope is very limited. The provincial government needs to formulate legislation for the control and prevention of drugs and substance abuse. It is advisable for Government to develop strategies in order to control the sale of over-the-counter drugs at private pharmaceutical stores.

The Chapter 7 explains legislations related to Target 3.6 "Halve the Number of global Deaths and Injuries from Road Traffic Accidents". The key challenges to achieving this target include lack of or delayed emergency care on the spot, dearth of transport to a health facility centre, non-availability, and poor quality of trauma care, excess speed, unsafe road designs, poor driver training and licensing mechanisms and shoddy enforcement of laws and safety regulations. The majority of legislations are adopted from the federal government. These legislations are outdated and do not account for the rapid innovations in the vehicle manufacturing industry. The provincial government needs to update road safety laws, establish vehicle certification mechanisms, and set up traffic tribunals for speedy trials. Limited post-accident emergency services are recently started in Balochistan which needs to be expanded to all the other areas as well. Government should ensure the provision of trauma centers in district headquarters and a burn center at the provincial capital. It is shocking that there is not a single burn center in the entire province.

The Chapter 8 focuses on Target 3.7 "Universal Access to Reproductive Healthcare Services". Preventing unintended pregnancies and reducing adolescent childbearing through universal access to sexual and reproductive health care is crucial to the health and well-being of women, children, and adolescents. The family planning programmes are underperforming in Balochistan. The province still has the highest population growth rate and largest family size. Advocacy and awareness programmes are often supported by donors. Government needs

to provide a dedicated budget for the sustainable execution and implementation of such programmes. There are no legislations at the provincial level to protect and provide reproductive healthcare services and restraint child marriages.

The Chapter 9 deals with Target 3.8 "Achieve Universal Health Coverage". The provincial government needs to expedite work on the implementation of the Balochistan Healthcare Commission Act 2019 to achieve universal health coverage (UHC) for all people and communities. Government needs significant reforms in governance, service delivery, health workforce, medical products, and health information management. Government should also scale the health insurance programme and integrate other similar programmes under one umbrella to protect and facilitate people against financial risk, ensuring that the cost of using services does not pose a financial strain on their resources.

The Chapter 10 discusses Target 3.9 "Reduce Deaths and Illnesses from Hazardous Chemicals, Pollution and Contamination". Under this target, it has been recommended that food safety and security legislation should be improved and a uniform mechanism be developed to define parameters of environmental quality standards and benchmarks for the province. The provincial EPA budget and staff training should be enhanced. Management and financing of equipment to monitor and record air, water and soil pollution are almost nonexistent. A centralised state of the art reference laboratory must be established at the provincial level and preferably at divisional headquarters accessible to all relevant public health-related departments. There is a need to develop a comprehensive and integrated strategy for wastewater and solid waste treatment at the provincial level. Engagement of the private sector through Public Private Partnership may add value and bring efficiency to the system.

The Chapter 11 deals with Target 3a "Strengthen Implementation of Tobacco Control". There are no provincial legislations to prohibit the use of tabaco in public area. Although there is a provincial Act related to the prohibition of Sheesha in public areas but unfortunately, it is not comprehensive enough to cover other tobacco products. The province generally replicates and governs through the federal laws to control tobacco. There is a need for a provincial tobacco control strategy and action plan. The Tobacco Control Cell should be established at the provincial level. The price of cigarettes shall be increased every year above the inflation rate. Government should conduct a study on the economic impact of tobacco use and disseminate the results for general public awareness. Lastly, Government should include tobacco control into the educational curriculum at all levels.

The Chapter 12 focuses on Target 3b "Support Research and Development of Vaccines and Medicines". The recommendations under this target include the establishment and notification of all statutory forums and laboratories to effectively implement the guidelines and spirit of the federal drug law. This also includes the establishment of the Provincial Quality Control Board, Provincial Drug Testing Labs, and Drug Courts/tribunals. Government needs to enhance the capacity of the EPI, NIH, LHW Programmes, the MNCH programme, and the Drug Regulatory Authority (DRAP) for increased access to use of vaccines and medicines. The Provincial Government must implement comprehensive MIS for inventory management of Essential Drugs Lists (EDL) at the facility level. The MIS/database system will enable Government to mobilise resources and track medicine utilisation and demand in each district and prevent losses in the stocks.

The Chapter 13 deals with Target 3c "Increase Health Financing and Development of the Health Workforce". Currently, there is no comprehensive strategy for HRH deployment, management and retention. There is a strong need to set standards for minimum density of physicians, nursing staff, dentists and pharmaceutical personnel considering local dynamics. Government needs to formulate a policy for Continuing Medical Education (CME) with a dedicated budget for CME and other training. The compensation packages of HRH should be

completely redesigned and they should be reflective of the efforts of different cadres. The revised package should be attached to measurable KPIs. The reward and punishment mechanism should be fairly implemented and monitored. The provincial health expenditure needs to be increased up to 15% of total expenditure to match the international gold standards including the Paris Declaration.

The Chapter 14 discusses Target 3d "Strengthen Capacity for Early Warning, Risk Reduction & Management of Health Risks". The recommendations under this target are that the provincial government needs to formulate and enact infectious disease surveillance and control legislation with a list of notifiable diseases. The provincial government should also strengthen the infrastructure of diagnostic laboratories in public health and animal health sectors and standardise antibiotic sensitivity testing and interpretation. A comprehensive Healthcare Associated Infection (HCAI) prevention and control mechanism is needed both at the federal and provincial levels. The comprehensive biosafety and biosecurity rules need to be developed. Regular assessments are required for biosafety and biosecurity at the province level. The National Laboratory Policy needs to be adopted and implemented to establish the licensing and inspection of all humans, veterinary and food laboratories. A coordinated EQAS should be established for all core human tests and relevant testing in the veterinary and food laboratories. Resource allocation and capacity-building for public health are needed in both the human and animal sectors. Public health laboratories (human and animal) to be linked with surveillance. Digital reporting systems should be established and expanded as part of surveillance systems in the entire province and linked with the national dashboard. A separate budget head should be created in hospitals to cover the financial needs in Health Care Waste Management.

Chapter 1. Introduction and Methodology

Health is a fundamental human right and a key indicator of sustainable development. Poor health threatens every segment of society. It limits the rights of children to education, reduces opportunities for men and women to earn a decent livelihood, increases inequalities, and plunges communities into poverty. Health is a very broad-spectrum sector and has an overarching impact and is strongly connected to other aspects of sustainable development, including poverty, water and sanitation, industrialisation, food security, climate change, governance, peace and stability.

1.1 Context and Background

Pakistan is the fifth most populous country in the world, with a population of 213.3 million in 2017. In addition, there are 1.395 million Afghan refugees registered in the country. The country has faced formidable social, economic, security, political and governance challenges during the last two decades. This has also been an era of unprecedented changes, confusion about the roles, and complexities in the health sector.

With the 18th constitutional amendment in 2011, the concurrent list and the Federal Ministry of Health were abolished. The residual health related functions in the Federal Legislative Lists (Part I & II) of the constitution were assigned to different federal ministries. To execute federal health functions effectively and in a harmonised way, the Cabinet decided in May 2013, to create the Federal Ministry for National Health Services, Regulations and Coordination (NHSR&C). The new Ministry was created with the mandate to provide a common strategic vision, to achieve universal health coverage (UHC) through efficient, equitable, accessible, and affordable health services, to coordinate public health and population welfare at the national and international level, to fulfill international obligations and commitments, to provide oversight to regulatory bodies, to enforce drug regulations, and to regulate medical profession and education.

The 2011 devolution of health portfolio to the provinces created confusion on roles and responsibilities along with capacity constraints at different levels. This responsibility and leadership are important as far as further efforts are required to achieve more challenging targets of the SDGs, Universal Health Coverage (UHC) and Health Security. The capacity of entities to regulate public and private sector health market (medical education, service delivery, pharmaceutical, and diagnostics etc.) is weak. There is no mechanism of regular technical backstopping and evidence-based reforms in the health system.

Although the province has a decent number of legislations in its arsenal to exercise its power in providing basic health services to its citizens, yet it may not be misplaced to say that the decision makers are not fully aware of the options available to them. Even when they are aware of the options at their disposal, they shy away from exercising their powers to the full extent for the fear of political repercussions. The institutional capacity has deteriorated over time to the point that it has become fragile and the current state of affairs is dependent on individuals rather than policies and institutional arrangements. The political leadership has made little efforts to reform the current health system. Historically, majority governments and political leaders found naive solutions on inputs side in the form of building more primary healthcare facilities in rural areas. This approach was perhaps driven by making political capital for constituency politics by appeasing the local leaders with construction contracts and low-scale jobs for their family members/loyal voters in the health facilities. This is evident from the province's non-development budget for the health sector where over 37000 employees are budgeted but only around 6500 are healthcare technical staff including doctors, nurses, pharmacists, and lady health workers. The majority of the remaining staff are in other

categories and posting against these positions are reported to have been politically influenced causing inefficiency, bribes, and corruption.

A large section of public apparently knowing the current fragile state of public health sector has started availing health services from the private sector. There is very limited critical mass to push for reforms in the health system in Balochistan. The majority of rural population is not fully aware of their right to initiate demands for reforms in the health system. The weak urbanisation and deeply rooted tribal setup have added more to the problems. In a tribal setup, collective identity bounds common citizens to support and remain loyal to their tribal leaders irrespective of their moral position. This has suppressed critical mass to push for reforms and has weakened the overall ownership of public infrastructure and services. Resultantly, the political elite is responding to tribal local leaders instead of the general public. Education, strong and vibrant democracy, and risk sensitive urbanisation will gradually reduce this grim phenomenon and will force political leaders to compete on service delivery instead of appeasing the local tribal leaders.

1.2 Scope of the work

In its recently published SDGs framework for Balochistan, the UNDP Balochistan identified a total of eight goals in the short-term priority which includes SDG 3 on health. Besides identifying priorities for the SDGs in Balochistan, the framework also stressed upon aligning policy, legislative and institutional factors to provide an enabling environment to achieve the SDG 3. To align policy, legislative and institutional factors with the SDG 3 priorities, the current study as a result of a gap analysis recommends pragmatic and doable measures which Government of Balochistan needs to implement. The outcomes of this study suggest the policymakers and implementing agencies to develop a concrete action plan to improve policy, legislative, and institutional setup in the province. The study reviewed the related policy, legislative, regulatory frameworks, and institutional aspects to identify gaps, potential areas for improvement, and the need for new legislation by focusing on all the nine (9) targets and four (4) sub-targets under the SDG-3- Good Health and Wellbeing.

More specifically, following are the main objectives of the study covered in this report:

i. Provide legislatures with knowledge about existing relevant international treaties and obligations covering the Sustainable Development Goal 3.
ii. Provide legislatures with relevant federal as well as provincial legislation about SDG 3 targets.
iii. Provide institutional arrangements and implementation in Balochistan regarding the SDG 3 targets.
iv. Propose a set of coherent recommendations to address legislative and regulatory gaps in Balochistan for each target, and enhance the effectiveness of monitoring, implementation, and enforcement mechanisms for existing legislation.

1.3 Methodology

This study has been carried out through a desk review of all existing laws related to SDG-3 in Balochistan. The study has also reviewed national legislation and international treaties/obligation. The study mainly focused on a qualitative approach to achieve the output required for this task. Secondary data was collected from provincial and national assembly websites, Health Management Information System (HMIS) at the health department, and the Bureau of Statistics at the Planning and Development Department.

After an initial desk review of documents related to policy, the legislative and institutional framework around SDG-3 and the health sector in Balochistan, the research team held fifteen in-depth interviews with representatives of different vertical programmes, primary

healthcare secretary, chief planning officer, and health faculty members. One consultative workshop was also held at the health department for the finalisation of recommendations with key stakeholders in the province. All the recommendations were duly incorporated to make this report substantive.

Chapter 2. Reduced Maternal Mortality Ratio

Target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

2.1 International Treaties/Convention Governing SDG 3.1

2.1.1 The Commission on the Status of Women (CSW or UNCSW) Resolution 56/3

In 2012, the United Nations Commission on the Status of Women passed Resolution 56/3 calling for elimination of preventable maternal mortality to reduce MMR to 70 per 100,000 live births and to reduce neonatal mortality to below 12 per 1,000 live births by 2030. Pakistan in general and Balochistan in particular are far behind in achieving this target in the coming years.

2.1.2 World Health Organization Maternal Death Surveillance and Response Guidelines

The WHO has built Maternal and Perinatal Death Surveillance and Response (MPDSR) on the principles of public health surveillance and supports the call for by the CSW. MPDSR promotes routine identification and timely notification of maternal and perinatal deaths and is a form of continuous surveillance linking health information systems and quality improvement processes from the local to national level. The MPDSR is now formally embedded in the World Health Organization's policy and activity. It is integral to the WHO Quality of Care initiative and the new Global Strategy for Women's, Children's and Adolescents' Health, and is also part of the Ending Preventable Maternal Mortality (EPMM) and Every Newborn Action Plan (ENAP) initiatives [1].

2.1.3 Midwives Standards: Joint Statement by WHO, UNFPA, UNICEF, ICM, ICN, FIGO and IPA

Midwives are considered Skilled Birth Attendants (SBAs), however, in many countries including Pakistan, the quality of community midwives' training programmes do not usually follow the WHO and International Confederation of Midwives' (ICM) standards. This is also the case for other health cadres who attend to deliveries and may not truly be SBAs, as per the international standards *(Appendix 1)*. Considering this challenge, a standard definition was calibrated in 2018 through a joint statement by the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the International Confederation of Midwives (ICM), the International Council of Nurses (ICN), the International Federation of Gynecology and Obstetrics (FIGO) and the International Pediatric Association (IPA). According to this joint statement, skilled health personnel, as referenced by SDG indicator 3.1.2, are competent Maternal and Newborn Health (MNH) professionals educated, trained, and regulated to national and international standards. In addition, as part of an integrated team of the MNH professionals (including midwives, nurses, obstetricians, pediatricians and anaesthetists), they perform all signal functions of emergency maternal and newborn care to optimise the health and well-being of women and newborns [2]. Balochistan has a long way to achieve these standards as the province faces a serious crisis in finding skilled workers.

2.2 Relevant National Legislations and Guidelines

2.2.1 National Guidelines on Maternal & Perinatal Death Surveillance and Response (MPDSR)

After the WHO MPDSR guidelines, the Ministry of National Health Services, Regulation & Coordination (MNHSR&C), Government of Pakistan, has developed National Guidelines on Maternal & Perinatal Death Surveillance and Response (MPDSR) in 2017. These national protocols include detailed guidelines and tools for implementing the MPDSR system at the facility and community levels [3]. Although the provision of health is a provincial subject, none of the subnational governments has implemented these guidelines yet.

2.2.2 Pakistan Nursing Council (PNC) (Amendment) Act 2021

At the national level, Pakistan Nursing Council (PNC) is an autonomous, regulatory body constituted under the Pakistan Nursing Council Act (1952, 1973, 2021) and is empowered to register (license) Nurses, Midwives, Lady Health Visitors (LHVs), and Nursing Auxiliaries to practice in Pakistan. The PNC was established in 1948. Its role is more of a regulator than implementing and executing nursing and midwives' programmes.

According to the PNC, the Provincial Government shall constitute a Provincial Nursing Examination Board. The functions of the Board shall be to confer, grant, or issue diplomas, licenses, certificates, or other documents stating or implying that the holder, grantee, or recipient has qualified in nursing, midwifery, health visiting, public health nursing, or auxiliary nursing. The Board can also recognise any institution or authority which conducts any courses of study of training in general nursing, midwifery, health visiting, public health nursing, auxiliary nursing, or nursing aide (N-aid). Another important responsibility of the PNC is designing curriculum and guidelines for nursing education. It is not clear if the PNC courses and curriculum are aligned with the International Confederation of Midwives (ICM) and other international accreditation-providing institutions. It is also not clear if these colleges provide customised courses for midwifery services as per the international standards as there are different requirements for each category (Appendix 1). In Balochistan, there is a social stigma associated with this noble profession. One interviewer pointed out that the people often consider nurses of loose character. There are quite a few incidences of harassment during training and even in-service with nurses from male supervisors and patient attendants. The local people are hesitant to enroll their family members in this profession. The majority of nurses working in Balochistan are from outside of the province. Government is struggling to find skilled nurses in rural areas as they prefer to work in Quetta. Government needs to strengthen legislation and its implementation against sexual harassment to create a conducive environment for nurses in peripheries.

2.3 Relevant Law/Policies in Balochistan

2.3.1 The Balochistan Lady Health Visitors (Compulsory Service) Act, 1975

This Act was passed by the Balochistan Assembly on 7th November 1975. The primary purpose of the act was requisition of services of Lady Health Visitors who have qualified the Lady Health Visitors Examination from approved institutions at the expense and quota of Government of Balochistan. According to this Act, Lady Health Visitor shall be liable to serve the Province of Balochistan for at least three years. In case of failure, Government can even impose a financial penalty or imprisonment for two years.

As discussed earlier the majority of nurses working in Balochistan are from outside. They often do not have a strong social and financial connection with the province and leave their job as they get some experience. The Government wanted more administrative powers to

bound LHVs for their services especially if they had availed scholarships and studied on government funding. It is not clear if the Government succeeded in achieving the intended objective. This Act has been tilted on quantity rather than quality of the services. There is still a large turnover and brain drain of skilled professionals because of the security situation and poor infrastructure in Balochistan.

2.3.2 The Balochistan Charge Nurses (Compulsory Service) Act, 1975.

In order the get more administrative control, Government of Balochistan also enacted the Balochistan Charge Nurse (Compulsory Service) Act in 1975. The main purpose was requisition of the services of professional nurses for at least three years after qualifying for the approved exam from the authorised institution on the Government of Balochistan quota and financial support.

2.3.3 Balochistan Integrated Reproductive, Maternal, Newborn, Child & Adolescent Health and Nutrition (IRMNCAH&N) Implementation Strategy & Action plan 2016-2020

The provincial health department in coordination with the WHO, UNICEF and UNFPA developed a five-year Action Plan for the province in line with the "Ten Point Agenda" on the RMNCAH and Nutrition 2016-2020 by the National Ministry for Health Services, Coordination and Regulation. This Action Plan chalks out activities needed in the province for betterment of the RMNCAH services through a multi-sectoral approach in light of the guiding principles in the National Ten Points Agenda elaborated in the document. The plan required over PKR 32 billion budget to implement its activities over the five years. The action plan in the document seems vague and fails to account for due to the ground financial and political realities. These kinds of plans often fail as they tend to re-invent the wheel and learn little from prior experience of similar action plans and strategies. The Government needs to look into opportunities to bring maternal and child health related issues under one umbrella. Punjab and Sindh have enacted legislation to form an authority in 2014 to lead, supervise and monitor such challenges.

2.4 Institutional Arrangement in Balochistan

2.4.1 National Programme for Lady Health Workers (LHWs)

The LHWs programme is one of the twelve vertical health programmes which were started in 1994 and became permanent in 2012. The programme is an integral part of the existing health care delivery system, extending outreach of the health care infrastructure into the communities for PHC with all preventive programmes. This programme directly contributes to achieving the SDGs 3. One of the primary goals of the LHW programme is to improve access to the skilled birth attendants through awareness.

Initially, this programme was designed for rural areas but later on was extended to underprivileged urban areas. In Balochistan, this programme is currently working in all 34 districts. A Lady Health Supervisor (LHS) supervises 20-25 LHWs in the vicinity of a health facility. The LHWs are required to pay visits for 5-7 houses per day to households in their area. Currently, the LHWs are covering about 31% of the total population (mostly rural) of Balochistan.

The programme is facing a challenge of high turnover of the LHWs. The programme recruits unmarried young female graduates. The majority of the LHWs do not work for the programme after they get married. The husband or extended family members often do not approve of the job as a lady health worker because of the bad reputation in terms of the reported harassment issues by male supervisors and hence the associated social stigma. The Government

needs to enforce anti-harassment policies in letter and spirit to earn trust for the LHW programmes in society. Moreover, there is a need to build image of LHWs as a great health soldiers and friends of communities to be respected by all as their own family members.

2.4.2 Maternal, Newborn, and Child Health (MNCH) Programme

The MNCH programme is responsible to provide EmONC services in Balochistan. MNCH is critical to reducing maternal and newborn mortality. Skilled Birth Attendants (SBAs) provide EmONC services within the context of community-focused and facility-based health systems, enabling timely prevention of and intervention for these complications and saving the lives of mothers and newborns.

In Balochistan, MNCH is providing comprehensive Emergency Obstetric and Newborn Care (EmONC) services in DHQ, THQ and Teaching Hospitals. The programme claims to have trained 1424 Community Midwife Workers (CMWs) and helped 811 CMWs to register with the Pakistan Nursing Council. The MNCH programme is also providing services for family planning, communication, and business skills training to the CMWs in several districts.

As with LHWs, the MNCH programme is also facing challenges in retaining professional and technical human resources including gynecologists, pediatricians, anesthetists, female doctors, and LHVs. This has negatively impacted in achieving the desired resulted and targets. Currently, the programme is not fully functional in all the areas of Balochistan.

2.4.3 Civil Registration/Vital Statistics System (CR/VS)

The civil registration and vital statistics (CRVS) systems are concerned with the legal registration and analysis of vital events among the population. The civil registration is defined as continuous, permanent, compulsory and universal recording of the occurrence and characteristics of vital events (live birth, death, marriage, divorce, and migration etc.) and other civil status events pertaining to population in accordance with the law. Records of vital events from civil registration are a critical source of vital statistics. Unfortunately, the current system of CRVS is very poor. Pakistan has been identified as one of the six priority countries for CRVS strengthening by the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP). The implementation of the CRVS is still very weak in several areas including provincial capital Quetta. The Government needs to develop a mechanism to link this system with other major data management systems including National Database and Registration Authority.

2.5 Recommendations:

- Government of Punjab and Sindh have already established authority in 2014 under the "Reproductive, Maternal, Neo-natal and Child Health Authority Act". The GoB also needs to establish authority through a similar Act. The LHWs and MNCH programmes may be brought under the authority for efficient working and monitoring.
- The Government needs to develop rules/policies to constitute provincial MPDSR committees to regularly analyse aggregated data from districts to determine trends. The Government also needs to make rules in order to make maternal death (and eventually perinatal death) a notifiable event.
- The Government needs to adopt the process of International Classification of Diseases-Maternal Mortality (ICD –MM) in existing HMIS and CR/VS systems. It is critical to avoid creating a parallel system but instead integrate it within existing mechanisms to the greatest extent possible. It will enable the policymakers to analyse the cause of death and devise policies to prevent it in the future.

- The private health providers may be added to the existing data eco-system by formulating a Standard Operating Procedure (SOPs). To achieve the intended benefit, the MPDSR must eventually be implemented at all levels where maternal and perinatal deaths can occur. The two major sources of information for timely reporting of maternal and co-occurring perinatal deaths are health-care facilities (where women give birth and are attended to when they have pregnancy complications) and communities (when women give birth at home or on the way to a healthcare facility or die during pregnancy without receiving medical care).
- The director of the nursing board needs to strengthen nursing colleges' accreditation process and expedite the implementation of ICM/WHO standards for the midwifery curriculum.
- The Government needs to ensure maximum financial and public/policy support to the midwifery education programme which is currently lacking.
- The Government needs to make legislations/policies for Continues Improvement Programmes (CIP) and in-service training for all health workers to keep them updated about international and national best practices which is lacking until now. A dedicated budget and strong political will is required to implement it.
- The Government needs to enforce stringent anti-harassment policies against female health workforce. Each hospital shall constitute harassment committees and ensure gender balance to represent female workers.

Chapter 3. End Preventable Deaths of Newborns and Children under 5 years of age

Target 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

3.1 International Treaties/Conventions/Guidelines related to SDG 3.2

3.1.1 World Health Assembly (WHA) resolutions

The World Health Assembly (WHA) has been issuing several resolutions governing and monitoring child mortality under age 5. For example, the WHA has issued resolutions on 'Comprehensive implementation plan on maternal, infant, and young child nutrition' (WHA65.6 (2012)); 'Ending inappropriate promotion of foods for infants and young children' (WHA69.9 (2016) and WHA71.9 (2018)); and 'Ending Childhood Obesity' (WHA69 (12) (2016) and WHA70 (19) (2017)). These resolutions include a range of global targets for mothers and children. Progress towards these targets requires both nutrition-specific interventions, such as support for breastfeeding, and nutrition-sensitive interventions across a range of sectors. The WHA also has decided to streamline future reporting requirements on maternal, infant, and young child's nutrition, through biennial reports until 2026 (to be issued in 2022, 2024, and 2026, respectively).

3.1.2 United Nations General Assembly; Universal Declaration of Human Rights, Article 25.

International law recognises the vulnerability of women and children and their right to the highest attainable standard of health. The Universal Declaration of Human Rights in its document A/810 (10 December 1948), Article 25 recognises that "motherhood and childhood are entitled to special care and assistance".

3.1.3 Convention on the Elimination of All Forms of Discrimination against Women, 1981, Articles 11, 12.

The Convention on the Elimination of All Forms of Discrimination against Women specifically protects the status of motherhood and special health needs of women and requires parties to provide access to medical care and other resources necessary for a safe pregnancy.

3.1.4 Convention on the Rights of the Child, 1990, Article 24.

The Convention on the Rights of the Child recognises that children are vulnerable in their health and that parties must take steps to ensure that all children achieve the highest attainable standard of health. This includes taking steps to reduce infant and child mortality, provide access to health care consistent with the needs of children, combat disease and malnutrition, provide maternal health care, and ensure adequate health education for children and their families.

3.1.5 International Covenant on Economic, Social, and Cultural Rights, 1976.

Article 12.2(a) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) requires all states to take necessary actions "for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child"

3.1.6 The International Code of Marketing of Breastmilk Substitutes

International Code of Marketing of Breastmilk Substitutes, adopted through resolution WHA34.22 (1981) provided guidance on ending the inappropriate promotion of food for infants and young children. Later, the WHO also supported infant nutrition by reducing

commercial marketing practices that undermine breastfeeding. Governments should consider implementing the Code through national legislation, and by monitoring the marketing practices of companies that manufacture and sell infant formula [4].

3.2 Relevant National Legislations

3.2.1 Protection of Breastfeeding and Child Nutrition Ordinance (2002)

Child health and wellbeing is affected by several factors. One of the primary factors is the provision of safe milk and promotion of breastfeeding. After the World Health Assembly passed the resolution on the International Code of Marketing of Breastmilk Substitutes (1981), Government of Pakistan passed an Ordinance to regulate marketing of Breastmilk Substitutes. Unfortunately, the implementation on this legislation is very challenging, and still, many doctors and health practitioners are recommending formula milk without any effective monitoring mechanism from the government. The infant formula companies often incentivise doctors by providing heavy discounts and sponsoring their leisure tours to national and international exotic locations.

3.2.2 Vaccination Ordinance (1958)

The primary aim of this legislation is to provide vaccination to an unprotected child at the age of six months and before one year of age. The parent or guardian of such a child shall ensure that the child is vaccinated against deadly diseases/viruses. It also empowers the Government to organise special drives in case of an outbreak of the virus. If the Superintendent of Vaccination believes that the parent or guardian of an unprotected child has contravened and has not vaccinated the child, he shall deliver a notice in the prescribed manner to such a person, parent or guardian requiring him/her to comply with health safety rules and properly vaccinate the child. In case of repeated non-compliance, the Superintendent may approach a first-class magistrate and the offender may be sentenced to three months of imprisonment and may also face a financial fine of hundred rupees. As the Act is over six decades old, the financial fine in relative terms has lost its impact.

The implementation on this legislation is not encouraging. There is hardly any case registered for breach of the provision under this law. The prevailing vaccination coverage ratio in Balochistan is around 29%.

3.3 Relevant Provincial Legislation/Policies and Guidelines

3.3.1 The Balochistan Vaccination (Amendment), Act 2021

The Balochistan Vaccination (Amendment) Act 2021 is recently passed by the Provincial Assembly of Balochistan on 31st May 2021. The provincial government has adopted the Balochistan Vaccination Ordinance, 1958 which is a federal legislation. This legislation provides a list of mandatory vaccines for preventable diseases and the schedule to administer the WHO-approved vaccines in 6 visits over 15 months. These vaccines play an important role in improving child health and protecting them from life-threatening diseases. The last PDHS 2017-18 reveals that the Balochistan vaccine coverage is merely 29%, which is the lowest among all the other provinces. The highest vaccine coverage (80%) was observed in Punjab. The Government needs to develop a mechanism to implement the mandatory vaccine law in true spirit.

3.3.2 The Balochistan Protection and Promotion of Breast-Feeding and Child Nutrition Act, 2014.

In response to the World Health Assembly resolution WHA34.22 (1981) and WHO call for the International Code of Marketing of Breastmilk Substitutes, the Balochistan Government

also has enacted the Balochistan Protection and Promotion of Breast-Feeding and Child Nutrition Act, 2014. The primary objective of the Act is to ensure safe and adequate nutrition for infants and young children by promoting and protecting breastfeeding and regulating marketing and promotion of designated products including breast milk substitutes, feeding bottles, values for feeding bottles, nipples shields, teats and pacifier associated with it.

The Act mandates the Government to constitute Infant Feeding Board (IFB). The Chairperson of the IFB shall be the Chairman of the Standing Committee on Health. The board shall receive reports of violations of the provisions of this Act or the rules; recommend investigation of cases against manufacturers, distributors, or health workers; devise plans for the dissemination of informational and educational materials on the topic of infant feeding and recommend continuing education courses for health workers. The board shall also advise the Government on policies for promotion and protection of breastfeeding, and matters relating to designated products especially infant and young child's nutrition. This Act is still dormant, and no practical steps have been taken to make it functional. No sub-ordinate rules are made yet. There is no mechanism developed to report, monitor, and evaluate infant formula products in the market.

3.4 Institutional Arrangement in Balochistan

3.4.1 Maternal, Newborn, and Child Health (MNCH) Programme

The health vertical programme MNCH discussed in the earlier section is mandated to provide comprehensive EmONC services related to children and mothers. The same programme is also working with the integrated nutrition directorate and is providing services to expand the programme on immunisation and nutrition.

3.4.2 Expanded Programme on Immunisation (EPI)

This programme is one of the most important provincial initiatives implemented in partnership with the Federal Government, WHO, and UNICEF. The EPI is providing immunisation services against 10 infectious diseases including measles, polio & hepatitis B. The main targets include polio eradication, measles, and neonatal tetanus elimination. The programme provides services through 551 permanent EPI sites, 850 outreach and mobile teams in the province.

According to the PDHS reports, the proportion of fully immunised children has improved from 16% in 2012-13 to 29% in 2017-18. The EPI, like other healthcare programmes, also faces challenges to find and recruit skilled vaccinators. There is an inequitable and disproportionate number of the EPI sites in the province. The programme also faces disruption in financial flows and low acceptability in the community for several reasons including culture and religion. The vaccinators are underpaid for their services. There is poor monitoring and reward and punishment mechanism for non-performing vaccinators. The cold value chain for storage and transportation of vaccines is not properly established in the province. The security challenges for the ground workers and vaccinators are very high. The vaccinators are quite often targeted by terrorist groups. This creates challenges for the programme in finding skilled vaccinators, especially in remote areas.

3.4.3 Nutrition Programme

The Provincial Nutrition Directorate with the support from Multi-Donor Trust Fund (MDTF) through the World Bank has implemented a nutrition programme (NP) in Balochistan during 2015-2019. The primary objective of the NP was to improve nutritional status of children under five years of age and that of women of reproductive age. The provincial nutrition directorate currently faces financial challenges to streamline the programme on a sustainable

basis. Government is unable to fund the programme itself and seeks funding from different donors to implement the programme in all districts. Currently, the PC-1 is under consideration by the Health Department and the Planning and Development Department. Government needs to find a mechanism to run the programme over a long time and ensure sustainability.

3.5 Recommendations:

- The provincial government enacted "The Balochistan Protection and Promotion of Breast-Feeding and Child Nutrition Act, 2014". Although it is an important step in the right direction, but legislation is not likely to be sufficient by itself. Governments should monitor the marketing practices of companies promoting infant formula. It also needs to sensitise parents and civil society to call out doctors and companies that ignore the code or engage in inappropriate marketing practices. Government also needs to formulate rules to make the Act functional.
- The Immunisation Programme severely lacks an effective monitoring mechanism. There is a very poor check and balance on vaccinators. Government may implement some GIS-based monitoring mechanisms to track performance of vaccinators. There is a weak punishment and reward system for vaccinators and their supervision teams. The incentive package for vaccinators is not reflective of the challenges and security threats that they face in discharge of their duties. Government may revisit incentive packages and transport allowances for vaccinators.
- Government needs to develop a comprehensive strategy for Human Resource for Health to retain and reduce the turnover of skilled health professionals.
- There is a need for adequate financial resources (budget) and strategy for the Continuous Improvement Programme for vaccinators and other health professionals.
- In Balochistan, there is no legislation related to Reproductive Maternal Neonatal and Child Health. Government needs to enact legislation like Punjab and Sindh.

Chapter 4. End Epidemics of Communicable Diseases

Target 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

4.1 International Treaties/Conventions/Guidelines related to SDG 3.3

4.1.1 United Nations General Assembly Resolution No. 75/284 (2021)

The General Assembly adopted the "Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030". The Declaration makes tangible commitments including ending inequalities and engaging stakeholders to end AIDS, effective implementation of combination HIV prevention, HIV testing, treatment, and viral suppression, and pediatric AIDS.

4.1.2 UN Commission on Human Rights, Discrimination against people infected with the human immunodeficiency virus (HIV) or with acquired immunodeficiency syndrome (AIDS) – 1992/56

The Commission calls upon all States to "take all the necessary steps to ensure the full engagement of civil, political, economic, social and cultural rights by people with HIV or AIDS, their families and those in any way associated with them, and people presumed to be at risk of infection, paying particular attention to women, children and other vulnerable groups, in order to prevent discriminatory action against them or their social stigmatisation, and to observe these obligations in particular in the context of AIDS policies and measures".

4.1.3 World Health Assembly Resolution No. WHA73.3 (2020), Global Strategy for tuberculosis research and innovation

The World Health Assembly resolution reaffirms resolution WHA67.1 (2014), which adopted the "End TB Strategy", a global strategy for tuberculosis prevention, care, and control and promotion of R&D. It also reaffirms WHA71.3 (2018) in which the Moscow Declaration's commitments were welcomed to pursue research and innovation along with a request to the Director-General to develop a global strategy for tuberculosis research and innovation.

The resolution primarily urges all Member States to pursue a global strategy for tuberculosis research and innovation to implement the 'End TB Strategy, ensure knowledge sharing, and adapt to and use WHO's multi-sectoral accountability framework to track progress, among other areas.

4.1.4 WHO "End TB Strategy"- 2016 – 2035

The World Health Assembly adopted this strategy in 2014. The strategy aims to end TB in twenty years where "Ending TB is defined as an incidence rate of fewer than 10 people per 100,000 population per year". The strategy targets to reduce TB deaths by 95%, cut new cases of TB by 90% between 2015 and 2035, and ensure no family is burdened with catastrophic expenses due to TB. The four principles of the strategy include "Government stewardship and accountability, with monitoring and evaluation, the strong coalition with civil society organisations and communities, protection and promotion of human rights, ethics and equity and adaptation of the strategy and targets at country level, with global collaboration".

4.1.5 World Health Assembly Resolution No. WHA74, recommitting to accelerate progress towards malaria elimination

The World Health Assembly adopted a resolution in 2021 which building upon previous resolutions including WHA64.17, WHA58.2 (Malaria Control), and WHA60.18

(World Malaria Day) aims to revitalise efforts to end malaria. The resolution emphasises on the Member States to move ahead with plans that are consistent with the WHO's updated global malaria strategy and the WHO guidelines for malaria. The resolution calls on the countries to (i) extend investments in health services; (ii) provide funding for global malaria response; and (iii) scale up investment in new R&D tools.

The resolution is closely aligned with the WHO's 13th Global Programme of Work (2019-2023) and global universal health coverage agenda. Moreover, the strategy's guiding principles have been reordered which places more emphasis on the importance of country leadership of malaria responses, and there is a stronger focus on the need for attainability of resilient health systems, innovative approaches, and evidence-based data-driven localised strategies.

4.1.6 Global Technical Strategy for Malaria 2016-2030

Adopted by the Assembly in May 2015, the strategy sets progressive goals to reduce case incidence and death rates of at least 90% by 2030, with milestones at each 5-year mark to track progress. In addition, it calls for eliminating malaria in 35 countries including Pakistan and preventing resurgence of malaria in all malaria-free countries.

4.1.7 World Health Assembly Resolution No. WHA67.6 on Hepatitis

This resolution reaffirms previous resolution WHA63.18 (2010) that recognised "viral hepatitis as a global public health problem and need for governments and populations to take action to prevent, diagnose and treat viral hepatitis". The same resolution called upon the WHO to "develop and implement a comprehensive global strategy to support these efforts and expressing concern at slow pace of implementation".

The resolution recalls resolutions WHA45.17 on "immunisation and vaccine quality, which urged the member states to include hepatitis B vaccines in national immunisation programmes" and WHA61.21, which "adopted the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property".

4.1.8 World Health Assembly Resolution No WHA 66.12 (2013) on Neglected Tropical Diseases

The resolution, among other areas, urges the member states to "ensure continued country ownership of the programme for neglected tropical disease prevention, control, elimination, and eradication", strengthen surveillance system, pursue interventions to reach the agreed targets in the Global Plan to Combat Neglected Tropical Diseases 2008–2015 and the London Declaration, "strengthen capacity for prevention and control of neglected tropical diseases", develop "capacity for monitoring and evaluation of the impact of interventions against neglected tropical diseases", "provide prompt diagnostic testing of all suspected cases of neglected tropical diseases and effective treatment with appropriate therapy of patients", and "to improve coordination for reducing transmission".

4.1.9 London Declaration on Neglected Tropical Diseases (2012)

The declaration is a collaborative effort, inspired by the World Health Organization's 2020 Roadmap on NTDs. It aims to end 10 NTDs by 2020 and committed to supply drugs and introduce interventions to eliminate lymphatic filariasis, guinea worm, leprosy, sleeping sickness, and blinding trachoma by 2020, supply drugs and introduce interventions to control schistosomiasis, soil-transmitted helminthiasis, Chagas disease, visceral leishmaniasis, and river blindness, undertake advance R&D, and to provide technical support and financing.

4.2 Relevant National Legislations

4.2.1 The HIV/AIDS (Safety and Control) Act 2013

The federal government enacted this legislation to ensure public safety and to control HIV/AIDS virus. The Act requires all public hospitals to carry out HIV/AIDS test free of cost. The HIV/AIDS test can be required by the court, public prosecutor, or a public physician which can be undertaken by a primary healthcare giver, nurses, attendants, paramedics involved in the care of the patient. The Act has made special emphasis on the issues of confidentiality, discrimination, and victimisation of the patients. It also advised government to run public awareness campaigns to clear misunderstanding and taboos around HIV/AIDS to end stigmatisation of and discrimination against the infected population.

4.2.2 National Strategic Plan for Tuberculosis Control, 2020-2023

The National Strategic Plan for Tuberculosis Control (NSPTC) for 2020-2023 lays out the full expression of Pakistan's needs in controlling tuberculosis (TB) and describes how to meet those needs between 2020 and 2023. The NSPTC enlists interventions that Pakistan will undertake to address TB. It takes into account national health system, both private and public sectors, and government health policies and strategies. It is backed by an up-to-date understanding of the epidemiology of TB in Pakistan, and the recommendations of the Joint Pakistan Review Mission (JPRM) conducted in February 2019. The implantation of this plan is still underway.

4.2.3 National Hepatitis Strategic Framework (NHSF) for Pakistan 2017-21

Recognising enormity of Hepatitis challenge and following the WHO and the SDG global targets, Pakistan has developed National Hepatitis Strategic Framework (NHSF). The framework has five strategic objectives to implement the priority area that has emerged from the epidemiology situation of viral hepatitis and its current national response. It emphasises the establishment of leadership, governance, and advocacy for a coordinated and integrated hepatitis response.

Unfortunately, there is no mechanism developed either at the national level or provincial level to map existing services, including the location of all current testing sites, uptake, and coverage rate. The accreditation process, testing/diagnostic capabilities, and human resource of private and public sector laboratories are very weak. There is no provincial or national testing strategy and alert system. During a blood transfusion, if someone is tested positive, there is no hepatitis information system that will integrate information into the broader National Health Information System.

4.2.4 National EPI Policy and Strategic Guideline 2015

The EPI policy document provides strategic guidance for the implementation of the immunisation programme. It builds on the direction and planning of the Comprehensive Multi-Year Plan (MYP), experience gained during the last many years of implementing routine and supplemental immunisation activities, and international technical immunisation guidelines. The immunisation Policy envisages ambitious Pakistan's Vision 2025 by addressing its Pillar 1 to reduce infant mortality rate from 74 to less than 40 (per 1000 births) and reduce maternal mortality rate from 276 to less than 140 (per 1000 births).

The policy is designed to provide a technically sound basis for vaccination procedures according to proven international standards and norms. It is very crucial to reorient all immunisation services in the country based on the policies, strategies, norms, and guidelines incorporated in the immunisation policy. The implementation of EPI Policy is still a challenge as the country is far behind in achieving immunisation goals especially in areas like Balochistan

where immunisation is still 29%. Balochistan has an undertrained EPI workforce, weak Cold Chain Equipment, religious and cultural barriers, and low budget provision for the EPI programmes.

4.2.5 Strategic Plan for Malaria Control Programme (SPMCP) Pakistan (2015-20)

The federal government developed Strategic Plan for Malaria Control 2015-20 to incorporate the changes in the country context due to post devolution scenario. The plan was a "full expression of demand" and was a tool mainly to give insight towards the Malaria programme, sensitising policymakers and partners. The plan was guided through key resources such as National Malaria Strategic Plan (2011-2015), Rapid Programmatic Assessment 2013, Malaria Programme Review-MPR 2013, Malaria Indicator Survey-MIS 2013, and provincial and regional malaria control strategic plans.

4.3 Relevant Provincial Legislations/Policies and Guidelines

4.3.1 The Balochistan Safe Blood Transfusion Authority Act, 2004

The primary aim of the Balochistan Safe Blood Transfusion Authority is to ensure quality blood transfusion services in the province. As a regulatory body, the authority will take all steps that may be required to ensure perpetually and sustained development of the service in the province in line with internationally acceptable standards. It calls upon all practitioners to ensure that the blood or blood products are free from an infective and injurious agent and is transfused in a manner as may be specified by the Authority in the rules.

As per the Safe Blood Authority Act, it should be governed through the Board and Secretary Health should be the chairman of the authority. The authority functions include registering, granting, extending, or revoking the registration status and/or license of a blood bank in the province. The authority also has the powers to develop and enforce guidelines, standards, SoPs, rules, and regulations, for blood banks, including but not limited to the requirement of professional qualification and training standards and professional staff working in a blood bank in the province.

The Balochistan Blood Transfusion Authority office is located at Regional Blood Center. The secretary position is given on an additional charge basis, and it has only two inspectors to ensure that guidelines are implemented in all hospitals and private blood banks. Although the authority is functional, but it is highly constrained in terms of human resources and technical staff to perform work in an effective manner and in line with the spirit of the authority.

4.3.2 The Balochistan Clinical Laboratory Regulatory Authority Ordinance 2001

The aim of this legislation was to establish Balochistan Clinical Laboratory Regulatory Authority in order to promote comprehensive and quality clinical laboratory services in the province. As per the Act, the Secretary Health of Government of Balochistan should be the chairman of the authority and the authority shall notify an Accreditation Committee with a chairman and three members.

The authority has the powers to develop, review, approve, and regulate fees and charges pertaining to clinical laboratory services; monitor and enforce compliance by licensees with conditions of their accreditation and licenses, and protect the interests of the patients and public. The implementation of this authority also never materialised and the Act is still dormant and non-functional.

4.3.3 Provincial Strategic Plan for Tuberculosis Control, 2020-2023

The purpose of the Provincial Strategic Plan for Tuberculosis Control (PSPTC) is to provide strategic direction in planning, programming, and implementation of interventions and activities through multi-sectoral and collaborative approaches both within and outside the health sector. It also aims to align the provincial TB response with the latest international evidence, strategic policies, and programmatic guidance. The PSPTC aspires to inform national, provincial, district, and community-level stakeholders on strategic directions for consideration when developing implementation plans. It will make TB control visible in the health agenda and advocacy for substantial resources from the Provincial Government. This serves as a framework for the Provincial Tuberculosis Programme (PTP).

4.4 Institutional Arrangement in Balochistan

4.4.1 Expanded Programme on Immunisation

As discussed earlier, this is one of the most strategic provincial programmes in the province. The EPI is providing immunisation services against 10 infectious diseases including measles, polio & hepatitis B. A significant proportion of union councils (and health facilities) in the provinces either have no vaccination staff or no facilities that provide vaccination. The poor illiterate communities are skeptical about the objectives of such programmes as historically these kinds of programmes were exploited for intelligence gathering as it reportedly happened in the case of Al-Qaida leader Osama Bin Ladin. Another potential reason that contributes to the situation is related to contamination of vaccines and subsequent mild side-effects. The province needs to enhance the infrastructure for cold storage and transportation. It shall also put serious efforts to build the trust of the general public in the programme. Effective communication and advocacy with religious and community leaders may help the programme in achieving its intended objective.

4.4.2 Malaria/Vector Borne Diseases Control Programme

Overall objective of the Malaria/Vector Borne Diseases Control Programme is to reduce morbidity and mortality due to malaria and vector borne diseases in Balochistan, through universal coverage of effective control interventions as per the WHO guidelines. The programme covers major Vector-Borne Diseases including Malaria, Dengue hemorrhagic fever, Crimean Congo Hemorrhagic Fever (CCHF), Leishmaniasis, Chikungunya, Zika and, any other Vector Borne diseases if and when reported.

This vertical health programme is historically supported by donors including the Bill and Melinda Gates Foundation which was effectively implemented in the province by utilising modern technology GIS for monitoring of the programme. It is important to mention that donors are only supporting initiatives related to Malaria. The Malaria/VBD programme needs to train human resource through the provincial budget in order to efficiently manage other Vector Bore Diseases (Dengue, Leishmaniasis and CCHF). The programme currently needs a strategic plan and political ownership. It also lacks a comprehensive Management Information System and Surveillance and Alert System.

4.4.3 Balochistan Aids Control Programme

Balochistan AIDS Control Programme (BACP) was established in 1994. The programme was initially supported by the World Bank. Later, the Global Fund (GF) supported the initiative. The objective of the programme is to increase the prevalence of 'safe behaviours' and improve availability of services for Sexually Transmitted Infections (STIs) among Most at Risk People (MARPs), improve knowledge and practice of HIV preventive measures, use of

high quality STI services, reduce transmission of HIV and other STIs through blood and blood products.

The HIV/AIDS treatment services are provided through 02 Triple Antiretroviral Therapy (ART) and Prevention of Parent to Child Transmission (PPTCT) Centers situated in BMCH Quetta and DHQ Hospital Turbat.

The programme has registered over 1200 HIV positive patients. It has also established screening centers at 28 DHQ hospitals. Recently the programme has run special awareness and screening sessions in selected jails of Balochistan.

4.4.4 District Health Information System (DHIS)

This programme aims at improving health care services through data and evidence-based management. The DHIS tries to provide information for management and performance to decision makers. The DHIS aspires to keep track of selected key information from First Level Care Facility (FLCF), Vertical Programmes, Secondary Hospitals, and sub-systems such as logistics, financial and human resource, and capital asset management for improving the District Health System's performance. It also envisions collecting the important routine information needed at the Federal and Provincial levels for policy formulation, planning, and M&E of health programmes.

Despite the good features, the current DHIS Software needs customisation to include the data reporting of other programmes. For example, the Regional Blood Center has an updated and well implemented MIS system; and currently, it is not connected with the DHIS. The existing system is primarily paper based, with computer links provided up to the divisional level. The scope of the system is limited to selected areas. Processing of information usually takes over a month and some districts are not reporting data. Unfortunately, the available data in the DHIS is not used for decision making since the reliability and validity of data is not trusted among the decision makers. The system needs serious customisation to include new data attributes in line with the SDGs and international standards. Government needs to commission a study to review and assess the current capacity and needs of the existing system.

4.4.5 Safe Blood Transfusion Project Balochistan

This programme was designed by the Safe Blood Transfusion Project of Pakistan in collaboration with the German Government. The first Regional Blood Centre (RBC) with a capacity of 50,000 blood units has been started in Quetta with support from the German Government through KfW Bank. The aim of the project is to ensure safe, efficacious, and well screened blood and blood components i.e., Red All Concentrate (RCC), Fresh Frozen Plasma (FFP), Platelets (Single and Mega Units), and Cryoprecipitate. RBC is providing these lifesaving products free of cost to the patients. The Regional Blood Centre (RBC) is linked with six (06) hospitals-based Blood Banks (HBB's) in Bolan Medical Complex Hospital Quetta, Sandeman Provincial Hospital Quetta, Fatima Jinnah Hospital Quetta, DHQ Hospital Mastung, DHQ Hospital Pishin, and DHQ Hospital Chaman.

The RBC is providing safe and clean Blood to 2700 registered patients of Thalassemia Care Centers of Government of Balochistan. The SBTP has also arranged workshops, training, and seminars to give awareness to the general public about blood donations and the developing skills of laboratory workers. There is a need to develop Regional Blood Centres in all divisional headquarters. The RBC Quetta is the largest blood bank and probably the only bank with the cutting-edge technology to screen blood before declaring it safe for transfusion. The Balochistan Blood Transfusion Authority needs to devise policies for all private and hospital-based blood banks to screen blood using the RBC as they have the technical and technological

advantage to screen blood with high level of accuracy and following internationally recognised standards.

4.4.6 Tuberculosis (TB) Control Programme

The Provincial Tuberculosis Control Programme (PTP) is responsible for coordinating, planning, implementing, managing, and financing the TB care and prevention activities in the province along with collaboration with the National TB Control Programme (NTP) and international donors. The PTP tries to strengthen laboratory network for diagnosis & quality control, and to ensure a continuous supply of anti TB drugs for complete treatment, provide training to existing health staff in designated health facilities, and undertake community mobilisation for awareness.

Currently, the programme has provided 40 LED Microscopes & 105 Solar Panels to 105 TB BMUs. It also has established BSL-III laboratory and Line Probe Assay (LPA) testing initiation at Provincial Reference Lab and provided digital X-ray machine at Fatima Jinnah Hospital Quetta and Teaching Hospital Khuzdar. Lastly, the programme has provided Xpert machines to 32 sites and adapted the DHIS-2 at the district level. The programme is still dependent on donor grants. It faces challenges in recruiting technical staff at peripheries. The programme needs to be expanded to all health care facilities as TB care BMUs. Unfortunately, there is still a large number of missing TB cases in the province (60% DS & 84 % DR-TB cases are still missing out of estimated incident cases). The programme has limited operational research to identify and justify the gaps in their activities and programming.

4.4.7 Chief Minister Initiative for Hepatitis Free Balochistan

This programme aims to prevent acute hepatitis infection in the province. There are a high number of Hepatitis positive cases in the province. This programme also aims to strengthen the current health system and increase public awareness in the province. The programme has launched the birth dose hepatitis "B" vaccine with the help of Provincial EPI. It has established screening centers in all DHQs & tertiary care hospitals of the province. The provincial government through this programme has provided over 14,000 free treatments of hepatitis B, C, and D. The WHO accredited hepatitis screening kits, syringes, hepatitis "B" vaccines along with other logistics were also provided to all districts.

To make the programme more successful, the provincial government needs to provide a confirmatory diagnostic facility of ELIZA & PCR for the patients with Hepatitis B, C & D in public sector hospitals. It also needs to improve hospital waste management in all districts of the province. Government needs to devise legislation for private clinics especially dental clinics to establish screening SoPs for hepatitis B & C patients which is one of the primary sources of prevailing cases.

Despite all the efforts, the situation of the hepatitis-positive case in the province is very alarming. Government needs to commission a study to assess the prevailing situation using available data from private and hospital-based blood banks and Regional Blood Centre. This will help in sensitising policymakers to make proper law/legislation against quackery practice and ancillary law to prevent and control hepatitis cases in the province. It is important to note that the implantation of current legislation is very poor to assess, monitor, and prevent quackery practices. There is also no law/ legislation for prevention and control of hepatitis B & C in the province. There is a need to develop a strong system to install incinerators for wastage management in all districts to control infectious diseases.

4.5 Recommendations

- Government needs to pass legislation for control and prevention of Hepatitis, HIV/AIDS, COVID19, and polio epidemics.

- Government needs to devise policies for all private and hospital-based blood banks to screen blood using RBC as they have technical and technological advantage to screen blood with high level accuracy observing internationally recognised standards.
- Government needs to expand immunisation service delivery and establish logistic/infrastructure and human resource networks in health facilities that currently are not providing the service.
- Government needs to rehabilitate services in union councils that lack vaccination staff or non-functioning EPI centers. It may explore options to enhance capabilities for mobile and outreach vaccination.
- EPI programmes need to establish robust systems for programme monitoring, the VPD surveillance, and capacity for data management at all levels to improve performance, accountability, and validation of disbursement linked indicators (DLIs). The data should be used in systematic assessment of future corrective actions and programme planning.
- Government needs to devise policies to engage private sector in epidemic control and prevention. Currently, only 5% of General Physicians (GPs) are engaged with the local TB control programmes, and yet they are providing 23% of the provincial health services.
- GoB needs to establish a comprehensive Surveillance and Alert System which may be integrated with all epidemic related vertical programmes and blood testing laboratories.
- Continuous Improvement Training and public advocacy programmes need to be enhanced and expanded to private sector health practitioners.

Chapter 5. Reduce Premature Mortality from Non-Communicable Diseases

Target 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

5.1 International Treaties/Conventions/Guidelines related to SDG 3.4

5.1.1 World Health Assembly Resolution No WHA 66.10 (2013) on Non-Communicable Diseases

The resolution acknowledged the "Moscow Declaration adopted by the First Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control" which is endorsed by the WHA resolution 64.11. The WHA 64.11 requires the UN Agencies to implement the decisions of the UNGA meeting to prevent the Prevention and Control of Non-communicable Diseases. It recalls the resolution EB130.R7 to develop a WHO global action plan for prevention of the NCDs. The resolution decided to adopt a comprehensive global monitoring framework with 25 indicators to counter NCDs. It also adopted "the nine voluntary global targets for achievement by 2025 for the prevention and control of non-communicable diseases".

5.1.2 World Health Organization Non-Communicable Disease (NCD) Accountability Framework (2013)

The framework includes the Global Monitoring Framework (GMF) for the NCD prevention and control aligned with extension of the NCD Global Action Plan till 2030. There are nine NCD targets and additional considerations for monitoring implementation on the NCD GAP till 2030. "Member States agreed in 2013 to the 25 indicators across three areas which focus on key outcomes, risk factor exposures, and national health systems' response needed to prevent and control the NCDs. The nine areas were selected from the 25 indicators in the GMF to be the NCD voluntary targets: one mortality target (previously agreed at the WHA in May 2012), six risk factor targets (harmful use of alcohol, physical inactivity, dietary sodium intake, tobacco use, raised blood pressure, and diabetes and obesity), and two national health systems targets (drug therapy to prevent heart attacks and strokes, and essential NCD medicines and technologies to treat major NCDs)".

5.1.3 United Nations General Assembly Resolution 66/2 (2012)

The resolution adopted the high-level meeting of the UNGA on prevention and control of the NCDs. Among other things, the resolution recognised impacts of the NCDs which can be prevented through proper interventions. It is committed to reducing risk factors and creating a health-improving environment by taking necessary actions by the member countries.

5.1.4 Word Health Organization – A53/14 (2000) - Global Strategy for Prevention and Control of Non-communicable Diseases

The resolution reaffirmed the WHO strategy to prevent and control the NCDs. It urged the Member States to develop policy frameworks and related programmes, build capacity at multiple levels including national and regional, and share experiences for concerted efforts to prevent and control the NCDs. The resolution urged the Member States to develop and implement programmes for prevention of the NCDs and thereafter aggressively evaluate the outcomes to improvise overall health system.

5.1.5 World Health Assembly Resolution No WHA 70.12 (2017) on Cancer prevention and control in the context of an integrated approach

The resolution recalls the resolution ‘WHA66.10 (2013)’ which endorses the Global Action Plan for prevention and control of non-communicable diseases 2013–2020 which provides guidance on how the Member States can realise the commitments they made in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, including those related to addressing cancer. The resolution urges the Member States, among other areas; to implement the road map of national commitments for prevention and control of cancer and other non-communicable diseases included in the United Nations General Assembly resolutions 66/2 (2011) and in the Prevention and Control of Non-communicable Diseases resolution 68/300 (2014), to implement the four time-bound national commitments for 2015 and 2016 including scale up national cancer prevention, develop and implement national cancer control plans, collect data on cancer, and promote primary prevention of cancers, to promote increased access to cost-effective vaccinations to prevent infections associated with cancers, to develop and implement evidence-based protocols for cancer management, to promote cancer research to improve the evidence base for cancer prevention and control, to provide pain relief and palliative care in line with resolution WHA67.19 (2014), to promote early detection of patients’ needs and access to rehabilitation, and to promote and facilitate psychosocial counselling and aftercare for cancer patients and their families.

5.1.6 World Health Assembly Resolution No. WHA74.4 on reducing the burden of NCDs through strengthening prevention and control of diabetes (2021)

The resolution recalls the UNGA resolution 70/1 (2015), which adopted the 2030 SDG Agenda and target 3.4 of reducing the risk of premature mortality from diabetes and other major NCDs by one third by 2030. It urges the Member States to, among other areas, raise, give priority to prevention and control of diabetes, “strengthen policy, legislative and regulatory measures”, promoting healthy diets and lifestyles, raise awareness about the national public health burden caused by diabetes, fortify health systems, primary health services, health management information systems, and develop well-trained and equipped health workforce.

5.1.7 United Nations General Assembly Resolution 61/225 (2017)

The resolution designated 14th of November as the World Diabetes Day. It recognised “the urgent need to pursue multilateral efforts to promote and improve human health and provide access to treatment and health-care education”. It encouraged the Member States to take sustainable actions in line with their health-care systems by developing appropriate national policies for prevention, treatment, and care of diabetes.

5.1.8 World Health Assembly Resolution No. 66.8 on comprehensive mental health action plan 2013-2020 (2013)

The resolution adopted the mental health action plan 2013-2020 and urged the Member States to implement the proposed actions in accordance with national priorities.

5.1.9 World Health Organization – Mental Health Action Plan 2013 – 2020

The plan aims to “promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce mortality, morbidity, and disability for persons with mental disorders”. Its objectives include to, along with targets and indicators, “strengthen effective leadership and governance for mental health”, “provide comprehensive, integrated and responsive mental health and social care services in community-based settings”,

"implement strategies for promotion and prevention in mental health", and "strengthen information systems, evidence, and research for mental health".

5.1.10 World Health Assembly Resolution No. 65.4-Mental Disorders

The resolution recalls WHA resolution WHA55.10 which urged the Member States to enhance investments in mental health. It recalls the UNGA resolution 65/69 which classifies the mental health as a major societal problem. It urged the Member States to develop policy and strategy for promotion of human rights, tackle stigmatisation, empower families and communities, address poverty and homelessness, tackle major modifiable risks, and create opportunities for generating income, providing housing and education, provide health care services and community-based interventions, and develop surveillance frameworks.

5.2 Relevant National Legislations

5.2.1 The Mental Health Ordinance 2001

This ordinance aimed to provide treatment and care to the persons living with mental disorder in terms of making better provision for their care, treatment, management of properties, and affairs. It encourages community care for prevention of mental disorders. Under this ordinance, the Federal Mental Health Authority was established with the aim of developing national standards of care of the patients, as well as setting a code of practice for all those involved in care of the patients under this ordinance. A Board of Visitors was also constituted to provide regular inspections and reviews of institutions such as jails and correction centers to ensure that a proper care is given to the people with mental disorders in these institutions.

However, despite these advances in the legislative framework, unsurprisingly, the best practices lagged behind. The Federal Mental Health Authority, which was formed in 2001, lapsed without achieving any significant progress in implementation of the ordinance. Similarly, the Board of Visitors of the provinces are also weakly/poorly functioning/managed.

5.2.2 National Action Plan for Prevention and Control of Non-Communicable Diseases and Health Promotion in Pakistan

The Action Plan has charted a course of action for addressing the NCDs in Pakistan in a prevention and health promotion paradigm through broad-based consensus. This course of action has been guided by a situational analysis which has outlined the present state of affairs, strengths and gaps, and the opportunities to build upon the existing efforts. The Action Plan needs to be supported by a clear, strong, and sustained political and policy commitment. This is even more important because of the long-term and life-course outlook of the strategy. Pakistan faces a formidable challenge in a fight against the NCD. There is a need to mitigate this risk at different levels. Merely, the signing of an official Memorandum of Understanding to lay down the terms of reference of various partners involved may not help in improving the grim circumstances at ground level. Strong political commitment from the federal and provincial cabinets and development of long-term policies and their implementation in true spirit from all stakeholders are required for the desired results.

5.3 Relevant Provincial Legislations/Policies and Guidelines

5.3.1 The Establishment of the Balochistan Institute of Nephro-Urology Quetta Act, 2015.

The objective of the Balochistan Institute of Nephro-Urology is to provide free renal care including dialysis and renal transplantation for diabetic and other patients. This Teaching Institute also strives to become a Centre of Excellence in Renal Transplantation in the province by producing qualified doctors, technicians, and paramedics who in future will be helpful in

planning and establishment of dialysis facilities at the Divisional and District levels. The institute is governed through a board with the provincial Minister of Health as the chairperson and secretary health as a vice chairperson. The institute may provide CPI training to health practitioners and other health related workers to diagnose early signs to mitigate the NCD formidability.

5.4 Institutional Arrangement in Balochistan

5.4.1 Balochistan Cancer Hospital

Last year, the Balochistan Government allocated PKR 1.6 billion to construct a dedicated cancer hospital in Quetta. At present, there are only two institutes which are providing cancer care services and handling all the cancer load of the region. These are Bolan Medical Complex Hospital Oncology Department, with a total of only 14 beds, and Center for Nuclear Medicine and Radiotherapy (CENAR) Quetta which does not fall under the ambit of the provincial government. Government commissioned a cancer hospital after persistent social media and civil society campaigns. The proposed hospital will help the province in providing curative care on the NCD diseases like cancer. Government in general and the hospital in particular need to establish a training wing/department to enhance HRH capacity in the province improving preventive care or at least diagnosing patients in the early stage of cancer.

5.4.2 Balochistan Cardiac Hospital

In 2019, Government of Balochistan in collaboration with the Government of the United Arab Emirate (UAE) took an initiative to establish 120 bed cardiac hospital in Quetta. The civil work is almost complete, and the Government believes that it will be functional soon. Recently, government has approved an amendment to the composition of the Board of Governors of the Cardiac Hospital Quetta and renamed it as Sheikh Salman bin Zayed Al Nahyan Institute of Cardiology. The cardiac diseases are prevailing in Balochistan and the patient load for curative care in tertiary care hospitals is increasing day by day. Government needs to establish a cardiology centre in every teaching hospital in the province. There is again a need to arrange CPI training for the provincial HRH so that they can pick early signs and refer cardiac patients to such facilities and provide quality primary care services in remote areas. To mitigate the risk of cardiac diseases, government needs to ensure essential medicines and equipment at the facility level. Sometimes, simple steps like checking blood pressure and providing Aspirin make a difference in the patients' life.

5.4.3 Balochistan Institute of Psychiatry and Behavioral Sciences

The Institute of Psychiatry is the only facility for providing mental health services in Balochistan. The Institute is providing all kinds of clinical services including outpatient, inpatient, emergency, and liaison services, forensic psychiatric services, and community mental health services. The OPD service is provided 6 days a week with an average daily turnover of 100 patients. The Institute of Psychiatry has a 100-bed unit, which is divided into a male ward, a female ward, and a forensic unit. There are separate units for occupational therapy and electro-convulsive therapy. The Institute also provides the services for the liaison cases from other departments of all the hospitals affiliated with Bolan Medical College and it also looks after the patients referred through the emergency department for psychiatry evaluation. Forensic services are provided to the prisoners of Quetta Central Jail, Muchh Jail. The BIPBS has established a separate Substance Abuse & Detoxification Center which provides complete services to drug abuse patients. It also has specialised doctors for Child and Adolescent psychiatric services and there is a special ward regarding these services.

This institute is under-utilised in terms of providing training, awareness, and control drives against drug use in the province. The institute needs to work in close coordination with donors and social welfare departments. It can play a significant role in designing curriculum not only for the HRH but the overall education system in promoting socially responsible behaviour in the province especially in the context of the EPI and other programmes through research and evidence.

5.4.4 Balochistan Institute of Nephro-Urology Quetta (BINUQ)

This institute is created through the Act of provincial parliament. It provides 115 dialysis services and over 300 OPD services to patients on a daily basis. It also has performed 38 renal transplantations in the province. Severe diabetic patients need high renal care and sometimes require repeated dialysis. The BINUQ provides these services free of cost.

5.5 Recommendations

- Special efforts should be made to improve the NCD data landscape at all levels in the province because this is a prerequisite for effective planning, implementation, and evaluation of the NCDs prevention programmes. Access to reliable and timely information on mortality, morbidity, risk factors, and their socio-economic determinants is very weak and nonexistent.
- Government needs to develop and introduce structured training programmes focused on the prevention of NCDs for medical students and all categories of healthcare providers.
- Currently, there is no cancer control policy either at national or provincial level. Government needs to develop a cancer control policy and spare resources to train oncologists.
- Government needs to introduce the NCDs relevant training packages in the work plans of District Health Development Centers (DHDC). It is also feasible to introduce such modules into the work plans of the LHWs and Primary Health Care providers to observe and pick early warnings on the NCDs and refer patients to secondary or tertiary care hospitals.
- Private sector physicians should also be provided with Continuous Medical Education (CME) training to make them aware of the NCDs.
- The availability of and accessibility to essential drugs is important in the context of the prevention of the NCDs. Government should ensure essential drugs in all health facilities.
- Given the widespread use of hydrogenated fats in the form of *banaspati ghee* in Pakistan, this is of particular concern for the NCDs including cancer and heart diseases. There is a need to examine the pattern of *ghee* and other diet manufacturing, marketing, and consumption. Such assessments will enable the development of policies and strategies to limit the production of, and access to, *ghee* as a medium for cooking. The institute of behavioural science, the Balochistan Food Authority, and universities may take a lead in assessing diet consumption patterns to inform policymakers.
- There should be an assessment of potential agricultural and fiscal policies and policies relating to the structure of production, transportation, storage, and marketing of food items that have implications for increasing the demand for and access to healthy food. Within this context, it is important to develop a nutritional policy along the lines of the WHO Global Strategy on Diet and Physical Activity; such a policy must be endorsed at the cabinet level.
- Social Protection and Health Insurance Programme needs to be improved as it plays an important role in reducing mental health issues.

Chapter 6. Strengthen Prevention and Treatment of Substance Abuse

Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

6.1 International Treaties/Conventions/Guidelines related to SDG 3.5

6.1.1 United Nations General Assembly Resolution No. 74/178 (2020) on international cooperation to address and counter world drug problem

It calls upon the Member States to undertake effective measures to counter the drug problem on principles of shared responsibility. It urges to address the relevant socioeconomic factors related to world's drug problem through policies and interventions in compliance with the three international drug control conventions. It also calls upon enhanced availability of evidence-based preventive measures.

6.1.2 United Nations General Assembly Resolution No. 70/181 (2015)

The resolution demands, among other areas, to ensure availability of controlled substances for medical purposes and prevent any sort of diversion, develop a comprehensive response to drug related crimes, cross cutting issues in addressing the world drug problem, and develop a drug control policy that also addresses socio-economic issues.

6.1.3 Convention on the Rights of the Child (1989)

The Convention urges the need to protect children from the illegal use of drugs and psychotropic substances. It also emphasises to "prevent the use of children in illicit production and trafficking of such substances".

6.1.4 World Health Organization - Global alcohol action plan 2022-2030 to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol (2021)

The strategy's draft identifies actionable areas which include implementation of high-impact interventions, promoting awareness and advocacy campaigns, enhanced dialogue, and joint efforts, building technical capacity, developing information systems, and mobilising the required resources to reduce the harmful use of alcohol. The strategy outlines clear indicators to achieve the desired targets.

6.1.5 World Health Organization – Executive Board Decision EB164(14) (2020) – Accelerating actions to reduce the harmful use of alcohol

The Decision requested to develop the action plan (2022 – 2030) to implement the global strategy which can assist in reducing the harmful use of alcohol as a public health priority. The Decision also requires to development a technical report to identify the impact of marketing and promoting alcohol for youth consumption.

6.1.6 World Health Assembly Resolution No. 63.13 on Global strategy to reduce the harmful use of alcohol

The resolution urged the Member States to implement a concerted global strategy to reduce harmful use of alcohol. It encouraged implementation of the resolution WHA61.4 on the strategies to reduce harmful use of alcohol. The resolution called for adoption of a national strategy to protect the at-risk, young population, and others from harmful drinking.

6.2 Relevant National Legislations

6.2.1 The Control of Narcotic Substances Act 1997

The aim of this legislation is to consolidate the laws relating to narcotic drugs, phototropic substances, and control the production, processing, and trafficking of such drugs and substances. Among other things the legislation also focuses on punishment, search warrants, criminal courts, and the establishment of rehabilitation centers. This is a very comprehensive law that has incorporated international best practices. The implementation of this act carries a question. Similar laws have also been passed in all other provinces, except for Balochistan. The federal government also passed Narcotic Control Force Act 1997 to establish a dedicated federal force to control trade, production, processing, and use of narcotics in Pakistan. Apart from the above legislation, the federal government is regulating narcotics control, establishment of rehabilitation centres and testing labs, etc., through Statutory Regulation Orders (SROs) from time to time.

6.2.2 The National Anti-Narcotics Policy-2019

The National Anti-Narcotics Policy-2019 seeks to strengthen narcotics control at the national level while ensuring full compliance with relevant international obligations. This policy, therefore, seeks to enhance capability of drugs law enforcement agencies and other relevant public sector stakeholders, forge more meaningful partnerships with public and private sector entities, develop effective inter-ministerial, inter-provincial, and inter-agency mechanisms among narcotics control related stakeholders in law enforcement, health, and education. The policy is focused on drug supply and demand reduction, and international cooperation.

6.3 Relevant Provincial Legislation/Policies and Guidelines

All other provinces have enacted legislation to control narcotic substances, Balochistan still lags behind in this legislation and draws inferences from the federal legislation and the taskforce to curtail use, production, and trade of substances use. As Balochistan shares a long border with Afghanistan, which is the main source of narcotic substance trade, production, and smuggling to neighboring countries, therefore, it needs to enact its own Act to curtail this menace from the society. It will enable government to establish special narcotic courts for speedy trials, establish drug testing labs to process evidence using modern scientific techniques which could be presented in drug courts to increase conviction rates, and establish rehabilitation centres.

There is no comprehensive provincial social protection programme and a majority of the people live in poverty which is one of the main contributors of narcotic substance use. Eleven (11) out of thirty-four (34) districts with a cumulative population of around 40% of Balochistan live along international border with Iran and Afghanistan which are notorious for international drug trafficking. There are no decent job opportunities in these districts and the main source of livelihood is illicit border trade. Government should also make policies to provide an alternative source of income to incentivise border district citizens to avoid narcotic substance trade, production, and cultivation.

Another policy gap is that although Balochistan medical education produces psychiatrists but it does not have any programme to produce clinical psychologists who can play a vital role in a rehabilitation centre and provide effective counseling services to drug substance addicts.

6.4 Institutional Arrangement in Balochistan

There is no law governing this issue in Balochistan and the province is still governed through federal laws. The antinarcotic force presence in the province is very limited. The provincial police are mandated to control use in the inland Balochistan whereas, the Frontier Constabulary (FC) is given the powers of border control and customs including control of narcotics at the border. The FC personnel are never trained on these issues and cannot enforce anti-narcotic substance laws in true spirit.

The provincial social welfare department runs limited youth awareness programmes and has established some drug rehabilitation centers. The majority of these centres has limited financial and technical human resources. These rehabilitation centres are either non-functional or semi-functional with limited positive results.

6.5 Recommendations

- Government needs to develop comprehensive provincial drug legislations to overcome the challenges of this multifaceted and neglected area. The potential legislation shall comply with international treaties considering local context.
- The provincial police department needs to be more empowered and trained on modern forensic science to gather evidence related to narcotic substance use that is admissible in drug courts.
- In order to meet the diverse needs of the population suffering from drug use disorders, the scope and coverage of treatment and care services should be expanded to all districts and mainstreamed in the health care delivery system at different levels.
- Such expansion of services would require developing the capacity of health care providers for a broader understanding of the nature and extent of drug use and disorders, and interventions to address it.
- Establishing a medication management system which ensures that pain relief medication and psychotropic substances are available to those who need it while monitoring for and preventing possible diversion at different levels i.e., production, storage, healthcare (prescribing physicians and pharmacists), patients, and the Internet.
- Over-the-counter prescription drugs should be controlled. Government needs to enhance awareness among policymakers, parents, young people, and teachers on the consequences of the misuse of prescription drugs in society. It requires strong implementation and commitment from all quarters.
- Training healthcare professionals on an ongoing basis on how to prevent, recognise and manage the non-medical use of prescription drugs and related consequences.
- Government needs to develop a mechanism to collect basic epidemiological data regarding the extent and patterns of non-medical use of prescription drugs and their consequences. Government needs to strictly implement the pharmacy accreditation process and curtail over-the-counter prescription. It is one of the most neglected areas in the province. This may require updating the outdated pharmacy related legislation.

Chapter 7. Halve the Number of Deaths and Injuries from Road Traffic Accidents

Target 3.6: By 2020, halve the number of global deaths and injuries from road traffic accidents.

7.1 International Treaties/Conventions/Guidelines related to SDG 3.6

7.1.1 CAREC Regional Road Safety Strategy 2017-2030

A Regional Road Safety Strategy 2017–2030 was developed to provide a framework for member countries of the Central Asia Regional Economic Cooperation (CAREC) to effectively implement CAREC's commitment to road safety. The strategy builds upon existing strengths within the region, addresses identified gaps, utilises existing good practices, and mitigates risks. Pakistan is a signatory to the CAREC Road Safety Strategy 2017-2030 which sets an overall objective of reducing fatalities on CAREC corridors by 50 percent by 2030 compared to 2010.

7.1.2 United Nations Global Road Safety Targets

In March 2010, the UN General Assembly proclaimed a global Decade of Action for Road Safety, 2011- 2020. Pakistan is a signatory to this resolution. In 2015, recognising the obstacle that road traffic injuries present to development efforts, the UN Member States, including Pakistan, included road safety targets (SDG 3.6 and SDG 11.2) in the UN 2030 Agenda for Sustainable Development. In November 2017, the Member States concluded work on a comprehensive set of 12 Global Road Safety Performance Targets for 2030.

7.1.3 United Nations General Assembly Resolution No. A/72/359 (2017) on Improving Global Road Safety

The Resolution 64/255, among other areas, emphasises policy interventions, providing technical support including road safety management, safer vehicles and roads, and adequate availability of facilities in accidents. The resolution also stresses upon collection of data for research purposes. It also urges to "develop comprehensive legislation on risk and protective factors, protect bystanders and first responders". It described five pillars that the countries should implement including road safety management, safer roads and mobility, safer vehicles, safer road users, and post-crash response.

7.2 Relevant National Legislation

7.2.1 The National Highway Safety Ordinance (NHSO) 2000

The NHSO regulates aspects of road safety on the national highway network including traffic signs, signals and markings, traffic movement, driver licensing, and third-party insurance. This legislation requires updating to address evolving technological development related to electric cars and driverless vehicles. It also needs to adapt to new technology and international best practices to manage and regulate road safety.

7.2.2 The Motor Vehicle Ordinance, 1965 (MVO) and the Motor Vehicle Regulation, 1969 (MVR)

The MVO and MVR regulate road user safety on the provincial road network. The differing requirements under provincial and national laws almost certainly result in a perception that different safety standards apply to the national and provincial road networks. Almost six decades old, the MVR cannot reflect the latest, evidence-based best practice in driver licensing, vehicle registration, and the safe management of drivers/vehicles. Vehicles

and drivers operate across national and provincial road networks. Legal requirements under the NHSO often conflict or overlap with those under the MVO and MVR. All laws regulating road users and vehicles require extensive updating to the extent that a new national/provincial road safety legislation is required. Penalties under these laws must be reviewed to reflect risk and effectively deter drivers and other road users from offending.

7.2.3 National Health Vision Pakistan 2016-2025

The objective of the National Health Vision 2016-2025 is to improve the health of all Pakistanis, particularly women and children, through universal access to affordable quality essential health services, and delivered through a resilient and responsive health system. It notes that road traffic injuries account for more than 11 percent of the burden of disease and are 'likely to rise with increasing road traffic and urbanisation. The Vision reinforces Pakistan's commitment to attain the UN Sustainable Development Goals and to fulfill its other global health commitments.

7.2.4 National Transport Policy of Pakistan

The National Transport Policy of Pakistan 2018 outlines urban and rural road safety challenges which will emerge from the increase in population, number of vehicles and passengers, and freight movements in the coming decades. It highlights the current poor safety standard of the network and the significant safety risks which are resulted from sharing urban roads with heavy and light vehicles and importance of a safe and efficient rural road network. It also highlights importance of ensuring safety of the national highway network which carries about 80 percent of inter-urban freight and passenger movements. This strategy supports implementation of the Transport Policy Direction 6.1 (ix) adoption of the 'Safe System' approach.

7.2.5 Pakistan National Road Safety Strategy 2018-2030

The Federal Ministry of Communications (MoC), in collaboration with the then UK Department for International Development (now the Foreign, Commonwealth, and Development Office-FCDO) and the Asian Development Bank, has developed the Pakistan National Road Safety Strategy 2018-2030. It follows guidelines coined in the Safe Systems approach, with a long-term vision that "no one should die or be seriously injured because of a road traffic crash". The primary challenge for Pakistan is to lay down the foundations for road safety by setting out goals, objectives, areas of intervention on major risk factors, and a target for saving more than 6000 lives by 2030.

7.3 Relevant Provincial Legislation/Policies and Guidelines

7.3.1 The Balochistan Mass-transit Authority Act 2017

The Provincial Assembly of Balochistan passed the BMA Act in 2017. The jurisdiction of the act is applicable to Quetta only. It may be extended to other regions by notification in Official Gazette. The authority is governed through a board and the Chief Minister as the chairperson of the Authority. The main functions of the authority are to own, control, maintain and develop a corridor, station, depot, and any other ancillary facility which are transferred to it by government; plan, construct, operate and maintain the corridors for future expansion; grant licenses to mass transit operators, ensure safe, efficient and comfortable mass transit operations on a corridor or a public transport route. The authority is mandated to maintain the mass-transit routes. It does not have the power to make road safety rules.

7.3.2 The Balochistan Motor Vehicles (Amendment) Act 2017

Government of Balochistan passed the Balochistan Motor Vehicle (Amendment) Act in 2017. The objective of this bill was to update different schedules related to fines and injuries mentioned in Motor Vehicles Ordinance, 1965 (Ordinance No. XIX of 1965). The primary law and regulation outlined in MVO 1965 are not amended and they remained the same. It is unfortunate that government did not update over five-decade law. It only updated schedules given in original legislation.

7.4 Institutional Arrangement in Balochistan

7.4.1 Provincial Transport Authority

The Provincial Transport Authority (PTA) was established under Section-46 of Motor Vehicle Ordinance-1965 in 1970 after the dismemberment of one unit. Since then, it works under different administrative departments. The PTA exercises its function throughout the provinces, in order to streamline the movement of Transport Vehicles throughout the province, to improve the service delivery of transportation. The primary aim of this legislation is to regulate inter-provincial traffic. The authority does not have the mandate to introduce safety protocols rather provide administrative power to manage the service delivery and transport permit.

7.4.2 MERC 1122 Balochistan

Government of Balochistan has established Emergency Response Centres on all major highways of the province through the People's Primary Health Initiative (PPHI). These centres are established at different locations on highways with a beat distance of 50 km. The central control room is established in MERC Head Office at Quetta with 1122 as UAN. Initial setup is established in containers with two fully equipped ambulances, 2 bikes, and 1 rescue vehicle at each centre. There are 14 functional MERC 1122 centres and has responded to over 13000 road injuries in last few years. The MERC 1122 should be expanded to all major areas. The monitoring mechanism should be strengthened by utilising modern GIS technologies. The MERC should also establish a comprehensive MIS for data record and it shall be shared with government for future planning, road accident prevention, and policy formulation.

7.5 Recommendations

- The provincial government may formulate road safety laws following international best practices.
- The provincial government may set up separate courts to expedite traffic and road violation cases.
- The existing law is very weak around vehicle safety. There must be a dedicated body to implement vehicle safety and issue a periodical warrant of fitness certificates. This may be implemented by engaging private parties.
- In the majority of traffic accident cases, both parties settle the case outside of court through mediation under the influence of religious and tribal leaders. The traffic laws should empower police to continue trial against the offender from stateside, even after both parties settle the case outside of court.
- Although post-crash care is provided at the national and sub-national levels, there is a limited emergency care system in place. The emergency 1122 programme should be enhanced and established on all highways. Additionally, there is limited data collection on road traffic crashes. Government should establish a registry to keep a record of traffic crashes and link it to the CRVS system for future planning and policymaking.

- Government needs to establish trauma cenrers in all major hospitals. Currently, there is no burn center in the entire province. Burn centers should be established on a priority basis.
- There is weak implementation of traffic laws, and the department is severely understaffed. The use of technology may be enhanced to effectively monitor road traffic accidents.
- Road traffic fine/fee are not updated on a regular basis.

Chapter 8. Universal Access to Reproductive Healthcare Services

Target 3.7: By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

8.1 International Treaties/Conventions/Guidelines related to SDG 3.7

8.1.1 The Commission on Population and Development Resolution No. 2011/1

The resolution urges the State Governments to ensure to contribute to the Programme of Action of the International Conference on Population and Development. It also stresses to "eliminate all forms of discrimination against the girl child and the root causes of son preference". It calls for strengthening of health care system. It also urges Governments to "redouble efforts to eliminate preventable maternal morbidity and mortality by ensuring that universal access to reproductive health, including family planning is achieved" among other areas.

8.1.2 World Health Organization Resolution No. A46/A/3 on Maternal and Child Health and Family Planning (1993)

It recalls resolutions no. "WHA32.42 and WHA38.22 on maternal and child health, including family planning, maturity before childbearing and promotion of responsible parenthood; resolution WHA39.18 on implementation of the Nairobi forward looking strategies for the advancement of women as they related to the health sector; resolution WHA45.22 on child health and development (health of the newborn); and resolution WHA45.25 on women, health and development".

The resolution calls for health for all and ending practices that affect the health of women and children. It encourages to determine managerial, social, and behavioural obstacles preventing satisfaction of the health and development needs of women and children.

8.1.3 World Health Assembly Resolution No. WHA57.12 (2004) on Reproductive Health

The resolution urges the Member States to make reproductive and sexual health an integral part of the national planning. It advises building upon the capacity of the health care system to provide universal access to sexual and reproductive health care, with a focus on maternal and neonatal health. It encourages to adoption of a strategy that strengthens reproductive and sexual healthcare programmes facilitating marginalised groups and broader community cross-section.

8.1.4 World Health Assembly Resolution No. WHA64.28 (2011) on Youth and Health Risks

The Resolution recalls "the resolutions that directly address young people; WHA38.22 on maturity before childbearing and promotion of responsible parenthood; WHA42.41 on the health of youth; WHA56.21 on the strategy for child and adolescent health and development; WPR/RC39.R12 Rev.1 on adolescent health; EM/RC43/R.11 on health education of adolescents; and AFR/RC51/R3 on adolescent health.

The resolution also urges the Member States to, among other things, accelerate actions to identify causes impacting the health of young people. It encourages to regulate and develop adequate policy to protect young people from harm, eliminate any discrimination experienced by youth, develop health MIS, and develop access to accurate information.

8.2 Relevant National Legislations

8.2.1 Pakistan's Child Marriage Restraint Act (Amendment) 2019

Pakistan inherited the Child Marriage Restraint Act (CMRA) of 1929 which penalises the solemnisation of a marriage of a girl before 16 years of age and a boy below 18 years of age. However, under global commitments on human rights, especially the UN Convention on the Rights of Child (CRC) and the Regional Action Plan to End Child Marriage in South Asia which was adopted in 2014 as noted in the aforementioned sections, the State Party is obligated to increase age of marriage to 18 years of age for both boys and girls. In 2015, the federal government tried to change the age to 18 years in the CMRA amendment bill but the Council of Islamic Ideology asserted that raising the age requirement for marriage to 18 years for girls is against the Islamic laws. After intensive efforts, the bill was passed by the National Assembly in 2019 as mentioned above. However, on the issue of age for Hindu marriages, the Sindh Government first passed Hindu Marriage Registration Act in 2016 and then the National Assembly also enacted a similar Act in 2017. The bills raised the legal age for both Hindu boys and girls to 18 years. The implementation of this legislation is a challenging task for both the federal and provincial governments.

8.2.2 The Criminal Law (Amendment) Act (2021)

The National Assembly passed the Criminal Law (Amendment) Act 2021. While this law should be commended for aiming to regulate several areas relating to children's rights neglected in the Penal Code and Code of Criminal Procedure. The new amendment provides protection to children from sexual assault and cruelty. After passing the amendment Act 2021, Pakistan became the first country in South Asia having gender neutral laws related to rape.

The mechanism for implementation of the law remains weak. For example, the Penal Code does not consider marriage as a defence to rape, but unfortunately, courts have continued to allow evidence of marriage to be a bar to the finding of rape. This has made married girls more vulnerable to experience sexual violence by their husbands without remedy or recourse.

Similarly, induced abortion is permissible before limbs or organs of baby have been formed for the purpose of 'necessary treatment'. This stipulation regarding limbs and organs is based on Islamic law, which states that induced abortion is permitted until the 'quickening' of the fetus up to 20 weeks gestation, according to Pakistani medical practice. Induced abortions that fall outside these conditions may be punished with a prison sentence ranging from three to ten years. This encourages unsafe practices and endangers mother's life. It also forces doctor to perform the procedure at last minute to avoid legal penalty under the law at the increased health risks for women.

8.2.3 Reproductive and Healthcare Rights Act 2013

The aim of this Act is to promote reproductive healthcare rights by providing reproductive healthcare information and awareness regarding mental and physical health and wellbeing of individuals and families, considering religious and cultural norms. This legislation ensures that no person shall be discriminated against in their reproductive lives, in their access to services and information on the grounds of race, colour, sex, creed, or any other criteria of discrimination. The Chapter III of the Act specifically emphasises on promotion and facilitation of reproductive healthcare services by providing quality and professional obstetric care, emergency obstetric care and improve reproductive healthcare systems, particularly, to reach the underserved and vulnerable including poor women by strengthening primary health units. Like other legislations, the implementation of this Act also is very weak.

8.2.4 The National Commission on the Rights of Child Act (NCRCA) 2017

Following the international obligation, the NCRCA provides for the establishment of a national commission on the protection of children's rights. This body is necessary for central monitoring and implementation of law reform efforts. The commission examines existing or proposed legislation and administrative instruments and proposals related to child rights and inquiries into violation of child rights and makes recommendations to relevant agencies. The implementation, enforcement, and interpretation of the commission are to be seen at the federal and provincial levels.

8.3 Relevant Provincial Legislations/Policies and Guidelines

8.3.1 Balochistan Child Protection (BCA) Act 2016

The BCP Act 2016 calls upon all provincial bodies, agencies and organisations, public and private social welfare institutions, and civil society organisations to safeguard and promote the best interests of the child. A child in need of protection shall include any child who has been subjected to physical violence or injury, mental violence, neglect or negligent treatment, maltreatment, exploitation, and sexual abuse or sexual exploitation. The Act briefly covers force child marriage but does not explain the legal age of marriage. All other provinces have enacted Child Marriage Restraint Acts except Balochistan.

8.4 Institutional Arrangement in Balochistan

The National MNCH Programme was launched in 2005. Among others, its responsibility included training and deployment of community midwives, provision of family planning services, strengthening communication of maternal health services to generate demand for maternal healthcare. There are two other important programmes in Balochistan, the Lady Health Workers Programme (LHWP) and the Costed Implementation Plan (CIP) on Family Planning. Both programmes are primarily national programmes with significant provincial support. The LHWP is a major frontline community health outreach programme to deliver family planning, immunisation, and antenatal screening to rural and urban areas. The CIP Balochistan commits to enhancing the Adolescent Awareness Programmes, Contraceptive Prevalence Rate (CPR), and establishing Adolescent Counseling Centres by 2022.

Balochistan, being a conservative and less educated province, is lagging behind in implementing family planning programmes. The decision of family planning still lies with male partners as women have less 'weightage' in such decisions. The population growth and average family size in Balochistan are the highest among all provinces. Access to contraceptive methods and products is still very limited especially in the rural area and there are still taboos around this very important issue. Historically social welfare department ran comparatively successful programmes with the help of donor funding. Once the funding ended, there was no institutional custodian of such programme.

8.5 Recommendations

- The provincial government shall formulate laws related to child marriage restraint and reproductive healthcare rights.
- Government shall pass a child marriage restraint law. Government shall also establish the Provincial Child Protection Commission to monitor implementation of the Child Marriage Restraint laws in the province.
- The implementation should be taken more seriously at the highest political level and it shall not remain an abandoned law.
- The majority of adolescent age marriages avoid prosecution as the birth registration is not fully implemented in the province. The provincial government needs to formulate a mechanism and policy where birth registration is no longer a discretion of the officials

rather it is a mandatory process under the international obligation as well as a fundamental human right.

- Government should allocate budget to ensure free of cost availability of contraceptive products, especially in rural areas.
- Historically the family planning programmes were implemented with a focus on women whereas in reality, the decision makers are male partners. Government should focus on male partners and involve religious leaders for advocacy and spreading awareness regarding family planning.
- Adolescent reproductive healthcare may be included in curriculum especially at university level.
- Dedicated helpline service may be established to report violations and provide psychological support services to adolescents and their parents.

Chapter 9. Achieve Universal Health Coverage

Target 3.8: 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.

9.1 International Treaties/Conventions/Guidelines related to SDG 3.8

9.1.1 World Health Assembly Resolution No. WHA64.9 on Sustainable Health Financing Structures and Universal Coverage

The resolution recalls WHA58.3 on health financing, insurance, and universal coverage. It also recalls Universal Declaration of Human Rights Article 25.1 which states that everyone has the right to a standard of living adequate for the health and well-being of himself/herself and of his/her family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his/her control.

The resolution urges the Member States to, among other areas, ensure the evolution of health financing, strive for affordable universal coverage, the transition of health systems to universal coverage, collaborate with the private sector for health system projects, and develop institutional capacity.

9.2 Relevant National Legislations

9.2.1 National Health Vision 2016 – 2025

Pakistan's National Health Vision 2016-2025 aims to develop a unified vision for improving healthcare in the country by improving coherence between federal and provincial tiers while ensuring autonomy of the provinces. Other objectives include synchronisation and coordination of information and evidence for local and international commitments. This holistic approach is expected to feed into the global SDG planning and implementation mechanisms in partnership with other sectors.

The vision focuses on health systems strengthening and inter-sectoral collaboration while recognising the UHC as a top priority among the country's health objectives. It also envisions transformation to drive toward change, ensure equity, bring resilience and enhance accountability in the health systems. Policy direction is provided on efficient use of existing funds, social protection investments such as the Poverty Reduction Strategy, and social protection initiatives through the country's Poverty Alleviation and Social Safety Division.

In addition to this, the national vision lays specific emphasis on a range of factors such as public service performance accountability, joint public-private target setting, regulation, human resource development for delivery of rural healthcare, and standardised, quality services beginning with the primary health sector. Before this roadmap, only four health policies had been formulated in the country's history – each one was mainly disease-oriented and focused on the public-sector service delivery without a clear translation into operational planning. Sector-wide planning was initiated for the first time after devolution of powers to the provinces.

9.3 Relevant Provincial Legislations

9.3.1 Balochistan Health Policy 2018-30

The Balochistan Government with the help of the World Health Organization developed the BHP 2018-30 in line with National Health Vision 2016-25. It serves as a long-

term plan for the province. It aims to strengthen health system and aspires to serve as a vehicle for any investment in the health sector.

9.3.2 Balochistan Health Strategy 2018-25

The Health Department, Government of Balochistan, has developed Balochistan Health Sector Strategy 2018-25. The strategy builds on health policy and provides an action plan and monitoring mechanism to measure the progress of achievement of the provincial health targets in order to achieve the UHC. This medium-term plan provides system wide approach to health system development in improving all building blocks of the health system. The strategy is presented as a set of eight log frames (six for health system, one for health in humanitarian emergencies and compliance, and another one for implementation and management of strategy).

9.3.3 Annual Budget Expenditures and Development Plan

Drawing on the recommendations of the Abuja Declaration (2001), the total health expenditure should be at least 15% of the total general government expenditure. Historically health sector budget in Balochistan on an average is around 6-8% annually. This means that the government needs to double the allocation for health in order to achieve the SDG goals.

9.4 Institutional Arrangement in Balochistan

9.4.1 Prime Minister National Health Insurance Programme

The Ministry of National Health Services, Regulations, and Coordination (NHSRC), Government of Pakistan, initiated a landmark health care initiative along with provincial governments, Sehat Sahulat Programme (Previously known as the Prime Minister's National Health Programme), with an objective to lead a path towards Universal Health Coverage (UHC) in Pakistan. The programme has been implemented in 38 districts across Pakistan and has provided health insurance to 121,441 families (over 600,000 individuals). In Balochistan, it is being implemented in five districts, Quetta, Loralai, Lasbella, Kech, and Gwadar. During Phase II expansion, the programme is going to be implemented in all districts of Balochistan while providing financial health protection to 543000 families.

One major issue with the programme is that it is utilising poverty scorecards of the Ehsaas Programme which itself is not reflective of Balochistan's poor population and has missed out on a significant number of deserving poor families through its National Socio-Economic Repository Survey (NSER).

9.4.2 Balochistan Health Insurance Scheme (BHIS)

Government of Balochistan has allocated PKR 5.914 billion in the financial budget 2021-22 to launch health insurance cards. Currently, it is being operationalised through Project Management Unit (PMU). However, government envisions establishing the Balochistan Health Insurance Company. The hiring process for PMU is being initiated. The BHIS will provide insurance to beneficiaries to avail healthcare services through six hundred (600) public and private hospitals. Each family will be covered up to PKR 1 million. Government anticipates that it will reach over 600,000 families in the first phase.

Government needs to develop a dynamic structure for the PMU and allow private sector experts to develop the mechanism on modern business practices and run it professionally. It seems that the current PMU structure encourages/favours bureaucrats that have contributed little to the existing healthcare system.

9.4.3 Telemedicine

Utilising the advantages of modern technology, Government of Balochistan through the PPHI has initiated to establish telemedicine at two BHUs in Quetta and Gwadar in collaboration with and technical expertise of the COMSATS Internet Services Islamabad. The programme has been extended to four sites in Washuk Town, Nasarabad-Dukki, Gandkha-Jaffarabad, and Kirdagap-Mastung. After the pilot phase, government intends to scale up the programme to include all primary healthcare facilities. This is an ongoing initiative which remains in limbo until present. It is important that comprehensive impact assessment should be carried out before scaling the programme to cover the entire province.

9.4.4 Balochistan Awami Endowment Fund (BAEF) Rs.2 billion

The BAEF is established under the Social Welfare Department, Government of Balochistan. The primary purpose for the establishment of the Balochistan Awami Endowment Fund is to provide financial support to vulnerable and poor suffering from very costly health conditions including cardiovascular diseases, burns/limb saving treatment/implant, kidney transplant, Hepatitis-C, liver transplant, Thalassemia (bone marrow transplant), cancer, medical rehabilitation of person with disabilities, and Cochlear implant. The enrollment mechanism of the programme is vague and vulnerable to misuse by influential elite. There is a need to conduct a performance evaluation of the programme to ensure the best use for the money.

9.4.5 People's Primary Healthcare Initiative

Government of Balochistan established the PPHI Balochistan as a not-for-profit Company under section 42 of the Securities and Exchange Commission of Pakistan in 2006-2007. This project was conceived after the Primary Health Care Model 1999 in district Rahim Yar Khan in 2003 on a pilot basis. This reinforced government's confidence in the effectiveness of the project and also raised hope that the ailing primary health care sector could be reinvigorated through a partnership arrangement. Currently, the PPHI manages over 653 Basic Health Units and Health Facilities across thirty-three districts of Balochistan. It also manages the MERC 1122 and Telemedicine initiative.

9.5 Recommendations

In order to achieve UHC in Balochistan, the policy level decision makers need to focus on the following areas which have already been outlined in Balochistan Health Policy (2018-30) and Balochistan Health Strategy (2018-25).

Governance:

- The implementation of major legislation and policies is weak in Balochistan. Government needs to have a functional Balochistan Healthcare Commission to develop a mechanism to unify health related initiatives under one umbrella.
- A comprehensive study and review of freeloading entities shall be commissioned. The outcomes of the study may be used to devise policy to ensure harmonisation in utilisation under a common funding platform.
- The health governance and accountability processes have been weak, poorly planned and maintained in the province. Government may benefit from utilising technology to develop monitoring mechanisms to bring efficiency to the system and hold poor performers accountable.
- The development planning has not been able to address health inequalities within and between districts and performance of public sector health institutions is sub-optimal.

Public health planning is concentrated around infectious diseases, while non-communicable diseases remain almost outside the mainstream agenda.

- The Public Private Partnership under Peoples Primary Healthcare Initiative (PPHI) and other organisations lack an institutional framework for establishing key elements of contracting and setting targets for the organisations. Such initiative should set clear and realistic performance indicators and establish a strong monitoring mechanism.
- The accreditation process, performance evaluation, and regulation of for-profit private health sector are weak. The Government needs to focus on reviving and strengthening the Private Hospital Act, the Laboratory Act, and the Health Commission Act.
- Similarly, drug and medicine regulation has been poor in the province. The Government needs to improve liaison with federal drug regulatory authority and implement all statutory mechanisms mentioned under the Federal Drug Act.

Service Delivery:

- There is an absence of a pro-poor integrated essential package of services and medicines. The health department with newly established healthcare insurance facility PMU and welfare department 'Balochistan Awami Fund' needs to design a minimum essential package for vulnerable groups.
- The Government needs to strengthen vertical programmes as they are facing a shortage of resources, infrastructure, and staff. The performance of TB-DOTS programme is very low and likewise, diagnosis and treatment services for malaria cases below district level are highly inadequate.
- The immunisation programme is strategic in reducing burden of disease. Unfortunately, it has been performing sub-optimally and with weak supportive supervision and monitoring mechanism.
- Primary Health Care (PHC) basic EmONC services are non-existent at the PHC facilities level. The Government needs to set KPI for the PPHI with a strong monitoring mechanism.
- The Government needs to strengthen secondary care hospitals as these hospitals are not well equipped and staffed to effectively provide quality services, especially comprehensive EmONC services are not available in all districts resulting in the Tertiary Care Hospitals being overburdened.
- The Government needs to strengthen tertiary care hospitals and implement an effective governance model on the similar lines as implemented in Khyber Pakhtunkhwa. The tertiary care hospitals are not providing services according to capacity. The Medical Superintendents lack even minimal autonomy to manage services.

Healthcare Workforce:

- The Government needs to develop a strategy to implement minimum essential staff and infrastructure requirements in the majority of primary and secondary health care facilities. This strategy will enable the Government to ensure provision of doctors, paramedics, and LHWs in districts to reduce inequalities.
- The Government needs to develop the HRH policy and strategy for skilled professional production, capacity development, deployment, staff mix, and skill mix, to ensure gender balance which is currently inadequate especially in rural areas.
- The Government should make continuing medical education (CME) mandatory for promotion and incentivise it through other reward systems for certain staff categories. The health sector is facing shortage of female health cadres and specialists. The policy for CME is virtually non-existent.

Medical Product:

- Expenditure on medicine and vaccine as a percent of total health expenditure exceeds 52% and yet there is a shortage and stock-outs at health facilities. The Government may outsource the purchase and management of essential medicine and equipment to private parties. This will improve the availability of essential drugs as the current system has built-in procurement and financial hindrances.
- The existing inventory management system is weak and distribution is not based on the principle of equity. There is no system for repair and maintenance of medical equipment. A Logistics Management System is almost non-existent. The expenditure on medicines at the PHC facilities is extremely low. The Government needs to deploy a strong medicine inventory and logistics management system.

Health Information

- The Government needs to strengthen the health information system. Data generated at primary health care facilities (MCH centers, civil dispensaries, basic health units, and rural health centers) is collected manually. Data collection and reporting should be made mandatory at all levels.
- The available data is not utilised for analysis and future planning. There is a need to establish a data analysis wing at the health department that will constantly provide feedback to the decision makers for policy formulation and future development.
- The Government needs to develop a mechanism to report data generated by vertical programmes and integrate it into the main DHIS.

Chapter 10. Reduce Deaths & Illnesses from Hazardous Chemicals, Pollution & Contamination

Target 3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

10.1 International Treaties/Conventions/Guidelines related to SDG 3.9

10.1.1 World Health Organization Resolution No 68.8 (2015) – Health and Environment: Addressing the health impact of air pollution

The resolution reaffirms the commitment to Rio+20 Conference. It urges the Member States to accelerate their efforts to prevent impacts of air pollution, establish health protection authorities to create awareness, facilitate R&D, enhance the morbidity and mortality surveillance for all illnesses related to air pollution, and optimise the linkage with monitoring systems of air pollutants, strengthen global cooperation by transfer of expertise, technologies and scientific data of air pollution, follow the WHO Air quality guidelines, and meet the commitments made at the 2011 UN High level meeting on noncommunicable diseases.

10.1.2 The United Nations Environment Assembly 1/7 – to Promote Air Quality Programme

The resolution recalls the "mandate of the United Nations Environment Programmes as outlined in the Governing Council decision 27/2, paragraph 2 and General Assembly resolution 66/288 of 27 July 2012, by which the Assembly endorsed. It encourages Member States to devise an action plan and share data for better decision-making.

10.1.3 International Labor Organization - Working Environment (Air Pollution, Noise, and Vibration) Convention, 1977

The scope of the Convention is to apply its recommendations to all branches of economic activity. It outlines in detail the preventive and protective measures and supervision of the health of workers. The convention also emphasises training, data collection, and adequate research.

10.1.4 World Health Assembly Resolution No. 72.7 (2019) for Resolution on WASH in health care facilities

The resolution recalls "resolution WHA64.24 (2011) on drinking water, sanitation and health, which emphasises the tenets of primary health care as set out in the Declaration of Alma-Ata on Primary Health Care and other resolutions recalled therein (WHA35.17 (1982), WHA39.20 (1986), WHA42.25 (1989), WHA44.28 (1991), WHA45.31 (1992), WHA51.28 (1998) and WHA63.23 (2010)) and resolution WHA70.7 (2017) which stressed the role of improving safe drinking water, sanitation facilities, health care, waste management and hygiene practices in primary health care.

The resolution calls upon the Member States to focus on provision of universal WASH in health care by engaging in the eight practical steps. These steps initiate with national assessments and analyses, roadmaps development, national standards, improvement of infrastructure, data review and monitoring, develop health force, engage communities and targets, and research for WASH in health care facilities. The resolution is aligned with global efforts.

10.1.5 World Health Assembly Resolution No. 64.24 (2011) for Drinking water, sanitation and health

The resolution recalls "Declaration of Alma-Ata on Primary Health Care and various resolutions stressing the role of improving safe drinking-water, sanitation facilities and hygiene practices in primary health care, environmental health, prevention of waterborne diseases, protection of high-risk communities, infant and young child nutrition, including resolutions WHA39.20, WHA42.25, WHA44.28, WHA45.31, WHA35.17, WHA51.28 and WHA63.23, as well as resolutions EB128.R7 and EB128.R6 containing respectively draft resolutions on cholera".

The resolution urges the Member States to, among other areas, develop national strategies, policy frameworks, and institutional mechanisms along with implementing and quality control of water safety plants.

10.1.6 World Health Organization Decision No. 70(23) 2017

It was decided to approve the enhancement of the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond. Regular updates were to be provided on the global progress made towards the implementation of the Minamata Convention, welcomed by the Health Assembly in resolution WHA67.11 (2014), as part of the reporting on the Strategic Approach. Various tools have been developed to support the roadmap and track diseases due to exposure to chemicals.

10.2 Relevant National Legislations

10.2.1 Pakistan Environmental Protection Ordinance (PEPO) 1983

The Pakistan Environmental Protection Ordinance (PEPO) was the first major consolidated environmental legislation. The PEPO established some high-level policy making forums including the Pakistan Environmental Protection Council (PEPC), Pakistan Environmental Protection Agency (Pak-EPA), and four provincial-level EPAs. In June 2011, the Ministry of Environment was abolished, and its functions and staff were transferred to a newly created Ministry of Disaster Management (MDM), later renamed as the Ministry of Climate Change (MoCC).

According to the 18th Amendment, the federal government can enact legislation on specific subjects that remain exclusively under federal jurisdiction. The MoCC is equipped with five wings to deliver on strategic priorities (Administration, Development, Environment, Forestry, and International Cooperation) and directly supervises four agencies: the Global Change Impact Studies Centre (GCISC), the National Disaster Management Authority (NDMA), the Pakistan Environmental Protection Agency (EPA), and the Zoological Survey Department.

10.2.2 National Environmental Quality Standard (NEQS) 1993

In 1993, the Government approved National Environmental Quality Standard (NEQS) for all new industrial units, requiring them to use more environment friendly processes and machinery to reduce health hazards for workers and general citizens. Three years later, the PEPC constituted two subcommittees, the Environmental Standards Committee and the Expert Advisory Committee, which have done very useful work for developing guidelines and regulations to implement environmental standards.

10.2.3 Pakistan Environmental Protection Act (PEPA) 1997

In 1997, the PEPO 1983 was improved after extensive and prolonged consultation with all stakeholders, and new law, the Pakistan Environmental Protection Act (PEPA) 1997, was

promulgated. The law notably included several provisions to enhance government enforcement powers and empowered all affected citizens to approach the courts regarding any environment-related damage. The hospital waste management rules were also developed by the EPA. The implementation of hospital management mechanisms is still poor in majority of hospitals.

10.2.4 The Canal and Drainage Act 1873

In Pakistan, drains are part of irrigation system and were specifically constructed to drain subsoil water, control waterlogging and salinity, and carry the surface runoff from surrounding lands. They mostly discharge to the rivers and partly to the canals. At present, most stormwater channels carry wastewater and thus function as part of urban sewerage/drainage networks with negligible perennial natural water inflows. These drains are governed under 'The Canal and Drainage Act 1873. The law has not been updated over a century and poses serious WASH related health issues.

10.2.5 National Consensus Strategy 1992

The NCS recommended action in 14 key programme areas, including protection of watersheds, water bodies, and fisheries; preventing and abating pollution, and managing urban wastes. A review report reveals that its achievements had focused primarily on raising awareness and building organisations, rather than on substantially changing Pakistan's environmental situation to improve drinking water and WASH related services.

10.2.6 Hazardous Substances Rules 2007

Hazardous Substances Rules 2007 is the relevant environmental legislation on the issue of hazardous waste management in estates. The compliance is very weak or nonexistent. Hazardous waste exposure can be minimised by adopting the best occupational health and safety measures. Detailed surveys are needed at the industrial unit level and by sector in all the estates as well as hospital sites to quantify hazardous waste generation and treatment.

This is an important area as industries dispose of some of the most toxic and persistent pollutants, including heavy metals and synthetic organic chemicals, directly on land and to water bodies, without any form of environmental treatment or protection. This indiscriminate disposal of toxic waste by industries is posing a serious threat for WASH related services as it is contaminating fresh groundwater and prime arable land. The leaching of heavy metals at dumping sites is one of the major sources of groundwater contamination. Open burning of toxic industrial and hospital waste at low temperatures produces carcinogenic pollutants with adverse public health implications. The Government needs to implement these rules on a sustainable basis. Ad-hoc arrangements through surprise visits may not result in intended benefits.

10.2.7 National Environmental Policy 2005-15

Faced with the need for a comprehensive national environmental policy to address continuing environmental degradation, the Federal Government prepared its NEP (2005–15). The policy's supplementary papers, strategies, and plans address a wide range of environmental issues. However, the NEP does not assign responsibility for certain tasks to specific institutions and agencies but relies on voluntary execution of its recommendations by federal, provincial, and local government agencies, and other environmental stakeholders.

10.2.8 Pakistan Council for Research in Water Resources (PCRWR)

The Pakistan Council for Research in Water Resources (PCRWR) is the only government department in the country that works on water resources research. The PCRWR is primarily a research organisation studying a broad array of topics related to water management. However, the PCRWR is not an implementation agency and it only collects and analyses data.

The recommendations of the PCRWR are rarely used by the Public Health Engineering Department or local government departments responsible for the provision of safe drinking water.

10.3 Relevant Provincial Legislations/Policies and Guidelines

10.3.1 The Balochistan Environmental Protection Act, 2012

The primary aim of the BEPA 2012 provides protection, conservation, rehabilitation, and improvement of environment, prevention and control of pollution, and promotion of sustainable development. This is a comprehensive legislation. It calls upon the Government to establish Balochistan Environmental Protection Council, Balochistan Environmental Protection Agency, Regional or District Environmental Protection Agencies, Balochistan Sustainable Development Fund, and Environmental Tribunals. The Act is not functional to its full scope because of limited political commitment, fewer funds, and lack of capacity of the environmental department.

10.3.2 Local Government Ordinance 2001

In rural areas, Tehsil Municipal Administrations (TMAs) manage urban water supply operations, wastewater and solid waste treatment, and the PHE Department constructs water and sanitation facilities to be operated and managed by TMAs. These functions are chalked out by the Local Government Ordinance (LGO) of 2001. Since certain sections of the ordinance relevant to TMAs and PHEDs are not being followed, therefore, a different scenario plays out on the ground. TMAs face significant capacity and resource issues to fulfill their responsibilities. The Government needs to empower TMAs and give them more autonomy to collect revenue and utilise funds for provision of WASH services.

10.4 Institutional Arrangement in Balochistan

In Balochistan, Environment Department, Environment Protection Authority, Water and Sanitation Authority, Tehsil Municipal Administrations, and Public Health Engineering Department are the main institutions responsible to implement, monitor and review air, water, and soil quality on a regular basis. The new setup with decentralisation created a provincial diversity to the point of developing some conflicting approaches for environmental management. Among others, the 18th amendment to the constitution transferred federal functions such as environment to the provinces. Balochistan, however, could not internalise this change. The province is still struggling to fully understand and comprehend the challenges.

Pakistan's decentralisation agenda has not been finalised in the environmental space. The 18th Constitutional Amendment is an important and the first step in a series of reforms to create a more responsive and accountable EMS in the country. However, over time, critical reforms which needed to ensure that environmental management serves citizens and reduces pollution were either not fully made or initiated.

Part of these key reforms could include implementation of networks of fixed and mobile air and water quality monitoring stations for the province, and establishment of environmental reference laboratories. Another reform area could be the creation of technical systems or partnerships with research and scientific entities including universities to support the Environment Protection Department. Such platforms will provide strategic guidance and help the Government in making decisions and initiating innovative pro-environment projects. The platform will also serve as a think tank for the EPD in advancing research related activities, especially in the local context.

Each province separately deals with food safety and security and there is no federal level authority/mechanism to enforce uniformity. Crop and animal health and safety, including

zoonoses, are responsibilities of the Agriculture, Livestock, and Dairy Departments at the provincial level. Quality control of the import of fish and fishery products is the responsibility of the Ministry of National Food Security and Research, but export-related issues are handled by the Ministry of Ports and Shipping at the federal level. Foodborne disease outbreaks are addressed by the departments of health at provincial level. There is a need to develop an integrated and cross departmental mechanism to deal with food security and environmental quality controls both at the provincial and federal levels. It has an overarching impact on the whole system.

10.5 Recommendations

- Food safety and security legislation generally covers only an end product inspection and testing and does not address the preventive approach to the complete food chain. The majority of food security legislations need a comprehensive update to abreast with the requirements of evolving food security and risk mitigation protocols.
- There are very limited staff training and environmental audits of the Balochistan Environmental Protection Agency to build departments' capacity (required human resources and technology). There is a need for staff to have relevant knowledge, especially from a public health perspective to enhance the BEPA productivity. Lack of funds, power, and resources is a limitation. Although the provincial BEPA has the authority over environment-related projects, they never assumed responsibilities to monitor medical waste treatment and issues related to public health. The BEPA lacks the power and required funds for enforcement activities.
- The development of a uniform mechanism to define parameters of environmental quality standards and benchmarks for provincial units which were previously defined by a federal framework is direly needed.
- Management and financing of equipment to monitor and record air, water, and soil pollution are almost nonexistent. A centralised state of the art reference lab must be established at the provincial level and preferable at divisional headquarters accessible to all relevant public health related departments.
- The BEPA, which is charged with implementation of the existing legal and regulatory framework, has ambitious mandates, but in general, it faces obstacles in its work because it has insufficient staff, small budget, and little administrative autonomy. The agency has rarely been adequately staffed with experts to monitor and enforce ambient air, water, and soil quality standards. As a result, the enforcement of mandatory regulations is lax, and stricter legal penalties are rarely imposed because of, among other reasons, the lack of technical capacity to provide sound evidence of infractions and the fear of political retribution.
- The 18th Amendment in 2010 transferred responsibility for AQM to the provinces. In this new governance hierarchy, local government bodies have a crucial role in managing air quality and curbing air pollution through various departments, such as solid-waste management, transport, urban forestry, agriculture, and health. However, this role has not been fully realised because of capacity, financial, and political issues. There is a need to develop a comprehensive and integrated approach to wastewater and solid waste treatment at the provincial level. Engagement of the private sector may add value and bring efficiency to the system.

Chapter 11. Strengthen the implementation of Tobacco Control

Target 3.a: Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate.

11.1 International Treaties/Conventions/Guidelines related to SDG 3a

11.1.1 The Economic and Social Council Resolution No. 2010/8 on Tobacco use and maternal and child health

The resolution calls upon the importance of protecting well-being of women and children. It urges the Member States to consider the importance of tobacco control in improving maternal and child health as part of their public health policies and in their development cooperation programmes. It also calls upon improving maternal and child health by protecting children and pregnant women from using tobacco and exposure to tobacco smoke.

11.1.2 World Health Assembly Resolution

The WHA resolutions WHA49.17 and WHA52.18 call for development of a WHO framework convention on tobacco control in accordance with Article 19 of the Constitution of WHO and adopting the convention. It urges all Member States for active implementation of the convention.

11.1.3 WHO Framework Convention on Tobacco Control

Pakistan ratified the framework in 2004. The framework provides a clear connection among all the approved regulations. It aims to inform every person of the health consequences and addiction posed by tobacco. It calls for a strong, concerted political commitment to protect every person from exposure to tobacco smoke, decrease the consumption of tobacco use, and address gender specific risks when developing tobacco control strategies among other objectives. It calls upon global cooperation including technology transfer, to implement effective tobacco control programmes.

The framework also calls upon stringent measures to reduce tobacco consumption including price, non-price, and tax measures. It encourages the members to provide protection from exposure to tobacco smoke in workplaces, public transport, and other public places. It calls for aggressive regulation of the contents of tobacco products and adequate disclosures including packaging of tobacco products. The framework calls on educating and ensuring proper communication to aware the general public of the harmful effects of tobacco use and discourage tobacco advertising and promotion.

The framework also stresses eliminating illicit trade in tobacco products and bringing legislation to stop sales to a minor. It calls upon providing alternate means of earning a livelihood to the workforce attached to tobacco ecosystem and also calls upon protection of environment and health of persons, among other areas.

11.2 National Legislations

11.2.1 The Prohibition of Smoking and Protection of Non-Smokers Health (Amendment) Act 2019

The federal government originally enacted this law through "The Prohibition of Smoking and Protection of Non-Smokers Health Ordinance, 2002". The aim of this legislation is to contain smoking and other tobacco uses in any place of public work and transport. It also prohibits advertisements, display exhibition, sale to minors, and store, sale, and distribution of cigarettes in immediate vicinity of educational institutions. After enactment of this law, the

West Pakistan Prohibition of Smoking in Cinema Houses Ordinance, 1960, and the West Pakistan Juvenile Smoking Ordinance (XII of 1959) stand repealed as the essential spirit of these laws has already been covered in this new legislation.

Apart from the Act, the federal government regulates tobacco use, printing, and media engagement through frequent Statutory Regulation Orders (SROs). For example, in 2010 the Government developed comprehensive rules to prohibit the sale of cigarettes to minors (2010, SRO 863(I)/2010). Similarly, in 2015 the Government issued SROs 22(KE)/2015 and 23(KE)/2015, prescribing 85% health warnings on front and back of cigarette packages.

11.2.2 Federal Excise Rule, 2005

One of the main reasons for the high prevalence rate of tobacco in Pakistan is the cheap prices of tobacco products. The Federal Excise Rules, 2005 includes provisions regulating minimum price, excise stamps, and banderoles and some packaging and labeling requirements.

11.3 Relevant Provincial Legislations

11.3.1 The Balochistan Prohibition of Sheesha Smoking Act, 2016

Under this legislation, manufacturing, selling, purchasing, storing, importing, or consuming flavoured tobacco for Sheesha (Glass Hukka) is completely banned in all places including street, road, ports, garden, playground, graveyard, hotel restaurant, motel, mess, club, house, building, tent, vessel, any restaurant or hotel roof, and open space. The offenders may face a sentence of up to six months and/or a fine of up to Rs.5000. The implementation of this law is very weak and almost nonexistent. There is no legislation related to tobacco in the province as the Sheesha Act especially targeting Sheesha (Flavoured Tobacco) under its definition. The province is governed through federal legislation when it comes to cigarettes and other tobacco products.

11.4 Institutional Arrangement in Balochistan

In 2007, the federal government developed its first coordinating mechanism for tobacco control known as Tobacco Control Cell (TCC). One of primary aims of TCC was to enhance tobacco control efforts (including provision of technical support, training, research, and dissemination), engagement with media, academia, and NGOs, and drafting of legislation. While the TCC works at the federal level, it also has very limited coordination with provincial governments to ensure that tobacco control activities are implemented and enforced at the subnational level. Other than this federally led effort Balochistan doesn’t have any institutional arrangement to implement the prohibition, spread awareness and control use of tobacco.

11.6 Recommendations

- There is no provincial legislation to prohibit the use of tobacco in public areas. The province is governed through federal laws.
- There is a need for a Provincial/National tobacco control strategy and action plan involving all sectors of governments (federal and provincial), as well as other partners.
- Although the Tobacco Control Cell was established at the federal level, the establishment of TCC should also be ensured at the provincial level. The provincial TCC should be strengthened, and their sustainability should be ensured. The network of TCC should also be used for effective enforcement of tobacco control laws which is missing at the moment.
- After the 18th amendment, there is an ambiguity whether tobacco legislation and enforcement should be governed provincially or at the federal level. This is evident from national assembly sub-committee meeting minutes documents which suggest that tobacco related legislation should be developed at the federal level, in coordination with

provincial governments. The TCC or other similar forums should also be established at the provincial level. The TCC regularly updates an inventory of laws and regulations including their regular evaluation vis-à-vis the requirements of the FCTC.

- The Government should develop a plan of action on the enforcement of existing regulations throughout the province and, to the extent possible, by utilising existing mechanisms for enforcement.
- The price of cigarettes in Pakistan is still low as compared to the countries in a similar economic position. All tobacco products should be taxed in a similar manner. The provincial government may also tax tobacco products over and above the federal excise duty; and tax rates should be increased every year above the inflation rate.
- There is a strong need to have unbiased authentic data about production of tobacco products including cigarettes, illicit trade, and tax collection. This should be independent and free from influence of the tobacco industry.
- The Government should conduct a study on economic impact (direct and indirect costs) of tobacco use and disseminate the results for general public awareness.
- The Government should produce factsheets with different tax scenarios including comparisons with other countries. It may consider developing tobacco tax modeling to assist the Balochistan Board of Revenue and policy makers in the analysis of possible tax changes. The proceeds of tobacco tax should be utilised on infant and child nutrition as well as tobacco control programmes.
- The Government should also explore option to integrate tobacco control into educational curriculum at all levels of education (primary, secondary, university including medical colleges), in collaboration with the Education Department and other relevant departments.

Chapter 12. Support Research and Development of Vaccines and Medicines

Target 3.b: Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines at all.

12.1 International Treaties/Conventions/Guidelines related to SDG 3b

12.1.1 DOHA Declaration on the TRIPS agreement and public health

It recognised, among other areas, that various developing countries are suffering from severe diseases and epidemics and stressed on the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) to be part of the wider national and international action to address these problems. It was agreed that “the TRIPS Agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of the WTO members’ right to protect public health and, in particular, to promote access to medicines for all.

12.1.2 United Nations Security Council Resolution No. 2565 (2021)

The resolution recalls its resolutions 2286 (2016) and 2532 (2020) and the General Assembly resolutions 74/270 and 74/274. It also recalls “the obligations under the International Health Regulations (2005) and applicable international law”. The resolution emphasises “the unity, common origin and solidarity of mankind, and the need for intensified international collaboration in the face of the common threat of pandemics, in particular by enabling equitable global access to quality, safe, efficacious and affordable diagnostics, therapeutics, medicines and vaccines, and essential health technologies, and their components”.

The resolution also calls for “COVID-19 national vaccination plans to include those at a higher risk of developing severe COVID-19 symptoms and the most vulnerable, including frontline workers, older people, refugees, internally displaced people, stateless people, indigenous people, migrants, persons with disabilities, detained persons, as well as people living in areas under the control of any non-state armed group”.

The resolution calls upon “the Member States and all relevant stakeholders to promote research and capacity-building initiatives, as well as to enhance cooperation on and access to science, innovation, technologies, technical assistance, and knowledge sharing, including through improved coordination among existing mechanisms, especially with developing countries, in a collaborative, coordinated and transparent manner in response to the COVID-19 pandemic.”

12.1.3 World Health Assembly Resolution 58.15 (2005) on Global Immunisation Strategy

The resolution recognises resolution WHA53.12 where immunisation has been identified as a major factor to promote child health. It urges the Member States to, among other areas, “meet immunisation targets expressed in the United Nations General Assembly special session on children”, “adopt the Global Immunisation Vision and Strategy as the framework for strengthening of national immunisation programmes” and “ensure that immunisation remains a national health agenda priority”.

12.1.4 WHO / UNICEF Global Immunisation Vision and Strategy (GIVS)

The GIVS focuses on four strategic areas: Protecting more people in a changing world, the introduction of new vaccines, integrating immunisation and other health interventions in the health systems context, and immunisation in the context of global interdependence. The document sets out clear goals to prevent morbidity and mortality. The GIVS framework comprises twenty-four sub-categories of the four well-defined strategic areas to promote, manage and monitor global immunisation.

12.1.5 World Health Organization Strategy on Research for Health (2012)

In order to achieve its constitutional objective, high quality research remains a hallmark for WHO. The strategy document outlines five interrelated goals, organisation, priorities, capacity, standards, and translation. The document outlines various actions to achieve these goals. The document enables the WHO to emphasise quality research work in health domain by the following three primary principles: quality, impact, and inclusiveness.

12.1.6 World Health Assembly Resolution No. 58.34 (2005) on Ministerial Summit on Health Research

The resolution acknowledged the need for high-quality research and its application to improve global health standards. The resolution urges the Member states to, among other areas, develop and implement national health-research policy, collaborate in health research, develop mechanisms for knowledge transfer for evidence-based healthcare delivery systems, and hold a public debate on the "ethical dimension and societal implications of health research among researchers, practitioners, patients, and representatives of civil society and the private sector".

The resolution also calls upon the global scientific community, international partners, the private sector, civil society, and other relevant stakeholders to support sustainable programmes of health systems, develop a voluntary platform to link clinical trials, and engage in the transfer of knowledge, establish global research partnerships among other areas.

12.1.7 World Health Organization – Measuring medicine prices, availability, affordability, and price components

In 2008, WHO prepared a document with Health Action International. The document outlines the fact that the right to health is a basic right but one of the crucial factors impacting this right is availability and affordability of the medicines. The document passes a reference to WHA54.11 where the Director-General was requested to implement the system for monitoring drug prices. The project aims to develop a reliable methodology for collecting and analysing medicines' price, availability, affordability, to publish survey data, and to advocate for implementation of policies.

12.1.8 World Health Assembly Resolution No. 54.11 (2001) WHO Medicines Strategy

The resolution recalls other resolutions including WHA39.27, WHA41.16, WHA43.20, WHA45.27, WHA47.12, WHA47.16, WHA47.17, WHA49.14, and WHA52.19. The resolution acknowledges "four main objectives of the WHO's medicines strategy, namely, to frame and implement policy, to ensure access and quality, safety, and efficacy, and to promote rational use of medicines".

The resolution urges the Member States to, among other areas, "reaffirm their commitment to ensuring public health interests and to make every effort to promote equitable access to medicines", "take effective measures in accordance with international law and international agreements acceded to in order to ensure improved access to medicines", "pursue

measures directed to expanding access of their populations to essential drugs, including implementation of the resolution WHA52.19 taking into account the cost-effectiveness of rational drug use as well as affordability", and "cooperate constructively in strengthening pharmaceutical policies and practices".

12.2 Relevant National Legislations

12.2.1 The National Institute of Health (Re-organization) Act, 2020

The purpose of this Act is to establish an autonomous body to set up and operate nine (09) institutes and centres for health and disease control. They include: the Center for Disease Control, Health Research Institute, National Health Laboratory, Health Data Center, Institute of Nutrition and Health, Vaccine and Biological Products Center, and Center for Environmental and Occupational Health. The NIH will provide a national or provincial health disease advisory to the Federal Government and any or all the provincial governments.

12.2.2 The Drugs Act, 1976

The aim of this legislation was to regulate import, export, manufacture, storage, distribution, and sale of drugs in Pakistan. Under this Act, each Provincial Government shall set up a Provincial Quality Control Board. The Provincial Quality Control Board has the power to inspect any premises where any drug is being manufactured or sold. The board needs to scrutinise the reports of Provincial Inspectors in respect of contraventions of this Act, and reports of the Government Analysts in respect of drugs sent to them by the Provincial Inspectors for test and analysis and issue instructions to the Inspectors as to what action needs to be taken on such reports. The Provincial Quality Control Board may specify the class of cases in which a Provincial Inspector may make a complaint to the Drug Court, or take any other action, without specific instructions of the Board.

The board may advise the Provincial Government on ways and means to ensure quality control of drugs manufactured in the province. Each provincial government needs to establish a drug testing lab and need to submit a monthly report of decisions and activities to the Federal Government.

12.2.3 The Drug Regulatory Authority of Pakistan Act, 2012

The primary objective of this Act is to establish a Drug Regulatory Authority of Pakistan (DRAP) to provide for effective coordination and enforcement of the Drugs Act 1976 (XXXI of 1976) and to bring harmony in inter-provincial trade and commerce of therapeutic goods. The DRAP administers the laws specified in Schedule-VI which apply to the Federal Government and advises the Provincial Governments for the laws which are applicable to the provinces. The DRAP also collects relevant data and information, issues guidelines, and monitors the enforcement of licensing of the manufacture of therapeutic goods, registration of therapeutic goods, regulation for advertisement and drug specifications, and laboratory practices.

There must be a Policy Board under this Act. The main functions of the policy board are to frame the policy and provide guidelines based on global and regional trends to the Authority and monitor the implementation and performance of the guidelines and of the functions of the Authority ensuring good governance and accountability. The provincial Secretary of Health is a member of the policy board.

12.2.4 National Drug Pricing Policy 2018

The drug prices are fixed by the federal government and the National Health Services Regulation and Coordination (NHSRC). The regional drug inspectors (DIs) are responsible for

monitoring drug prices in the pharmacies of their area. The NHSRC has been taking different policy measures to curb these issues through the DRAP. The first ever National Drug Pricing Policy (NDPP) was launched in 2015 for making the pricing mechanism transparent but it had minimal impact on medicine prices, suitable for both patients and manufacturers as per media reports and available literature evidence. The federal government developed a new drug pricing policy in 2018. The objectives of this policy were to improve access to EMs, devise rational prices, ensure a transparent mechanism for medicine pricing and discourage illegal increases in drug prices. The implementation of this policy is still very poor and the medicine prices are continuously on the rise as the industry is a very lucrative sector and has strong lobbying power. Pakistan is still lax in developing a comprehensive generic medicine policy to restraint medicine marketing companies' ill practices over some EMs and products. There was Generic Drug Act 1972 which was later repealed after the Government found substandard practices by a local manufacturer. The policy makers should learn from other countries where effective generic drug policy enforcement has been driven by the enactment of high-profile policies/regulations.

12.2.5 Ethical Marketing to Healthcare Professionals Rules, 2021

One of the major challenges in Pakistan in general and Balochistan, in particular, is related to ethical marketing and professional practice of doctors. There is a general perception that healthcare professionals are prescribing medicines to appease medicine manufacturing companies. These companies pay hefty commissions, provide expensive gifts and sponsor international tours to exotic destinations not only for the doctors but sometimes for the entire family. Most recently, the federal government on November 17, 2021, notified comprehensive rules that no company shall provide gifts to individual beneficiary healthcare professionals in any shape whatsoever. Under these rules, companies shall not provide, organise or pay for recreational or entertainment activities for healthcare professionals, including but not limited to tours, cultural and artistic activities. The rules chalk out the comprehensive guidelines and rules of engagement for company sponsored educational training, giving away donations, financing business meetings, and providing educational items. The implementation of these rules is a challenging task as this menace is overwhelmingly prevailing in medical practice in Pakistan. The implementation of a comprehensive MIS system for writing prescriptions and analysing trends may help in implementing these rules. It will significantly reduce the out-of-pocket cost of poor patients.

12.3 Relevant Provincial Legislations

Under the Federal Government Drugs Act 1976, the Provincial Government may by notification in the Official Gazette, make rules in respect of the establishment of laboratories for testing and analysing drugs, and qualifications and procedure for exercise of powers and performance of functions of Provincial Inspectors. The provincial government may also develop the procedure to be followed by the Provincial Quality Control Board. Similarly, the provincial Secretary Health is a member of the policy board under the DRAP Act 2012. Apart from the aforementioned federal legislation, the provincial government has not amalgamated its law, rules, and policies to regulate and monitor drugs in the province.

Considering the complexity of the subject, all provinces passed a resolution under Article 144 of the Constitution of the Islamic Republic of Pakistan to the effect that Majlis-e-Shoora (Parliament) may by law regulate the issue. This is a better option as each province may never reach the capacity to formulate drug related laws because of the complexity of the drug discipline and high human risk factor involved. However, provinces can play an active role in monitoring and effective implementation of the laws.

12.4 Institutional Arrangement in Balochistan

The provincial government has some drug inspectors at the health department to monitor, evaluate and control quality standards of private sector pharmacies. The implementation of private sector pharmacy licensing and quality controls is very poor. The health department is highly understaffed in terms of drug inspectors. The pharmacy company's products are rarely inspected and tested for quality control. The drug tribunal is almost non-functional. The conviction rate is very low as the drug inspectors are not trained on legislative aspects to collect the evidence on sites. Another major issue is the non-availability of reference labs at the provincial level. The sample testing is often done at the federal level which sometimes creates a legal issue. Although the statutory forums under the DRAP Act are notified but the implementation and effectiveness of these forums are very weak.

12.6 Recommendations

- The provincial government needs to actively take part in the committee, sub-committee, and policy board made under the federal acts.
- The provincial government also needs to establish statutory forum and labs to effectively implement the guidelines and spirit of the federal laws. This includes Provincial Quality Control Board, Provincial Drug Testing Labs, Drug Courts/tribunals and other such instruments as mentioned in the law.
- The Government needs to develop a holistic approach to good health and wellbeing and ensure universal access to healthcare and to making medicine and vaccines affordable.
- The Government needs to enhance the capacity of the EPI, NIH, LHW Programme, the MNCH programme, and Drug Regulatory Authority (DRAP) for increased access to use of vaccines and medicines.
- Both federal and provincial governments need to increase the investment into research and development in the health sector especially in vaccines and medicine.
- The district governments need to be mandated for preparing Essential Drugs Lists (EDL) based on the district-specific burden of disease.
- Provincial Government must implement a comprehensive MIS for inventory management of the minimum level of Essential Drugs Lists (EDL) at each BHU, RHC, DHQ and THQ facility. The MIS/database system will enable the Government to mobilise resources and track medicine utilisation and demand in each district. It will also reduce corruption, wastage, and misuse of medicine.

Chapter 13. Increase Health Financing and Development of the Health Workforce

Target 3.c: Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and Small Island developing states.

13.1 International Treaties/Conventions/Guidelines related to SDG 3c

13.1.1 World Health Assembly Resolution N0. 64.9 (2011) - Sustainable health financing and universal coverage

The resolution recalls “Article 25.1 of the Universal Declaration of Human Rights, which states that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family”. It recognises that the effective health system, including preventive services, are of primary importance. The report considers “the world health report 2008 and resolution WHA62.12 that highlighted universal coverage as one of the four key pillars of primary health care”.

The resolution urges the Member States to work on the evolution of health financing system, to aim for affordable insurance coverage, to strengthen health delivery system, to transit health system to universal coverage, to ensure allocation of resources is balanced among health promotion, disease prevention, rehabilitation and health care provision, and to establish and strengthen institutional capacity in order to generate country-level evidence and effective, evidence-based policy decision-making on the design of universal health coverage systems.

13.1.2 World Health Assembly Resolution N0. 58.33 - Sustainable health financing, universal coverage and social health insurance

The resolution urges Member States to ensure provision of health financing system with risk sharing mechanism to avoid impoverishment of individuals, ensure appropriate heath care infrastructure so that the insured persons receive quality health services, ensure usage of funds for health programmes contributes to development of sustainable financing mechanism, transition to universal coverage of citizens, and share experiences on various health financing methods.

13.1.3 World Health Assembly Resolution No. 70.6 - Human Resources for Health

The resolution reaffirms its commitment to WHA69.19 (2016) on global strategy on human resources for health. It also recalls WHA63.16 (2010) on the WHO Global Code of Practice on Global Recruitment of Health Resources. It also recalls “the United Nations General Assembly resolutions in 2015 (resolution 70/183) and 2016 (resolution 71/159) that, respectively, requested the establishment of the United Nations’ High-Level Commission on Health Employment and Economic Growth”. It urges all the Member States to act on the “Commission’s recommendations and immediate actions, with support of the WHO, ILO and OECD as appropriate and consistent with national contexts”.

13.1.4 United Nation General Assembly Resolution No. 71/159 (2016) on global health and foreign policy: health employment and economic growth

The resolution recalls “Human Rights Council resolution 32/16 of 1 July 2016 on promoting the right of everyone to enjoyment of the highest attainable standard of physical and mental health through enhancing capacity-building in public health”. The resolution calls upon Member States to implement resolution 69/132, including the development of effective preventive measures for protection of health workers. It further calls to fortify institutional

mechanisms to coordinate an inter-sectoral work force agenda. It also calls for decent work with appropriate remuneration for health and social sectors.

13.2 Relevant National Legislations

13.2.1 The Pakistan Medical Commission Act, 2020

This legislation aims to provide for regulation and control of medical profession and to establish uniform minimum standards of basic and higher medical education and training and recognition of qualifications in medicine and dentistry. The federal government has established three councils under this legislation "the Pakistan Medical Commission, the Medical and Dental Council", "National Dental Academic Board", and "National Medical Authority". The authority implements the decisions taken by either council or board. This legislation has abolished the old Pakistan Medical and Dental Council. The Government claims that this Act will bring efficiency to the current system and now no doctor can practice in Pakistan without passing the exit exam. The implementation of this legislation is yet to be seen.

13.2.2 The Pakistan Allied Health Professionals Council Act, 2021.

The aim of the PAHPC Act 2021 is to constitute a council for the purpose of making a uniform standard of basic higher qualification in various allied health disciplines and to consolidate the law relating to the registration of all disciplines of allied health and for matters connected to it. The council has provincial representation and needs to establish offices in provinces as well. The council will regulate the standard of services for practice of Allied Health Professional (AHP), assist regulatory bodies of health facilities to monitor and inspect allied health facilities and ensure that no AHP shall designate himself/herself as a doctor for professional purposes.

13.2.3 Pakistan Nursing Council (Amendment) Act 2021

At the national level, Pakistan Nursing Council (PNC) is an autonomous, regulatory body constituted under the Pakistan Nursing Council Act (1952, 1973, 2021) and empowered to register (license) Nurses, Midwives, and Lady Health Visitors (LHVs) to practice in Pakistan. The PNC was established in 1948. Its role is more of a regulator than implementing and executing nursing and midwives' programmes.

According to the PNC Act, the Provincial Government shall constitute a Provincial Nursing and Midwifery Examination Board. The functions of boards shall be to confer, grant or issue diplomas, licenses, certificates or other documents stating or implying that the holder, grantee or recipient has acquired a qualification in nursing, midwifery, health visiting, public health nursing or auxiliary nursing. The board can also recognise any institution or authority which conducts courses/trainings in general nursing, midwifery, health visiting, public health nursing, auxiliary nursing or nursing aide (N-aid).

13.2.4 The Pakistan Health Research Council (Amendment) Act, 2020

The PHRC aims to promote, organise, coordinate, and conduct scientific research in the fields of health including allopathy, homeopathy, herbal, unani, ayuvedic and traditional medicine. The PHRC facilitates development of institutional capacity for research including training of human resources. It also advises the Federal and Provincial Governments on matters related to health research. The PHRC tries to establish, strengthen and expand information resources for support of research, to sensitise the public through information dissemination of the findings of health-related research through publications, conferences, seminars, and media engagement.

13.2.5 The Unani, Ayurvedic and Homoeopathic Practitioners Act, 1965

The federal government through this legislation established National Council for Homoeopathy (NCH) and National Council for Tib (NCT). These councils mandate to ensure the maintenance of an adequate standard of education in recognised institutions, make arrangements for registration of duly qualified persons following the provisions of this Act and also provide for research in the system of medicine with which the council is concerned. This is still a very poorly monitored discipline in Pakistan as both councils the NCH and the NCT lack capacity to formulate rules, regularly monitor and evaluate the practitioners.

13.2.6 The Medical Tribunal Act, 2020

The aim of the Medical Tribunal Act 2020 is to establish special judicial tribunal to efficiently and expeditiously hear and decide disputes arising out of matters pertaining to the actions of authorities formed to regulate different areas of the medical sector in Pakistan and to provide cost effective adjudication of such disputes. Any matter related to public health can be tried in the medical tribunal. The tribunal shall hear and decide all appeals, complaints or claims before it within 120 days without exception and shall refuse all requests for adjournments if sought by any party given that such adjournment would lead to the Tribunal not being able to decide a case within the stipulated time period. The right of appeal can only be made in the Supreme Court of Pakistan instead of High Courts which is deemed as unjustified by many stakeholders.

13.2.7 Action Plan National Health Services, Regulations & Coordination Division-2019-23

This Action Plan augments current health sectoral and sub-sectoral strategies and plans in the country and supports implementation of the SDGs, UHC and IHR agenda. The Action Plan is underpinned by the guiding values of good governance, provision of high-quality services to the needs of people, innovation and transformation, equity and pro-poor approach, responsiveness, transparency and accountability besides integration and cross sectoral linkages.

The Action Plan has been developed in line with the strategic priorities set by the NHSR&C Division, which are: 1) Advancing universal health coverage, 2) Protecting people and addressing health emergencies and disease outbreaks, 3) Promoting healthier population, and 4) More effective and efficient organisation for better supporting the health system.

13.3 Relevant Provincial Legislations

13.3.1 The Balochistan Healthcare Commission Act, 2019

The primary aim of the BHC is to make provisions for improvement of quality of healthcare services, clinical governance and to ban medical or health quackery in all its forms and manifestations. The BHC will maintain a register of all healthcare service providers and healthcare establishments, develop standards, tools, guidelines, proforma, criteria, terms and conditions, rules, regulations, and instructions for all components of the healthcare service. It will also take all steps to ban quackery including collection of data of quackery in all components of healthcare services including investigating into maladministration, malpractice and failures in provision of healthcare services. The BHC will have the power to grant, revoke and renew licenses to healthcare providers/persons/licensee involved in the provision of the healthcare services, to monitor and to regulate quality and standards of all healthcare services.

13.3.2 The Balochistan Health Foundation Act, 1994

The Government of Balochistan established the Balochistan Health Foundation (BHF) in order to promote and finance development of Health Services in the province. The BHF gives grants to non-profit Health Institutions in rural and urban areas for purchase of medicines, land, construction of a building, purchase of equipment, furniture etc., not exceeding 1/3rd of the total cost as grant, and 1/3rd as a loan, while the remaining cost shall be borne by the organization/institution. It also extends support in the form of loans to commercial and individual doctors to establish healthcare facilities in urban and rural areas. Another function of the BHF is to commission scholarships, provide facilities or otherwise assist in medical education, research and training.

13.3.3 The Balochistan Private Hospitals Regulatory Act, 2004

The purpose of this Act is to regulate establishment, accreditation, licensing, control and supervision of private hospitals in the province. As per the Act, the Government shall establish District Hospital Regulatory Board at every district headed by the Executive District Officer Health. The Board shall ensure presence of minimum prescribed standards regarding physical and technical facilities required to be provided in private hospitals, which shall be fulfilled before registration/accreditation is granted. All existing private hospitals in all the districts of Balochistan need to get registration and a valid license from their respective District Hospital Regulatory Boards.

13.4 Institutional Arrangement in Balochistan

Currently, there are over 40 institutes providing pre-service as well as in-service training related to healthcare. Apart from Bolan Medical College, three medical colleges (Loralai, Kech and Khuzdar) are being established. In-service trainings are provided by Postgraduate Medical Institute, Institute of Public Health and Midwifery Training Schools. Moreover, Provincial and six District Health Development Centers are established to provide training on a wide range of topics including trainings on the preventive and curative programme. Detail of medical education institutions in the province is given in Table 1.

Table 1 Training Institutions in Balochistan

Type of Training Institution	Number
Postgraduate Medical Institute	1
Institute of Public Health	1
Medical University	1
Medical Colleges	4
Psychiatry institute of Behavioural Science	1
Nursing College	1
Nursing Schools	5
Public Health Schools	6
Paramedical Schools	1
Midwifery Schools	16
Provincial Health Development Centre	1
District Health Development Centres	6
Total	44

As per the Government budget record, there are 37,038 employees working in the provincial health department. A vast majority of these employees are non-technical and support staff. According to the provincial Bureau of Statistics 2018-19 report, there are only 2427 doctors available for a population of over 12 million in Balochistan. Of these, only 538 are female doctors. The situation for nursing and other paramedic staff is even worse. The total

nurses available in the province in 2018-19 were 777, LHVs were 801, Dai and Midwife combined were 1729. The geographic and district wise break up is even more depressing. The majority of health workers prefer to work in comparatively larger urban centres. The total human resource for health is given in Table 2.

Table 2 Human Resource for Health (HRH) in Balochistan

Category Name	Numbers
Doctors	2427
Dentist Surgeon	210
Pharmacist	388
Drug Inspector	65
Health Education Officer	16
Nurses	777
LHV	801
Dai/Mid Wives	1729
Health Worker per 1000 pop	0.00052
Total Number of Health Facility	7,720
Total Number of Beds	1,590

13.5 Recommendations

- The Government needs to develop a comprehensive strategy for the HRH deployment, management and retention. There is a strong need to set standards for minimum density of physicians, nursing staff, dentists and pharmaceutical personnel considering local dynamics and ensuring equity principle in all areas.
- The Government needs to formulate a policy for Continuing Medical Education (CME) with a dedicated budget for CME and other trainings. It may introduce simulation-based trainings and paid apprenticeships with renowned health providers in the country.
- The compensation packages should be completely redesigned reflective of the efforts and rural-urban divide of different cadres. The revised package should be attached to measurable KPIs. The reward and punishment mechanism should be fairly implemented and monitored.
- The Government should ensure that long pending Healthcare Commission is properly established and functional.
- The national and provincial health expenditure needs to be increased around 15% of total expenditure to match the international gold standards including the Paris Declaration.

Chapter 14. Strengthen Capacity for Early Warning, Risk Reduction & Management of Health Risks

Target 3.d: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

14.1 International Treaties/Conventions/Guidelines related to SDG 3d

14.1.1 World Health Assembly Resolution No. 58.3 (2005)

The resolution welcomes United Nations General Assembly resolution no. 58/3 "on enhancing capacity building in global public health, which underscores the importance of the International Health Regulations and urges that high priority should be given to their revision".

The resolution urges Member States to, among other areas, "build, strengthen and maintain the capacities required under the International Health Regulations (2005), and to mobilise the resources necessary for that purpose" and "provide support to developing countries and countries with economies in transition if they so request in the building, strengthening and maintenance of the public health capacities required under the International Health Regulations (2005)".

14.1.2 International Health Regulations (IHR) 2005

In May 2005, the 58th World Health Assembly (WHA) adopted the International Health Regulations (2005) which subsequently entered into force on 15 June 2007. The purpose and scope of the IHR (2005) are "to prevent, protect against, control and provide a public health response to international spread of disease in the ways which commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade". State parties are required by the IHR (2005) to develop certain minimum core public health capacities.

The IHR capacity requirements are defined as "the capacity to detect, assess, notify and report events"; "Core capacity requirements for surveillance and response" and "Core capacity requirements for designated airports, ports and 14 ground crossings". In addition, the WHO core capacity monitoring framework has a checklist and indicators which should be used for monitoring progress in the 15 developments of the IHR core capacities.

Like many UN member states, Pakistan is a signatory to the IHR but, has yet to meet the required core capacities despite multiple extensions, a situation which has the potential to jeopardise country's travel and trade. Even more important, it means the country is not fully prepared to prevent, detect and respond to health threats to protect its population, irrespective of whether the threats arise internally or externally.

14.1.3 World Health Assembly Resolution No. 58.1 (2005)

The resolution explicitly urges the Member State to, among other areas, collectively put effort to establish global and regional preparedness plans to integrate risk reduction in health sector, develop national emergency preparedness plans through risk mapping, and women and men to have formal and informal education on emergency preparedness and disaster reduction through early warning system.

14.1.4 World Health Assembly Resolution No. EB140.R5 (2017)

The resolution acknowledges that "the global action plan on antimicrobial resistance adopted by the resolution WHA68.7 (2015), as well as resolution WHA67.25 (2014), urged the WHO to accelerate efforts to secure access to effective antimicrobial" and "ineffective or

incomplete antimicrobial therapy for infections including sepsis may be a major contributor to the increasing threat of antimicrobial resistance".

It urges Member States to, among other areas, "continue in their efforts to reduce antimicrobial resistance, and promote the appropriate use of antimicrobials in accordance with the global action plan on antimicrobial resistance including development and implementation of comprehensive antimicrobial stewardship activities".

14.2 National Legislations

14.2.1 Hospital Waste Management Rules, Notification S.R.O.1013 (1), 2005

These rules are made under Pakistan Environmental Protection Act. The HWM rules 2005 urge to notify waste management team, development of a waste management plan and written procedures, and weekly record maintenance for quantities of generated waste. There is very poor compliance of these rules at the national as well as provincial level. According to a survey study, 40% of surveyed hospitals' Medical Superintendent were not aware of the HWM rules 2005[5]. Only 30% of the surveyed hospitals had an HWM plan and 20% of the hospitals had written HWM procedures. Similarly, only 20% of the surveyed hospitals mentioned the HWM related duties in the job descriptions of the relevant personnel, and 90% of the surveyed hospitals had no formal records of the quantity and type of waste that they produced. The HWM practices are not reflected in the budget of the majority of hospitals as over 60% of the hospitals did not allocate a dedicated budget to HWM practices [5].

14.2.2 Pakistan National Action Plan for Antimicrobial Resistance (AMR) 2017

The primary objective of the AMR National Action Plan is to ensure that current Antimicrobials remain effective as long as possible for all those who need them while minimising the expense associated with indiscriminate use. The country needs to have a consistent, coherent, comprehensive and integrated approach at the national level to address the AMR which is aligned with and complements global and regional efforts.

The National Institute of Health (NIH), as the national focal point for the IHR and the AMR designated by MoNHSR&C, is responsible for implementation of selected technical areas of surveillance & response, workforce development, laboratory system and the AMR. Additionally, provincial IHR focal persons are also notified. However, there is a need for policy dialogue and decisions for the establishment of dedicated federal and provincial setups for the implementation and governance of the AMR activities. Similarly, some donor funding is available for the AMR, however, advocacy and focus on the allocation of domestic resources for the AMR is required for sustainability.

14.2.3 National Epidemic and Pandemic Preparedness Plan 2014

The general objectives of the National Epidemic and Pandemic Preparedness Plan (NEPPP) are to minimise the opportunities for human infection, strengthen epidemic surveillance and early warning system and response, contain spread of viruses, minimise associated morbidity, mortality, and to monitor and evaluate the response capacity, and coordination mechanisms. To achieve the aforementioned objectives, the NEPPP envisages some specific objectives, which can be translated into strategic actions. It includes establishment of the National Steering Committee, Executive Committee and their counterparts in the provinces to develop policies, undertake political decisions for implementation of the plan and ensure collaboration and coordination amongst relevant sectors. It also envisages to develop capacities of the provincial and regional laboratories in both human and animal health in diagnosing viruses and to establish their close coordination and collaboration with the national and global laboratory system.

The implementation of NEPPP is very minimal as the current public diagnostic system in the country is very fragmented and poor. There are very few epidemiologists available in the country. The political buy-in for the control and surveillance system is also very low and it is almost left on a free-float to donors and international community. The recent Covid-19 surge challenged the current system and exposed the capacity of the existing system. There is a need to review the complete ecosystem around epidemic control and surveillance system in the country.

14.2.4 National Blood Policy & Strategic Framework 2014-20

The basic aim of developing a National Strategic Framework 2014-2020 in the light of National Blood Policy is to provide a sound basis for future planning of the Blood Transfusion Services (BTS) in the country. The framework incorporates fundamental principles and identifies clear priority areas, which need to be focused in a coordinated manner in order to ensure a successful outcome of implementation. These efforts resulted in establishing Regional Blood Centre in Quetta which is providing excellent service in the province. The provincial government, however, did not effectively implement the policy as there is still a fragmented system of public and private blood banks providing unsafe blood transfusion services in the province.

14.2.5 National Action Plan for the Implementation of Bangkok Principles on Health Aspects of the Sendai Framework for Disaster Risk Reduction (SFDRR)

This document provides an Action Plan and Road Map for seven fundamental principles of SFDRR in order to establish and strengthen the health component of disaster management based on their relevant provincial perspectives. The implementation of this NAP is highly unlikely, especially in the Balochistan perspective. The province does not have even a basic infrastructure to kick off implementation. The budgetary requirements of the NAP are unrealistic and very costly for the resource constraint province. The Balochistan Provincial Disaster Management Authority needs to develop its own plan in the context of local realities and needs.

14.2.6 Pakistan Biosafety Rules 2005

These Rules provide for the manufacture, import and storage of micro-organisms, work involved in the field of genetically manipulated plants, animals and micro-organisms, import, export, sale and purchase of living modified organisms. The rules 4 to 9 deal with matters related to establishment of a National Biosafety Committee, a Technical Advisory Committee and Institutional Biosafety Committee and their functions. Although these rules regulate genetically modified objects but it does not cover naturally occurring infectious agents. There is a need for a comprehensive system to keep inventory and monitoring of dangerous pathogens.

14.2.7 National Laboratory Biosafety & Biosecurity Policy 2017

The objective of the National Laboratory Policy is to give direction to laboratory strengthening efforts for all laboratories involved in human, animal, agricultural, food safety and environmental care under the concept of "One Health" and to ensure the development of a sustainable system of laboratory services in line with international standards and able to meet the need of the population while safeguarding efficient use of Government funds and donor investments. It emphasises on licensing, disease early warning systems, sample selection and shipment protocols and capacity building. The implementation of this policy is still weak across the country. The regulatory authority is not fully functional in majority of the provinces.

14.2.8 National Guidelines Infection Prevention & Control 2020

The primary aim of these guidelines is to provide basic and simple Infection Prevention Control (IPC) practices that must be implemented at all times for extending safe care in all healthcare facilities (primary, secondary and tertiary healthcare facilities- in both private and public sectors) as a part of the routine (standard) practices for all patients.

Currently, there is no formal IPC programme either at national, provincial or facility level. As such, the need to produce National IPC Guidelines was regarded urgent and essential not only to provide a nationally agreed policy but also to apply these IPC practices throughout the country based on the current evidence in a uniform manner, using basic IPC training material for the teaching of all stakeholders. It is contemplated that these guidelines should be revised on a two-yearly basis to keep them updated in the light of the latest information and developments. Hospitals need to adapt them as suitable to their needs, context and resources without changing the basic IPC principles. In the wake of Covid-19, Government of Balochistan through postgraduate medical institute needs to run capacity-building programmes to implement IPC guidelines. They may also commission a study to tweak these guidelines as per local needs.

14.3 Relevant Legislation in Balochistan

14.3.1 Balochistan Hospital Waste Management Rules 2020

The Balochistan Hospital Waste Management Rules 2020 are made under the Environmental Protection Agency Act 2012. Under these rules, every hospital, public or private, shall be responsible for the proper management of the waste generated by it till its final disposal in accordance with the provisions of the EPA Act and the rules. A Medical Superintendent (MS) shall constitute the hospital waste management team, designate a waste management officer, and supervise implementation, monitoring and review of the waste management plan and ensure that it is kept up to date. The MS shall also arrange for a waste audit of the hospital by an external agency, allocate sufficient financial and human resources to ensure efficient and effective implementation of the Waste management plan and ensure adequate training and refresher courses for the concerned hospital staff.

Depending upon the types and nature of waste material and organisms in waste, risk waste shall be inactivated or rendered safe before final disposal by a suitable thermal, chemical, irradiation incineration, filtration or other treatment methods, or by a combination of such methods involving proper validation and monitoring procedures.

Unfortunately, medical waste management has not received much attention in Balochistan. Segregation into risk and non-risk waste is usually not performed. Workers have little awareness of hazards associated, and disposal techniques are poor. There is also a lack of awareness at health policy and law levels. There are only two inclinators available in Quetta in public sector hospitals. The private sector hospitals are seldom regulated on this front. The medical waste is often ended up in open pits and creates a hazard. Monitoring and implementation of these rules are almost nonexistent. The Government may outsource the treatment of medical waste to private sector firms with a stringent monitoring mechanism and clear performance indicator.

14.4 Institutional Arrangement in Balochistan

This is another neglected area in Balochistan with almost no institutional custodian. The DG-Health is a notified provincial focal point (FP) for the IHR Task Forces/committees. The institutional setup in Balochistan is primarily designed to react to a situation rather take preemptive action to prevent a disaster. It requires multi-sectoral coordination among stakeholders to strengthen the existing system, especially with those outside the health sector

under the umbrella of "One Health" approach e.g., coordination between human and animal health surveillance programmes to address priority zoonotic diseases and antimicrobial resistance (AMR).

There is a need for a permanent cross-sector platform for surveillance and response cooperation and data sharing between human health, livestock management, food safety and wildlife sectors at national, provincial and district levels. The provincial government needs to start the process to integrate vertical surveillance systems into a wider comprehensive horizontal surveillance system, replicating and building on current strengths and the best practices.

Surveillance reports are limited in the province. Even the available report from the EPI, Regional Blood Centres etc., are never used by decision-makers. No formal mechanism exists to share reports, including lab data among stakeholders. Linkages between health information systems are not fully established at the district and provincial levels. There is no standardisation (electronic or otherwise) for data collection of different health information systems operating in the health sector; and there is a need for a centrally located mechanism to integrate data from clinical case reporting and clinical or reference microbiological labs. A mechanism is needed to feed public health lab data from both human and animal sectors into the surveillance systems. There is a need for efficiently working on the Disease Early Warning System (DEWS).

14.5 Recommendations

- The provincial government needs to formulate and enact infectious disease surveillance and control legislation with a list of notifiable diseases and the AMR indicators.
- Balochistan Healthcare Commission must be made functional to coordinate and strengthen health sub-sectors' efforts and provide leadership for the 'One Health' agenda.
- The provincial government should strengthen infrastructure of diagnostic laboratories in public health and animal health sectors and standardise antibiotic sensitivity testing and interpretation. It may adopt National Laboratory Policy in true spirit.
- The provincial government should build laboratory technician capacities and ensure laboratory supplies to maintain a minimum functional surveillance system. The provincial stewardship and patronage are highly required for successful implementation.
- A comprehensive Healthcare Associated Infection (HCAI) prevention and control mechanism is needed both at the federal and provincial levels.
- Awareness of antimicrobial stewardship is generally low, even among healthcare providers. Advocacy and knowledge dissemination is needed. The Government needs to develop policy/regulations to monitor and control use of antibiotics in human and animal sectors.
- Comprehensive biosafety and biosecurity rules need to be developed. Regular assessments are required for biosafety and biosecurity needs in the province.
- The provincial government needs to establish a comprehensive diagnostic reference lab ideally at each divisional headquarters. Local regulations for sample transportation need to be developed. The specimen shipment network to referral labs is to be strengthened. Systems for transportation of samples including TB and polio need to be improved.
- The National Laboratory Policy needs to be adopted and implemented to establish the licensing and inspection of all humans, veterinary and food

laboratories. A coordinated EQAS should be established for all core human tests and relevant testing in veterinary and food laboratories. The adoption of quality management systems should be promoted.

- The healthcare education institutes should improve epidemiology programmes/trainings in the province. The existing numbers are far below the basic functional level.
- Resource allocation and capacity-building for public health are needed in both human and animal sectors. Public health laboratories (human and animal) to be linked with main surveillance system.
- Electronic reporting systems should be established and expanded as part of surveillance systems in the entire province and linked with the national dashboard. Vertical programme data should be integrated into main surveillance platforms. The IT communication equipment and tools should be enhanced at the facility level where possible. It may also complement the provincial government efforts to scale-up telemedicine to the entire province.
- A separate budget head should be created in the hospital to meet the financial needs in Health Care Waste Management.

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Appendix 1. Allied Healthcare Professionals Occupational Accreditation

Occupation groups considered to be part of the Sexual, Reproductive, Maternal, Newborn and Adolescent Health (SRMNAH) workforce*

OCCUPATION GROUP	ISCO CODE	EXAMPLES
Midwifery professionals	2222	Professional midwife, technical midwife, midwife
Nursing professionals with midwifery training	2221	Nurse-midwife, perinatal nurse, maternity nurse
Nursing professionals	2221	Clinical nurse consultant, district nurse, nurse anesthetist, nurse practitioner, operating theatre nurse, professional nurse, public health nurse, specialist nurse
Midwifery associate professionals	3222	Assistant midwife, auxiliary midwife
Nursing associate professionals with midwifery training	3221	Auxiliary nurse-midwife
Nursing associate professionals	3221	Assistant nurse, associate professional nurse, enrolled nurse, practical nurse, auxiliary nurse
Obstetricians and gynaecologists	2212	Obstetrician, gynaecologist
Pediatrician practitioners	2212	Pediatrician
General medical practitioners	2211	Family medical practitioner, general practitioner, medical doctor (general), medical officer (general), physician (general), primary care physician
Paramedical practitioners	2240	Advanced care paramedic, clinical officer (paramedical), feldscher, primary care paramedic, surgical technician, MEDEX
Medical assistants	3256	Clinical assistant, medical assistant
Community health workers	3253	Community health aide, community health promoter, community health worker, village health worker

* This list is not comprehensive; other SRMNAH occupation groups include dieticians and nutritionists, anaesthetists, pharmacists and physiotherapists. However, these groups (a) are considered necessary for delivery of the essential SRMNAH interventions listed in the *Global Strategy for Women's, Children's and Adolescents' Health,* and (b) are identified in the WHO's National Health Workforce Accounts platform.
Source: adapted from the International Labor Organization's International Standard Classification of Occupations ISCO-08 (14).

Appendix 2. Questions for Interviews

Secretary Primary Healthcare Department, Secretary Tertiary Healthcare and Medical Education, and Director General Health Department:

i. Is there any sector plan, policy, or strategy for the province related to healthcare planning and service delivery? if any, is it approved by the provincial cabinet?
ii. How much are you aware of the SDG 3 Target? (The researcher needs to reflect on each target to refresh memory) What efforts is the province is making to align the provincial legislation with SDG-3?
iii. Is the political leadership aware of SDG-3 and has it ever made a decision in the context of the SDG-3 target?
iv. Can you enlist legislations that are developed as a result of international obligations and UN resolutions?
v. Ensuring good health is a monumental task for government. What steps the health department has taken in the last 5-10 years to ensure Universal Health Coverage?
vi. Is there any strategy or action plan to enhance the capacity, quantity, and quality of the healthcare workforce in the province?
vii. How much is the role of PPHI in improving the primary healthcare landscape? Do you think Public Private Partnership can bring efficiency to the healthcare system?
viii. How much is the role of the vertical program in shaping and improving preventive health systems? Who is overlooking the performance of the vertical programs? What legal cover is provided to these programs?
ix. Is there any regulatory mechanism or accreditation process for private healthcare providers and laboratories?
x. Has the delegation of power through 18th constitutional amendment improved the healthcare service delivery?
xi. Is the development budget enough for primary, secondary, and tertiary healthcare? How are the development project decisions made?
xii. How the equity of the healthcare workforce, medicine, the outreach of vertical programs and equipment are ensured at the intra and inter-district levels?
xiii. Which of the policy decisions are supervised and monitored by the federal government? How are the medicine registration, research and development supervised at the province level?
xiv. Who is the custodian of health sector policy and strategy? What mechanism is developed to perform a periodical review of implementation? What mechanism the health department has developed to review the implementation of available legislation?

Health Vertical Programs:

i. Do you have the strategic planning or policy documents for your vertical program? If any, is it endorsed by the political leadership?
ii. How is the performance measured at Vertical Program? Is there a periodic performance review mechanism at the vertical program? Who is monitoring the performance?
iii. How healthcare workers and other employees are hired at the vertical program? How are employees trained? Is there a detailed job description for the different positions?

iv. How is employee performance tracked? Is there a reward and punishment mechanism developed in the program? How effective is this system?
v. How does the program ensure equity principles across different regions in the province?
vi. How is the data gathered and recorded? What is the data dissemination and sharing policies? is any activity ever been revised at the program as a result of new data-based evidence?
vii. How frequently the health authorities are reviewing the performance of the program?
viii. Is the budget for the program enough to achieve the objective of the program? Is there any budget or plan for continuous improvement training?

Health Department and Planning and Development Department Officials related to Development Section:

i. Who is ensuring that the health policy and strategy are implemented?
ii. How is the development project conceived? Who appraises the development project and reviews if it is needed for the area?
iii. What kind of tools are available for you to perform an effective appraisal mechanism?
iv. Who is approving the development project?
v. How often are you using data from health management information systems or data from other vertical programs?
vi. How are donor lead initiatives monitored?
vii. Is your development decision ever restraint or supported by the bucket of available legislation?
viii. Do you wish to have legislation available to you for effective decision-making?

Civil Society leaders

i. Are you aware of SDG initiatives?
ii. Is there an effective difference between pre- and post- 18th amendment on health delivery?
iii. What changes and reform initiatives were introduced post-18th amendment?
iv. How has the portfolio of development projects for health evolved in last ten years?
v. How has devolution affected accountability chains and mechanisms in health service delivery? Do you feel any change in terms of service delivery in the last ten years?
vi. What are the key interests of politicians? How can these interests be aligned with the objectives of health delivery?
vii. Is there any role of civil society in budget-making? Is the budget as per the needs of the health sector? Do the majority of the schemes fall in constituencies of the powerful ministers and members of the opposition?
viii. Is there any role of civil society in the performance audit of the health sector?

Healthcare Academia

i. Are you aware of SDG -3 Good Health and Wellbeing?

ii. How effective is the healthcare curriculum in the skill development of healthcare professionals in the province?
iii. What changes/innovations health education institutions have implemented in the last ten years?
iv. How evolving technology has changed the landscape of the health education sector?
v. Do you feel that our healthcare education system is effective in providing skills to the allied healthcare workforce including midwives and nurses?
vi. How important is continuous medical education training during service for doctors or allied healthcare workers?
vii. What changes do you wish to see from the bureaucrats or politicians to improve healthcare education?
viii. What changes the healthcare commission can bring in the province?

Appendix 3. List of Candidates Contacted

i. Secretary, Primary Healthcare Balochistan
ii. Secretary, Specialized Healthcare and Medical Education Balochistan
iii. Secretary, Planning and Development
iv. Additional Secretary (Dev.) Health Department
v. Chief Planning Officer, Health Department
vi. Director-General Health Department
vii. Five (05) Provincial Coordinator of Vertical Programs
    - Maternal, New Born, and Child Health (MNCH) Program
    - District Health Information System
    - Safe Blood Transfusion Project
    - Tuberculosis (TB) Control Program
    - Expanded Program on Immunization
viii. Chief of Section Health, Planning and Development Department
ix. Open Door Health Services (Community Organization)
x. Chief Executive Officer Sheikh Zahid Hospital
xi. Two faculty members from Bolan Medical College and PGMI
xii. Secretary, Primary Healthcare Balochistan
xiii. Secretary, Specialized Healthcare and Medical Education Balochistan
xiv. Secretary, Planning and Development
xv. Additional Secretary (Dev.) Health Department
xvi. Chief Planning Officer, Health Department
xvii. Director-General Health Department
xviii. Five (05) Provincial Coordinator of Vertical Programs
    - Maternal, Newborn, and Child Health (MNCH) Program
    - District Health Information System
    - Safe Blood Transfusion Project
    - Tuberculosis (TB) Control Program
    - Expanded Program on Immunization
xix. Chief of Section Health, Planning and Development Department
xx. Open Door Health Services (Community Organization)
xxi. Chief Executive Officer Sheikh Zahid Hospital
xxii. Two faculty members from Bolan Medical College and PGMI

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