Horizontal PHC Integration Assessment in Pakistan

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WORLD BANK GROUP

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CONTECH INTERNATIONAL

ACRONYMS

BHU	Basic Health Unit
BPS	Basic Pay Scale
CHC	Community Health Center
CMW	Community Midwife
DCP3	Disease Control Priorities Edition 3
DGHS	Directorate General Health Services
DHO	District Health Officer
EPHS	Essential Package of Health Services
EPI	Expanded Program for Immunization
FATA	Federally Administered Tribal Areas
FY	Financial Year
GOP	Government of Pakistan
HPSIU	Health Planning, System Strengthening, and Information Analysis Unit
HRH	Human Resource for Health
IMH&PC	Inter-Ministerial Health & Population Council of Pakistan
IRMNCH & N	Integrated Reproductive, Maternal, Newborn, Child Health & Nutrition
KP	Khyber Pakhtunkhwa
LHWs	Lady Health Workers
M/o NHSR&C	Ministry of National Health Services, Regulations & Coordination
NCD	Non-Communicable Disease
NHV	National Health Vision
NIPS	National Institute of Population Studies
P&SHD	Primary & Secondary Healthcare Department
PASA	Program of Advisory Services & Analytics
PC-1	Planning Commission Proforma - 1
PHC	Primary Health Care
PKR	Pakistani Rupee
PPHI	People's Primary Healthcare Initiative
RHC	Rural Health Center
RMNCH	Reproductive, Maternal, Newborn and Child Health
SCM	Supply Chain Management
SDGs	Sustainable Development Goals
SH&ME	Specialized Health and Medical Education
UHC	Universal Health Coverage
UHC BP	Universal Health Coverage Benefit Package

CONTEXT

Attaining universal health coverage (UHC) is a top priority of the Government of Pakistan and it is higher on the reform agenda than ever before. UHC is described as all people receiving the health services they need, which is of sufficient quality and without any financial hardship. Political will and commitment are reflected in government's policies and developmental plans to achieve UHC target for all citizens by 2030. Primary healthcare (PHC) is the mainstay of achieving universal coverage and acts as the front door of the healthcare system (WHO, 2021). Pakistan has developed a well-established PHC infrastructure following the Alma-Ata declaration. Historically, focus has remained on implementing a vertical approach. This verticalization has led to short term approaches but have resulted in very few structural reforms or capacity building. Meanwhile, the chronic underfunding of PHC along with the constraints of human resources, essential medicines and equipment and lack of regulation and monitoring have led to subpar delivery of healthcare services to the communities (WHO, 2017).

Broader Policy Environment for UHC & Integration

Provision of healthcare services is one of the policy principles for the state as per Constitution of Pakistan (Article 38). It is reflected in the government's commitments at national and international levels. Pakistan has adopted **Sustainable Development Goals (SDGs)** and among priority goals, UHC is one of the main health-related outcomes (Target 3.8), with 3.8.1 on coverage of essential health services measured through UHC Service Coverage Index and 3.8.2 on the proportion of catastrophic spending on health measured through Financial Risk Protection Index. **Regional Health Alliance, Global Action Plan on Healthy Lives and Well Being for All** is aimed at accelerating the achievement of SDGs in Pakistan and a joint statement was issued in March 2021 to support the country in achieving UHC through strengthening of PHC. The **Astana Declaration** (2018) recognizes that PHC provides a platform for accessible, affordable, equitable, integrated, quality primary care and public health services for all. Through a High-Level meeting on UHC, the Declaration was connected to the head of state and not just health ministries (General Assembly of the United National, 2019). **Salalah Declaration for UHC** endorses a vision of UHC incorporated in all social, economic and health policies, and countries reaffirmed their commitment to UHC through a High-Level Ministerial Meeting in September 2018. UHC 2030 **International Health Partnership Global Compact** was signed, and countries were urged to develop national UHC compacts for advancing UHC.

Overview of Federal Directions – Pakistan's **National Health Vision** (NHV) 2016-2025 looks to provide equitable, accessible affordable and quality healthcare for all Pakistanis. The NHV in its third thematic pillar of "Packaging Health Services", focuses on providing an integrated system of health delivery rather than a fragmented system. Aligned with the NHV, the **12th Five Year Plan** has set the strategic directions in Pakistan and outlines how the federal, provincial and districts governments will proceed for 'advancing UHC' as the number one strategic priority. In order to attain the targets of SDGs, the **National Action Plan (2019-2023)** was developed to augment the current health sectoral and sub-sectoral strategies and plans. Specifically, strategic priorities include advancement of universal health coverage in addition to protecting people from health emergencies and outbreaks, promoting healthier population, and effective and efficient health system.

Universal Health Coverage Benefit Package (UHC BP) provides a policy framework for strategic service provision based on scientific evidence on health interventions. It consists of Essential Packages of Health Services (EPHS) for all levels of healthcare services. The team at Health Planning, System Strengthening, and Information Analysis Unit (HPSIU) developed the initial criteria for UHC BP with support of the DCP-3 secretariat. Selection of interventions was based on cost-effectiveness, burden of disease, budget impact, feasibility of implementation, equity and the social context. From 218 DCP3 recommended interventions, the generic national EPHS included total of 151 prioritized interventions. EPHS was endorsed in the meeting of Inter-Ministerial Health & Population Council on October 22, 2020. Federal UHC team facilitated the provinces in reviewing, analyzing, interpreting and prioritizing an evidence-based set of interventions (Table 1) having greatest potential in addressing local health problems.

Table 1: Number of Priority Interventions Across Platforms

Platforms	EPHS Immediate Priority Interventions			
	Sindh	KP	Balochistan	Punjab
Community level	21	21	19	23
PHC center level	37	35	39	39
First level hospital	36	42	38	41
District EPHS	94	98	96	103
Tertiary hospital	25	22	25	22
Population level	12	12	11	12
All five platforms	131	132	132	137

Institutional Arrangements for UHC

Inter-Ministerial Health & Population Council of Pakistan (IMH&PC) – Pakistan Health and Population Strategic Forum, established in 2014, was renamed to IMH&PC of Pakistan in 2019 with the mandate to facilitate deliberations and coordination efforts of the Government of Pakistan for health and population outcomes.

Universal Health Coverage (UHC) Country Platform – Notified on 3rd February 2022 to undertake strategic and programmatic discussions for achieving UHC, this platform is established to serve as technical coordination body for development and implementation of evidence-based strategies to accelerate progress on UHC. It has provisions to establish Technical Sub-committees to propose recommendations for consideration of the Ministry.

National Advisory Committee – Established by the decision of IMH&PC, it is a high-level decision-making body. It provides technical oversight of programmatic reforms and initiatives at national level and makes recommendations for consideration of the UHC Country Platform and IMH&PC.

UHC Secretariat – HPSIU at M/o NHSR&C is providing technical assistance, particularly in the areas of financial management, regulation, purchasing, and capacity building. In the provinces, UHC Coordinators are nominated and at district levels, UHC Implementation Units are being established to steer the implementation.

Role of Development Partners – UHC BP Investment Case of Pakistan identifies three-fold roles of development partners and donors – advocating with government and key decision makers for prioritizing UHC in development agenda, coordinating the actions of key stakeholders for building synergies and complementarity, providing technical assistance and financial support for UHC implementation and service delivery. Key partners include Bill and Melinda Gates Foundation (BMGF), Center for Disease Control (CDC), Global Alliance for Vaccine Initiative (GAVI), Global Financing Facility (GFF), Global Fund, Islamic Development Bank (IDB), Japan International Cooperation Agency (JICA), United States Agency for International Development (USAID), UN Agencies and the World Bank, in addition to academia, private sector and NGOs.

Box 1: Verticality and Horizontal Integration - Review of Approaches

Vertical program consists of a coherent package of activities established to manage more effectively a single health problem, for example tuberculosis or malaria, or a group of linked health problems, like diarrheal diseases and respiratory infections, to strengthen services for sub-group of population at a particular risk, like maternal health, or to structure preventive activities, vaccinations, for instance (Walsh and Warren, 1979; Cairncross, 1997; and Tulloch, 1999). Both vertical programs as well as horizontal integration have shown successes in the past. While Smallpox eradication is cited as a success of verticality (Gounder, 1998), malaria eradication program is frequently argued as an example of little achievements with consequent consideration to integrate malaria control programs (Dhiman, 2019; Brew et al, 2020). In Pakistan, after introduction of MNCH and LHWs Programs in 1990s, there has been steady decline in maternal mortality from 276 (PDHS, 2008) to 186 (NIPS, 2019).

In recent years, an urgency is observed for integrating vertical structures into their regular systems as countries are moving towards UHC and are committed to take financial responsibility of their healthcare services. Verticality relies on certain preconditions and reasons which will have to be transferred to routine health services during their institutionalization. Dismantling a vertical structure, for reasons good or bad, comes at a price to be paid in terms of technical inputs, capacity building, resources and organizational restructuring. Even for a short period, once integrated, there is a drop in technical quality of services as integration is not just mere shift of vertical structure to regular services but involves real transfer of roles and responsibilities (Shigayeva, 2010). Nevertheless, horizontal approach has the potential to strengthen health system and has a greater impact in terms of cost-effectiveness and sustainability (Brown & Oliver-Baxter, 2016). Hence, a tailored, custom designed model may be able to incorporate the administrative advantages of a horizontal model while retaining the operational expertise of the vertical program.

Assessment Rationale

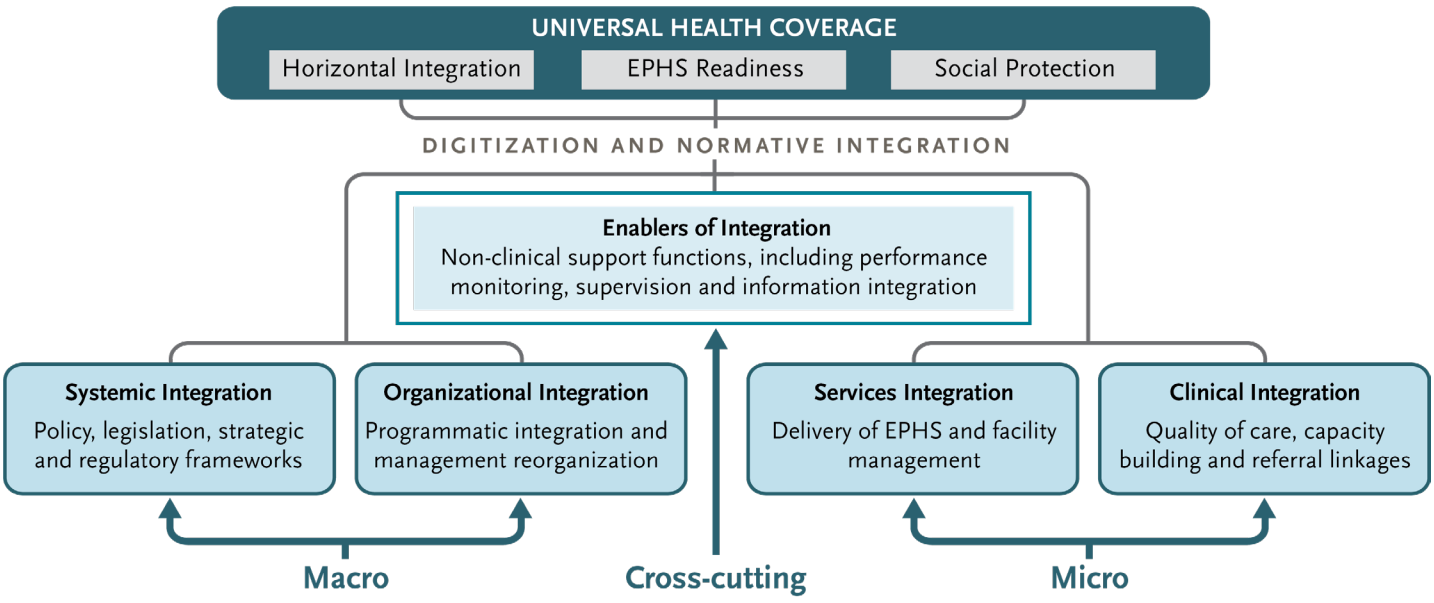
The Government of Pakistan (GOP) under the 12th Five Year Plan (health chapter) proposed a Health for All initiative to achieve improved health outcomes and meet the health targets of the SDGs. In the light of the mission proposed by the GOP, UHC is viewed as a notable catalyst and significant enabler for this goal, especially with its focus on PHC. In this regard, several important developmental actions have been undertaken by the provincial health authorities in consultation with the M/o NHSR&C. These include the localization and costing of DCP3 based EPHS and prioritization of interventions. These processes have resulted in consensus-based EPHS that are being rolled out in all provinces and federating areas of the country. An accompanying UHC Investment Case will provide policy-relevant evidence to assist the provincial departments of health and finance to develop costed 5-year plans for integrated financing of health towards UHC. This ongoing activity provides a significant opportunity to revisit the district health system mandated to implement the UHC package of services. This activity further assessed the feasibility and processes necessary for the horizontal integration of services at the primary care level, with a view to derive recommendations for service delivery and management reform aimed at increased service quality, access, and efficiency.

Aim and Objectives – World Bank, under Program of Advisory Services & Analytics (PASA), assigned Contech International to carry out a national level assessment of horizontal PHC integration in Pakistan. Specific assessment objectives were to consolidate all aspects of the defined UHC benefits package interventions, map the requirements for horizontally integrated PHC services, and conduct a gap analysis of the mapped parameters against the existing situation. Scope of work consisted of review of all information related to UHC benefit package, conducting a survey of provincial and district management units for horizontal integration, and assessment of EPHS requirements in PHC facilities for gap analysis. In each of the surveyed four provinces, one district was selected for assessment in consultation with the Federal Ministry and Health Departments. Based on EPHS gap analysis, frontload costing was ascertained for each type of surveyed PHC facilities. This analysis further informs the governments how much it would cost to achieve EPHS benchmark standards while keeping in view overall fiscal constraints and the opportunity cost of investment in other high-priority areas. Findings of the district level assessment will serve as a model for gap analysis and frontload costing, and are not generalizable to their respective categories.

INTEGRATION FRAMEWORK

Integration in healthcare refers to a healthcare system having aligned all healthcare functions and delivery of healthcare services, along with successful change management to achieve a truly integrated healthcare model (WHO, 2018). The process of integration provides a significant opportunity to revisit the health system to implement UHC Benefit Package and to assess the feasibility and processes necessary for horizontal integration at PHC level. Integration of vertical/preventive programs into broader PHC services has become increasingly crucial in view of UHC reform agenda, which has strengthened the argument for integration to increase health system's efficiency. Different frameworks have identified the various dimensions for horizontal integration. Fulop et al (2005) have identified six necessary dimensions for successful integration. These include systemic integration focusing on coherence of policies, organizational integration centering formal structures, functional integration encompassing supporting process, services integration within health facilities, clinical integration focusing on care pathways and team coordination, and normative integration denoting shared values and goals. In another model of integration (Valentjin et al, 2013, 2015), dimensions of integration are organized from a PHC perspective at macro, meso and micro levels with dimensions of functional and normative integration operating as cross-cutting enablers. Suter et al (2009) have described ten key principles for effective integration comprising of comprehensiveness across continuum of care, patient focus, geographic coverage, standardized care, performance management, information systems, organizational culture, physician integration, governance and financial management. Building on these essential dimensions, key principles and element of integration, the proposed assessment framework (Figure 1) developed by the assessment team comprises of macro, micro and cross-cutting enablers, encompassing all six dimensions for effective horizontal integration.

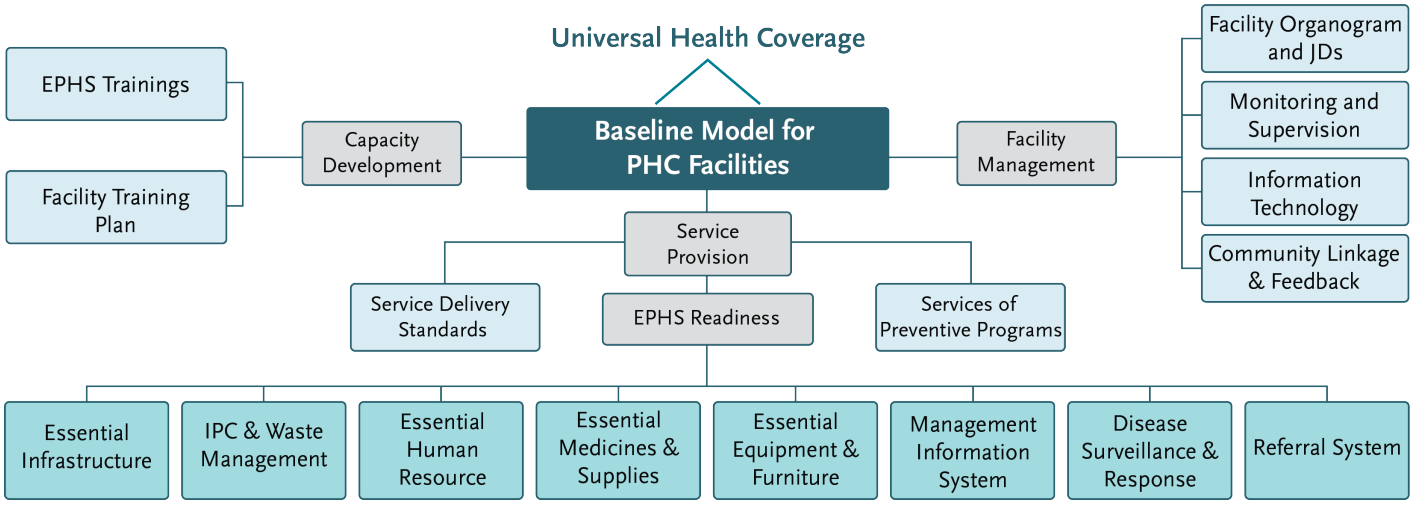
Figure 1: Horizontal PHC Integration Framework



Baseline Model for PHC Facilities

PHC facilities are the mainstay of realizing the ambitious goal of UHC. Review of standards and yardsticks laid down in the EPHS for the Community and PHC Level were used to develop the readiness assessment tools for health facilities selected for this assessment. This resource mapping provides information on the readiness status of assessed health facilities in each surveyed district. Requirements of baseline models have been defined separately for different types of PHC facilities, including Basic Health Unit (BHU), 24/7 BHU Plus or Community Health Center (CHC) and Rural Health Center (RHC). Provincial variations in requirements of UHC BP have been catered for in developing localized toolkits and conducting province specific analysis. Following figure (Figure 2) describes the facility level dimensions to deliver integrated PHC services as well as indicative areas of the assessment.

Figure 2: Baseline Model for PHC Facilities



EPHS Costing

EPHS provides both capital and recurrent costs for each type of PHC facilities (Table 2). With this in view, level specific frontload costing of EPHS is calculated for different types of PHC facilities, i.e., BHUs, 24/7 BHU Plus/CHCs and RHCs while factoring in their catchment population.

Table 2: Facility Specific Capital and Recurrent Cost under EPHS (in PKR)

Cost Components	BHU	BHU Plus	RHC
CAPITAL COST (in Million PKR)			
Civil Works	38,080,000	57,120,000	76,160,000
Equipment & Transport	8,255,100	8,927,450	12,593,870
RECURRENT COST (in Million PKR)			
Catchment Population	5,000 – 25,000	25,000 – 40,000	40,000 – 80,000
Repair & Maintenance	3,808,000	5,712,000	7,616,000
Staff Related Expenditure	4,557,588 – 7,568,400	13,588,524 – 16,757,700	20,790,972 – 34,076,076
In-service Trainings	500,000	750,000	1,000,000
Medicines and Supplies	4,714,327 – 8,951,505	15,504,379 – 27,367,282	73,269,117 – 86,864,593
HMIS Tools	376,020	511,770	677,520
Utilities	792,000	852,000	1,200,000

PROVINCIAL SNAPSHOTS

Horizontal Integration in Sindh

Sindh is the second largest province of Pakistan based on population, with over 52 million residents. As reflected in the strategic documents, the Government of Sindh aims to provide 'health for all' while ensuring an enabling environment for improving healthcare services. At present, there is no specific legislation to ensure UHC for the people of Sindh and during provincial consultations, it was suggested that the province will follow directions of the M/o NHSR&C to promulgate such Act. Achieving UHC is as much a political process as a technical one. Sindh Health Department has embarked on an ambitious yet considered reform agenda for transformation of the health sector to achieve UHC. Sindh has endorsed the EPHS in 2021 and the province has constituted **UHC Steering Committee** under chairpersonship of Honorable Health Minister with representation from auxiliary departments to provide oversight and a larger **UHC Technical Committee** has worked on localization of the UHC BP to Sindh's context and has a key role in monitoring the progress of UHC related interventions.

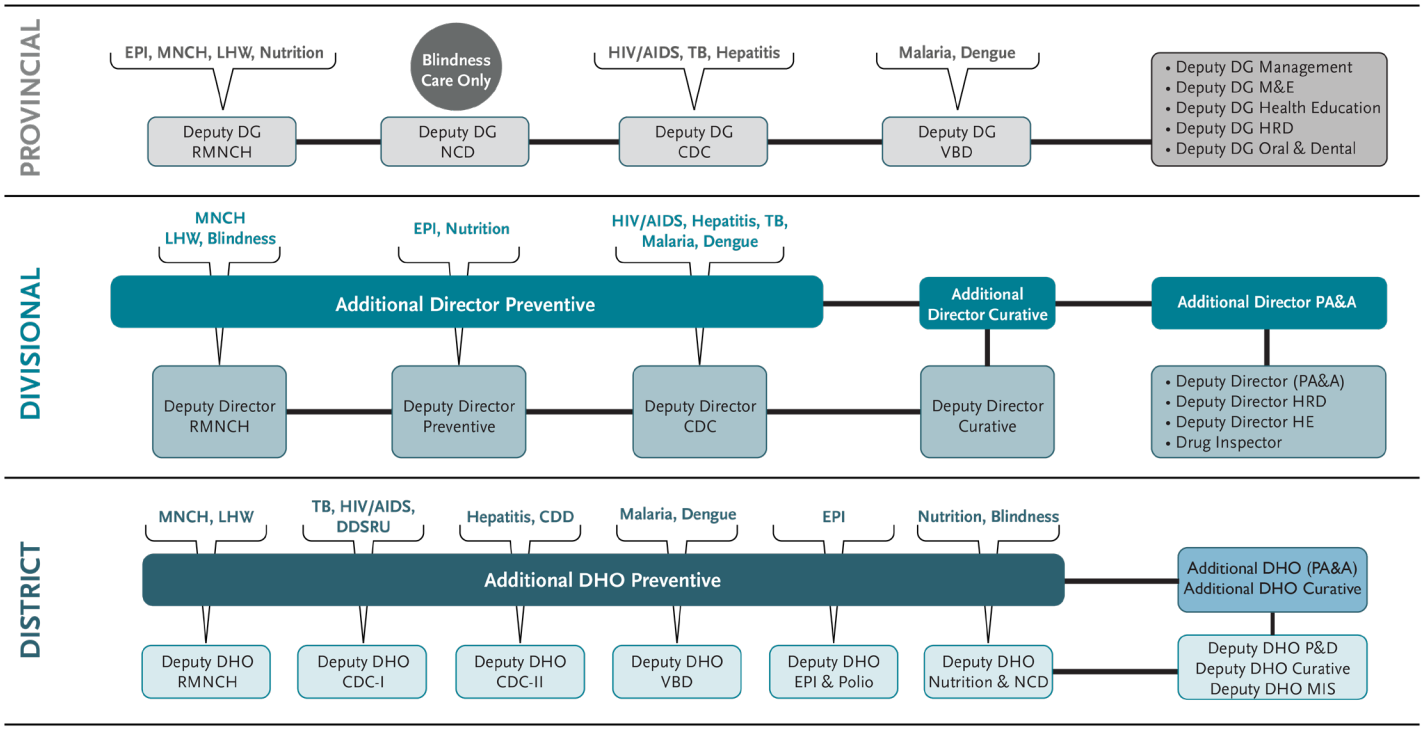
Integration of Vertical Programs – All the vertical programs have been shifted to regular budget and development allocations for vertical programs has reduced from PKR 4,354 million in FY 2019-20 to 25 million in FY 2020-21 and nil in FY 2021-22 (Table 3). The process for shifting of vertical programs followed a consultative approach with focus on minimal financial implication. PC-Is of all vertical programs were reviewed for planned activities, targets, timelines and budgetary allocations followed by consultations with respective Project Management Units of vertical programs to identify program wise functions, activities, revision of targets, assigning responsibilities, identification of service delivery points, and budget allocation.

Table 3: Development Budget Allocations for Vertical Programs in Sindh (in PKR Million)

Vertical Programs	2019-20	2020-21	2021-22
Enhanced HIV/AIDS Control Program Sindh	600	Nil	Nil
Prevention & Control of Hepatitis in Sindh	900	Nil	Nil
Expansion of Sindh LHW Program for FP & PHC	50	Nil	Nil
Maternal Neonatal & Child Health Program - MNCH	23	Nil	Nil
Strengthening of Malaria Control Program in Sindh	50	Nil	Nil
Prevention & Control Program for Dengue in Sindh	88	Nil	Nil
Strengthening of TB Control Program Sindh	100	Nil	Nil
Prevention and Control of Blindness in Sindh	50	Nil	Nil
Sindh Immunization Support Program	2,163	25	Nil
Nutrition Support Programme in Sindh	331	Nil	Nil
Total	**4,354**	**25**	**Nil**

Management Reorganization – An important component of horizontal integration was restructuring of the Health Department to meet the requirements of management reorganization (figure 3). Organograms for management positions (from BPS-20 to BPS-17) were revised for offices of DGHS, six Divisional Directors and 29 DHO offices. Total number of posts required across the province according to the revised organograms was 1425. Out of these, 66 posts were available with the same nomenclature in the respective cost centers; while 621 posts were re-designated from posts present in the same cost center; and 628 posts had to be shifted from other cost centers or re-designated to match the revised organogram. Furthermore, 110 posts were pending creation and among those, 99 posts were initially re-designated, however, these had to be reverted back due to administrative and legal reasons. The reorganization of management structure in the department has resulted in creation of offices of 9 Deputy Director Generals. However, the current infrastructure of the Directorate General Health Services office did not have adequate space to accommodate this enhanced workforce. This highlights the need for expansion of the governance physical infrastructure as an essential component of functional integration.

Figure 3: Departmental Reorganization at Provincial, Divisional and District Levels



Job descriptions of the posts included in the revised organograms were developed through a consultative process. Notified JDs clearly outlined the BPS, educational qualification with relevant experience, reporting line, appraisal authority, training requirements, and individual roles and responsibilities for each post. **Cost centers** are the basic budgeting units and there were 625 cost centers before the process of integration and restructuring. In post-integration scenario, the number of cost centers had increased to 871 with creation of 246 new cost centers to streamline the activities by placing the resources, targets, budget allocation, achievement and expenditure tracking under one cost center. Originally it was proposed that budget should be allocated to the service delivery points, and allocation was done accordingly; however, budget allocated to the districts was reverted back to the provinces, mainly due to inherent deficiencies related to planning, budgeting and procurement.

EPHS Gap Analysis –Sindh has endorsed the essential package for PHC facilities and within the surveyed health facilities, there were varied levels of gaps when assessed against the EPHS standards and yardsticks. While HR and their trainings emerged as the main challenge, situation of infrastructure, medicines and supplies and essential equipment were also found to be far less than EPHS requirements. Frontload costing for filling these gaps has been estimated at PKR 8.9 million to cover the additional requirements for surveyed BHU, PKR 18.5 million for surveyed BHU Plus and PKR 62.1 million for surveyed RHC in their annual recurrent budget.

Horizontal Integration in Punjab

Punjab is the largest province of Pakistan based on population, with over 125 million residents. 'Health for All' is a theme highlighted in all the strategic and policy documentation of Punjab. In order to bring efficiencies, in 2015, the Health Department of Punjab was bifurcated into Specialized Health and Medical Education (SH&ME) and Primary and Secondary Healthcare Department (P&SHD). After bifurcation of health department, all the vertical programs were managed by P&SHD. In terms of integrating the various vertical programs, the agenda of the province as described in Punjab Health Sector Strategy (2019-2028) remains clear. Regulating healthcare is also high on the agenda of Government of Punjab and pursuant to that the province promulgated the Punjab Healthcare Commission Act in 2010 and became the first province in the country to have established a Commission to assess, monitor, and ensure the quality of healthcare across Punjab. The province has constituted **UHC Steering Committee** to oversee the activities for UHC by providing strategic directions, monitoring the implementation plan, and to ensure the involvement of relevant stakeholders. **UHC Technical Committee** is constituted under the chairpersonship of DGHS Punjab with mandate to support technical work of UHC BP localization and implementation.

Integration of Vertical Programs – Process of integration of programs was initiated in Punjab as early as 2014 when LHW Program, MNCH Program and Nutrition Program were integrated as stipulated in Punjab Health Sector Strategy (2012-2020) to form Integrated Reproductive, Maternal, Newborn, Child Health and Nutrition Program. This improved the integration of services delivered through LHWs and Community Midwives (CMWs), which were part of outreach services under these programs. The integrated PC-1 was intending to deliver better health outcomes by improving coverage and access of the services. The IRMNCH&NP has also recognized the need for regularization of budget although, there is a gap of two years before this can be implemented due to ongoing PC-1 supporting funds from developmental budget until FY 2023-2024. Out of 11 vertical programs (Table 4), Expanded Program for Immunization (EPI), Infection Control Program, Communicable Disease Control Program and TB Control Program have been fully shifted to regular budget whereas rest of the programs have also started to gradually move towards regular budgets. Overall, budget of vertical/preventive programs in Annual Development Programme has reduced from PKR 10,210 million in FY 2019-20 to PKR 3,460 million in FY 2021-22.

Table 4: Development Budget Allocations for Vertical Programs in Punjab (in PKR Million)

Vertical Programs	2019-20	2020-21	2021-22
Enhanced HIV/AIDS Control Program Punjab	300	400	400
Prevention & Control of Hepatitis in Punjab	1,000	934	800
TB Control Program	300	257	Nil
Strengthening of Provincial TB Control Program	Nil	Nil	100
Strengthening of Expended Programme for Immunization	5,200	Nil	Nil
Infection Control Program	464	943	Nil
IRMNCH & Nutrition Program	2,200	1,700	1,200
Prevention and Control of Non-Communicable Diseases	200	206	210
Communicable Disease Control Program	46	20	Nil
Integrated Program for Communicable Disease Control	Nil	200	250
Chief Minister's Stunning Reduction Programme Punjab	500	478	500
Total	**10,210**	**5,138**	**3,460**

Management Reorganization – Currently, all the program managers of the vertical programs are linked to the DG Office with dotted lines on the organograms, showing no direct association but not completely disconnected or autonomous. A thorough reorganization of the directorate level of DGHS organogram is needed to facilitate the

horizontal integration. As seen from the organograms and based on input from the consultative meetings, it is evident that no vertical program is truly integrated at the provincial level. There has been no reorganization of management and the organograms remain the same that had been drafted years ago. During consultations, need was felt for revision of organograms and the management units along with updated JDs. Even at the directorate level, the job descriptions were not conveyed to the gazetted officers. Health managers are of the view that JDs restrict from assigning additional responsibilities to officers which are inevitable due to critically deficient HRH in Punjab. Additionally, another challenge is lack of management professionals which results in transfer of staff from a clinical setting to management positions or vice versa. Furthermore, there are no induction training or capacity building systems to cater to the need of integrated management.

EPHS Gap Analysis – Within the surveyed health facilities, there were serious gaps in all the requirements of EPHS standards and yardsticks. Frontload costing for filling these gaps has been estimated at PKR 6.6 million additional requirements for surveyed BHU, PKR 21.8 million for surveyed BHU Plus and PKR 54.4 million for surveyed RHC in their annual recurrent budget. Referral system was more developed as compared to other provinces with availability of ambulances services in the community and their linkages established with health facilities and outreach workers.

Horizontal Integration in Khyber Pakhtunkhwa

Khyber Pakhtunkhwa (KP) province has a population of over 52 million residents and over 81% of the population of KP is settled in rural areas. Key challenges being faced by the healthcare system of the province relate to coverage and access of essential health services, with reduction in the morbidity and mortality being poor due to lack of health infrastructure to cover the essential health services, poor human resource management and lack of accountability. All these challenges are of utmost importance as they overlap in provision of the essential health services promised in the UHC Benefit Package. Vision of the Government of KP government as stated in the Khyber Pakhtunkhwa Health Policy (2018-25) is to ensure "optimal health across the lifespan for the people and communities of Khyber Pakhtunkhwa". The policy also highlights the need for strengthening delivery of integrated services through primary healthcare centers following the district health approach. Integration at community level by involving the community workers and amplifying their skill set is also one of the policy actions of KP. In addition to KP Health Policy, a number of other initiatives have been undertaken by the Health Department to reform the health sector, including development of District Health Plans, KP Health Survey 2017 and to improve financial management, KP Public Financial Management Reform Strategy 2017-20 has also been prepared.

UHC Commitment – Government of Khyber Pakhtunkhwa has notified a governance mechanism for UHC Benefit Package, comprising of a **Technical Committee**, a **Steering Committee** and a UHC Secretariat. Technical Committee had worked intensively on localization of UHC BP EPHS with technical assistance from M/o NHSR&C and development partners. Localization was completed through two workshops at provincial level with more than sixty participants, including health managers, academia and representatives from other departments. KP has also initiated Health Roadmap Program, which will support implementation of UHC BP through ensuring adequate HR and physical resources to deliver essential services.

Integration of Vertical Programs – Like other provinces, Khyber Pakhtunkhwa also had structures and systems in place based on vertical control of programs which had been working without horizontal linkages and coordination with other programs. In 2018, when federal funding ceased in aftermath of the 18th amendment, it highlighted the need to shift towards an integrated health system. This was also envisaged in KP Health Policy and was part of the provincial government's commitment with federal government that vertical programs would be shifted to the recurrent budget. Currently, a major portion of EPI has been shifted to regular budget with the exception of some of its staff working through project mode under PC1.Similarly, LHW Program is also being shifted to the recurrent budget with some gaps being filled through PC-1 while the rest of the program has been shifted to recurrent budget. The situation is also similar for MNCH Program and MCH Directorate has been established in the DGHS office, headed by Director MCH, as a regular structure of DGHS office. However, other programs, e.g., TB, Malaria, HIV/

AIDS and integrated welfare management etc., are still working under vertical structure. Overall, budget of vertical/preventive programs in Annual Development Programme has reduced from PKR 6,250 million in FY 2019-20 to PKR 3,864 million in FY 2021-22 (Table 5).

Table 5: Development Budget Allocations for Vertical Programs in KP (in PKR Million)

Vertical Programs	2019-20	2020-21	2021-22
Programs in KP Province			
Integrated HIV, Hepatitis and Thalassemia Control Program	10	5	49.56
Integrated Vector Control Programme	10	20	103.46
Treatment of Poor Cancer Patients	821.75	900	900
Establishment of Safe Blood Transfusion Project	365.1	311.1	361.38
Strengthening of TB Control Program in Khyber Pakhtunkhwa	10	10	20
Integrated Disease Surveillance Response System	20	5	5
Extension of D-Talk and Insulin for Life	70	55	88.31
Integration of Health Services Delivery with Special focus on MNCH, LHW and Nutrition Programme	2,400	2,411.56	1,200
Life-Saving Maternal and Reproductive Health, Protection Support Services for Women and Girls	150	53.32	Nil
Regional Blood Center along with screening, storage, transportation of blood to DHQs	Nil	100	Nil
Topping up of preventive Healthcare Regime (Hepatitis, TB, EPI, NCD, HIV, etc.)	Nil	200	200
Topping up of MNCH Program (AIP)	Nil	400	200
Strengthening of National Program for Family Planning (AIP)		500	120
Expanded Programme on Immunization Khyber Pakhtunkhwa	2,047.23	Nil	Nil
Strengthening of EPI Programme (AIP)	NIL	52.78	200
Treatment of Multiple Sclerosis Patients (pilot basis) in Khyber Pakhtunkhwa (on cost sharing basis)	40	Nil	Nil
Mental Health & Psychosocial Support Services KP	15	Nil	Nil
Piloting Integration of Diabetes & Hypertension Management into Primary Care	15	Nil	Nil
Programs in FATA			
Thalassemia Control Program in FATA	15	20	25
AIDS Control Programme in FATA	35	15	30
Hepatitis Control Program in FATA	40	31.31	55
Integrated Vector Management Program in FATA	30	80	60
TB Control Program in FATA	30	42.01	40
Health Nutrition Program in FATA	25	180	66
Strengthening of EPI Program in FATA	60	200	65
Strengthening of National Program for Family Planning and Primary Healthcare in all tribal districts	40	157.24	75
Total	**6,249.08**	**5,749.32**	**3,863.71**

Management Reorganization – With regard to restructuring of Health Department, the process was started in 2015, with creation of four posts of Additional DGs in the DG office, viz., Additional DG Health Services (all the vertical/ preventive programs, primary healthcare etc. and curative care services), Additional DG HRM (HR related matters and Communication Cell), Additional DG Administration and Development)procurement, administration, accounts and drugs control) and Additional DG Monitoring & Surveillance (M&E and Implementation Cell). Recently, after further deliberations it was decided to decentralize the authority to regional level. For this purpose, the province has been divided into 4 regions with its own Additional DG having administrative authority and financial powers. This decentralization of authority has facilitated swift decision making contributing to a responsive health system.

EPHS Gap Analysis – Within the surveyed PHC facilities, there were critical shortages of staff and essential medicines and frontload costing for filling these gaps is estimated at PKR 11.0 million additional requirements for surveyed BHU, PKR 20.1 million for surveyed 24/7 BHU and PKR 85.7 million for surveyed RHC in their annual recurrent budget. Like rest of the provinces, facility level organograms, job descriptions and training plans were lacking in all the surveyed PHC facilities.

Horizontal Integration in Balochistan

Balochistan is geographically the largest of the four provinces of Pakistan, spreading over an area of 347,190 Sq. Kms., in contrast to its size, the province has one of the smallest and scattered population of 13.9 million with a low density of 40 per square kilometer. Balochistan is suffering from multidimensional poverty, having the highest poverty incidence (56.8%) in the country. In comparison to Pakistan's aggregate score of 52.51, the province showed lowest services access and capacity score (29.4), calculated for UHC service coverage index based on four proxy and priority indicators related to hospital beds density, essential health workforce density, access to essential medicines, vaccines and commodities, and capacities for International Health Regulations. Balochistan Health Policy (2018-2030) has been developed with tenets of the policy based on National Health Vision. Consequently, Balochistan Health Sector Strategy (2018-2025) is also formulated, bringing focus of the government on reforms and building a responsive health system to ensure access to the needed health services without facing financial hardship. Further, the Strategy aims at developing a specific HRH plan to fulfill the health workforce requirements for achieving universal health coverage.

UHC Commitment – In relevance to the policy documents, the support and willingness of the Government of Balochistan is evident in establishing integrative services under the UHC BP and EPHS packages. Although Health Department of Balochistan recognized its need and importance and initiated work in 2018, multiple delays were faced in forming a UHC Steering Committee in Balochistan due to shuffling of political structure (CM, minister health, health secretary and home secretary were repeatedly changed). However, notifications were issued by the P&SHD and DGHS in pursuance of prior meetings with the M/o NHSR&C to initiate the formation of relevant governance platforms in assisting the coordination of UHC BP. Now, **UHC Steering Committee**, under convenorship of the Parliamentary Secretary for Health and **UHC Technical Working Committee (TWC)** under chairpersonship of DGHS have been established to steer the localization and implementation of UHC activities in the province.

Integration of Vertical Programs – Overall Balochistan caters to 10 different vertical programs to provide preventative services through its Health Department. As stipulated in the sector strategy, Government of Balochistan has committed to organize resources to integrate vertical programmes with the primary health care network to address SDG target of ending the epidemics of AIDS, tuberculosis, malaria, neglected tropical diseases and combating hepatitis, water-borne diseases and other communicable diseases. The province has formulated the Health Sector Plan but full-scale integration is yet to be achieved. Out of these vertical programs, the Expanded Program for Immunization (EPI), Malaria Control Program, MNCH Program, National Program on FP & PHC, Hepatitis Control Program along with Programs on Blindness and Nutrition are gradually being shifted to regular budgets. Overall, budget of vertical/preventive programs in Annual Development Programme has reduced from PKR 1,852 million in FY 2019-20 to PKR 323 million in FY 2021-22 (Table 6).

Table 6: Development Budget Allocations for Vertical Programs in Balochistan (in PKR Million)

Vertical Programs	2019-20	2020-21	2021-22
HIV/AIDS Control Program Balochistan	50	40	Nil
National Maternal Newborn & Child Care Programme	150	100	322.80
Chief Minister's Initiative for Hepatitis Control Program	150	100	Nil
National Program for Family Planning and PHC Balochistan	100	80	Nil
Vector Borne Diseases (Malaria, Zika, Leishmaniasis, Dengue, Chikungunya & CCHF)	100	Nil	Nil
Blindness Control Program	10	5	Nil
TB Control Programme (DOTS)	80	50	Nil
Strengthening of Expanded Programme on Immunization (GAVI)	477	321	Nil
Balochistan Nutrition Program for Mother and Children	725	20	Nil
AVIAN Pandemic Influenza Control Program	10	Nil	Nil
Total	**1,852**	**716.00**	**322.80**

Management Reorganization – In June 2021, Balochistan Health department was split into two administrative units (Primary and Secondary Healthcare Department and Specialized Healthcare and Medical Education Department) to facilitate the provision of quality health services and ease managerial matters in the province. However, this bifurcation was reverted and both departments were merged after strikes in the province with a notification issued in December 2021. In Balochistan, an extensive contracting-out initiative was started in the mid-2000s. Under this initiative, management of more than 750 PHC facilities have been contracted out to a non-governmental organization, Peoples Primary Healthcare Initiative (PPHI). Job descriptions along with reporting lines remain a vital piece of information that guides employees to be task oriented and thus give the best results in an efficient and time saving manner, while reducing redundancies and duplication in the nature of work. In Balochistan, work on developing JDs is underway, although this process has been delayed due to the bifurcation and subsequent re-merger of the department.

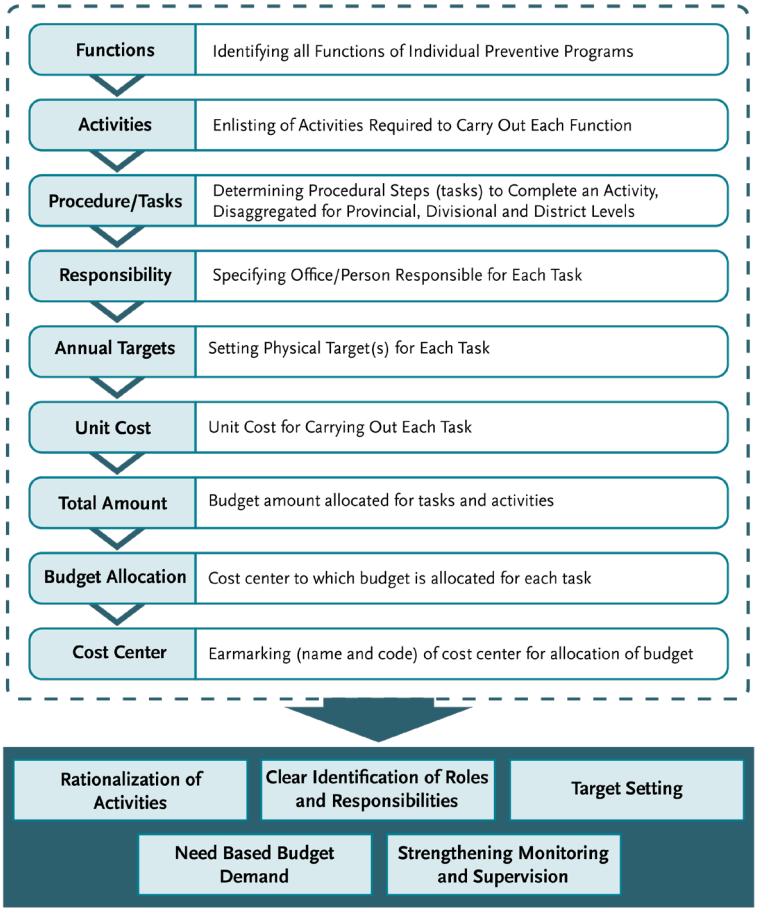
EPHS Gap Analysis –Within the surveyed PHC facilities, gaps in EPHS requirements were more pronounced than rest of the country and frontload costing for filling these gaps estimated at PKR 8.1 million additional requirements for surveyed BHU, PKR 21.6 million for surveyed BHU Plus and PKR 63.3 million for surveyed RHC in their annual recurrent budget. Despite having the low catchment population of these surveyed facilities, high frontload cost depicted extremely debilitated state of PHC facilities.

RECOMMENDATIONS FOR INTEGRATION

Integration of vertical programs has been carried out differently across the provinces. While most of the provinces simply shifted the total budget from development to regular side, Sindh carried out a more systematic approach for redistribution of the activities and reorganization of management structures. In order to make the integration of vertical programs work, it is required to carry out programs' activities through existing institutions. In this aspect, listing key activities along with identification of implementing institutions, integration-oriented field management structures, bringing clarity in the roles and responsibilities, and developing detailed budget demands are imperative for this paradigm shift. Major activities of all the shifted vertical programs are broadly categorized into:

- Establishing field management structures replacing isolated implementing units,
- Distribution of promotive, preventive, and curative services to related institutions,
- Supply of resources like medicines, consumables and equipment,
- Skills development training of health managers, clinical staff, and outreach workers,
- Social mobilization and advocacy for public awareness and engaging key stakeholders,
- Revisiting facility level workflows, and
- Strengthening field monitoring and supervisory structures and mechanisms.

Figure 4: Process of Integration of Vertical Programs



Integration Process – The whole process entails the review of PC-1s, stakeholders' consensus on scope of work and implementation strategy through targeted engagement with project management units of vertical programs, and development of activity plans using a uniform format (Figure 4). As a result, an actionable roadmap for integration and restructuring would be the key outcome.

Need Based Budgeting – These Activity Plans provide the basis for need based budgeting for activities of integrated vertical programs, through 1) development of activity category wise cost estimation tools; 2) budget allocation for activities under specific object codes; 3) identification and listing of assigned cost centers; and 4) compilation of cost center wise budget estimates using prescribed forms.

Rationalization of Cost Centers – Analysis of budget books of all provinces has revealed that there is a need to rationalize the cost centers with respect to nomenclature, functional classification, post codes, SNE status and staffing. This is essential to improve strategic planning and decision making. Specific criteria will be established for rationalizing cost centers, which will serve as reference for development of formats to determine what revisions are required. Through detailed review of budget books, consultations and gap analysis, proposal for rationalization of cost centers will be developed and implemented for improving financial management at district, divisional and provincial levels for bringing efficiencies in health sector.

Management Reorganization

Once financial integration of vertical/preventive programs is implemented, it would necessitate organizational restructuring and strengthening of existing field management structures. Horizontal integration cannot be complete without structural changes in the Health Department to accommodate the vertical programs and their respective staff into the regular structure. This entails detailed review and revision of organograms at DGHS, Divisional/ Regional and District levels. At **DGHS**, using the activities outlined in Activity Plans as reference, responsibility of management of integrated programs may be assigned to Additional/Deputy Director Generals, supported by Additional, Deputy, and Assistant Directors along with relevant support staff, as per following recommendations:

- **RMNCH** may be assigned responsibility for activities of MNCH, LHW, Nutrition and other Maternal and Child health related activities, while catering to the provincial variations of staff engaged in these activities
- **EPI** may be assigned responsibility for activities of EPI and related immunization activities
- **CDC** may be assigned responsibility for TB, Hepatitis, HIV/AIDS, Malaria and Dengue, and other communicable disease related activities
- **NCD** may be assigned responsibility for non-communicable disease control related activities
- **Planning** may be assigned responsibility for preparation of strategic and operational plans and implementation
- **Admin & Accounts** may be assigned responsibility for administrative and accounts related matters
- **HR** may be assigned responsibility of all aspects of HR management for staff capacity building
- **M&E** may be assigned responsibility for monitoring and supervision related activities.
- **Procurement & SCM** An important function of the vertical programs and would require dedicated unit at DGHS

At **divisional/regional level**, Director level offices should be established/strengthened for monitoring and supervision of ongoing activities, as well as provide a coordination role between provincial and district level. The organogram at Director Health Services may be reviewed and revised in accordance with the restructuring at DGHS level. **District Health Offices** have a vital role in implementation of activities. The organogram at District Health Office may be reviewed and revised in accordance with the restructuring at DGHS and Director Health Services levels. At **PHC facility level**, organograms with clear reporting lines are required to be developed for facilities while keeping in view the delivery of EPHS and integration of services delivered through vertical programs.

Shifting and Re-designation of Posts – Based on the revised organograms, proposal has to be prepared for shifting or re-designation of posts. Health Departments have suitable managers having relevant experience and grade, who may be preferred for posting against revised posts through routine transfer posting. For some posts re-designation will be required as per revised organograms. Preferably no financial implication, or at the most minimal financial implication would be a key consideration during preparation of shifting and re-designation proposal.

Job Descriptions – Job descriptions have been developed for management positions in all the provinces. While some of them were developed decades ago, they have not been revised to meet the current requirements. In most of the instances, health managers were not aware about their JDs at all levels. Shifting, redesignation and post creation must be coupled with revised JDs to make managers aware of their roles and responsibilities.

Capacity Building – New responsibilities will necessitate capacity building of the managers. Numerous activities once integrated into regular system will be implemented and managed at the district level. In order to make this work, mere change in nomenclature of managers will not be sufficient and concerted efforts must be made for building their capacities to take up the new roles. Vertical programs were responsible for carrying out a number of trainings for managerial as well as service delivery staff. In their absence, these activities must be taken up by the

regular structures. Revitalizing the network of **Provincial and District Health Development Centers** will provide a platform for carrying out trainings. At facility level, through task shifting and retraining of existing staff to perform missing tasks, services can be improved without any extra hiring and existing staff will be better utilized.

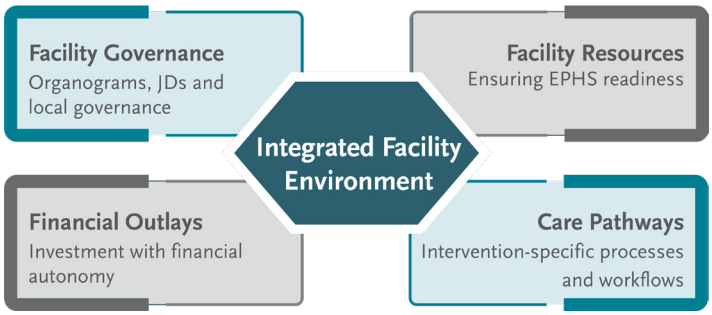
Monitoring and Evaluation – Considering vertical programs have M&E mechanisms of their own, it is imperative that with integration, capacities and resources for monitoring are also strengthened in regular systems. Establishment of M&E units at all levels with financial resources, logistic support for vehicle, POL and maintenance will be required. Digital platforms like integrated M&E dashboards have proved useful in facilitating M&E functions.

Integrated PHC Facility Workflows

Horizontal integration within PHC facility would require complete revisioning of facility level workflows. EPHS lays down the foundations of reorganizing facility processes to improve service delivery in an integrated environment. At facility level, comprehensive PHC integration is based on certain prerequisites and requirements (Figure 5).

Facility Governance – Management functions are organized to be conducive for horizontal integration. While designing facility level organograms and JDs, the facility should bear responsibilities of individual staff in mind. As part of facility governance, community engagement is critical to establish linkage with community representatives to obtain feedback on quality and adequacy of services.

Figure 5: Requirements of Integrated Environment



Financial Outlays – Delivery of EPHS in an integrated environment is not possible without considerable investments of government and development partners. Frontload costing based on EPHS gap analysis has estimated financial implications of UHC BP. Considering the current transfer of financial authority to districts, certain level of financial autonomy should be devolved to the facility level, particularly for meeting ad-hoc expenses. Formation of facility-wise cost centers will further facilitate the delegation of financial powers.

EPHS Readiness – In terms of resources, there are significant gaps in PHC facilities. While gaps are more pronounced in KP and Balochistan, they are far less than acceptable in Sindh and Punjab as well. Without fulfilling the requirements of EPHS, delivery of prioritized interventions in an integrated manner would not be possible. Once these gaps are filled, details provided in the guiding document on *Interventions' Description of Essential Package of Health Services/ UHC Benefit Package of Pakistan* will assist in achievement of integrated environment within health facility. Other aspects of facility level integration include digitized patient records, facility signage and reorganization of referral services with bed registry and ambulance services.

Intervention Specific Workflow – In EPHS at Community and PHC Level, all prioritized interventions are described in terms of key parameters to explain the process of interaction with patient/client for each intervention along with platform and identification of major direct and indirect cost heads. Province-specific EPHS assessment toolkits, developed as part of this assessment, can be easily replicated across health facilities. The gaps thus ascertained will inform Health Departments about the total financial outlay to fulfill EPHS requirements through evidence-based action planning and need-based budgeting.

Anticipated Outcomes of Horizontal Integration

Horizontal integration provides opportunities to deliver services in line with UHC BP and SDGs commitments. Through incorporation of different components of health systems, integration overcomes duplications and redundancies in health workforce. It further aims to bring efficiencies through multipurpose use of resources, thus allowing more outputs for given inputs. Horizontal integration will strengthen bottom-up approach and will also pave way for identifying local needs through community involvement. Therefore, integration is viewed as a more holistic approach to cater person-specific health needs. Historically, in Pakistan, budget cuts are mostly made on ADP releases and with shifting of vertical programs to recurrent budget, they are less prone to budgetary slashes.

CONCLUSION

Pakistan and all its federating units are making steady progress to achieve the UHC Service Coverage Index of 65 by 2030 as the indicator has improved from 39.7 in 2015 to 49.9 in 2020. UHC Benefit Package has been developed and approved through Inter Ministerial Health and Population Council and provinces are in the process of localizing the generic national Essential Package of Health Services. At the time of this assessment, only Sindh has endorsed the localized essential package for starting implementation in pilot districts, whereas in rest of the provinces, drafts have been developed and will be approved in due course. Extensive postings and transfers of key government officials is an inherent challenge of advocacy efforts and has led to the delays in approval of essential packages. Integration of vertical programs has initiated in all the provinces couple of years ago. Majority of the budget of vertical programs has been shifted from development to recurrent budget. While the progress to shift the budget to the regular side is complete to a certain extent, some critical gaps are still pending. Budgetary redistribution along with management reorganization is required to allocate all the activities of vertical programs to regular structures at both provincial and district levels. This reorganization necessitates the revision of organograms, redistribution of staff, capacity development, rationalization of cost centers and need-based budgeting. Provinces has recognized the need for technical assistance to facilitate the integration process and management reorganization for harnessing the outcomes of horizontal integration and bringing efficiencies in the health sector.

In pursuance of UHC agenda, primary healthcare facilities are the mainstay of realizing this ambitious goal. Focusing on the immediate priority interventions, the assessment revealed serious gaps in meeting the EPHS requirements. While HR has emerged as a major concern, the situation of infrastructure, equipment, and medicines and supplies is also far less than acceptable. Based on this gap analysis, the governments will have to consider the cost involved in EPHS implementation and may require additional thinking to bridge this gap while keeping in view the macro-fiscal situation, financial constraints and competing priorities. EPHS readiness, once attained, will pave way towards achieving UHC through providing financial risk protection and access to quality essential healthcare services for the citizens of Pakistan.

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