



**HEALTH POLICY
FOR THE
PROVINCE OF SINDH
2005**

PAVING THE WAY FOR HEALTH SECTOR REFORM

**HEALTH DEPARTMENT
GOVERNMENT OF SINDH**

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PROVINCIAL HEALTH POLICY 2005

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MESSAGE

Pakistan achieved independence in 1947 and currently has a population of around 150 million, of which Sindh share is 34 million. In this new era, our country faces enormous challenges with regard to the health state and health indicators. The state of maternal & child health indicators stands highest in Asia.

Under the constitution, health is both a Federal and Provincial responsibility as it falls in the concurrent list. Policy formulation comes essentially under the purview of the Federal Government; however, remaining within the framework of the National Policy, the provinces can draw up their own policies. Apart from actual health services delivery, the provincial health authorities are also responsible for planning and management of human and physical resources and allocation of resources to the lower levels in collaboration with the departments for Finance and Planning & Development.

I have gone through this Provincial Health Policy of Health Department and found it a complete and comprehensive document leading to the way forward to provide protection to ailing population against hazardous diseases, promoting public health, upgrading curative health facilities, enhancing equity, efficiency & affectivity in health sector. The identified key areas are justified and reflect the best intentions of Health Department making efforts to eliminate the communicable and non communicable diseases from the community, Moreover, the idea of reforming Medical Education, Legislation and revamping of Medical legal Services, to control private health sector, Quackery, Saniasi baba and irrational publicity of spurious and misleading drugs, is also commendable, which will cause minimum hardship to the ailing populations.

In the last, I endorse the contents of the health policy, congratulating and acknowledging the efforts of Mr. Faisal Malik, Prof. Dr. Noshad A. Shaikh, Dr. Shafquat Hussain Abbasi and Dr. Muhammad Jamil Mughal, for formulating this policy.

(DR. ARBAB GHULAM RAHIM)

F O R E W O R D

With a population of around 34 million, Sindh is the second most populous province of Pakistan. At the turn of the new millennium, our country and province faces enormous challenges with regard to its health sector. Of special concern is the state of maternal and child health indicators which remain quite dismal owing largely to gender inequity and lower access of females to health, population welfare and education services.

A health policy summarizes the vision, goals, objectives and targets of the government with regard to its health sector, which justifiably aims at an improvement in the health status and the overall quality of life of its citizens. While framing a health policy it is pertinent to take into account the socio-economic factors and also delineate the role of other sectors that have a direct bearing on health. It appears that Health Policy Formulation does not receive the incisive and painstaking approach in its development process that is warranted by our health situation. In the process, key considerations are overlooked that lead to development of major gaps, which manifest themselves during the implementation phase. Furthermore, it appears that successive policies were either overly ambitious, not backed up by the requisite financing, or their implementation did not keep pace with policy.

The Government of Sindh is committed to improve the quality of health services provided to our masses and therefore every effort has been made to draw up a workable policy, followed by an implementation plan and backed up by adequate resources so that a visible difference can be brought about in the quality of our medical, nursing and paramedical education, health services delivery and collaboration with other sectors to the ultimate benefit of the people of this province.

FAISAL MALIK
ADVISER TO CHIEF MINISTER SINDH
FOR HEALTH

P R E F A C E

It is after a long period of time that the Provincial Health Policy has been announced in Sindh in order to give a clear sense of direction to our senior and mid-level managers. The provincial policy is fully in conformity and in line with the National Health Policy. I may add that although the National Health Policy is very sound, pragmatic and workable, it leaves a lot of questions unanswered, which could be addressed through the Provincial Health Policy in Sindh. It is therefore imperative to dilate on the policy to include the working modalities for all key areas mentioned in the policy so that they can be effectively pursued and addressed. I am therefore confident that this policy, which has the vibrancy and tenacity to cope with our health problems will succeed in accomplishing its objectives and bring about tangible benefits for the Sindh Health Sector. An implementation plan will be produced in a few weeks' time in order to give practical shape to the policy and make a significant difference at the grassroots level, where these interventions are required the most.

I must appreciate the fact that a paradigm shift occurred in the last National Health Policy of Pakistan announced in 2001, whereby the role of health was acknowledged as the center of all socio-economic development, and linked with poverty reduction strategies. The key to success now lies in modifying the existing health policy to fill in the gaps and bring it totally in line with the Millennium Development Goals (MDGs) and the Poverty Reduction Strategy of Pakistan (PRSP), and our province-specific needs. This will require enhancing health sector financing, ensuring efficient utilization of available resources, mainstreaming the private health sector, reforming all aspects of health, bringing about inter-sectoral collaboration and empowering communities with regard to their health needs in a sustainable manner.

I am grateful to the Hon'ble Adviser for Health Mr. Faisal Malik for his valuable guidance in the preparation of this document. I must also acknowledge the efforts of Dr. Shafqat Hussain Abbassi Additional Secretary (Technical) Health, Dr. M. Kamil Rajpar, a former Secretary of health, Dr. M. Sajjan Memon ex-Director General Health, Dr. Ghulam Nabi Kazi, WHO Operations Officer for Sindh, Dr. Sher Shah Syed General Secretary PMA Sindh and Dr. M. Jamil Mughal, Section Officer (Tech-I) Health, in addition to other members of the core group who were largely instrumental in drawing up this policy. I am confident that this policy will lay a sound basis for further health inputs in the province.

PROF. NOSHAD A. SHAIKH
SECRETARY HEALTH

MISSION STATEMENT

**THE OVERALL VISION IS BASED ON
“HEALTH FOR ALL”**

**THE NEW HEALTH POLICY AIMS TO
IMPLEMENT THE STRATEGY OF
PROTECTING PEOPLE AGAINST
HAZARDOUS DISEASES, PROMOTING PUBLIC
HEALTH, UPGRADING CURATIVE HEALTH
FACILITIES, ENHANCING EQUITY,
EFFICIENCY AND EFFECTIVENESS IN
HEALTH SECTOR.**

P R E A M B L E

The present Provincial Health Policy for Sindh is fully in conformity with the ten broad key areas for intensive action identified in the National Health Policy announced in 2001. The key areas envisioned for the health sector include reducing prevalence of Communicable diseases, addressing inadequacies in primary/secondary health services, removing professional/ managerial deficiencies in the district health system; promoting greater gender equity, bridging basic nutritional gaps in the target-population, correcting the urban bias in Health sector, introducing required regulation in Private medical sector, creating mass awareness in public health matters, effecting improvements in the Drug sector and capacity-building for health policy monitoring.

The Government of Sindh is determined to put into place a number of interventions that include focus on the District Health System based on primary health care philosophy where the role of community participation, inter-sectoral action and the implementation of well defined essential health care services package for each level of care is ensured. There is also the need to endorse the health related MDGs (see Annex-I) which focus specially on reducing child mortality by 2/3 and maternal mortality by 3/4 by the year 2015 taking 1990 as the baseline by implementing a strong MCH package by employing a provincial programme of community health midwives on the line and the strategy of LHWs.

It is also critical to address the communicable diseases endemic in the province most effectively by carrying out Tuberculosis control using the DOTS strategy, Malaria using the Roll Back Malaria approach, Hepatitis B & C and HIV/AIDS control. The problem of Leishmaniasis endemicity must also be addressed to this effect.

It is imperative to put into place the correct nutrition interventions with a focus on child and maternal health including food fortification with regard to iodized salt, vitamins-A ghee fortification, iron and folic acid. The effective control of non-communicable diseases especially cardiovascular diseases and diabetes, paying attention to the issue of road traffic injuries and mental health is also vital. Similarly the importance of controlling Hepatitis B & C through safe blood transfusion and other relevant strategies, provision of safe drinking water, improving routine EPI coverage, and arresting the growing spread of tobacco use, cannot be over-emphasized.

The lack of school health interventions is another major gap in the delivery of the provincial health services and therefore this proactive health policy includes the establishment of healthy school programmes in partnership with the Departments of Education and District Governments. It is obvious that the health sector cannot operate in isolation from other socio-economic development sectors of the province; hence it is important to employ programmes with a holistic approach such as the Basic Development Needs Programme, which brings together different line departments and the community on a unified platform of action for a better quality of life. The policy touches are several other critical aspects such as reforming medical education, medico-legal services, providing incentives to health professional serving in rural areas, catering to the needs of nurses, paramedics and support staff and health sector financing.

I. INTRODUCTION

1.1 Major Determinants of ill Health

The determinants of ill-health within the health sector in Sindh include a generally low priority accorded to communicable disease control programmes while scant attention is paid to non-communicable diseases such as cardiovascular diseases, strokes, cancers, diabetes, mental illnesses and diseases caused due to the consumption of tobacco. Other points of concern include the lack of community oriented medical education, unsafe deliveries, low utilization of health facilities in rural areas, nutritional deficiencies, unhealthy lifestyles and a general lack of health awareness.

1.2 The Case for Inter-Sectoral Collaboration

It is important to acknowledge that extraneous factors severely impede health efforts, including poverty, gender inequality, and unsafe water, lack of sanitation, improper waste disposal, environmental pollution, low literacy rates, rapid urbanization, overcrowding and lack of road safety. About 70% of the people live in the rural areas and have limited civic services such as education, health, safe water and sanitation. It is estimated that more than half of the rural population is without safe drinking water, 80% without sanitation facilities, and about 55% without electricity. Furthermore, with the current annual population growth exceeding 2%, Sindh's population, which is currently around 34 million would double in approximately 33 years negating all developmental activity unless concrete measures are taken to contain it. This makes it imperative to carry out inter-sectoral collaboration in order to make a tangible difference in the quality of life of our citizens.

1.3 The Health and Poverty Nexus

According to estimates of the World Health Organization, those living in absolute poverty are five times more likely to die before reaching the age of five, and two and half times more likely to die between the ages of 15 and 59, compared to those living in higher-income groups. In the scenario of Sindh, this factor has greater relevance where close to 40% of the population or over 13 million people live below the poverty line, if income and other deprivations of life are taken into account.

1.4 The Health Scenario and Infrastructure in Sindh

The Sindh Department of Health currently has more than 14,000 doctors, 2,000 nurses, and over 12,000 paramedics serving all over the province. The province has two medical universities; one each at Karachi and Jamshoro, and three medical colleges; one each in Sukkur, Nawabshah and Larkana, 12 Nursing Schools, 10 Midwifery Schools and 5 Public Health School for lady health visitors. The huge network of hospitals and health facilities include 6 teaching hospitals, 5 specialized institutions for chest, dermatological and mental illnesses, 11 district headquarter hospitals, 27 major hospitals located in the major cities, 44 taluka hospitals, 99 rural health centers in small towns, 738 basic health units in union councils, 305 dispensaries in larger union councils, 36 MCH centers, 12 maternity homes and 39 centers for traditional medicine. The rural health centers provide specialist care in the morning hours in addition to minor emergency services and have indoor facilities that are

Seldom utilized, while the BHUs and dispensaries provide outdoor medication and Preventive care till 2 p.m. The rural facilities are usually ill equipped, under-staffed, and under-utilized. There is a marked urban bias for both the health facilities and hospitals of the public and private sectors, with little linkages between the two.

1.5 The Lady Health Worker's Programme:

A cadre of lady health workers (LHWs) was established at the grassroots level in 1994, in order to ensure that health education, reproductive health, vaccination, control of diarrhea and other communicable diseases, promotion of safe water and sanitation and other dimensions of PHC could be made easily accessible to the local community. The LHWs are middle level educated, preferably married and residing in the catchment areas, which they serve. They are subsequently trained enabling them to provide preventive, promotive and simple curative care. Currently, 17,704 Lady Health Workers (LHWs) and 705 Lady Health Workers' Supervisors working in the field in Sindh, while around 4,000 more LHWs are required in order to cover the entire rural population of the province.

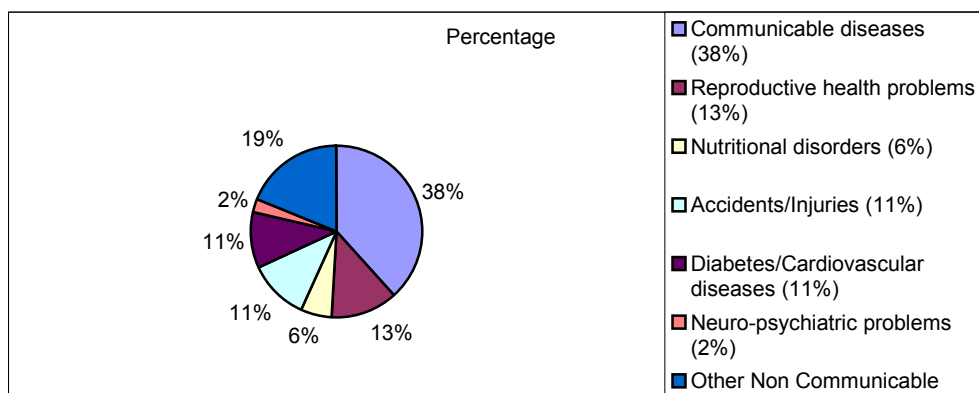
1.6 Low level of financing for the Health Sector

Despite the huge proportions of poverty in the country, the public spending on social sectors remains low all over the country. In Sindh, however, the provincial governments have been making steady increases both in the development and non-development budgets in order to reduce the level of out-of-pocket expenses on Health on the part of the population.

1.7 Major Health Problems of Sindh

The burden of disease in the province can be seen in Figure-1, which shows that communicable and non-communicable diseases together constitute 70% of the problems and pose the worst threat to the population. These problems are briefly described below:

Figure-1: Burden of Disease in Pakistan



Source: Ministry of Health, Government of Pakistan

II. **THE WAY FORWARD:** (Key Areas of the Provincial Health Policy)

(A) **SPECIFIC OBJECTIVES**

Key Area No. 1 CONTROL OF COMMUNICABLE DISEASES

1.1 Tuberculosis

Pakistan has the sixth highest burden of Tuberculosis in the world. Every year more than 60,000 new people develop Tuberculosis in Sindh, while 27,200 of them are smear positive and capable of transmitting the disease to 10-15 otherwise healthy people in a year. The WHO recommended the strategy of Directly Observed Treatment Short Course (TB-DOTS) that is the most efficient, cost-effective and successful method of Tuberculosis control in the world, which has been introduced in all 16 districts of Sindh since November 2003.

Implementation Modalities

- Efforts will be made to strengthen the system and achieve the objects vis-à-vis case detection, success rate and lowering the disease-related mortality and morbidity.
- In the process, linkages will be developed with the private sector, urban DOTS will be introduced in Karachi, the provincial referral laboratory established at Ojha Institute of Chest Diseases Karachi and intermediate laboratories at Institute of Chest Diseases Kotri and TB Hospital Khairpur will be strengthened, enhanced utilization of LHWs in the program and creating social mobilization shall be the main thrust of the program.

1.2 Vaccine-preventable Illnesses and Polio Eradication

Although childhood immunization is the most cost-effective health intervention that we have at our disposal, and is an investment in the future, the routine coverage for the seven deadly diseases included under the National Expanded Programme on Immunization (EPI), including neonatal tetanus, poliomyelitis, diphtheria, whooping cough, tuberculosis, measles and Hepatitis-B remains below par.

Implementation Modalities

- National Immunization days against polio will continue to be observed till WHO certification.
- Routine EPI facilities will be strengthened through GAVI's grant assistance.
- The present modest performance of the EPI will be rectified by strengthening the performance of the district health system and achieving a target of at least 80 per cent nation-wide routine immunization coverage by 2007. The province has reached very close to interrupting wild Poliovirus transmission and every effort will be made to touch zero polio level by the end of this year.

1.3 *Malaria and Leishmaniasis*

Malaria is a disease of poverty that causes thousands of premature yet preventable deaths. It is one of the major public health challenges eroding development by perpetuating poverty and impeding economic growth. Recently Cutaneous Leishmaniasis have been spread in various districts of Sindh mimic the endemic situation.

Implementation Modalities

- In line with the national policy, Sindh has started implementing the WHO-strategy of Roll Back Malaria (RBM) by assigning a high priority to the disease. The RBM strategy reduces mortality and morbidity through improved prevention and treatment and has already been started in 10 districts of the province. All districts of the province will be covered by June 2006, in order to reach the explicit goal of lowering the malaria burden in Sindh by half by the year 2010.
- In the process, communities will be sensitized on personal protection methods, while the health facilities will be strengthened by provision of medicines and training of staff for early detection and treatment.
- Highly selective spraying and operational research will be carried out where necessary.
- The program will also look after the control and treatment of Leishmaniasis patients especially in the endemic districts.

1.4 *Blood Safety and Control of HIV/AIDS*

The Department of Health has recently re-vitalized its Blood Transfusion Authority and the process of registration of Blood Banks both in the private and public sectors has got underway and establishments not working according to the terms laid down in the law are being shut down. As regards, the control of HIV/AIDS, a comprehensive PC-I has been approved by the ECNEC at Federal level, which covers the Sindh province that envisages financial support from the World Bank and technical support from WHO and UNAIDS.

Implementation Modalities

- Program activities include advocacy and social mobilization, establishment of STDs clinics for diagnosing cases and providing health education, capacity-building of staff through training and refresher courses, provision of Blood Bank facilities at each THQH, planning exercise for safety of injection programmes, assistance in provision of anti-retroviral drugs, promotion of safe blood transfusion, peer education program for prisoners and drug sensitivity studies.
- The recent outbreak of HIV/AIDS amongst injectable drug users is a cause for concern warranting the up scaling of control efforts in the province through creation of mass awareness.
- “Safe blood transfusion Act” will be implemented in letter and spirit.

1.5 Hepatitis B and C

The prevalence of Hepatitis B infection in the general population in Sindh is about 3%, while that of Hepatitis C is about 4%, which is higher than the reported world average. No vaccine is currently available to prevent Hepatitis C, thus prevention remains the most effective intervention to combat this virus.

Implementation Modalities

- This can be achieved by reducing the risk of HCV transmission from blood transfusions, unsafe injection practices, intravenous drug use, unsafe use of blades by barbers, use of un-sterilized equipment by dental surgeons, use of tattoo marks and unethical practices on the part of quacks.
- The routine immunization for Hepatitis B will also be increased substantially to eliminate the risk of children contracting the disease with heightened risk of chronic liver damage.

Key Area No.2 CONTROL OF NON-COMMUNICABLE DISEASES (NCD)

2.1 Cardiac diseases, Diabetes, Cancers, Mental Illnesses, Genetic disorders, Snake bite & Dog bite.

An important area of the Health Sector that has been accorded a low priority in the past is the control and prevention of NCDs such as cardiac problems, strokes, cancers, diabetes, mental illnesses and genetic disorders. These diseases are preventable to a great extent through public health interventions, as they are linked to preventable risk factors that include tobacco use, unhealthy diets and low physical activity. The up scaling of the NCDs control can only be realized through a partnership among patients and their families, health care teams and the communities. The preparation of the national action plan for NCDs at the national level has created an enabling environment for this initiative and incorporates two very important interventions that will secure the successful implementation of this programme. Snakebite and Dog bite are also the major public health problems of rural areas.

Implementation Modalities

- The Provincial Government shall initiate health awareness programmes relating to preventive aspects of cardiology, diabetes, mental illnesses, hypertension, hazards of tobacco use and promotion of healthy lifestyle, to adopt preventive measures for snake & dog bites and integrate this into the primary health care system.
- A sufficient quantity of ASV and ARV injections will be ensured to be made available at all District and Taluka Hospitals.
- Emphasis will be given to eliminate /kill the street dogs, which is much easier and cheaper, saving the huge expenditure of curative side.

2.2 Prevention of Blindness (Vision 2020) Programme in Sindh

Close to 400,000 persons in the province are totally blind while several others are partially blind. Sindh has an approved Programme for the Prevention of Blindness Programme reflecting the commitment of the provincial government for the same. The project life is till June 2006. Since 1999, the Programme had been instrumental in training hundreds of LHWs, general practitioners, health care professionals and ophthalmologists. Additionally the Programme had provided equipment in order to provide certain basic equipment to various health facilities in the province after carrying out a situational analysis in various districts. The Programme has also carried out more than a hundred eye camps and trained Ophthalmology Operation Theatre Technicians and optometrists in collaboration with the Allama Iqbal Open University. Since 1997 the Programme had carried out more than 10,000 cataract operations. WHO is facilitating effective partnerships with other governmental and non-governmental organizations under the umbrella of the provincial Programme.

Implementation Modalities

- The matter requires effective decentralization in order to give the provincial and district level a free hand in planning, monitoring and implementing their activities.
- The use of lady health workers in the Programme will also be made in the Programme, while NGOs will be urged to carry out their activities in liaison with government agencies. The training of community ophthalmologists and ophthalmic technicians shall be trained in greater numbers enabling them to take on the problems of the community.

Key area No. 3 TO IMPROVE MATERNAL AND CHILD HEALTH

In Sindh, the total fertility rate is estimated to well exceed four, a high percentage of pregnant and lactating mothers are anemic and more than 80% of pregnant women give birth at home with limited access to community midwives or skilled birth attendants. The maternal mortality rate of 300 per 100,000 live births constitutes a major cause of death among women of childbearing age. Women affected by diseases such as Tuberculosis, Malaria and Hepatitis give birth to under weight and premature babies whose chances of survival are quite diminished. Likewise, poor nutrition of girls and women increases their chances of developing life-threatening complications at the time of pregnancy or during the time of an obstetric emergency. Women's education is also correlated with positive maternal health outcomes, while conversely illiteracy among women contributes to maternal mortality.

Implementation Modalities

- It is imperative to take affirmative action in this regard enabling us to effectively pursue the health related Millennium Development Goals, which focus specifically on significantly reducing maternal and child mortality. This can only be achieved by implementing a strong MCH package through a provincial cadre of **community**

midwives along the lines of LHWs, in order to make deliveries safer and pre-empt any complications.

- Awareness programmes will be instituted on a wide scale to promote exclusive breast-feeding for six months followed by weaning, detecting child abnormalities at an early stage.

Key Area No. 4 COUNTERING MALNUTRITION

In Pakistan, moderate to severe malnourishment occurs in a significant proportion of children and about 25% babies are born with low birth weight due to maternal predispositions. A National Nutrition Survey conducted over the past two years to probe the nutritional status of women and children has shown that almost 38% of children between the ages of six months and five years are underweight, leading to stunting in 37% of the children. These malnutrition levels both with regard to proteins and micronutrients are very higher warranting urgent consideration. These findings highlight the need for more effective and coordinated action amongst all stakeholders including governments, non-governmental organizations and communities so that the problem can be addressed along scientific lines.

Implementation Modalities

- Nutrition counseling, food safety, food security, food fortification and eliminating micronutrient deficiency relating to Vitamin A, Iron and Iodine will be the main strategies to be employed through a well coordinated effort at the provincial and district levels.
- All districts will be covered under World Food Program.
- Print and electronic media authorities will be asked to air programs dedicated to Health and Nutrition mass awareness.

Key Area No. 5 TO ENSURE ROAD SAFETY

The issue of road safety is very grave both in the national and provincial contexts and concerted efforts are required to reduce the number of preventable deaths and disabilities in the country. Jacobs et al, 2000 have revealed that 3 deaths per 100,000 population occur in Pakistan annually while data collected from the Bureau of Statistics, the National Highway Authority and Law Enforcing Agencies has shown that the figure varies from 4 to 5 per 100,000 population in different provinces of the country. The trend since the year 2000 reveals some improvement in the situation till 2003, however, there is yet a great scope for lessening the preventable mortality and injuries on this score. Enforcement of road safety rules, such as speed limits, rules against driving under the influence of alcohol and other drugs, driver and vehicle licensing renewal, and involving law enforcement agencies in the development of road safety policies is assuming greater significance in Pakistan.

Implementation Modalities

- The Department of Health will collaborate with the Home Department, Police department and other agencies in a serious effort to ensure the restricted issuance of driving licenses to reduce the risks to human life. Furthermore, a Trauma Center will be established in the mega city of Karachi to handle mass casualties and disasters.

Key Area No. 6. DEVELOPMENT OF THE DISTRICT HEALTH SYSTEM

In Sindh, governmental policy has led to devolution of power at the district level; a critical tier of the administration as in other provinces and this move is expected to lead to equity in the developmental processes. The process has, however, also posed certain formidable challenges for the district health system that are discussed below, which highlight the need for restructuring the finer modalities of the devolved system:

6.1 Need for Capacity Building and to remove Professional & Managerial deficiencies in District Health System.

In the field of Human Resource Development for Health, substantial technical assistance needs to be extended to undergraduate Programmes in medical, nursing and paramedical institutions in curriculum development, teacher training and institution building. Furthermore, in the context of devolution the training of district health teams assumes great significance as they are now entrusted with responsibilities they were not previously familiar with such as planning, budgeting and epidemiological studies. The main deficiency identified is that EDO's are generally lacking in essential public health qualification and management skills. Moreover a large number of posts of male and female doctors and paramedics are lying vacant at primary and secondary health facilities, as well as specialist's positions in District and Taluka hospitals. The tertiary care hospitals are managed in adhoc manner.

HUMAN RESOURCE FOR HEALTH	
Doctors:	96,248 (1,506 persons / Doctor)
Dentist:	4,622 (31,371 persons / Dentist)
Nurses:	40,019 (3,623 persons / Nurse)
LHVs:	5,669
Lady Health Workers:	70,000

Implementation Modalities

- A Public Health Academy will be established for postgraduate training of Health managers.

- The EDO's will be posted on merit-based criteria, with a Master in Public Health or equivalent minimum qualification. District Health Managers will undergo compulsory in-service training at health academy.
- It is necessary to have a qualified epidemiologist in every district.
- Effective linkages will be developed between the Human Resource Development Unit of the Department of Health, the Provincial (PHDC) and District Health Development Centers (DHDC) and Medical Universities with a view to train District managers (EDO's & others) in public health disciplines. The first training of this nature has been carried out with the support of WHO and College of Physicians and Surgeons of Pakistan.
- A group of doctors having postgraduate qualification in Public Health (MPH), from amongst the general cadre, will be taken up in a managerial pool and will be posted on managerial and administrative posts in order to improve the working of District health system.
- A sufficient number of doctors will be taken up from amongst the general cadre, to be properly trained in the relevant disciplines of public health and assigned managerial responsibilities.
- Medical officers and health workers at district and Taluka hospitals will be given hands-on-training in Anesthesia and Gynecology/Obstetrics to address the acute shortage of trained staff in these priority areas.
- Efforts will be made for the provision of Dialysis facilities at DHQ hospitals.

6.2 Incentive Packages for Rural Health Services

In order to cater to the needs of people living in remote and underserved areas, it would be appropriate to design a Basic incentive Package of Rural Health Services in order to include the services that would be most cost-effective, have the greatest impact and could bridge the disparity between the rural and urban populations. The delivery of such a package of services will ensure standardization of basic services in health facilities and promote health services by providing equitable access, especially in underserved areas.

Implementation Modalities

- A comprehensive list of services needs to be designed for each level of health facilities including District Headquarter Hospitals, other secondary level hospitals, Taluka Hospitals, Rural Health Centres, Basic Health Units and Dispensaries. The designing of such a package will also help in addressing other significant challenges facing the district health systems such as inadequate supportive supervision and monitoring, staff absenteeism, reluctance in building partnerships with the private sector, a weak referral system, inadequate inter-sectoral collaboration and community involvement.
- The incentive package already approved by the Provincial Cabinet and notified by Health Department vide No: SO (B) MISC-10/2002 dated 21st September, 2002, in respect of specialists and other health professionals and care providers working in the rural settings will be implemented in letter and spirit.
- Efforts will be made for introduction of incentive package for doctors & paramedics and NPA will also be enhanced according to BPS ranging from 1000 to 4000.

- A package to improve the working and living conditions of doctors, nurses and paramedics in rural areas will be developed. In this regard, a proposal embracing rural area allowance, Non-practicing allowance, anaesthesia allowance and nursing allowance will be submitted to Federal Government for approval.
- District Health Management Boards with representation from all walks of life can effectively monitor the implementation of this package
- The service structure of Specialist Cadre doctors will be prepared and implemented.
- The service structure of Paramedical staff will be prepared and implemented.
- Well-equipped Laboratories will be established at all DHQ hospitals.
- As an incentive, preference will be given to those Medical officers to enter into post graduation who have completed 2 years rural services.

6.3 Implementation of the Basic Development Needs concept

Ever since the report of the Health Survey and Development Committee headed by Sir Joseph Bhore was published in 1946, which advocated community participation, this aspect has been highlighted in all subsequent health policies after the creation of Pakistan. Although community-based initiatives serve as an entry point for addressing all determinants of health and reducing poverty, it is unfortunate that no significant headway has been made in this regard. Apart from involving communities, it is important to employ a multi-sectoral concept designed to capture the broad-based support for health and social welfare systems by integrating collaboration between grass-root communities, civil society organizations, district authorities and public sector line departments. The initiative is aimed at empowering communities in distant or deprived areas to identify their own development needs and work together towards their realization. The Basic Development Needs (BDN) approach has been adopted to address all the determinants of health collectively through community empowerment in order to transform social lifestyles and enhance human development in Taluka Sehwan in district Dadu, which merits closer consideration and further replication in other districts.

6.4 Strengthening Health Management Information System

The Health Management Information System (HMIS) has been in place all over the province since 1994. The system has a number of strengths being a well-organized information system and source of collection of data from first level care facilities. It is fundamental tool for planning and management in the health sector, and is supposed to facilitate decision making at various managerial level of health care delivery system. The system is standardized all over the country and the relevant staff has been trained in collection of data on the various HMIS instruments, while the managers have been trained to strategically utilize the data and analyze the scenario leading to decision making. HMIS is totally computerized and includes a Diseases Early Warning System (DEWS). Some constraints of the system include huge resources required for printing its instruments putting its sustainability in doubt, an old DOS-based system of computerization, information is restricted to diseases alone, reporting is delayed and usually full of errors. The system of

feedback from the federal level to provinces, provinces to districts, districts to facilities and vice versa is also lacking.

Implementation Modalities

- The instruments were developed 10-12 years ago and need updating while its users require ongoing training.
- Efforts will be made to obviate the reporting delays and errors and include all hospitals including teaching hospitals in HMIS with a view to make it a reliable tool for decision making as it was originally meant to be.

Key Area No.7 REGULATION OF PRIVATE HEALTH SECTOR

Regulation of the private Health sector is of critical importance in order to lie down and implement certain standards of quality assurance of equipments & services in private hospitals, Laboratories & clinics as well as Tibb/Homeopathic institutions, to make the treatment as affordable and cost effective and to control the diagnostic & services charges. Quality assurance would ensure an improvement in the services without entailing any additional cost. Legislation in this regard has already been enacted and sent to the Law Department for vetting, which is expected to be approved soon by Sindh Assembly & Cabinet..

Key Area No.8. REFORMING MEDICAL EDUCATION

Pakistan has been making efforts over the last two decades to bring the curriculum of its 57-year old system of medical education more in line with the requirements of our medical system and the community needs. The envisaged reforms in the field of Medical Education are based on a vision fostering sustainable integration of medicine and public health, and making the different actors of the health system more aware of the need to adhere to the values of quality, equity, relevance and cost effectiveness in medical education and at the service delivery level. In the traditional model, basic and clinical sciences are studied separately; students are exposed to patients after several years and the pattern of education primarily revolves around disciplines, teachers, lectures and hospitals. Conversely, in the system of problem-based learning or Community Oriented Medical Education (COME) Programme, basic sciences are taught throughout the study parallel with clinical subjects, related disciplines are often taught concurrently and teaching is student-directed, problem-based and community-oriented. The COME methodology proposed by the World Health Organization has been implemented by the Government of Pakistan, embodying a dynamic system, which exposes medical students to the national health problems, with an emphasis on acquiring skills and relevant theory in an integrated manner with a problem-based learning methodology conceptualized in Pakistan. Initially the project is being initiated in the Dow University of Health Sciences at Karachi and later will be applied to other medical institutions in the province as well. COME is a highly cost-effective Programme

given the fact that billions of rupees are invested in medical education in both the public and private health sectors. However, if the proper attention is not paid to the main health problems of the people through training our undergraduates properly, then the costs entailed by the families of the patients would be enormous both in economic and human terms.

Implementation Modalities

- Efforts will also be initiated to gradually lower the number of medical seats in the province with a concomitant increase in the quality of education imparted and streamlining the process of continuing medical education (CME) in order to ensure that medical graduates keep themselves abreast of the latest developments in all disciplines of medicine and public health.
- Every Medical College will be required to adopt one District/ Taluka hospital or PHC health facility in addition to the teaching hospital, affiliated to it. This will entail mandatory visits on rotation basis by faculty members and medical students to spend more time in rural settings while helping to provide specialist services to the ailing population.
- The compulsory rural service bond strategy will be introduced for new medical graduates, selected to fill up vacancies in rural areas.

Key Area No.9. REFORMING MEDICO-LEGAL AND ALLIED SERVICES

Difficulties are usually created, as general duty medical officers have to deal with medico-legal as well as routine cases at the same time. Furthermore, they are not properly trained in medico-legal work, neither well versed with the introduced Qisas & Diyat laws nor a separate cadre of medico-legal officers is there. Moreover, the flaws in such ordinance also need to be rectified. The difficulties are also experienced in analysis of preserved samples and specialized tests.

Implementation Modalities

- The existing instructions/ rules for Medico legal officers and others regarding MLC and Medical Boards will be implemented in letter and spirit.
- Legislation will be enacted to revamp this service and cause minimum hardships to the population.
- The minor ML centers will be made functional and active.
- SNE/PC-1 will be prepared & get approved, for creation of separate cadre of medico-legal officers, backed up with sufficient funding for creating infrastructure at Directorate, District, Taluka & RHC level with provision of incentives. The Directorate of Medico legal Services will be created under the administrative control of Secretariat for this purpose.

- The Medico legal Officers will be recruited on contract basis and after a training of six months will be posted at DHQ, Taluka hospitals and Rural Health Centers to deal Medico legal cases, sparing Medical officers from such duty.
- Forensic Science Laboratories will be established at Police Surgeon offices at Karachi, Hyderabad, Nawabshah, Larkana and Sukkur.
- Utilization of Pathology and Forensic Medicine departments at Medical Colleges as Forensic Science laboratories.
- Standardized mortuaries will be established at all ML centers equipped with digital cameras, portable X-ray and paraphernalia.

Key Area No.10. TRAINING OF NURSES AND OTHER PARAMEDICS

Nursing staff and other paramedics play an important role in effective delivery of health services. At present Health Department is facing shortage of trained nurses and other paramedical staff especially OT, anesthesia, dialyses, blood transfusion etc etc. Similarly, the training facilities at paramedical schools and at all hospitals are not up to mark and standard. Sindh Medical Faculty, the examining body for paramedical courses has been remained highly ignored institution since long and running on adhoc basis. Moreover,. Luckily, the procedure & criteria of admission, rules & regulations/ policy for enrolment & examinations have been designed in September 2003, to make the training and examination process transparent.

Implementation Modalities

- Care will be taken to improve the quality of training of nurses, midwives and lady health visitors and the opportunities for carrying out training in these disciplines will be augmented.
- A career structure will be developed for nurses and all cadres of paramedical staff in order to retain their motivation.
- As already mentioned, a cadre of community midwives will be established all over the province enabling safe home or facility-based deliveries.
- Nursing & Midwifery schools will be established at all DHQ hospitals.
- The Sindh Medical Faculty, which is the body primarily responsible for the training of paramedical staff, will be re-organized. It's personal staff including Registrar & controller of examination, will be recruited. Sindh Medical faculty is in dire need of strengthening in terms of curriculum design and to implement the already designed rules & regulations for admission, enrolment and examination, enabling it to perform better in its capacity of an examining body.
- The Para-medical and health technician institutions shall be strengthened in terms of training facilities enabling better output.

Key area No.11. EMERGENCY PREPAREDNESS AND RESPONSE TO EPIDEMICS

The master plan for emergency & mass disaster is also a hallmark that needs to be revoked in letter & spirit, to cop up any emergency or disaster. Effective referral system, having data of Surgeons, Orthopedicians and other related trained staff, Comprehensive ambulance system can made this possible. Training of managers and other relevant personnel has already been carried out in emergency preparedness and response.

Implementation Modalities

- Future activities will include development of a model district for EHA, technical assistance for survey and training of district staff, activation of district mobile medical and surgical units for emergency response and up gradation of THQ Hospitals through provision of Blood Bank, OT, Surgery, anesthesia and immunization facilities.
- A public sector ambulance service system will be evolved throughout the province.
- A referral System between the village level and the health facilities up to district and tertiary care hospital level will be established.
- The SOP for emergency Preparedness will be made available.
- Crises Management Boards/ Task force, comprised of Health, police, NGO's, philanthropists, specialists and Blood banks etc, will be established at provincial and a district level.
- A permanent emergency fund/budget will be get allocated, to be operated by Secretary Health, Secretary Finance & Secretary GA, to deal any emergency or disaster.

Key Area No.12. SCHOOL HEALTH SERVICES

The Department of Health in collaboration with the Education Department will attempt to develop 'healthy schools' in conformity with the recommendations of WHO that include effective health and environment education, policies and practices that promote and protect health, effective parental and teacher involvement, child participation in school management, good opportunities for physical education, recreation and sport; and school medical service that emphasizes prevention. The schools should strive to improve the health of school personnel, families and community members as well as students, engage health and education officials, teachers, students, parents and community leaders in efforts to make the school a health place. Schools also strive to provide a healthy environment and implement policies that respect an individual's esteem, provide opportunities for success and acknowledge good efforts and personal achievements.

Implementation Modalities

- More specifically the school health services need to carry out early detection of physical and mental defects through periodic examinations, maintaining health cards of individual students, minimize the chances for the spread of communicable diseases, protect children from hazards liable to cause injury, disease or disability, provide services aimed to provide a healthy environment to a child and promote

- healthy lifestyle, provide health education and periodical immunization and advise children on sanitation, personal hygiene, nutrition and environmental hazards, management of emergencies and referral of school children to hospitals.
- The services of medical officers of the School Health Services posted in Karachi will be compulsory on rotation basis and effectively utilized while those working in the general health services in the interior of Sindh will also compulsory and be motivated to carry out services related to school health to bridge this major gap.
 - Education Department will be approached to provide a separate room for Doctors at all public and private schools to enable the doctor to identify eye, ENT, dental, immunization problems.

Key Area No.13 NEED FOR DEVELOPMENT OF CAREER STRUCTURE FOR HEALTH PROFESSIONALS

There is a strong need for development of a sound career structure for health professionals to improve efficiency, discourage migration of scarce commodity of health professionals to other countries and above all to meet the health challenges to achieve the United Nation's Millennium Development Goals (MDGs). The MDGs commit the international community to an expanded vision of development, on that vigorously promotes human development as the key to sustaining social and economic progress in all countries.

Major groups of health professionals awaiting for career structure are: -

- Doctors of General/Specialist Cadre.
- Public Health Researchers.
- Dentists
- Nurses and Paramedics
- Medical Laboratory Technologists and Technicians
- Pharmacists
- Physiotherapists and Occupational therapists

Key Area No.14 ENSURING TRANSPARENCY IN PROCURMENT

The Sindh purchase Manual has certain flaws regarding tender and purchase of medicines, which need to be rectified.

Implementation Modalities

- All out efforts will be taken to ensure that the population is provided with drugs of proven efficacy and manufacturers of spurious drugs are taken to task through transparent implementation of the existing laws.
- Efforts will be made for amendment in financial powers of DDO's.
- S&GACD and Industries Department will be approached for amendment in Sindh Purchase Manual.
- Rational and Standardization of purchase of medicines will be ensured.

- Monitoring of tender, rate contract & purchase of medicines will be made by Health Department to ensure the quality & quantity of purchased medicines.

Key Area No. 15 REVIVING DEVOLUTION PLAN AND REMOVING PROFESSIONAL AND ADMINISTRATIVE DEFICIENCIES

Under the existing devolution plan of Health Department, various difficulties and constraints have been experienced in proper discharge of quality services due to improper infra structure and inequity of Health and CDG/District Government/Local Government. Certain posts from BPS-17 to BPS-20 are required to be readjusted for proper functioning of the Health System. Budgetary inadequacies are also experienced which need to be removed.

Provincial Drug Inspectors are recruited under Drug Act, at provincial level but as per devolution Plan they are under the administrative control of CDG/ Local Government, causing restriction to perform duties at cantonment areas. Moreover, the “Drug Act 1976” and “Sindh Drug Rules 1979” also have certain flaws/pitfalls hindering the discharge of proper and effective services. The infrastructure and facilities at Provincial Drug Testing laboratory are not up to mark, which need to be improved.

Implementation Modalities

- The existing devolution plan of Health Department will be reviewed and necessary creative steps will be taken to strengthen the Health System and to remove the bottlenecks.
- The readjustment of posts from BPS-17 to BPS-20 shall be made at Provincial & District level for better and effective administrative health services.
- The two separate cadres of pharmacists and drug inspectors will work closely in liaison with each other in order to eradicate the possibility of malpractices.
- To improve the Drug Control Administration viz Provincial Quality Control Board and Drug Inspectorate.
- Up gradation and to improve the functioning of Provincial Drug Testing Laboratory Karachi.
- Establishment of Regional Drug Testing Laboratories at Hyderabad, Nawabshah, Sukkur and Larkana.
- Federal Ministry of Health will be approached for necessary amendments in Drug Act 1976.
- Necessary amendments as required shall be made in “Sindh Drug Rules 1979” to remove certain flaws.
- To revive the issue of administrative control of drug inspectors.
- Quality control of drugs will be ensured.

Key Area No. 16 ENVIRONMENTAL HEALTH

The basic causes for environmental problems in Pakistan are numerous and complex. However they can be summed up to include our past tendency to emphasize

quantitative growth and expense of quality, the failure of our economy provide full accounting for the social costs of environmental pollution, the failure to take environmental factors in to account as a normal integral party of our planning and decision making is dependent on expediencies. Without regard to there impact on the environment and more fundamentally the inadequacy and failure of our institutions to perceive the environment in its totality and understand or recognize the fundamental interdependence of man, resources, environment and development. Pakistan generates 47,920 metric tones of slid waste per day, i.e. 17.5 million metric tones per year.

Implementation Modalities

- Efforts will be made for coordination among different Departments related with environmental protection.
- The hospital waste management system will be improved.

Key Area No. 17 DRUG ABUSE CONTROL

Drug abuse has become a universally growing issue of concern for public health researchers and policy makers. Apart from health, social and economic consequences are also a threat to peace, stability and tranquility of humanity. The issue now requiring both health measures and efforts to control trafficking/smuggling and manufacturing of illicit drugs.

Over the last almost two decades drug abuse has become a steady growing issue of concern in Pakistan like other countries not only due to its large scale implication on health but also about the social and economic well being drug addiction problem at micro level causes suffering for the individuals, his family and immediate social circle but at mass level, especially large scale use and trafficking of illicit drugs. It cause enormous lose to society in terms of wasted manpower and productivity and it threatens to district or destabilize the social and economic macro structure of the entire national as a whole.

The National survey on Drug Abuse in 1993 identified that there were 3.01 million drug abusers in Pakistan raising at a rate of 7% annually. Almost 1.5 million of the total drug abusers are addicted to heroin.

Those on Cannabis (Hashish, Chars) are 0.9 million while opium is the preferred drug of 170,000 persons. A large majority of the drug abuser (97.2%) are male, just over half of them married. Nearly 72% of the abusers are under 35 year, the most reproductive age with the highest proportion in age group 26 – 30 years. Nearly 60% of the total abusers are able to read while similar percentage in employed the highest rate of drug abusers is amongst skilled and unskilled labour followed by sale persons, students and agriculture workers. The average monthly expenditure per drug abuser is reckoned at Rs. 1,259.00.

This situation is very alarming and needs long-term policymaking and planning in terms of drug supply control, drug demand reduction, detoxification, rehabilitation and social integration programs.

Implementation Modalities.

- To minimize the drugs addiction below the level of “Public Health Problem”.
- To establish and strengthen exclusive detoxification and rehabilitation facilities.
- To undertake quantitative and qualitative research for planning and implementation process on sound database.
- To reduce drug demand by social mobilization and advocacy program.

- To develop human resources for undertaking preventive and rehabilitative activities/program.
- Integration and coordination of preventive, detoxification and rehabilitative activities within the Ministry of Health and with sector concerned with drug abuse control.
- To establish appropriate diagnostic facilities.
- To initiate community based preventive and rehabilitative activities.
- To draft/amend appropriate legislation for effective drug abuse control.

Key Area No.18. HEALTH LEGISLATION

The existing health legislation on promotion of breastfeeding, mental health issues, protection of non-smokers and transfusion of safe blood will be effectively implemented while fresh legislation will be enacted to curb quackery, Aamils, Tabib, Saniasi baba, Peer Faqeer, Spiritual and sex healer, with the support of professional bodies like Pakistan Medical Association, regulation of the private health sector, Legislation and reforming the medico-legal department and ensuring ethical practices in organ transplantation. The legislation to control advertisement of un-authorized, un-registered, spurious and sex stimulating drugs will also be enacted. Legislation to control drug abuse.

Key Area No.19. REVIVING SINDH HEALTH FOUNDATION

The Sindh Health Foundation was created during the nineties with very good objectives; however, the institution has been dormant since nearly a decade. The Department of Health is committed to revitalize the institution so that its objectives can be met. The Sindh Health Foundation can be particularly useful in making around 250 newly constructed health facilities functional, which have not been provided with funds for operationalization. It can also support junior doctors both in the public and private health sectors in setting up clinics in under-served areas to benefit the local population.

Implementation Modalities

- Sindh Health Foundation will be re-organized and be made functional.
- A summary to Chief Minister Sindh will be floated for delegation of powers to Minister or Secretary Health, for its speedy functioning.

Key Area No.20 REGULARIZATION OF TEACHING HOSPITALS

The present performance of teaching hospitals is not 100% satisfactory producing distrust of public. In order to improve the working of the teaching hospitals, the Department of Health will regularize their functioning.

Implementation Modalities

- Hospital Management Boards comprising of notables from all walks of life will govern their certain services.

- The process of public-private partnerships that has already been initiated will be up-scaled. This move is expected to ease the burden on the public exchequer and make more resources available for primary health care services.
- The ambulance services will be improved.
- More Specialized units will be established.
- Provision of waiting and shade services to attendants.
- Establishment of Private Wards at all teaching hospitals.

Key Area No.21 FINANCING OF THE HEALTH SECTOR

User charges will be applied where necessary in the teaching hospitals for sophisticated investigations. Care will, however, be taken to ensure that the imposition of these charges do not in any way hinder the access of poor patients to general health services, with sufficient provisions for destitute and marginalized segments of the population. The amount so generated will be reverted back to the Health Sector. Furthermore, the issue of imposing mandatory health insurance will be explored in an effort to identify alternate sources of health sector financing without posing an additional burden on the masses.

Key Area No. 22 CAPACITY BUILDING FOR HEALTH POLICY

A policy Analysis and research Unit will be established under Additional Secretary (Technical), to monitor the progress of Health Policy implementation in the Key areas.

An Implementation task force is constituted to ensure the implementation of Health Policy and to furnish further recommendations and strategies according to provincial needs, comprised of;

1. Dr. Shafquat Hussain Abbasi	Additional Secretary (Tech)
2. Dr. Shireen Narejo	Deputy Secretary (Admn-I)
3. Dr. Hafeez Memon	Deputy Secretary (Proc)
4. Dr. M. Umer Abro	Deputy Director (P&D)
5. DGHSS, Hyderabad	DGHSS Office, Hyderabad
6. Director (Public Health) DGHSS office	DGHSS office Hyderabad
7. Dr. Akber Memon	PHDC Hyderabad
8. Dr. M. Jamil Mughal	Section Officer (Tech-I)

(B) GENERAL OBJECTIVES

- All vacancies of WMO's, Nurses, LHV's will be filled on priority basis.
- To review the performance of all the institutions, offices, personal and service delivery outlets and steps for improvement.

- To review the existing development programs and projects and ensure removal of bottlenecks, if any and their speedy completion.
- To establish Thalassemia centers at Karachi, Hyderabad and Sukkur.
- The vacant posts of BPS 01 to 09 will be filled immediately.
- The promotion cases of BPS 17 to 20 will be expedited.
- Award and rewards to good workers and punishment to delinquent, especially to absentees.
- Exercise vigilance over allotted, in use and misuse of vehicles and ambulances.

CONCLUSION

Sindh has to redefine its priorities in order to take on the unfinished agenda of the Health Sector by averting the dual epidemic of communicable and non-communicable diseases, augmenting mother and child health facilities, improving the routine immunization coverage, making advances in vaccines development, reversing the growing trend of smoking, adopting a holistic approach to combat poverty and develop protocols for meeting mass emergencies. The province also needs to revisit its financing patterns in order to achieve the objectives set out in the Poverty Reduction Strategy of Pakistan and the Millennium Development Goals. Inter-sectoral and intra-sectoral collaboration, and community participation are essential pre-requisites for this process paving the way for Health Sector Reform in the province of Sindh.

PRAY

*MAY ALMIGHTY ALLAH FULLFILL OUR AIMS, OBJECTIVES AND GOALS TO
SUPPORT AND HELP AILING PEOPLE REGARDING THEIR RIGHTS FOR
HEALTH, LEADING OUR PATH TO HOLY HEAVEN.*

(AAMEEN SUMMA AAMEEN)

THE END