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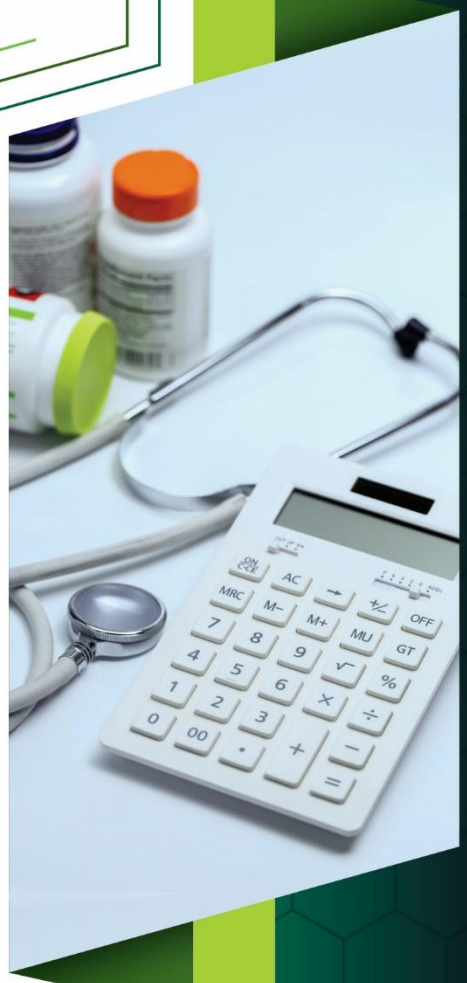

UNIVERSAL HEALTH COVERAGE

Ministry of National Health Services, Regulations and Coordination

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GOOD HEALTH
AND WELL-BEIG

UNIVERSAL HEALTH COVERAGE

MONITORING REPORT 2024

PAKISTAN

DECEMBER 2024

Ministry of National Health Services,
Regulations & Coordination

MONITORING REPORT 2024

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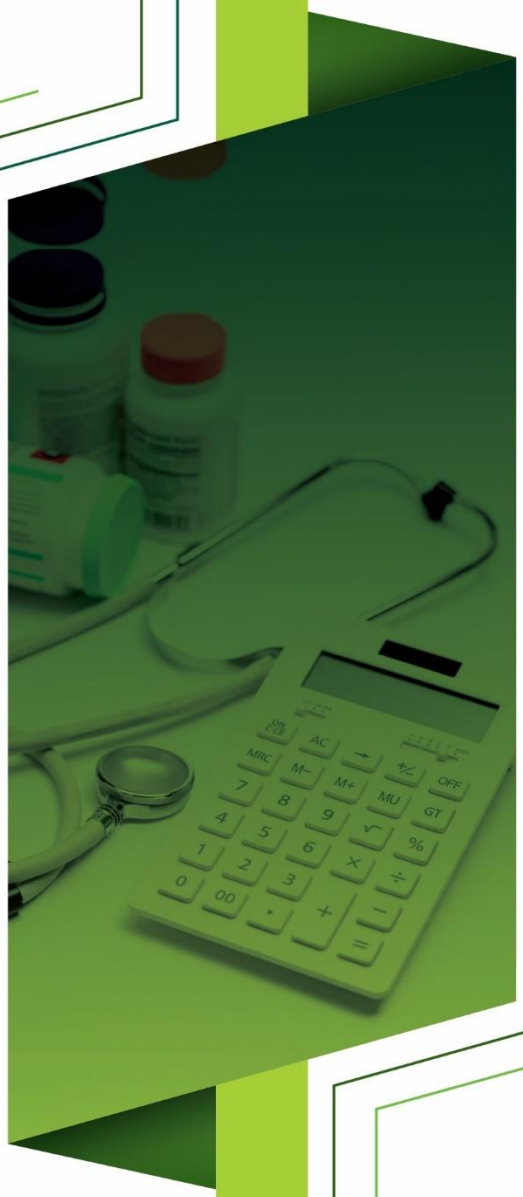

@ December 2024

PAKISTAN:
Universal Health Coverage Monitoring Report - 2024

Produced by:
Health Planning, System Strengthening and Information Analysis Unit (HPSIU)/
Evidence for Health (E4H) Programme,
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MESSAGE

From Honourable Coordinator to PM on Health

“Universal Health Coverage (UHC) is essential for inclusive and sustainable development. Pakistan’s commitment to UHC is reflected in the National Health Vision 2016-25 and the upcoming National Health and Population Policy 2025-34.

The government recognizes health as a shared responsibility and is dedicated to building an accessible, equitable, and resilient healthcare system. The new policy integrates health and population priorities, addressing service quality and population growth challenges.

Through collaboration and determination, we are committed to advancing UHC, ensuring "Health for All" becomes a reality for a healthier and more prosperous Pakistan.”

Dr Malik Mukhtar Ahmed
Coordinator to Prime Minister on Health

FOREWORD

From Secretary Health

"The UHC Monitoring Report for Pakistan is a significant milestone in our pursuit of equitable healthcare for all. It captures progress under the National Health Vision 2016-25, highlight gaps, and emphasises the importance of monitoring to strengthen health policies and strategies.

In the face of challenges like COVID-19 and natural disasters, the report showcases the resilience of our health systems and the collective dedication of the government, healthcare workforce, and partners to advancing UHC.

More than a progress review, this report provides a roadmap for action. A call for stakeholders to use its findings to drive our shared goal of universal, quality healthcare for every Pakistani."

Mr Nadeem Mahbub
Secretary Health

ACKNOWLEDGEMENTS

Universal Health Coverage monitoring provides a comprehensive evaluation of the health sector across national, provincial, and district levels, reaffirming our commitment to health sector development and the critical role of continuous monitoring.

I extend my gratitude to Dr Malik Mukhtar Ahmed Bharath, Coordinator to the Prime Minister on Health, Provincial Health Ministers, Health Secretaries, Directors General Health Services, Technical wing of Mo NHSR&C, Health Planning, System Strengthening & Information Analysis Unit, Provincial and Federating areas UHC focal points and colleagues from the Health Departments for their invaluable leadership and contributions to the UHC monitoring process.

Special thanks to the UK's Foreign, Commonwealth & Development Office (FCDO)/ British High Commission in Pakistan for their support through the Evidence for Health (E4H) Programme.

I also deeply appreciate the efforts of WHO, UN agencies, bilateral and multilateral organizations, Global Health Initiatives, Foundations, the private sector, and academic institutions in advancing UHC reforms.

Dr Shabana Saleem
Director General (Health & Population)

UNIVERSAL HEALTH COVERAGE

MONITORING REPORT

2024

PAKISTAN

EXECUTIVE SUMMARY

Health is a long-term investment in human capital needed to fully realise human potential by contributing to the protection and empowerment of all people. The 2030 Sustainable Development Goals (SDGs) emphasise having all people receive the quality health services they need without financial hardship. Critical to attaining universal health coverage (UHC) is a formal monitoring mechanism to assess progress. This report highlights the status of health services coverage and financial protection in the country. It also highlights primary health care as the best approach to achieve universal health coverage in Pakistan.

The 2024 UHC Monitoring Report directly aligns with a key aspect of the SDGs, focusing on fostering accountability by urging the health sector stakeholders and institutions to regularly report on the progress of UHC. The data presented in the subsequent pages primarily originates from national and provincial surveys, as well as administrative data from regulatory bodies, entities and programmes. Additionally, the report provides a UHC Service Coverage Index (SCI) at the district level, despite facing challenges related to substantial data gaps and quality issues.

The success in achieving the SDGs hinges on the active involvement and ownership of national and provincial/ federating areas. The process of monitoring through this report takes account of national and potentially subnational priorities. Its objective is to contribute to regional and global SDG monitoring frameworks. The intention is that, through the development of metrics and reporting, this report will motivate provinces/ federating areas and districts to customize them according to their local circumstances. As demonstrated by the data in this report, the journey is riddled with challenges, not only in attaining the targets but also in measuring progress toward them. While the path to UHC may be lengthy, the commitment to achieving and measuring it is already in progress.

Primary health care (PHC) provides the programmatic engine for UHC in most contexts if not all. It reflects the right priorities and is a critical milestone along with the road to achieving UHC targets. Emphasising community empowerment and social accountability, it is multisectoral with links to education, nutrition, and water and sanitation. It provides a platform for integrating previously separate services for communicable diseases with those for women and children's health and noncommunicable diseases, for addressing both the demographic and epidemiological challenges facing most countries, and for innovations such as digital health. It remains the most cost-effective way to address comprehensive health needs close to people's homes and communities.

UHC is the main outcome of health-related SDGs and is measured with two targets, one for coverage of essential service delivery (3.8.1) and other for financial protection (3.8.2).

The analysis reveals that around half of the Population in the country has access to essential health services/ UHC and we are far behind reaching the global UHC SCI target of 80+ by 2030. Though there is considerable improvement in the UHC service coverage index from 40 in 2015 to 53.9 in 2023, the real challenge still lies ahead. With expected enhanced investment for provision of essential health services at community and PHC level, there would be a need to ensure efficiency and effectiveness, while building the capacity of districts and private sector to deliver these essential services. There is also a need to address serious equity issues as Balochistan and Gilgit-Baltistan have a lower score in comparison to the other provinces/ federating areas.

Furthermore, the indicator to monitor catastrophic health expenditure is also critical and has shown a worsening trend during 2013 and 2021. As the government is currently scaling up Sehat Sahulat Programme, the results in the future should indicate the effectiveness of this investment. In 2021, 5.4 percent of the households in Pakistan spent more than 10 percent of their household budget on health care. Also, low government investment in health including out of pocket

(OOP) payments constitute a large share of total health expenditure in Pakistan i.e. 46.8 percent, significantly higher than the recommended level of <15 percent. These payments deter some people from using essential health services and push them into poverty.

Although the burden of disease has declined from 70,086 DALYs lost per 100,000 population in 1990 to 42,399 DALYs lost per 100,000 population in 2021, with improved performance in maternal and child health sectors, the report also highlights the forthcoming challenge of tackling non-communicable diseases and mental health issues.

More than half of the burden of disease in Pakistan could be tackled through inter-sectoral policies and interventions. However, that would require a very strong commitment from health and other sectors to work in a unified manner.

In an ideal scenario, monitoring UHC at the district level should make optimal use of existing health management information system data. However, significant quality challenges and data incompleteness within the information system pose obstacles. Moreover, information from the private sector is unavailable. To address these limitations, any additional data collection efforts at the district level for UHC monitoring should prioritize processes and employ cost-effective techniques. This approach aims to enhance the reliability and comprehensiveness of the data, even in the face of existing challenges within the health management information system.

To earnestly achieve the target of UHC by 2030, the health sector must adopt a more ambitious stance. There is an urgent need for a heightened commitment to collaborating with provinces, federating areas, and districts to enhance access to essential health services, prevent individuals from descending into poverty due to health expenses, and move closer to the target of UHC by 2030. While the journey may be challenging, it remains within the realm of possibility.

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LIST OF ACRONYMS

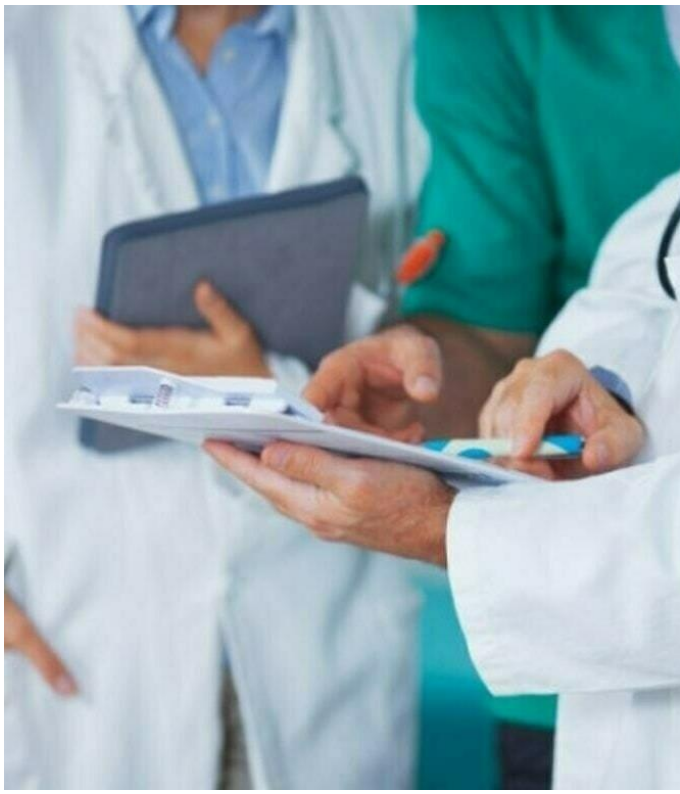
ANC	Antenatal Care
AFC	Afghan Citizen Card
API	Annual Parasite Incidence
ART	Anti-Retroviral Therapy
BHU	Basic Health Unit
BMGF	Bill & Malinda Gates Foundation
BoD	Burden of Disease
BTI	Bertelsmann Stiftung's Transformation Index
CMW	Community Midwife
COPD	Chronic obstructive pulmonary diseases
CPI	Corruption Perception Index
CPR	Contraceptive Prevalence Rate
CVD	Cardiovascular Disease
CKD	Chronic Kidney Disease
DALY	Disability Adjusted Life Years
DCP3	Disease Control Priorities – 3rd Edition
EPHS	Essential Package of Health Services
FCDO	UK's Foreign, Commonwealth and Development Office
FCTC	Framework Convention on Tobacco Control
FELTP	Field Epidemiology and Laboratory Training Programme
GATS	Global Adult Tobacco Survey
GB	Gilgit Baltistan
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GP	General Physician
GYTS	Global Youth Tobacco Survey
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPSIU	Health Planning, System Strengthening & Information Analysis Unit
HRH	Human Resource for Health
ICT	Islamabad Capital Territory
IDPs	Internally Displaced People
IHD	Ischemic Heart Disease
IHME	Institute of Health Matrix & Evaluation
IHR	International Health Regulations
IMR	Infant Mortality Rate
KP	Khyber Pakhtunkhwa
LFR	Labour Force Participation
LHV	Lady Health Visitor
LHW	Lady Health Worker
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MHGAP	Mental Health Global Action Programme

MICS	Multiple Indicators Cluster Survey
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
M/o NHSR&C	Ministry of National Health Services, Regulations & Coordination
M/o PDSI	Ministry of Planning, Development and Special Initiatives
MPI	Multidimensional Poverty Index
NAPHS	National Action Plan on Health Security
NCD	Non-Communicable Diseases
NGOs	Non-Government Organizations
NHV	National Health Vision
OOP	Out of Pocket Expenditure
PAEC	Pakistan Atomic Energy Commission
PDHS	Pakistan Demographic Health Survey
PHC	Primary Health Care
PLHIV	People Living with Human Immunodeficiency Virus
PMC	Pakistan Medical Commission
PMMS	Pakistan Maternal Mortality Survey
PNC	Pakistan Nursing Council
PPP	Public Private Partnership
PPM	Public Private Mix
PSLM	Pakistan Social and Living Standards Measurement Survey
RMNCH	Reproductive, Maternal, New-born & Child Health
RHC	Rural Health Centre
SBA	Skilled Birth Attendant
SCP	Sehat Card Programme
SDG	Sustainable Development Goal
SHPI	Social Health Protection Initiative
STEPS	STEP wise Approach to NCD Risk Factor Surveillance
TB	Tuberculosis
TFR	Total Fertility Rate
TI	Transparency International
THE	Total Health Expenditure
TPVICS	Third Party Verification Immunization Coverage Survey
UHC	Universal Health Coverage
UHC-BP	Universal Health Coverage- Benefit Package
UHC Index	UHC Service Coverage Index
YLD	Years Lived with Disability
YLL	Years of Life Lost
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
WPV	Wild Polio Virus

1 INTRODUCTION

Envision a world where access to quality healthcare is not a privilege reserved for a few but a fundamental right for everyone. This is the promise of Universal Health Coverage (UHC)—a future where every individual, regardless of their economic, social or geographic status, can receive the healthcare they need without the burden of financial hardship.

Pakistan, with a population exceeding 252 million[1] in 2024, is gradually advancing toward the realisation of UHC. While grappling with a complex history of healthcare challenges marked by unequal access and variable quality, Pakistan has initiated a far-reaching journey of transformation. The National Health Vision of Pakistan (NHV 2016-25) and Provincial/ Area health strategies have set the course for delivering high-quality essential integrated health services to all its citizens, underpinned by a resilient and inclusive healthcare system. The government has initiated the development of a new National Health and Population Policy (2025-34) based on the key recommendations of the NHV mid-term review. Strategic policy frameworks underscore UHC as a key objective within Pakistan's broader health goals, harmonising with the overarching national economic plans and their commitment to pro-poor social protection reforms.



Monitoring trends and patterns in UHC across the country is critical to ensure equitable and affordable access to effective health services that **leaves no one behind**. The health agenda calls for all stakeholders, including international agencies, private sector and civil society organisations, to better coordinate and support country's progress towards the 2030 Sustainable Development Goal (SDG) health targets.

The three key Objectives of UHC are

EQUITABLE ACCESS TO HEALTH SERVICES

Everyone should be able to obtain the healthcare they need without discrimination, ensuring that even marginalised and vulnerable population can benefit from quality health services

FINANCIAL PROTECTION

Protect individuals and families from experiencing financial hardship as a result of healthcare expenses. Effective UHC models involve various financing mechanisms to mitigate financial barriers

QUALITY OF CARE

Ensure that the care delivered is effective and meets appropriate standards of quality, improving health outcomes and patient satisfaction

This monitoring report analyses progress towards and impediments to achieving UHC, using the following UHC framework (Fig 1).

The UHC covers the full continuum of key services from health **promotion** to **prevention, protection, treatment, rehabilitation** and **palliative care**. Progress on UHC is tracked using two indicators:

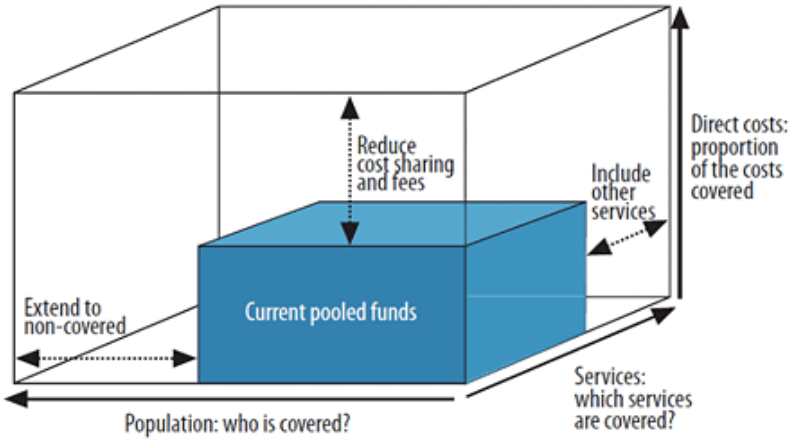
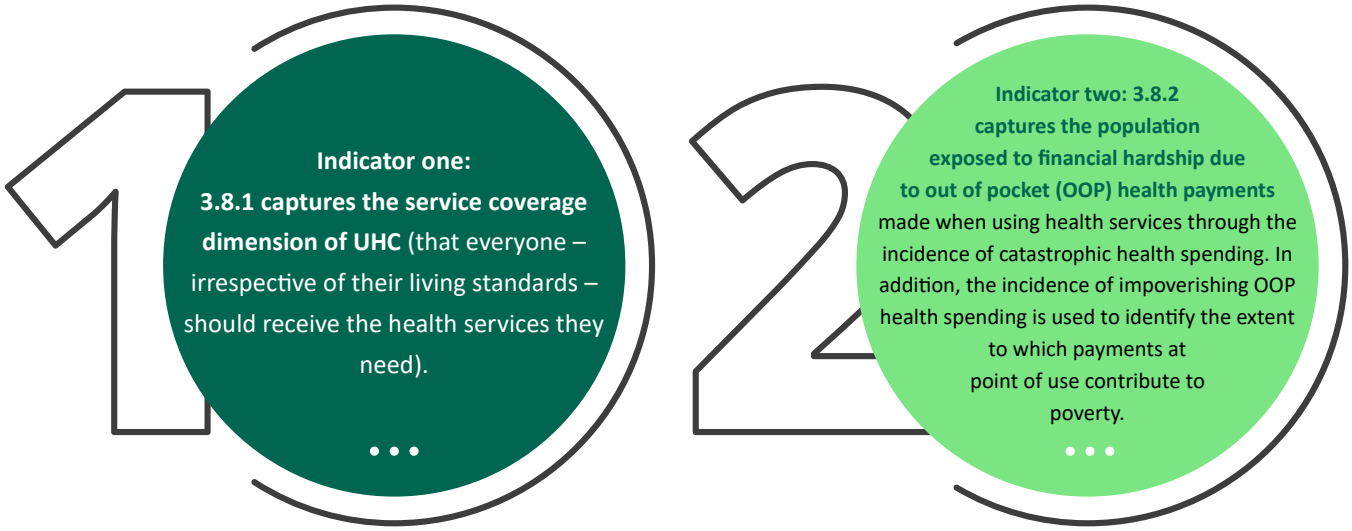


Figure 1: Universal Health Coverage Framework



Both the indicators must be measured together to obtain a clear picture of those who are unable to access healthcare and those who face financial hardship due to spending on healthcare.

The report offers a comprehensive contextual analysis of Pakistan, elucidating on the prevailing health landscape. It delves into the health situation in the country, providing insights into the status of health-related SDGs. Furthermore, the report conducts an in-depth analysis of the UHC Service Coverage Index (SCI) and examines the extent of catastrophic health expenditures in Pakistan. In the pursuit of advancing towards UHC, the report also places a strong focus on intersectoral collaboration and strategies to address the multifaceted challenges in achieving equitable and quality healthcare for all.

Figure 2: UHC Monitoring Indicators

2 CONTEXT

Imagine Pakistan where every citizen—whether from bustling urban centres or the most remote rural villages—has access to essential healthcare services without the fear of financial hardship. This is the vision of Universal Health Coverage (UHC) in Pakistan: a commitment to ensuring equitable, quality healthcare for all. As we step into 2025, Pakistan's pursuit of UHC is a story of resilience, innovation, and an unyielding commitment to leave no one behind.

In 2024, Pakistan's **UHC Service Coverage Index (SGH 3.8.1)** stood at 53.9 - an improvement from 2015 when index was only 40 - but achieving the global target of 80+ by 2030 still remains a dream. Whereas last documented **percentage of population with household expenditures on health greater than 10 percent of total household income (SDG 3.8.2)** was 5.4 percent. This also mean that close to half of the population were not able to access essential healthcare services, whereas annual 13.4 million people were at risk of entering into poverty as a result of catastrophic health expenditures.

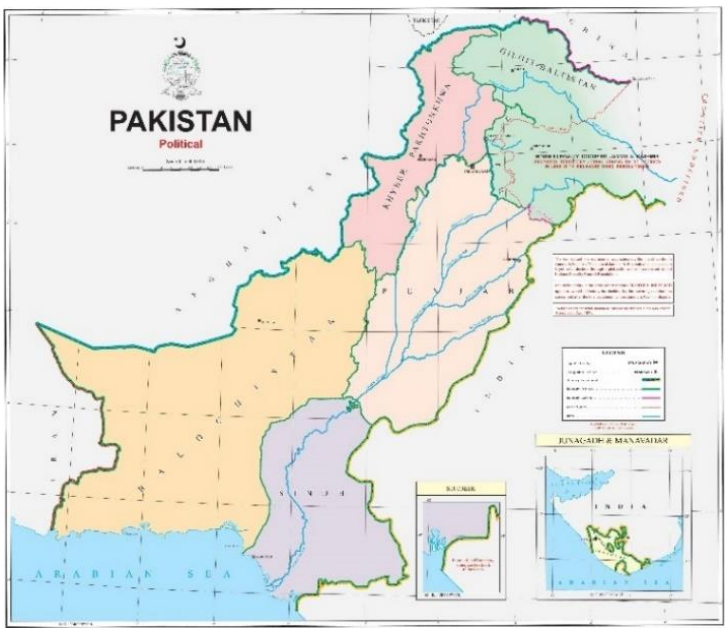


Figure 3: Map of Pakistan

The nation grapples with rapid population growth, economic pressures, political instability, and the lingering effects of COVID-19, compounded by devastating natural disasters like the 2022 floods. These challenges highlight Pakistan's complex realities on its path toward UHC, also demanding a more coordinated effort to address gaps while ensuring resilience.

However, amidst these crises, the push toward UHC continues to spur transformative change, aiming to develop a more inclusive, resilient, and equitable health system for all Pakistanis. This document explores the positive strides Pakistan has made in its healthcare journey, while also addressing the persistent barriers that threaten the achievement of UHC.

Pakistan's contextual landscape is complex, shaped by its historical, political, economic, social, climatic and environmental realities. The country is strategically located in South Asia, sharing borders with India, China, Afghanistan, and Iran. Since its inception in 1947, Pakistan has emerged as a resilient nation, overcoming numerous challenges to achieve significant milestones in various sectors, including health, economy, and infrastructure. Born out of the struggles of millions for independence, Pakistan's journey has been one of persistence and adaptation, shaping a unique cultural and socio-economic identity that continues to evolve.

Area-wise, Pakistan is the **33rd largest country**, spanning 881,913 square kilometres (km^2) and administratively divided into four provinces, namely Punjab, Sindh, Khyber Pakhtunkhwa (KP) and Balochistan in addition to three federating areas of Islamabad Capital Territory (ICT), Azad Jammu and Kashmir (AJ&K) and Gilgit Baltistan (GB). Federally Administered Tribal Area (FATA) was merged with the KP province, through a constitutional amendment in 2018.

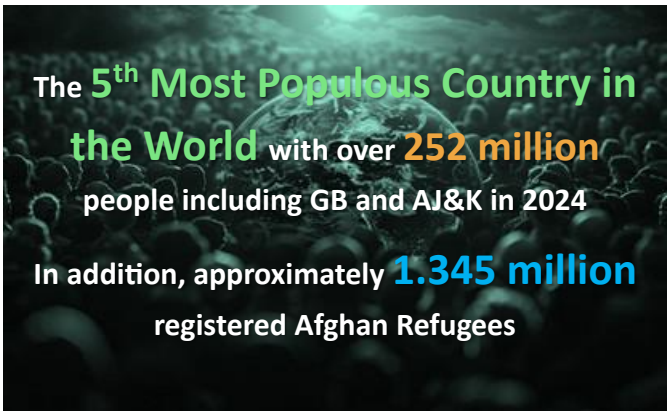


Table 1 National and Province/ Area wise Population with Density per Km^2

Province/Area	Population in 2023	Area (Km2)	Density/ Km2	Projected Population 2030
Punjab	127,688,922	205,344	621.8	143.5 million
Sindh	55,696,147	140,914	395.2	63.8 million
Khyber Pakhtunkhwa	40,856,097	101,741	401.6	47.9 million
Balochistan	14,894,402	347,190	42.9	18.5million
Islamabad Capital Territory	2,363,863	906	2,609.1	2.9 million
Gilgit Baltistan	1,685,895	72,971	23.1	1.9 million
Azad Jammu & Kashmir	4,568,257	13,297	343.6	5.2 million
PAKISTAN	**247,753,583**	**881,913**	**280.9**	**283.5 million**
Urban	**38.82%**			**39.6%**
Rural	**61.18%**			**60.5%**

The population density in Pakistan shows significant geographical variation, reflecting disparities in population distribution. Nationally, Pakistan's population density stands at 286 people per km^2 in 2024.

The country is characterized by a rich tapestry of cultures, languages, and traditions. **Punjab**, Pakistan's most populous province, is the nation's agricultural hub, often called the "breadbasket," known for its Sufi music, bustling cities like Lahore, Faisalabad, Multan and Rawalpindi, and a rural life deeply tied to family and farming traditions. **Sindh**, the cradle of the ancient Indus Valley Civilization, juxtaposes the multi-ethnic, urban life of Karachi, Hyderabad and Sukkar with the traditional, irrigation-based rural lifestyle in its interior. **KP**, home to a Pashtun majority, is rich in tribal values and natural beauty from the Swat Valley to Chitral. **Balochistan**, despite its wealth in natural resources, retains a slower pace of life shaped by tribal hierarchies and pastoralism. **GB**, with its majestic Karakoram Range, blends Tibetan influences and sustainable farming, while **AJ&K**, known for its scenic beauty, offers a rich cultural heritage of Kashmiri crafts and cuisine. Together, these provinces and federating areas, form a vibrant cultural mosaic, united by Urdu, yet preserving distinct identities through their languages, customs, and arts.

Pakistan, with 96.3 percent of its population adhering to **Islam** and 3.5 percent representing **minorities,** reflects rich religious and cultural diversity that also shapes healthcare-seeking behaviours. Cultural norms, traditional practices, and gender roles often influence access to healthcare, particularly in vaccinations, family planning and maternal health. In some areas, societal and religious traditions limit access, especially for women and marginalized groups, while vaccine hesitancy has posed challenges. However, religious and community leaders have helped improve public health efforts, notably in polio eradication and COVID-19 vaccination. To achieve Universal Health Coverage, Pakistan must bridge these cultural and regional gaps for equitable healthcare access.

Punjab, the most populous province, has the second highest population density at 633 people per km^2, indicating heavy population concentration. KP follows with a density of 410 people per km^2, while Sindh has 403 people per km^2. In

comparison, Balochistan has the lowest population density among provinces, with only 44 people per km^2, highlighting its vast, sparsely populated areas. The Islamabad Capital Territory (ICT) registers the highest population density of 2,681 people per km square.[1]

Between 2010 and 2023, Pakistan has witnessed a slight decline in its **rural population**, which now stands at 61.2 percent.[2] In contrast, rapid urbanisation has reshaped the demographic landscape, with 38.8 percent of the population residing in urban areas by 2023. This shift highlights the growing urban pull and the changing socio-economic dynamics driving migration to cities. Cities contribute immensely to the national economy, generating 55 percent of the GDP and 95 percent of federal tax revenue, with Karachi alone accounting for 12-15 percent of GDP. Yet, this unchecked urban growth has significant repercussions for public health and social equity.[3] Nonetheless, despite recent progress, healthcare access remains uneven, with stark contrasts between urban and rural areas, and among different geographical areas.

Pakistan is among the largest **refugee-hosting** countries globally, showing remarkable generosity for over 40 years to those in search of safety. As a result of previous waves of displacement, second and third generation of Afghans are living in protracted displacement, with Pakistan providing refuge to some 1.345 million registered Afghan women, children and men. The Government of Pakistan estimates a further 600,000 have sought refuge since the events of 2021 in neighbouring Afghanistan.[4]

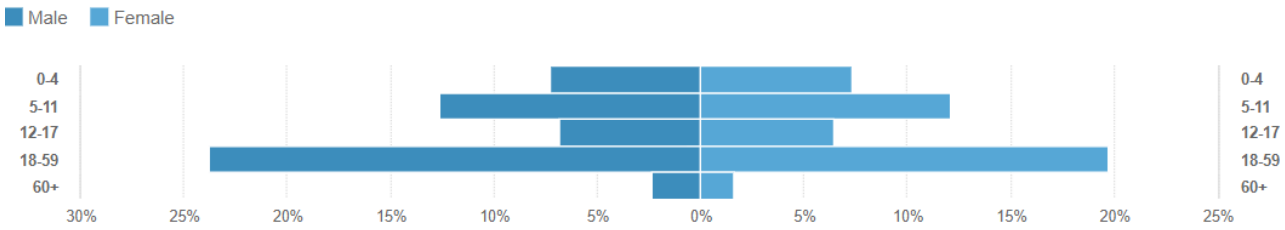
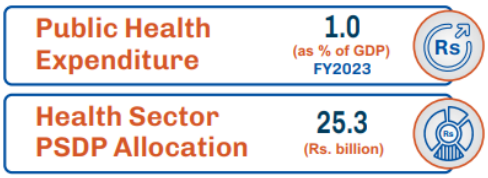


Figure 4: Afghan Refugees in Pakistan by Age and Gender



Restoring macroeconomic stability is crucial for promoting growth, employment, and improving quality of life. Since FY 2018, Pakistan has faced persistent challenges, including global shocks like macro-economic instability, COVID-19 pandemic, supply chain disruptions from the Russia-Ukraine conflict, inflation-driven monetary tightening, and oil price spikes from Middle East tensions. In FY 2022, Pakistan's unsustainable 6.1 percent growth, fuelled by domestic demand, led to high fiscal and current account deficits. Further, catastrophic floods in FY 2023 caused significant damage, equivalent to 4.8 percent of GDP, severely hindering growth prospects.

1 https://www.pbs.gov.pk/sites/default/files/population/2023/tables/national/table_1.pdf
2 Pakistan Population Census 2023
3 https://www.undp.org/pakistan/urbanisation-pakistan
4 UNHCR Country Profile-Pakistan June 2024 (https://data.unhcr.org/en/country/pak)

GDP growth rebounded to 2.38 percent compared to the previous year's negative growth. This recovery was led primarily by the agriculture sector, which saw a robust growth of 6.25 percent, largely due to bumper crops of wheat, rice, and cotton. Wheat production rose by 11.6 percent, and cotton output doubled, reflecting a strong recovery from the previous year's losses due to floods. The industrial and services sectors, while recovering, experienced modest growth at 1.21 percent each, indicating gradual stabilization.

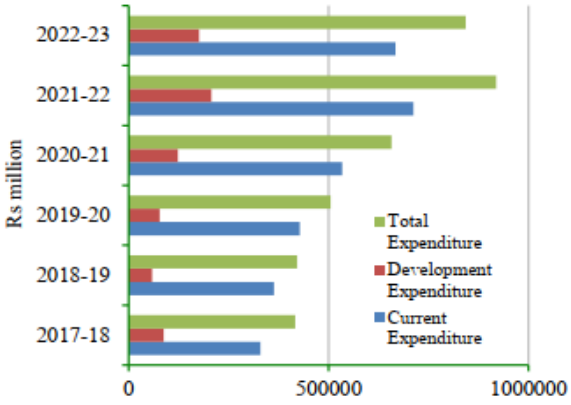


Figure 5: Public Expenditure on Health Sector

To achieve universal health coverage, it is crucial to allocate a significant **percentage of GDP to public sector health expenditures.** In Pakistan, health expenditure as a percentage of GDP is currently very low, but there are positive signs that this allocation has increased over time in nominal terms. The figure 5 shows the trend of public expenditure on health sector.

According to report on **Multidimensional Poverty Index (MPI) of Pakistan** 2019-2020, Multidimensional poverty slightly increased in 2019-20 compared to 2014- 15. The percentage share of multidimensional poor increased from 38.6 percent in 2014-15 to 39.5 percent in 2019-20. This marginal increase signifies a deviation from the historical pattern of multidimensional poverty in Pakistan. Over the last fifteen years multidimensional poverty in Pakistan has consistently declined. The trajectory from 2014-15 to 2019-20 however is in the opposite direction. For the first time in fifteen years the population share of multidimensional poor in the country has increased. However, according to the Pakistan Economic Survey 2023-24, the real GDP posted a growth of 2.38 percent in FY2024. Per capita income increased by US$129 to US$1,680 as compared to US$1,551 of last year on the account of increase in economic activity and appreciation in the exchange rate.

Table 2 Province wise Multidimensional Poverty 2019-20

Province		MPI	Incidence %	Intensity %
KPK	Over All	0.236	48.5	48.9
	Urban	0.079	19.6	40.5
	Rural	0.264	54.1	48.7
Punjab	Over All	0.141	30.4	46.3
	Urban	0.056	13.7	40.6
	Rural	0.188	40.5	46.5
Sindh	Over All	0.236	45.2	52.1
	Urban	0.080	18.9	42.6
	Rural	0.402	75.2	53.5
Baluchistan	Over All	0.378	70.5	53.6
	Urban	0.216	44.6	48.4
	Rural	0.432	80.4	53.8

Pakistan's geographical location endows it with a variety of climatic zones, ranging from the arid deserts of Balochistan and Sindh to the lush green valleys of Khyber Pakhtunkhwa and the snow-capped peaks of Gilgit-Baltistan. In recent years, Pakistan's federal and provincial governments have made notable strides in enhancing the performance of the tourism

sector in Pakistan. The **World Economic Forum's (WEF) Report** Ranks Pakistan 101st globally in 2024, showing an improvement of 20 ranks as compared to 2019, with a score of 3.41, reflecting a 3.6 percent improvement since 2019, and a 14 percent improvement on its 2019 rankings.

Pakistan is classified as a lower-middle-income economy and part of the Asia-Pacific regional group in the **Travel & Tourism Development Index** (TTDI) 2024. Pakistan's positive performance on the TTDI between 2019 and 2024 is part of a broader trend where low to middle-income economies have shown significant enhancement in performance on the TTDI, with these economies accounting for much of the above-average improvements in scores in various regions. Pakistan's advancement on the index signifies a positive trajectory in its tourism sector, indicating potential growth and readiness for future opportunities in the travel and tourism market.

Pakistan is at the forefront of climate challenges and is among the most vulnerable to **climate change**, facing issues such as erratic monsoons, glacial melt, and increased frequency of natural disasters like floods. Despite contributing only 0.88 percent of global greenhouse emissions, Pakistan ranks as the fifth most vulnerable nation to climate-related adversities. The country faces escalating temperatures, increasing by about 0.5°C since the 1960s, with projections indicating a further rise of 1.3°C to 1.5°C by 2050. This warming aggravates extreme weather events, including intensified heatwaves, erratic rainfall, and more severe floods and droughts, significantly impacting the nation's ecosystems, economic stability, and public health. The economic toll is substantial, with 2022 floods alone causing over USD 40 billion in damage, and anticipated GDP reductions of 18 to 20 percent by 2050 due to climate risks, environmental degradation, and pollution. Additionally, the incidence of flooding is expected to worsen, with projections of 5 million more people facing extreme river floods by 2035-2044, and a further million annually at risk from coastal flooding by 2070-2100.[5]

As per **Climate Change Performance Index**, Pakistan ranks 30th overall, placing it among medium performers in climate-related efforts. The country scores low in Climate Policy, very low in Renewable Energy, but high in GHG Emissions and Energy Use. Vulnerable to extreme weather events, Pakistan updated its Nationally Determined Contribution (NDC) in 2021, targeting a 50 percent reduction in projected emissions by 2030, with 15 percent from domestic sources and 35 percent reliant on international grants. Additionally, Pakistan aims to shift to 60 percent renewable energy, 30 percent electric vehicles, and completely ban imported coal by 2030.[6]

The 2023-24 Human Development Report reveals that Pakistan's **Human Development Index (HDI)** has declined to 0.540, placing it now in the 'low' development category with a global ranking of 164 out of 193 countries, down from 161 in the previous report. A significant 33 percent drop in Pakistan's inequality-adjusted HDI, now at 0.360, reflects persistent inequalities.

5https://scp.gov.pk/Conference2024/downloads/Climate_Chage_in_Pakistan.pdf
6 https://ccpi.org/country/pak/

The **Global Gender Gap** Report 2024 ranked Pakistan second last i.e. 145 out of 146 countries. It has an index of 0.57 which reflects a stark gender gap. Regarding economic participation, Pakistan has been ranked 143rd with an index of 0.36. In the educational achievement area, Pakistan ranks at 139th, which was previously 138th according to the report of 2023. The gender gap in literacy is at 67.1 percent resulting in no change from the previous year. In the overall health and survival area of the Global Gender Gap Index 2024, Pakistan ranks 132nd. The country ranks 1st in sex ratio at birth but is at the 141st rank in healthy life expectancy which means a very poor quality of life. The parameter of health and survival shows a closed gender gap of 0.961

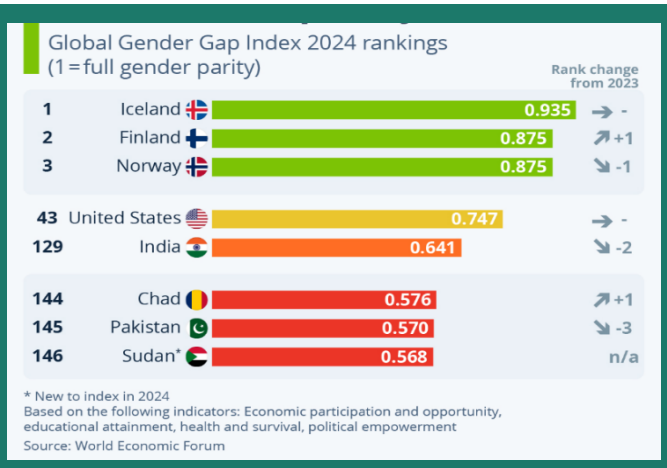


Figure 6: Comparison of Countries for Gender Equality

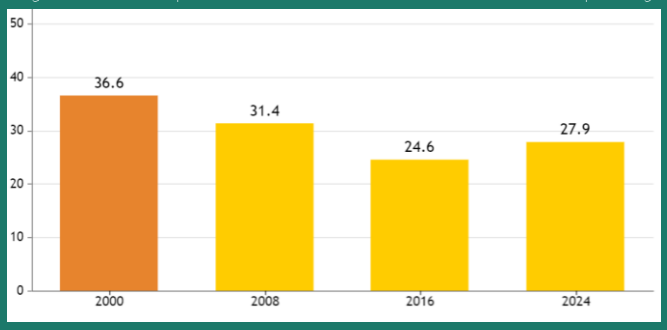


Figure 7: Global Hunger Index Score Trend for Pakistan

According to the **Global Hunger Index (GHI),** Pakistan ranks 102nd out of 125 countries, with a GHI score of 26.6, reflecting a serious level of hunger. The data, spanning from 1998 to 2022, highlights persistent issues such as child stunting and wasting, which are key indicators of undernutrition in the country. Undernourishment remains a significant problem, as shown by data collected from 2000 to 2022. Additionally, child mortality rates, tracked since 2000, emphasise the broader health challenges facing children in Pakistan.[7]

On the **Corruption Perceptions Index (CPI)** by Transparency International, Pakistan ranks 133rd out of 180 countries in 2023, reflecting persistent corruption issues. This position marks a slight improvement from previous years, but the country's performance remains concerning due to ongoing challenges in governance and accountability. High levels of corruption continue to hinder development and aggravate economic difficulties, particularly in relation to weak rule of law and political instability.[8]

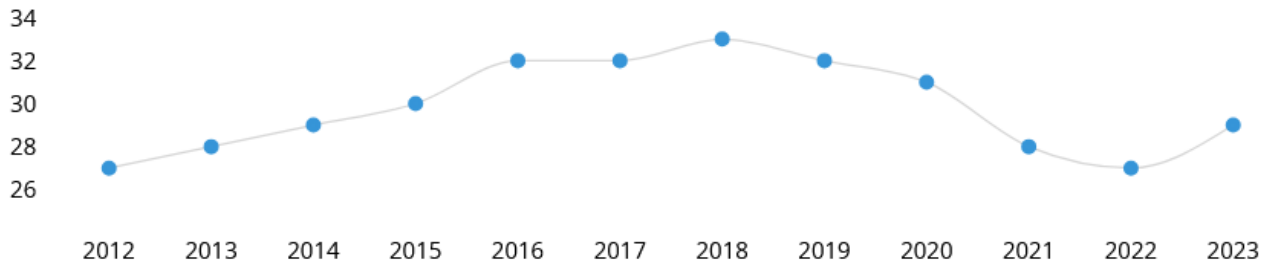


Figure 8: Trend of Corruption Perception Index 2012-23

The **Bertelsmann Stiftung Index (BTI)** 2024 for Pakistan reveals several concerning trends in governance, democracy, and economic performance, highlighting the critical need for reforms. With Pakistan ranked 112th globally in both the Status and Economy indices, it faces significant governance and socio-political challenges. A Democracy Status score of 3.7 and

7 https://www.globalhungerindex.org/pakistan.html
8 https://www.transparency.org/en/cpi/2023/index/pak

a Governance score of 3.3 highlights the issues of political instability, fragile rule of law, and an underperforming economy. Despite some gains in international cooperation, these scores indicate that the country remains vulnerable to governance weaknesses and economic volatility. The "Level of Difficulty" score of 7.7 further illustrates the severity of challenges ahead, emphasising the need for comprehensive reforms.

From 2016 to 2024, Pakistan's Economy Status score declined by 0.47 points, while its economic performance fell sharply by 2.0 points. These figures point to a significant weakening of the country's economic foundations, making the path towards recovery more difficult. Moreover, the Socio-Economic Status and Sustainability scores have stagnated, suggesting that efforts to improve societal well-being and sustainability have not gained traction over the years. A notable decline in the overall Status Index score by 0.25 points reflects the country's deepening economic and institutional challenges.

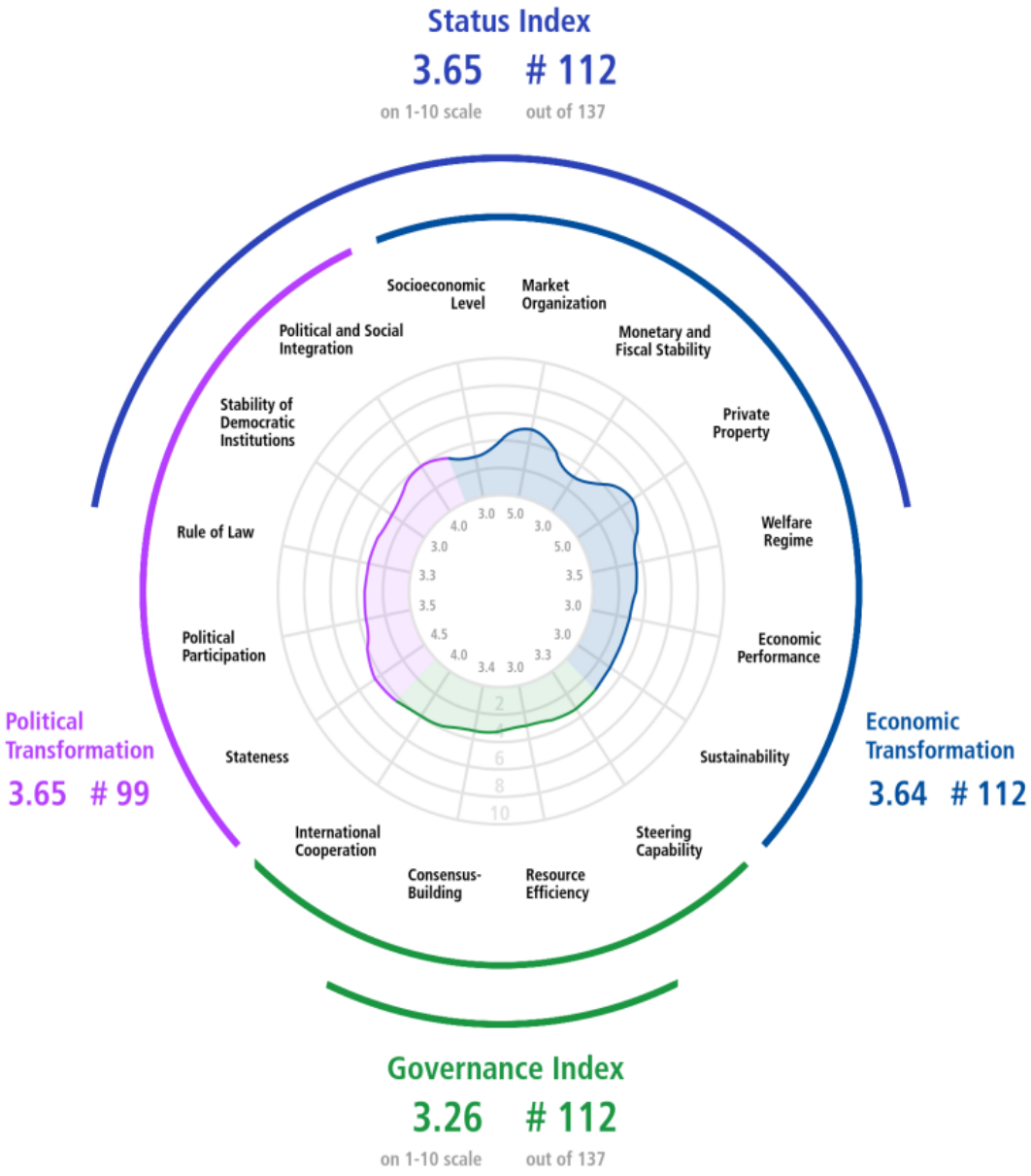


Figure 9: Bertelsmann Stiftung Index, Pakistan-2024

In terms of democracy, while Pakistan's stateness score saw a modest improvement of 0.5 points, its political participation score fell by 0.8 points, reflecting a deteriorating political landscape. The stagnant Rule of Law score (3.3 since 2016)

indicates persistent issues with legal frameworks and accountability. These trends suggest a failure to significantly improve governance standards, leading to an erosion of state capacity to respond to the pressing needs of its people.[9]

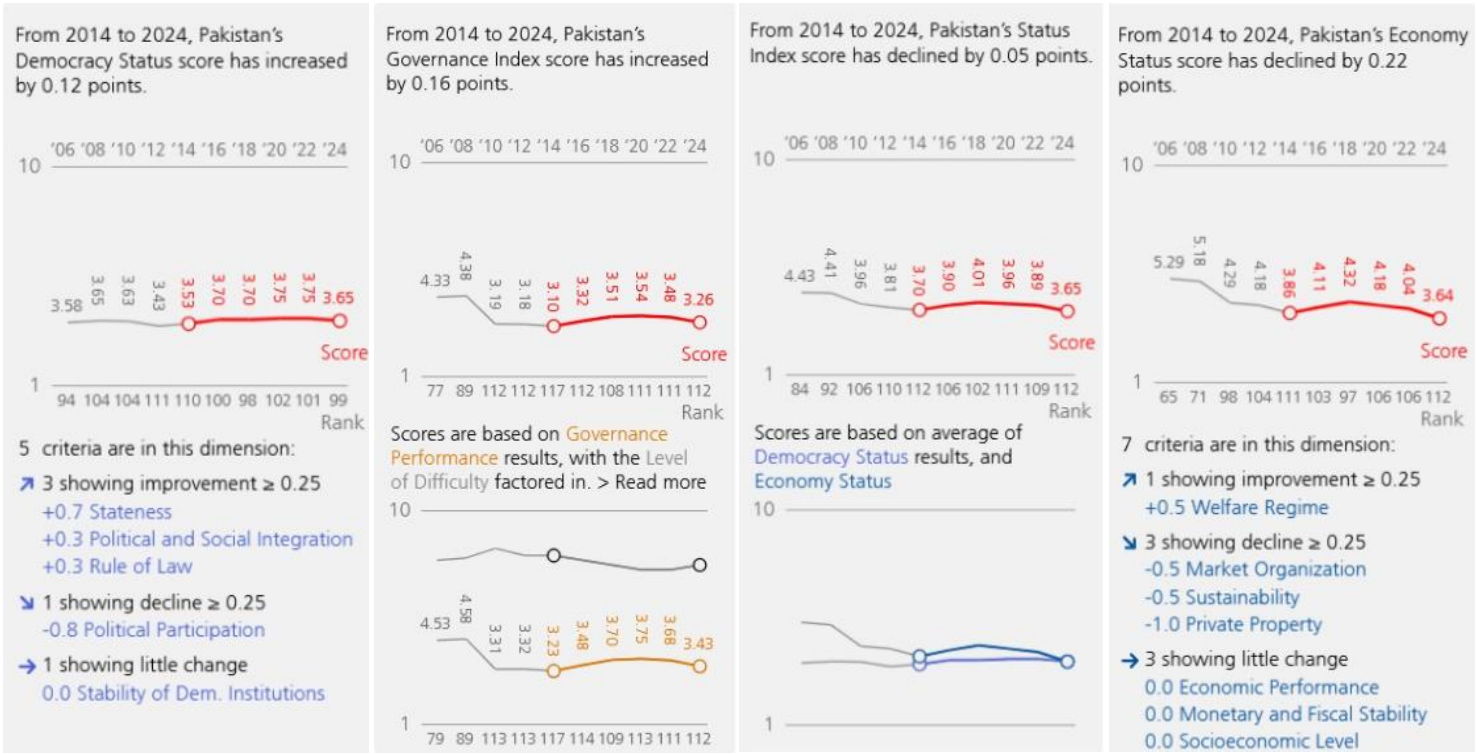


Figure 10: Trend of Disaggregated Bertelsmann Stiftung Index, Pakistan-2014-24

9 https://atlas.bti-project.org/1*2024*CV:CTC:SELPAK*CAT*PAK*REG:TAB

3 HEALTH STATUS

The burden of disease (BOD), measured as the annual rate of Disability Adjusted Life Years (DALYs) lost per 100,000 population in 2021 across different countries summarises the health status and challenges in Pakistan compared to others. The rate of DALYs 42,399 lost per 100,000 people in Pakistan through declining slowly, is comparatively worse to many of its regional, global and neighbouring counties and indicates a pressing need for expansion of UHC and other reforms. Countries with better socio-economic status such as Qatar and Singapore have significantly lower rates of disease burden, standing at 16,685 and 19,089 respectively. Oman, with 22,265, and China, at 28,299, also show much better health outcomes than Pakistan. Socio-economically worse countries such as Somalia, with a rate of 72,886, and the Central African Republic at 82,875, further illustrate the negative extreme health outcomes. This comparison underscores the urgent need for effective implementation of health strategies in Pakistan to reduce its disease burden and improve overall outcome of UHC.

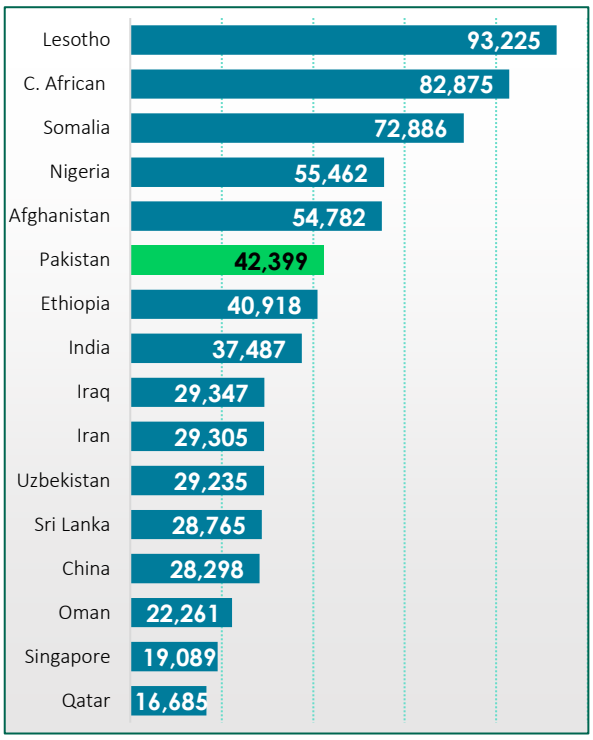


Figure 11: BOD rates per 100,000 population across different countries - 2021

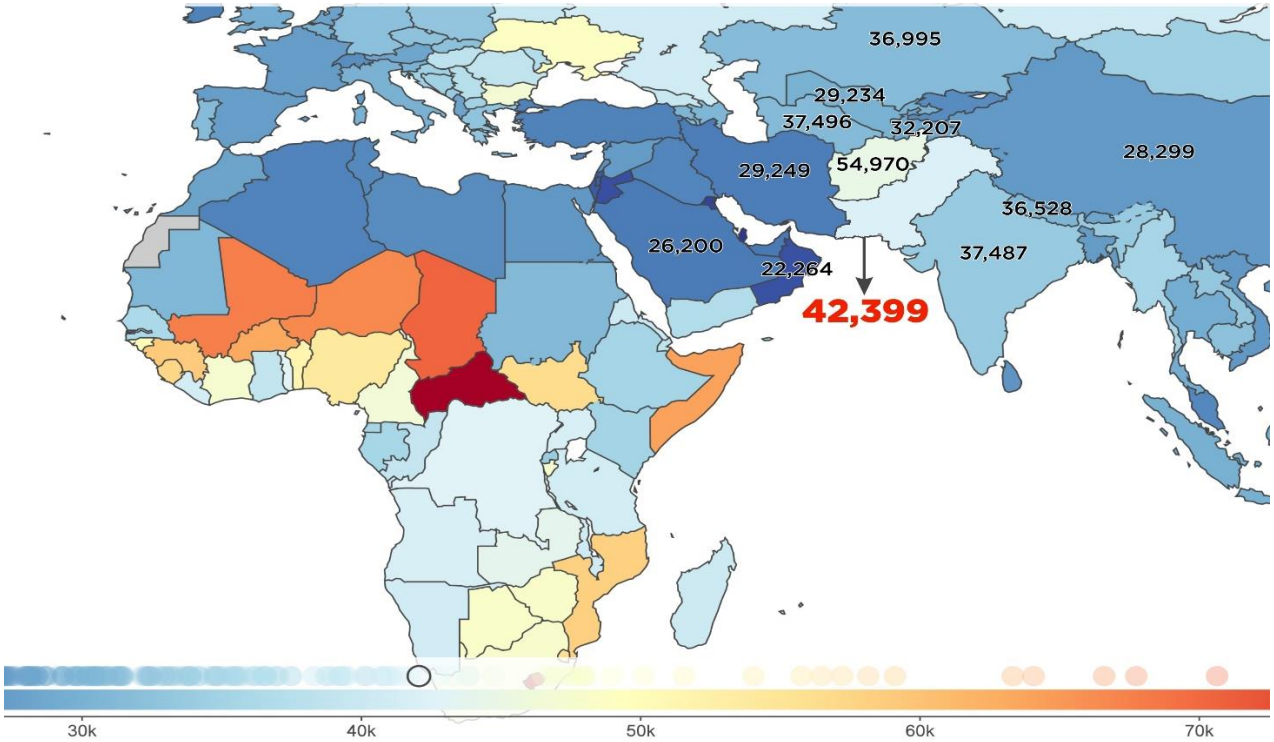


Figure 12: BOD rates per 100,000 population across countries in 2021

The BoD in Pakistan illustrates a multifaceted landscape shaped by infectious diseases along with maternal, neonatal & child health disorders, an escalating share of non-communicable diseases (NCDs), and significant health disparities across socio-economic divides. Measured through DALYs, Years of life lost (YLLs), Years of life lost with disabilities (YLDs) and other key health metrics, the BoD indicates the extent to which various health conditions impede population well-being and productivity. This data-driven understanding is critical for prioritising resources effectively, as highlighted by the findings of the Global Burden of Disease (GBD) studies.[10]

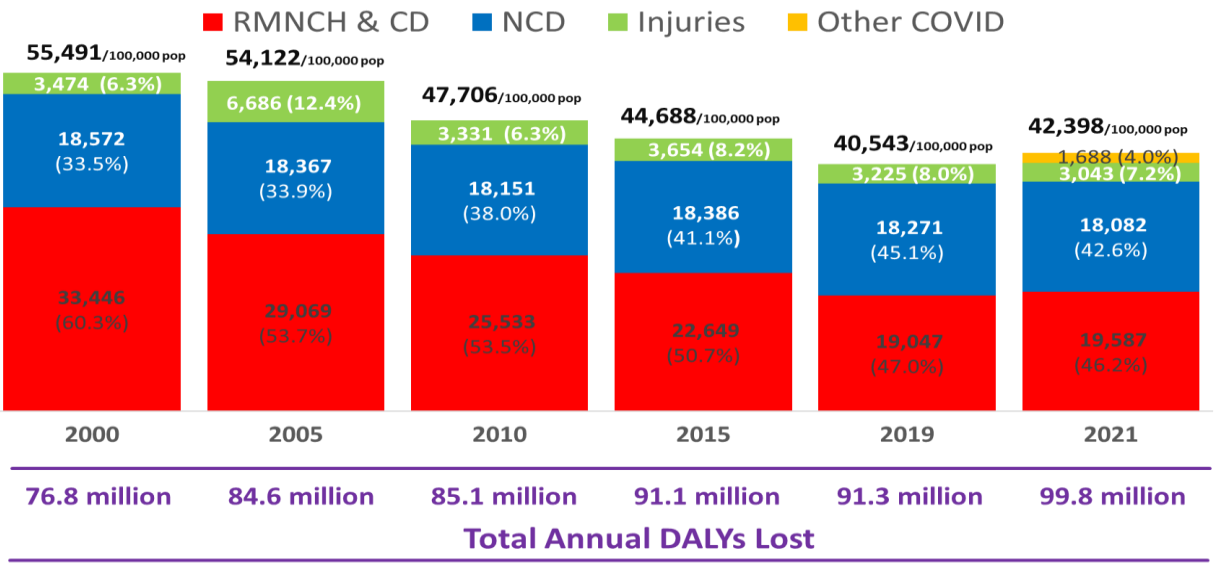


Figure 13: Trend of BOD (Rate per 100,000 population and Total Annual DALYs

The national DALY rate is substantial at 42,369 per 100,000 people which is greater than the global average with marked regional disparities.[11] These trend analysis of BOD reveal a health system in Pakistan with some improvement in maternal and child health but still under strain and grappling with entrenched infectious diseases and neonatal disorders, rising share of NCD burden, and other obstacles in achieving Universal Health Coverage (UHC) and other health outcomes. The COVID-19 led to increase in BOD in 2021, otherwise there is a gradually declining trend in the overall

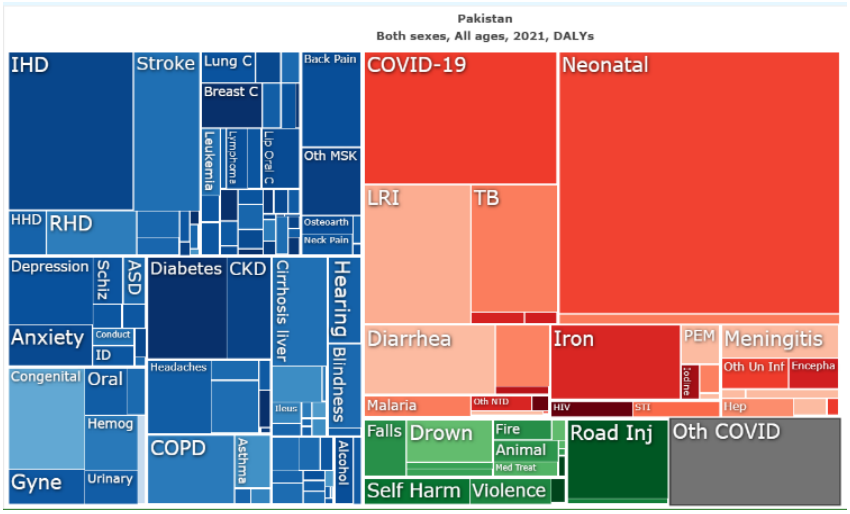


Figure 14: Breakdown of BOD rate per 100,000 population in Pakistan for both sexes and all age groups in 2021

10https://www.healthdata.org/sites/default/files/2024-05/GBD_2021_Booklet_FINAL_2024.05.16.pdf
11 VizHub - GBD Compare

BOD rate / 100,000 population, whereas the Total Annual DALYs lost is on a rise considering very high increase of the population of country.

Neonatal disorders have the highest share in the overall national BOD rate in both sexes and all age groups, followed by cardiovascular diseases and respiratory infections with a surge of COVID-19 in 2021. NCD constitute more than half of the total deaths. Cardiovascular diseases are the top cause of deaths with a share of 20.87 percent (observed value) of the total 1.718 million deaths, followed by 19.88 percent share of respiratory infections including tuberculosis and share of 12.71 percent of maternal and neonatal deaths of the total deaths in 2021.

The last three decades have seen a modest rise in life expectancy in Pakistan, increasing from 61.1 years in 1990 to 68 years in 2023. This progress, however, is unevenly distributed across the country. While Islamabad demonstrates the highest life expectancy, provinces like Balochistan and Khyber Pakhtunkhwa (KP) have reported minimal gains, hindered by limited healthcare access and ongoing conflict.

Islamabad has the lowest DALYs lost rate at 22,226, whereas rate in Balochistan is more than double, underscoring inequities in health access and outcomes.[12,13] However, Punjab which earlier had a lower rate of BoD at 41,861 DAYLs is now having the highest rate of BOD at 44,120.[14] These variations emphasise variations in disease patterns, inequalities in healthcare access and socioeconomic conditions. These figures also stress upon the need for targeted health interventions related to UHC.

Table 3 Disability-Adjusted Life Years (DALYs) lost per 100,000 population by Province/Area (2021)

Province/Area	DALYs lost per 100,000 Population
Islamabad	24,301
Khyber Pakhtunkhwa	39,344
Azad Jammu and Kashmir	40,374
Sindh	41,378
Gilgit-Baltistan	41,856
Balochistan	43,749
Punjab	44,126

BURDEN OF RMNCH & COMMUNICABLE, NON-COMMUNICABLE DISEASES, AND INJURIES

Between 2000 and 2021, the proportion of RMNCH and infectious disease burden declined from 60.3 percent to 46.2 percent of the total BoD. Whereas share of NCDs increased from 33.5 percent to remain high at 42.6 percent. The share of burden of injuries also increased from 6.3 percent to 7.2 percent.

Maternal and child health indicators reflect significant disparities within Pakistan and contribute to 22.3 percent of total DALYs lost. Maternal mortality remains high due to preventable causes like haemorrhage and sepsis, with gradually rising access to skilled birth attendants. Neonatal mortality is concerning, driven by factors such as asphyxia, infections, congenital disorders and low birthweight. Nutritional deficiencies are widespread among children under five, with 37.6 percent experiencing stunting, and 7.1 percent wasting. Among women of reproductive age, anaemia affects over half the population, underscoring critical gaps in maternal nutrition and public health interventions.

12 https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(22)00497-1/fulltext
13 https://www.healthdata.org/news-events/newsroom/news-releases/lancet-pakistan-faces-double-burden-communicable-non
14 VizHub - GBD Compare

Pakistan's infectious disease burden remains a significant challenge. With the fifth-highest tuberculosis (TB) burden globally, TB continues to affect substantial portions of the population, with drug-resistant TB impacting 4.3 percent of new cases and 19 percent of previously treated cases. Hepatitis B and C are similarly prevalent, with a population prevalence rate of 7.6 percent, while HIV & AIDS persists among high-risk populations, particularly people who inject drugs. Malaria is concentrated in focal areas of KP and Balochistan, adding strain to healthcare resources. Polio also remains a priority health concern, with NIH confirming the 56 cases of Wild Poliovirus Type-1 (WPV1) by Dec 2024. Gaps in immunization coverage indicate ongoing vulnerability in certain districts, necessitating vigilant public health efforts.

Non-communicable diseases (NCDs) are emerging as a leading public health concern in Pakistan, reflecting the country's ongoing epidemiological transition. Cardiovascular diseases, particularly ischemic heart disease, rheumatic heart disease, and stroke, contribute significantly to mortality and morbidity. Diabetes is also on the rise, with Pakistan having the seventh-highest prevalence worldwide. Cancers, including breast, lip and oral cavity, and prostate, are similarly increasing.

Risk factors such as high blood pressure, high blood sugar, and tobacco use compound the disease burden. Injuries now represent more than 7 percent of the national disease burden. Mental health conditions (4.07 percent) add to the public health challenges, while limited mental health services and resources for people with disabilities present significant barriers to addressing this need.

According to burden disease by province/area, showcasing the impact of health issues across different regions. In Islamabad, the total annual DALYs loss equated to 561,720 or 0.56 percent of the overall burden in 2021. Moving to GB, the figure increased to 783,692 DALYs, which constitutes 0.79 percent of the total. In AJ&K, the situation is more pronounced, with DALYs reaching 1,660,712, making up 1.66 percent of the total. Balochistan exhibits huge burden recording 6,330,833 DALYs, accounting for 6.34 percent of the overall figure. KP follows with 15,679,972 DALYs - 15.71 percent of the total burden. Sindh shows a significant DALY figure of 21,768,376, which accounts for 21.81 percent. The province of Punjab experiences the largest share of the DALYs, with a staggering 53,015,222, which translates to 53.12 percent of the total burden across Pakistan.

Table 4 Leading Risk Factors Association with Diseases in Pakistan (2021)

Risk Factor	Association with Diseases (%)
Child and Maternal Malnutrition	22.3
Air Pollution	18.5
Elevated Blood Pressure	16.0
Dietary Risks	15.2
Tobacco Use	14.1

ENVIRONMENTAL AND CLIMATE VULNERABILITIES

Pakistan's health system is continually tested by environmental and climate-related challenges. The 2022 floods, which displaced millions, accentuated Pakistan's vulnerability to climate-induced disasters, exacerbating risks of malnutrition, waterborne diseases, and healthcare disruptions. The disaster prompted calls for sustainable healthcare solutions and resilient infrastructure to protect vulnerable populations.

Urban air pollution also presents serious risks, particularly in cities like Karachi and Lahore, where exposure to particulate matter has been linked to respiratory diseases. Addressing these environmental health threats is vital for public health resilience and for protecting vulnerable populations from recurrent climate shocks.

PERSISTENT HEALTH CHALLENGES AND SYSTEMIC INEQUALITIES

Despite some improvements, inequities in healthcare access and quality persist. Disparities in life expectancy, maternal and child health, and healthcare delivery systems are evident across socioeconomic and geographic lines.

HEALTH SYSTEM CONSTRAINTS AND UHC CHALLENGES

Pakistan's healthcare system faces substantial structural and financial constraints, especially in its pursuit of UHC. Ranked 124th out of 195 countries on the Healthcare Access and Quality Index, Pakistan's public health infrastructure struggles to meet demand, particularly in underserved rural regions. With out-of-pocket expenditures constituting roughly 47% of total healthcare costs as indicated in the National Health Accounts 2021-22, access remains out of reach for many, posing significant barriers to affordable care. The private sector provides a large share of services, yet its high-cost limits access for low-income groups.[15]

These structural limitations are reflected in Pakistan's International Health Regulations (IHR) Index score, which stands 42.7 according to Joint External Evaluation 2023. Critical gaps in biosafety, dual-use research, infection control, and crisis communication reveal vulnerabilities in healthcare preparedness. While there are relative strengths in areas like immunization and laboratory quality, weaknesses in supply chain management, risk communication, and emergency response planning undermine the health system's effectiveness. Although Pakistan shows resilience in medical countermeasure approvals and certain socio-economic areas, severe deficiencies in infection control and political security highlight an urgent need for improved resilience and response capacity. [16]

These challenges directly impact Pakistan's efforts to achieve UHC, which requires healthcare that is accessible, affordable, and of high quality. Limited human resources, insufficient infrastructure, and low public health spending continue to hinder progress. Initiatives like the Sehat Sahulat Programme, aimed at expanding health insurance coverage for low-income households, represent important steps forward. However, gaps in rural healthcare access, service quality, and funding persist, underscoring the need for systemic and programmatic reforms.

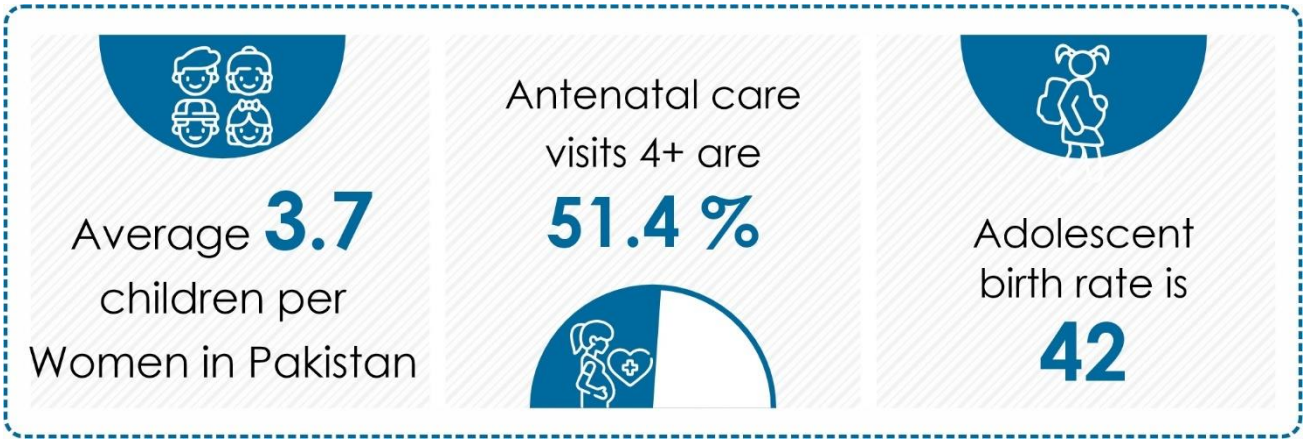
15 https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-024-18320-4
16 https://ghsindex.org/country/pakistan/

7 AFFORDABLE AND CLEAN ENERGY
5 GENDER EQUALITY
4 QUALITY EDUCATION
14 LIFE BELOW WATER
13 CLIMATE ACTION
• Energy access
• Renewable energy share
• Energy efficiency
• Access to natural resources
• Participation in economic and public life
• Knowledge and skills for sustainable development
15 LIFE ON LAND
• Marine pollution
• Marine and coastal management
• Marine and coastal areas conservation
• Climate resilience and adaptation
• Climate change education and capacity
9 INDUSTRY, INNOVATION AND INFRASTRUCTURE
• Land conservation and restoration
• Natural habitats
• Sustainable and resilient infrastructure
11 SUSTAINABLE CITIES AND COMMUNITIES
• Access to green space
• Sustainable urbanization
• Access to safe, sustainable transport
• Housing access
• Disaster prevention
• Air quality and waste management
3 GOOD HEALTH AND WELL-BEING
• Integrated water management
• Water-use efficiency
• Water quality
• Sanitation access
• Drinking water access
6 CLEAN WATER AND SANITATION
• Safe work environment
• Sustainable consumption and production
• Resilience to disasters
8 DECENT WORK AND ECONOMIC GROWTH
• Finance
• Technology
• Capacity Building
• Systemic Issues
• Chemicals and waste management
• Information on sustainable lifestyles
1 NO POVERTY
• Access to food
• End of malnutrition
• Ensure equal opportunity
17 PARTNERSHIPS FOR THE GOALS
• Public access to information
• Participatory decision-making
• Effective institutions
• Equal access to justice
12 RESPONSIBLE CONSUMPTION AND PRODUCTION
2 ZERO HUNGER
16 PEACE, JUSTICE AND STRONG INSTITUTIONS
10 REDUCED INEQUALITIES

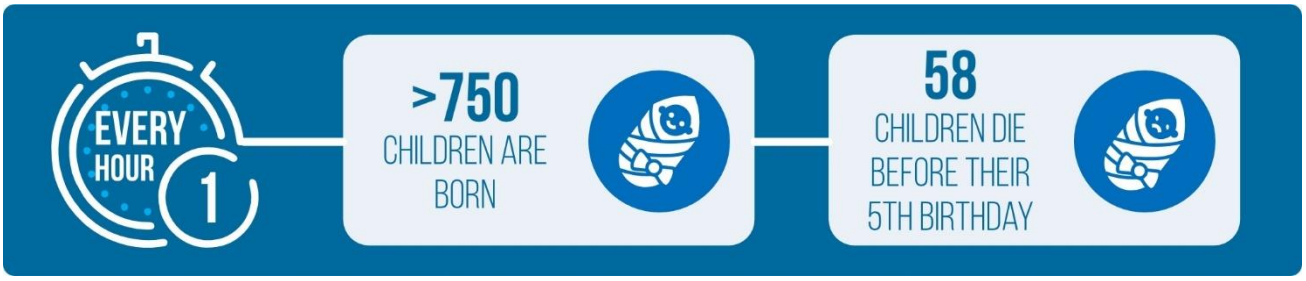
4 GOOD HEALTH & WELL-BEING (SDG3)

The SDG 3 aims to ensure healthy lives and promote well-being for all at all ages, reflecting a commitment to addressing the global health challenges of our time. In Pakistan, progress towards achieving SDG 3 has been a multifaceted endeavour, encompassing maternal and child health improvements, combating communicable diseases, and enhancing access to quality healthcare services. Despite facing significant challenges, such as limited healthcare infrastructure and high rates of malnutrition, the country has made notable strides in areas like vaccination coverage and reducing maternal mortality. The rising prevalence of non-communicable diseases, such as diabetes and cardiovascular disorders, highlights the need for a robust public health response and health education campaigns. Continued efforts are essential to overcome barriers and ensure that health equity is achieved across all regions and demographics in Pakistan. To further accelerate progress towards SDG 3, there is a pressing need for a comprehensive approach that includes strengthening healthcare systems, improving health education, and ensuring equitable access to services for all citizens.

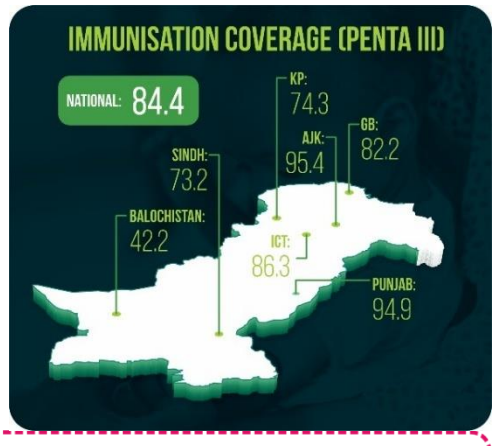
Efforts to reduce maternal mortality rates have gained traction through initiatives aimed at increasing access to skilled birth attendants and improving antenatal care services. A sustained commitment to strengthening healthcare systems, ensuring access to quality maternal care, and addressing socio-economic barriers is critical to reducing maternal mortality and safeguarding the lives of mothers across the country.

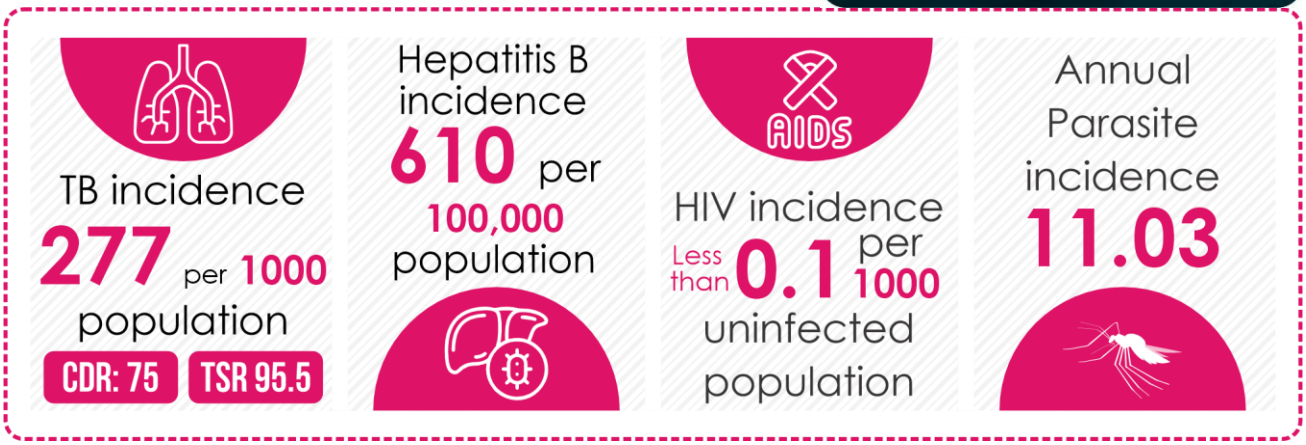


Child mortality in Pakistan remains a pressing concern, with thousands of preventable deaths occurring each year due to inadequate healthcare services, malnutrition, and limited access to essential interventions for children under five. Reducing child mortality in Pakistan requires a concerted effort to improve healthcare access, enhance nutrition, and implement evidence-based interventions, ensuring every child has the opportunity to survive and thrive.

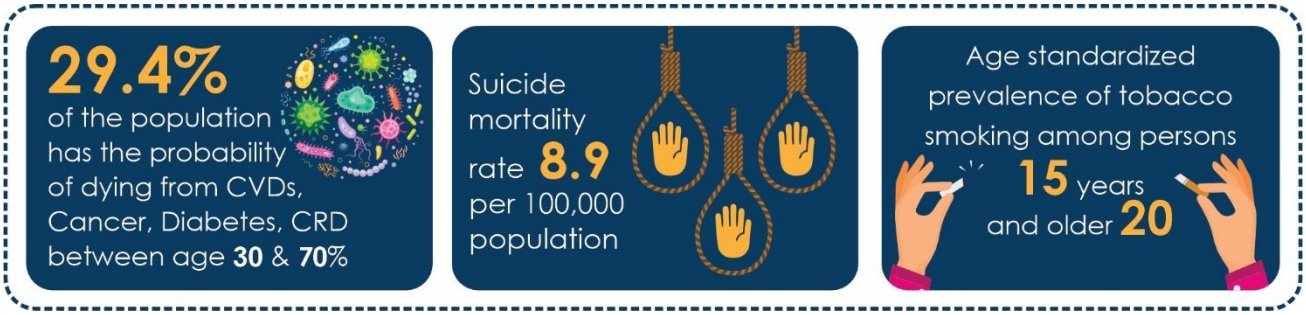


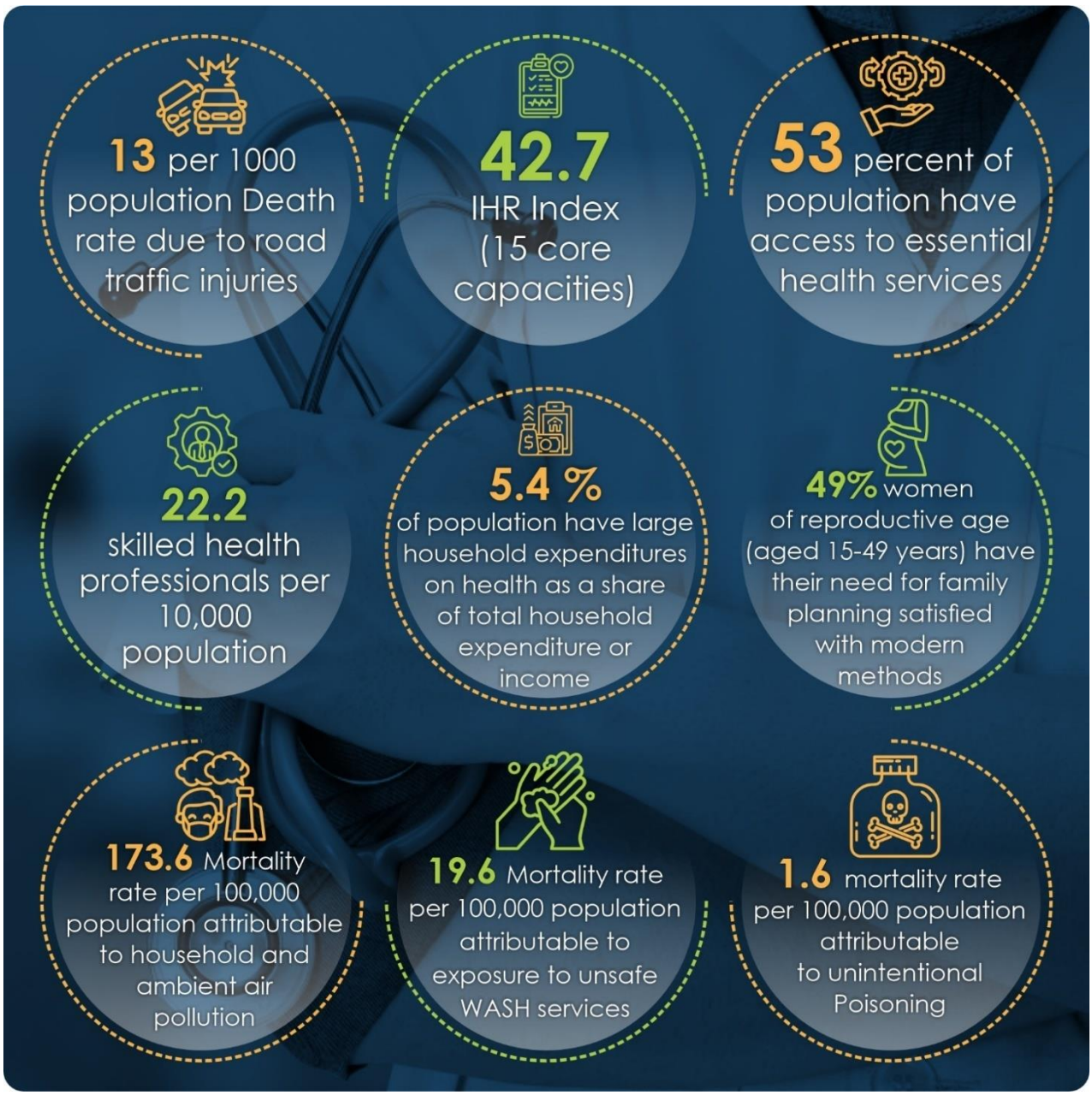
In Pakistan, communicable diseases still remain a major public health concern and is the prime cause of morbidity and mortality due to socio-economic, environmental and behavioural risk factors. Pakistan bears a significant portion of the Eastern Mediterranean regional burden of many communicable diseases including Tuberculosis (TB), HIV & AIDS, Malaria and certain water borne diseases. Sustained investment in public health infrastructure, improved vaccination coverage, enhanced disease surveillance, and strong community engagement are essential to building a healthier, more resilient population.





Non-communicable diseases (NCDs) in Pakistan, such as cardiovascular diseases, diabetes, cancer, and chronic respiratory conditions, are rising at an alarming rate, driven by lifestyle changes, urbanization, and limited access to preventive healthcare services. Addressing this growing burden requires urgent action and a comprehensive approach. By implementing a well-coordinated National NCD Action Plan (2021-30), Pakistan can effectively curb the rising tide of non-communicable diseases and improve health outcomes for its population.





OTHER HEALTH-RELATED SDGs

1 NO POVERTY

39.5%
of Population living below the poverty line (%).

Among this, **17.3%** in Urban and **51.9%** in rural areas

At the dimension level education makes up nearly half of the MPI with 49.4% contribution. The standard of living has the second highest contribution with 26.5%, followed by health. With 24.1%, deprivation in health has the lowest contribution to national MPI among the three dimensions

2 ZERO HUNGER

37.6% are stunted

7.1% are wasted

2.5% are overweight

48% of U5 children have moderate and 5.7 have severe micronutrient deficiencies

Pakistan manages to reduce the prevalence of anaemia in women aged 15 to 49 years, by pregnancy status between 2011 and 2018. According to the latest figures (2018), 43% of the non-pregnant women were anaemic, aged 15 to 49, which was 51% in 2011. Despite Overall improvement at the national level, the anaemic women (non-pregnant) increased in Balochistan (from 49% to 61.8%), AJ&K (from 41.3% to 56.4%) and Gilgit-Baltistan (from 23.4% to 36.1%).

4 QUALITY EDUCATION

60%
of population aged 10 year and older are literate

32% children are out of school

25.8% never seen to school

5.7% drop put rate

Large regional disparities persist in primary completion rates across the provinces. In Punjab, Sindh, KP and Balochistan; 67%, 56%, 67% and 48% of the children respectively completed their primary education in 2019-20.

5 GENDER EQUALITY

31%
women aged **15-49** years can make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care

6 CLEAN WATER AND SANITATION

94% have access to improved drinking water

83% have access to improved sanitation

Among the provinces/regions, the highest proportion of the population using improved drinking water was in Punjab, 99%, followed by Sindh 94%, Balochistan 84% and Khyber Pakhtunkhwa 83%. Significant improvement was seen in Balochistan with an increase of 17% in the last five years (from 2014-15 to 2019-20).

7 AFFORDABLE AND CLEAN ENERGY

49%
population are primarily relying on clean fuels and technologies at the household level

Among this, **17.3%** in Urban and **51.9%** in rural areas

At the dimension level education makes up nearly half of the MPI with 49.4% contribution. The standard of living has the second highest contribution with 26.5%, followed by health. With 24.1%, deprivation in health has the lowest contribution to national MPI among the three dimensions.

8 DECENT WORK AND ECONOMIC GROWTH

6.3% of population are unemployed including **5.5%** Men and **8.9%** Women.

the number of unemployed persons has decreased to 4.51 million from 4.71 million in 2018-19. The decrease is 0.20 million. The decreases is more of females (0.14 million) than males (0.07 million)

11 SUSTAINABLE CITIES AND COMMUNITIES

52
microgram/m3 is the Annual mean concentrations of fine particulate matter (PM 2.5) in urban area

16 PEACE, JUSTICE AND STRONG INSTITUTIONS

6
mortality rate per **100,000** population due to homicide

5.2
mortality rate per **100,000** population due to conflicts

5 STATUS OF UNIVERSAL HEALTH COVERAGE SERVICE COVERAGE INDEX

KEY FINDINGS

1	At the National level, performance on the **UHC service coverage index** improved from 40 in 2015 to 52.7 in 2022 and **53.9 by the end of 2023** with a percentage change since 2015 and 2022 of 35.8 percent and 2.2 percent respectively, marking a positive but slow trajectory.
2	Around **114 million individuals in the country are not able to access** essential health services either through public or private sector.
3	Notable **improvements since 2015 were predominantly seen in reproductive, maternal and child health indicators**, while neonatal health, infectious diseases and service access & capacity have demonstrated some improvement, with data scarcity for non-communicable disease indicators.
4	Among provinces/ federating areas, the UHC SCI of the **Islamabad Capital Territory (ICT)** ranked the highest with a score of 63.9 and followed by **Punjab** at 55.5.
5	At national level among districts, **Karachi South** has the highest UHC SCI score of 72.6 followed by **Lahore** at 65.6, **Hyderabad** 63.9, **Islamabad** 63.9 and **Abbottabad** 63.7.
6	Among the districts of provinces, **Lahore** is the highest-scoring district in Punjab, **Karachi South** is on the top in Sindh, **Abbottabad** in Khyber Pakhtunkhwa and **Quetta** in Balochistan.
7	Among the districts of Federating areas, **Mirpur** has the highest UHC SCI score in Azad Jammu and Kashmir and **Hunza** in Gilgit Baltistan.
8	For Reproductive, Maternal, Newborn and Child Health (RMNCH) category, **Jhelum** has the highest aggregate score of 78.4 followed by **Hunza** at 77.8 and **Lahore** at 76.4.
9	For Infectious Diseases category, **Peshawar** has the highest aggregate score of 56.4 followed by **Gilgit** at 54.7 and **Chitral** at 53.2.
10	For Non-communicable Disease category, the score remains the same for all provinces/ federating areas, as no survey results/ disaggregated data are available.
11	For Services Capacity & Access category, **Karachi South** topped with score of 129.3, then **Islamabad** at 100.6 and **Lahore** at 95.7, also indicating significant investment on hospitals in major cities.
12	Slow improvement in the UHC SCI from 2021 can also be attributed to a **10-points decrease in the International Health Regulations (IHR) index score** considering 15 core capacities, referenced to the Joint External Evaluation (JEE) done in 2023, with a major change in the new JEE tool.

Achieving the service coverage dimension of UHC means that all people receive the **promotive, preventative, curative, rehabilitative, and palliative** health services they need, of sufficient quality. These services must not only be readily available but also maintain high standards to foster improvements in health and overall well-being. The advancement towards the SDG target 3.8.1 is assessed through the evaluation of essential health services coverage in a country or

geographical area. In this chapter, we present the latest estimates for SDG 3.8.1 at national, provincial/ federating area and district level and delve into an analysis of the prevailing trends, the rate of progress observed in the UHC SCI and on the status of associated indicators.

UNIVERSAL HEALTH COVERAGE SERVICE COVERAGE INDEX, SDG 3.8.1

To measure the service coverage dimension of UHC (SDG 3.8.1), a basket of representative essential health services is considered. This encompasses 14 representative proxy indicators grouped into four categories: 1) reproductive, maternal, new-born and child health; 2) infectious diseases; 3) non-infectious diseases; and 4) services capacity & access. UHC places significant emphasis on the integration of these four categories across all five tiers of the healthcare delivery system, which includes **community level, primary healthcare facility, first-level hospital, tertiary hospital, and the population level** and through both the public and private sector.

Monitoring the coverage of essential health services presents unique challenges due to the inclusionary nature of UHC and its emphasis on providing health services (**promotive, preventive, curative, rehabilitative and palliative**) of sufficient quality to be effective to persons in need. No index can fully summarize all the health services required across the life course to achieve UHC. Given this fact, the current UHC SCI (SDG 3.8.1) uses a selection of proxy indicators to track overall coverage of essential health services. The UHC SCI, is calculated as the geometric mean of 14 indicators. For countries that are not endemic for malaria, the insecticide-treated net (ITN) coverage indicator is excluded, and the geometric mean is calculated using only 13 indicators. The latest formula to estimate UHC SCI was updated on 24 January 2023 for the SDG indicators metadata repository.

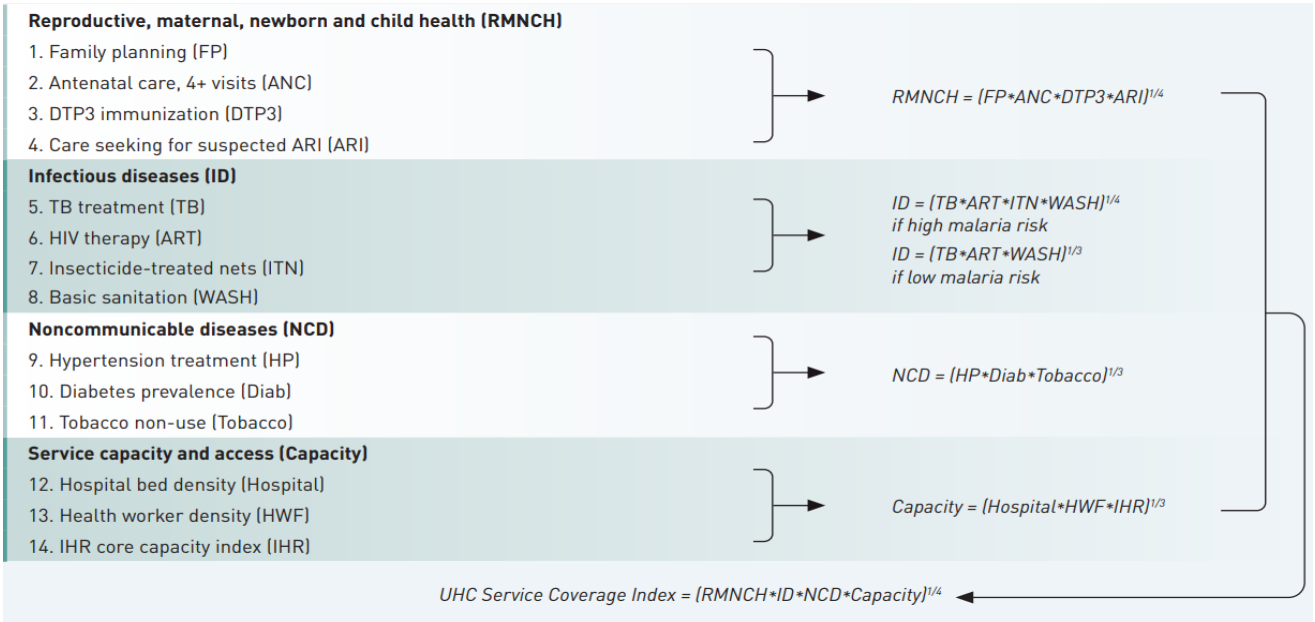


Figure 15: UHC SCI (SDG 3.8.1) components and calculation

Methodology used for estimation is based on the approach described in the 2023-Global UHC Monitoring Report (World Bank and WHO). The primary data sources used for indicators of service coverage include the Pakistan Demographic & Health Surveys (PDHS), Pakistan Social & Living Standards Measurement Surveys (PSLM), Multiple Indicator Cluster Surveys (MICS), National and Provincial Bureau of Statistics reports, Programmatic data of Health Departments, Pakistan Medical and Dental Council, JEE 2023, Global Monitoring Reports and others. Pakistan UHC SCI is improving but much low compared to other countries and the regions. Considering 2015 as a baseline by WHO and WB, the UHC index depicted

that the situation was not good with a SCI score of 39.7 in 2015. Based on Global UHC Monitoring Report 2023, the UHC SCI score among the countries are shown in the following figure.

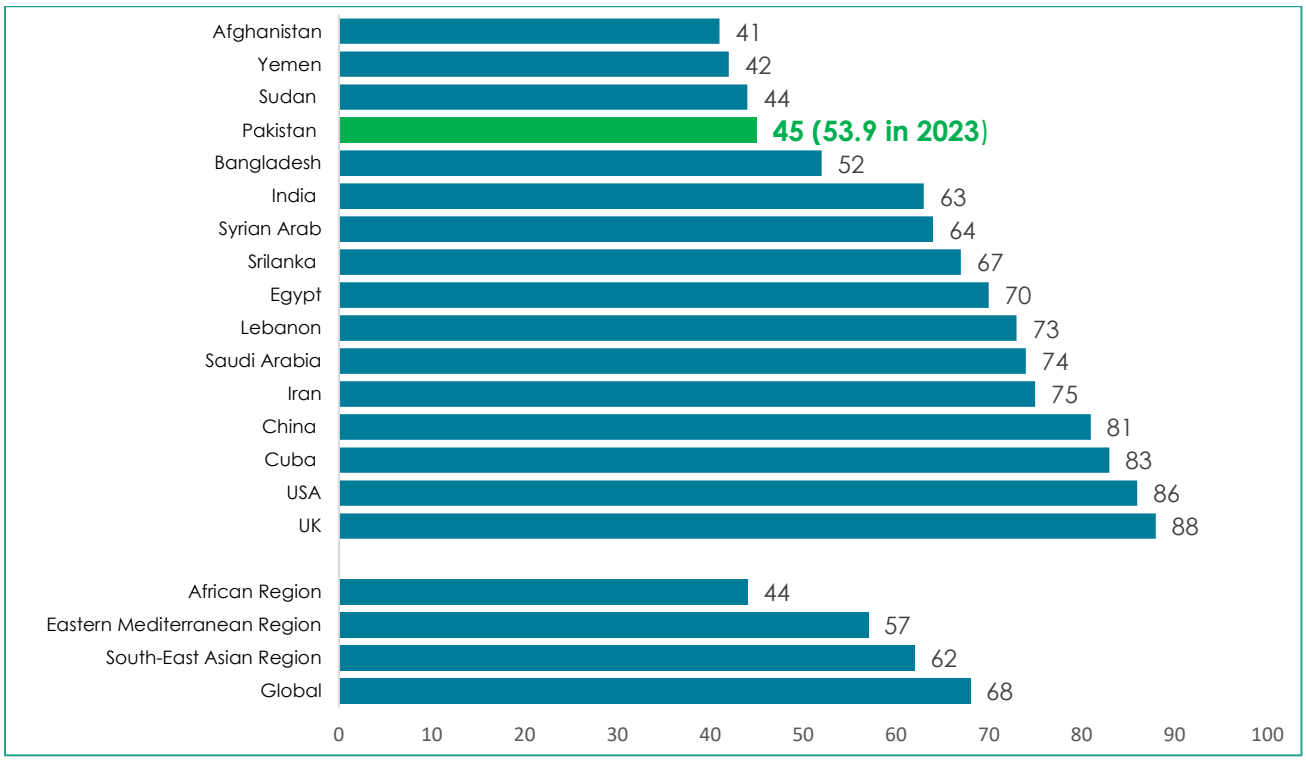


Figure 16: Country Comparison UHC SCI Index (2021)

The National level analysis of UHC SCI indicates a gloomy picture of the health sector. Trend in UHC SCI of Pakistan is positive but slow and has increased from 39.7 in 2015 to 53.9 in 2023, as shown below.

Table 5 Trend in the UHC SCI at National and Provincial level (2015-23)

Province/Area	2015	2016	2017	2018	2019	2020	2021	2022	2023	%change Since 2022	%change Since 2015
Islamabad	44.7	47.7	48.9	48.5	51.3	56.0	56.3	58.2	**63.8**	8.8%	42.7%
Punjab	40.6	42.8	45.6	47.3	48.2	52.0	53.8	53.8	**55.4**	3.0%	36.5%
Azad Jammu & Kashmir	39.0	40.7	43.6	46.2	47.9	49.8	50.2	49.3	**51.2**	3.7%	31.2%
Khyber Pakhtunkhwa	36.2	40.7	45.8	47.3	47.6	50.3	49.8	51.0	**51.0**	0.0%	40.9%
Sindh	37.6	40.6	43.9	45.0	46.7	48.6	48.0	49.2	**50.7**	3.0%	34.9%
Gilgit Baltistan	35.8	39.3	41.0	42.6	43.5	45.2	48.5	48.5	**50.4**	3.8%	40.8%
Balochistan	27.1	29.3	32.3	33.5	35.0	35.2	35.7	37.4	**38.4**	2.6%	41.6%
Pakistan	**39.7**	**42.1**	**45.3**	**46.3**	**47.1**	**49.9**	**52.0**	**52.7**	**53.9**	**2.2%**	**35.8%**

There is also noteworthy variation in UHC SCI at the provincial/ federating area level. The UHC SCI of the Islamabad Capital Territory (ICT) ranks highest among all with a score of 63.8. The UHC SCI of KP remains static from last year estimates. However, Punjab, AJ&K and GB increased by 3 percent or more, whereas Balochistan has shown over 2 percent increase, over the same period.

Inequities in the provision of healthcare services persist at all levels, as various demographic sub-groups encounter differential access to essential health services. It is crucial to measure and closely monitor these intra-country disparities, as this allows us to identify and address the marginalized populations that are being left underserved. This, in turn, informs targeted efforts aimed at closing the existing gaps in healthcare equity. However, a significant challenge in tracking these disparities within the UHC SCI lies in the limited availability of disaggregated data. There are some indicators in the sub-components of the UHC SCI, where the disaggregated data is not available at all, e.g. NCD and IHR Index, human resources

for health. Figures were therefore, estimated at the provincial and district levels by applying weightage of the human development index (HDI) on national figures.

The UHC SCI comprises sub-indices covering four key health domains: RMNCH, infectious diseases, NCDs, and health service capacity & access. When examining the overall UHC index scores across all four categories, 45 districts were having UHC SCI score of less than 40; 39 districts scored in the range of 40 to 49, while 57 districts were in the range of 50 to 59. Only 11 districts were having UHC SCI score of 60 and above. The breakdown highlights the variations in health coverage across four categories as shown below.

Table 6 Number of Districts by Variation in Scoring – Category-wise and overall UHC SCI

Category	No of districts with score <40	No of districts with score 40-49	No of districts with score 50-59	No of districts with score 60 & >
RMNCH	40	21	28	63
Infectious Diseases	75	63	11	0
Non-Communicable Diseases	0	0	152	0
Services Capacity & Access	61	29	34	28
Universal Health Coverage SCI	**45**	**39**	**57**	**11**

Notable improvements since 2015 were observed in reproductive, maternal, newborn, and child health category, while infectious diseases and health service capacity & access demonstrated gradual increase, with insignificant improvement in non-communicable disease category.

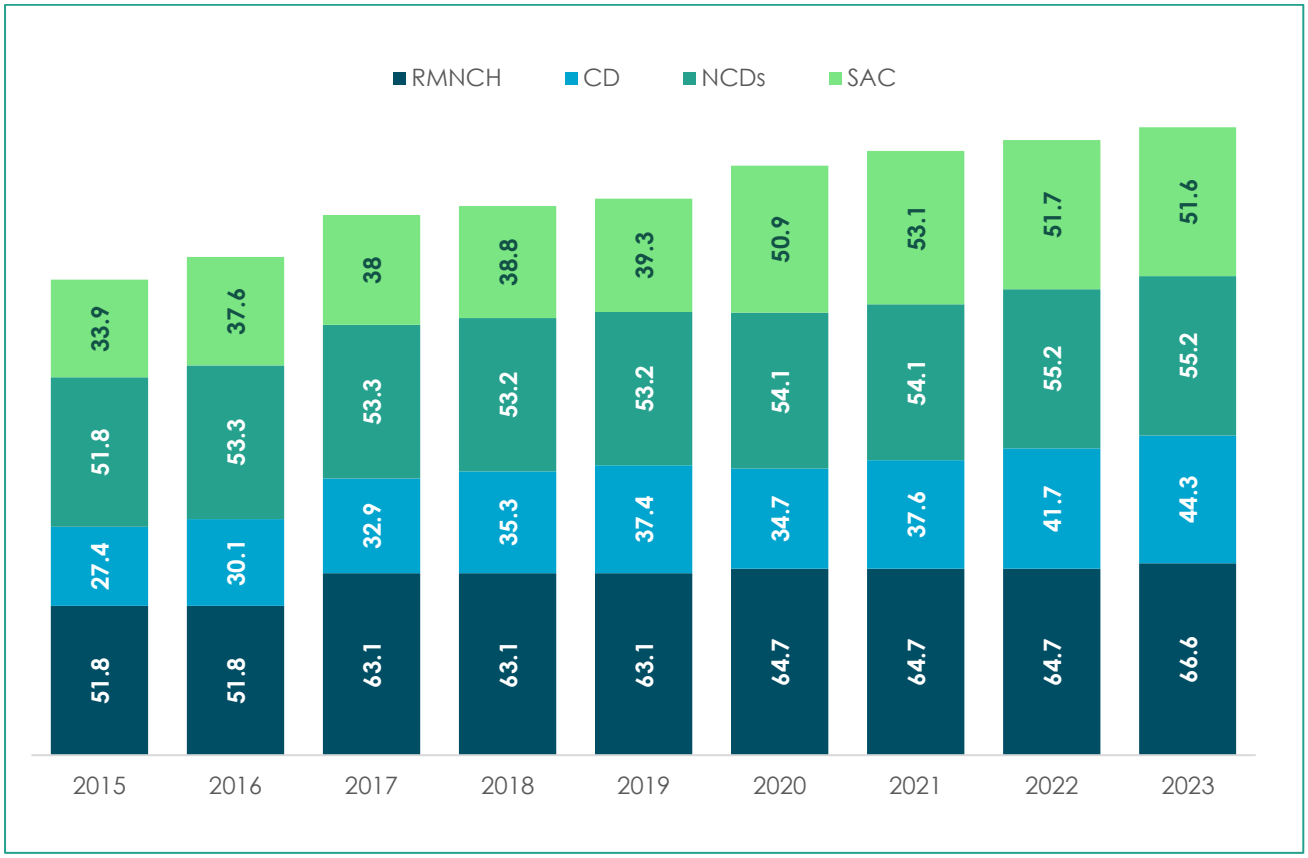


Figure 17: Trends in UHC SCI by Scores of the Four Categories (2015-2023)

MAP 1: UHC SERVICE COVERAGE INDEX (2023)

TARGET 2030

Global: **80+**

National: **65+**

GB
50.4

ISLAMABAD CAPITAL TERRITORY
63.8

KHYBER PAKHTUNKHWA
51.0

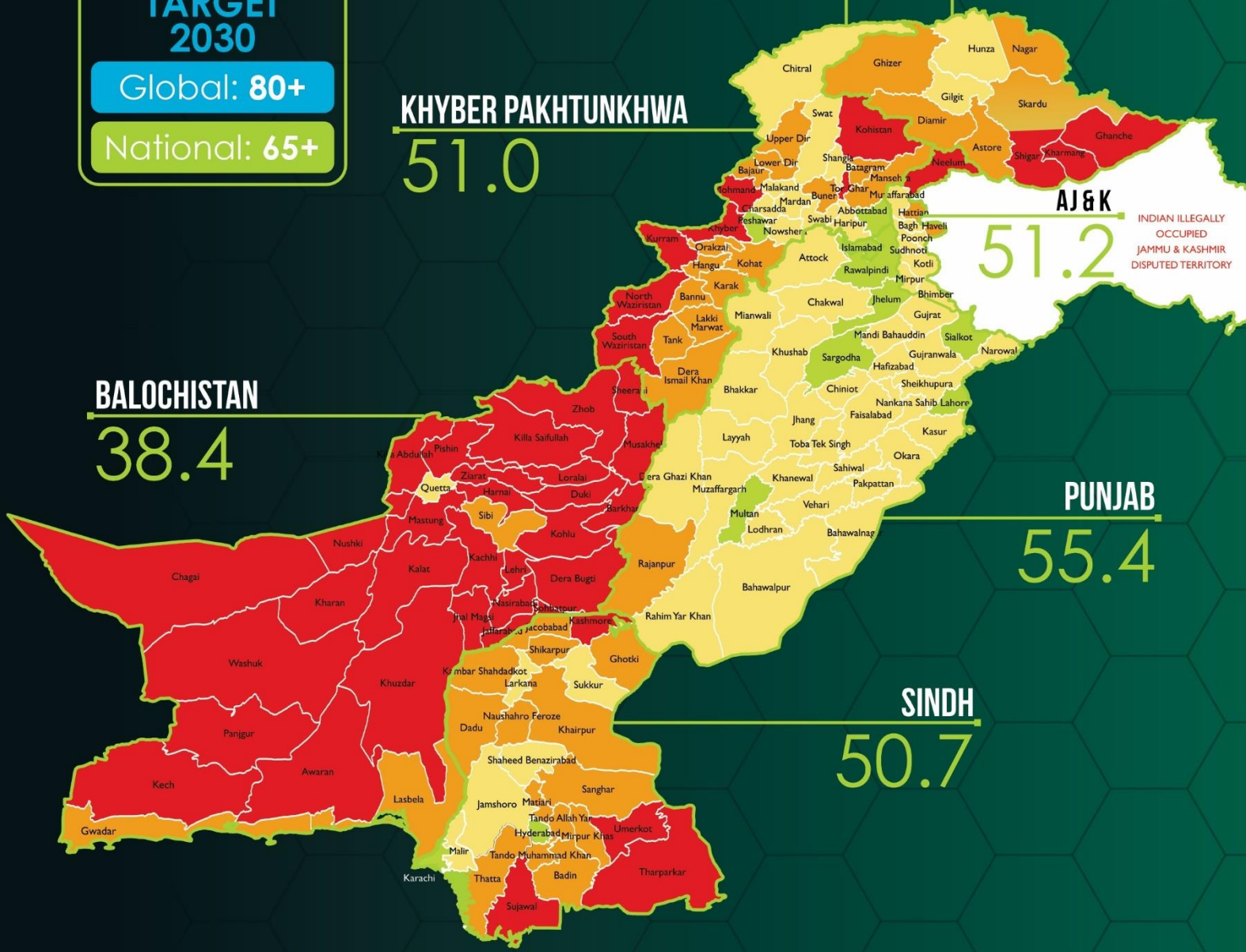
AJ&K
51.2

INDIAN ILLEGALLY OCCUPIED JAMMU & KASHMIR DISPUTED TERRITORY

BALOCHISTAN
38.4

PUNJAB
55.4

SINDH
50.7



PAKISTAN
53.9

DISTRICT-WISE UHC SCI 2023

<40 | 40-49 | 50-59 | >60

5.1 REPRODUCTIVE MATERNAL, NEWBORN AND CHILD HEALTH

For UHC service coverage index, the RMNCH category consist of four proxy and priority indicators related to: i) Family planning; ii) Antenatal care (4+) visits; iii) Child immunization (Penta 3); and iv) Care- seeking behaviour for childhood pneumonia. RMNCH aggregate score for Pakistan is estimated to be 66.6 in 2023 and has improved significantly from a baseline of 51.8 in 2015. With continued efforts, universal access to RMNCH services can easily be assured. Further, description of the status of RMNCH category is as follows.

Table 7 National and Province/Federating Area wise RMNCH Aggregate Score

UHC Indicators for RMNCH Category	Punjab	Sindh	KP	Balochistan	ICT	GB	AJ&K	National
Family Planning demand satisfied with modern methods (%)	50.3	44.3	50.2	34.5	55.1	46.4	51.6	**54.0**
Antenatal care -4+ visits	56.2	44.3	44.6	17.4	80.8	27.9	49.2	**51.4**
Child immunization (Penta 3) (%)	95.2	76.7	70.9	45.9	86.5	82.2	95.6	**84.4**
Care-seeking behaviour for child pneumonia (%)	86.1	69.0	70.0	67.6	83.6	76.3	52.8	**84.2**
RMNCH Aggregate Score	**69.3**	**56.7**	**57.7**	**36.9**	**75.3**	**53.3**	**59.8**	**66.6**

Reproductive, Maternal, Newborn, and Child Health (RMNCH) addresses health concerns across different stages of life, focusing on women before and during pregnancy, newborns (first 28 days), and children up to their fifth birthday. This area has remained a priority for both governments and civil society in low- and middle-income countries (LMICs). The government of Pakistan has developed the National Vision 2016-2025 for coordinated priority actions to address challenges of reproductive, maternal, newborn, child, adolescent health and nutrition.

Pursuing the SDG 3 targets, a series of initiatives launched during the last two decades. Reproductive, maternal, new-born, child health (RMNCH) impact level indicators showed a positive trend towards the implementation of UHC roadmap. A good progress in safe motherhood as shown in Pakistan Maternal Mortality Survey (PMMS) 2019 as **Maternal Mortality Ratio** of 186/100,000 live births (199 in rural areas and 158 in urban areas) was estimated[17] during three years preceding the survey. A positive declining trend is also estimated by the UN Inter-Agency (UN IGME) group, as shown in figure on trend on maternal mortality.[18]

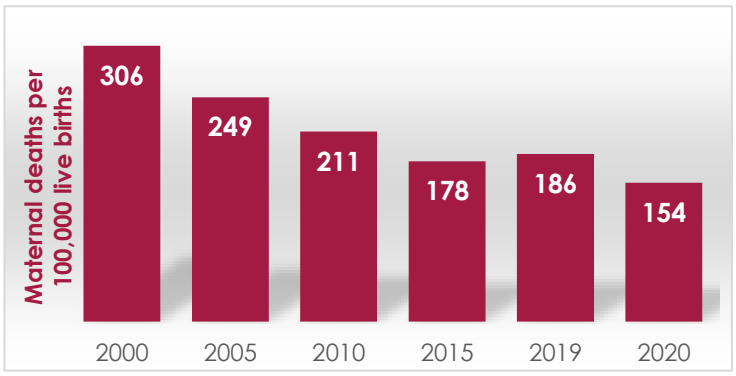


Figure 18: Trend of Maternal Mortality Ratio in Pakistan

17 Pakistan Maternal Mortality Survey (PMMS) 2019.
18 Trends in Maternal Mortality 2020, UN IGME Estimates

According to Pakistan Maternal Mortality Survey 2019, maternal deaths are categorised as either direct or indirect. Direct maternal deaths in Pakistan accounts for 96 percent, resulting from obstetric complications during pregnancy, labour, or within 42 days after delivery. Indirect maternal deaths, which make up the remaining 4 percent, stem from non-obstetric conditions aggravated by pregnancy. A smaller percentage of deaths remain unspecified due to a lack of adequate health data, particularly for those occurring outside healthcare facilities. This lack of clarity remains a significant barrier to improving maternal health outcomes and highlights the urgent need for better data collection systems.

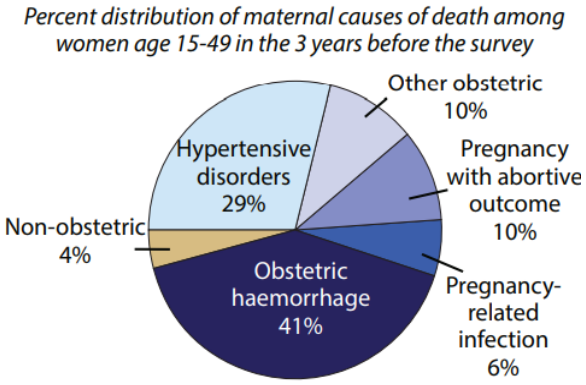


Figure 19: Maternal Causes of Death 2019

The leading causes of maternal deaths in Pakistan reflect global patterns, with obstetric haemorrhage (41 percent) and hypertensive disorders (29 percent). Other common pregnancy-related complications include abortion-related issues, sepsis, and prolonged or obstructed labour, which also contribute significantly to maternal morbidity. Poor health reporting and underreporting of abortion-related deaths due to societal stigma further exacerbate these issues, hindering an accurate understanding of maternal mortality.

Maternal morbidity is also a serious concern in Pakistan, with common conditions including anaemia, pre-existing hypertension, diabetes, and mental health disorders such as depression. The high prevalence of these preventable conditions further underscores the inequities in access to healthcare, particularly in rural and underserved areas. In addition to these challenges, complications from prolonged and obstructed labour often result in conditions like obstetric fistula, severely affecting the quality of life for affected women.

Pakistan was one of the earliest developing countries to launch family planning initiatives, starting in the 1950s. Despite these early efforts, the outcomes have been inconsistent and underwhelming. By the 1990, Pakistan's **Total Fertility Rate (TFR)** was an alarming >6 births per woman, revealing the slow progress of family planning programmes. While the TFR gradually declined to 5.4 by the early 1990s, the contraceptive prevalence rate (CPR) remained critically low, thus contributing to the high population growth rate.

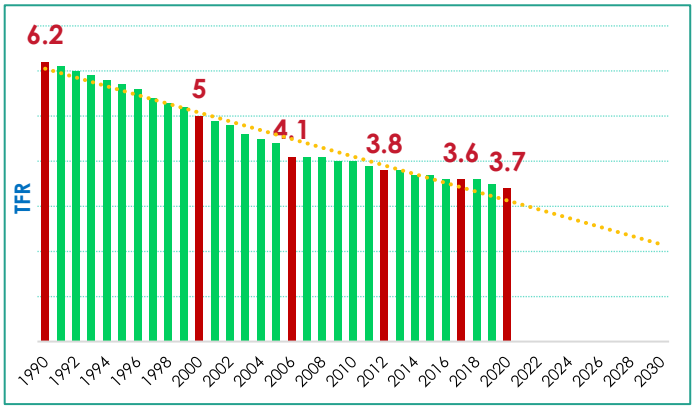


Figure 20: Trend of Total Fertility Rate in Pakistan

The TFR in Pakistan is 3.7 births per woman according to PDS 2020. Mothers living in rural areas, on average, bear one more child than mothers in urban areas (4.1 versus 3.1 births per woman).

Age-specific fertility rates (ASFRs) among women aged 15-19 is 41 births per 1,000 women, a figure that increases sharply to 176 births among women age 20-24 and peaks at 215 births among women age 25-29 according to PDS 2020.

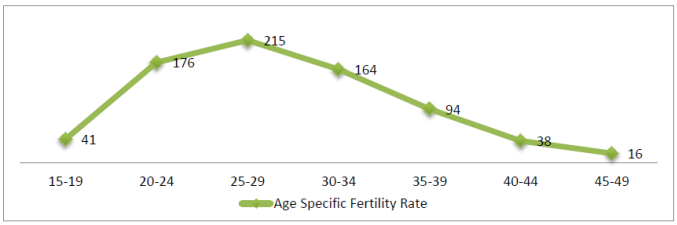


Figure 21: Age Specific Fertility Rates - PDS 2020

The relationship between wealth quantiles and fertility rates is complex, generally indicating that lower wealth quantiles tend to have higher fertility rates, while wealthier groups exhibit lower rates. Access to education plays a significant role in these dynamic, as wealthier individuals, particularly women, have better educational opportunities that correlate with increased awareness of family planning methods and a preference for smaller family sizes. Educated women often choose to delay marriage and childbearing, contributing to lower fertility in higher wealth brackets. Moreover, economic stability allows wealthier families to focus on smaller family sizes, whereas lower wealth quantiles perceive larger families as necessary for economic support.

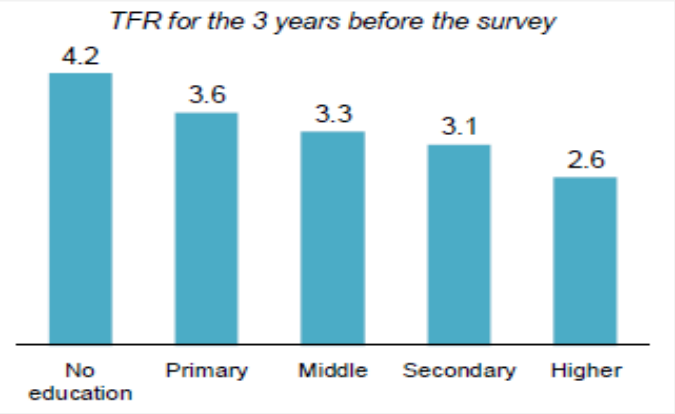


Figure 22: Relationship of Fertility by Education

ADOLESCENT HEALTH

In Pakistan, adolescent females face a significant burden of various diseases. According to GBD 2021, communicable diseases like enteric infections have declined in relative burden, while non-communicable diseases, including mental and neurological disorders, have gained prominence. Nutritional deficiencies remain a major issue, ranking first in 2021, underscoring persistent challenges in adolescent nutrition. The number of DALYS lost due to nutritional deficiencies among females age 10-19 years are 1,477 per 100,000 population. However, Mental disorders ranked two with number of DALYs lost 1,312 per 100,000 population. Maternal disorders are crucial and improved from 1990 to 2021, with DALY lost from 1,349 per 100,000 population in 1990 to 859 per 100,000 population in 2021.

The National Nutrition Survey 2018 shows that a significant proportion of adolescent girls face malnutrition, with 11.8 percent being underweight and 54.7 percent suffering from anaemia. The PDHS 2017-18 shows that in Pakistan, 8 percent of adolescent women aged 15-19 are already mothers or pregnant with their first child. Teenage childbearing has remained unchanged since 2012-13. Five percent of adolescent women in the wealthiest households have begun childbearing, compared to 10 percent of adolescent women in the two lowest wealth quintiles. Women have their first birth more than two years after marriage. The proportion of teenagers who had begun childbearing rises rapidly with age, from 1 percent at age 15 to 19 percent at age 19. Rural teenagers tend to start childbearing earlier than urban teenagers. Teenagers with more than a secondary education and those in the highest wealth quintile tend to start childbearing later than those with no education or with lower levels of education and those in other quintile.

FAMILY PLANNING

Pakistan's population growth poses a significant challenge to its development trajectory. High fertility rates are compounded by socio-cultural barriers, especially in rural areas where family planning is considered taboo. Cultural preferences for sons, early marriages, and misconceptions about modern contraceptive methods remain prevalent, contributing to a high incidence of unwanted pregnancies. On average, couples in Pakistan have one more child than they desire, signalling a gap in both awareness and access to family planning services. These supply-side issues, including insufficient service access, lack of counselling, and unmotivated healthcare providers, remain key barriers to effective family planning.

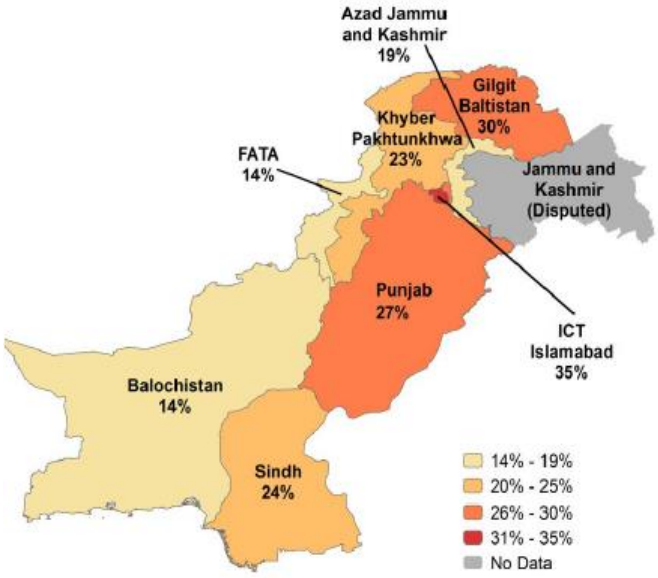


Figure 23: Modern contraceptive use by province/ area

Despite some early successes at the start of this millennium, family planning momentum has waned in recent years. According to PDHS 2017-18, the overall contraceptive prevalence rate is 34 percent of currently married women aged 15-49, with 25 percent using modern contraceptive methods and 9 percent using traditional methods. Use of a family planning method rises with age of currently married women. Modern contraceptive use among currently married women increases according to wealth quintile, from 17 percent for women in the lowest quintile to 30 percent for those in the highest quintile.

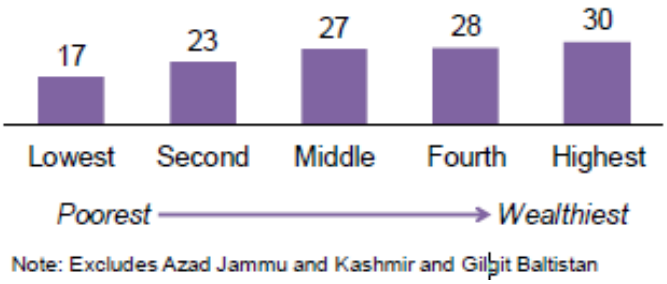


Figure 24: Modern Contraceptive Use by Income quintile

Contraceptive prevalence of the modern methods (mCPR) increased in Pakistan from 9 percent of currently married women using a modern method in 1990-91 to about 25 percent in 2017-18. By province/ area, it varied greatly in 2017-18 from a low of 14 percent in Balochistan to 30 percent in GB and 35 percent in ICT percent.

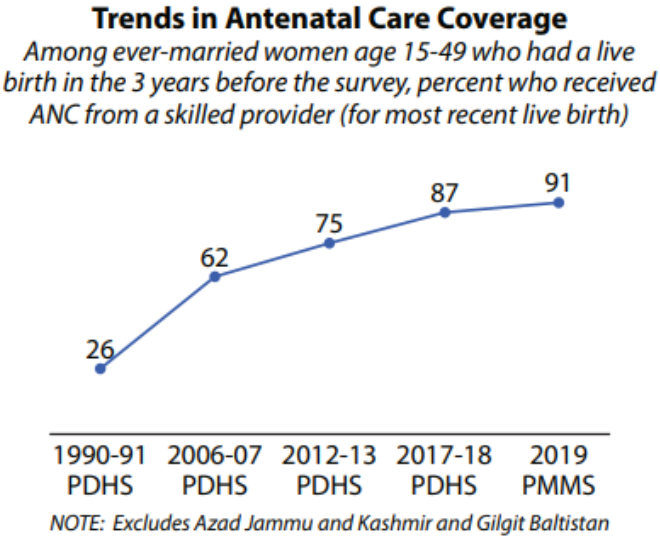


Figure 25: Antenatal Coverage from Skilled Provider PMMS 2019

ANTENATAL CARE VISITS

Antenatal care (ANC) related indicators are improving in the country. ANC by skilled providers rose to 91 percent (PMMS 2019). The timing and number of ANC visits are also important. More than half (56 percent) of ever-married women age 15-49 had their first ANC visit in the first trimester for their most recent live birth or stillbirth, as recommended. Half of women (52 percent) made

four or more ANC visits. The 2019 PMMS results show that 68 percent of women who had a miscarriage or abortion and 90 percent of women who had a stillbirth received antenatal care from a skilled provider at least once for last miscarriage, abortion, or stillbirth. The figure 25 show trends in ANC service utilisation from a skilled provider

Institutional deliveries also increased to 71 percent, primarily in private sector facilities, while 3 in 10 births are delivered at home. Births to women with higher education (93 percent) and those in the wealthiest households (90 percent) are more likely to be delivered at a health facility. Regionally, health facility deliveries range from 51 percent in Balochistan to 75 percent in Punjab. Health facility deliveries have dramatically increased since 1990-91 when only 14 percent of live births were delivered in a health facility. Home deliveries have declined from 85 percent in 1990-91 to 29 percent in 2019.

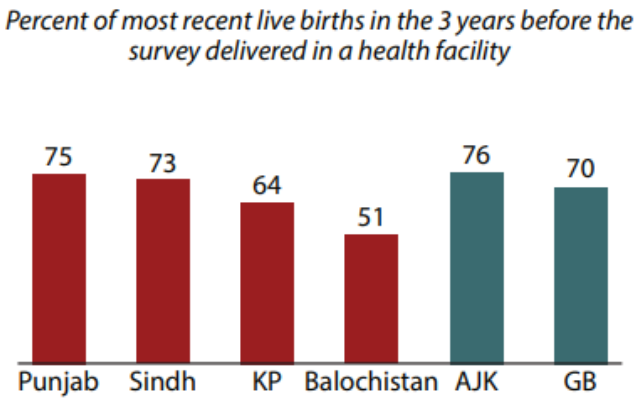


Figure 26: Institutional Deliveries by Province/Area 2019

According to PDHS 2017-18, disparities according to socioeconomic characteristics persist; urban women are more likely than rural women to have received ANC from a skilled provider (94 percent and 82 percent, respectively).; women in the highest wealth quintile and the highest education category are more likely to receive ANC services (98 percent and 99 percent respectively) from a skilled provider. By province/ area, use of ANC services from skilled providers is highest in Punjab (92 percent) and lowest in Balochistan (55 percent).

CHILD IMMUNIZATION

Pakistan, as part of its commitment to the SDGs, aims to reduce the under-five mortality rate (U5MR) to 25 deaths per 1,000 live births by 2030 (SDG 3.2). However, achieving this target requires a multifaceted approach to strengthen child health services, especially in immunization. Pakistan has a neonatal mortality rate **(NMR)** of 39 deaths per 1000 live births, one of the highest in the world, and an under-5 child mortality rate **(U5MR)** of 61 deaths per 1000 live births exceeds that of its neighbours and underscores significant challenges in child healthcare. Neonatal deaths, which account for a large proportion of under-five mortality, emphasise the need for improved prenatal and neonatal care. Stillbirths and complications from preterm births, pneumonia, diarrhoea, and neonatal infections remain prevalent, contributing to Pakistan's high child mortality rates. These conditions are exacerbated by inadequate access to essential health services, skilled birth attendants, and timely interventions during delivery and postnatal care.

Despite global advancements, Pakistan's progress in reducing child mortality remains slow, particularly in rural areas where healthcare access and quality are limited. The persistence of infectious causes of death, such as pneumonia and diarrhoea, is particularly concerning, although further implementation of proven health interventions could help reduce these numbers.

The TPVICS (R-II) showed that 89 percent of the children aged 12-23 months in Punjab were fully immunized. In Sindh 69.0 percent, KP 61.0 percent and in Balochistan 37.0 percent of the targeted children were fully immunized. In the federal regions, KP-NMDs 41.0 percent and Islamabad, 81.0 percent of children were fully immunized.

Seventy-six percent of children under the age of 2 years have received the full course of vaccinations recommended by Pakistan's government compared to 65 percent in 2017-18.

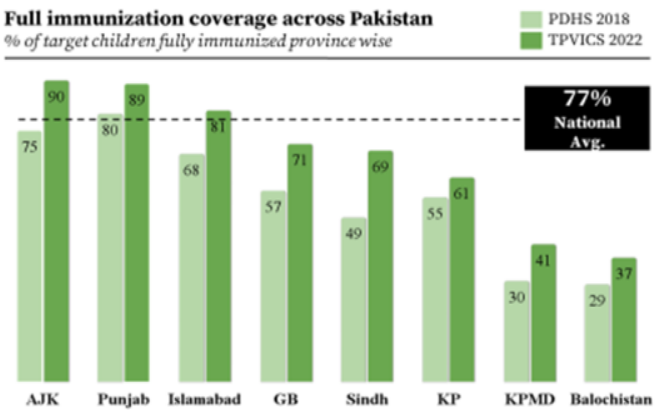


Figure 27. Full Immunisation coverage across Pakistan

According to the TPVICS (R-II), in Punjab, all 36 districts reported at least 80 percent coverage of Penat3 immunization, while 44.8 percent districts (13 out of 29) in Sindh, 24 percent (6 out of 25) in KP, and 18.2 percent (6 out of 33) in Balochistan reported at least 80 percent coverage of Penat3 immunization among targeted children. One district in KP-NMD and the sole district in Islamabad recorded at least 80 percent Penta3 coverage.

The Expanded Programme for Immunization (EPI) has been instrumental in addressing major child health concerns, with the introduction of vaccines for rotavirus and pneumococcal pneumonia to reduce morbidity. Despite these advances, socioeconomic factors, maternal education, and short birth intervals continue to influence child mortality risk. While immunization rates have improved, gaps remain in areas such as care-seeking for Acute Respiratory Infections (ARI). According to the PDHS 2017-18, 85 percent of children had vaccination cards, but actual verification during interviews revealed a lower rate, indicating inconsistencies in record-keeping and follow-up.

POLIO

Polio was declared a national public health emergency in 2011 by the Government of Pakistan. Pakistan's polio eradication efforts are overseen by the National Task Force, chaired by the Prime Minister, with the National Emergency Operations Centre (NEOC) leading the implementation. Till December 27, 2024, **67** cases have been reported all across the country.

Table 8 WPV Polio Cases Across Pakistan's Province (2015 - 2024)

PROVINCE	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
PUNJAB	2	0	1	0	12	14	0	0	0	1
SINDH	12	8	2	1	30	22	0	0	2	19
KHYBER PAKHTUNKHWA	33	10	1	8	93	22	0	20	4	19
BALOCHISTAN	7	2	3	3	12	26	1	0	0	27
GILGIT-BALTISTAN	0	0	1	0	0	0	0	0	0	0
AZAD JAMMU & KASHMIR	0	0	0	0	0	0	0	0	0	0
ICT	0	0	0	0	0	0	0	0	0	1
TOTAL POLIO CASES	54	20	8	12	147	84	1	20	6	67

The Polio programme uses four distinct risk tiers to classify areas according to the risk they present and to devise risk appropriate eradication strategies and activities. This includes core reservoir districts (Tier 1 districts), high-risk districts (Tier 2 districts), vulnerable districts (Tier 3 districts), and low-risk districts (Tier 4 districts). A 'core reservoir' (Tier 1) refers to an area which has persistent local WPV1 circulation for at least 18 months and a repeated history of reseeding the virus outside immediate transmission zones. Meanwhile, 'high-risk districts' (Tier 2) have detected intermittent transmission or sustained risk due to low levels of population immunity or other known risk factors. Lastly, districts in Tiers 3 and 4 are determined based on variabilities in both quantitative and qualitative risk assessments

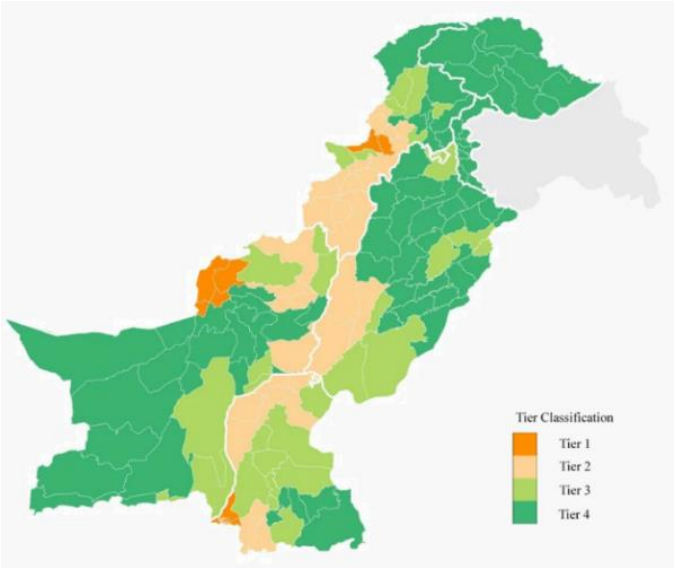


Figure 28: Tier Classification of High-Risk Districts

Till October 2024 so far, five polio campaigns have been conducted: 2 nationwide and 3 in high-risk zones and outbreak districts along with complementary vaccination activities for high-risk populations. 2.4 million children vaccinated at permanent transit points, 5.7 million at seasonal transit points and 85,000 through Nomads Immunization teams. Resistance to vaccination, boycotts, security related access challenges and high population mobility are key challenges hampering progress.

ACUTE RESPIRATORY INFECTIONS AND DIARRHOEA

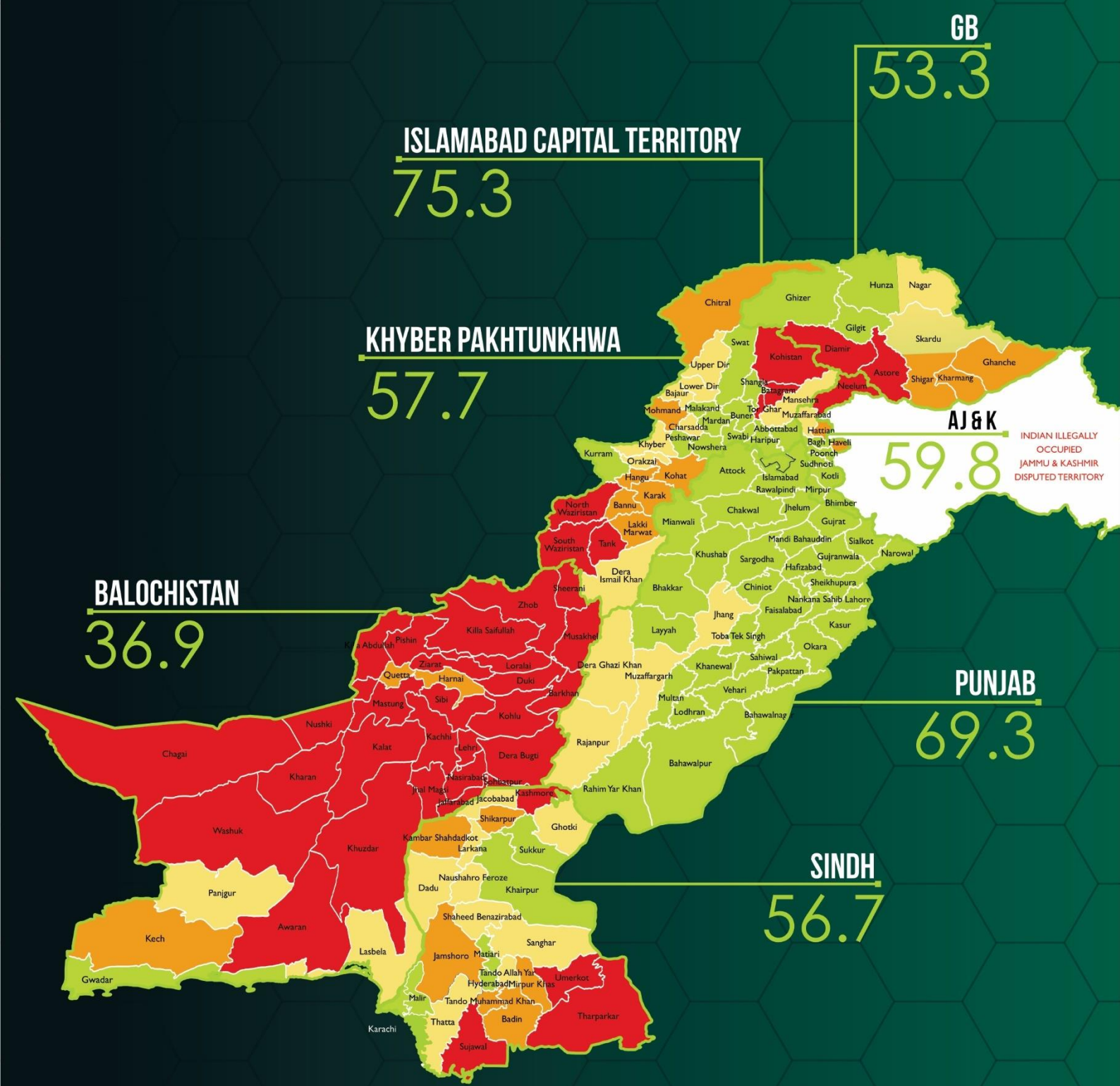
Acute respiratory infections (ARIs) are a significant public health concern in Pakistan, contributing to a high burden of morbidity and mortality, particularly among children under five years of age. In rural and urban areas alike, ARIs remain a leading cause of hospital visits and deaths. Among these, pneumonia is the most prevalent and deadly form, accounting for a substantial proportion of child mortality in the country.

Care-seeking behaviour for child pneumonia varies significantly across provinces. In Punjab, it is 74.7 in 2018, in Sindh, it is 69 percent in 2019, Khyber Pakhtunkhwa (KP) at 70 percent in 2019, while Balochistan improved from 62.2 percent in 2018 to 67.6 percent in 2020. Accordingly, care seeking behaviour for Diarrhoea is 65.7 percent in 2018, 67.4 percent in Sindh, 56.5 percent in KP and in Balochistan it is 54.5 percent

Improvements in health-seeking behaviour are noted for children under five with acute respiratory infections (ARI), with the percentage seeking care from appropriate health providers rising from 64 percent in 2013 to 71 percent in 2018. In contrast, diarrhoea treatment has stagnated; the use of oral rehydration salts (ORS) slightly decreased from 38 percent in 2013 to 37 percent in 2018, and the combined use of ORS and zinc, recommended for diarrhoea treatment, remains critically low, increasing only from 1 percent to 8 percent over five years.

While Pakistan has made notable strides in improving child and adolescent health, particularly in immunisation coverage and care-seeking for respiratory infections, significant challenges remain. The stagnation in diarrhoea treatment, gaps in malaria prevention, and a substantial number of unvaccinated children highlight the need for focused interventions. Strengthening healthcare outreach, improving access to essential treatments, and enhancing preventive measures are critical to further reducing child morbidity and mortality across the country. Addressing these disparities will be essential in meeting national and global health targets.

MAP 2: RMNCH AGGREGATE SCORE IN 2023



DISTRICT-WISE UHC SCI 2023

PAKISTAN

66.6

5.2 INFECTIOUS DISEASES

The Infectious Diseases category consist of four proxy and priority indicators including i) Tuberculosis; ii) HIV & AIDS; iii) Malaria prevention; and iv) Water and Sanitation. Malaria prevention indicator is not currently monitored at global and national level for UHC reporting. Infectious Diseases aggregate score for Pakistan is estimated to be 44.3 in 2023 and has improved significantly from a baseline of 27.4 in 2015. Among provinces, GB has the highest score of 49.3, however, Balochistan has the lowest score of 28.8.

Table 9 National and Province/Federating Area wise Infectious Diseases Aggregate Score

UHC Indicators for Infectious Diseases Category	Punjab	Sindh	KP	Balochistan	ICT	GB	AJ&K	National
Tuberculosis effective treatment (%)	80.2	73.7	55.3	33.3	42.9	95.0	53.4	**71.6**
HIV treatment (%)	14.7	11.7	19.4	16.2	14.7	14.7	14.7	**14.7**
Insecticide-treated nets for malaria prevention (%)	NA	NA	NA	NA	NA	NA	NA	**NA**
At least basic sanitation (%)	89.0	76.0	84.0	44.0	99.0	86.0	82.3	**83.0**
Infectious Diseases Aggregate Score	**47.2**	**40.3**	**44.8**	**28.8**	**39.7**	**49.3**	**40.1**	**44.3**

Infectious diseases have long been a significant public health concern in Pakistan, contributing to a large portion of the country's morbidity and mortality. Despite progress in recent decades, Pakistan continues to grapple with both communicable diseases, including tuberculosis (TB), malaria, and HIV/AIDS, alongside the challenges posed by outbreaks like dengue, hepatitis, and COVID-19. According to the Institute for Health Metrics and Evaluation (IHME), infectious diseases remain a major cause of Disability Adjusted Life Years (DALYs) lost in Pakistan, particularly in underprivileged and rural populations. Since 2021, communicable, maternal, neonatal, and nutritional diseases accounted for almost 46.22 percent of the total disease burden in Pakistan.[19]

Tuberculosis (TB) remains a significant public health challenge in Pakistan. Despite improvements in TB incidence rates, the country faces major hurdles in controlling the disease due to its large population, high prevalence, and socioeconomic factors. In 2024, the TB incidence is 277 cases per 100,000 population [188 - 368] according to Global TB Report 2024.

The population pyramid in figure 30 illustrates the distribution of TB cases by age group and gender, comparing estimated cases (light pink bars) with notified cases (dark red bars) for both males and females. In most age groups, the estimated cases exceed the **notified cases,** indicating a gap between the actual TB burden and officially reported cases. This discrepancy is more

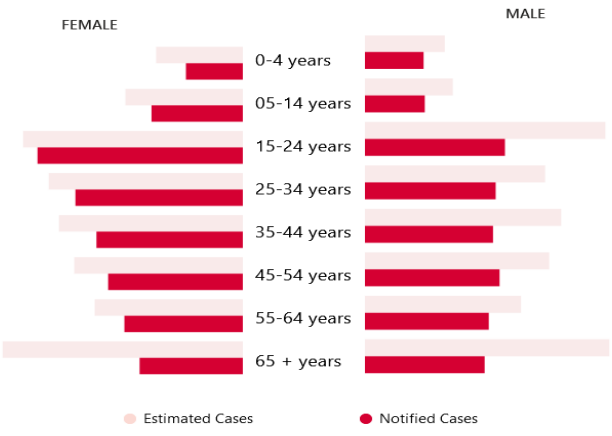


Figure 29: Age-Sex Disaggregation of People with TB, 2022

19 https://vizhub.healthdata.org/gbd-compare/ (IHME GBD 2021)

prominent in certain age groups, highlighting potential challenges in TB detection, diagnosis, or reporting. There is a need for improved case notification systems to address underreporting and ensure more accurate surveillance of TB cases across all demographics.

Pakistan continues to rank among the top 10 countries most affected by TB worldwide.[20] The graph illustrates a comparative analysis of Disability-Adjusted Life Years (DALYs) per 100,000 population due to TB across Pakistan, Philippines, Nigeria, India, Bangladesh, and Indonesia from 1990 to 2020. Pakistan has made significant progress, reducing DALYs consistently since the 2000s, it remains among the countries with a higher burden by 2020, particularly when compared to Bangladesh and Indonesia, which exhibited steeper declines. Pakistan continues to face considerable challenges, requiring ongoing efforts to reduce its TB burden further and align more closely with countries that have shown greater success, such as Bangladesh and Indonesia.

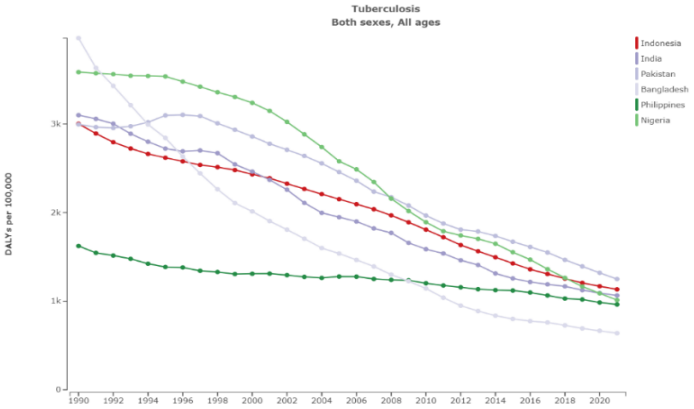


Figure 30: Country wise Comparison of DALYs for TB per 100,000 population 1990-2021

The information system of TB Programme reported that 475,761 cases of TB were notified in 2023 across the 4 provinces (Punjab, Sindh, KP and Balochistan) and the 3 federally administered areas (AJ&K, GB and ICT). Among them, 41 percent were pulmonary TB (PTB) cases, while rest include the extrapulmonary TB (EPTB) cases and TB relapse cases. A substantial decline in the number of notified TB cases occurred in 2020 because of the COVID-19 pandemic. However, national notification in 2021 reached the 2019 pre- COVID period. The figures below shows the trends in the TB case notification for all forms of TB, pulmonary TB and their percentages.

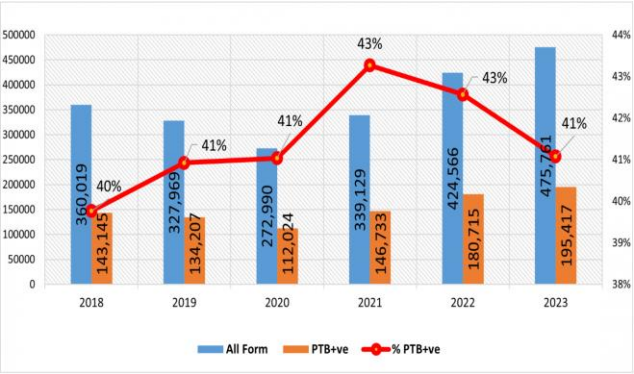


Figure 31: Number of TB Cases Notified (all forms and pulmonary TB)-2018-2023

	PTB +	PTB -	EPTB	All Form
AJK	3108	1714	1643	6465
Baluchistan	6473	5180	3437	15090
GB	523	2740	1084	4347
ICT	1328	1167	881	3376
KP NMD	15624	23296	20178	59098
Punjab	116563	119229	39960	275752
Sindh	51798	38664	21171	111633
Grand Total	195417	191990	88354	475761

Figure 32: Province/Area wise TB Case Notification by Types and All Forms - 2023

The initiatives taken to detect TB cases in the country includes the introduction of GeneXpert machines for rapid TB diagnosis and the expansion of Directly Observed Treatment Short-Course (DOTS) Programmes. These efforts have improved diagnostic efficiency and treatment access, which are crucial components of UHC programmes. However, challenges remain in reaching marginalised populations and addressing the increasing cases of drug-resistant TB.

20 https://www.who.int/teams/global-tuberculosis-programme/tb-reports

The National TB Control Programme (NTP), is the main authority responsible for TB control, diagnosis, and treatment in Pakistan. It follows the WHO-recommended Directly Observed Treatment Short Course (DOTS) strategy and aligns its targets with the WHO End TB Strategy and the Sustainable Development Goals (SDGs).[21] TB Programme is providing free of Cost state of art Diagnostic and Quality assured treatment services through the network of more than 1,700 TB care facilities in public and private sectors across the country. During the Year 2022, more than 424,000 TB cases were successfully treated.

Pakistan also faces a significant burden of multidrug-resistant tuberculosis (MDR-TB), making it the fourth-highest globally in terms of MDR-TB prevalence. Contributing factors to this public health crisis include delays in diagnosis, inappropriate or unsupervised treatments, inadequate drug regimens, and poor patient follow-up. The figure shows a combined trend analysis of the number of drug-resistant TB treatment sites and enrolment from 2017 to 2023. The red line shows fluctuations in enrolment that begins at 3,081 in 2017, slightly increases until 2019, dips to its lowest point of 2,372 in 2020 due to Covid-19, and then recovers sharply, reaching its peak at 3,959 in 2023.

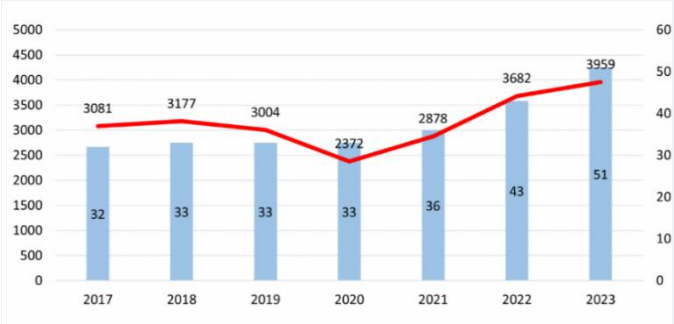


Figure 33: Number of Drug-Resistant TB Treatment sites and enrolment (2017-2023)

The table below outlines the distribution of healthcare facilities involved in tuberculosis (TB) and multidrug-resistant TB (MDR-TB) management across Pakistan, categorised by province/area and type of facility. Public sector facilities, known as Basic Management Units (BMUs), are divided into primary, secondary, and tertiary care levels, with Punjab leading in total BMUs (548). Private sector involvement is represented through the Public-Private Mix (PPM) models, including general practitioner clinics (PPM-1), NGO-run BMUs (PPM-2), large private hospitals (PPM-3), and non-health public sector facilities (PPM-4). Punjab again shows the highest engagement with 5,968 PPM-1 facilities. The table also lists TB/HIV sentinel sites and PMDT (Programmatic Management of Drug-resistant Tuberculosis) sites, crucial for TB/HIV co-infection monitoring and MDR-TB treatment, respectively. This data reflects a collaborative effort between public and private sectors to strengthen TB care and control across the country.[22]

Table 10 Distribution of healthcare facilities involved in tuberculosis (TB) and multidrug-resistant TB (MDR-TB) management across Pakistan in 2022

	# Districts	Public sector BMUs				Private sector Facilities				TB/HIV sentinel sites	PMDT sites
		Primary care level	Secondary care level	Tertiary care level	Total	PPM-1 (GP Models) Updated Till June 2023	PPM-2 (NGO run BMUs)	PPM-3 (large Pvt Hosp)	PPM-4 (Non-health public sector)		
AJ&K	10	38	21	1	60	181	0	0	1	1	1
Baluchistan	33	67	36	6	109	302	3	4	3	4	3
GB	10	13	21		34	59	0	0	0	1	1
ICT	01	3	2	2	7	62	0	1	0	1	1
KP & NMD	34	103	116	9	228	1248	11	1	4	7	5
Punjab	36	365	151	32	548	5968	34	27	22	15	13
Sindh	29	255	85	12	352	3185	26	16	7	16	9
Pakistan	153	844	432	62	1338	11005	74	49	37	45	33

21 https://www.cmu.gov.pk/ntp-national-tb-control-programme/
22 National TB Control Programme (https://www.cmu.gov.pk/ntp-national-tb-control-programme/)

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

HIV remains a critical public health concern in Pakistan, with the country experiencing a concentrated epidemic. Over the last decade, Pakistan has seen a steady rise in HIV/AIDS cases, with an estimated 290,000 people living with HIV as of 2023. However, only 63,202 individuals are aware of their HIV-positive status, and merely 40,652 are receiving antiretroviral therapy (ART). The majority of cases are concentrated among key populations, but the broader community has also been affected, particularly bridging populations.[23]

VULNERABLE POPULATION WITH HIV PREVALENCE

PWID:	TGSW:	TG:
38.4%	7.5%	7.1%
MSW:	**MSM:**	**SW:**
5.6%	5.4%	2.2 %

Despite some progress through interventions such as ART and prevention of mother-to-child transmission, Pakistan remains one of the 12 countries globally experiencing a rise in new HIV infections since 2010. This places Pakistan among countries like Afghanistan, Egypt, and Saudi Arabia that have not managed to curb the spread of HIV, indicating significant gaps in prevention strategies compared to regional neighbours. Pakistan also stands out negatively as one of the 10 countries with an increase in AIDS related deaths, placing it behind other nations that have successfully reduced mortality through better treatment and care.[24] The figure illustrates the distribution of AIDS-related deaths across different countries. Pakistan accounts for the largest share at 48 percent, highlighting its disproportionately high burden of AIDS-related mortality in the region. Iran follows with 19 percent, indicating a significant share, while Sudan contributes 14 percent of the total deaths. Other countries, collectively, account for 16 percent, showing a more scattered distribution of mortality outside the highlighted nations. Afghanistan records the smallest proportion at just 3 percent.[25] This distribution underscores the need for urgent intervention in Pakistan, where nearly half of all AIDS-related deaths are concentrated, suggesting challenges in prevention, diagnosis, and treatment.

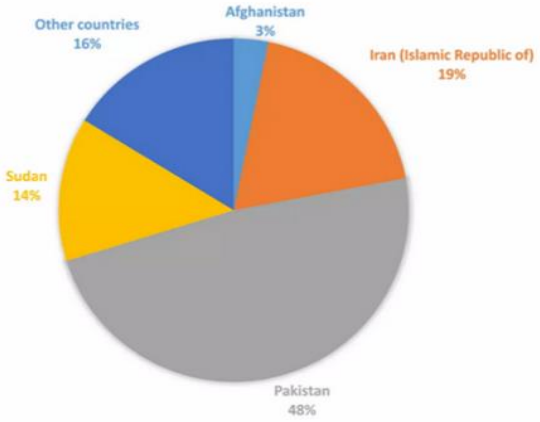


Figure 34: AIDS-related Death Distribution in Countries

Pakistan's HIV prevalence has shifted from low to concentrated, especially among key populations (People who Inject Drugs (PWID)s, Female Sex Workers (FSWs), Transgenders (TGs), Male Sex Workers (MSWs) and Men who have sex with Men (MSM).[26] Nearly 5 million people in bridging populations are at risk due to unprotected sexual contact with key populations.[27]

23 https://www.cmu.gov.pk/about/
24 https://www.emro.who.int/asd/country-activities/
25 https://www.emro.who.int/asd/country-activities/
26 https://www.nih.org.pk/public/national-aids-control-programme
27 https://nacp.gov.pk/howwework/strategies.html

Table 11 Vulnerable Population with their HIV Testing and ART Coverage in %

Population Group	HIV Testing (%)	ART Coverage (%)
Sex Workers	37.5%	9.7%
MSM	49.5%	2.1%
PWID	100%	13.7%
Prisoners	2%	99.2%
TGs	34.3%	5.3%

From 2010 to 2023, the estimated number of people living with HIV in Pakistan surged from 79,000 to 290,000. While the HIV prevalence among adults aged 15-49 has increased from less than 0.1 percent to 0.2 percent, the number of AIDS-related deaths rose sharply from 2,200 in 2010 to 11,000 in 2023. ART coverage remains low, improving from 2 percent in 2010 to just 15 percent in 2023. The gaps in treatment access and healthcare services are critical drivers of these outcomes.[28] Pakistan's testing and treatment cascade reveals significant gaps as shown in table 10.

Only 23 percent of individuals living with HIV are aware of their status, and just 15 percent are receiving ART. Stigma, healthcare access barriers, and limited outreach contribute to these disparities. Women show slightly better ART access due to maternal health interventions, while men and key populations face significant challenges.[29] According to UNAIDS, Pakistan is among countries like Brazil, India, Indonesia, Mexico, Pakistan and Thailand who has the highest numbers of people living with HIV but not on treatment.[30]

The Global Report 2024[31] also reveals that HIV prevention programmes for key populations is underfunded and Proportion of spending on prevention programmes for people from key populations out of total HIV expenditure is almost 13 percent. The tables show the number of newly reported HIV cases across provinces in 2023, with men comprising the majority of cases and the estimated number of new HIV infections by province in 2023 is as follows:

Table 12 Number of newly reported HIV cases in Year 2023

Province	Male	Female	TG	Total
Punjab	6,019	1,482	433	**7,934**
Sindh	1,596	909	214	**2,719**
Khyber Pakhtunkhwa	780	289	54	**1,123**
Balochistan	251	73	20	**344**
ICT-Federal	394	110	107	**611**
National	**9,040**	**2,863**	**828**	**12,731**

Table 13 Estimated number of new HIV infections cases of Year 2023

Province	Male	Female	Total
Punjab	20,087	2,870	**22,957**
Sindh	10,581	420	**11,001**
Khyber Pakhtunkhwa	3,494	212	**3,706**
Balochistan	1,125	47	**1,172**
ICT-Federal	2,485	59	**2,544**
National	**37,771**	**3,609**	**41,380**

HIV estimates for 2024 show a significant burden of HIV among children aged 0-14, primarily due to mother to child transmission (MTCT). While maternal ART and early infant diagnosis (EID) have reduced AIDS-related mortality in children,

28 https://aidsinfo.unaids.org/
29 https://www.unaids.org/en/regionscountries/countries/pakistan
30 https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update_en.pdf
31 https://www.unaids.org/sites/default/files/media_asset/2024-unaids-global-aids-update-asia-pacific_en.pdf

gaps in ART coverage remain. Among adolescents aged 15-19, HIV transmission has shifted from perinatal to sexual causes, necessitating a focus on sexual health education and prevention strategies.[32]

Table 14 Adolescent ART Coverage (%) 2020-2023

	2020	2021	2022	2023		2020	2021	2022	2023
	Age 10-19					Age 15-24			
All	27	13	16	19	**All**	13	6	6	6
Boys	29	14	16	19	**Boys**	13	5	5	6
Girls	23	13	15	19	**Girls**	12	7	7	8

Pakistan's HIV response is also complicated by co-infections, such as tuberculosis (TB), which require integrated care approaches. Key populations, particularly PWID, are at higher risk of co-infections. Currently, Pakistan boasts 70 treatment centres dedicated to providing vital antiretroviral therapy (ART) services to individuals across the nation. [33] Along with these public centres, Community based Organizations (CBOs) also provide HIV treatment services led by representatives from key populations. Among the notable organizations leading this charge are *Nai Zindagi,* dedicated to supporting people who inject drugs (PWIDs), *Dareecha*, providing essential services for TG individuals, and *Hamraz* and *Parwaz, etc.,* catering to MSMs and male sex workers (MSWs).[34]

HEPATITIS

Pakistan along with Egypt together bear 80 percent of the burden in the region, with Pakistan alone having nearly 12 million people infected with hepatitis B or C and reporting around 150,000 new cases each year. The disease is often transmitted through unsafe healthcare practices, including syringe reuse, improper sterilization, and unregulated blood transfusions, with certain populations, such as injecting drug users and thalassemia patients, particularly vulnerable.[35]

Viral hepatitis B and C specifically represent a significant public health challenge, contributing heavily to the global burden of disease. Pakistan is among the top 10 countries accounting for nearly two-thirds of the global hepatitis burden. Unsafe medical injections are a major driver of new hepatitis C infections, with Pakistan responsible for 44 percent of such cases in 60 countries.

Pakistan has made strides in providing affordable treatment, offering a 12-week generic course of sofosbuvir/daclatasvir (SOF/DAC) for as low as US$ 33, the lowest globally. Viral hepatitis testing and treatment, especially for hepatitis C, are expanding under the Prime Minister's initiative, with medicines available in selected provinces. National guidelines now include SOF/ DAC for both adults and children, supporting efforts to eliminate hepatitis in the country. Local production of hepatitis medicines enhances Pakistan's capacity to scale up

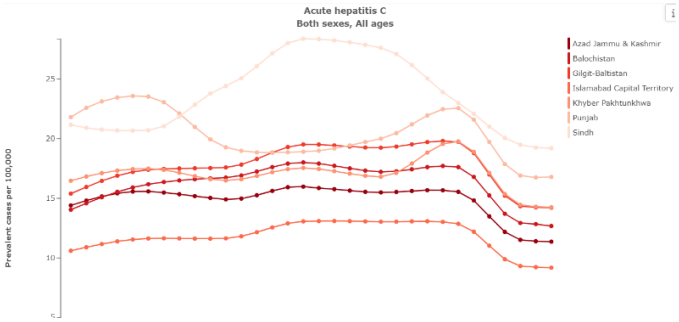


Figure 35: Province-wise Acute Hepatitis C Prevalence per 100,000 population, 2021

32 https://public.tableau.com/app/profile/unicefdata/viz/2024HIVEstimatesforChildren-CountrySnapshot/Page1
33 https://nacp.gov.pk/whatwedo/treatment.html
34 https://nacp.gov.pk/whatwedo/communitybasedservices.html
35 https://www.emro.who.int/pak/programmes/prevention-a-control-of-hepatitis.html

treatment, similar to Egypt's successful national campaign.[36] The last national survey conducted in 2008 estimated a 2.5 percent prevalence of HBV in Pakistan. Subsequent regional surveys reported varying prevalence, with Punjab reporting an estimated 2 percent prevalence of Hepatitis B and 8.9 percent prevalence of Hepatitis C.[37] In contrast, HBV prevalence in Sindh decreased to 1.1 percent whereas HCV rose to 6.2 percent.[38]

Pakistan now holds the grim title of having the highest hepatitis C burden globally, with an estimated national prevalence of 7.5 percent. The prevalence varies significantly across regions. Hepatitis C is a "silent killer" because it often remains asymptomatic for years, slowly damaging the liver until it results in cirrhosis or liver cancer. Without significant intervention, Pakistan could soon face not just an epidemic of HCV but also an epidemic of liver cancer.

HDV, which only occurs in individuals already infected with HBV, is a co-infection that accelerates liver damage. It is more challenging to control, as it relies on the prevention and management of HBV through vaccination. Despite Pakistan's growing hepatitis burden, efforts to control and eliminate the disease have been limited by a lack of resources and coordination. The Prime Minister's Programme for Prevention and Control of Hepatitis (2005-2010) was Pakistan's first large-scale effort to combat the disease, later extended to 2015. However, after the devolution of health services following the 18th amendment, provincial governments assumed responsibility for the Programme, with limited financial and operational capacity. Currently, only 16 percent of the infected population has been screened and treated, leaving a vast majority of hepatitis patients undiagnosed and untreated.

While previous HCV treatments were ineffective and had severe side effects, the advent of direct-acting antivirals (DAAs) has revolutionized hepatitis C treatment. DAAs can cure up to 96 percent of HCV cases in just 12 weeks, with minimal side effects. Pakistan produces DAAs at some of the lowest prices in the world, making it an opportune moment to scale up HCV testing and treatment.

MALARIA

Pakistan is one of the seven countries in the Eastern Mediterranean Region that collectively account for 98 percent of the total malaria burden. With approximately 217 million people at moderate risk and 63 million at high risk, Pakistan's situation reflects a significant public health challenge. The global malaria burden in 2022 was approximately 249 million cases across 85 endemic countries, with Pakistan contributing a staggering 2.1 million cases, marking a fivefold increase from the previous year. The interplay of climate change, poor vector management, and inadequate healthcare resources have worsened this increase.[39]

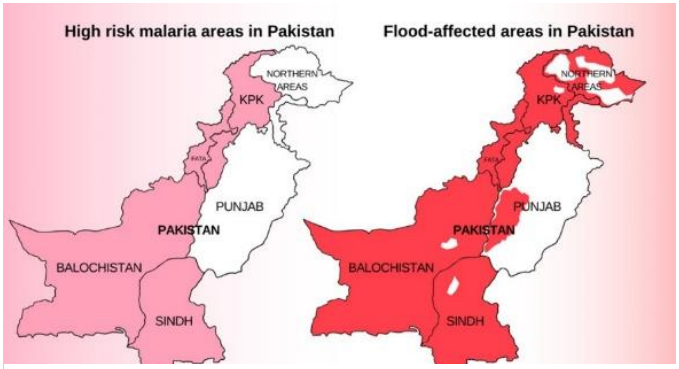


Figure 36: High risk Malaria Areas and Flood Affected Areas in Pakistan

36 https://www.who.int/publications/i/item/9789240091672
37 https://pshealthpunjab.gov.pk/Home/VerticalProgramChilds/2
38 https://scholars.aku.edu/en/publications/changes-in-the-prevalence-of-hepatitis-b-and-c-viral-infections-i
39 https://doi.org/10.1016/j.heliyon.2023.e15373

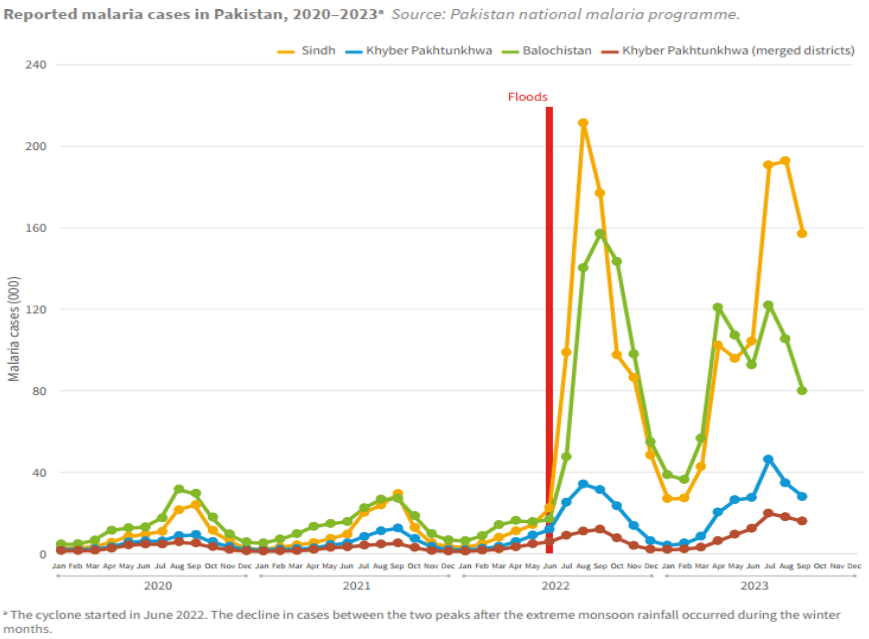


Figure 37: Province-wise Reported Malaria Cases 2020-2023, Pakistan Malaria Control Programme

In recent years, Pakistan has experienced an alarming surge in malaria cases, particularly in Khyber Pakhtunkhwa (KP) and Sindh provinces. Reported cases tripled from 150,000 in 2022 to 500,000 in 2023, with over 1.1 million suspected cases noted in the same period. This spike is closely linked to climate change and extreme weather events, particularly the severe flooding experienced in 2022, which affected over 33 million people and caused damages exceeding $15 billion. The floods created optimal breeding conditions for malaria-carrying mosquitoes, leading to a significant public health crisis.[40]

Table 15 Malaria Cases January-December 2023

S. No	Province	Number of malaria cases	API
1	**Sindh**	1,346,210	25.1
2	**Khyber Pakhtunkhwa**	240,872	6.9
3	**Khyber Pakhtunkhwa (Merged Districts)**	101,922	13.8
4	**Balochistan**	1,034,112	70.3
5	**Punjab**	3,202	0.03
6	**AJ&K**	165	0.04
7	**GB**	-	-
8	**Islamabad PHC Health Facilities**	6	0.00
Total		**2,726,489**	**11.03**

The primary malarial pathogen in Pakistan is *Plasmodium vivax*, responsible for 84 percent of malaria cases. However, the virulent *Plasmodium falciparum* has also contributed to the outbreak's severity, especially in areas with compromised healthcare infrastructure. Malaria transmission occurs mainly through bites from infected female Anopheles mosquitoes, with symptoms typically manifesting within 10–15 days post-infection. The cumulative cases during January to August 2022 exceeded 3.4 million, with 170,000 laboratory-confirmed cases reported. In August 2022 alone, Sindh and

40 https://www.gavi.org/vaccineswork/climate-change-causes-malaria-cases-triple-northwest-pakistan

Balochistan provinces reported 69,123 and 41,368 confirmed cases, respectively, representing 78 percent of all reported cases in Pakistan for that year. In 2023, the situation remained dire, with reported malaria cases as shown in Table 13.

The catastrophic floods of 2022 triggered the worst malaria outbreak in Pakistan since 1973, with cases soaring from 400,000 in 2021 to over 1.6 million in 2022. Stagnant water from the floods became a breeding ground for mosquitoes, particularly in already vulnerable areas such as Balochistan and Sindh. The rise in cases was further exacerbated by the *P. falciparum* malaria parasite, which poses a significant risk of rapid fatalities if left untreated. The Government of Pakistan, in collaboration with the World Health Organization (WHO) and other partners, has initiated various interventions including the Integrated Disease Surveillance and Response (IDSR), Rapid Diagnostics Tests, and Mass Distribution Campaigns which includes distribution of over 2 million mosquito nets, with an additional 600,000 long-lasting insecticidal nets (LLINs) allocated for displaced populations in high-burden districts.[41] WHO has also mobilized approximately 230,000 rapid diagnostic tests (RDTs) for malaria and other diseases.

ANTIMICROBIAL RESISTANCE

Anti-Microbial Resistance (AMR) poses a significant threat to public health in Pakistan, where limited access to education and healthcare contributes to rising infections from resistant strains. Pakistan is among the top five countries with the highest neonatal deaths attributed to resistant bacteria. As the third-highest antibiotic-consuming nation among low- and middle-income countries, Pakistan experienced a 65 percent increase in antibiotic consumption from 2000 to 2015, reaching approximately 20 defined daily doses (DDDs) per 1,000 inhabitants daily.

Between 2014 and 2018, there was a notable 65 percent increase in the consumption of cephalosporins classified as 'Watch' antibiotics by the WHO, with the use of 'Reserve' cephalosporins also doubling, while ciprofloxacin consumption surged among fluoroquinolones. Despite existing legislation requiring prescriptions for antibiotics, they are often available over-the-counter, with an estimated 9 percent of sales occurring without a prescription, highlighting the challenges of antibiotic misuse and the potential for escalating resistance in resource-limited settings.[42]

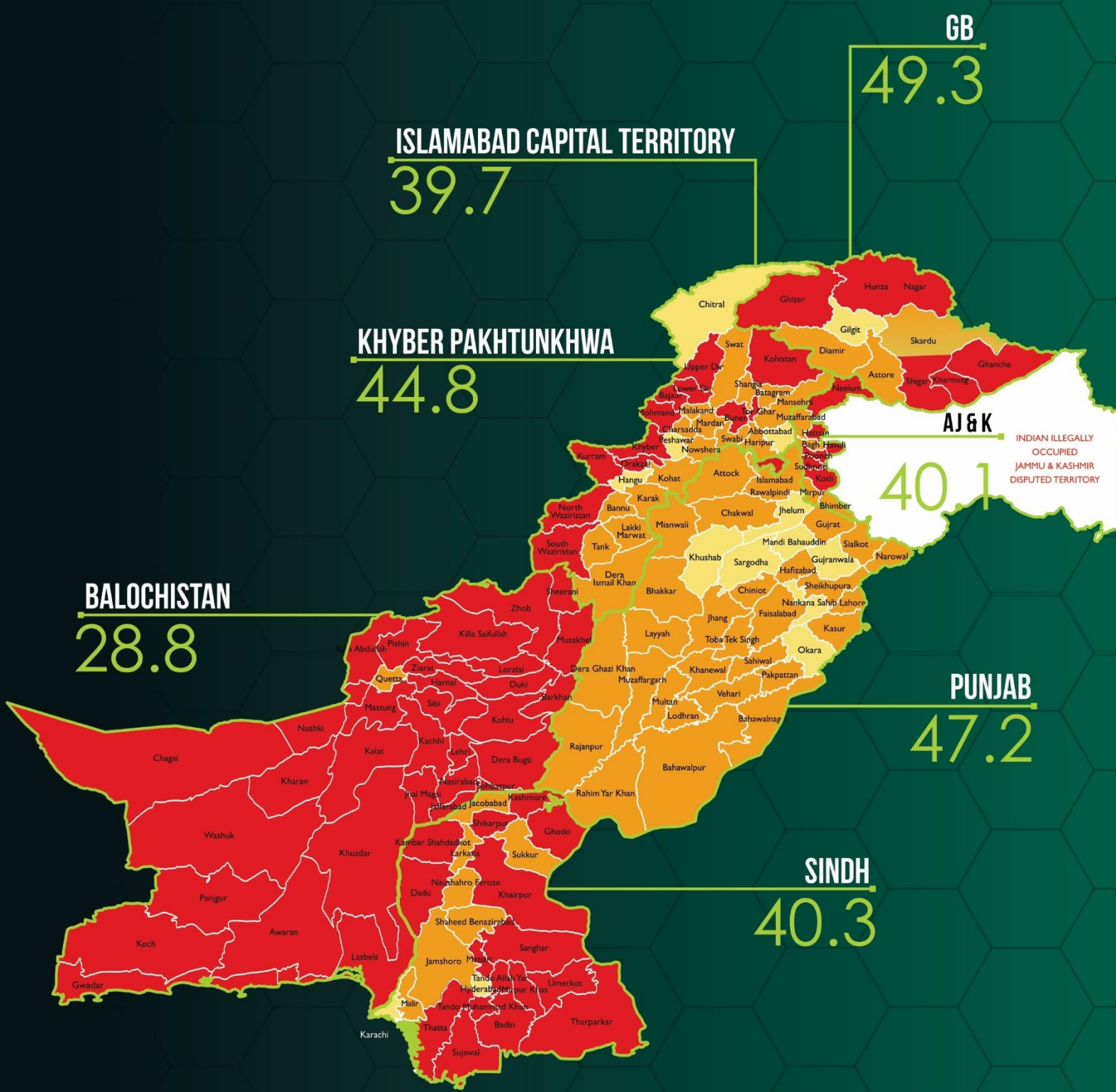
The World Health Organization (WHO) has highlighted AMR as a pressing global health crisis, emphasising the urgent need for focused actions to combat this issue. The Government of Pakistan recognizes this crisis as a priority and is actively engaging with provincial authorities, the veterinary sector, and health development partners to enhance national capacity in several areas.[43] Many emerging and re-emerging human diseases originate in animals, and addressing zoonotic diseases is critical for ensuring overall public health. Key zoonotic diseases of concern in Pakistan include leishmaniasis, rabies, brucellosis, Crimean-Congo haemorrhagic fever (CCHF), pandemic influenza, and anthrax.

To effectively manage these challenges, WHO Pakistan collaborates with the Ministries of National Health Services Regulations and Coordination and National Food Security and Research. These partnerships aim to strengthen capacities to prevent, detect, and respond to emerging zoonotic diseases, recognising the importance of coordinated efforts across human and veterinary health sectors.

In Pakistan, the rising threat of AMR is intensified by factors such as inadequate regulation of antibiotic use, lack of public awareness, and insufficient surveillance systems. The country's healthcare system faces challenges in managing infections due to resistant strains, leading to increased morbidity and mortality rates. The agricultural sector also contributes to AMR through the use of antibiotics in livestock, which can enter the human food chain.

41 https://www.who.int/emergencies/disease-outbreak-news/item/2022-DON413
42 https://doi.org/10.1093/jac/dkac213
43 https://www.emro.who.int/pak/programmes/antimicrobial-resistance.html

MAP 3: COMMUNICABLE DISEASES AGGREGATE SCORE IN 2023



DISTRICT-WISE UHC SCI 2023

<40 | 40-49 | 50-59 | >60

PAKISTAN

44.3

5.3 NON-COMMUNICABLE DISEASES (NCDS)

The NCDs category consist of three proxy and priority indicators including i) Non-elevated Blood Pressure (BP); ii) Mean Fasting Plasma Glucose (FPG) iii) Tobacco non-use (Tobacco). NCDs aggregate score for Pakistan is estimated to be 55.2 in 2023 and has improved significantly from a baseline of 51.8 in 2015.

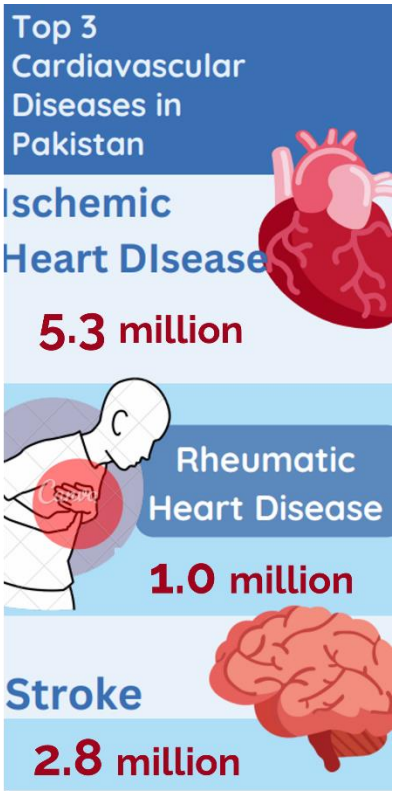
Table 16 National and Province/Federating Area wise NCDs Aggregate Score

UHC Indicators for Infectious Diseases Category	Punjab	Sindh	KP	Balochistan	ICT	GB	AJ&K	National
Normal blood pressure (%)	35.0	35.0	35.0	35.0	35.0	35.0	35.0	**35.0**
Mean fasting plasma glucose (mmol/L)	68.0	68.0	68.0	68.0	68.0	68.0	68.0	**68.0**
Tobacco non-smoking (%)	71.0	71.0	71.0	71.0	71.0	71.0	71.0	**71.0**
NCD Aggregate Score	**55.2**	**55.2**	**55.2**	**55.2**	**55.2**	**55.2**	**55.2**	**55.2**

Pakistan is currently undergoing a profound epidemiological transition. While significant strides have been made in reducing the burden of infectious diseases and improving maternal and child health, the country is facing a growing challenge in managing non-communicable diseases (NCDs) and mental health disorders. NCDs now account for over 42 percent (DALYs) [44] of the country's disease burden, emphasising the need for an approach that adapts to these evolving health threats.

CARDIOVASCULAR DISEASES

In Pakistan, the burden of non-communicable diseases (NCDs) is high and growing, heavily impacting both individual health outcomes and the national healthcare infrastructure. Cardiovascular diseases (CVDs) dominate this category, representing one of the leading causes of mortality and morbidity in the country. According to the Institute for Health Metrics and Evaluation (IHME), Pakistan's age-standardised incidence rate for CVDs in 2021 was 1,066.22 per 100,000 population, accounting for roughly 33.16 percent of all NCDs.



Breaking down this data, Ischemic heart disease (IHD) is identified as the most common type of CVD, with an age-standardised prevalence of 5,155.8 cases per 100,000 population. IHD is characterised by reduced blood flow to the heart, leading to serious complications like heart attacks and long-term disability.

Stroke, another major CVD, has an age-standardised incidence rate of 152 cases per 100,000 population. Stroke incidence in Pakistan is compounded by many modifiable risk factors such as uncontrolled blood pressure, poor dietary habits, and high levels of physical inactivity. The associated healthcare costs are

44 IHME GBD 2021

substantial, with many stroke survivors requiring long-term rehabilitation and care, placing strain on both healthcare facilities and families.

Below figure provides a comprehensive overview of the hypertension situation in Pakistan, contrasting it with global benchmarks and highlighting significant gaps in diagnosis, treatment, and control. Pakistan has a high hypertension prevalence among adults aged 30–79 years, with nearly 40 percent affected—one of the highest rates globally. Of the estimated 32.2 million adults in this age group with hypertension, only 54 percent of women and 34 percent of men are diagnosed. Among those diagnosed, 44 percent of women and 25 percent of men receive treatment, but effective blood pressure control is achieved in just 14 percent of women and 8 percent of men, amounting to only 11 percent of the hypertensive population. To reach a target of 50 percent control, 12.5 million more people would need effective treatment. Despite some efforts over the past two decades, trends in uncontrolled hypertension have shown minimal improvement, with projections indicating that rates will remain above 40 percent, far from the global target.

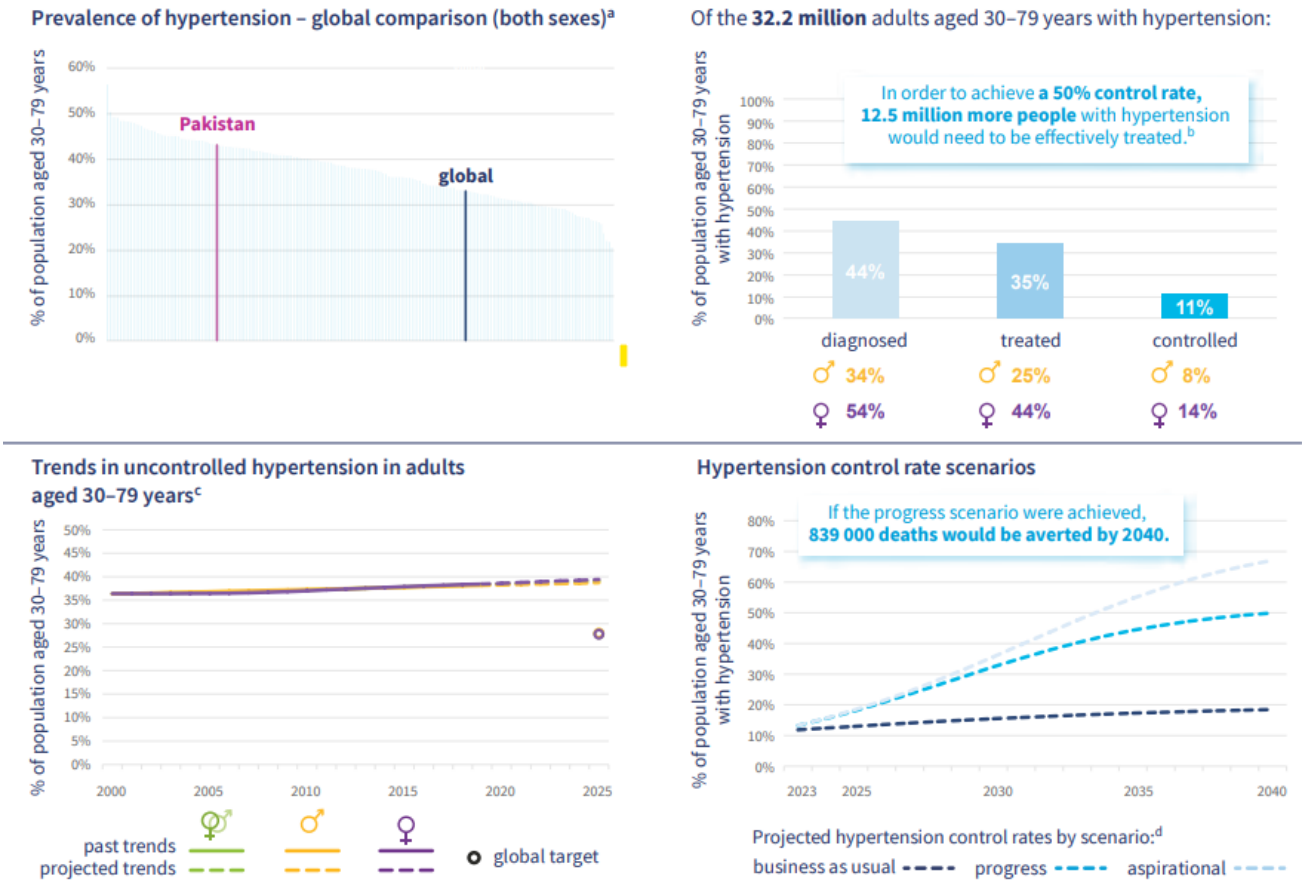


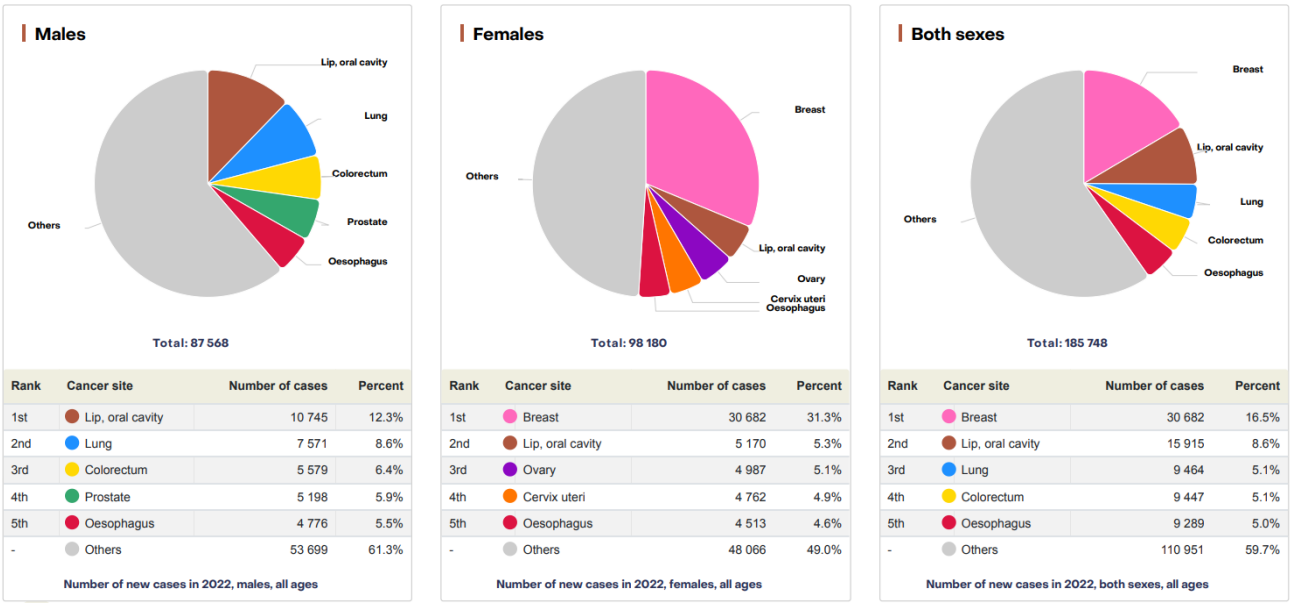
Figure 38: Hypertensive Profile in Pakistan 2023

In addition to IHD, rheumatic heart disease (RHD) also remains a considerable concern in Pakistan, with an age-standardised prevalence rate of 991.01 cases per 100,000 population. While the incidence of RHD has decreased in many high-income countries, Pakistan continues to face significant rates due to persistent gaps in early diagnosis, lack of routine healthcare access, and limited preventive measures for infections that contribute to RHD onset.

CANCERS

In 2022, a total of 185,748 new cancer cases were reported, accompanied by 118,631 cancer-related deaths, with a five-year prevalence of 390,443 cases indicating a significant number of individuals living with cancer diagnoses within recent

years.[45] The Global Cancer Observatory (Pakistan Factsheet 2022) shows an age-standardised cancer incidence rate of 105.6 per 100,000 population, coupled with a cumulative lifetime risk of 11 percent for developing cancer before the age of 75 years. Mortality rates are similarly concerning, with an age-standardized mortality rate of 69.8 per 100,000 and a cumulative risk of 7.6 percent for cancer-related death before age 75, highlighting the necessity for targeted cancer control interventions.



Rank	Cancer site	Number of cases	Percent
1st	Lip, oral cavity	10 745	12.3%
2nd	Lung	7 571	8.6%
3rd	Colorectum	5 579	6.4%
4th	Prostate	5 198	5.9%
5th	Oesophagus	4 776	5.5%
-	Others	53 699	61.3%

Number of new cases in 2022, males, all ages

Rank	Cancer site	Number of cases	Percent
1st	Breast	30 682	31.3%
2nd	Lip, oral cavity	5 170	5.3%
3rd	Ovary	4 987	5.1%
4th	Cervix uteri	4 762	4.9%
5th	Oesophagus	4 513	4.6%
-	Others	48 066	49.0%

Number of new cases in 2022, females, all ages

Rank	Cancer site	Number of cases	Percent
1st	Breast	30 682	16.5%
2nd	Lip, oral cavity	15 915	8.6%
3rd	Lung	9 464	5.1%
4th	Colorectum	9 447	5.1%
5th	Oesophagus	9 289	5.0%
-	Others	110 951	59.7%

Number of new cases in 2022, both sexes, all ages

Figure 39: Top Five Most Frequent Cancers in Pakistan 2022

The burden of cancer shows distinct gender-based patterns in Pakistan. Among males, 87,568 new cases were identified in 2022, with an incidence rate of 99.5 per 100,000, while mortality data indicated 58,934 cancer-related deaths with a mortality rate of 68.8 per 100,000. The primary cancer sites for males include the lip and oral cavity (12.3 percent), lung (8.6 percent), and colorectum (6.4 percent), marking these as priority areas for screening and preventive measures. Females reported a slightly higher incidence with 98,180 new cases and an age-standardised incidence rate of 111.8 per 100,000, along with 59,697 deaths and a corresponding rate of 70.8 per 100,000. Notably, breast cancer accounted for 31.3 percent of cases in females, followed by lip and oral cavity cancer (5.3 percent) and ovarian cancer (5.1 percent), underscoring the importance of gender-specific cancer control strategies, including enhanced access to early screening and diagnostic services for these cancers.[46]

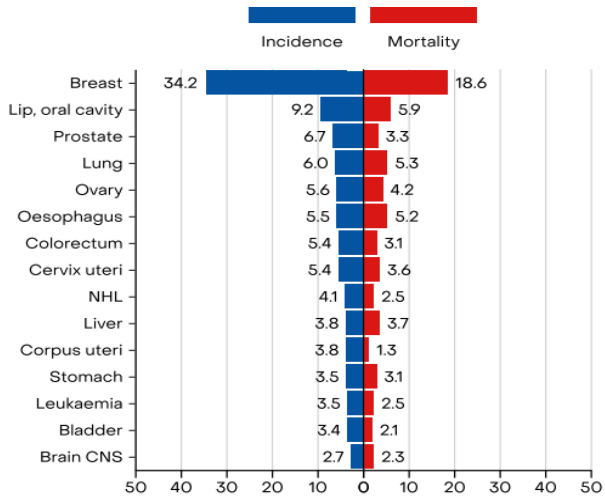


Figure 40: Incidence and Mortality Rates of top 15 Cancers

45 Global Cancer Observatory Pakistan Factsheet 2022
46 https://gco.iarc.who.int/media/globocan/factsheets/populations/586-pakistan-fact-sheet.pdf

Across both sexes, several cancer types emerge as critical focal points due to their high incidence and mortality. Breast cancer is the most prevalent, with 30,682 new cases representing 16.5 percent of the total cancer burden and accounting for 15,552 deaths or 13.1 percent of all cancer-related mortality. Lip and oral cavity cancer follows with 15,915 cases (8.6 percent) and 10,181 deaths (8.6 percent), and lung cancer ranks third, with 9,464 cases (5.1 percent) and 8,307 deaths (7.0 percent).

Over the past two decades, the prevalence of breast cancer has risen dramatically, particularly among women over 50 years of age, with the peak incidence observed in those aged 45 to 59.[47] Despite the high burden, awareness of breast cancer risk factors, symptoms, and diagnostic options remains critically low. Only 40 percent of women in Pakistan are knowledgeable about one or more aspects of the disease. Approximately half are aware of available treatment options; however, only 30 percent regularly practice breast self-exams (BSE), and fewer than 20 percent have ever undergone a clinical breast exam (CBE).[48] The figure shows the DALYs in both sexes across provincial and federating areas for all the cancers type.

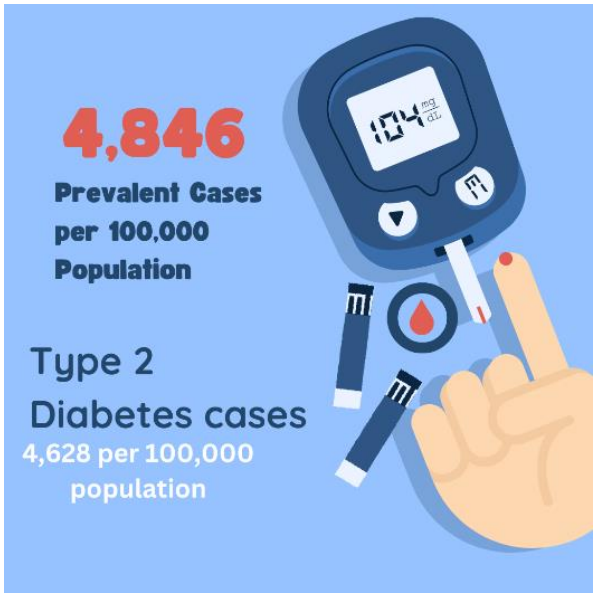
Higher rank ... Lower rank

	Pakistan	Balochistan	Gilgit-Baltistan	KPK	Punjab	Sindh	Azad Jammu & Kashmir	Islamabad
Maternal & neonatal	1	1	1	1	1	1	2	3
Respiratory infections & TB	2	2	2	2	2	2	1	1
Cardiovascular diseases	3	3	3	3	3	3	3	2
Neoplasms	4	9	5	4	4	4	4	5
Other non-communicable	5	4	6	5	5	5	5	8
Mental disorders	6	11	8	8	6	7	6	4
Other COVID Outcomes	7	6	4	6	7	8	7	9
Enteric infections	8	5	7	9	11	10	14	15
Nutritional deficiencies	9	8	15	7	13	6	13	11
Diabetes & CKD	10	14	9	14	8	9	9	7
Musculoskeletal disorders	11	13	11	10	9	11	10	6
Unintentional inj	12	10	13	13	10	12	8	16
Other infectious	13	7	10	11	12	13	17	21
Digestive diseases	14	16	14	15	14	14	12	12
Neurological disorders	15	17	17	16	15	15	15	10
Transport injuries	16	15	16	17	16	16	16	17
Chronic respiratory	17	18	12	12	17	17	11	13
Sense organ diseases	18	20	18	19	18	19	18	14
Self-harm & violence	19	19	19	18	19	20	19	19
Skin diseases	20	21	20	21	20	21	20	18
NTDs & malaria	21	12	22	20	23	18	23	20
HIV/AIDS & STIs	22	22	21	22	21	22	21	22
Substance use	23	23	23	23	22	23	22	23

Figure 41: DALYs in both sexes across provincial and federating areas for all the cancers type

DIABETES

Diabetes mellitus (DM) is the fastest growing global public health concern and has become a major health concern in Pakistan due to its rapid rise in prevalence and substantial health and economic implications. It is among the top three causes of death in Pakistan, and highlights the growing NCD burden.



The number of adults with diabetes in Pakistan surged from approximately 5.2 million in 2000 to around 33 million in 2021.[49] Type 2 diabetes in Pakistan is a substantial economic burden, costing an average of USD 740 per patient annually, with direct

47 Zaheer, S., & Yasmeen, F. (2023). Historical trends in breast cancer presentation among women in Pakistan from join-point regression analysis. *Pakistan Journal of Medical Sciences*, *40*(1). https://doi.org/10.12669/pjms.40.1.7123
48 Abdul Rehman M, Tahir E, Ghulam Hussain H, Khalid A, Taqi SM, Meenai EA (2024) Awareness regarding breast cancer amongst women in Pakistan: A systematic review and meta-analysis. PLoS ONE 19(3): e0298275. https://doi.org/10.1371/journal.pone.0298275
49 Hasan SU, Siddiqui MAR Epidemiology of diabetes mellitus in Pakistan: a systematic review protocol BMJ open 2024;14:e079513. doi: 10.1136/bmjopen-2023-079513

costs (medications and hospitalizations) being the largest contributors. Productivity losses significantly add to indirect costs. Diabetes management equates to 1.67 percent of Pakistan's GDP, which emphasises the need for comprehensive, nationwide diabetes policies to alleviate this strain.[50]

The variation in NCD prevalence across regions like AJ&K, Punjab, Sindh, and GB indicates that while some areas have seen improvements, others continue to experience a rise in diseases such as diabetes and cancer. Azad Jammu and Kashmir (AJ&K) has experienced the most significant rise in NCDs, particularly in neoplasms (cancer), which increased from 78.92 in 2018 to 81.72 in 2021, and diabetes, which rose from 24.33 to 25.56. Sindh also saw a rise in diabetes cases, from 19.33 to 20.01, while Gilgit-Baltistan experienced a slight increase from 19.16 to 19.43. Cardiovascular diseases (CVDs) remain the most prevalent, with AJ&K reporting 167.88 cases in 2021, despite a slight decrease since 2018, and Punjab showing 169.1 cases. Conversely, several provinces, including Punjab (170.8 to 169.1), Sindh (141.01 to 138.85), Khyber Pakhtunkhwa (KP) (144.85 to 140.82), and Balochistan (105.73 to 100.67), have witnessed a decline in CVD rates. Nevertheless, AJ&K and Punjab exhibit the highest burden of NCDs, particularly for CVDs and neoplasms, indicating a growing concern for these health issues.

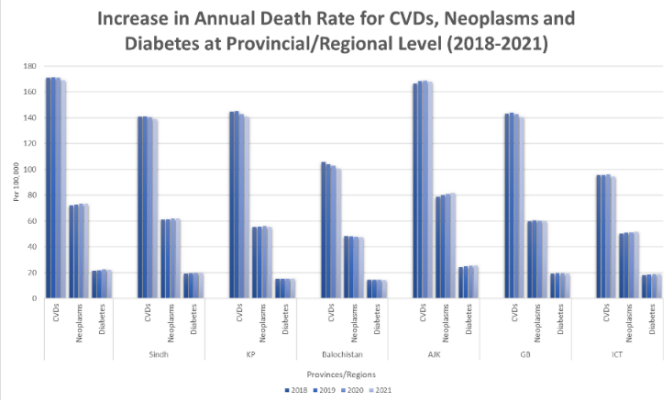


Figure 42: Annual Death Rate for CVDs, Neoplasms and Diabetes 2018-21

RISK FACTORS

This burden of NCDs is driven by socioeconomic challenges, sedentary lifestyles, and dietary shifts, which fall under three categories; metabolic, environmental/occupational and behavioural risk factors. These risk factors contribute to the prevalence of cardiovascular diseases, cancers, and other non-communicable diseases (NCDs).

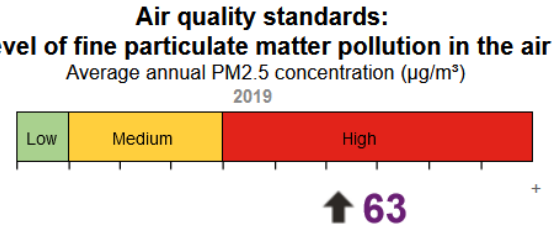
Table 17 Number of Deaths Attributed to Major NCD Risk Factors in Pakistan 2018-21

Major Risk Factors	2018	2019	2020	2021
High blood pressure	180,194.41	185,369.97	189,591.61	191,618.66
High fasting plasma glucose	101,460.85	105,237.64	108,631.59	110,596.52
Ambient Particulate Matter	72,991.03.	73,238.79	65,869.19	75,519.01
Smoking	87,041.29	88,253.44	89,002.62	89,287.02
House hold Air pollution	96,461.92	98,217.15	101,485.5	100,853.81

50 Butt MD, Ong SC, Wahab MU, Rasool MF, Saleem F, Hashmi A, Sajjad A, Chaudhry FA, Babar Z-U-D. Cost of Illness Analysis of Type 2 Diabetes Mellitus: The Findings from a Lower-Middle Income Country. *International Journal of Environmental Research and Public Health*. 2022; 19(19):12611. https://doi.org/10.3390/ijerph191912611

Metabolic risk factors, particularly elevated systolic blood pressure, have been the leading cause of mortality in Pakistan, with a death rate of 81.35 per 100,000. The highest mortality rates are observed in Punjab (91.68 deaths per 100,000) and AJ&K (90.88 deaths per 100,000), with hypertension being a primary contributor. In addition to that, elevated fasting plasma glucose, a major risk factor for diabetes and chronic kidney disease, has also shown a gradual increase, ranking as the second leading cause of NCD-related deaths in 2021, with 46.95 deaths per 100,000.

Household air pollution and ambient particulate matter have also emerged as significant contributors to ischemic heart disease, cerebrovascular disease, and lung cancer. The exposure primarily stems from the use of biomass fuels for cooking in rural areas and urban air quality issues. The level of fine particulate matter pollution in the air increased to 63 in 2019.[51]



HEALTH AND ECONOMIC IMPLICATIONS OF TOBACCO USE

Tobacco consumption remains widespread in Pakistan, contributing significantly to the elevated burden of lung cancer, cardiovascular diseases, and chronic respiratory illnesses. Despite ongoing health promotion campaigns aimed at raising awareness of these severe health consequences, approximately 11.6 percent of the population still uses tobacco products[52]. In 2022, Pakistan reported an estimated 25.4 million tobacco users, ranking 7th globally and the highest within the WHO Eastern Mediterranean Region. Tobacco use continues to impose a significant health and economic burden, resulting in approximately 130,600 deaths and contributing to 4.3 million disability-adjusted life years (DALYs) lost in 2021. Economically, the tobacco cost in Pakistan was around USD 3.85 billion in 2019. Despite measures like implementing the WHO Framework Convention on Tobacco Control (FCTC) and mandating pictorial health warnings, illicit trade in cigarettes remains high, reaching 36 percent in 2020. Furthermore, Pakistan ranks as the 7th largest tobacco producer globally, with production and cultivation trends rising since 2010. [53]

Table 18 Number and Prevalence of Tobacco uses with Gender Bifurcation

Category[54]	No. of Users (Million)	Overall Prevalence (%)	Men (%)	Women (%)
Tobacco Users (Any Form)	23.9	19.1	31.8	5.8
Smokers	15.6	12.4	22.2	2.1
Sheesha/Hookah Smokers	3.7	3.0	4.7	1.1
Smokeless Tobacco Users	9.6	7.7	11.4	3.7

The country's socioeconomic landscape complicates efforts to combat NCDs. High out-of-pocket expenditures and limited infrastructure impede access to consistent and comprehensive care. While Pakistan has initiatives such as the Sehat Sahulat Programme and the National Health Vision 2016–25 aimed at achieving UHC, these have yet to significantly reduce the NCD burden.

51 https://data.unicef.org/resources/adolescent-health-dashboards-country-profiles/
52 https://tobaccocontrol.bmj.com/content/33/Suppl_2/101
53 https://globalactiontoendsmoking.org/research/tobacco-around-the-world/pakistan/
54 Pakistan Tobacco Control Cell-Factsheet

Pakistan's GDP per capita has increased so did the burden of NCDs. This is a common trend seen in developing countries where economic growth often leads to lifestyle changes (urbanization, decreased physical activity, unhealthy diets) that contribute to the rise in NCDs like cardiovascular diseases, diabetes, and cancers. In 1990, the share of the disease burden from NCDs in Pakistan was around 35 percent which has steadily increased, with a noticeable rise to above 43 percent in 2021. [55]

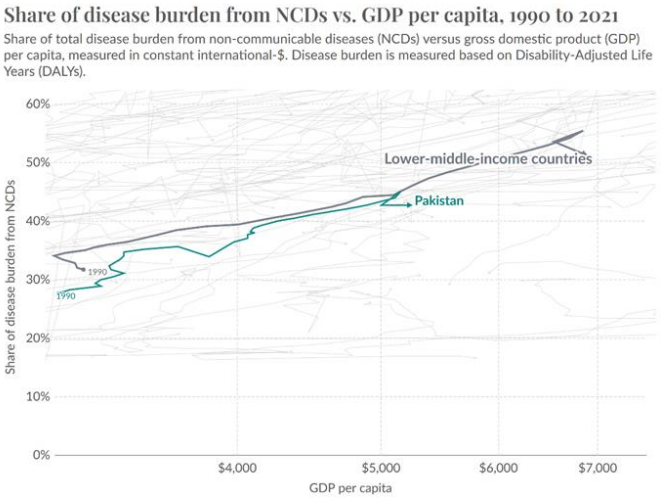
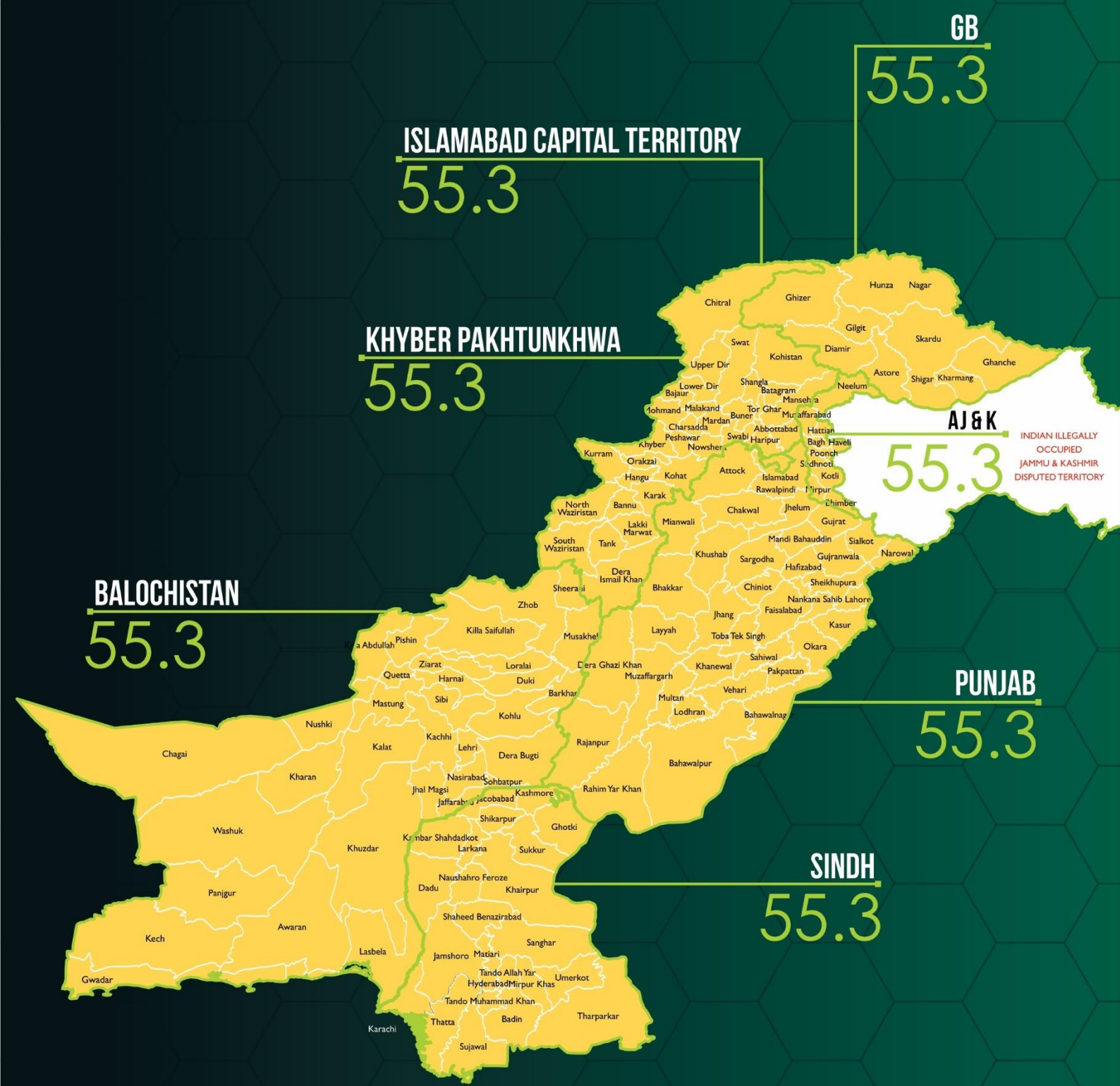


Figure 43: Share of Disease Burden from NCDs Vs GDP per Capita 1990-2021

The increase in the burden of NCDs despite economic growth suggests that country's healthcare system may need to prioritize prevention and management of NCDs. It also highlights the potential strain on healthcare resources as the population ages and the prevalence of NCDs grows. To reduce the growing NCD burden, Pakistan must enhance its UHC efforts by focusing on prevention, the integration of services, and addressing health disparities. The effects of climate change, natural disasters, and the COVID-19 pandemic has further strained the healthcare system, highlighting the need for a comprehensive, multi-sectoral response to address both communicable and non-communicable diseases under UHC.

55 https://ourworldindata.org/grapher/share-of-disease-burden-from-ncds-vs-gdp?zoomToSelection=true&time=earliest..latest&showSelectionOnlyInTable=1&country=Lower-middle-income+countries~PAK

MAP 4: NON-COMMUNICABLE DISEASES AGGREGATE SCORE IN 2023



DISTRICT-WISE UHC SCI 2023

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5.4 SERVICES CAPACITY & ACCESS

The SCA category consist of three proxy and priority indicators including i) Hospital bed density per 10,000 population against threshold (%); ii) Health Worker Density (Physicians *Psychiatrist* Surgeon) density against threshold (%) iii) International Health Regulations Index. SCA aggregate score for Pakistan is estimated to be 51.6 in 2023 and has improved significantly from a baseline of 33.9 in 2015.

Table 19 National and Province/Federating Area wise SCA Aggregate Score

UHC Indicators for Infectious Diseases Category	Punjab	Sindh	KP	Balochistan	ICT	GB	AJ&K	National
Hospital beds density 10,000 population against threshold (%)	65.3	52.8	53.2	40.5	205.7	44.2	61.5	**60.0**
Health worker density (Physicians*Psychiatrist*Surgeon) density against threshold (%)	50.5	67.4	49.4	34.0	72.1	43.7	48.4	**53.8**
International Health Regulations index (15 core capacities- new tool)	43.4	40.8	40.7	36.6	68.6	45.7	46.8	**42.7**
SCA Aggregate Score	**52.4**	**52.6**	**47.5**	**36.9**	**100.6**	**44.6**	**51.8**	**51.6**

Health service capacity and access in the country face significant challenges due to limited infrastructure, workforce shortages, and inadequate health financing. The shortage of healthcare professionals exacerbates these issues, with the country having fewer doctors and nurses per capita than recommended. Although maternal and child health Programmes, such as the Lady Health Workers initiative, have improved some aspects of community care, high maternal and child mortality rates persist. Addressing these challenges through focused investment and policy reform is essential for advancing equitable healthcare access and achieving universal health coverage.

HOSPITAL BEDS

Pakistan faces shortage of hospital beds, which limits its ability to provide adequate inpatient care, especially in times of increased demand, such as during disease outbreaks or natural disasters. The planning of hospital capacity is a critical concern given the rising expenses of inpatient care, resource limitations, and the increasing demand for hospital services. Key metrics such as bed capacity, bed occupancy, and the ratio of beds to the population are crucial for assessing the availability of inpatient care. The number of beds within a hospital can be likened to a capital stock, which is influenced by the performance of medical staff and the availability of equipment. A shortage of available beds can significantly disrupt hospital operations, leading to issues such as admission and surgery cancellations, delays in emergency admissions, premature patient transfers from intensive care units, delays in patient transfers between units, and early patient discharges.

Globally the required threshold for hospital bed density is 18 per 10,000 population. Against this need, only 10.84 hospital beds per 10,000 population were available in 2023 in the public and private sector of country. Hospital beds (public & private) density is the highest in Islamabad, followed by Punjab and Azad Jammu & Kashmir and KP. Total hospital beds in public & private sector were 150,289 in Punjab; 52,955 in Sindh; 39,201 in Khyber Pakhtunkhwa; 10,868 in Balochistan;

8,756 in Islamabad; 1,393 in Gilgit-Baltistan; and 5,058 in Azad Jammu & Kashmir. Out of total **268,520 hospital beds** in Pakistan, 127,209 were in public sector whereas 141,311 were in private sector in 2023.

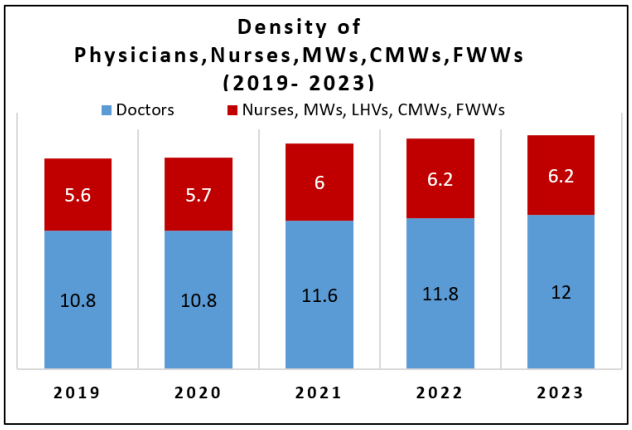
Table 20 National and Province/federating areas wise number of public and Private hospital beds

	Public	Private	Total	Density per 10,000 population
Punjab	56,337	93,952	**150,289**	**11.7**
Sindh	30,665	22,290	**52,955**	**9.5**
KP	25,082	14,119	**39,201**	**9.6**
Balochistan	8,145	2,723	**10,868**	**7.2**
AJ&K	2,950	2,108	**5,058**	**11.0**
GB	1,265	128	**1,393**	**8.2**
ICT	2,765	5,991	**8,756**	**37.0**
National	**127,209**	**141311**	**268,520**	**10.8**

ESSENTIAL HEALTH WORKFORCE

In Pakistan, there are 298,143 registered doctors along with 5,145 registered foreign doctors. The nursing workforce comprises 103,694 registered nurses, while the total number of registered midwives, community midwives, and family welfare workers stands at 27,504. Additionally, there are 20,465 registered Lady Health Visitors (LHVs), 3,619 Lady Health Supervisors (LHSs), and 88,561 Lady Health Workers (LHWs). The population per nurse, midwife, and LHV is 1,778, while the ratio for nurses alone is 2,389.

The graphs below provide valuable insights into the **density of health professionals** in Pakistan from **2019 to 2023**.Figure 19 illustrates the density of various health professionals, including doctors, nurses, midwives, community midwives (CMWs), and family welfare workers (FWWs) over 5 years period, and the density of selected health professionals per 10,000 population for the year 2023, comparing the figures for physicians, nurses, midwives and FWW, dentists, and pharmacists.



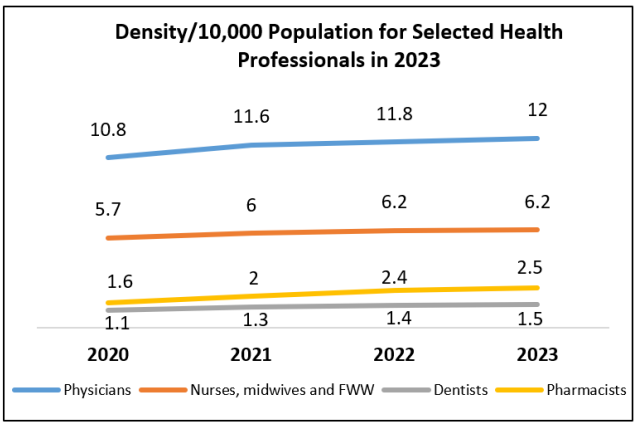


Figure 44: Trend Analysis of the Densities per 10,000 population of Physicians, Dentists, Nurses and Pharmacists 2020-23

In terms of the density of the health workforce, the data reveals that the number of physicians has increased slightly from 10.8 per 10,000 population in 2019 to 12 in 2023. This gradual rise signifies ongoing efforts to strengthen the healthcare workforce amid rising healthcare demands. In contrast, the density of nurses, MWs, LHVs, CMWs, and FWWs has shown

trend from 5.6 per 10,000 in 2019 to 6.2 in 2023. In addition, dentists and pharmacists have densities of 1.5 and 2.5 respectively.

The trend indicates that while there is a steady increase in the healthcare workforce, particularly among physicians, the ratio of nursing staff remains disproportionately low. This discrepancy is particularly concerning as it suggests potential challenges in delivering comprehensive healthcare services across the population.

Pakistan is facing a critical shortage in its health workforce, particularly in nursing staff, with an increasing gap between the number of physicians and nurses produced each year, potentially affecting future healthcare service delivery. Additionally, many female physicians are not joining the workforce, highlighting the need for targeted interventions to boost their participation. In 2023, 3,619 Lady Health Supervisors (LHSs) and 88,561 Lady Health Workers (LHWs) are playing a crucial role in providing basic health services in rural areas, yet approximately 48 percent of the population remains uncovered under the Universal Health Coverage (UHC) initiative. To address these gaps, the LHWs Strategic Plan (2022-28) aims to enhance primary healthcare delivery, particularly in underserved areas, while healthcare professionals continue to be regulated by respective councils to maintain standards and oversight.

The Provincial Distribution of the Essential Health Workforce in 2023 indicates that Punjab (including Islamabad, AJ&K, and GB) has the highest concentration of healthcare professionals, total in 153,188, which reflects its larger population and more developed healthcare infrastructure. Sindh follows with 94,109 health professionals, while Khyber Pakhtunkhwa (KP) and Balochistan have 42,300 and 8,546, respectively. The data reveals that the distribution of healthcare professionals is uneven across provinces, with Balochistan displaying a notably low number of health professionals, which may suggest barriers to healthcare access in that region. This provincial disparity raises concerns regarding equitable healthcare service provision, as regions with fewer healthcare professionals may face challenges in meeting the health needs of their populations. The figure below shows the cumulative number of essential health workforce till December 2023

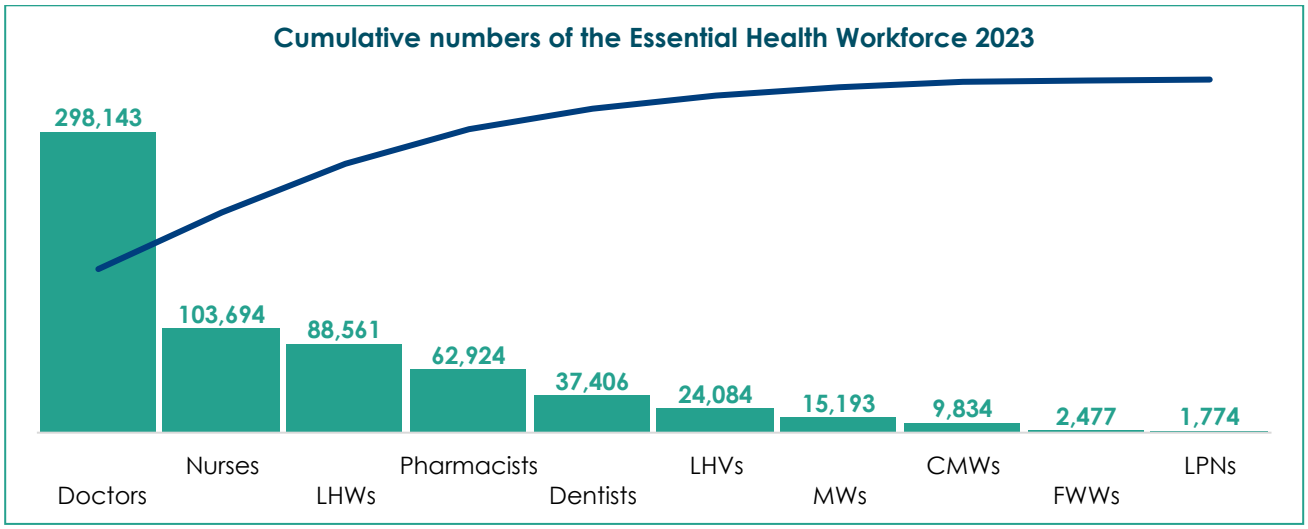


Figure 45: Cumulative Numbers of Essential Health Workforce till December 2023

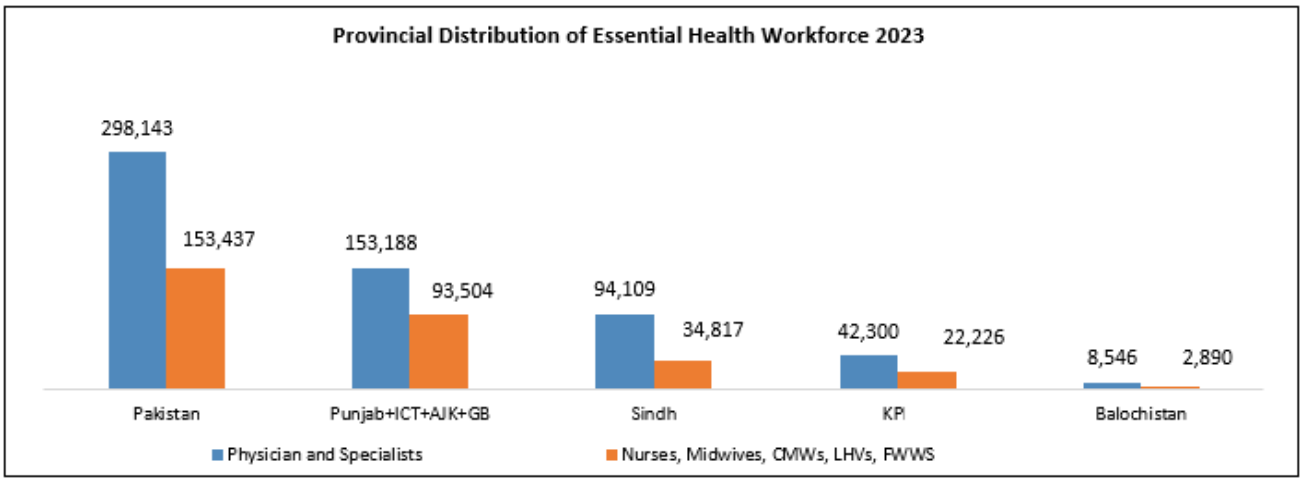


Figure 46: Provincial Distribution of Essential Health Workforce Registered till December 2023

Annual Health Sector Workforce Emigration by Pakistan Bureau of Emigration reveals a concerning trend in the emigration of healthcare professionals from Pakistan. The total number of doctors who emigrated has increased substantially from 1,223 in 2020 to 3,486 in 2023, with a continued exodus projected into 2024. Among the emigrants, nurses represent the largest group, highlighting the demand for nursing professionals in global markets. The increasing emigration rates pose challenges to Pakistan's healthcare sector, as the loss of trained professionals could hinder efforts to improve health outcomes and expand access to care.

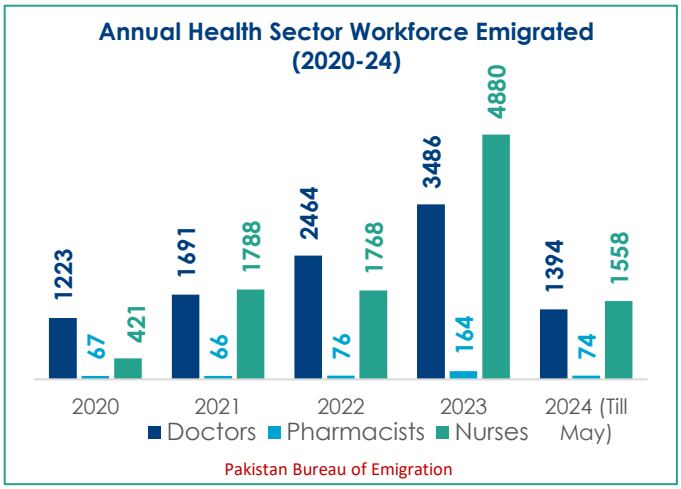


Figure 47: Annual Health Sector Workforce Emigration (2020-2024)

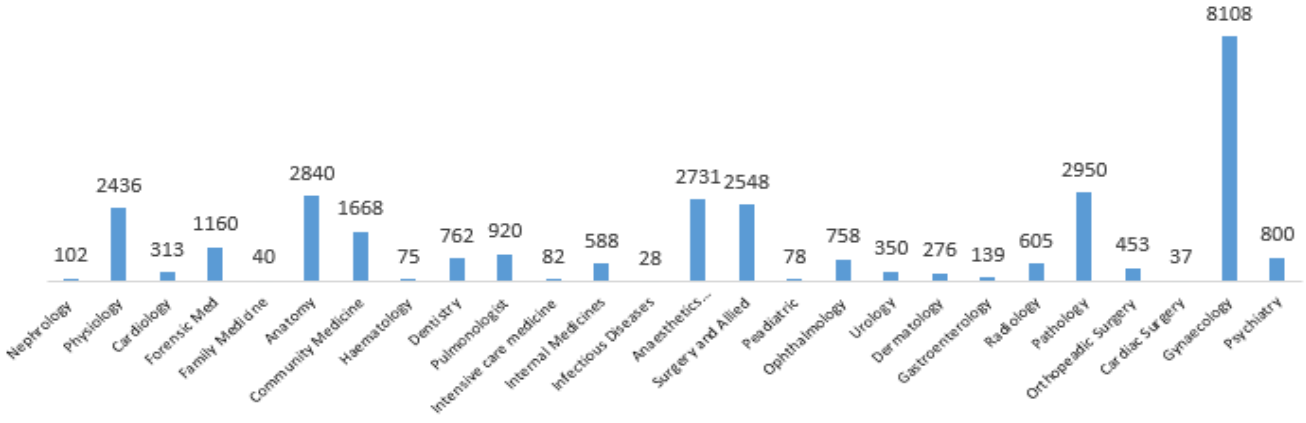


Figure 48: Specialty Cadre at National level in 2023

For UHC SCI, the HRH density is estimated by estimating three types of specialists i.e., Physicians, Psychiatrists and Surgeons. According to Pakistan Medical Commission (PMC), there were 298,143 (registered since 1962) physicians including 800 Psychiatrists and 12,510 surgeons (The categories surgeon include general surgeons, gynocologist/obstetricians, urologist, neuro, cardic, orthopaedic, thoracic surgeons.

In 2023, Pakistan's health professional education landscape shows a significant reliance on private sector. A total of 621 nursing institutes including 418b private institutes highlighted the country's focus on expanding nursing education. The production capacity of medical and dental institutes reflects that private institutions contribute heavily to producing dentists and pharmacists, while the output of doctors is balanced between public and private sector.

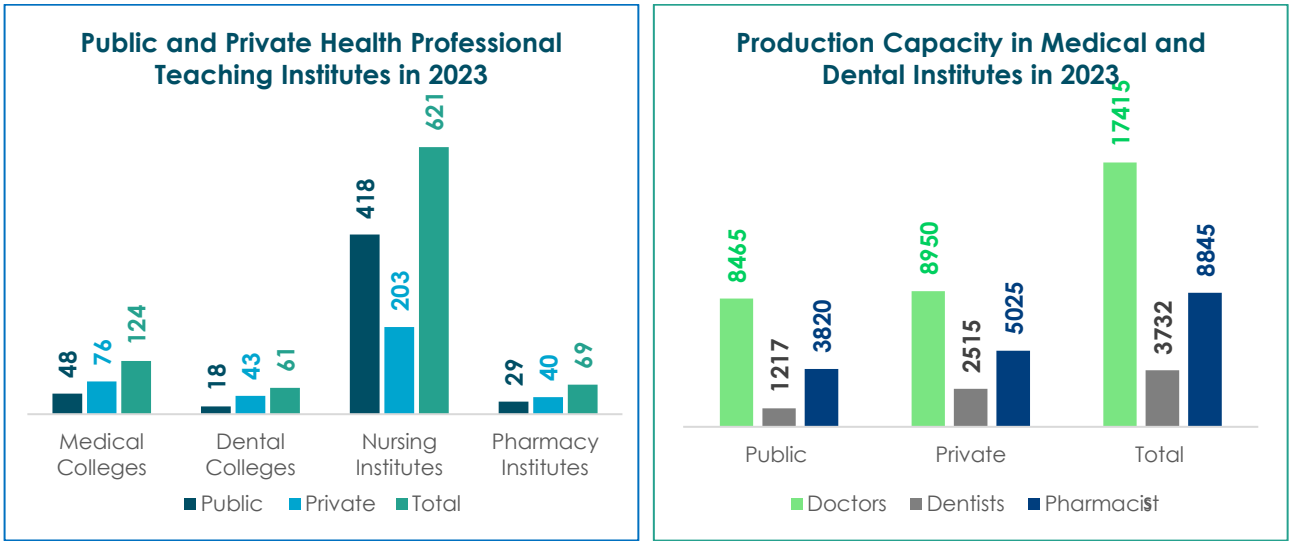


Figure 49: Public and Private Professional Teaching Institutes with their Production Capacity in 2023

Within nursing education, most institutes focus on basic and mid-level qualifications, with the General Bachelor of Science in Nursing (GBSN) Programme having the highest capacity (22,860 graduates), followed by the Post RN BSN. In contrast, advanced degrees like MSN and PhD are offered in only a few institutions, limiting the number of graduates at these levels. This focus on foundational nursing qualifications suggests a need for increased investment in advanced nursing education to address the shortage of specialized skills and leadership within Pakistan's healthcare system.

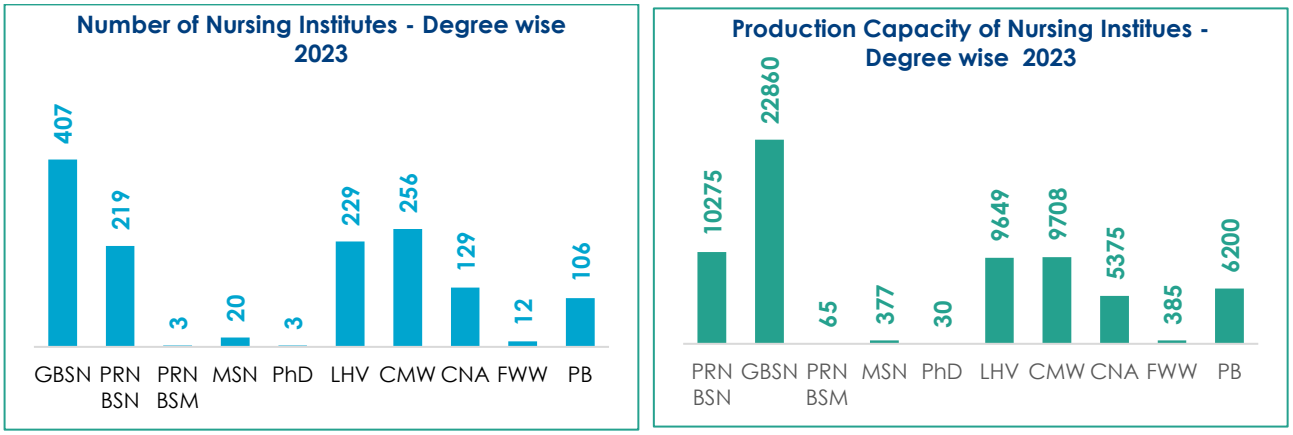


Figure 50: Degree-wise Nursing Institutes with their Production Capacity

INTERNATIONAL HEALTH REGULATIONS

As a signatory to the International Health Regulations (IHR) 2005, Pakistan is committed to enhancing its core public health capacities to prevent, detect, and respond to potential health emergencies. The IHR encompasses 19 technical areas, from surveillance and laboratory capabilities to emergency response systems, intended to fortify global health security. However, despite Pakistan's commitment, the country has struggled to meet the required IHR core capacities, posing risks not only to public health but also to trade, travel, and economic stability. Deficiencies in health security can amplify the

impact of both domestic and international health crises, making it imperative for Pakistan to build a robust health system that can swiftly and effectively address these challenges.

In 2016, Pakistan underwent a Joint External Evaluation (JEE), an independent assessment aimed at identifying the country's strengths and weaknesses across the IHR core capacities. The evaluation measured 48 indicators, scoring Pakistan at 48, and provided a roadmap of recommendations to guide improvement efforts. In response, the country formulated a five-year, costed National Action Plan for Health Security (NAPHS) to address these recommendations. This strategic plan aimed to improve preparedness and strengthen response mechanisms across various sectors, from health and emergency management to animal health and food safety, reflecting the multisectoral nature of health security.

Despite these efforts, the COVID-19 pandemic exposed significant gaps in Pakistan's health security infrastructure, particularly in emergency response, surveillance, and healthcare delivery. Challenges such as limited hospital capacity, inadequate laboratory networks, and resource constraints underscored the need for continued investment and reform. The pandemic underscored that, even with the NAPHS in place, substantial gaps remained, preventing an adequate response to large-scale health emergencies.

In May 2023, Pakistan underwent a second JEE, which evaluated the country against 56 revised indicators to reflect evolving global health priorities. The evaluation resulted in a lower score of 43, highlighting critical areas where progress had stagnated or even regressed. This assessment outlined specific recommendations for each technical area, identifying weaknesses in areas such as coordination, workforce capacity, and surveillance. The findings of the 2023 JEE illustrate the urgency for Pakistan to reinforce its health security framework and align its capacities with international standards.

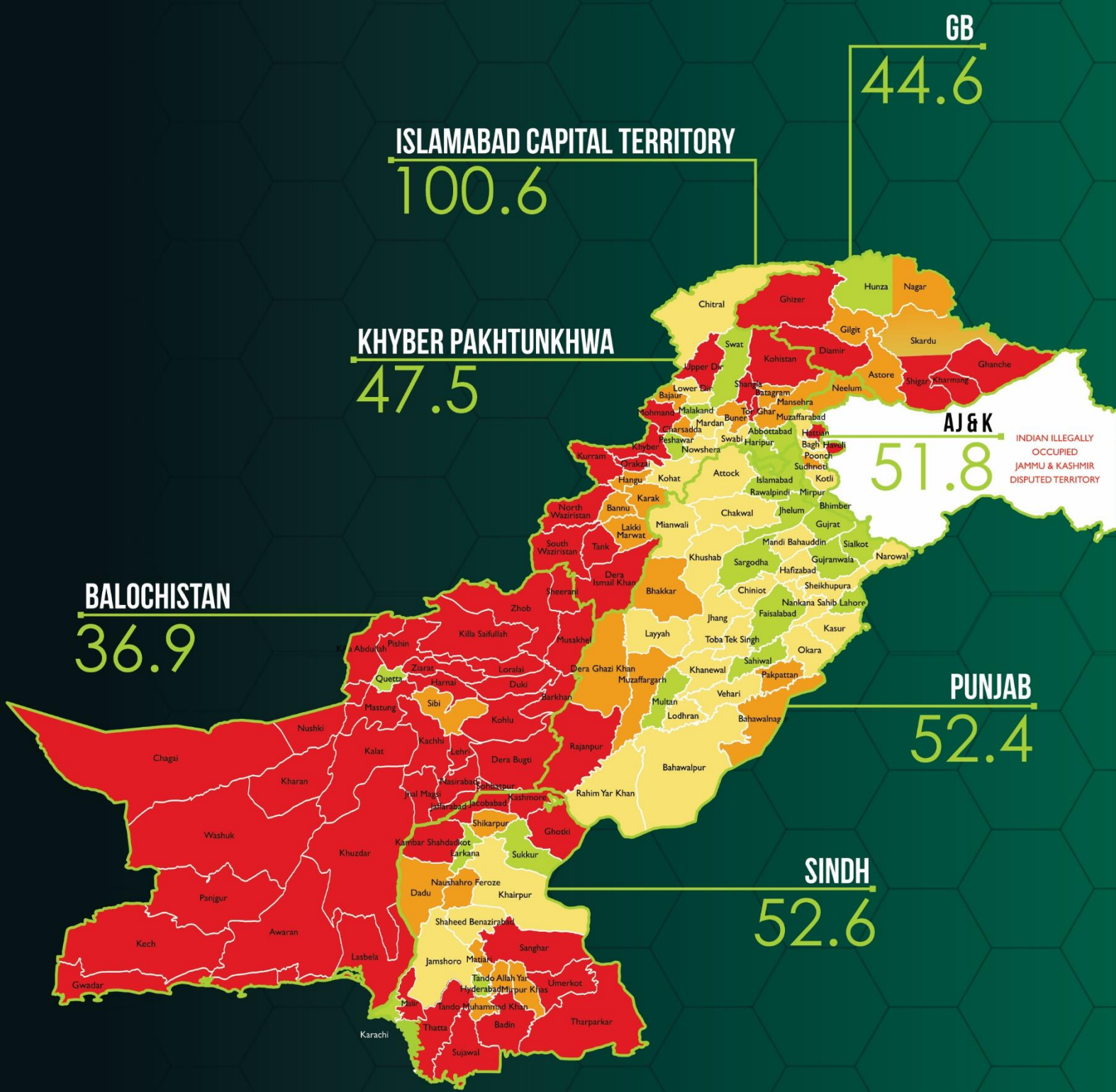
Table 21 National and Provincial IHR Index based in JEE 2023 (19 Capacities)

National	Punjab	Sindh	Khyber Pakhtunkhwa	Balochistan	AJ&K	Gilgit Baltistan	ICT
43	43.7	41.1	40.9	36.8	47	45.9	52.2

To address these identified Government of Pakistan has developed the costed NAPHS-II. This revised plan focus on closing the gaps identified in the 2023 JEE, enhancing Pakistan's resilience against potential health emergencies. A comprehensive NAPH allows for strategic resource allocation, prioritization of high-impact interventions, and strengthening of multisectoral coordination. To take effective steps towards implementation of the activities identified and elaborated in NAPHS, the Government of Pakistan recently developed a proposal to mobilise financing from the Pandemic Preparedness and Response Fund. This Fund finances critical investments to strengthen pandemic prevention, preparedness, and response capacities

By aligning its health security efforts with global best practices, Pakistan can work towards a health system capable of safeguarding its citizens while fulfilling its international obligations under the IHR. Enhanced capacity in health security will also contribute to economic stability, supporting Pakistan's ability to withstand and recover from future public health threats.

MAP 5: SERVICES CAPACITY & ACCESS AGGREGATE SCORE IN 2023



DISTRICT-WISE UHC SCI 2023

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6 FINANCIAL HARDSHIP

KEY FINDINGS

HIGH OUT-OF-POCKET (OOP) EXPENDITURES:

OOP payments constitute **46.86 percent** of total health expenditure in Pakistan, far exceeding the global average of 15 percent, resulting in significant financial hardship, deterring health service utilization, and pushing millions into poverty.

CATASTROPHIC HEALTH EXPENDITURE (CHE) IMPACT:

In 2023, approximately **13.4 million individuals** risked poverty due to catastrophic health expenditures exceeding 10 percent of household income, with CHE predominantly affecting the poor and escalating amidst high inflation rates.

PROVINCIAL DISPARITIES AND SYSTEM INEFFICIENCIES:

Punjab achieves the highest UHC Service Coverage Index (**55.4**) despite low per capita government health expenditure (GHE), while Sindh and Khyber Pakhtunkhwa demonstrate inefficiencies relative to their spending. Underfunded regions like Balochistan face severe financial protection challenges.

CALL FOR URGENT HEALTH FINANCING REFORMS:

Low government health investments necessitate sharp increases in public health expenditure, with an emphasis on **primary, preventive, and promotive care**, alongside reforms to ensure equity and financial protection for both poor and middle-income households.

FINANCIAL PROTECTION: A CORE PILLAR FOR UHC

Financial protection is fundamental to UHC. Financial protection in health is achieved when (1) there are no financial constraints to health service access; and (2) direct payments required to acquire health services are not a source of financial hardship.[56]

High OOP spending highlights the gap in health coverage and the urgent need for financial protection to prevent impoverishment due to health costs. Financial protection under SDG 3.8.2 ensures health access without financial hardship, achieved when direct payments do not strain household income. **Another dimension of UHC is the catastrophic health expenditure, which is a healthcare-related bill that exceeds a person's capacity to pay.** It often involves the encashment of savings and assets, including, at times, homes, and businesses. It can impoverish and devastate families for many years.

56 Global UHC Monitoring Report 2023

As a result of low government investment in health, **out of pocket (OOP) payments constitute a large share of total health expenditure in Pakistan – 46.86 percent**[57], significantly higher than the global average of about 15 percent. These payments deter some people from using necessary health services and push others into poverty.

Pakistan is firmly committed to achieving the targets set for Universal Health Coverage (UHC) and addressing the health- and poverty-related Sustainable Development Goals (SDGs). To achieve this, it is crucial that urgent steps be taken to strengthen and strategically manage health financing within the nation. As we approach the 2030 deadline for the SDGs, a significant challenge remains: approximately half of Pakistan's population, which equates to around **117 million people, not covered for provision of essential health services** (SDG 3.8.1).[58] Moreover, in 2023, approximately **13.4 million individuals were at a risk of entering into poverty due to substantial out-of-pocket (OOP) health expenditures** - exceeding 10 percent of total household income (SDG 3.8.2).[59]

In Pakistan, the population with household expenditures on health >10 percent of total household expenditure or income (%) was 5.4 in 2021-22, 4 in 2018-19, 4.5 in 2015 and 3 in 2010.[59] The current value indicate that more than 13.4 million of the population is at a risk of entering into poverty due to catastrophic health expenditure. Currently the inflation rate is expected to have a further negative impact on the health of the poor.

In advanced societies, particularly the United Kingdom and Western Europe, the existence of cradle-to-grave social welfare programmes buffers individuals from such costs, whereas in Pakistan social protection mechanisms are still emerging. It's also worth noting that catastrophic health expenditure (CHE) usually occurs in the last few years of a person's lifetime, contributing in no small way to the dissatisfaction with the spending.

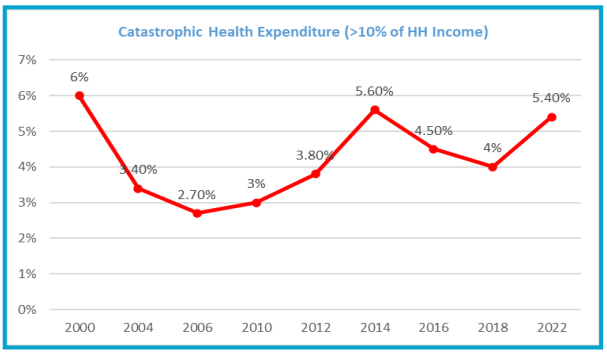


Figure 51- Catastrophic Health Expenditure

Catastrophic health expenditure is an escalating issue in Pakistan where many people cannot afford health care services when these expenditures increase up to a certain level. A sharp and immediate increase in current government health expenditures is required to achieve cost-effectiveness, efficiency, and equity in the health care system. The devastating economic cost of CHE make a strong case for UHC investments with a focus more on primary, preventive, and promotive health care services. The government should protect the poor from health expenditure catastrophe, but simultaneously it is also essential to protect non-poor or middle-income people from health expenditure shock. In this regard, major reforms on health care financing and health policies are required to improve the efficiency and equity in the health care system of Pakistan.

OUT-OF-POCKET HEALTH EXPENDITURE

In FY 2021-22, Pakistan's total health expenditure (THE) rose 34 percent to Rs. 1,962 billion, driven by COVID-19 investments. Government spending contributed 46 percent, while private sector accounted for 53.5 percent, with 89

57 National health Accounts 2021-22
58 WHO, 2021; Global UHC Monitoring Report – Number projected for Pakistan based on the indicator 3.8.1 reported
59 Federal Bureau of Statistics, 2018; Household Income and Expenditure Survey

percent from out-of-pocket payments. Donor support was minimal (0.4 percent). Per capita health spending increased to Rs. 8,526, with a 2.91 percent CHE-to-GDP ratio.

OOP expenditures are excessively high in Pakistan and make up 47.1 percent of the current health expenditures, and 46.86 percent of the total health expenditures. OOP health expenditures in the private sector are significantly higher than those in the public sector.

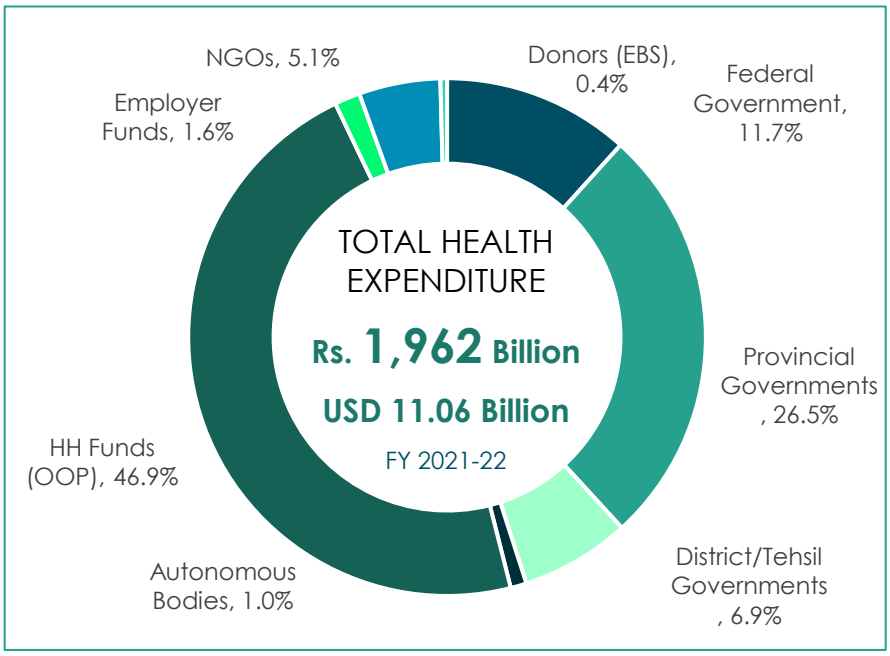


Figure 52: OOP expenditure according to health care provider

An analysis of the 2021-22 NHA, and Household Integrated Economic Survey 2019-20 shows that Punjab has the highest share (53 percent), while Islamabad has the lowest share (1 percent) of the total OOP health spending. Furthermore, the level of OOP health expenditure in urban areas is higher compared to that in rural areas. More than half of the total OOP expenditure can be attributed to the purchase of medical products, appliances and equipment. Other categories with high share of OOP spending include doctors' fees, costs of diagnostic tests and transportation costs.

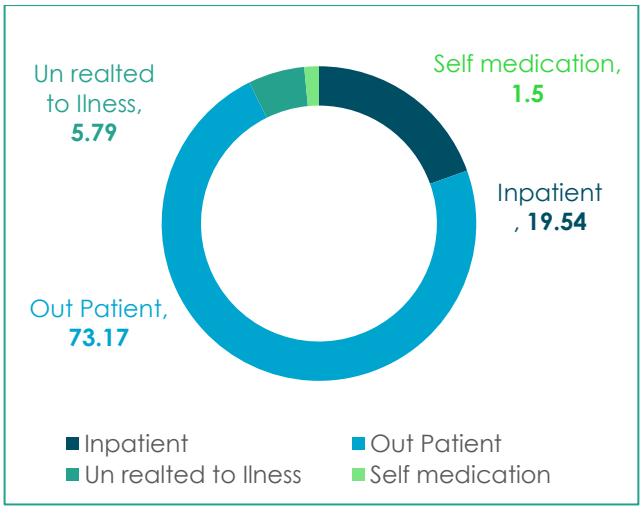


Figure 53: OOP expenditure according to type of health care

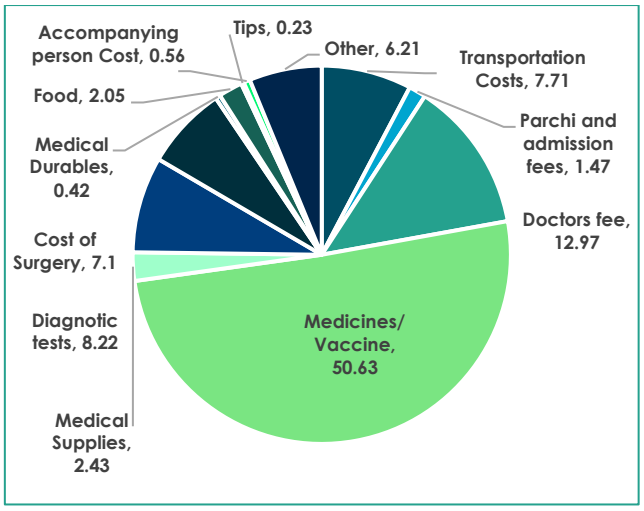


Figure 54: OOP expenditure according to categories

For 2021-22, around 73.17 percent of the total OOP expenditures were spent on outpatient services, while around 19.54 percent of total OOP expenditures were disbursed for inpatient care. 5.79 percent of total OOP spending went to "unrelated to illness" and just 1.5 percent expenditures reflected self- medication which included all those people who were taking medicines without consultation/prescription, or all those people who were taking medicines for chronic diseases like diabetes and high blood pressure that were already prescribed by doctors.

Table 22 Provincial Inequities and Systemic Inefficiencies

Province	Health Expenditure (PKR)	Population (#)	Per capita PKR - GHE	Per capita $ - GHE	UHC-SCI
Punjab	329,227,613,774	127,688,922	2,578	9.92	**55.4**
Sindh	217,403,877,660	55,696,147	3,903	15.01	**50.7**
Khyber Pakhtunkhwa	143,612,916,077	40,856,097	3,515	13.52	**51.0**
Balochistan	49,999,913,003	14,894,402	3,357	12.91	**38.4**
Azad Jammu Kashmir	22,677,043,572	4,568,257	4,964	19.09	**51.2**
Gilgit Baltistan	11,137,467,012	1,685,895	6,606	25.41	**50.4**
Federal	48,581,377,667	2,363,863	20,552	79.04	**63.8**
Pakistan	**822,640,208,765**	**247,753,583**	**3,320**	**12.77**	**53.9**

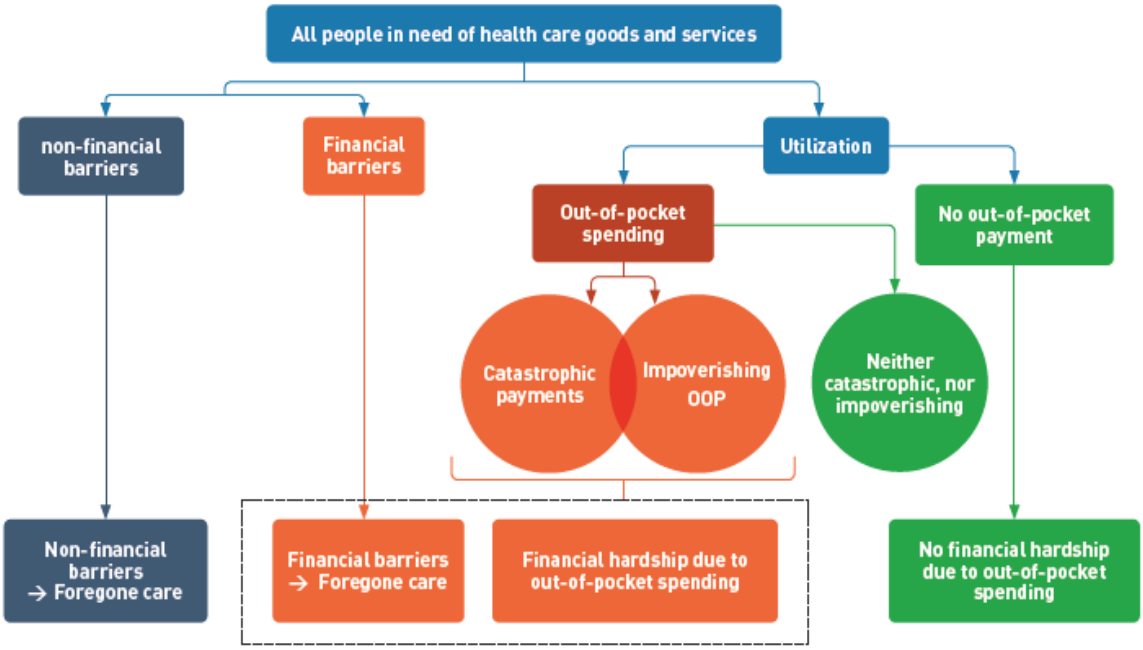
Source: (1) Country Integrated Financial Management Information System, Controller General of Accounts, Government of Pakistan, (2) https://www.pbs.gov.pk/digital-census/detailed-results

The above data provides a snapshot of government health expenditures (GHE) across Pakistan's provinces and regions, but it excludes private expenditures, including out-of-pocket (OOP) and donor contributions, which are substantial in Pakistan's health financing landscape. This omission underestimates the total health spending and distorts the understanding of financial coverage and healthcare access. For instance, low per capita GHE in Punjab (PKR 2,578 or $9.92) and Balochistan (PKR 3,357 or $12.91) likely shifts the healthcare burden onto households through high OOP expenditures, exacerbating inequities and financial risks for poorer populations. Regions like Gilgit Baltistan (PKR 6,606 or $25.41) and the Federal Area (PKR 20,552 or $79.04) benefit from disproportionately high government allocations, though their outcomes, as reflected in Universal Health Coverage Service Coverage Index (UHC-SCI) scores, do not indicate significantly higher effectiveness, highlighting inefficiencies. Moreover, donor-dependent regions such as AJ&K and GB may appear better off in terms of UHC-SCI (51.2 and 50.4, respectively), but their reliance on external funding raises concerns about sustainability. Punjab demonstrates moderate efficiency by achieving the highest UHC-SCI score (55.4) despite having one of the lowest per capita GHE, whereas Sindh and Khyber Pakhtunkhwa underperform relative to their spending levels, indicating systemic inefficiencies in fund utilization. Overall, excluding OOP and donor contributions limits the comprehensiveness of the analysis and masks critical disparities in access, financial protection, and efficiency. A complete resource mapping, integrating all sources of health financing, is essential for crafting equitable and sustainable strategies, with a focus on reducing the reliance on OOP payments and addressing gaps in underserved regions like Balochistan and Sindh.

The data reveals significant disparities in per capita Government Health Expenditure (GHE) and SCI (Service Coverage Index) across districts in Pakistan, pointing to critical equity and efficiency challenges in health resource allocation. **Lahore in Punjab ($70.9, 65.6)** and **Islamabad ($79.0, 63.9)** far outpace other districts, suggesting concentration of resources in urban centres and federal regions, while areas like **Sheikhupura ($0.3, 56.6) and Bahawalnagar ($0.4, 53.2)** suffer from stark underinvestment, despite relatively moderate SCI scores mainly due to high out of pocket expenditure or the people of that area went to other cities to take the services. Sindh portrays a similar dichotomy, with **Karachi ($24.9, 57.5) and Hyderabad ($38.1, 63.9)** enjoying better resource allocation compared to districts such as **Kashmore ($1.8, 29.9) and Thatta ($7.0, 41.8**), which highlight a correlation between lower GHE and lagging SCI. The disparities within Khyber Pakhtunkhwa also underscore uneven development, where **Peshawar ($51.5, 63.7) and Abbottabad ($20.9, 63.7)** benefit disproportionately compared to **Torghar ($2.5, 24.5) and Kohistan ($9.5, 22.8)**, showcasing persistently poor service coverage in underserved areas despite allocation increases.

Balochistan exemplifies the most acute inequities, with Quetta ($37.2, 51.4) relatively better off compared to severely neglected districts like Awaran ($12.3, 19.0), Dera Bugti ($6.3, 17.9), and Sherani ($3.9, 23.8). These figures indicate

systemic governance and access constraints, where increased GHE does not necessarily translate into improved SCI outcomes, raising concerns about the efficiency of expenditure. For example, districts with comparatively higher expenditures, such as Loralai ($25.7, 37.4) and Zhob ($9.0, 28.8), still exhibit low service coverage, reflecting gaps in health systems performance. In Gilgit-Baltistan, higher GHE in districts like Gilgit ($61.7, 53.1) and Hunza ($25.1, 53.2) suggests targeted investment in key areas, though lower-performing districts like Kharmang ($15.5, 35.2) and Shigar ($9.4, 39.0) indicate ongoing inequities. Similarly, while Azad Jammu and Kashmir's Bhimber ($30.2, 58.6) and Mirpur ($26.4, 59.9) perform well, districts like Haveli ($5.5, 42.9) trail, suggesting imbalanced resource allocation.



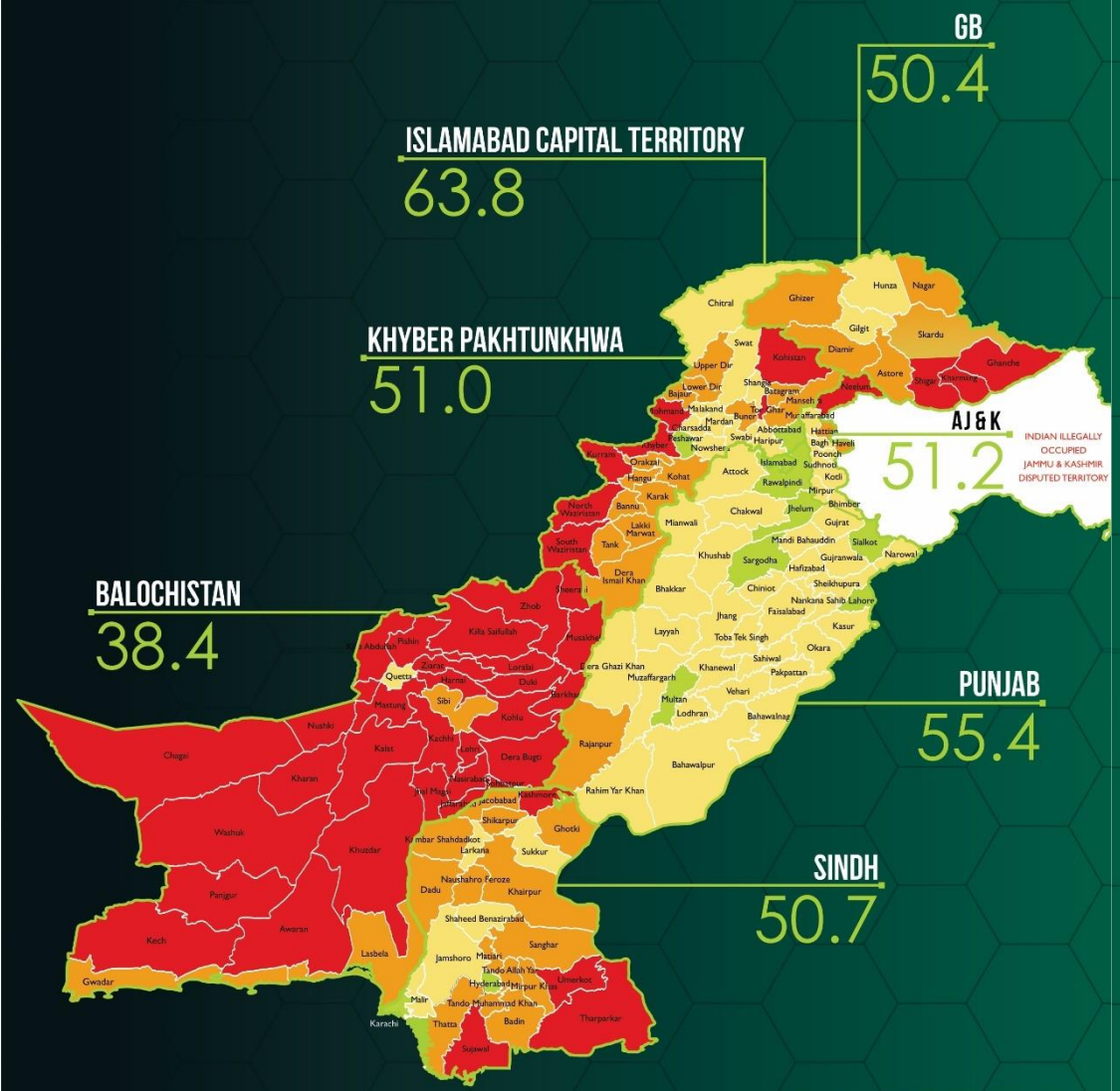
These findings highlight three critical points: first, health expenditures are disproportionately concentrated in a few urban and accessible regions, **exacerbating inequities** in rural and marginalized areas. Second, higher expenditures do not consistently result in improved SCI, reflecting **inefficiencies in spending**, **inadequate governance**, or systemic barriers like **workforce shortages**, infrastructure deficits, and **lack of monitoring**. Third, for provinces like Balochistan and Khyber Pakhtunkhwa, the combination of underinvestment and poor outcomes signals a **chronic neglect of health systems strengthening**. This analysis underscores an **urgent need to rebalance resource allocation**, improve efficiency in expenditure, and **adopt targeted interventions for low-performing districts** to bridge regional disparities and **achieve equitable health** outcomes across Pakistan.

DISTRICT WISE INEQUITIES AND SYSTEMIC INEFFICIENCIES

District	Per capita GHE $	SCI 2023
PUNJAB		
Bhawalpur	7.5	55.6
Dera Ghazi Khan	7.0	50.8
Faisalabad	6.5	59.5
Gujranwala	4.6	57.7
Lahore	70.9	65.6
Multan	11.5	61.0
Rahim Yar Khan	3.5	52.9
Rawalpindi	7.4	62.8
Sargodha	2.4	60.6
Sheikhupura	0.3	56.6
Sahiwal	8.4	58.2
Sialkot	1.9	61.2
Bahawalnagar	0.4	53.2
Chinot	0.2	52.9
Hafizabad	0.7	54.7
Jhang	0.3	54.2
Jhelum	0.7	61.4
Khushab	0.5	56.6
Lodhran	0.4	53.6
Narowal	0.5	56.4
Attock	0.5	54.7
Bhakar	0.5	51.8
Chakwal	0.5	57.8
Gujrat	2.7	58.1
Kasur	0.3	55.0
Khanewal	0.3	54.8
Layyah	0.4	56.1
Mandi Bahauddin	0.4	56.6
Mianwali	0.5	55.9
Muzzafargarh	0.3	51.0
Nankana Sahib	0.3	56.1
Okara	0.4	55.0
Pakpattan	0.4	52.4
Rajanpur	0.4	45.4
Toba Tek Singh	0.6	57.5
Vehari	0.3	54.7
SINDH		
Badin	4.4	41.4
Dadu	5.1	45.6
Karachi	24.9	57.5
Kashmor	1.8	29.9
Khairpur	17.4	49.6
Larkana	12.5	55.3
Matiari	5.8	48.2
Mirpur Khas	6.2	46.6
Tharparkar	9.5	31.3
Sujawal	6.8	34.7
Sanghar	4.4	44.5
Sukkar	9.9	55.5
Tando Allahyar	5.5	45.1
Tando Mohummad Khan	4.9	45.5
Thatta	7.0	41.8
Umer Kot	10.4	39.7
Ghotki	3.9	45.3
Jacobabad	7.2	47.6
Kambar Shadad Kot	4.3	43.0
Shaheed Benazirabad	10.7	53.8
Naushero Feroz	6.2	49.4
Shikkarpur	5.7	43.4
Jamshoro	14.1	50.3
Hyderabad	38.1	63.9
KHYBER PAKHTUNKHWA		
Abbottabad	20.9	63.7
Bannu	11.5	49.5
Batagram	6.1	45.8
Charsadda	6.5	50.4
Dera Ismail Khan	10.4	47.1
Lower Dir	6.9	49.8
Upper Dir	5.0	43.2
Haripur	7.4	56.1
Hangu	5.6	48.3
Karak	9.3	47.6
Kohat	6.7	48.4
Lakki Marwat	9.0	48.0
Malakand	10.7	57.0
Mansehra	6.1	48.8
Mardan	8.6	54.2
Nowshera	8.5	54.4
Swabi	6.8	53.9
Swat	9.0	56.5
Shangla	5.8	51.9
Tank	9.1	41.0
Buner	5.5	47.6
Chitral	14.6	53.1
Bajaur Agency	5.3	44.0
Khyber Agency	6.0	39.2
Kurram Agency	7.4	38.8
North Waziristan Agency	14.1	33.2
Mohmand Agency	7.2	32.2
South Waziristan Agency	6.7	33.1
Kohistan	9.5	22.8
Peshawar	51.5	63.7
Orakzai Agency	8.4	40.3
Torghar	2.5	24.5
BALOCHISTAN		
Quetta	37.2	51.4
Chaghi	5.6	25.3
Jaffarabad	5.0	30.6
Khuzdar	6.7	21.6
Nushki	9.8	24.4
Panjgur	7.0	33.5
Lasbela	7.4	40.3
Washuk	4.5	24.0
Awaran	12.3	19.0
Dera Bugti	6.3	17.9
Gwadar	16.9	40.8
Harnai	6.5	27.9
Jhal Magsi	5.8	28.9
Kharan	6.8	26.0
Kohlu	10.9	31.0
Kachhi	4.6	22.6
Kalat	8.1	21.4
Loralai	25.7	37.4
Musakhel	9.6	27.9
Mustang	11.7	32.0
Nasirabad	5.2	29.7
Pishin	4.3	34.5
Killa Saifullah	6.2	28.4
Sibi	13.4	40.5
Kech	6.8	32.9
Zhob	9.0	28.8
Ziarat	14.3	26.0
Killa Abdullah	11.5	19.6
Lehri	2.2	26.8
Barkhan	7.5	25.9
Sherani	3.9	23.8
Duki	6.6	26.0
Sohbatput	4.6	31.2
AZAD JAMMU & KASHMIR		
Bhimber	30.2	58.6
Bagh	20.8	54.8
Hattian Bala / Jehlum velley	8.0	42.8
Haveli	5.5	42.9
Kotli	14.2	53.8
Mirpur	26.4	59.9
Muzaffarabad	21.7	51.8
Neelum	21.5	38.5
Poonch	23.9	50.9
Sudhnoti	14.5	51.8
GILGIT BALTISTAN		
Astore	18.9	45.3
Diamer	14.9	41.4
Gilgit	61.7	53.1
Ghanche	14.6	38.6
Ghizer	15.9	47.6
Hunza	25.1	53.2
Nagar	16.1	44.4
Kharmang	15.5	35.2
Skardu	20.1	49.0
Shigar	9.4	39.0
FEDERAL		
Islamabad	79.0	63.9

Note: GHE does not include donors' financing not channelled through the public financial system

MAP 1: UHC SERVICE COVERAGE INDEX (2023)



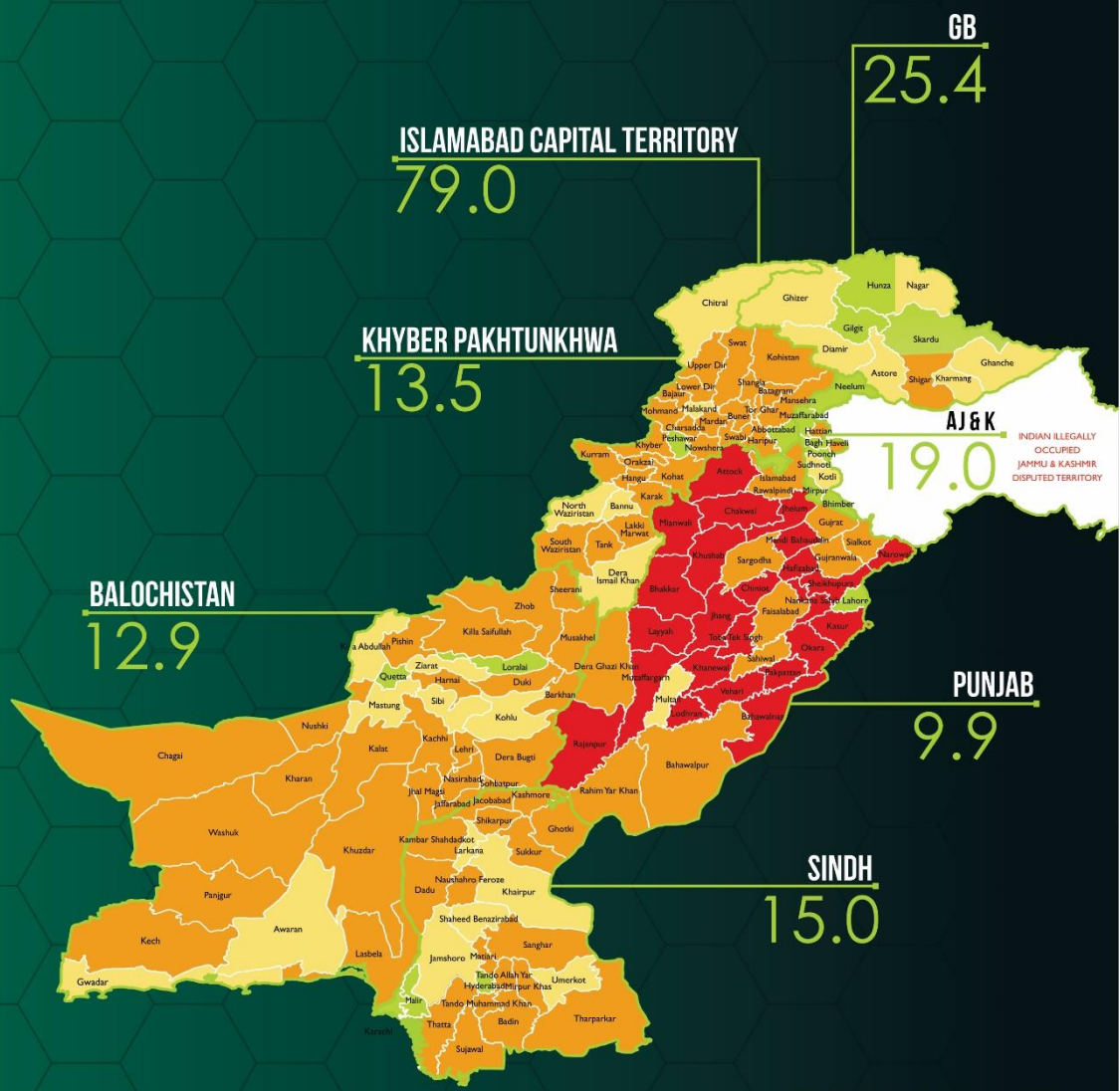
DISTRICT-WISE UHC SCI 2023

<40 | 40-49 | 50-59 | >60

PAKISTAN

53.9

MAP 6: PER CAPITA GHE$ 2023 PROVINCE AND DISTRICT WISE



DISTRICT-WISE GHE$ 2023

<$1 | 1$-10$ | 10.1$ -19.9$ | >20$

PAKISTAN

12.7

UNIVERSAL
HEALTH
COVERAGE

7 CROSS-CUTTING/ INTERSECTORAL AREAS

Health and well-being are at the heart of sustainable development, reflected in SDG 3, calls for ensuring healthy lives and promoting well-being for all at all ages. However, Universal Health Coverage (UHC), a key target under SDG 3, cannot be achieved in isolation. In Pakistan, as in many other countries, health outcomes are intricately linked to multiple other social, economic, and environmental determinants that are encapsulated in the broader SDG framework. Addressing these interlinkages is critical for tackling the root causes of health inequities and ensuring that no one is left behind.

Achieving UHC requires multisectoral action that recognises the interconnectedness of health with other development goals. This chapter explores these interlinkages in the context of Pakistan, with a focus on how progress across the SDGs influences UHC, and why intersectoral collaboration is key to attaining sustainable, equitable health outcomes.

The social determinants of health (SDH)—the conditions in which people are born, grow, live, work, and age play a pivotal role in shaping health outcomes and access to healthcare. In Pakistan, key social determinants are closely tied to other SDGs, highlighting the need for integrated policy approaches that extend beyond the healthcare sector.

Poverty is one of the most significant barriers to achieving UHC in Pakistan. Financial constraints often lead to delayed healthcare seeking, limited access to essential medicines, and catastrophic health expenditures that push families deeper into poverty. Multidimensional poverty has slightly increased in 2019-20 compared to 2014- 15. The percentage share of multidimensional poor has increased from 38.6 percent in 2014-15 (the last time MPI was calculated) to 39.5 percent in 2019-20. This marginal increase signifies a deviation from the historical pattern of multidimensional poverty in Pakistan. Over the last fifteen years multidimensional poverty in Pakistan has consistently declined. The trajectory from 2014-15 to 2019-20 however is in the opposite direction. For the first time in fifteen years the population share of multidimensional poor in the country has increased.

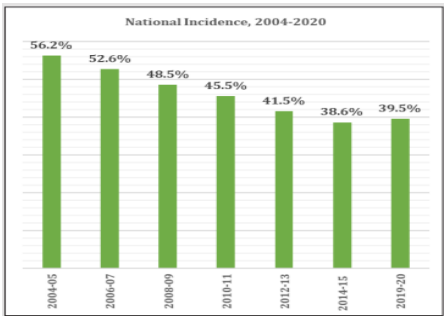


Figure 55: National Multidimensional Poverty

Among the four provinces of Pakistan, multidimensional poverty is highest in Balochistan. According to the data 70 percent of the population in Balochistan are identified as multidimensionally poor. This is followed by 48 percent in Khyber Pakhtunkhwa and 45 percent in Sindh. Punjab has the lowest incidence (headcount ratio) of multidimensional poverty in the country. With 30 percent of its population identified as poor, it is the only province that has a lower headcount ratio than the national average of 39.1 percent. Except for Sindh, multidimensional poverty has decreased in the provinces. For instance, in Balochistan the headcount ratio has dropped from 72.4 percent in 2014-15 to 70.5 percent in 2019-20, in KP from 49.1 percent to 48.8 percent while in Punjab the share of multidimensional poor decreased from 31.0 percent to 30.4. In Sindh, however the headcount ratio increased from 43.1 percent in 2014-15 to 45.2 percent in 2019-20.

Figure 56: Urban/Rural MPI, Incidence and Intensity Trend, 2004-2020

The Benazir Income Support Programme (BISP) and the Sehat Sahulat Programme aim to alleviate these barriers, yet their limited reach and integration with health systems highlight the need for stronger social protection mechanisms that ensure universal access to healthcare without financial hardship. Achieving SDG 1 directly reduces health inequities by enabling more equitable access to services, contributing to the UHC agenda.

Addressing the impact of poverty on health requires comprehensive policy interventions. Effective strategies may include:

UNIVERSAL HEALTH COVERAGE:

Expanding health insurance and access to affordable healthcare services can mitigate the financial burden on low-income families.

NUTRITION PROGRAMMES:

Implementing targeted nutrition Programmes, particularly for children and pregnant women, can improve health outcomes and break the cycle of malnutrition.

EDUCATION AND HEALTH LITERACY INITIATIVES:

Increasing access to education and health literacy Programmes can empower individuals to make informed health choices.

INFRASTRUCTURE IMPROVEMENTS:

Investing in clean water and sanitation facilities can significantly reduce the burden of disease in impoverished communities.

2 ZERO HUNGER

Proper nutrition at the right time is crucial for a child's survival, health, and development. Well-nourished children are better prepared to grow, learn, contribute productively to society, and withstand challenges posed by disease, disasters, and other global crises. Conversely, poor nutrition can negatively impact health, education, and overall well-being across generations.

In Pakistan, the situation is severe, with high rates of stunting and wasting among children. Stunting goes beyond insufficient food intake; it also involves the quality and diversity of diet, along with other factors. A major contributor to childhood malnutrition is inadequate maternal nutrition during pregnancy, which often leads to stunting and long-term developmental issues for children.

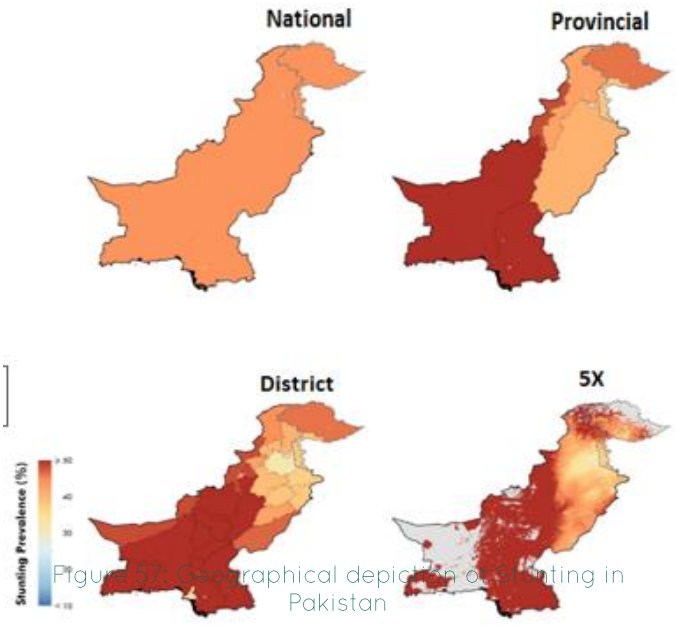


Figure 57: Geographical depiction of Stunting in Pakistan

The interplay between SDG 2 and health is profound, as poor nutrition worsens maternal and child mortality, undermines cognitive development, and increases susceptibility to infectious diseases.

Pakistan grapples with significant challenges related to nutrition and food insecurity, posing serious threats to the health and well-being of its population. The prevalence of malnutrition, particularly among children under five, is a pressing issue, with stunting at 37.6 percent and wasting 7.1 percent contributing to chronic developmental concerns.

Micronutrient deficiencies, including those of iron, vitamin A, and iodine, compound the health risks, impacting vulnerable groups such as children and pregnant women. The situation is quite dire in Pakistan, with stunting and wasting heavily prevalent in the country. Stunting does not only mean that a child is not having enough to eat. It is about the quantity and quality of diet besides other factors. Inadequate nutrition among mothers during pregnancy is one of the main reasons of malnutrition among children leading to stunting.[60]

More than half of children under five years of age are deficient in vitamin A, 18.6 percent are deficient in zinc, and nearly 28.6 percent are anaemic[3]	Fe IRON	Zn ZINC	Vitamin A
	Deficient	Deficient	Severe
	28.6%	18.6%	12.1%
	Non-Deficient	Non-Deficient	Moderate
	71.4%	81.4%	39.4%

Nutrition is multisectoral and just investing on health-related interventions may not be enough. There is a need to

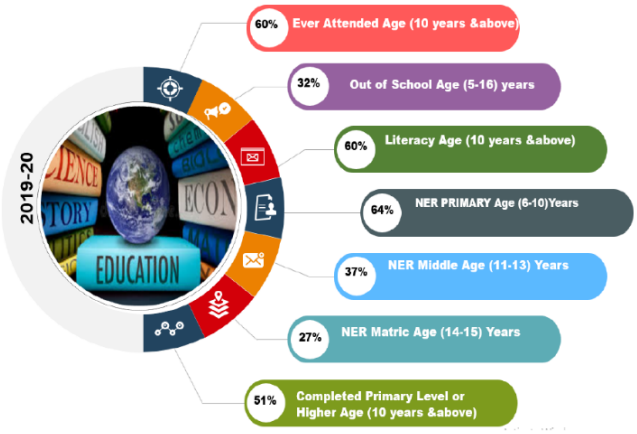
- Adopt and implement policies in relevant to non-health sectors and use the approach of wider determinants of health to address this issue. To support adequate nutrition and essential maternal and child nutrition services. Pakistan has also adopted Global Action Plan (GAP) for management of wasting
- Enhance investment in essential maternal and child nutrition services, particularly during the first 1,000+ days of life, and improve the quality and coverage of such services.
- Strengthen community components for the delivery and reach of nutrition counselling and social and behaviour change interventions at the community and facility levels. There is a need to expand the coverage to community health workers, which at present hovers around 40 percent of the total population.
- Enhance community skills to improve child nutrition and expand the role of social prescribing.

60 https://www.unicef.org/pakistan/nutrition-0

UHC cannot be achieved without addressing undernutrition and food insecurity, which directly influence both short-term and long-term health outcomes. By integrating nutrition-sensitive interventions into health services and promoting food security through multisectoral collaboration, progress on SDG 2 can significantly enhance health outcomes.

Education is a powerful determinant of health that influences health literacy, healthcare-seeking behaviours, and long-term health outcomes. Education serves as a cornerstone for the economic and social progress of a nation, playing a pivotal role in shaping the intellectual landscape and fostering growth.

Education enhances health literacy, equipping individuals with the knowledge to make informed health decisions. For instance, people with higher education levels are more likely to understand preventive measures, adhere to medical treatments, and make healthier lifestyle choices. Literacy is an important indicator of education and it has significant impact on development of the country. The literacy rate of population 10 years and older at National level remains stagnant at 60 percent in 2019-20 as in 2014-15. Provincial picture depicts that Punjab has the highest literacy rate with 64 percent among all provinces followed by Sindh with 58 percent however Balochistan has the lowest literacy with 46 percent.



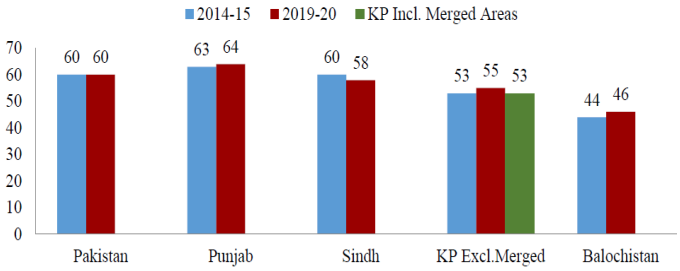


Figure 58: Literacy Rate 10 years and above by Provinces

School attendance is a crucial determinant of both immediate and long-term health outcomes. By fostering health literacy, facilitating access to health services, encouraging positive social development, reducing risky behaviours, and providing pathways to economic stability, school attendance contributes to healthier, more resilient individuals and communities. Investing in policies and Programmes that promote school attendance can have far-reaching impacts on public health and social equity, making it a foundational component of any strategy to improve health outcomes across populations

In Pakistan, where literacy rates (10 years and above) hover 60%, low levels of education, especially among women (%) and rural populations (%), pose challenges to UHC. Health literacy is crucial for individuals to understand and engage with health services, follow treatment regimens, and adopt preventive behaviours. The integration of health education into school curricula, alongside public awareness campaigns, can enhance health literacy and empower communities to participate in their own health care, advancing the UHC agenda.

5 GENDER EQUALITY

Gender inequalities are pervasive in Pakistan, where cultural norms and systemic barriers prevent women from accessing timely and adequate healthcare, particularly in rural areas. The Government of Pakistan has taken significant measures in recent years to improve gender equality as pledged in the Constitution and the country's international commitments. Most notably, a sound legislative and policy framework has been established, including the enactment of many pro-women laws, policy reforms to enhance women's empowerment and participation as well as a National Gender Policy Framework (2022). Many good practices are being implemented, and success stories, small and big, can be found across the country. This includes the Benazir Income Support Programme (BISP), launched in 2008, which is the largest single social safety net programme in the country specifically targeting women, with a total of 8.7 million women beneficiaries to date. Further, the establishment of Gender-Based Violence (GBV) courts and women police stations, as well as progressive court judgments on women's issues such as sexual assault, domestic violence and child marriage, demonstrate the commitment of the Government to tackle gender-based violence, advance gender equality and empower women.

However, there are a host of structural and socio-cultural barriers that continue to curtail women and girls' mobility. A highly patriarchal society, regressive social norms and gender stereotypes give rise to discrimination and violence against women and girls. Further, Pakistan fares poorly on global indices and reports, ranking at 145 out of 146 countries on the Global Gender Gap Report 2024.

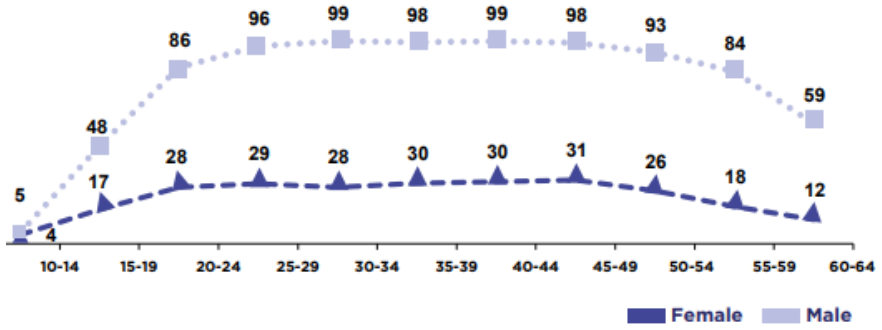


Figure 59: Age-Specific LFP Rate of Workers by Sex

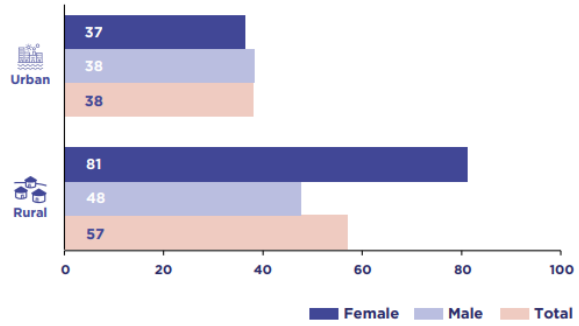


Figure 60: Vulnerable Employment of Workers (Ages 15-64 years) by Area (%)[1]

Key Legislations for Addressing VAWG

- Prevention of Anti-Women Practices (Criminal Law Amendment) Act 2011 (pertaining to forced marriages and inheritance deprivation in the name of custom)
- The Women in Distress and Detention Fund (Amendment) Act 2011
- Right to Ownership (Women) Act 2011
- The Acid Control and Acid Crime Prevention Act 2011
- The Protection Against Harassment of Women at the Workplace Act 2010
- Domestic Violence Prevention and Protection Act Sindh (2013) and Balochistan (2014)
- Child Marriage Restraint Act (Punjab Marriage Restraint Amendment Act 2015, Sindh 2014)
- Criminal Law (Amendment) (Offences relating to Rape) Act 2016
- Criminal Law (Amendment) (Offences in the name or on pretext of Honor) Act 2016
- Punjab Protection of Women against Violence Act 2016
- Prevention of Electronic Crimes Act (PECA) 2016
- Khyber Pakhtunkhwa Domestic Violence Against Women Act, 2021
- Anti-Rape (Investigation & Trial) Act 2021

The overall labour force participation rate (LFPR) of women in Pakistan at 21 percent stands well below the global percentage at 39 percent. At the national level, the refined LFPR of women (aged 15-64 years) is very low at 26 percent compared to 84 percent for men. The country has seen improvement in the LFPR of women in the past twenty years, a 10-percentage point increase.[61]

According to National Report on the Status of Women in Pakistan 2023, several interconnected factors are responsible for the vulnerable employment of women,

61National Report on the Status of Women in Pakistan 2023

including lack of education and information that opens up opportunities for formal work; restrictions on working outside the home; social, cultural, and religious norms that restrict women to a few occupations and sectors; safety and security risks; and lack of safe and adequate transport services. This situation limits women from developing their full potential, enhancing their agency and financial empowerment as well as contributing meaningfully to the development of the nation.

In Pakistan, Violence Against Women and Girls (VAWG) manifests in various forms. It is evident that enhancing women's access to justice is essential for reducing gender inequality, discrimination and violence and is also essential for sustainable economic development. A study by the International Centre for Research on Women found that households lose nearly $146 million in income annually due to VAWG and spend $19 million on violence related expenditure. Further, Pakistan has an annual direct cost of $189.7 million due to VAWG. According to the Pakistan Demographic and Health Survey (PDHS) 2017-18, 23 percent of ever-married women (15-49 years) report having experienced physical violence, 26 percent emotional violence, and 5 percent sexual violence at the hands of husbands or intimate partners.

6 CLEAN WATER AND SANITATION

Access to clean water and adequate sanitation (WASH) is fundamental to reducing the burden of communicable diseases in Pakistan. Access to safe drinking water is essential for health; it is a basic human right and can result in tangible benefit to health. Provision of safe drinking water and basic sanitation coupled with personal hygiene are recognized as an essential component for promoting healthy living. Failure to ensure drinking water safety and proper sanitation system may expose the community to the risk of outbreak of infectious diseases.

Pakistan is inherently a water-dependent country. The country's water security and lack of proper sanitation have been augmented by multiple challenges including weak governance mechanism. The country's rising urban demand for water for hygiene and sanitation facilities has not been addressed due to increasing water scarcity. The Government of Pakistan, while recognizing that access to safe drinking water is the basic human right for every citizen and is the responsibility of the state to ensure its provision to all citizens. Therefore, to fulfil this commitment, Government has formulated the National Drinking Water Policy 2009.

Recognizing the importance of sanitation facilities in improving the quality of life of the people, the Government of Pakistan has formulated National Sanitation Policy in 2006[62] wherein broad framework and policy guidelines have been provided to enhance and support the sanitation coverage. It is, however, important that the implementation of the policy guidelines be carried out following an ecological approach to have sustainable sanitation systems.

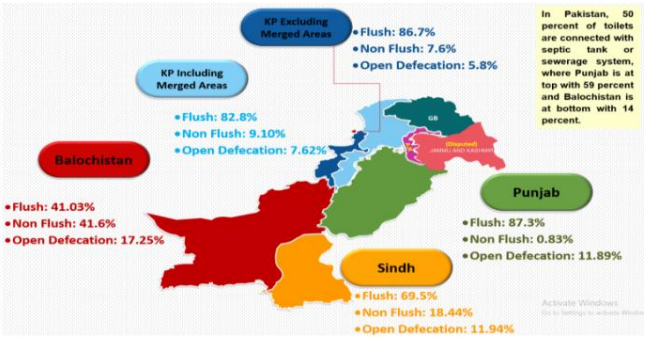
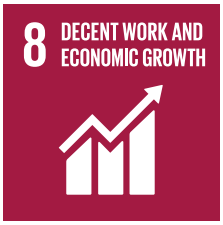


Figure 61: Percentage of Population by type of toilet across the country

Overall 83 percent household have access to Improved Toilet facility. About 50 percent of household were reported with specific place of hand washing with soap and water, while only 11 percent reported that there is no place for hand washing and non-availability of cleansing agent for hand washing.

Flush connected to septic tank and sewerage system are considered as improved sanitation system for which it is considered that on-site treatment has taken place. In Pakistan, 50 percent of toilets are connected with septic tank or sewerage system, where Punjab is at top with 59 percent and Balochistan is at bottom with 14 percent.

Investments to improve WASH infrastructure and services, particularly in underserved rural and urban informal settlements is required. Collaborative efforts between the health, water, and sanitation sectors are critical to reducing waterborne diseases and improving health outcomes, contributing to the overall goal of UHC.



The relationship between employment, economic stability, and health is well-established. Poor working conditions, low wages, and informal employment are associated with a higher prevalence of occupational injuries, mental health issues, and chronic diseases. Although, in 2024, Pakistan's economy demonstrated resilience, with GDP growth rebounding to 2.38 percent, primarily driven by the agricultural sector, which showed strong recovery following the 2023 floods. Inflation decreased significantly to 11.8 percent, down from a peak of 38 percent in May 2023, largely due to government interventions such as monetary tightening and improvements in food supply chains. The current account deficit was also reduced to $0.5 billion. However, despite these improvements, there are persistent challenges in economic performance. There is a need for comprehensive reforms to achieve long-term economic stability and growth.

62 National Sanitation Policy 2006

For Pakistan to advance toward UHC, it must ensure that decent work opportunities are available, and that occupational health and safety standards are enforced. By promoting healthy work environments and providing social protection for workers, progress on SDG 8 can contribute to reducing health inequities and improving access to care. According to LFS 2020-21, the number of unemployed persons has decreased to 4.51 million from 4.71 million in 2018-19. The decrease is 0.20 million. The decreases is more in case of females (0.14 million) than males (0.07 million) as shown in table below:

Table 23 Provincial Inequities and Systemic Inefficiencies

Indicator	2018-19 (Million)			2018-19 (Percentage)		
	Unemployed	Labour Force	Working Age Population	Unemployed	Labour Force	Working Age Population
Total	**4.71**	**68.75**	**153.49**	**100.00**	**100.00**	**100.00**
Male	3.08	52.41	77.42	65.3	76.2	50.4
Female	1.64	16.34	76.07	34.7	23.8	49.6
	2020-21 (Million)			2020-21 (Percentage)		
Total	**4.51**	**71.76**	**159.83**	**100.00**	**100.00**	**100.00**
Male	3.01	54.92	80.92	66.7	76.5	50.6
Female	1.50	16.84	78.91	33.3	23.5	49.4

Urbanisation presents unique challenges for health, particularly in Pakistan's rapidly growing cities. Issues such as air pollution, overcrowding, and inadequate healthcare infrastructure in urban slums exacerbate the burden of non-communicable and infectious diseases. In 2019,[63] Pakistan approved its first National Electric Vehicle Policy. In addition to climate change concerns, Pakistan's policy seeks to decrease urban air pollution and oil imports.To support this policy, planning measures include investments charging infrastructure and financial incentives, such as reduced customs and sales taxes. Pakistan's ambitious target is that by 2030, 30 per cent of all new sales of cars and trucks will be EVs, rising to 90 per cent by 2040. For bikes and rickshaws, the policy aims even higher, with a target of 50 per cent new vehicles to be electrified by 2030, reaching 90 per cent in 2040. The policy has already helped incentivize domestic electric vehicle manufacturers to invest in e-buses and the production of electric motorcycles.

Smog in cities like Lahore significantly increases the incidence of respiratory illnesses, while urban poverty limits access to quality healthcare services. The development of sustainable and resilient cities is crucial for improving urban health outcomes and ensuring that urban populations have access to

It is essential to develop urban planning strategies that facilitate the transition to clean, renewable energy sources and improved energy efficiency

63World Cities Report 2024

essential healthcare services, advancing the UHC agenda.

NATIONAL

Source: UN-Habitat World Cities Report 2024

BASELINE

2014

45.50%

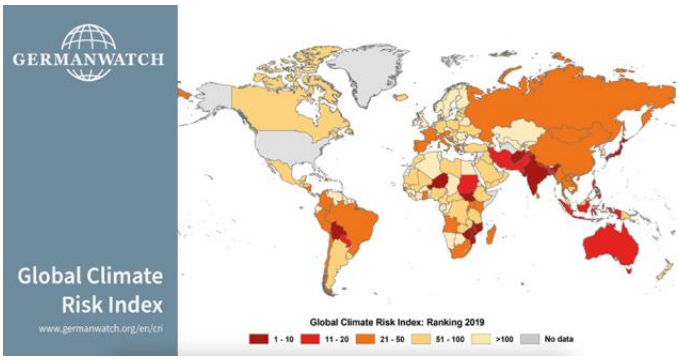
LATEST

2022

56

13 CLIMATE ACTION

Climate change poses an existential threat to health in Pakistan, a country highly vulnerable to climate-related disasters such as floods, droughts, and heatwaves. The 2022-23 floods not only devastated infrastructure but also led to widespread outbreaks of waterborne diseases and drug-resistant infectious diseases and overwhelming the healthcare system. Vector-borne diseases like malaria and dengue are also increasing due to climate change. Integrating climate resilience into health systems, through cross-sectoral collaboration with disaster management and environmental agencies, is essential for ensuring that healthcare services can withstand and respond to climate-related emergencies.



Climate change is severely impacting the Pakistani health system and the health of its inhabitants. According to the German Watch 2021 Global Climate Risk Index, Pakistan ranks as the 8th most climate-vulnerable country in the world. A compendium of climate-related risks including floods, glacial melt, extreme temperatures, landslides, and cyclones have often impacted healthcare systems and infrastructure, increased the prevalence of vector and waterborne diseases and mental illnesses, and on numerous occasions led to large disruptions in agriculture and food supplies causing widespread humanitarian crises.[64] [65]These risks coupled with air pollution and high multidimensional poverty rates are burdening an already strained healthcare system. These challenges highlight and urgent need to address the climate resilience of health systems, especially the need for proactive measures. In 2023, the Ministry of National Health Services, Regulations, and Coordination (M/o NHSR&C), with FCDO support, commissioned a Scoping Study on CRHS in Pakistan.

64 German Watch (2021) *Global Climate Risk Index*. Available from www.germanwatch.org/sites/default/files/Global%20Climate%20Risk%20Index%202021_2.pdf

65 Riaz, K., Ahmad, M., Gul, S., Malik, M. H. B. A., & Ur Rehman, M. E. (2022). Climate change and its implications on health and the healthcare system: A perspective from Pakistan. *Annals of Medicine & Surgery*, *81*. https://doi.org/10.1016/j.amsu.2022.104507

Key findings included:

1 Weak Leadership and Governance:
There is a lack of leadership and governance capacity to build CRHS effectively.

2 Lack of Evidence-based Approaches:
There is a need for evidence-based approaches to highlight the health effects of climate change.

3 Neglected Area of Research:
CRHS and GHG reduction are neglected areas of research in Pakistan.

4 Adaptation of Disease Surveillance:
The disease surveillance system lacks adaptation to consider climate-sensitive health risks.

A targeted assessment of climate-health vulnerabilities and adaptation (CHVA) is now underway in Pakistan, providing a model for further CHVAs across the country and fostering stronger collaboration between the climate and health sectors. The World Health Organization (WHO) is supporting this effort in Punjab and Balochistan, while the Foreign, Commonwealth & Development Office (FCDO) is focused on Khyber Pakhtunkhwa (KP). Similarly, the United Nations Children's Fund (UNICEF) is working in Azad Jammu and Kashmir (AJ&K), Gilgit Baltistan (GB), and Sindh. These initiatives will further enhance Pakistan's capacity to build climate-resilient health systems. Once the CHVAs are completed, the next phase will involve drafting the Health National Adaptation Plan (H-NAP).

The country has adopted and implemented national Disaster Risk Reduction (DRR) strategies in line with the Sendai Framework with an index score of 0.4 in 2018 while it has been 0.8 in 2020. Pakistan remains at the receiving end and has been affected due to extreme climatic events with minimal contribution to greenhouse gas emissions, 436,609 kt of CO2 Equivalent in 2016. Concerning the SDGs indicator 13.2.2, total greenhouse gas emissions per year.

Pakistan is committed to climate action by sharing nationally determined contributions in 2016 as needed under the SDGs indicator 13.2.1 that requires countries to share nationally determined contributions, long-term strategies and national adaptation plans.

The agricultural sector, a cornerstone of Pakistan's economy, is particularly susceptible to climate change, with shifts in temperature and precipitation patterns affecting crop yields and food security. Additionally, the melting of glaciers in the Himalayas poses a long-term threat to water resources, as Pakistan relies heavily on glacier-fed rivers for its water supply.

The challenges and gaps that need to be addressed are:

Strengthening the **capacity** and **coordination** of the health sector at all levels to plan, implement, monitor and evaluate climate change adaptation actions	**Enhancing** the **availability** and **quality** of **data** and **information** on climate change and health, including integrated risk monitoring and early warning systems	**Mobilizing adequate** and **sustainable** resources for climate change adaptation in the health sector, both from domestic and external sources

8 POLICY RESPONSE

The chapter provides a comprehensive outline of Pakistan's strategic approach to achieveing Universal Health Coverage within the context of a decentralized health system. Following the 18th Amendment, healthcare functions shifted primarily to provincial governments, with the Ministry of National Health Services, Regulations, and Coordination (M/o NHSR&C) leading federal coordination and National Health strategies.

National Health Vision (NHV) 2016-25, a key document, emphasizing affordable, quality healthcare access for all, with a focus on maternal and child health. Supporting this vision are eight strategic pillars, which align with Sustainable Development Goals (SDGs) and guide provincial Health Sector Strategic Plans (HSSPs).

Following are some of the significant strategies including:

The **National Vision (2016-25) for Coordinated Priority Actions to address Challenges of Reproductive, Maternal, New-born, Child, Adolescent Health (RMNCAH) and Nutrition**– Targets improvements in reproductive, maternal, and child health through better access to quality primary care and increased funding.

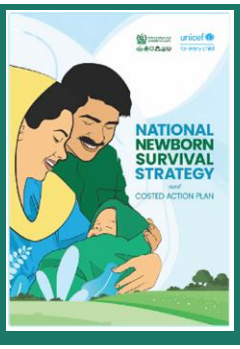
Pakistan National Action Plan for Health Security– Following evaluations by WHO, the plan emphasizes health security and emergency management.

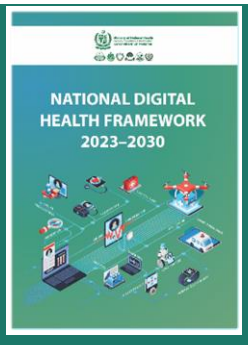
Population Growth Action Plan (2019-24) – Seeks to reduce fertility rates by expanding contraceptive access and collaborating with public, private, and civil society sectors.

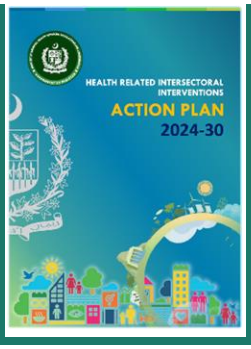
Pakistan Human Resources for Health Vision (2018-30) – Addresses critical health workforce shortages by improving training, distribution, and skill development.

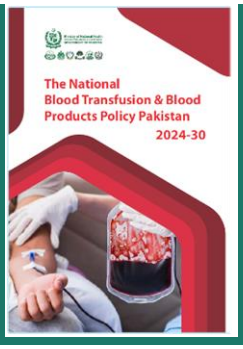
Additional frameworks focus on addressing Pakistan's high NCD burden, climate resilience, and specific disease challenges, including tuberculosis, AIDS, malaria, hepatitis, and antimicrobial resistance. Through cross-sector collaboration and robust policy planning, these frameworks aim to enhance health service quality, equity, and resilience across Pakistan.

The endorsement of below policies by the Inter-Ministerial Health and Population Forum in Pakistan marks a significant milestone in the country's healthcare landscape. These policies are a vital part of the government's broader reform agenda aimed at improving health outcomes, enhancing service delivery, and promoting universal health coverage.



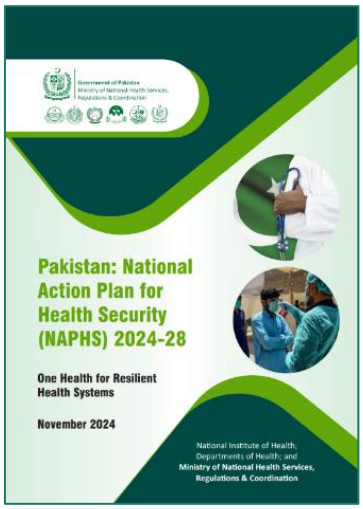






The recent **Mid-Term Review of the National Health Vision (NHV) 2016-25** by the M/o NHSRC has provided crucial insights for developing the **National Health and Population Policy (2025-34).** The review highlighted both achievements and challenges, particularly in improving maternal and child health, addressing non-communicable diseases, and ensuring equitable access to healthcare services for marginalized communities. Moving forward, the new policy aims to adopt a holistic approach that integrates health services with population management, aligns with international frameworks such as the Sustainable Development Goals (SDGs), and emphasizes strengthening health infrastructure, preventive health measures, and community engagement.

The development of the **National Action Plan for Health Security-II (2024-28**), following the **Joint External Evaluation (JEE) 2023,** aims to enhance the country's health security framework by addressing key areas identified in the evaluation. The plan prioritises strengthening disease surveillance upgrading laboratory capacity, and improving health infrastructure to effectively manage emergencies. It emphasises workforce development through training healthcare workers and establishing robust emergency preparedness and response protocols. Community engagement and risk communication will be integral to fostering public awareness and participation in health security efforts. Additionally, the NAPHS will promote intersectoral coordination, align with global health standards, mobilise resources, and include a comprehensive monitoring and evaluation framework to track implementation progress. By focusing on these components, the NAPHS seeks to build a resilient health system capable of effectively responding to health threats and ensuring better health security for all citizens in Pakistan



9 POLICY GAPS AND RECOMMENDATIONS

THE KEY POLICY GAPS IDENTIFIED ARE:

A LIMITED ACCESS TO PRIMARY HEALTH SERVICES

Despite improvements, access to primary health services remains inconsistent, particularly in rural and underserved regions. This inequity undermines UHC principles by limiting populations' access to essential healthcare.

B FINANCIAL BARRIERS TO CARE

Out-of-pocket (OOP) spending continues to be a major barrier to healthcare access. Insufficient coverage exacerbates these financial challenges.

C HUMAN RESOURCES SHORTAGES

Shortages of trained healthcare professionals, especially in rural areas, create service delivery gaps that weaken UHC efforts and impact service quality and patient outcomes

D INADEQUATE HEALTH INFORMATION SYSTEMS

Gaps in health data management and sharing hinder evidence-based policymaking, reducing the ability to monitor progress effectively and deploy timely interventions) Limited Public Health Awareness and Education

Insufficient community engagement and public health education campaigns contribute to lower utilization of preventive health services, such as vaccinations, screenings, and family planning.

THE KEY STRATEGIC POLICY RESPONSES ARE AS FOLLOWS:

A

STRENGTHENING PRIMARY HEALTHCARE NETWORKS

- Enhancing Infrastructure: Increase funding and development for primary health centres, with a focus on rural and hard-to-reach areas.
- Integrated Service Delivery Models: Develop models that integrate primary care with specialized services to optimize resource use and improve patient outcomes.

B

EXPANDING FINANCIAL PROTECTION MECHANISMS

- National Health Insurance Expansion: Strengthen and expand the national health insurance system to include underserved populations, with tiered coverage options to reduce out-of-pocket spending.
- Targeted Subsidies: Introduce targeted subsidies for vulnerable groups, particularly those below the poverty line, to reduce the financial burden associated with healthcare.

C

INVESTING IN HEALTHCARE WORKFORCE DEVELOPMENT

- Incentivizing Rural Health Workforce Deployment: Provide financial and professional incentives for healthcare providers to serve in rural and underserved areas.
- Continuous Professional Development Programs: Establish structured training and upskilling programs, with a focus on primary healthcare providers, to improve service quality across the health system.

D

ENHANCING HEALTH INFORMATION SYSTEMS AND DATA ANALYTICS

- Unified Health Data Platform: Develop a unified national health information system that integrates data across health facilities, enabling real-time monitoring of UHC indicators and more effective planning.
- Capacity Building in Data Analytics: Strengthen the technical capacity of health personnel in data analytics to improve the accuracy, timeliness, and application of health data for decision-making.

E

COMMUNITY ENGAGEMENT AND PUBLIC HEALTH EDUCATION

- Public Health Campaigns: Launch national public health awareness campaigns, focusing on preventive care, vaccinations, and the benefits of early medical intervention.
- Community Health Workers and Peer Educators: Leverage community health workers to disseminate health information, increase healthcare utilization, and empower individuals to make informed health decisions.

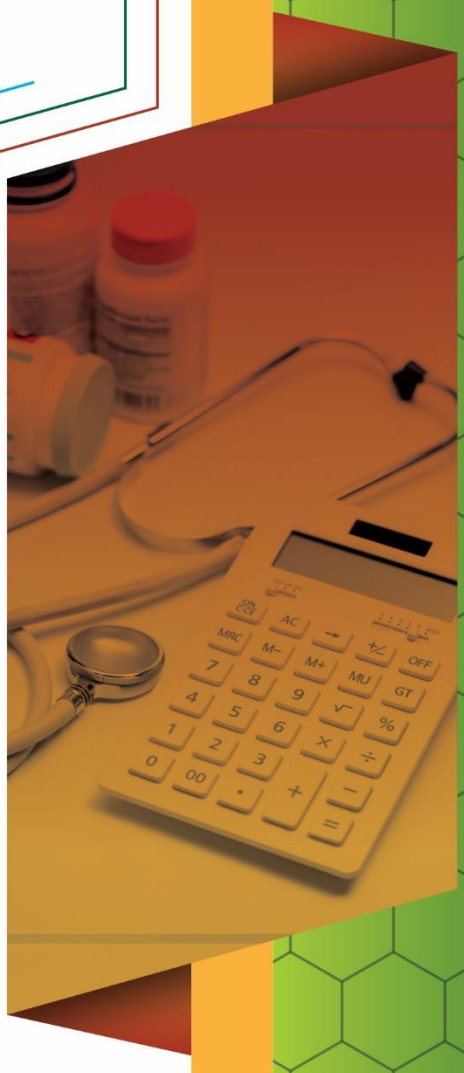
F

CROSS-SECTORAL COLLABORATION

- Multi-sectoral Coordination: Facilitate collaboration between the Ministry of NHSR&C and other government bodies (e.g., education, finance, climate change and environmental coordination) to address root causes impacting health outcomes.
- Public-Private Partnerships (PPP): Encourage public-private partnerships to increase resource mobilization, improve infrastructure, and foster innovations in healthcare delivery.

ANNEXURES

Universal
Health Coverage
MONITORING
REPORT
2024
PAKISTAN



UNIVERSAL
HEALTH
COVERAGE

ANNEX 1

UNIVERSAL HEALTH COVERAGE (UHC) SERVICE COVERAGE INDEX CALCULATION

REPRODUCTIVE, MATERNAL, NEW-BORN AND CHILD HEALTH

1. Family planning (FP)
2. Antenatal care 4+ visits (ANC)
3. Child immunization (DTP3)
4. Care seeking suspected pneumonia (Pneumonia)

RMNCH

=

*(FP * ANC * DTP3 * Pneumonia)* $^{1/4}$

INFECTIOUS DISEASE CONTROL

1. TB effective treatment (TB)
2. HIV treatment (ART)
3. Insecticide-treated nets (ITN)
4. At least basic sanitation (WASH)

INFECTIOUS

=

(TB * ART* ITN *WASH) $^{1/4}$ *if high risk malaria*

(TB * ART*WASH) $^{1/3}$

NON-COMMUNICABLE DISEASES

1. Hypertension treatment (HP)
2. Mean fasting Plasma glucose (Diab)
3. Tobacco non-smoking (TB)

NCD

=

(HP * Diab *Tobacco) $^{1/3}$

SERVICE CAPACITY AND ACCESS

1. Hospital bed density (HB)
2. Health worker density (HWD)
3. IHR core capacity index (IHR)

SERVICES ACCESS & CAPACITY

=

(Hospital * HWD * IHR) $^{1/3}$

UHC SERVICE COVERAGE INDEX = (RMNCH * INFECTIOUS * NCD * CAPACITY)$^{1/4}$

ANNEX 2 NATIONAL AND PROVINCIAL/ FEDERATING AREA UHC SERVICE COVERAGE INDEX FROM 2015 TO 2023

Province/Area	YEAR WISE UHC SCI										
	2015	2016	2017	2018	2019	2020	2021	2022	2023	%change since 2022	%change Since 2015
Islamabad	44.7	47.7	48.9	48.5	51.3	56.0	56.3	58.2	63.8	8.8%	30.1%
Punjab	40.6	42.8	45.6	47.3	48.2	52.0	53.8	53.8	55.4	3.0%	32.4%
Khyber Pakhtunkhwa	36.2	40.7	45.8	47.3	47.6	50.3	49.8	51.1	51.0	0.0%	41.2%
Azad Jammu & Kashmir	39.0	40.7	43.6	46.2	47.9	49.8	50.2	49.3	51.2	3.7%	26.4%
Sindh	37.6	40.6	43.9	45.0	46.7	48.6	48.0	49.2	50.7	3.0%	30.9%
Gilgit Baltistan	35.8	39.3	41.0	42.6	43.5	45.2	48.5	48.5	50.4	3.8%	35.5%
Baluchistan	27.1	29.3	32.3	33.5	35.0	35.2	35.7	37.4	38.4	2.6%	38.0%
Pakistan	39.7	42.1	45.3	46.3	47.1	49.9	52.0	52.7	53.9	2.2%	32.8%

DETAILED BREAKDOWN OF THE UHC SCI 2023 AT PROVINCIAL/ FEDERATING AREA LEVEL

UHC Indicators	Punjab	Sindh	KP	Balochistan	ICT	GB	AJ&K	National
Family Planning demand satisfied with modern methods (%)	50.3	44.3	50.2	34.5	55.1	46.4	51.6	54.0
Antenatal care 4+ visits	56.2	44.3	44.6	17.4	80.8	27.9	49.2	51.4
Child immunization (Penta 3) (%)	95.2	76.7	70.9	45.9	86.5	82.2	95.6	84.4
Care-seeking behaviour for child pneumonia (%)	86.1	69.0	70.0	67.6	83.6	76.3	52.8	84.2
RMNCH Aggregate Score	69.3	56.7	57.7	36.9	75.3	53.3	59.8	66.6
Tuberculosis effective treatment (%)	80.2	73.7	55.3	33.3	42.9	95.0	53.4	71.6
HIV treatment (%)	14.7	11.7	19.4	16.2	14.7	14.7	14.7	14.7
Insecticide-treated nets for malaria prevention (%)	NA	NA	NA	NA	NA	NA	NA	NA
At least basic sanitation (%)	89.0	76.0	84.0	44.0	99.0	86.0	82.3	83.0
CD Aggregate Score	47.2	40.3	44.8	28.8	39.7	49.3	40.1	44.3
Hypertension treatment – rescaled value	35.0	35.0	35.0	35.0	35.0	35.0	35.0	35.0
Mean fasting Plasma glucose – rescaled value	68.0	68.0	68.0	68.0	68.0	68.0	68.0	68.0
Tobacco non-smoking – rescaled value	71.0	71.0	71.0	71.0	71.0	71.0	71.0	71.0
NCD Aggregate Score	55.2	55.2	55.2	55.2	55.2	55.2	55.2	55.2
Hospital beds density 10,000 population against threshold (%)	65.3	52.8	53.2	40.5	205.7	44.2	61.5	60.0
Health worker density (Physicians*Psychiatrist*Surgeon) density against threshold (%)	50.5	67.4	49.4	34.0	72.1	43.7	48.4	53.8
International Health Regulations index core capacities- new tool)	43.4	40.8	40.7	36.6	68.6	45.7	46.8	42.7
SCA Aggregate Score	52.4	52.6	47.5	36.9	100.6	44.6	51.8	51.6
UHC Index	55.4	50.7	51.0	38.4	63.8	50.4	51.2	53.9

ANNEX 3: Provincial and District level UHC SCI

PUNJAB

UHC SERVICE COVERAGE INDEX
2023

District/ Province/ Area	Population (2023)	District UHC Index Ranking (National)	District UHC Index Ranking (Provincial)	REPRODUCTIVE, MATERNAL, NEW-BORN AND CHILD HEALTH					INFECTIOUS DISEASE CONTROL				
				FP demand satisfied with modern method (%)	ANC – 4+ visits (%)	Child immunization (Penta 3) (%)	Care-seeking behavior for child pneumonia (%)	RMNCH Score	TB effective treatment (%)	HIV treatment (%)	Insecticide-treated nets for malaria prevention (%)	At least basic sanitation (%)	Infectious Diseases Score
Attock	2,170,331	41	24	46.4	60.3	98.1	78.3	**68.1**	63.5	14.7	NA	96.4	**44.9**
Bakhar	1,957,387	61	33	57.9	34.3	99.1	67.8	**60.4**	94.6	14.7	NA	60.6	**43.9**
Bhawalnagar	3,550,191	52	29	66.7	40.3	92.3	69.4	**64.4**	89.3	14.7	NA	75.5	**46.3**
Bhawalpur	4,290,200	34	20	68.4	35.5	96.7	69.6	**63.6**	80.3	14.7	NA	82.8	**46.1**
Chakwal	1,734,780	19	10	54.1	72.2	98.0	78.4	**74.0**	75.7	14.7	NA	97.3	**47.7**
Chinot	1,562,958	55	30	52.7	48.8	97.4	58.1	**61.8**	93.3	14.7	NA	68.4	**45.5**
Dera Ghazi Khan	3,393,561	66	35	46.4	36.3	92.4	77.4	**58.9**	107.0	14.7	NA	74.9	**49.1**
Faisalabad	9,075,434	13	7	63.5	64.7	95.5	82.7	**75.5**	65.3	14.7	NA	93.4	**44.8**
Gujaranwala	5,959,497	20	11	34.8	58.7	93.0	79.6	**62.4**	94.2	14.7	NA	99.1	**51.6**
Gujrat	3,219,238	18	9	53.2	70.0	93.1	86.8	**74.1**	57.1	14.7	NA	98.6	**43.6**
Hafizabad	1,319,853	43	26	46.2	43.0	98.9	87.6	**64.4**	70.6	14.7	NA	92.4	**45.8**
Jhang	3,065,509	45	27	46.5	42.8	93.4	62.1	**58.3**	102.2	14.7	NA	73.8	**48.1**
Jhelum	1,382,249	8	3	55.8	81.3	96.1	86.8	**78.4**	93.9	14.7	NA	96.2	**51.1**
Kasur	4,084,113	37	21	62.2	42.3	97.1	62.6	**63.2**	83.1	14.7	NA	96.2	**49.0**
Khanewal	3,363,934	40	23	63.3	45.3	94.7	80.4	**68.4**	73.9	14.7	NA	86.4	**45.5**
Khushab	1,501,025	26	15	50.7	38.7	99.7	77.7	**62.4**	117.2	14.7	NA	83.4	**52.4**
Lahore	13,003,583	2	1	60.5	75.4	82.5	90.3	**76.4**	65.5	14.7	NA	99.2	**45.8**
Layyah	2,102,297	30	17	65.8	44.5	95.7	78.2	**68.4**	72.5	14.7	NA	84.7	**44.9**
Lodhran	1,928,217	50	28	63.3	36.5	95.5	76.2	**64.0**	63.0	14.7	NA	91.8	**44.0**
Mandi bahauddin	1,829,408	25	14	39.9	58.6	98.6	88.2	**67.2**	99.7	14.7	NA	91.1	**51.2**
Mianwali	1,798,192	33	19	48.8	53.6	98.0	71.6	**65.5**	92.5	14.7	NA	81.3	**48.0**
Multan	5,362,077	10	5	71.1	56.8	98.9	77.8	**74.7**	81.6	14.7	NA	91.2	**47.9**
Muzzafargarh	5,015,112	64	34	48.1	37.5	98.9	65.3	**58.4**	90.3	14.7	NA	72.9	**46.0**
Nankana Sahib	1,634,802	32	18	53.6	63.1	99.5	69.8	**69.6**	87.5	14.7	NA	98.7	**50.3**
Narowal	1,950,871	29	16	47.6	60.6	98.2	83.6	**69.8**	62.5	14.7	NA	96.2	**44.6**
Okara Distrct	3,515,341	38	22	56.6	46.7	93.8	63.6	**63.0**	88.6	14.7	NA	95.9	**50.0**
Pakpattan	2,136,079	57	32	60.2	38.3	94.3	64.5	**61.2**	94.8	14.7	NA	86.8	**49.5**
Rahim Yar Khan	5,564,467	56	31	63.4	30.8	99.1	80.8	**62.9**	69.9	14.7	NA	78.6	**43.3**
Rajanpur	2,380,948	89	36	46.0	27.2	92.6	66.3	**52.6**	64.2	14.7	NA	69.1	**40.3**
Rawalpindi	6,118,651	7	2	55.8	75.3	97.5	82.7	**76.3**	68.6	14.7	NA	97.4	**46.2**
Sahiwal	2,881,689	16	8	68.9	59.3	98.2	63.0	**70.9**	79.4	14.7	NA	94.5	**48.0**
Sargodha	4,334,264	11	6	54.8	49.3	99.4	81.9	**68.5**	110.8	14.7	NA	87.0	**52.2**
Sheikhupura	4,049,246	24	13	52.0	62.0	98.4	87.1	**72.5**	70.1	14.7	NA	99.0	**46.8**
Sialkot	4,499,203	9	4	49.6	63.4	99.8	83.6	**71.6**	83.6	14.7	NA	98.9	**49.6**
Toba Tek Singh	2,523,937	21	12	58.6	51.5	99.2	83.0	**70.6**	88.9	14.7	NA	90.9	**49.2**
Vehari	3,430,275	42	25	67.8	44.8	95.6	92.2	**71.9**	88.3	14.7	NA	66.3	**44.2**
Punjab	127,688,922			**50.3**	**56.2**	**95.4**	**86.1**	**69.4**	**80.3**	**14.7**	**NA**	**89.0**	**47.2**

NON-COMMUNICABLE DISEASES				SERVICES CAPACITY & ACCESS				UHC Index 2023	District UHC Index Ranking (Provincial)	District UHC Index Ranking (National)	District/ Province/Area
Normal blood pressure	Normal blood sugar	Tobacco non-smoking	Non-Communicable Diseases Score	Hospital beds per 10,000 population	(Physicians*Psychiatrist*Surgeon) density against threshold (%)	International Health Regulations core capacity Index (%)	Services Access & Capacity Score				
35.0	68.0	71.0	**55.3**	33.6	72.3	61.7	**53.1**	**54.7**	24	41	Attock
35.0	68.0	71.0	**55.3**	41.8	57.8	49.3	**49.2**	**51.8**	33	61	Bakhar
35.0	68.0	71.0	**55.3**	39.7	58.0	49.5	**48.5**	**53.2**	29	52	Bhawalnagar
35.0	68.0	71.0	**55.3**	68.3	59.3	50.6	**59.0**	**55.6**	20	34	Bhawalpur
35.0	68.0	71.0	**55.3**	41.4	72.9	62.2	**57.2**	**57.8**	10	19	Chakwal
35.0	68.0	71.0	**55.3**	40.8	60.4	51.6	**50.3**	**52.9**	30	55	Chinot
35.0	68.0	71.0	**55.3**	35.2	49.2	42.0	**41.7**	**50.8**	35	66	Dera Ghazi Khan
35.0	68.0	71.0	**55.3**	68.9	71.9	61.4	**67.2**	**59.5**	7	13	Faisalabad
35.0	68.0	71.0	**55.3**	56.6	70.7	60.4	**62.3**	**57.7**	11	20	Gujaranwala
35.0	68.0	71.0	**55.3**	56.4	73.1	62.4	**63.6**	**58.1**	9	18	Gujrat
35.0	68.0	71.0	**55.3**	46.0	64.9	55.3	**54.9**	**54.7**	26	43	Hafizabad
35.0	68.0	71.0	**55.3**	52.0	62.7	53.5	**55.9**	**54.2**	27	45	Jhang
35.0	68.0	71.0	**55.3**	53.2	76.3	65.1	**64.2**	**61.4**	3	8	Jhelum
35.0	68.0	71.0	**55.3**	41.5	65.7	56.0	**53.5**	**55.0**	21	37	Kasur
35.0	68.0	71.0	**55.3**	40.6	64.3	54.9	**52.3**	**54.8**	23	40	Khanewal
35.0	68.0	71.0	**55.3**	50.7	65.0	55.4	**56.7**	**56.6**	15	26	Khushab
35.0	68.0	71.0	**55.3**	157.7	80.7	68.8	**95.7**	**65.6**	1	2	Lahore
35.0	68.0	71.0	**55.3**	52.2	67.1	57.2	**58.5**	**56.1**	17	30	Layyah
35.0	68.0	71.0	**55.3**	46.9	60.6	51.7	**52.8**	**53.6**	28	50	Lodhran
35.0	68.0	71.0	**55.3**	42.7	65.9	56.2	**54.1**	**56.6**	14	25	M. Bahauddin
35.0	68.0	71.0	**55.3**	59.0	59.3	50.6	**56.2**	**55.9**	19	33	Mianwali
35.0	68.0	71.0	**55.3**	91.6	66.1	56.4	**69.9**	**61.0**	5	10	Multan
35.0	68.0	71.0	**55.3**	38.5	53.7	45.8	**45.6**	**51.0**	34	64	Muzzafargarh
35.0	68.0	71.0	**55.3**	33.5	68.1	58.1	**51.0**	**56.1**	18	32	Nankana Sahib
35.0	68.0	71.0	**55.3**	50.9	68.8	58.7	**59.0**	**56.4**	16	29	Narowal
35.0	68.0	71.0	**55.3**	40.2	64.9	55.3	**52.4**	**55.0**	22	38	Okara Distrct
35.0	68.0	71.0	**55.3**	29.1	60.7	51.8	**45.1**	**52.4**	32	57	Pakpattan
35.0	68.0	71.0	**55.3**	49.6	57.5	49.1	**51.9**	**52.9**	31	56	Rahim Yar Khan
35.0	68.0	71.0	**55.3**	25.9	46.6	39.7	**36.3**	**45.4**	36	89	Rajanpur
35.0	68.0	71.0	**55.3**	93.5	80.1	68.4	**80.0**	**62.8**	2	7	Rawalpindi
35.0	68.0	71.0	**55.3**	62.4	65.3	55.7	**61.0**	**58.2**	8	16	Sahiwal
35.0	68.0	71.0	**55.3**	83.0	67.0	57.1	**68.2**	**60.6**	6	11	Sargodha
35.0	68.0	71.0	**55.3**	42.1	67.9	57.9	**54.9**	**56.6**	13	24	Sheikhupura
35.0	68.0	71.0	**55.3**	73.4	76.7	65.5	**71.7**	**61.2**	4	9	Sialkot
35.0	68.0	71.0	**55.3**	44.3	70.2	59.9	**57.1**	**57.5**	12	21	Toba Tek Singh
35.0	68.0	71.0	**55.3**	42.8	60.3	51.4	**51.0**	**54.7**	25	42	Vehari
35.0	**68.0**	**71.0**	**55.2**	**65.3**	**50.5**	**43.4**	**52.4**	**55.5**			Punjab

SINDH

UHC SERVICE COVERAGE INDEX
2023

District/ Province/ Area	Population (2023)	District UHC Index Ranking (National)	District UHC Index Ranking (Provincial)	REPRODUCTIVE, MATERNAL, NEW-BORN AND CHILD HEALTH					INFECTIOUS DISEASE CONTROL				
				FP demand satisfied with modern method (%)	ANC – 4+ visits (%)	Child immunization (Penta 3) (%)	Care-seeking behavior for child pneumonia (%)	RMNCH Score	TB effective treatment (%)	HIV treatment (%)	Insecticide-treated nets for malaria prevention (%)	At least basic sanitation (%)	Infectious Diseases Score
Badin	1,945,335	102	26	64.2	19.2	80.5	42.8	**45.4**	61.3	11.7	NA	41.6	**31.0**
Dadu	1,740,757	87	18	34.0	29.4	82.2	77.7	**50.3**	51.1	11.7	NA	74.4	**35.4**
Ghotki	1,771,019	91	20	43.5	42.6	69.3	73.7	**55.5**	58.6	11.7	NA	63.8	**35.2**
Hyderabad	2,430,358	3	2	62.3	67.4	78.6	64.9	**68.0**	129.8	11.7	NA	90.0	**51.5**
Jacobabad	1,173,044	81	16	51.7	28.6	78.9	83.4	**55.9**	84.9	11.7	NA	79.4	**42.9**
Jamshoro	1,116,306	68	11	41.9	26.0	70.6	49.9	**44.3**	127.3	11.7	NA	70.4	**47.2**
Kambar Shadad Kot	1,563,465	98	24	35.0	38.5	71.0	59.9	**48.9**	65.3	11.7	NA	78.7	**39.2**
Karachi Central	3,818,897	17	4	50.3	89.9	76.9	90.6	**74.9**	75.9	11.7	NA	98.4	**44.4**
Karachi East	3,918,224	14	3	41.4	64.8	70.7	76.6	**61.7**	57.2	11.7	NA	99.8	**40.6**
Karachi South	2,327,674	1	1	46.4	82.3	84.4	78.1	**70.8**	119.9	11.7	NA	99.6	**51.9**
Karachi West	2,676,977	58	10	39.3	66.1	72.8	58.3	**57.6**	54.3	11.7	NA	98.4	**39.7**
Keamari	1,232,850	78	15	39.3	66.1	72.8	58.3	**57.6**	48.4	11.7	NA	98.4	**38.2**
Kashmor	2,066,596	129	30	15.9	7.5	68.4	94.4	**29.6**	10.9	11.7	NA	68.0	**20.5**
Khairpur	2,595,205	70	12	49.7	44.9	87.6	69.1	**60.6**	66.6	11.7	NA	51.9	**34.3**
Korangi	3,126,165	28	6	44.7	78.6	78.6	76.6	**67.8**	70.4	11.7	NA	100.0	**43.5**
Larkana	1,782,852	36	8	52.6	44.7	79.7	59.9	**57.9**	96.7	11.7	NA	78.0	**44.5**
Malir	2,430,066	22	5	60.9	64.2	68.3	66.0	**64.8**	64.0	11.7	NA	97.6	**41.8**
Matiari	848,621	77	14	46.6	52.9	79.9	70.6	**61.1**	72.5	11.7	NA	60.5	**37.2**
Mirpur Khas	1,679,878	85	17	32.6	28.4	71.0	74.7	**47.1**	95.6	11.7	NA	47.1	**37.5**
Naushero Feroz	1,775,488	72	13	42.4	42.9	83.1	77.7	**58.5**	69.2	11.7	NA	89.5	**41.7**
Sanghar	2,306,394	93	22	49.8	21.6	90.6	79.3	**52.7**	75.3	11.7	NA	52.3	**35.9**
S. Benazirabad	1,843,447	49	9	44.9	35.1	81.6	88.9	**58.1**	127.3	11.7	NA	56.9	**43.9**
Shikkarpur	1,385,087	96	23	39.1	24.9	60.7	57.0	**42.8**	67.5	11.7	NA	58.3	**35.9**
Sujawal	838,539	117	28	31.7	29.8	21.1	59.1	**32.9**	38.7	11.7	NA	33.9	**24.9**
Sukkar	1,638,426	35	7	51.6	54.1	67.3	75.5	**61.4**	98.0	11.7	NA	76.2	**44.4**
Tando Allahyar	921,185	92	21	38.1	44.2	85.8	63.8	**55.1**	54.5	11.7	NA	59.9	**33.7**
TM Khan	725,468	88	19	29.3	41.4	82.5	48.3	**46.9**	86.6	11.7	NA	48.9	**36.7**
Tharparkar	1,776,812	125	29	13.1	19.3	87.1	83.9	**36.9**	40.5	11.7	NA	21.1	**21.6**
Thatta	1,082,219	101	25	44.2	46.6	58.8	100.0	**59.0**	35.1	11.7	NA	50.2	**27.4**
Umer Kot	1,158,791	108	27	33.2	6.3	89.3	83.9	**35.4**	132.4	11.7	NA	33.0	**37.1**
Sindh	55,696,147			**44.3**	**44.3**	**76.7**	**69.0**	**56.7**	**73.7**	**11.7**	**NA**	**76.0**	**40.3**

NON-COMMUNICABLE DISEASES				SERVICES CAPACITY & ACCESS				UHC Index 2023	District UHC Index Ranking (Provincial)	District UHC Index Ranking (National)	District/ Province/Area
Normal blood pressure	Normal blood sugar	Tobacco non-smoking	Non-Communicable Diseases Score	Hospital beds per 10,000 population	(Physicians*Psychiatrist*Surgeon) density against threshold (%)	International Health Regulations core capacity index (%)	Services Access & Capacity Score				
35.0	68.0	71.0	55.3	31.3	53.7	32.3	**37.9**	**41.4**	26	102	**Badin**
35.0	68.0	71.0	**55.3**	20.5	82.4	49.6	**43.8**	**45.6**	18	87	**Dadu**
35.0	68.0	71.0	**55.3**	21.9	67.0	40.3	**39.0**	**45.3**	20	91	**Ghotki**
35.0	68.0	71.0	**55.3**	122.1	93.4	56.2	**86.2**	**63.9**	2	3	**Hyderabad**
35.0	68.0	71.0	**55.3**	29.6	57.4	34.5	**38.9**	**47.6**	16	81	**Jacobabad**
35.0	68.0	71.0	**55.3**	50.9	74.6	44.9	**55.5**	**50.3**	11	68	**Jamshoro**
35.0	68.0	71.0	**55.3**	15.8	59.5	35.8	**32.3**	**43.0**	24	98	**Kambar Shadad**
35.0	68.0	71.0	**55.3**	32.2	111.4	67.0	**62.2**	**58.1**	4	17	**Karachi Central**
35.0	68.0	71.0	**55.3**	97.5	111.4	67.0	**90.0**	**59.4**	3	14	**Karachi East**
35.0	68.0	71.0	**55.3**	289.9	111.4	67.0	**129.3**	**71.6**	1	1	**Karachi South**
35.0	68.0	71.0	**55.3**	27.6	111.4	67.0	**59.0**	**52.3**	10	58	**Karachi West**
35.0	68.0	71.0	**55.3**	11.5	111.4	67.0	**44.1**	**48.1**	15	78	**Keamari**
35.0	68.0	71.0	**55.3**	6.0	61.4	37.0	**23.9**	**29.9**	30	129	**Kashmor**
35.0	68.0	71.0	**55.3**	46.0	72.5	43.6	**52.6**	**49.6**	12	70	**Khairpur**
35.0	68.0	71.0	**55.3**	32.3	111.4	67.0	**62.2**	**56.4**	6	28	**Korangi**
35.0	68.0	71.0	**55.3**	71.9	80.6	48.5	**65.5**	**55.3**	8	36	**Larkana**
35.0	68.0	71.0	**55.3**	48.0	111.4	67.0	**71.0**	**57.1**	5	22	**Malir**
35.0	68.0	71.0	**55.3**	23.9	74.2	44.7	**42.9**	**48.2**	14	77	**Matiari**
35.0	68.0	71.0	**55.3**	59.1	56.1	33.8	**48.2**	**46.6**	17	85	**Mirpur Khas**
35.0	68.0	71.0	**55.3**	19.1	86.7	52.2	**44.3**	**49.4**	13	72	**Naushero Feroz**
35.0	68.0	71.0	**55.3**	21.3	64.0	38.5	**37.5**	**44.5**	22	93	**Sanghar**
35.0	68.0	71.0	**55.3**	62.2	74.6	44.9	**59.3**	**53.8**	9	49	**S. Benazirabad**
35.0	68.0	71.0	**55.3**	26.6	67.8	40.8	**41.9**	**43.4**	23	96	**Shikkarpur**
35.0	68.0	71.0	**55.3**	29.9	42.5	25.6	**31.9**	**34.7**	28	117	**Sujawal**
35.0	68.0	71.0	**55.3**	56.8	85.9	51.7	**63.2**	**55.5**	7	35	**Sukkar**
35.0	68.0	71.0	**55.3**	23.3	68.9	41.4	**40.5**	**45.1**	21	92	**Tando Allahyar**
35.0	68.0	71.0	**55.3**	62.9	49.2	29.6	**45.1**	**45.5**	19	88	**TM Khan**
35.0	68.0	71.0	**55.3**	19.9	29.6	17.8	**21.9**	**31.3**	29	125	**Tharparkar**
35.0	68.0	71.0	**55.3**	27.2	49.2	29.6	**34.1**	**41.8**	25	101	**Thatta**
35.0	68.0	71.0	**55.3**	37.8	42.0	25.3	**34.2**	**39.7**	27	108	**Umer Kot**
35.0	**68.0**	**71.0**	**55.3**	**52.8**	**67.4**	**40.8**	**52.6**	**50.7**			**Sindh**

KHYBER PAKHTUNKHWA

UHC SERVICE COVERAGE INDEX
2023

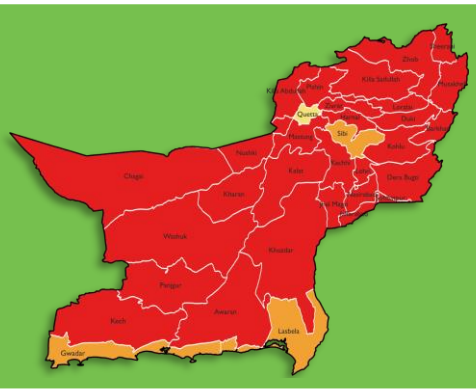
District/ Province/ Area	Population (2023)	District UHC Index Ranking (National)	District UHC Index Ranking (Provincial)	REPRODUCTIVE, MATERNAL, NEW-BORN AND CHILD HEALTH					INFECTIOUS DISEASE CONTROL				
				FP demand satisfied with modern method (%)	ANC – 4+ visits (%)	Child immunization (Penta 3) (%)	Care-seeking behavior for child pneumonia (%)	RMNCH Score	TB effective treatment (%)	HIV treatment (%)	Insecticide-treated nets for malaria prevention (%)	At least basic sanitation (%)	Infectious Diseases Score
Abbotabad	1,443,406	5	1	62.0	71.5	93.2	67.6	**72.7**	68.8	19.4	NA	96.2	**50.5**
Bajour District	1,310,045	95	22	74.6	33.3	61.2	68.3	**56.8**	19.6	19.4	NA	45.5	**25.9**
Bannu	1,381,175	71	13	65.7	17.5	68.1	69.5	**48.3**	67.8	19.4	NA	74.5	**46.2**
Batagram	563,635	86	21	32.5	17.8	38.8	78.3	**36.4**	64.5	19.4	NA	79.3	**46.4**
Buner	1,034,306	82	18	43.5	67.5	85.4	90.8	**69.1**	28.6	19.4	NA	67.0	**33.4**
Charsadda	1,866,978	67	11	60.4	43.7	57.4	68.9	**56.8**	49.0	19.4	NA	89.7	**44.1**
Chitral	524,782	54	9	73.7	35.0	90.4	25.0	**49.1**	80.3	19.4	NA	96.4	**53.2**
Dera Ismail Khan	1,861,188	84	20	46.9	23.6	77.2	92.1	**53.0**	46.7	19.4	NA	83.8	**42.4**
Hangu	537,971	76	16	22.0	47.6	47.7	79.9	**44.7**	76.4	19.4	NA	95.6	**52.2**
Haripur	1,194,928	31	5	61.0	68.2	93.8	76.3	**73.9**	35.9	19.4	NA	93.9	**40.4**
Karak	829,868	83	19	30.7	44.1	48.7	61.4	**44.9**	40.5	19.4	NA	92.1	**41.7**
Khyber District	1,165,923	109	26	53.1	27.7	70.9	67.2	**51.5**	44.8	19.4	NA	66.2	**38.7**
Kohat	1,255,832	75	15	36.6	19.3	71.7	62.3	**42.1**	59.4	19.4	NA	88.0	**46.7**
Kohistan	345,847	146	32	21.2	2.2	15.1	17.8	**10.6**	27.0	19.4	NA	61.4	**31.8**
Kurram District	798,902	112	27	45.7	60.8	82.7	70.3	**63.4**	17.2	19.4	NA	65.9	**28.1**
Lakki Marwat	1,058,704	79	17	49.4	27.2	56.2	63.3	**46.8**	68.1	19.4	NA	85.1	**48.4**
Lower Dir	1,678,480	69	12	59.7	47.9	69.3	55.5	**57.6**	33.4	19.4	NA	84.0	**38.0**
Malakand	840,418	23	3	54.7	58.2	76.7	72.1	**64.8**	51.5	19.4	NA	93.9	**45.5**
Mansehra	1,827,994	74	14	51.5	37.7	82.3	39.4	**50.1**	40.2	19.4	NA	90.9	**41.5**
Mardan	2,791,966	46	7	61.6	59.4	67.9	60.7	**62.3**	46.7	19.4	NA	90.8	**43.6**
Mohmand District	563,432	123	30	51.3	24.2	51.3	49.1	**42.1**	25.3	19.4	NA	32.2	**25.1**
North Waziristan	705,221	120	28	58.3	15.0	14.0	62.3	**29.6**	31.2	19.4	NA	56.6	**32.5**
Nowshera	1,770,554	44	6	73.2	63.5	67.9	80.1	**70.9**	39.3	19.4	NA	92.6	**41.4**
Orakzai District	394,207	106	25	57.7	29.4	61.8	70.1	**52.1**	36.3	19.4	NA	79.7	**38.3**
Peshawar	4,854,946	6	2	71.5	56.1	77.0	67.1	**67.5**	97.4	19.4	NA	94.6	**56.4**
Shangla	906,535	59	10	74.5	52.6	73.0	93.4	**71.9**	72.1	19.4	NA	72.6	**46.7**
S Waziristan	903,914	121	29	62.7	17.3	25.6	44.9	**33.4**	25.1	19.4	NA	50.2	**29.1**
Swabi	1,927,088	47	8	70.6	58.1	77.3	75.9	**70.0**	34.9	19.4	NA	94.2	**40.0**
Swat	2,733,466	27	4	86.8	50.6	80.2	74.8	**71.6**	44.5	19.4	NA	89.6	**42.7**
Tank	478,357	103	24	49.7	8.7	35.1	67.3	**31.8**	56.6	19.4	NA	74.5	**43.5**
Torghar	203,882	142	31	8.5	5.5	35.0	26.8	**14.5**	27.0	19.4	NA	51.5	**30.0**
Upper Dir	1,102,147	97	23	44.0	39.1	55.8	77.9	**52.3**	28.2	19.4	NA	88.4	**36.5**
Khyber Pakhtunkhwa	40,856,097			**50.2**	**44.6**	**70.9**	**70.0**	**57.7**	**55.0**	**19.4**	**NA**	**84.0**	**44.8**

NON-COMMUNICABLE DISEASES				SERVICES CAPACITY & ACCESS				UHC Index 2023	District UHC Index Ranking (Provincial)	District UHC Index Ranking (National)	District/ Province/Area
Normal blood pressure	Normal blood sugar	Tobacco non-smoking	Non-Communicable Diseases Score	Hospital beds per 10,000 population	(Physicians*Psychiatrist*Surgeon) density against threshold (%)	International Health Regulations core capacity index (%)	Services Access & Capacity Score				
35.0	68.0	71.0	**55.3**	123.1	73.1	59.7	81.3	**63.7**	1	5	**Abbotabad**
35.0	68.0	71.0	**55.3**	27.4	66.3	54.2	46.2	**44.0**	22	95	**Bajour District**
35.0	68.0	71.0	**55.3**	40.6	58.9	48.1	48.6	**49.5**	13	71	**Bannu**
35.0	68.0	71.0	**55.3**	54.3	48.5	39.6	47.1	**45.8**	21	86	**Batagram**
35.0	68.0	71.0	**55.3**	31.1	50.7	41.4	40.3	**47.6**	18	82	**Buner**
35.0	68.0	71.0	**55.3**	30.3	64.0	52.3	46.6	**50.4**	11	67	**Charsadda**
35.0	68.0	71.0	**55.3**	48.0	64.8	52.9	54.8	**53.1**	9	54	**Chitral**
35.0	68.0	71.0	**55.3**	33.7	47.7	38.9	39.7	**47.1**	20	84	**Dera Ismail Khan**
35.0	68.0	71.0	**55.3**	28.1	57.1	46.6	42.1	**48.3**	16	76	**Hangu**
35.0	68.0	71.0	**55.3**	53.7	70.3	57.5	60.1	**56.1**	5	31	**Haripur**
35.0	68.0	71.0	**55.3**	42.8	59.1	48.3	49.6	**47.6**	19	83	**Karak**
35.0	68.0	71.0	**55.3**	27.7	20.8	17.0	21.4	**39.2**	26	109	**Khyber District**
35.0	68.0	71.0	**55.3**	40.4	62.5	51.0	50.5	**48.4**	15	75	**Kohat**
35.0	68.0	71.0	**55.3**	7.7	22.0	18.0	14.5	**22.8**	32	146	**Kohistan**
35.0	68.0	71.0	**55.3**	34.5	20.8	17.0	23.0	**38.8**	27	112	**Kurram District**
35.0	68.0	71.0	**55.3**	30.2	55.4	45.3	42.3	**48.0**	17	79	**Lakki Marwat**
35.0	68.0	71.0	**55.3**	48.7	57.7	47.1	51.0	**49.8**	12	69	**Lower Dir**
35.0	68.0	71.0	**55.3**	75.6	66.3	54.2	64.7	**57.0**	3	23	**Malakand**
35.0	68.0	71.0	**55.3**	35.0	65.0	53.1	49.4	**48.8**	14	74	**Mansehra**
35.0	68.0	71.0	**55.3**	50.9	67.6	55.2	57.5	**54.2**	7	46	**Mardan**
35.0	68.0	71.0	**55.3**	17.9	20.8	17.0	18.5	**32.2**	30	123	**Mohmand District**
35.0	68.0	71.0	**55.3**	33.6	20.8	17.0	22.8	**33.2**	28	120	**North Waziristan**
35.0	68.0	71.0	**55.3**	43.0	67.0	54.7	54.0	**54.4**	6	44	**Nowshera**
35.0	68.0	71.0	**55.3**	39.2	20.8	17.0	24.0	**40.3**	25	106	**Orakzai District**
35.0	68.0	71.0	**55.3**	111.7	72.6	59.3	78.4	**63.7**	2	6	**Peshawar**
35.0	68.0	71.0	**55.3**	41.1	42.1	34.4	39.0	**51.9**	10	59	**Shangla**
35.0	68.0	71.0	**55.3**	31.8	20.8	17.0	22.4	**33.1**	29	121	**S Waziristan**
35.0	68.0	71.0	**55.3**	49.6	62.8	51.3	54.3	**53.9**	8	47	**Swabi**
35.0	68.0	71.0	**55.3**	76.2	59.4	48.5	60.3	**56.5**	4	27	**Swat**
35.0	68.0	71.0	**55.3**	32.1	44.1	36.0	37.1	**41.0**	24	103	**Tank**
35.0	68.0	71.0	**55.3**	7.7	23.1	18.8	15.0	**24.5**	31	142	**Torghar**
35.0	68.0	71.0	**55.3**	33.5	36.0	29.4	32.9	**43.2**	23	97	**Upper Dir**
35.0	**68.0**	**71.0**	**55.3**	**53.28**	**49.49**	**40.72**	**47.53**	**51.07**			**Khyber Pakhtunkhwa**

BALOCHISTAN

UHC SERVICE COVERAGE INDEX
2023

District/ Province/ Area	Population (2023)	District UHC Index Ranking (National)	District UHC Index Ranking (Provincial)	REPRODUCTIVE, MATERNAL, NEW-BORN AND CHILD HEALTH					INFECTIOUS DISEASE CONTROL				
				FP demand satisfied with modern method (%)	ANC – 4+ visits (%)	Child immunization (Penta 3) (%)	Care-seeking behavior for child pneumonia (%)	RMNCH Score	TB effective treatment (%)	HIV treatment (%)	Insecticide-treated nets for malaria prevention (%)	At least basic sanitation (%)	Infectious Diseases Score
Awaran	182,375	151	32	16.7	3.5	52.6	26.0	**16.8**	18.6	16.3	NA	2.5	**9.1**
Barkhan	214,263	140	23	12.3	13.0	83.9	23.5	**23.7**	30.8	16.3	NA	22.7	**22.5**
Chaghi	274,331	141	24	18.7	1.4	87.9	69.7	**20.0**	30.2	16.3	NA	12.2	**18.2**
Dera Bhugti	362,057	152	33	42.0	0.0	77.5	64.7	**6.8**	11.9	16.3	NA	24.0	**16.7**
Duki	208,959	139	22	25.6	13.0	77.1	73.4	**37.0**	0.8	16.3	NA	89.9	**10.7**
Gwadar	310,986	104	2	42.5	54.3	71.1	85.4	**61.2**	11.5	16.3	NA	62.1	**22.7**
Harnai	130,007	134	17	46.4	22.7	71.1	48.0	**43.5**	15.7	16.3	NA	12.3	**14.7**
Jaffarabad	605,909	128	12	29.8	0.8	43.4	81.3	**17.0**	66.1	16.3	NA	55.8	**39.1**
Jhal Magsi	207,251	131	14	20.0	6.4	48.7	81.3	**26.7**	125.9	16.3	NA	12.2	**29.2**
Kachhi	451,062	147	28	7.8	2.8	17.8	81.3	**13.3**	14.7	16.3	NA	13.8	**14.9**
Kalat	276,745	149	30	15.0	6.1	33.9	50.0	**19.8**	7.1	16.3	NA	1.6	**5.7**
Kech	1,081,186	122	8	40.9	29.0	36.0	85.4	**43.7**	11.1	16.3	NA	15.5	**14.1**
Kharan	265,323	137	20	39.7	6.5	89.3	94.5	**38.4**	28.0	16.3	NA	2.3	**10.1**
Khuzdar	1,016,253	148	29	18.2	5.1	45.5	50.0	**21.4**	18.6	16.3	NA	0.9	**6.5**
Killa Abdullah	368,882	150	31	22.1	2.8	44.7	44.3	**18.7**	0.4	16.3	NA	35.5	**6.3**
Killa Saifullah	387,459	133	16	9.3	4.2	44.0	73.4	**18.8**	48.4	16.3	NA	9.3	**19.4**
Kohlu	265,188	127	11	39.1	4.8	59.3	84.0	**31.1**	5.0	16.3	NA	94.2	**19.8**
Lasbela	693,978	107	4	71.0	56.5	32.2	92.5	**58.8**	23.2	16.3	NA	63.7	**28.9**
Lehri	475,119	136	19	8.8	9.5	34.0	64.7	**20.7**	9.8	16.3	NA	72.8	**22.6**
Loralai	277,633	115	5	25.6	13.0	25.0	73.4	**28.0**	36.3	16.3	NA	72.8	**35.0**
Musakhel	185,755	135	18	8.6	8.7	17.3	73.4	**17.6**	14.4	16.3	NA	72.8	**25.7**
Mustang	319,252	124	9	22.7	20.4	49.1	22.1	**26.6**	17.4	16.3	NA	29.6	**20.3**
Nasirabad	574,133	130	13	37.2	1.0	32.2	81.3	**17.7**	46.6	16.3	NA	54.1	**34.5**
Nushki	211,802	143	25	1.2	2.9	89.1	55.5	**11.5**	35.2	16.3	NA	7.0	**15.9**
Panjgur	519,514	119	7	35.1	29.8	83.4	85.4	**52.2**	13.4	16.3	NA	12.2	**13.9**
Pishin	851,433	118	6	18.3	15.8	21.9	66.8	**25.5**	30.5	16.3	NA	65.2	**31.9**
Quetta	2,645,045	63	1	52.6	34.4	48.4	66.8	**49.2**	54.1	16.3	NA	75.2	**40.5**
Sherani	195,347	145	27	9.5	4.3	24.9	47.6	**14.8**	40.6	16.3	NA	20.6	**23.9**
Sibi	228,427	105	3	29.5	16.3	34.0	64.7	**32.1**	77.5	16.3	NA	34.6	**35.2**
Sohbatput	244,690	126	10	25.7	10.0	72.6	81.3	**35.1**	26.5	16.3	NA	36.0	**24.9**
Washuk	308,401	144	26	60.7	4.8	87.3	69.7	**36.5**	9.3	16.3	NA	12.2	**12.3**
Zhob	362,483	132	15	29.7	2.0	23.7	73.4	**17.9**	60.8	16.3	NA	20.6	**27.3**
Ziarat	193,154	138	21	13.1	21.3	68.3	44.8	**30.4**	5.8	16.3	NA	5.2	**7.9**
Balochistan	14,894,402			**34.5**	**17.4**	**45.9**	**67.6**	**36.9**	**33.3**	**16.2**	**NA**	**44.0**	**28.8**



NON-COMMUNICABLE DISEASES				SERVICES CAPACITY & ACCESS				UHC Index 2023	District UHC Index Ranking (Provincial)	District UHC Index Ranking (National)	District/ Province/Area
Normal blood pressure	Normal blood sugar	Tobacco non-smoking	Non-Communicable Diseases Score	Hospital beds per 10,000 population	(Physicians*Psychiatrist*Surgeon) density against threshold (%)	International Health Regulations core capacity index (%)	Services Access & Capacity Score				
35.0	68.0	71.0	**55.3**	21.3	12.8	13.6	**15.5**	**19.0**	32	151	Awaran
35.0	68.0	71.0	**55.3**	5.2	25.4	27.1	**15.3**	**25.9**	23	140	Barkhan
35.0	68.0	71.0	**55.3**	26.3	17.5	18.6	**20.5**	**25.3**	24	141	Chaghi
35.0	68.0	71.0	**55.3**	16.9	15.5	16.5	**16.3**	**17.9**	33	152	Dera Bhugti
35.0	68.0	71.0	**55.3**	21.3	20.0	21.3	**20.8**	**26.0**	22	139	Duki
35.0	68.0	71.0	**55.3**	41.1	32.7	34.8	**36.0**	**40.8**	2	104	Gwadar
35.0	68.0	71.0	**55.3**	25.6	13.6	14.4	**17.1**	**27.9**	17	134	Harnai
35.0	68.0	71.0	**55.3**	19.3	25.4	27.1	**23.7**	**30.6**	12	128	Jaffarabad
35.0	68.0	71.0	**55.3**	21.4	13.5	14.4	**16.1**	**28.9**	14	131	Jhal Magsi
35.0	68.0	71.0	**55.3**	19.7	25.4	27.1	**23.9**	**22.6**	28	147	Kachhi
35.0	68.0	71.0	**55.3**	39.1	29.9	31.8	**33.4**	**21.4**	30	149	Kalat
35.0	68.0	71.0	**55.3**	36.1	32.7	34.8	**34.5**	**32.9**	8	122	Kech
35.0	68.0	71.0	**55.3**	19.9	21.4	22.8	**21.3**	**26.0**	20	137	Kharan
35.0	68.0	71.0	**55.3**	23.0	30.4	32.3	**28.3**	**21.6**	29	148	Khuzdar
35.0	68.0	71.0	**55.3**	36.6	17.6	18.7	**22.9**	**19.6**	31	150	Killa Abdullah
35.0	68.0	71.0	**55.3**	31.5	31.1	33.1	**31.9**	**28.4**	16	133	Killa Saifullah
35.0	68.0	71.0	**55.3**	48.2	19.7	21.0	**27.1**	**31.0**	11	127	Kohlu
35.0	68.0	71.0	**55.3**	22.0	30.7	32.7	**28.0**	**40.3**	4	107	Lasbela
35.0	68.0	71.0	**55.3**	7.0	32.5	34.6	**19.9**	**26.8**	19	136	Lehri
35.0	68.0	71.0	**55.3**	56.0	28.1	29.9	**36.1**	**37.4**	5	115	Loralai
35.0	68.0	71.0	**55.3**	17.9	27.1	28.9	**24.1**	**27.9**	18	135	Musakhel
35.0	68.0	71.0	**55.3**	34.8	33.9	36.0	**34.9**	**32.0**	9	124	Mustang
35.0	68.0	71.0	**55.3**	22.3	22.9	24.4	**23.2**	**29.7**	13	130	Nasirabad
35.0	68.0	71.0	**55.3**	39.3	32.5	34.6	**35.4**	**24.4**	25	143	Nushki
35.0	68.0	71.0	**55.3**	27.8	32.7	34.8	**31.6**	**33.5**	7	119	Panjgur
35.0	68.0	71.0	**55.3**	23.5	35.6	37.8	**31.6**	**34.5**	6	118	Pishin
35.0	68.0	71.0	**55.3**	100.8	49.0	52.1	**63.6**	**51.4**	1	63	Quetta
35.0	68.0	71.0	**55.3**	8.5	21.8	23.2	**16.3**	**23.8**	27	145	Sherani
35.0	68.0	71.0	**55.3**	71.7	32.5	34.6	**43.2**	**40.5**	3	105	Sibi
35.0	68.0	71.0	**55.3**	13.6	22.9	24.4	**19.7**	**31.2**	10	126	Sohbatput
35.0	68.0	71.0	**55.3**	11.7	13.9	14.8	**13.4**	**24.0**	26	144	Washuk
35.0	68.0	71.0	**55.3**	33.0	21.8	23.2	**25.5**	**28.8**	15	132	Zhob
35.0	68.0	71.0	**55.3**	78.8	22.2	23.6	**34.6**	**26.0**	21	138	Ziarat
35.0	**68.0**	**71.0**	**55.3**	**40.5**	**34.0**	**36.6**	**36.9**	**38.4**			**Balochistan**

AZAD JAMMU AND KASHMIR

UHC SERVICE COVERAGE INDEX 2023

District/ Province/ Area	Population (2023)	District UHC Index Ranking (National)	District UHC Index Ranking (Provincial)	REPRODUCTIVE, MATERNAL, NEW-BORN AND CHILD HEALTH					INFECTIOUS DISEASE CONTROL				
				FP demand satisfied with modern method (%)	ANC – 4+ visits (%)	Child immunization (Penta 3) (%)	Care-seeking behavior for child pneumonia (%)	RMNCH Score	TB effective treatment (%)	HIV treatment (%)	Insecticide-treated nets for malaria prevention (%)	At least basic sanitation (%)	Infectious Diseases Score
Bagh	398,836	39	3	45.7	54.4	96.3	66.6	**63.2**	80.6	14.7	NA	84.0	**46.4**
Bhimber	230,110	15	2	72.4	60.0	98.3	64.4	**72.4**	66.8	14.7	NA	89.2	**44.5**
Hattian Bala/J. Valley	247,213	100	9	37.7	36.3	91.0	35.1	**45.7**	55.2	14.7	NA	72.9	**39.0**
Haveli	253,346	99	8	55.7	17.4	92.2	66.6	**49.4**	44.4	14.7	NA	64.8	**34.9**
Kotli	920,438	48	4	61.0	60.6	97.2	64.4	**69.4**	45.2	14.7	NA	81.1	**37.8**
Mirpur	579,430	12	1	53.8	73.1	97.8	64.4	**70.5**	48.4	14.7	NA	91.2	**40.2**
Muzaffarabad	787,653	60	5	40.8	34.5	93.1	52.3	**51.2**	63.9	14.7	NA	82.4	**42.7**
Neelum	205,097	114	10	29.0	7.7	87.2	27.5	**27.1**	39.0	14.7	NA	65.0	**33.4**
Poonch	536,800	65	7	49.4	54.3	95.5	66.6	**64.3**	35.9	14.7	NA	83.1	**35.3**
Sudhnoti	409,334	62	6	56.5	59.9	98.0	64.4	**68.0**	49.8	14.7	NA	85.3	**39.7**
Azad Jammu and Kashmir	4,568,257			**51.6**	**49.2**	**95.6**	**52.8**	**59.8**	**53.4**	**14.7**	**NA**	**82.3**	**40.1**

GILGIT BALTISTAN

UHC SERVICE COVERAGE INDEX 2023

District/ Province/ Area	Population (2023)	District UHC Index Ranking (National)	District UHC Index Ranking (Provincial)	REPRODUCTIVE, MATERNAL, NEW-BORN AND CHILD HEALTH					INFECTIOUS DISEASE CONTROL				
				FP demand satisfied with modern method (%)	ANC – 4+ visits (%)	Child immunization (Penta 3) (%)	Care-seeking behavior for child pneumonia (%)	RMNCH Score	TB effective treatment (%)	HIV treatment (%)	Insecticide-treated nets for malaria prevention (%)	At least basic sanitation (%)	Infectious Diseases Score
Astore	113,147	90	5	46.4	14.5	69.6	51.4	**39.4**	67.2	14.7	NA	78.6	**42.7**
Diamer	305,498	111	8	46.4	5.2	39.5	46.3	**25.8**	120.9	14.7	NA	61.1	**47.7**
Ghanche	181,036	113	9	46.4	11.7	98.3	72.6	**44.4**	11.7	14.7	NA	98.6	**25.7**
Ghizer	192,350	80	4	46.4	68.3	96.0	79.1	**70.0**	31.2	14.7	NA	92.6	**34.9**
Gilgit	328,127	53	2	46.4	53.6	79.1	72.3	**61.4**	120.9	14.7	NA	92.1	**54.7**
Hunza	56,574	51	1	46.4	92.2	98.1	87.2	**77.8**	16.6	14.7	NA	98.8	**28.9**
Kharmang	56,574	116	10	46.4	8.5	95.0	75.2	**41.0**	4.2	14.7	NA	91.4	**17.8**
Nagar	79,203	94	6	46.4	30.1	96.9	79.3	**57.2**	14.6	14.7	NA	93.6	**27.2**
Shigar	79,203	110	7	46.4	11.0	99.2	69.5	**43.3**	10.5	14.7	NA	94.3	**24.4**
Skardu	294,183	73	4	46.4	24.8	99.2	56.1	**50.3**	80.8	14.7	NA	91.2	**47.7**
Gilgit Baltistan	1,685,895			**46.4**	**27.9**	**82.2**	**76.3**	**56.4**	**95.0**	**14.7**	**NA**	**86.0**	**49.3**

ISLAMABAD

UHC SERVICE COVERAGE INDEX 2023

District/ Province/ Area	Population (2023)	District UHC Index Ranking (National)	District UHC Index Ranking (Provincial)	REPRODUCTIVE, MATERNAL, NEW-BORN AND CHILD HEALTH					INFECTIOUS DISEASE CONTROL				
				FP demand satisfied with modern method (%)	ANC – 4+ visits (%)	Child immunization (Penta 3) (%)	Care-seeking behavior for child pneumonia (%)	RMNCH Score	TB effective treatment (%)	HIV treatment (%)	Insecticide-treated nets for malaria prevention (%)	At least basic sanitation (%)	Infectious Diseases Score
Islamabad	**2,218,678**	**4**	**1**	**55.1**	**80.8**	**86.5**	**83.6**	**75.3**	**42.9**	**14.7**	**NA**	**99.0**	**39.7**

NON-COMMUNICABLE DISEASES				SERVICES CAPACITY & ACCESS				UHC Index 2023	District UHC Index Ranking (Provincial)	District UHC Index Ranking (National)	District/ Province/Area
Normal blood pressure	Normal blood sugar	Tobacco non-smoking	Non-Communicable Diseases Score	Hospital beds per 10,000 population	(Physicians*Psychiatrist*Surgeon) density against threshold (%)	International Health Regulations core capacity index (%)	Services Access & Capacity Score				
35.0	68.0	71.0	**55.3**	50.0	60.1	57.6	**55.7**	**54.8**	3	39	**Bagh**
35.0	68.0	71.0	**55.3**	84.3	60.1	57.6	**66.3**	**58.6**	2	15	**Bhimber**
35.0	68.0	71.0	**55.3**	11.2	60.1	57.6	**33.9**	**42.8**	9	100	**Hattian Bala/J. Valley**
35.0	68.0	71.0	**55.3**	13.2	60.1	57.6	**35.7**	**42.9**	8	99	**Haveli**
35.0	68.0	71.0	**55.3**	55.8	60.1	57.6	**57.8**	**53.8**	4	48	**Kotli**
35.0	68.0	71.0	**55.3**	160.8	60.1	57.6	**82.3**	**59.9**	1	12	**Mirpur**
35.0	68.0	71.0	**55.3**	62.0	60.1	57.6	**59.9**	**51.8**	5	60	**Muzaffarabad**
35.0	68.0	71.0	**55.3**	24.4	60.1	57.6	**43.9**	**38.5**	10	114	**Neelum**
35.0	68.0	71.0	**55.3**	44.6	60.1	57.6	**53.7**	**50.9**	7	65	**Poonch**
35.0	68.0	71.0	**55.3**	32.3	60.1	57.6	**48.2**	**51.8**	6	62	**Sudhnoti**
35.0	**68.0**	**71.0**	55.3	**61.5**	**48.4**	**46.8**	**51.8**	**51.2**			**Azad Jammu and Kashmir**

NON-COMMUNICABLE DISEASES				SERVICES CAPACITY & ACCESS				UHC Index 2023	District UHC Index Ranking (Provincial)	District UHC Index Ranking (National)	District/ Province/Area
Normal blood pressure	Normal blood sugar	Tobacco non-smoking	Non-Communicable Diseases Score	Hospital beds per 10,000 population	(Physicians*Psychiatrist*Surgeon) density against threshold (%)	International Health Regulations core capacity index (%)	Services Access & Capacity Score				
35.0	68.0	71.0	**55.3**	57.9	39.5	41.1	**45.5**	**45.3**	5	90	**Astore**
35.0	68.0	71.0	**55.3**	23.6	39.5	41.1	**33.7**	**38.9**	8	111	**Diamer**
35.0	68.0	71.0	**55.3**	27.0	39.5	41.1	**35.3**	**38.6**	9	113	**Ghanche**
35.0	68.0	71.0	**55.3**	34.1	39.5	41.1	**38.1**	**47.6**	4	80	**Ghizer**
35.0	68.0	71.0	**55.3**	47.9	39.5	41.1	**42.7**	**53.1**	2	53	**Gilgit**
35.0	68.0	71.0	**55.3**	166.9	39.5	41.1	**64.7**	**53.2**	1	51	**Hunza**
35.0	68.0	71.0	**55.3**	34.4	39.5	41.1	**38.2**	**35.2**	10	116	**Kharmang**
35.0	68.0	71.0	**55.3**	56.1	39.5	41.1	**45.0**	**44.4**	6	94	**Nagar**
35.0	68.0	71.0	**55.3**	38.6	39.5	41.1	**39.7**	**39.0**	7	110	**Shigar**
35.0	68.0	71.0	**55.3**	50.2	39.5	41.1	**43.4**	**49.0**	4	73	**Skardu**
35.0	**68.0**	**71.0**	55.3	**57.9**	**43.7**	**45.7**	**44.6**	**50.4**			**Gilgit Baltistan**

NON-COMMUNICABLE DISEASES				SERVICES CAPACITY & ACCESS				UHC Index 2023	District UHC Index Ranking (Provincial)	District UHC Index Ranking (National)	District/ Province/Area
Normal blood pressure	Normal blood sugar	Tobacco non-smoking	Non-Communicable Diseases Score	Hospital beds per 10,000 population	(Physicians*Psychiatrist*Surgeon) density against threshold (%)	International Health Regulations core capacity index (%)	Services Access & Capacity Score				
35.0	**68.0**	**71.0**	55.3	**205.7**	**72.1**	**68.6**	**100.6**	**63.8**	**1**	**4**	**Islamabad**

ANNEX 4

DISTRICT WISE UHC PROGRESS FROM PREVIOUS YEARS

Districts / Provinces	2015	2016	2017	2018	2019	2020	2021	2022	2023
Abbottabad	44.2	47.6	49.7	51.3	52.0	58.4	60.4	61.2	63.75
Bajaur Agency	35.0	37.7	38.5	38.8	39.6	41.2	44.4	43.6	44.03
Bannu	36.8	38.1	39.5	39.8	41.1	46.8	42.7	43.7	49.48
Batagram	35.6	37.2	38.8	40.2	41.0	43.6	43.5	44.8	45.79
Buner	37.0	39.6	41.6	43.0	43.1	43.5	47.2	47.3	47.62
Charsadda	39.0	41.1	42.6	44.1	44.8	45.5	46.1	49.9	50.41
Chitral	41.7	44.3	46.1	47.4	47.9	50.8	53.4	50.7	53.05
Dera Ismail Khan	33.0	33.6	35.2	36.3	37.4	42.0	45.3	43.7	47.12
Hangu	42.2	44.1	45.6	47.0	47.3	47.9	50.4	48.2	48.29
Haripur	44.1	46.5	48.0	48.5	48.8	52.0	50.2	56.1	56.11
Karak	36.9	38.0	39.3	40.4	41.4	49.4	48.5	47.7	47.60
Khyber Agency	28.1	30.6	31.4	32.6	32.4	35.9	37.7	38.5	39.15
Kohat	41.2	43.2	44.7	46.5	46.9	49.1	45.3	48.1	48.42
Kohistan	18.4	17.7	18.9	20.0	20.4	22.0	21.6	21.9	22.80
Kurram Agency	27.6	28.9	29.8	28.6	30.3	34.3	38.3	40.8	38.79
Lakki Marwat	34.5	33.8	35.0	36.3	36.9	42.5	44.2	48.4	47.96
Lower Dir	40.6	43.0	44.6	45.7	45.5	46.7	47.0	49.0	49.82
Malakand projected Area	41.9	45.1	47.3	48.3	48.6	51.0	56.4	57.0	57.00
Mansehra	41.0	44.5	44.7	45.9	46.5	48.1	47.1	48.7	48.80
Mardan	43.9	46.7	47.2	48.2	48.4	48.6	55.6	52.3	54.19
Mohmand Agency	27.7	29.6	33.0	31.6	32.1	31.7	33.5	32.0	32.24
North Waziristan Agency	22.4	22.8	27.6	27.4	27.7	33.5	35.9	33.5	33.17
Nowshera	44.5	47.5	49.3	49.1	49.3	50.3	54.4	51.5	54.42
Orakzai Agency	24.6	27.2	31.1	34.3	33.9	39.5	40.4	41.3	40.33
Peshawar	45.6	48.5	51.3	52.9	53.9	59.2	55.7	60.3	63.73
Shangla	31.6	38.7	40.6	42.4	43.1	45.3	51.4	51.4	51.90
South Waziristan Agency	24.4	24.6	25.0	25.2	26.0	27.0	29.1	32.8	33.10
Swabi	42.3	44.3	45.0	46.6	47.2	47.6	46.6	51.1	53.86
Swat	42.0	44.8	46.9	48.4	49.1	52.1	51.0	55.9	56.51
Tank	30.5	31.1	32.6	33.8	34.4	39.7	44.0	41.1	41.03
Torghar	21.1	19.2	20.0	20.5	20.9	25.1	31.6	33.5	24.49
Upper Dir	31.2	33.0	34.3	35.6	36.2	38.8	38.1	42.6	43.17
Khyber Pakhtunkhwa	36.2	40.7	45.9	47.3	47.6	50.4	49.8	51.1	51.07
Attock	41.6	44.2	45.4	46.3	47.4	48.4	50.2	53.3	54.73
Bakhar	35.2	36.6	39.6	40.0	41.2	46.5	49.2	50.7	51.83
Bhawalnagar	36.0	38.8	41.8	43.2	43.8	50.3	50.8	52.1	53.18
Bhawalpur	38.2	39.9	42.7	44.3	44.5	45.4	51.3	54.7	55.60

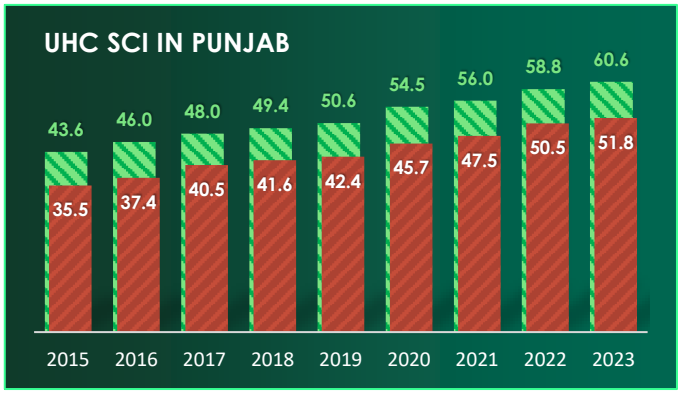
Districts / Provinces	2015	2016	2017	2018	2019	2020	2021	2022	2023
Chakwal	42.4	45.0	46.7	47.6	47.6	49.0	51.9	55.5	57.82
Chinot	38.0	40.2	41.4	42.3	44.3	46.5	48.1	51.2	52.87
Dera Ghazi Khan	33.0	34.8	38.6	39.5	40.9	46.2	48.3	49.2	50.82
Faisalabad	43.3	45.5	47.3	49.0	50.1	54.6	56.4	58.6	59.54
Gujaranwala	43.7	45.9	47.5	49.6	51.0	52.6	53.4	56.0	57.71
Gujrat	43.1	45.5	46.7	48.5	49.4	52.7	53.5	56.0	58.06
Hafizabad	39.4	42.1	44.4	46.8	47.7	49.8	50.3	53.7	54.70
Jhang	38.2	39.3	43.1	44.3	44.0	47.1	48.1	52.4	54.25
Jhelum	45.0	47.1	49.2	50.9	52.6	55.1	57.7	60.2	61.39
Kasur	39.6	41.8	43.3	45.2	46.7	49.0	51.0	54.3	55.02
Khanewal	38.5	40.7	43.2	45.2	45.8	47.8	50.2	53.9	54.77
Khushab	39.0	41.3	44.1	45.5	46.9	50.4	50.9	54.7	56.60
Lahore	46.2	48.3	50.1	50.8	52.3	59.5	60.6	63.8	65.57
Layyah	38.3	40.6	44.9	45.3	45.3	48.7	51.1	54.9	56.15
Lodhran	36.7	38.1	40.8	41.7	42.8	48.0	49.4	52.7	53.55
Mandi bahauddin	41.2	43.4	47.3	48.0	49.9	51.6	54.2	55.8	56.61
Mianwali	38.0	39.6	43.3	44.6	45.5	48.2	51.2	54.3	55.90
Multan	40.2	43.3	45.9	47.5	48.6	55.0	56.9	58.7	60.96
Muzzafargarh	34.5	36.6	39.5	40.3	41.4	43.4	45.0	49.8	51.00
Nankana Sahib	41.2	43.3	46.2	47.5	48.7	49.9	52.9	55.4	56.06
Narowal	40.1	42.4	45.1	46.7	48.1	50.6	51.9	54.8	56.44
Okara Distrct	39.5	42.2	44.5	45.6	46.2	48.8	51.0	53.5	54.98
Pakpattan	38.7	40.3	42.0	43.5	45.1	46.1	47.8	50.7	52.42
Rahim Yar Khan	34.2	36.8	40.5	41.8	42.4	46.3	47.3	51.8	52.86
Rajanpur	31.6	33.2	37.7	39.1	39.0	41.2	41.4	44.6	45.42
Rawalpindi	46.0	48.1	50.2	51.7	52.3	56.7	58.2	60.1	62.83
Sahiwal	40.3	42.7	45.3	46.8	47.7	50.8	52.6	56.4	58.21
Sargodha	41.1	43.1	45.7	47.4	49.1	54.2	55.1	59.0	60.59
Sheikhupura	40.9	43.2	45.5	46.9	48.2	49.5	50.8	55.0	56.64
Sialkot	43.9	46.8	48.8	49.9	50.7	53.1	54.2	59.7	61.24
Toba Tek Singh	40.6	43.1	44.9	46.9	48.3	50.1	52.2	55.4	57.55
Vehari	38.4	40.6	43.0	44.6	45.6	48.6	50.4	52.9	54.72
Punjab	40.7	42.9	45.7	47.3	48.3	52.0	53.8	53.8	55.51
Badin	28.9	31.6	32.7	33.5	34.9	36.4	37.3	41.4	41.45
Dadu	32.7	35.6	36.7	38.3	40.1	42.5	42.4	45.1	45.57
Ghotki	31.7	34.5	35.5	35.8	37.3	41.5	42.0	45.3	45.30
Hyderabad	41.0	44.5	47.2	48.5	50.3	56.5	56.2	60.9	63.93
Jacobabad	28.0	31.0	33.2	34.5	35.7	42.2	42.6	46.1	47.63
Jamshoro	39.7	42.6	43.6	44.4	45.7	45.6	45.9	49.2	50.29
Kambar Shadad Kot	30.9	33.8	35.0	35.7	37.0	37.6	38.6	40.0	43.01
Karachi Central	45.3	48.8	51.5	52.6	54.1	55.6	55.1	55.9	58.14

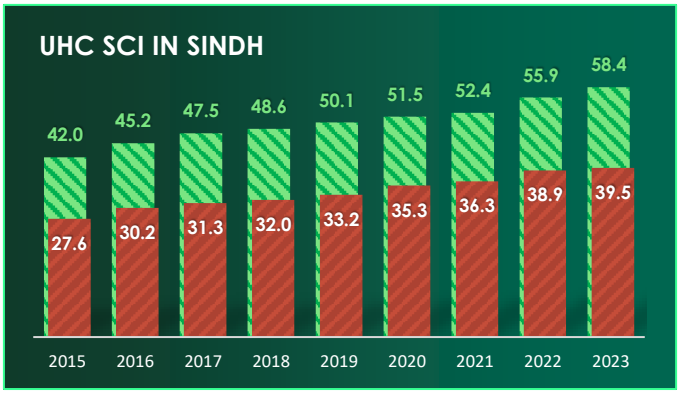
Districts / Provinces	2015	2016	2017	2018	2019	2020	2021	2022	2023
Karachi East	44.1	47.5	50.2	51.3	52.7	50.2	51.6	56.6	59.41
Karachi South	44.8	48.3	51.0	52.1	53.6	63.3	65.2	66.6	71.60
Karachi West	43.0	46.3	48.9	49.9	51.3	46.6	43.2	49.0	52.28
Kashmor	28.3	31.2	33.0	33.8	34.1	29.9	31.3	35.0	29.94
Khairpur	33.7	36.4	38.0	38.8	40.3	45.1	45.5	48.5	49.60
Korangi	42.6	45.9	48.5	49.5	50.9	47.6	51.3	54.2	56.45
Larkana	37.0	40.1	41.3	42.2	44.5	51.2	49.9	53.9	55.27
Malir	43.1	45.9	48.5	49.5	50.9	45.9	50.1	55.4	57.12
Matiari	34.6	37.1	38.4	39.3	40.5	42.7	43.7	46.6	48.18
Mirpur Khas	30.6	33.9	35.1	35.8	37.5	40.0	43.0	45.6	46.56
Naushero Feroz	38.2	41.0	42.3	43.2	44.6	45.1	45.4	48.8	49.44
Sanghar	34.0	36.9	38.1	39.0	40.4	40.6	42.4	44.2	44.48
Shaheed Benazirabad	35.2	38.3	39.5	40.3	41.6	47.4	48.1	52.0	53.79
Shikkarpur	32.0	35.2	36.2	37.0	39.1	41.1	40.8	42.8	43.43
Sujawal	24.8	27.1	27.0	27.6	29.4	33.4	33.7	34.2	34.67
Sukkar	37.9	41.4	43.8	44.8	46.7	50.5	50.1	54.5	55.54
Tando Allahyar	34.0	36.6	37.1	37.9	38.2	39.8	39.6	42.2	45.15
Tando Mohummad Khan	29.5	31.6	32.9	33.7	33.2	35.8	40.9	44.4	45.51
Tharparkar	20.1	21.9	22.6	23.1	24.9	28.1	28.0	30.4	31.32
Thatta	26.6	29.0	29.7	30.4	31.9	38.5	39.2	41.0	41.79
Umer Kot	28.0	30.6	31.6	32.3	33.4	34.0	34.0	37.7	39.70
Sindh	37.6	40.6	43.9	45.0	46.8	48.6	48.0	49.2	50.79
Awaran	14.8	16.3	16.6	17.5	18.2	19.0	18.1	18.4	19.04
Barkhan	20.5	21.7	21.9	24.3	25.8	19.0	21.9	24.4	25.91
Chaghi	19.4	21.3	22.0	22.7	22.5	22.9	22.1	24.0	25.32
Dera Bhugti	17.4	18.7	18.2	19.6	20.9	22.6	15.3	17.3	17.86
Duki	19.8	21.1	22.0	23.6	24.8	29.3	29.5	31.3	25.99
Gwadar	25.5	28.9	27.0	29.8	32.5	31.0	37.5	36.9	40.76
Harnai	17.0	18.4	17.7	18.1	18.8	21.7	24.7	25.6	27.88
Jaffarabad	24.4	27.0	27.6	29.2	35.6	35.8	30.1	29.6	30.56
Jhal Magsi	18.0	18.8	20.1	21.4	23.2	25.0	26.8	29.1	28.86
Kachhi	21.5	23.2	24.3	25.3	27.0	25.6	21.6	21.8	22.62
Kalat	23.4	25.3	26.0	26.3	27.1	18.6	17.5	20.6	21.41
Kech	26.8	28.9	30.0	30.3	31.8	28.1	32.2	32.0	32.93
Kharan	21.3	22.4	23.2	25.7	27.3	24.3	26.2	25.8	26.03
Khuzdar	23.2	25.1	25.7	26.1	26.8	20.2	19.3	21.8	21.62
Killa Abdullah	20.5	22.1	22.5	22.7	23.6	24.7	23.8	27.0	19.62
Killa Saifullah	23.7	25.9	26.9	27.8	30.2	25.0	26.5	28.3	28.35
Kohlu	21.0	22.7	23.0	22.9	23.7	27.5	29.4	32.8	30.98
Lasbela	26.9	29.3	30.5	30.7	31.7	32.8	39.4	40.6	40.28
Lehri	27.2	32.4	33.6	34.8	35.7	28.2	26.2	28.2	26.81

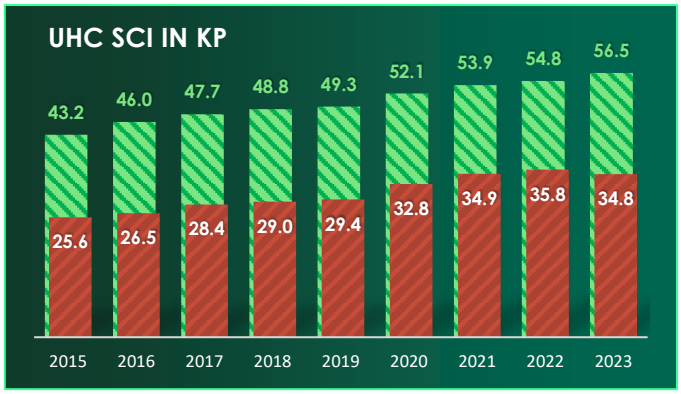
Districts / Provinces	2015	2016	2017	2018	2019	2020	2021	2022	2023
Loralai	23.7	25.5	25.9	28.3	28.6	31.1	39.0	31.6	37.40
Musakhel	20.7	23.2	23.4	23.4	22.4	22.0	25.3	27.4	27.87
Mustang	25.3	26.7	28.1	29.2	31.0	26.7	28.0	30.1	31.95
Nasirabad	23.2	25.7	26.5	27.3	28.8	26.5	25.4	27.3	29.73
Nushki	27.1	29.7	29.8	31.1	33.3	26.5	20.0	24.4	24.43
Panjgur	24.8	27.3	28.8	29.6	31.1	26.4	29.7	31.8	33.54
Pishin	30.6	33.0	34.1	34.7	35.9	33.6	34.5	34.3	34.52
Quetta	38.0	41.5	42.8	43.3	44.8	44.1	48.2	50.1	51.43
Sherani	20.5	21.9	22.4	22.9	23.0	23.2	21.8	22.2	23.75
Sibi	30.8	32.5	33.6	34.8	35.7	34.6	37.1	39.4	40.53
Sohbatput	23.2	26.5	26.5	27.3	28.8	24.1	24.4	27.1	31.24
Washuk	14.9	17.3	18.0	18.8	19.5	21.6	23.9	23.2	23.99
Zhob	24.6	26.2	26.5	28.6	28.8	25.9	27.8	28.3	28.83
Ziarat	23.7	26.8	24.6	24.9	25.5	21.6	24.3	25.9	26.02
Balochistan	27.1	29.4	32.3	33.5	35.0	35.3	35.7	37.4	38.40
Bagh	41.0	40.8	44.8	47.3	49.0	52.1	52.8	52.4	54.82
Bhimber	38.9	41.5	42.7	45.2	47.2	50.9	52.5	56.4	58.62
Hattian Bala	39.5	42.2	45.7	45.7	48.5	50.4	43.9	41.0	42.75
Haveli	39.7	41.8	42.4	45.3	46.8	49.6	42.5	41.6	42.94
Kotli	38.7	41.1	42.5	44.3	45.2	49.2	53.9	51.0	53.81
Mirpur	39.3	40.9	42.4	43.7	45.6	48.8	54.2	57.3	59.94
Muzaffarabad	38.9	40.3	42.8	45.0	46.5	49.2	49.7	49.6	51.85
Neelum	39.6	41.4	42.7	44.1	45.3	48.5	36.3	37.0	38.49
Poonch	37.6	39.7	43.2	43.0	44.6	47.5	48.0	49.0	50.93
Sudhnoti	37.8	40.0	39.4	42.6	44.0	47.3	48.7	49.5	51.78
Azad Jammu & Kashmir (AJ&K)	39.1	40.8	43.7	46.2	48.0	49.9	50.3	49.3	51.24
Astore	37.4	39.1	35.0	36.9	38.2	42.1	42.5	43.0	45.35
Diamer	28.1	32.2	34.8	36.4	36.9	39.9	40.2	39.2	38.92
Ghanche	31.8	33.4	36.9	37.4	39.2	39.0	38.8	36.7	38.62
Ghizer	38.0	41.3	40.1	41.0	43.1	43.6	47.7	45.7	47.64
Gilgit	39.2	43.5	42.5	44.6	46.5	47.2	52.3	50.4	53.07
Hunza	39.6	40.9	38.0	40.4	40.0	42.0	46.3	50.3	53.25
Kharmang	33.6	36.8	38.0	38.8	39.7	40.7	35.4	34.2	35.24
Nagar	36.5	37.7	34.9	37.2	36.8	38.8	42.9	42.1	44.37
Shigar	33.7	37.0	38.2	39.0	39.9	39.3	38.9	38.3	39.04
Skardu	34.6	37.9	39.2	40.0	40.9	42.9	45.5	46.5	48.97
Gilgit Baltistan (GB)	35.9	39.4	41.0	42.7	43.6	45.2	48.6	48.5	0.00
Islamabad	44.7	47.7	48.9	48.5	51.3	56.0	56.3	58.17	63.87

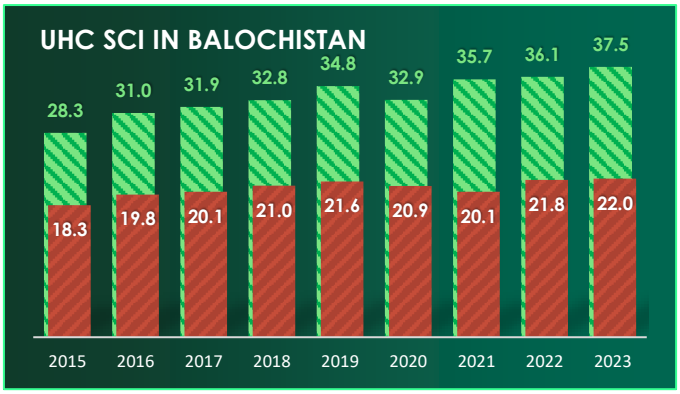
ANNEX 5

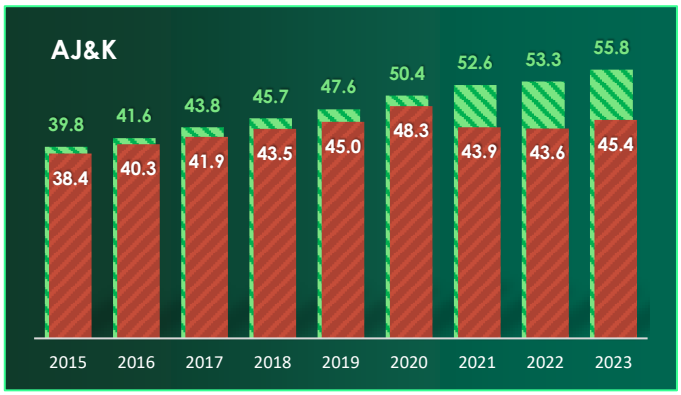
Average UHC Service Coverage Index of the Top and Worst Districts at Provincial and National Level

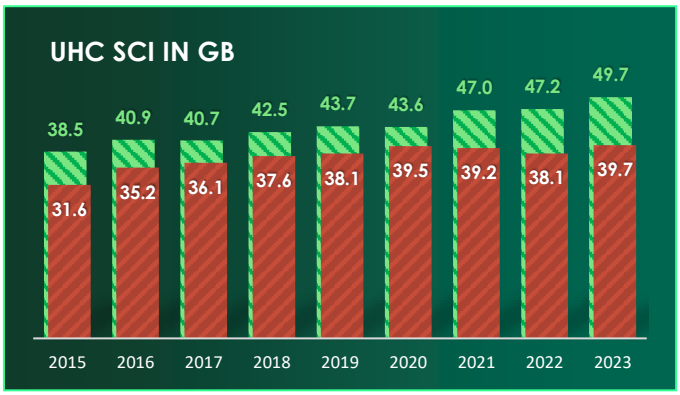


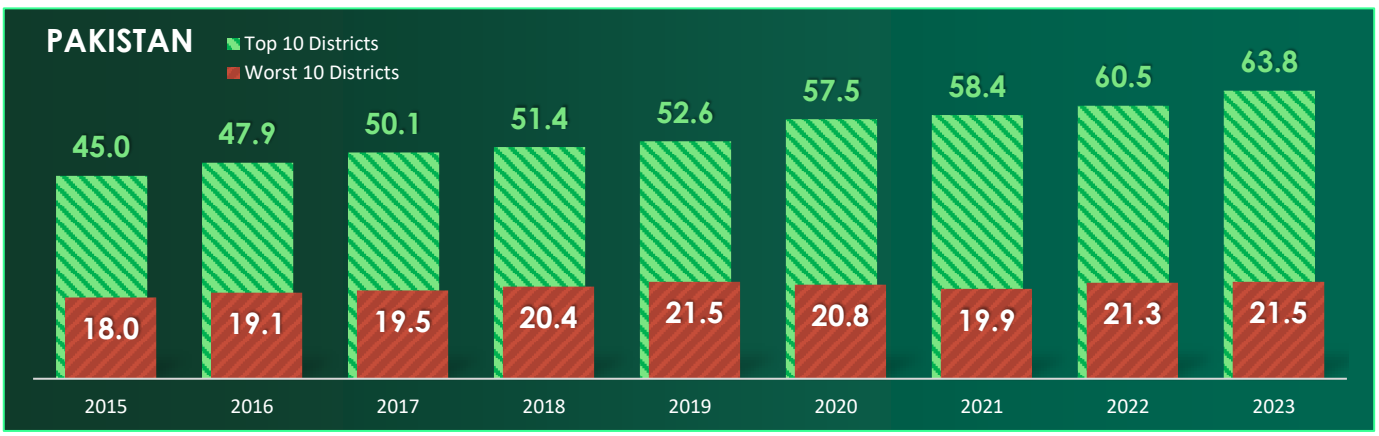










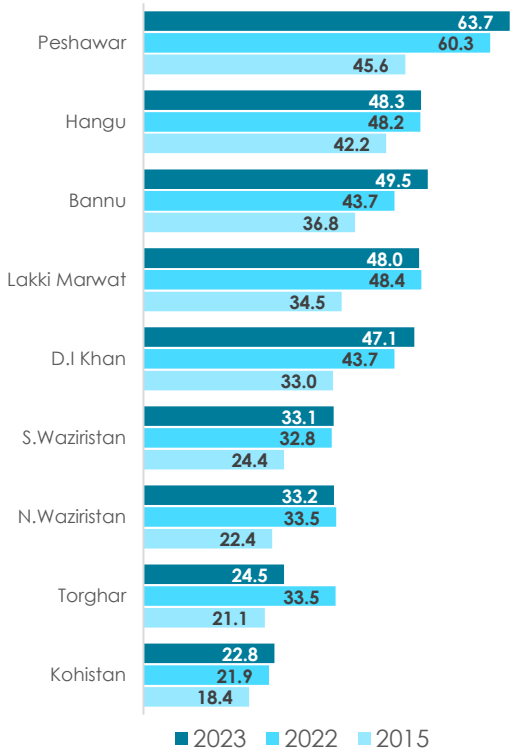


TOP 10 or 5 DISTRICTS | WORST 10 or 5 DISTRICTS

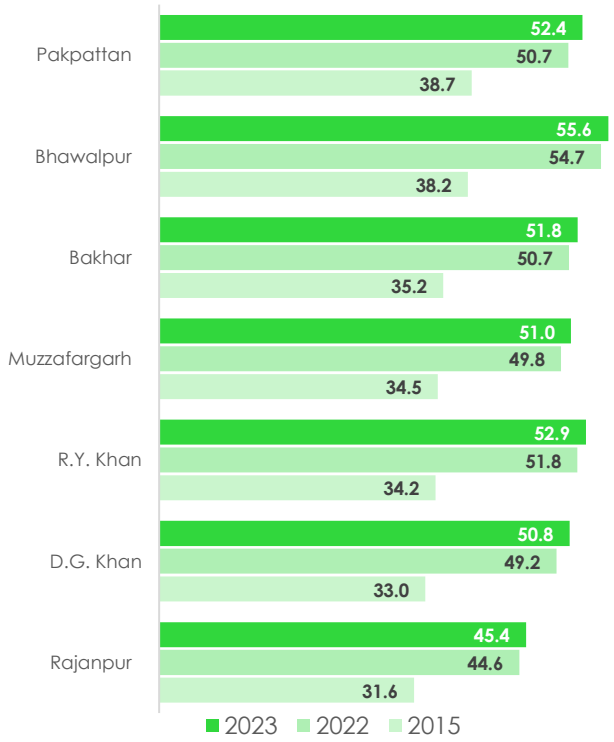
ANNEX 6

National Health Support Programme: Lagging Districts (Balochistan not included in NHSP so far)

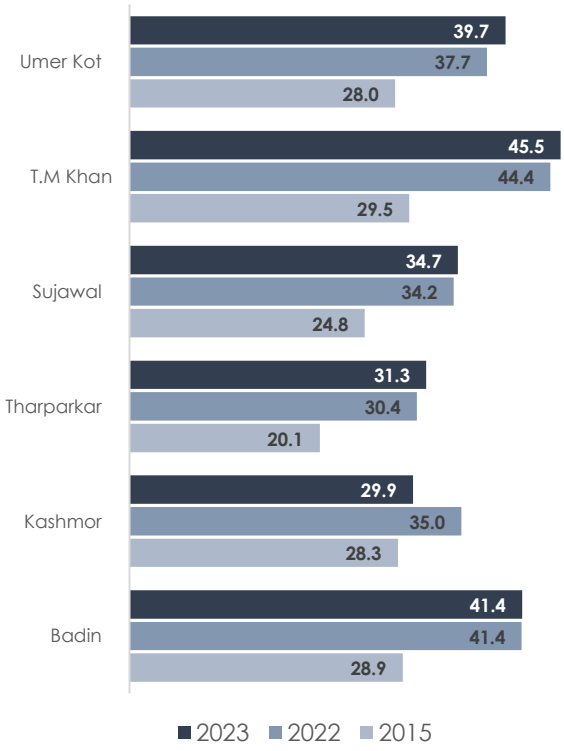
KP LAGGING DISTRICTS



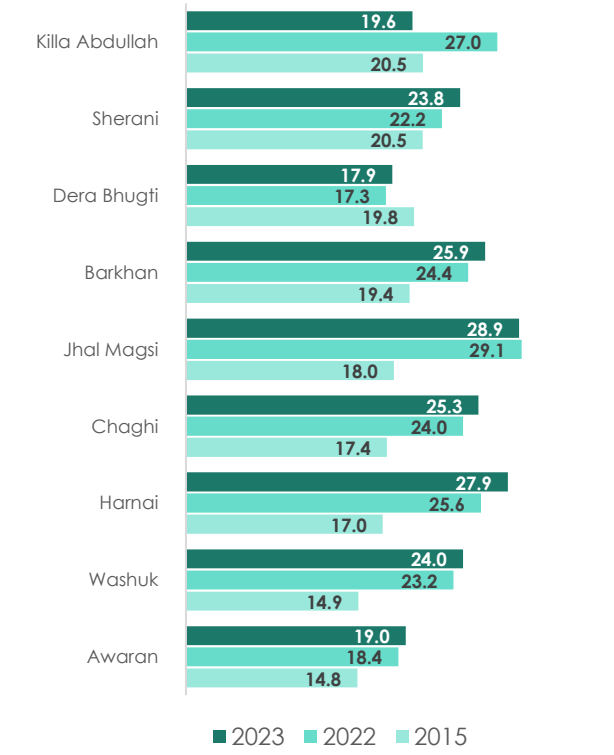
PUNJAB LAGGING DISTRICTS



SINDH LAGGING DISTRICTS



BALOCHISTAN LAGGING DISTRICTS



ANNEX 7

STATUS OF KEY HEALTH INDICATORS AT NATIONAL AND PROVINCIAL/AREA LEVEL

Indicator	Punjab	Sindh	KP	Balochistan	Islamabad	GB	AJ&K	Pakistan
Maternal Mortality Ratio (per 100,000 live birth) (PMMS 2016-19)	157	224	165	298	-	157	104	**186**
(UNIA 2020)								**154**
Neonatal Mortality Rate (per 1,000 live birth) (PDHS 2017-18)	51	38	42	34	24	47	30	**42**
(MICS Punjab 17-18, Sindh 18-19, KP19, Balochistan19-20, GB 16-17, AJ&K 20-21)	41	24	23	29	-	-	36	-
(PDS 2020)	40.2	46.0	39.5	46.8	-	-	-	42
UNIGME 2022								**39**
Infant Mortality Rate (per 1,000 live births) (PDHS 2017-18)	73	60	53	66	44	63	67	**62**
(MICS Punjab 17-18, Sindh 18-19, KP19, Balochistan19-20, GB 16-17, AJ&K 20-21)	60	39	35	48	-	73.5	51	-
(PDS 2020)	55.3	58.1	53.2	55.9	-	-	-	**55.7**
UNIGME 2022								**51**
Under five Mortality Rate (per 1,000 live births) (PDHS 2017-18)	85	77	64	78	49	76	53	**74**
(MICS Punjab 17-18, Sindh 18-19, KP19, Balochistan19-20, GB 16-17, AJ&K 20-21)	69	46	39	53	-	91.8	59	-
UNIGME 2022								**61**
(PDS 2020)	64.6	70.1	58.2	71.6	-	-	-	**65.4**
UHC Service Coverage Index (2020)	52.0	48.6	50.3	35.2	56.0	45.2	49.8	**49.9**
(2021)	53.8	48.0	49.8	35.7	56.3	48.5	50.2	**52.0**
(2022)	53.8	49.2	51.1	37.4	58.2	48.5	49.2	**52.7**
(2023)	55.4	50.7	51.0	38.4	63.8	50.4	51.2	**53.9**
Immunization (Penta III) Coverage (%) (PDHS 2017-18)	89.0	59.2	64.9	37.3	84.0	61.1	84.3	**75.4**
(TPVICS 2020)	94.9	73.2	74.3	42.2	86.3	82.2	95.4	**83.5**

Indicator	Punjab	Sindh	KP	Balochistan	Islamabad	GB	AJ&K	Pakistan
(TPVICS 2022)	95.2	75.9	70.7	46.4	87.0	-	-	-
Immunization (Measles 1) Coverage (%) (PDHS 2017-18)	85.4	61.2	63.3	33.3	82.8	66.1	82.6	**73.2**
(TPVICS 2020)	92.5	67.1	73.1	42.6	81.7	81.2	93.2	**80.4**
(TPVICS 2022)	92.5	76.1	67.4	46.0	81.0	-	-	-
Care seeking behaviour for pneumonia (%) (PDHS 2017-18)	86.1	85.4	84.3	62.2	83.6	80.8	76.3	**84.2**
(MICS Punjab 17-18, Sindh 18-19, KP19, Balochistan19-20, GB 16-17, AJ&K 20-21)	74.7	69.0	70.0	67.6	-	64.7	52.8	-
Care seeking behaviour for Diarrhoea (%) (PDHS 2017-18)	75.2	74.0	59.7	63.1	67.9	71.2	64.9	**70.8**
(MICS Punjab 17-18, Sindh 18-19, KP19, Balochistan19-20, GB 16-17, AJ&K 20-21)	65.7	67.4	56.5	54.5	-	53.6	42.4	-
Number of Polio cases (NEOC 2021)	0	0	0	1	0	0	0	**1**
(NEOC 2022)	0	0	20	0	0	0	0	**20**
(NEOC 2023)	0	2	4	0	0	0	0	**6**
(NEOC by Nov 2024)	1	19	19	27	1	0	0	**67**
Stunting (%) (PDHS 2017-18)	29.8	49.9	40.4	47.4	24.4	47.2	30.0	**37.6**
(MICS Punjab 17-18, Sindh 18-19, KP19, Balochistan19-20, GB 16-17, AJ&K 20-21)	31.5	50.2	36.7	49.7	-	46.2	24.2	-
(NNS 2018)	36.4	45.5	40.0	46.6	32.6	46.6	39.3	**40.2**
Wasting (%) (PDHS 2017-18)	4.0	11.7	7.5	18.3	2.8	1.1	6.4	**7.1**
(MICS Punjab 17-18, Sindh 18-19, KP19, Balochistan19-20, GB 6-17, AJ&K 20-21)	7.5	14.8	11.1	9.2	-	3.8	4.4	-
(NNS 2018)	15.3	23.3	15.0	18.9	12.1	9.4	16.1	**17.7**
Total Fertility Rate (PDHS 2017-18)	3.4	3.6	4.0	4.0	3.0	4.7	3.5	**3.6**
(MICS Punjab 17-18, Sindh 18-19, KP19, Balochistan19-20, GB 16-17, AJ&K 20-21)	3.7	3.7	4.0	4.0	-	4.6	3.4	-
(PMMS 2019)	3.7	3.9	4.0	5.1	-	4.8	3.6	**3.9**
(PDS 2020)	-	-	-	-	-	-	-	**3.7**

Indicator	Punjab	Sindh	KP	Balochistan	Islamabad	GB	AJ&K	Pakistan
Contraceptive (MM) Prevalence Rate (%) (PDHS 2017-18)	27.2	24.4	23.2	14	34.7	30.2	19.1	**25**
(MICS Punjab 17-18, Sindh 18-19, KP19, Balochistan19-20, GB 16-17, AJ&K 20-21)	29.9	20.7	28.2	17.9	-	32.1	30.0	-
Demand for FP satisfied with MM (%) (PDHS 2017-18)	50.3	50.2	45.1	33.8	55.1	46.4	38.5	**48.6**
(MICS Punjab 17-18, Sindh 18-19, KP19, Balochistan19-20, GB 16-17, AJ&K 20-21)	57.2	44.3	50.2	34.5	-	-	51.6	-
Antenatal Care from Skilled provider (%) (PDHS 2017-18)	92.3	85.7	80.1	55.5	93.6	79.6	89.6	**86.2**
(PMMS 2019)								**91.0**
(MICS Punjab 17-18, Sindh 18-19, KP19, Balochistan19-20, GB 16-17, AJ&K 20-21)	87.3	76.7	74.0	40.2	-	72.5	89.1	-
Mothers protected against Tetanus (%) (PDHS 2017-18)	81	61.9	58.9	26.7	79.8	64.2	80	**68.9**
(MICS Punjab 17-18, Sindh 18-19, KP19, Balochistan19-20, GB 16-17, AJ&K 20-21)	75.9	56.1	55.6	55.6	-	52.2	74.9	-
Skilled Birth Attendance (%) (PDHS 2017-18)	71.3	74.8	67.4	38.2	86.6	64.4	64.1	**69.3**
(MICS Punjab 17-18, Sindh 18-19, KP19, Balochistan19-20, GB 16-17, AJ&K 20-21)	76.4	82.7	76.6	49.9	-	62.0	74.4	-
(PSLM 19-20)	70.0	70.0	66.0	52.0	-	-	-	**68.0**
(PDS 2020)	-	-	-	-	-	-	-	**74.0**
Institutional Delivery (%) (PDHS 2017-18)	68.9	71.8	61.8	34.6	84	62.3	62.3	**66.2**
(MICS Punjab 17-18, Sindh 18-19, KP19, Balochistan19-20, GB 16-17, AJ&K 20-21)	73.3	70.2	67.8	40.4	-	60.3	71.7	-
(PSLM 19-20)	74.0	70.0	66.0	52.0	-	-	-	**70**
(PMMS 2019)	75	73	64	51		70	76	**71**
Tuberculosis Case Detection Rate (%) (NTP 2019)	62	56	48	32	28	70	48	**55**
(NTP 2020)	49	48	40	26	16	50	35	**45**

Indicator	Punjab	Sindh	KP	Balochistan	Islamabad	GB	AJ&K	Pakistan
(NTP 2021)	67	49	42	31	19	73	43	**56**
(NTP 2022)	80	62	50	34	34	75	52	**67**
(NTP 2023)	83.7	76.7	57.2	37.1	48.2	95.8	54.8	**71.6**
Tuberculosis Treatment Success Rate (%) (NTP 2019)	92	85	93	86	87	98	93	**90**
(NTP 2020)	93	91	95	86	76	99	94	**93**
(NTP 2021)	95	92	96	91	83	98	94	**94**
(NTP 2022)	94	94	96	91	84	98	91	**93.9**
(NTP 2023)	95.9	96.1	96.2	89.9	89.1	99.2	97.6	**95.5**
HIV & AIDS Cases (%) (estimated #) (NACP 2020)	92,110	74,685	12,127	4,783	Added in Punjab	Added in Punjab	Added in Punjab	**183,705**
(NACP 2021)	120,730	97,890	15,895	6,269	Added in Punjab	Added in Punjab	Added in Punjab	**240,785**
(NACP 2023)	154467	109,909	23,764	8,912	Added in Punjab	Added in Punjab	Added in Punjab	**297,052**
Hepatitis B Prevalence (%) (Punjab Prevalence survey 2018)* (PHRC 2007-08)**	2.2*	2.5**	1.3**	4.3**	-	-	-	**2.5****
Hepatitis C Prevalence (%) (PPS 2018)* (PHRC 2007-08)**	8.9*	5**	1.1**	1.5**	-	-	-	**4.9****
Annual Parasitic Incidence for Malaria (API) (DoMC 2021)	0.01	2.7	1.7	11.8	-	-	0.01	**1.8**
Annual Parasitic Incidence for Malaria (API) (DoMC 2023)	0.3	25.1	6.9	70.3	-	-	0.04	**11.03**

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