PAKISTAN NATIONAL ACTION PLAN FOR HEALTH SECURITY (NAPHS)

A SHARED OPPORTUNITY FOR SUSTAINABLE IMPLEMENTATION OF IHR (2005)

Ministry of National Health Services Regulations & Coordination

Foreword by the Honorable Minister of Health, Pakistan

The global community has long recognized the need for international collaboration and governance oversight to contain the spread of infectious diseases. In the 1800's international agreements and discussion focused on a select subset of diseases (primarily cholera, and later plague and yellow fever) and quarantine regulations necessary to prevent the shipping trade from transporting these diseases across international borders. The discussions and negotiations were codified into the first International Sanitary Convention of 1892, later to become the International Sanitary Regulations. Through many revisions, the structure of these agreements remained fairly static until after World War II, with the establishment of the World Health Organization (WHO). In 1951, WHO adopted the existing conventions and related agreements - the International Sanitary Regulations, which became binding on WHO member state parties. In 1969, the regulations were revised and renamed the International Health Regulations with subsequent revision to the current form of IHR 2005.

Pakistan is proud to be the first country in the Eastern Mediterranean Region to have undertaken the Joint External Evaluation for the IHR 2005, and stands fully committed to implement the NAPHS in its full capacity.

This document is the first "National Action Plan for Health Security (NAPHS)" developed through an all-inclusive, fully consultative and participatory approach. The NAPHS has drawn expertise from various sectors and reflects a shared commitment to enhanced collaboration for addressing national health security. The NAPHS aims to create and maintain active collaboration between the Federal and Provincial entities working in Pakistan for addressing health security through the "One Health" approach to ensure timely preparedness, consistent and coordinated response in the event of occurrence of an event of public health concern.

The NAPHS will serve the purposes of a uniform benchmarked coordination platform, which will be used to map and ensure interplay between multiple sectors of the country. The plan will be implemented under the guidance of the Federal Ministry of National Health Services Regulations & Coordination. Successful implementation of the NAPHS will contribute significantly to the overall goal of improving national, regional and global health security. All strategic documents are living documents, amenable to changes and I foresee these modifications as we learn more from our experiences.

The National Action Plan for Health Security is in my opinion one of the proudest achievement of the current government. It is my pleasure and proud privilege to see this through during my tenure as the Minister for Health, Islamic Republic of Pakistan.

I sincerely hope that the National Action Plan for Health Security will serve as an inspiration and guiding roadmap for all stakeholders. With the reiteration, that the Government of Pakistan is committed to ensuring the delivery of its commitment as a responsible member of world community, I pray that this NAPHS is implemented in its true spirit.

Mrs. Saira Afzal Tarar
Federal Minister for National Health Services, Regulations and Coordination,
Government of Pakistan

Acknowledgements

The National Action Plan for Health Security reflects the commitment of the Government of Pakistan to fulfill its constitutional obligation for interacting with the world health community on IHR implementation and Global Health Security Agenda in a coordinated, partnership approach with the provincial Departments of Health and health development partners as a global health safety responsibility.

The National Action Plan for Health Security has taken into account the federal and provincial roles and responsibilities in a decentralized and devolved setup. It has been developed through a consultative process involving all stakeholders in the provincial governments, line ministries and departments, development partners and autonomous entities. The making of this National Action Plan for Health Security is thoroughly owned by the political and administrative leadership of the health sector at the Federal and Provincial/Regional levels of the country.

The National Action Plan for Health Security is the result of several discussions and debates that were held under the aegis of the Ministry of National Health Services, Regulation & Coordination (M/o NHSR&C). It took a little over a year, for the M/o NHSR&C to develop consensus through holding extensive consultations and meetings at the Federal and Provincial Capitals of the country, to come up with the roadmap contained in this Document.

The National Action Plan for Health Security would not have materialized, had it not been for the able coordination efforts of the Health Policy, Planning and Systems Analysis Unit of the Ministry under the able leadership of Director Programs and the assistance and supportive role of the development partners in particular WHO. I would like to extend my special thanks to all line ministries and the Provincial and Regional health departments for their valuable inputs and contributions in developing this national document.

The making of Pakistan National Action Plan for Health Security is indebted to Madam Saira Afzal Tarar, Minister for Health, Ministry of National Health Services, Regulation and Coordination for leading the process and articulating the essence and importance of the need for developing Pakistan National Action Plan for Health Security. Secretary to the Government of Pakistan, M/o NHSR&C Mr. Naveed Kamran Baloch immensely supported the making of this National Action Plan for Health Security and I am grateful for the trust and confidence that he placed in the team during the development process.

In the end, I pray for the successful achievement of the targets set in the National Action Plan for Health Security.

Dr. Assad Hafeez
Director General Health, Ministry of NHSR&C, Pakistan

Executive Summary

Pakistan along with all Member States has been a signatory to International Health Regulations (IHR) 2005 which calls for the countries to work together to prevent, detect and respond to public health emergencies under the IHR (2005). The signatory countries have also agreed to work towards Universal Health Coverage and to build resilient health systems which can adapt and respond to the challenges posed by outbreaks and other health hazards and emergencies of national and international concern.

WHO Member States had been following the practice of annual self-reporting for monitoring IHR implementation since 2007. The global threat of Ebola precipitated the need to review and revisit the practice of exclusive self–evaluation, resulting in development and subsequent endorsement of revised IHR Monitoring and Evaluation Framework (69th World Health Assembly) in 2015. The new approach was adopted by EMRO in October 2015 (62nd session of the WHO Regional Committee for the Eastern Mediterranean (EM) Region EM/RC62/R.3); and, in line with the recommendation of IHR Review Committee on Second Extensions in WHA 68/22 Add.1 (Ref: 62nd session of the WHO Regional Committee for the EM Region EM/RC62/R.3), the Government of Pakistan also adopted the new approach of Joint External Evaluation (JEE) for monitoring and assessment of IHR implementation.

Pakistan is the first country in the EM Region and fourth globally to volunteer for JEE. The Government of Pakistan under the overall lead of the Ministry of National Health Services Regulations & Coordination (NHSR&C) conducted the JEE from 27th April to 6th May 2016. The process included comprehensive collaboration between the Federal & Provincial/Federating Areas' involving both Health and non-Health Sectors. The evaluation of national IHR core capacities was derived from joint discussions between external experts and government peers/counterparts for the 19 technical areas in the JEE Tool.

The JEE results and recommended priority actions have guided Pakistan in developing the 5 Year National Action Plan for Health Security with the aim to establish a strong public health system to meet the standards for IHR core capacities.

The JEE was followed by strengthening and establishment of coordination mechanisms with National IHR Task Force re-designated as the National Multi-sectoral Taskforce for IHR (2005) and GHSA; nomination of focal persons from Federal non-Health Ministries; notification of HPSIU as focal point for IHR-GHSA and counterpart notifications of Provincial IHR Task Force in four major provinces.

The development of Draft 5 Year National Action Plan for Health Security commenced with formulation of a technical working group (TWG) by the M/o NHSR&C. An extensive and comprehensive process was then undertaken with involvement and participation area relevant technical experts and focal persons from Health and non-Health sector at the Federal & Provincial/ Federating Areas in six consultative workshops through Oct- Nov 2016. The draft 5 Year National Action Plan for Health Security defined the goal, objectives and key activities under each of the 19 technical areas.

The implementation of the NAPPHS considers a set of guiding principles and core values such as country ownership and leadership; community participation; gender and human rights principles; equity in access to services; strengthening partnerships; fostering inter-sectoral collaboration; evidence-led; shared responsibility; transparency; resilience and dynamism.

Funds for implementation of the plan will come from National and Provincial resource envelopes as well as from development partners. The National Health Security Plan will be a coordination platform, anchored under the guidance of the M/o NHSR&C.

Progress towards the attainment of the targets set out in this national action plan will be evaluated quarterly, annually, at midterm and end term. Data will be collected through surveillance systems in human and animal health, annual reviews/assessments and reporting, after action reviews, exercises and simulations and joint external evaluations and other relevant assessments, as well as periodic supervision and facility based surveys/assessments. For some technical areas, there will be a need to re-conceptualize and reorganize the managerial and support mechanisms and structures at national, provincial and district levels including defining a clear supervisory mechanism and roles of various decentralized levels and involvement of the community.

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AFP	Acute Flaccid Paralysis
AJK	Azad Jammu & Kashmir
AMR	Antimicrobial Resistance
ATM Program	AIDS, Tuberculosis & Malaria Program
BSL	Biosafety Level
CADD	Capital Administration & Development Division
CHE	Central Health Establishment
DEWS	Disease Early Warning System
DHIS	District Health Information System
DoCHE	Directorate of Central Health Establishments
DSS	Disease Surveillance System
EET	External Evaluation Team
EMRO	Eastern Mediterranean Regional Office (WHO)
EOC	Emergency Operations Center
EPA	Environment Protection Agency
EPI	Expanded Program on Immunization
EPR	Emergency Preparedness and Response
FAO	Food and Agriculture Organization of the United Nations
FATA	Federally Administrated Tribal Areas
FELTP	Field Epidemiology & Laboratory Training Facility
FP	Focal Point
GAP	WHO Global Action Plan for influenza vaccines
GB	Gilgit-Baltistan
GHSA	Global Health Security Agenda
GOARN	Global Outbreak Alert and Response Network
GoP	Government of Pakistan
HCAI	Health Care Associated Infections
HEPRN	Health Emergency Preparedness and Response Network
HRH	Human Resource for Health
ICT	Islamabad Capital Territory
IDSR	Integrated Disease Surveillance and Response System
IEC	Information, Education and Communication
IHR	International Health Regulations
ILI	Influenza Like Illness
ISO	International Organization for Standardization
JEE	Joint External Evaluation of the IHR
MERS-CoV	Middle East Respiratory Syndrome Coronavirus
Mo/NFS&R	Ministry of National Food Security & Research
Mo/NHSR&C	Ministry of National Health Services, Regulation & Coordination
NAPHIS	National Plant, Animal Health and Inspection Service
NAPHS	National Action Plan for Health Security
NARC	National Agricultural Research Centre
NDMA	National Disaster Management Authority
NFP	National Focal Point
NGO	Non-Governmental Organization
NHEPRN	National Health Emergency Preparedness and Response Network
NIH	National Institute of Health
NRLPD	National Reference Laboratory for Poultry Disease

OIE	World Organization for Animal Health
PDHS	Pakistan Demographic Health Survey
PDMA	Provincial Disaster Management Authority
PNRA	Pakistan Nuclear Regulatory Authority
POE	Points of Entry
PPE	Personal Protective Equipment
PVS	Performance of Veterinary Services
RRT	Rapid Response Team
SARI	Severe Acute Respiratory Infection
SOP	Standard Operating Procedures
TB	Tuberculosis
UNICEF	United Nations Children's Fund
UVS	University of Veterinary and Animal Sciences
VHF	Viral Hemorrhagic Fever
vLMIS	Vaccine Logistics Management Information System
VPD	Vaccine Preventable Disease
WHO	World Health Organization

1. Background

1..1 Context

The IHR (2005) is the international legally binding instrument designed to help protect all States from the international spread of disease including public health risks and public health emergencies.

The previous WHO International Sanitary Regulations (1951), were initially revised and renamed the International Health Regulations in 1969. Subsequently, in response to the enhanced risks of international transmission of disease, the Regulations were again substantially revised over a 10-year process and adopted by the WHO Member States at the 58th World Health Assembly on May 23, 2005. In accordance to the Constitution of WHO, the Regulations entered into force on 15 June 2007 and are currently legally binding upon 194 around the world (including all WHO Member States).

The purpose and scope of the IHR (2005) are very broad and according to Article 2 of the IHR, the purpose and scope of the Regulations are "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade." To this end, the IHR (2005) contain rights and obligations for countries (and functions for WHO) concerning national and international surveillance; assessment and public health response; health measures applied by member countries to international travelers, aircraft, ships, motor vehicles and goods; public health at international ports, airports and ground crossings (together referred to as “points of entry”); and many other subjects.

Pakistan along with all the Member States has been a signatory to International Health Regulations (IHR 2005) which requires all countries to acquire core capacities to prevent, detect and respond to public health events and emergencies of national and international concern. The National Institute of Health (NIH) has been the designated IHR focal point since 2014, with a notified focal person assigned to oversee the day to day response and reporting requirements under the IHR.

The Ebola outbreak in 2014-15 raised considerable concerns on implementation gaps in the existing IHR mechanisms, resulting in the development and launch of the Global Health Security Agenda (GHSA) as a framework for IHR implementation. Pakistan as a signatory to the GHSA, is included in the priority one countries for strengthening IHR-GHSA core capacities. The other significant development after the Ebola Viral Disease crisis was the revision of IHR M&E Framework. The collective consensus resulted in the addition of Joint External Evaluation (JEE) as a voluntary step to the annual self- assessment and reporting on IHR implementation by Member states.

Pakistan volunteered and conducted the JEE in April-May 2016 as the first country in the Eastern Mediterranean Region to complete the process. The JEE tool includes 19 technical areas for IHR implementation under the four thematic domains of Prevent, Detect, Respond and Others. Pakistan applied a multi-sectoral One Health approach to the health system review for conducting the JEE, with collation of data on all the 19 technical areas and capacities from all levels across the country. The JEE report after country review and approval was finalized in September 2016.

The priorities and recommendations in the JEE were subsequently translated into the 5 year IHR-GHSA National Action Plan (NAP) through a comprehensive consultative process through One Health approach.

This NAP was presented and endorsed by the Government/ Ministry of National Health Services Regulations & Coordination in the national workshop conducted in Dec 2016 chaired by the Minister of Health with participation of all relevant stakeholders.

The NAP was subsequently costed for defining funding needs for implementation, through detailing major activities under each of the 19 technical areas into sub-components. A comprehensive document as excel sheets, with unit cost tables generated for each component of the activities as well as breakdown into federal and provincial/regional level has also been completed and endorsed by the government.

1..2 Country Profile

Pakistan covers an area of 796,095 km2 (307,374 sq. miles), being the 36th largest nation by total land area. Apart from the 1,046 km (650 miles) coastline along the Arabian Sea, Pakistan's land borders are a total of 6,774 km (4,209 miles) - 2,430 km (1,510 miles) with Afghanistan, 523 km (325 miles) with China, 2,912 km (1,809 miles) with India and 909 km (565 miles) with Iran. The territory of Pakistan mostly lies between latitudes 23° and 37° N (a small area is north of 37°), and longitudes 61° and 78° E (a small area is west of 61°).
The total population of Pakistan is 207.77 million[1] (sixth most populous country of the world); the male to female ratio is 105.07 males: 100 females (51% Males and 49% Females – Census 2017), the population density is 231 people per square kilometers, with 65.6% of the population living in rural areas and 34.4% of the population residing in the urban areas, the average urban growth rate is 2.7%, while the literacy rate is 58% (Pakistan Economic Survey 2017-18).

FIGURE 1: MAP OF PAKISTAN SHOWING NEIGHBORING COUNTRIES & MAIN POINTS OF ENTRY

1..3 Socio Economic & Health Indices

Pakistan as the world's sixth most populous country with a population of over 200 million is categorized as a lower middle-income country with a per capita income of US$1,641 in 2017/18. Pakistan's total

[1] Pakistan Economic Survey 2017-18

expenditure on health as a percentage of the GDP is around 2.8[2] per cent which is quite low as compared to 5-19.7[3] per cent in the developed countries of the world. The effectiveness of any country's health sector depends upon its budget allocation; however, Pakistan is spending less than one percent of its Gross National Product (GNP) on health care. Pakistan faces a double burden of disease, where it is still struggling with communicable diseases, there is a rising trend of non-communicable disease as well.

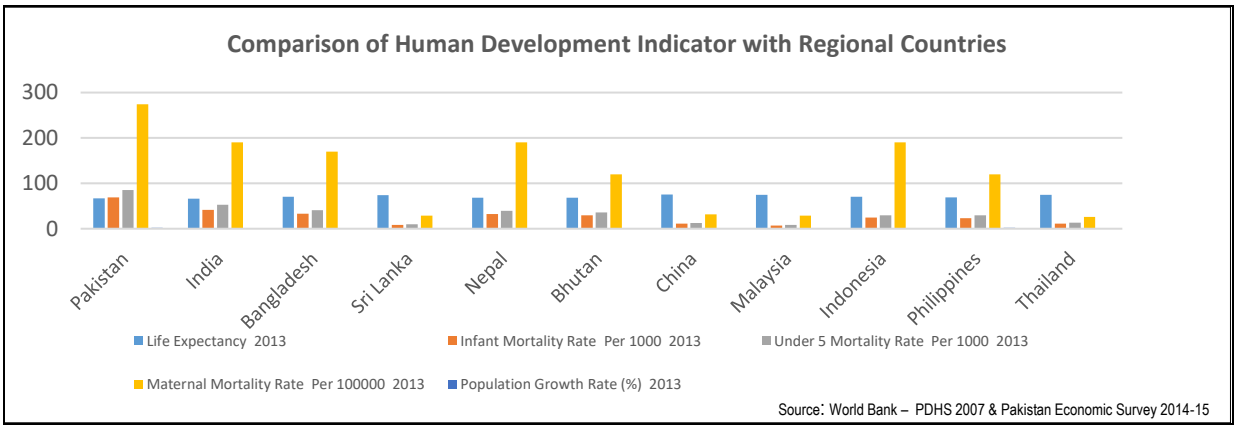


FIGURE 2: COMPARISON OF HUMAN DEVELOPMENT INDICATOR WITH REGIONAL COUNTRIES

1..4 Basic Socio Demographic Indicators

Accelerating progress in human development remains the key factor for sustain economic development in any country including Pakistan. Pakistan has undergone a major demographic transition over the last 40 years having more urban and a young population.

TABLE 1: PAKISTAN DEMOGRAPHICS PROFILE 2017 (MULTI- SOURCE)

Population	**Provisional results of Pakistan's 2017 national census estimate the country's total population to be 207,774,520**
Age structure	**0-14 years:** 31.36% (male 33,005,623/female 31,265,463) **15-24 years:** 21.14% (male 22,337,897/female 20,980,455) **25-54 years:** 37.45% (male 39,846,417/female 36,907,683) **55-64 years:** 5.57% (male 5,739,817/female 5,669,495) **65 years and over:** 4.48% (male 4,261,917/female 4,910,094) (2017 est.)
Growth rate	2.40% (2017)
Birth rate	25.4 births/1,000 population (2017 est.)
Death rate	6.4 deaths/1,000 population (2017 est.)
Net migration rate	-1.3 migrant(s)/1,000 population (2017 est.)
Urbanization	**Urban population:** 36.38% of total population (2017) **rate of urbanization:** 2.7% (2017 est.)
Major cities - population	Karachi 14.910 million; Lahore 11.126 million; Faisalabad 3.203 million; Rawalpindi 2.098 million; Multan 1.871 million; Islamabad (capital) 1.014 million (2015)
Sex ratio	**Total population:** 1.05 male(s)/female (2017 est.)

[2] Pakistan National Health Accounts 2011-12; World Bank 2013
[3] The World Bank 2015 (http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS)

Life expectancy at birth	**Total population:** 68.1 years **Male:** 66.1 years **Female:** 70.1 years (2017 est.)
Drinking water source	**Improved:** urban: 96.8% of population rural: 91.2% of population total: 93% of population **Unimproved:** urban: 2.8% of population rural: 8.2% of population total: 6.4% of population (2012-3 est.)
Sanitation facility access	**Improved:** total: 69.1% of population **Unimproved:** total: 30.9% of population (2012-13 est.)
Major infectious diseases	**Degree of risk:** high **Food or waterborne diseases:** bacterial diarrhea, hepatitis A and E, and typhoid fever **Vector borne diseases:** dengue fever and malaria **Animal contact disease:** rabies (2016)
Literacy	**Definition:** age 15 and over can read and write **Total population:** 58% **Male:** 70% **Female:** 48% (2017-18 est.)
Maternal mortality rate	170 deaths/100,000 live births (2016-17 est.)
Health expenditures	0.91% of GDP (2014)
Physicians density	0.98 physicians/1,000 population (2017)
Health Professional Density	1.4/1,000 population
Hospital bed density	6 beds/10,000 population (2017)

1..5 Health Sector in Pakistan: Governance and Financing

Pakistan is a Federation with three levels of government namely Federal, Provincial and District. There are 4 major provinces of Punjab, Sindh, Khyber Pakhtunkhwa and Balochistan. In addition, there are 4 regions /federating areas including the Islamabad Capitol Territory (ICT), Federally Administered Tribal Areas (FATA) and the Federally Administered Northern Areas (FANA) which come under the jurisdiction of the Federal government; whereas, Azad Jammu and Kashmir (AJK) is an autonomous region with its own government. In 1971, the federal and provincial governments were made responsible for the delivery of healthcare with implementation through the district administrations. The Constitution of Pakistan (1973) specified the subjects that come under the respective domains of the federal and provincial governments. Constitutionally, the provision of health services has always been the responsibility provincial governments while stewardship role was assigned to the Federal Government. The main responsibilities of the Federal Government were policy and strategy development, international commitments, monitoring and evaluation, health communication, advocacy and information and the prevention of cross border transmission of diseases. The provincial governments' primary responsibility were provision of health services, including planning, management and oversight, financing, implementation, medical education and training, monitoring and supervision, and regulation.

In 2011, the 18th Amendment to the Constitution of Pakistan resulted in devolution of the social sectors, including health to the provinces and the Federal Ministry of Health was abolished. However certain functions were retained by the Federal Government including Coordination in Health, International treaties and agreements (SDGs, IHR, AMR etc), Cross Border Transmission of Disease including

Surveillance, Research & Statistics, Drug Regulations, Export/Import of Good and Services, and Health Regulatory Bodies. The mandate for priority setting, strategy development, management of vertical programs and initiatives were devolved to the provinces.

General taxation is the major source of revenue and government's financing for health in addition to external financial support as well as out of pocket expenditure. Government funds are channeled through three levels – federal, provincial and district. The federal government makes grants to provinces; decisions about health sector allocations are made by the provinces themselves. The total expenditures as a proportion of GDP is 2.8%, while the total government health expenditure as a proportion of GDP is 1%[4]. Furthermore, the public expenditures as a proportion of total health expenditure is 32[5] and out of pocket expenditures as proportion of total expenditure on health is 67%[5]. The donor contribution is approximately 0.8%[5]. Other sources such as insurance (voluntary health insurance as proportion of total expenditure on health is only 0.2%[6]).

2. IHR (2005) JEE & Other Complementary Assessments

2.1 Summary of Prior Assessments

2.1.1 IHR Self Reporting

The Government of Pakistan in recognition of its responsibility as a Member state has been reporting progress on IHR implementation to the World Health Assembly on an annual basis. In this regard, the National Institute of Health (NIH) as the focal point for IHR 2005 is regularly reporting to WHO since 2014 as per the IHR Self Reporting Questionnaire. The information about potential hazards and events at the point of entries as per IHR core capacities is consolidated from the respective organizations and provincial health departments for onward sharing to IHR Secretariat at WHO HQ under intimation to WHO EMRO office.

2.1.2 Previous IHR Related Assessments

Pakistan had also previously undergone some relevant assessments in the context of IHR such as Assessment of Public Health Surveillance System (2005), Points of Entry Assessment (2014), Ebola Mission (2014), Laboratory Assessment (2015) and drafting of Pakistan Public Health Surveillance and Response Act (2010) to name a few (**Table 2**).

TABLE 2: IHR Related Assessments

Assessment	*Year*	*Major recommendations*
1. Public Health Surveillance Act	2010	The Act was drafted to ensure implementation and enforcement of measures: i. To prevent and control spread of disease ii. Disease surveillance, detection, assessment and reporting system from grassroots to national and international levels iii. Provide health response and health emergency systems iv. To provide measures at all airports, seaports and ground crossings to ensure surveillance, detection , prevention and control of spread of disease through travel, import and export of goods, animals and plants

[4] The World Bank Report 2014
[5] Pakistan National Health Accounts 2013-14
[6] Health Equity & Financial Protection Report Pakistan: World Bank 2012

2. Points of Entry Assessment	2014	i. Partnership strengthening ii. Strengthen core capacity iii. Prevent and Respond to International Public Health Emergencies iv. Establishment of the legal and regulatory frameworks that specify the roles of participating partners and stakeholders to ensure justification for applications of measures to facilitate quick and timely response
3. Ebola Mission	2014	i. Build the capacity of the health staff in the Isolation area on Surveillance, Case management and IPC including proper waste management ii. Identify separate Isolation area for EVD case management including PPES Donning and Doffing rooms iii. Use the asset of Dengue Fever reporting to report EVD suspected cases immediately iv. Arrange PPEs and disinfectants to run the isolation facility for one month v. Build the capacity of the health staff in the outpatient clinic to identify the EVD suspected cases earlier vi. Designate pathway for the EVD cases so that not to be exposed to the other people in the hospital and spreading the disease
4. Laboratory Assessment	2015	Assessment was conducted on the Laboratory Assessment tool (LAT) on 8 major domains: i. Coordination ii. Structure iii. Regulations iv. Quality v. Information Systems vi. Infrastructure vii. Human Resource viii. Bio Risk

2.1.3 Risk Assessment

The physiographic setting of Pakistan makes the country vulnerable to a number of natural and human induced disasters. Natural disasters that repeatedly affect the country include: earthquakes, river and flash floods, drought, snow avalanches, glacier lake outburst flooding (GLOF) and landslides etc. In addition to this, the country has been affected by human induced disasters including bomb blasts, fires; both forest and urban fires, road accidents, and many extremism related incidents. The effects of these disasters are further exacerbated by poor infrastructure, scanty emergency response services and poverty, particularly in rural areas lowering coping mechanisms at all levels. With the advent of this century, Pakistan has witnessed series of natural disasters, including 2005's devastating earthquake, horrendous river floods of 2010, 2013 and 2014. Thousands of precious lives were lost causing losses of billions of rupees in addition to high mortality and morbidity incidents. Large-scale destruction of infrastructure, housing, livestock, agriculture, equipment and other assets of livelihoods were destroyed.

	Value	Rank	Trend (3 years)
INFORM Risk	6.4	12	→
Hazard & Exposure	9.0	1	→
Vulnerability	5.2	40	→
Lack of Coping Capacity	5.7	56	→

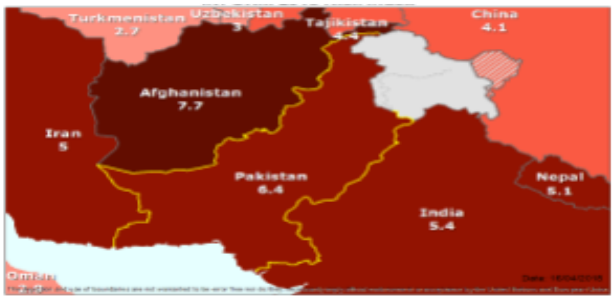


FIGURE 3: RISK INDEX PAKISTAN

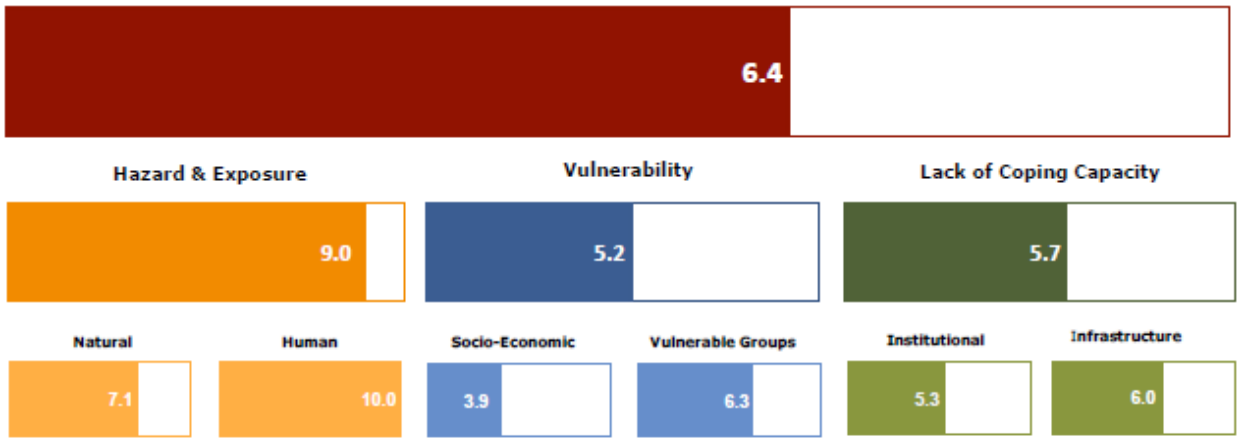


FIGURE 4: RISK PROFILE PAKISTAN

RISK INDICATORS

	Indicator	Component	Index	Value	Unit
HIGHEST 5 RISK INDICATORS	Physical exposure to earthquake MMI VI	Earthquake	10.0	0.00	Average annual population exposed per country
	Current High Violent Conflict Intensity Score	Current Conflicts Intensity	10.0	0.19	Index
	GCRI Internal Conflict Score	Projected Conflict Risk	9.8	0.00	Index
	One-year-olds fully immunized against measles	Access to health care	9.7	90.00	%
	Health expenditure per capita	Access to health care	9.7	872.93	current int USD PPP
LOWEST 5 RISK INDICATORS	Access to electricity	Communication	0.2	98.20	%
	Malaria death rate	Other Vulnerable Groups	0.2	0.00	per 100,000 people
	Estimated number of people living with HIV - Adult (>15) rate	Other Vulnerable Groups	0.2	0.40	%
	People affected by Natural Disasters	Other Vulnerable Groups	0.3	383535.00	Number
	Humanitarian & Development Aid	Economical Dependency	0.8	157.57	USD Million

FIGURE 5: RISK INDICATORS PAKISTAN

Various international entities have put their efforts to reduce the risk of hazards and strengthening of health systems during disasters. Noteworthy are the WHO's International Health Regulations (IHR 2005), and Hyogo Framework for Action (HFA, 2005-2015) on DRR, followed by the Sendai Framework for Disaster Risk Reduction (SFDRR, 2015-2030). The Sendai framework has laid down fundamental principles agreed in an International Conference held during 10-11 March 2016 in Bangkok, Thailand, on the implementation of the health aspects of the SFDRR, which has served the basis of guidance to establish a National Action Plan in Pakistan for mainstreaming Disaster Risk Reduction into Health Sector. The said document provides an Action Plan and Road Map for the forthcoming ten years devised through a series of consultative meetings and workshops with all relevant stakeholders at national and provincial level under the auspices of national and provincial disaster management authorities.

2.2 IHR Joint External Evaluation

Pakistan along with other member states endorsed the revised IHR M&E framework and volunteered to undergo Joint External Evaluation (JEE) assessment at the WHO Regional Conference meeting held in Kuwait (resolution EM/RC62/R.3) in October 2015 **(Annex 1**). JEE was conducted from 27th April- 6th May 2016 making Pakistan the first country in the Eastern Mediterranean Region and the fourth globally to complete the process.

The JEE was conducted using the World Health Organization (WHO) IHR JEE tool which included 19 technical areas under the four thematic domains of Prevent, Detect, Respond and Other (**Table 3**) for IHR implementation. Pakistan applied a multi sectoral One Health approach to the health system review for conducting the JEE, with collation of data on all the 19 technical areas and capacities from all administrative levels of the country.

TABLE 3: JEE ASSESSMENT; THEMES & TECHNICAL AREAS

JEE Assessment: Themes and Technical Areas				
Thematic Areas	***PREVENT***	***DETECT***	***RESPOND***	***OTHER***
Technical Areas	5. National legislation, policy and financing 6. IHR coordination and advocacy 7. Antimicrobial resistance 8. Zoonotic diseases 9. Food safety 10. Biosafety and biosecurity 11. Immunization	12. National Laboratory Systems 13. Real Time Surveillance 14. Reporting 15. Workforce Development	16. Preparedness 17. Emergency Response Operations 18. Linking public health and security authorities 19. Medical countermeasures and personnel deployment 20. Risk communication	21. Point of entries 22. Chemical events 23. Radiation emergencies

A multi-sectoral international External Evaluation Team (EET) selected on the basis of their recognized technical expertise from a number of countries and international organizations jointly conducted the assessment with their national counterparts. The mission conducted from April 27 to 6 May 2016 was based on completely collaborative, multi-sectoral discussions with country experts at both the national and provincial level.

2.2.1 Preparatory Steps

As a first step, an official communication was sent by the Ministry requesting WHO's support for conducting JEE to identify gaps and future needs of the public health sector to implement IHR 2005 as a responsible member state **(Annex 2**).

The M/o NHSR&C took several initiatives to prepare and streamline the process for conducting JEE. These steps included formulation of a country planning team; notification of Provincial IHR Focal Persons; and a detailed orientation and sensitization of provincial and regional stakeholders from Health & other sectors such as Agriculture, Veterinary and environment etc. This detailed preparation enabled the country to draw on the experience of all relevant departments and ministries to provide a comprehensive snapshot of the health system vis-à-vis JEE assessment.

2.2.2 Self-Reporting

As a requirement of JEE, the Government of Pakistan completed the process of self-reporting prior to the arrival of the external team. In this regard, four weeks of rigorous preparatory work was done at national and provincial level to compile data and information on all 19 technical areas in the JEE tool. Two major orientation sessions were conducted in Karachi and Lahore involving 120 participants from the national, provincial and federating areas. There was representation from health, environment and climate change, food security, livestock, agriculture, national and provincial disaster management authorities, and the Pakistan Atomic Energy Commission.

In view of the extensive work required to complete the self-reporting template for all the technical areas, Pakistan elected to engage consultants (18 JEE Support officers) with the responsibility to review, validate and fill in the information gaps. This was a unique initiative which contributed significantly to the successful completion of the self-reporting template, thereby enormously facilitating the EET's work in country.

2.2.3 Joint External Evaluation 27th April – 6th May 2016

The JEE Mission consisting of 18 international subject matter experts for each of the 19 technical areas, visited Pakistan to conduct the JEE. **(Annex 3**). The process commenced on 27th of April with a detailed orientation session at the ministry with participation EET and National experts. The results of the self-reporting for all technical areas were formally presented and discussed in detail in this first day session.

The external team and host country experts then participated in a series of facilitated discussions to jointly assess Pakistan's current strengths/best practices, areas requiring strengthening and challenges. These discussions generated scores and recommendations on 3–5 priority actions for each of the 19 technical areas. Additionally, there were follow-up meetings and site visits in Islamabad and four major provinces to consult and elicit perspectives of national, provincial levels and federating areas governments from all relevant sectors **(Annex 4)**. It is to be noted that Pakistan approached the JEE as a system wide assessment, utilizing a multi sectoral One Health approach for collating data on all JEE technical areas and capacities existing in the country.

2.2.4 Findings of the IHR Joint External Evaluation

The timing of the JEE was optimal given international attention to IHR and global health security. With reference to Pakistan and the post-devolution scenario in the country it was an opportunity to optimize federal and provincial coordination across multiple sectors in a "One Health" approach. The detailed deliberations and extensive consultation with all relevant stakeholders resulted in mutual consensus for scoring of JEE indicators (**Table 4**).

Table 4: Pakistan Scores on Joint External Evaluation

Capacities	Indicators	Score
National legislation, policy and financing	P.1.1 Legislation, laws, regulations, administrative requirements, policies or other government instruments in place are sufficient for implementation of IHR	2
	P.1.2 The state can demonstrate that it has adjusted and aligned its domestic legislation, policies and administrative arrangements to enable compliance with the IHR (2005)	3
IHR coordination, communication and advocacy	P.2.1 A functional mechanism is established for the coordination and integration of relevant sectors in the implementation of IHR.	3
Antimicrobial resistance	P.3.1 Antimicrobial resistance (AMR) detection	1
	P.3.2 Surveillance of infections caused by AMR pathogens	1
	P.3.3 Healthcare associated infection (HCAI) prevention and control programs	1
	P.3.4 Antimicrobial stewardship activities	1
Zoonotic diseases	P.4.1 Surveillance systems in place for priority zoonotic diseases/pathogens	3

	P.4.2 Veterinary or Animal Health Workforce	3
	P.4.3 Mechanisms for responding to zoonosis and potential zoonosis are established and functional	2
Food safety	P.5.1 Mechanisms are established and functioning for detecting and responding to foodborne disease and food contamination.	2
Biosafety and biosecurity	P.6.1 Whole-of-Government biosafety and biosecurity system is in place for human, animal, and agriculture facilities	2
	P.6.2 Biosafety and biosecurity training and practices	2
Immunization	P.7.1 Vaccine coverage (measles) as part of national program	2
	P.7.2 National vaccine access and delivery	4
National laboratory system	D.1.1 Laboratory testing for detection of priority diseases	4
	D.1.2 Specimen referral and transport system	3
	D.1.3 Effective modern point of care and laboratory based diagnostics	2
	D.1.4 Laboratory Quality System	2
Real-time surveillance	D.2.1 Indicator and event based surveillance systems	3
	D.2.2 Inter-operable, interconnected, electronic real-time reporting system	2
	D.2.3 Analysis of surveillance data	2
	D.2.4 Syndromic surveillance systems	4
Reporting	D.3.1 System for efficient reporting to WHO, FAO and OIE	2
	D.3.2 Reporting network and protocols in country	2
Workforce development	D.4.1 Human resources are available to implement IHR core capacity requirements	3
	D.4.2 Field epidemiology training program or other applied epidemiology training program in place	3
	D.4.3 Workforce strategy	2
Preparedness	R.1.1 Multi-hazard National Public Health Emergency Preparedness and Response Plan is developed and implemented	1
	R.1.2 Priority public health risks and resources are mapped and utilized	1
Emergency response operations	R.2.1 Capacity to activate emergency operations	2
	R.2.2 Emergency Operations Centre operating procedures and plans	2
	R.2.3 Emergency operations Programme	3
	R.2.4 Case management procedures are implemented for IHR relevant hazards	2
Linking public health and security Authorities	R.3.1 Public health and security authorities (e.g. law enforcement, border control, customs) are linked during a suspect or confirmed biological event	3
Medical countermeasures and personnel deployment	R.4.1 System is in place for sending and receiving medical countermeasures during a public health emergency	4
	R.4.2 System is in place for sending and receiving health personnel during a public health emergency	4
Risk communication	R.5.1 Risk communication systems (plans, mechanisms etc.)	1
	R.5.2 Internal and partner communication and coordination	2
	R.5.3 Public communication	2
	R.5.4 Communication engagement with affected communities	2
	R.5.5 Dynamic listening and rumor management	3

Points of Entry (PoE)	PoE.1 Routine capacities are established at PoE.	2
	PoE.2 Effective public health response at Points of Entry	2
Chemical events	CE.1 Mechanisms are established and functioning for detecting and responding to chemical events or emergencies	2
	CE.2 Enabling environment is in place for management of chemical events	2
Radiation emergencies	RE.1 Mechanisms are established and functioning for detecting and responding to radiological and nuclear emergencies	5
	RE.2 Enabling environment is in place for management of radiation emergencies	5

Subsequently, the recommendations and priority actions were jointly developed from the discussions between the EET and their Pakistani peers representing all the sectors relevant to the 19 IHR technical areas. The following five major cross-cutting themes emerged from the review of 19 technical areas, to prevent, detect and respond to public health events under IHR:

1. Critical need for continued and expanded multi-sectoral communication and coordination. This extends in all directions – between sectors (including but not limited to public health, animal health, security, and environment) and between the Federal Government and provincial authorities. The devolution and subsequent re-notification of the Ministry, the "One Health" concept was introduced at the beginning of the 2000s. Pakistan has begun to capitalize on the opportunities by establishing the regulatory base, structures and systems that maximize the strengths of each. Work to define roles and responsibilities should be continued: in any devolved or federated system, clarity on the roles and responsibilities at all levels is critical to success and forms the basis on which to build effective collaboration and coordination.

2. Critical need for a sufficiently funded, widely supported country 5-year plan/roadmap to strengthen IHR capabilities. This plan will provide the basis for the Gov. of Pakistan, the Ministry of NHSR&C, Ministry of National Food Security and Research, Ministry of Climate Change and other stakeholders to agree on priorities for implementation and negotiation with internal and external partners for investment and support. The roadmap will also provide the core platform to develop action plans for the key priorities identified across the 19 technical areas. The roadmap should include clear milestones (for example establishing a functioning public health laboratory in each province within three years) and identify the responsible implementing authorities/stakeholders.

3. Need to establish a strong, visible, active surveillance and tiered public health laboratory system, covering human and zoonotic animal health as well as food and water safety, with appropriate infrastructure, at national and provincial levels. The development of a National Public Health Institute would need to be considered in the context of a "One Health" approach. The organization of the surveillance system could be modelled on the overall approach to devolution in Pakistan with the national level setting the policy and framework in mutual consultation, and the provincial level implementing the framework.

4. Emphasis was made for the need to develop and enhance regulations, standards, and coordination mechanisms for food safety, from the beginning to end of the production chain, addressing both chemical and microbiological contamination.

5. Emphasis was made for the need for a national cross-sectoral approach to managing antimicrobial resistance and control of health care-associated infections.

The priorities and recommendations in the JEE were translated into the 5 year IHR-GHSA National Action Plan through a comprehensive consultative process through One Health approach. This NAP was presented and endorsed by the Government/ Ministry of National Health Services Regulations & Coordination in the national workshop conducted on 1st December 2016 which was chaired by the Minister of Health with representation of all sectors from provincial and regional governments.

The commitment and mutual consensus of the federal and provincial governments and federating areas was apparent throughout the assessment. This engagement between federal and provincial governments facilitated confidence building and coordination, which will contribute and create opportunities for development of an equitable system of health care for the population of Pakistan.

3. National Action Plan for Health Security

The National Action Plan for Health Security takes its guidance from the National Health Vision 2016-2025 of Pakistan. Further, it cues from the intention of the Government of Pakistan to fulfil its commitments with the international community. Additionally the plan takes due consideration and linkage with provincial and regional health sector strategic policy frameworks.

3.1 Vision

A resilient nation able to prevent, promptly detect and effectively respond to public health threats to protect population health (Human and animal and environment) and mitigate against negative impacts on the economy.

3.2 Mission

To attain and be able to sustain IHR (2005) core capacities to protect all Pakistanis from public health events of national and international concern.

3.3 Goals

To reduce morbidity, mortality, disability and socio-economic disruptions due to public health threats in the context of SDGs and Universal Health Coverage through a responsive and resilient health system.

3.4 Objectives

1) To strengthen and sustain national capacity to prevent, detect and respond to outbreaks and other public health events and emergencies of national and international concern;
2) To align IHR activities through the “One Health approach” in the broader context of health system strengthening;
3) To map existing domestic and external financing to support the implementation of the national action plan;

4) To strengthen institutional and coordination frameworks to enable compliance with IHR and Health Security under One Health approach.

3.5 Guiding Principles & Core Values

1) **Country ownership and leadership** with the government coordinating between federal and provincial levels to ensure alignment of activities with national policies and priorities;
2) **Fostering Inter-sectoral collaboration** at all administrative levels between human health, animal health, and the environment using the "One health Approach";
3) **Strengthening partnerships** across all stakeholders in the public and private domain including research and academic institutions;
4) **Cross border collaboration** between countries, regional and sub-regional level for timely information sharing and coordination of IHR interventions;
5) **Community participation** with the involvement of communities, civil society and the private sector;
6) **Evidence-based approach** taking into account emerging disease trends, risks and health status of communities for developing policy advice on IHR;
7) **Transparency & accountability** for openness and willingness to promote and share information for enabling rapid response;
8) **Equity in access to services** with focus on highly vulnerable population groups and under-served areas;
9) **Gender and human rights principles** that ensure incorporation of gender equity and human rights perspectives into policies and programmes.

4. Development of National Action Plan for Health Security

4.1 Key Approach

A fully consultative approach was adopted for the development an all-inclusive National Action Plan for Health Security (NAPHS). The relevant ministries at the federal level, provincial departments and other relevant stakeholders were fully engaged in this consultative process (**Table 5**). Given the above fully consultative process adopted NAPHS addresses heterogeneity between/within provinces and FATA in terms of vulnerability, socio-economic status, health service delivery and context. The plan ensures inclusive health security and prosperity for all citizens of Pakistan and beyond. Thus the plan is inclusive of the consideration for resource mobilisation, allocation and cooperation.

TABLE 5: MULTI-SECTORAL CONSULTATION: KEY STAKEHOLDERS

National Ministries	Provincial Line Departments (All Provinces/Region)
1. **National Health Services, Regulations & Coordination** a) Central Health Establishments b) National Institute of Health ▪ Nutrition ▪ Field Epidemiology & Surveillance Department ▪ Public Health Laboratory Division ▪ Field Epidemiology Lab Training Program c) Expanded Programme on Immunization	1. Department of Health 2. Department of Planning 3. Department of Finance 4. Department of Livestock & Dairy Development 5. Department of Food 6. Department of Environment 7. Department of Agriculture 8. Department of Forestry wildlife and Fisheries 9. Department of Law 10. Department of industries and commerce

d) National Health Emergency Preparedness and Response Network e) National of TB control programs f) National AIDs control program g) Directorate of Malaria Control h) Polio Eradication Initiative i) Health Service Academy 2. **National Food Security & Research** a) National Agricultural Research Council b) Pakistan Agricultural Research Council c) National Veterinary Laboratory 3. **Climate Change** 4. **Finance** 5. **Planning, Development and Reforms** 6. **Civil Aviation Division** 7. **Economic Affairs Division** 8. **Law & Justice** 9. **Industries and Commerce** 10. **Defence** a) Pakistan Nuclear Regulatory Authority b) Strategic Planning Division 11. **National Disaster Management Authority**	11. Provincial Disaster Management Authority 12. Provincial Food Authority **Health Development Partners** 1. WHO 2. USAID 3. UNICEF 4. DFID 5. PHE 6. CDC 7. JSI 8. World Bank 9. FAO

After completing JEE from 27th April to 6th May 2016, a comprehensive report was shared on the existing situation and recommendations for strengthening the IHR-GHSA core capacities in Pakistan.

The development of 5 Year National Action Plan for Health Security commenced with formulation of a technical working group (TWG) by the M/o NHSR&C **(Annex 5**). An extensive and comprehensive process was then undertaken with involvement and participation of area relevant technical experts and focal persons from Health and other sectors at the Federal and Provincial/ Federating Areas. The process and steps for consultation, development and finalization of 5 year NAP is summarized as follows:

- Template received from WHO;
- ZERO draft derived from JEE Report, Draft GHSA Action Plan and OIE PVS assessment report;
- Targets of report converted into GOALS for each Technical Area;
- Recommendations for Priority Actions & Indicators converted into objectives;
- Recommendations for Priority Actions & Areas which need strengthening / Challenges into key activities;
- Orientation of the Provincial/Regional IHR focal persons on Zero draft to start discussions with their relevant departments was conducted on 8th September 2016;
- One technical national consultation from 26-28 Sep 2016 was held for consensus on the methodology for IHR NAP goal, objective and target and main activity area setting (in the zero draft);
- Provincial consultative meetings were planned for development of the Provincial/Regional 5 year IHR Action Plans (sub activities under each main activity of the Zero draft);
- The template was converted into excel spread sheets from word document;
- A series of five provincial/ regional consultative workshops for development of provincial and regional plans were conducted with the involvement of relevant stakeholders at each level.

Table 6: Schedule of Provincial & Regional Consultative Meetings & Workshops

Provincial & Regional Consultations		
Area /Provinces	**Dates**	**Venue**
Khyber Pakhtunkhwa	20th – 21th Oct 2016	Peshawar
Sindh	26th – 27th Oct 2016	Karachi
Baluchistan	31st Oct – 1st Nov 2016	Quetta
AJK/GB/FATA/ICT	3rd – 4th Nov 2016	Islamabad
Punjab	9th – 10th Nov 2016	Lahore

The National Action Plan development for each technical area included defining the goal, objective setting with broad activity areas derived from the targets, priorities and recommendations, indicators and identified areas of strengthening in the JEE report, National Health Vision, draft AMR framework and OIE PVS assessment report. The action plan has focused on ensuring the development competent health systems for implementation of IHR in Pakistan in line with the One Health Approach. It is also aligned with the ongoing relevant initiatives in the government sector as well as activities being supported through HDPs.

This development process is depicted in a diagrammatic format given below (Figure 6):

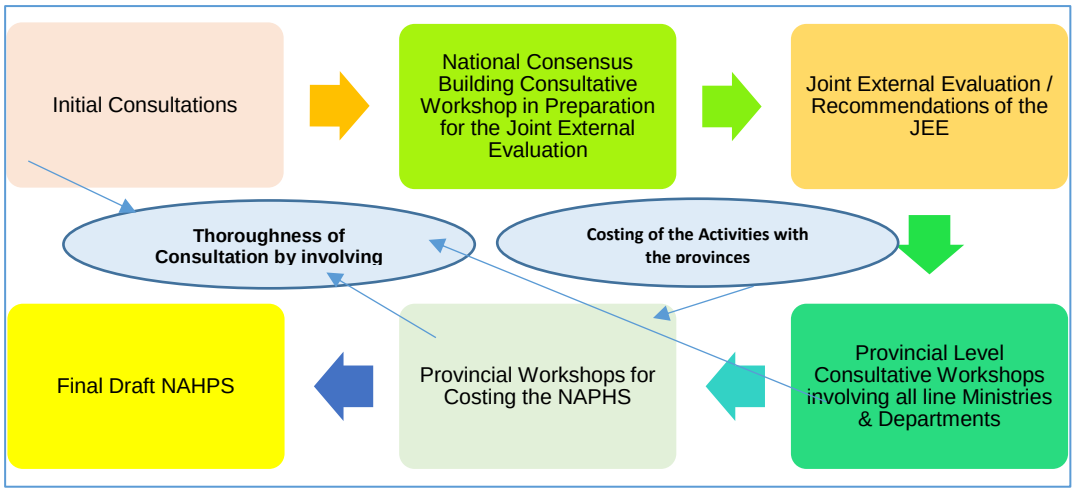


FIGURE 6: NAPHS DEVELOPMENT PROCESS

4.2 Pakistan National Consultative Meeting

The National Consultative meeting was held in Islamabad from 30th November to 1st December 2016 for final review and endorsement of 5 Year National Action Plan for Health Security with participation of all relevant stakeholders in the context of One Health and multi-sectorial approaches. The workshop also initiated the discussion on cost drivers for commencement of costing exercise by determining the financial resource allocation according to domestic & external financing **(Annex 6)**.

Over 70 participants attended the consultative meeting organised by the Ministry of National Health Services Regulations & Coordination with the support of WHO from 30th November to 1st December 2016. The Secretary and Director General Health, M/o NHSR&C graced the inaugural session which was co-chaired by WHO and OIE delegates in Pakistan. Provincial Director Generals of relevant departments, important line ministries such PD&R Division, Ministry of Finance, Ministry of National Food Security and

Research, Ministry of Law and Justice, Ministry of Climate Change, Ministry of Foreign Affairs, Ministry of Commerce, Ministry of Industries and Production, Ministry of Port & Shipping, Ministry of Federal Education and Professional Training, Ministry of Interior and Narcotic Control, GHQ & Strategic Planning Division, Pakistan Nuclear Regulatory Authority, Pakistan Atomic Energy Commission, Civil Aviation, NDMA.

The workshop also reiterated the commitment of the Gov. of Pakistan to strengthen health security, and the importance of for national financing for sustainability in IHR implementation. The meeting further emphasised strong country ownership, WHO leadership and active partnership to develop and implement the 5 Year National Action Plan for Health Security for building resilient health systems in Pakistan.

It was emphasized that the 5 Year National Action Plan for Health Security will serve as the coordination platform to map and ensure interplay between multiple sectors and other existing plans at all administrative levels of the country. The M/o NHSR&C, along with relevant Provincial Departments will be the custodian of the plan for providing close coordination and collaboration for implementation. The Multi-sectoral National IHR Taskforce with representation of all the relevant stakeholders will be responsible to provide oversight on the plan, and monitor and evaluate its implementation.

4.3 Costing of the National Action Plan for Health Security

The mechanism of costing for the NAP Pakistan was unique due to the devolved health setup in Pakistan. Detailed meetings were conducted with federal, provincial and regional stakeholders for each of the 19 technical areas. A prioritization exercise based on a set agreed technical, financial and political criteria was undertaken to underpin the plan, and to ensure its timely, sequential and progressive implementation. The exercise took into consideration the current process status at the provincial/regional level and the existent capacities and the available resources (man, money & material). The activities under each specific technical area identified and included participation of wider sectors (**Table 5)** under One Health sector-wide development approach.

The planned major activities in each technical area of the IHR NAP was discussed and detailed into sub-activities to enable costing in consultation with the regional and provincial departments. The major cost categories included: technical assistance; trainings, meetings, workshops; equipment cost; HR cost; civil works & infrastructure and M&E related cost. An excel sheet with unit cost tables was generated for each component of each activity (**Table 7**). Subsequent collation of the costing exercise yielded the complete costing of the entire NAP **(Annex 7 - 9).**

It is pertinent to note that such a multi-sectoral activity has never before been attempted in Pakistan and the ground breaking approach was appreciated as a case study for regional countries by the WHO's Independent Oversight & Advisory Committee (IOAC).

> '*Strong country ownership, cross-government working, and engagement of multiple sectors are key to the success of JEE and NAP. Pakistan could be considered a case study for excellence in high-level political leadership, engagement with the local authorities and multiple sectors, and ownership of the provincial governments. It would be helpful to share best practices and learn from Pakistan's experience with the JEE and NAP' (Conclusion: IOAC Report 2017).*

Costing of NAPHS: The Process

- A series of eight consultative meetings with provincial/regional relevant stakeholders were conducted from Jan- June 2017 to acquire the costing requirements against each sub activity of the 19 technical areas;
- The costing requirements were then budgeted according to the prevailing rules and regulations of the Government of Pakistan for the cost components (such salaries, per-diems, plinth area cost etc.);
- The cost and costing requirements were fed into the NAP for a comprehensive document and shared for review and feedback of the relevant officials in the Provinces and Regions;
- The funding requirements have been segregated into domestic and external resources. In principle the recurrent and development cost incurred will be borne by the Government while support for funding gaps, if any, will be sought from partners (bilateral/multilateral).

After compilation of the costed 5 year National Action Plan, a final review was undertaken by the technical working group for IHR NAP development led by ED NIH and Director Programs (Mo NHSRC). The relevant experts for some technical areas were invited for this exercise (EPI, NARC, CHE, WHO, Lab division, Field Epidemiology division etc.). The experts reviewed in detail each and every activity of their relevant technical area for each province and region, including attempting to rationalize the cost. It was also decided that the federal counterparts for each relevant technical area will coordinate with the provincial/regional offices to share the draft costed IHR NAP for final review and respond to the clarifications sought by the federal team.

The document after final review was compiled for sharing with and endorsement of the provincial/regional governments before final submission to the M/o NHSR&C. The completed costed plan was presented to the Pakistan Health & Population Interagency Coordination Consortium in August 2017 **(Annex 10).** The final costed plan was formally endorsed in the 1st meeting of the Multisectoral National IHR Taskforce held on 20th February 2018.

The cost summarized according to the thematic areas is tabulated below:

TABLE 7: TOTAL COSTS BY CATEGORY

Total Cost	PREVENT	DETECT	RESPOND	OTHERS
PKR Million	**59755.91158**	**27233.17504**	**10596.35076**	**9965.9112**
USD Million	**516.29**	**235.29**	**91.55**	**86.11**
Note: The National Action Plan for Health Security is perceived as a living document and its target activities / costs are expected to change during the implementation period. .				

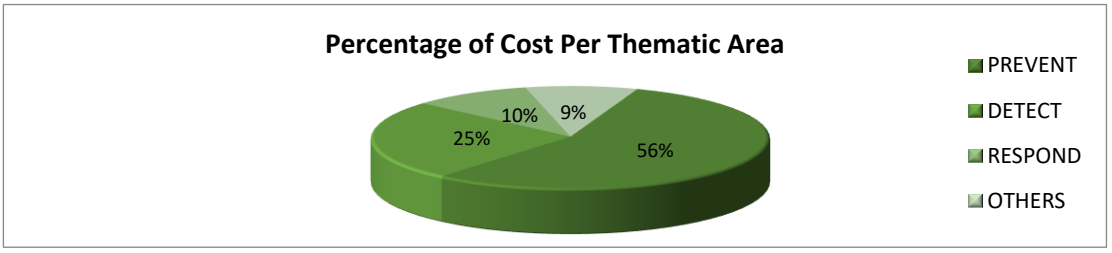


FIGURE 7: TOTAL COSTS BY CATEGORY

5. Implementation Arrangements

There is consensus that the Ministry of National Health Services, Regulation & Coordination will provide stewardship and coordination oversight for implementation of the NAPHS, for which the following steps have been taken:

- The National IHR Taskforce was revised to include multi-sectoral participation **(Annex 12);** this taskforce will be responsible for overall coordination at strategic level and will be responsible for monitoring and reporting of this plan.
- National Institute of Health (NIH) as the notified IHR focal point will take lead in implementation of JEE technical areas like surveillance & response; public health labs network; Emergency Operations Centre (EOC); biosafety & biosecurity; health workforce development for IHR; AMR, etc. Therefore, NIH has initiated steps for attaining the status of NPHI;
- Notification of Provincial IHR Taskforces;
- Notification of IHR FP in health and other sectors at federal and provincial level (One Health Stakeholders);
- Communication to the Chief Secretaries of each province for inter-sectoral coordination and resource allocation;
- Development of PC1s for key prioritised technical areas (IDSR; AMR; POE; NPHI);

6. Supervision, Monitoring and Evaluation

1) Monitoring and evaluating the progress of national action plan towards attainment of the targets will be undertaken on a systematic and regular basis;
2) Data will be collected through surveillance systems in human and animal health, annual reviews/assessments and reporting, after action reviews, exercises and simulations and joint external evaluations and other relevant assessments like the PVS, as well as periodic supervision and facility based surveys/assessments. In addition mid-term reviews will be conducted to assess interim progress; and a final programme review will be undertaken before development of the next action plan.
3) Building sustainable capacity at all levels-national, local governments, the private sector, facilities and communities to carry out supervision, monitoring and evaluation of IHR core capacity building is important. For some technical areas, there will be a need to reconceptualise and re-organise the managerial and support mechanisms and structures at national, provincial and district levels, including defining a clear supervisory mechanism, roles of the various decentralized entities.
4) Recruitment and deployment of the required human resources for health security and one health at all levels. In addition, it will be critical to ensure the utilization and dissemination of information to all stakeholders for purposes of improving management, sharing experiences, upholding transparency and accountability.
5) A harmonised and coordinated framework for supervision, monitoring and evaluation in order to generate data for decision making, programme development, resource allocation and management at all levels and among all stakeholders is envisaged to be developed in due course. However, a result based monitoring indicator matrix is placed at **Annex 13.**
6) Strategies:
    a) Periodic supervision to ensure activities are implemented according to target. These activities will be integrated in to the routine quarterly supervision schedules within

respective sectors. The supervision will be carried at all levels; starting from the National level i.e. Ministry, down to provincial and district levels.

b) Monitoring and evaluation of the surveillance systems in human and animal health Routine health information systems (HMIS), well-functioning integrated disease surveillance and response system (IDSR) and good zoonotic and animal surveillance systems enable the monitoring of financing, the establishment of IHR core capacities and the trends in priority diseases, conditions and events. Improving the performance of the HIMS, the IDSR, zoonotic and animal surveillance systems. Monitoring the surveillance systems themselves will identify weaknesses so as to enable actions to be taken to improve the surveillance systems, under the IDSR technical guidelines, and Veterinary Act, No 16, 2003 which guides surveillance of zoonotic diseases (2010).

c) Annual assessments and reporting on the annual International Health Regulations (2005) Monitoring tool questionnaire to fulfil the obligation of Member States and the WHO Secretariat to report annually to the World Health Assembly on the implementation of IHR (2005).

d) Reviews: under the IHR Review Committee (WHA 68/22 Add.1) there is a need to move towards a more action-oriented approach to periodic evaluation of functional capacities. The management of public health events reflects the functionality of national core capacity and of the readiness of the alert and response system. The outbreak of Ebola virus disease outbreak tested the capacity against the information shared by Member States in the annual reporting questionnaire. It is imperative to complement the annual reporting tool by reviewing a real-life experience of a public health event, which can offer an opportunity to learn lessons and identify opportunities for improvement. This plan will support after action review using the methodology proposed by WHO.

e) Simulations/exercises: The IHR Review Committee (WHA 68/22 Add.1) recommended need for moving towards a more action-oriented approach to periodic evaluation of functional capacities. In addition to annual reporting, the IHR Monitoring and Evaluation Framework post 2015 (IHRMEF post 2015), recommends that when there is no suitable public health event(s) to review, exercises can serve as an alternative for testing the functioning of IHR core capacities. These will be more suitable for rather rare events such as chemical and radio-nuclear events, or when there is a need to test the performance of a particular subnational level, because it has not been included in an after action review for a long period of time, or any other particular reason, such as the change of structure or the introduction of new plans, etc. This plan will support the conduct of exercises and simulations as per the guidance provided in the IHRMEF post 2015.

f) Joint External Evaluations (JEE) During 2015, WHO developed the JEE tool based on existing tools, including: the IHR monitoring questionnaires, the Global Health Security Agenda (GHSA) assessment tools and the path way for veterinary services developed by the Food and Agriculture Organization and the Organization for Animal health (OIE). JEEs are an important component of the post 2015 IHR supervision monitoring and evaluation framework because they provide an objective basis for the development of national action plans for health security.

ANNEX 1: RC RESOLUTION EM/RC62/R.3 OCTOBER 2015

Resolution

REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN — **EM/RC62/R.3 October 2015**

Sixty-second Session
Agenda item 4(c)

Assessment and monitoring of the implementation of the International Health Regulations (2005)

The Regional Committee,

Having reviewed the progress report on national core capacities for implementation of the International Health Regulations (2005)[1] and the technical paper on assessment and monitoring of the implementation of the International Health Regulations (2005)[2];

Recalling World Health Assembly resolutions WHA61.2 on implementation of the International Health Regulations (2005) and WHA68.5 on the recommendations of the Review Committee on second extensions for establishing national public health capacities and on IHR Implementation; and Regional Committee resolution EM/RC61/R.2 on global health security: challenges and opportunities with special emphasis on the International Health Regulations (2005);

Recognizing that Member States are collectively accountable for protecting global health in accordance with the International Health Regulations (2005) and that the assessments of preparedness for Ebola virus disease conducted in the Region exposed considerable gaps in the capacities of countries with regard to effective monitoring and detection of, and response to, emerging health threats;

1. **ESTABLISHES** an independent regional assessment commission comprising experts from States Parties of the Region and WHO to assess implementation of the International Health Regulations (2005) in the Region and to advise Member States on issues relating to implementation of the national core capacities required under the Regulations;

2. **URGES** Member States to conduct objective assessment of implementation of the International Health Regulations with WHO support and report annually to the regional assessment commission on progress in implementing the regulations, using a harmonized tool and standardized methodology;

3. **REQUESTS** the Regional Director to:

   3.1 Establish terms of reference for the regional assessment commission and organize the first meeting of the commission before the end of 2015;

[1] EM/RC62/INF.Doc.4
[2] EM/RC62/Tech.Disc.2

3.2 Establish a regional task force to harmonize the existing tools for assessment of implementation of the International Health Regulations, including the global health security agenda assessment tool.

4. **REQUESTS** the Regional Assessment Commission to report to the Regional Committee on the status of implementation of the International Health Regulations (2005) annually through the Regional Director.

ANNEX 2: REQUEST LETTER TO WHO FOR JOINT EXTERNAL EVALUATION

Government of Pakistan
Ministry of National Health Services Regulations & Coordination
LG&RD Complex, G-5/2, Islamabad
*****

No. F.8-71/2015-GHSA-DD(P) Islamabad, the 10th February, 2016

SAY NO TO CORRUPTION

Subject: **JOINT IHR AND GHSA ASSESSMENT IN PAKISTAN**

Dear Dr. Ala Alwan

In response to the exponential increase in international travel and trade, and emergence and reemergence of international disease threats and other health risks, countries across the globe have agreed to accelerate progress toward a world safe and secure from infectious disease threats; to promote global health security(GHSA) as an international priority; and to spur progress toward full implementation of the World Health Organization (WHO) International Health Regulations 2005 (IHR), the World Organization for Animal Health (OIE) Performance of Veterinary Services (PVS) pathway, and other relevant global health security frameworks.

2. Pakistan being the signatory of the IHR 2005 is fully cognizant of the fact that all state parties are required to develop certain minimum core public health capacities including detection, identification and response to the public health events, potential hazards and to strengthen core surveillance and response capacities at the primary, intermediate and national level, at all Points of Entries. In view of the importance of putting in place the institutional mechanism for IHR implementation, the Ministry of National Health Services Regulations and Coordination (NHSRC) has designated the National Institute of Health as the National Focal Point (NFP) for IHR and Health Planning System Strengthening and Information Analysis Unit in the Ministry as NFP for GHSA. The Ministry of NHSRC is fulfilling its constitutional obligation by interacting with world health community on IHR implementation and Global Health Security agenda as well as coordinating with provincial departments of health in taking forward IHR implementation process. However Pakistan is facing many challenges in full implementation of IHR and GHSA

3. Keeping this global and regional situation in view, and subsequent to the recommendations of series of mission of WHO regarding the IHR 2005 implementation of Pakistan including the Ebola Assessment mission, and commitment Government of Pakistan in the Regional Committee held in Kuwait in 2015 (EM/RC62/R.3), Ministry would like to request WHO and CDC for joint assessment of IHR / GHSA in Pakistan to identify gaps and future needs of the public health sector to implement IHR 2005 as a responsible member state.

(Dr Asad Hafeez)
Director General Health
+92-51-9245933

Dr. Ala Alwan
Regional Director,
Eastern Mediterranean Region Office, WHO,
Cairo, Egypt

Cc

1. Dr. Thomas R. Frieden, Director of the U.S. Centers for Disease Control and Prevention (CDC) and Acting Administrator of the Agency for Toxic Substances and Disease Registry (ATSDR), Atlanta, USA
2. Dr. Michael J.J.Thieren, WHO representative , WHO country office Pakistan, Islamabad

ANNEX 3: LIST OF MEMBERS OF JEE MISSION TO PAKISTAN

Team Leads (Joint Leadership)

No.	Name	Title/Affiliation	City, Country	Email Address
1.	**Brian McCloskey**	Director of Global Health, Public Health England	London, UK	Brian.McCloskey@phe.gov.uk
2.	**Mika Salminen**	Director, Professor, Department of Infectious Disease, Finish National Institute for Health and Welfare	Helsinki, Finland	mika.salminen@thl.fi
3.	**Karen Sliter**	Regional Manager for Europe, Africa and the Middle East International Services, APHIS, USDA, US Mission to the European Union, Brussels, Belgium	USA	karen.sliter@aphis.usda.gov

Team Members

No.	Ares to be covered	Name	Title/Affiliation	City, Country	Email Address
4	**IHR Coordination and Communication**	Nirmal Kandel	Technical Officer, IHR capacity assessment, Development and Maintenance, WHO HQ	Nepal, Based in Geneva, Switzerland	kandeln@who.int
5	**Medical Countermeasures and Personnel Deployment**	Irshad Shaikh	Regional Advisor, Epidemiology Surveillance and IHR, WHO EMRO	Cairo, Egypt	shaikhi@who.int
6	**Observer & process oversight**	Thomas Hofmann	IHR Coordinator, Preparedness & response to emergencies and health conditions, WHO EURO	Copenhagen , Denmark	hofmannt@who.int
7	**Immunization and Coordination/Lining Public Health and Security**	Hamid Jafari	Senior Advisor, Global Health Security Agenda, Division of Global Health Protection, Centers for Disease Control and Prevention	Atlanta, USA	hsj0@cdc.gov
8	**Risk Communications**	Christina Banluta	Technical Officer, Pandemic and Epidemic Diseases, WHO EMRO	Cairo, Egypt	banlutac@who.int
9	**Legislation, Policy and Finance**	Michele Forzley	Public Health Legal advisor, Forzley & Associates	Washington DC, USA	mforzley@comcast.net
		Kleio Stoidou	Independent Public Health Legal advisor	Athens, Greece	cliostoidis@gmail.com

10	**Antimicrobial Resistance and Infection Control**	Abdullah Assiri	Assistant Deputy Minster, Preventive Health, Ministry of Health	Riyadh, Saudi Arabia	AbdullahM.Asiri@moh.gov.sa
11	**Zoonosis**	Ghazi Kayali	Chief Executive Officer, Human Link	Beirut, Lebanon	ghazi@human-link.org
12	**Food Safety**	Sareen Shashi	Senior Regional Food Safety Officer, FAO Regional Office for Asia and the Pacific	Bangkok, Thailand	Shashi.Sareen@fao.org
13	**Surveillance & Reporting**	Mika Salminen	Director, Professor, Department of Infectious Disease, Finish National Institute for Health and Welfare	Helsinki, Finland	mika.salminen@thl.fi
14	**Preparedness and Emergency Response Operations**	Khalid Abu Haimed	Consultant Emergency Medicine, Pre Hospital Care, Mass Gathering and Disaster Management, Ministry of Health, Saudi Arabia	Riyadh, Saudi Arabia	Khalid.abuhaimed@kfsh.med.sa
15	**Points of Entry**	Mohammed Moussif	Head of Public Health Department, Moahmmed V Airport, Casablanca, Morocco	Rabat, Morocco	moussifmohamed@gmail.com
16	**Chemical Events**	Sohel Saikat	Principal Environmental Public Health Scientist, Centre for Radiation, Chemical and Environmental Hazards (CRCE), Public Health England	London, UK	Sohel.Saikat@phe.gov.uk
17	**Radiation Emergencies**	Wael Khouly	Professor of Medical protection of Radiation Effects, Supervisor of Safety Sector of Radioactive Sources & Radiation Facilities, Egyptian Nuclear & Radiological Regulatory Authority (ENRRA)	Cairo, Egypt	wael.elkhouly17@yahoo.com
18	**Laboratory**	Wayne Dimech	General Manager, National Reference Laboratory, Australia.	Melbourne, Australia	wayne@nrl.gov.au
19	**Workforce Development**	Kashef Ijaz	Deputy Principal Director, Centre for Global Health, Division of Global Health Protection, Centers for Disease Control and Prevention	Atlanta, USA	kil6@cdc.gov

ANNEX 4: AGENDA OF JEE MISSION

Time	Agenda Item	Facilitator	Venue
25th April	Arrival of the Mission		
26th April	Orientation Training of JEE Assessment Team		WHO Country Office NIH Chak Shehzad
27th April	**Day 1: Introductory Meeting with M/o NHSR&C**		
Meeting with Ministry of NHSR&C & Other Stakeholders:			
9:30 am	Introduction	Dr. Malik Safi, Director Programs	Committee Room Ministry of National Health Services Regulations & Coordination (NHSR&C)
9:40 am	Welcome Remarks	Mr. Muhammad Ayub Sheikh, Secretary Mo NHSR&C	
9:50 am	Mission Objectives & Expected Outcomes	Dr. Assad Hafeez, Director General Health	
10:00 am	Remarks by JEE Mission	Dr. Brian McCloskey JEE Mission Lead	
10:15 am	Remarks by WR, WHO Country	Dr. Michel Thieren, WR	
10:30 am	Overview of Health Sector in the Post Devolution Context	Dr. Sabeen Afzal, Deputy Director Programs	
11:00 am 03:00 pm	Pakistan Current Status: Self Reporting & Feedback on JEE Assessment Tool With Discussion	Dr. Malik Safi, Director Programs Country Team & Mission Members	
	Working Lunch		
Mission Team Visit to National EOC, EPI Warehouse			
4:00 pm	Meeting & Briefing	Dr. Rana Safdar, National EOC Coordinator	Federal EPI Building
4:30 pm	Meeting & Briefing	Dr. Saqlain Gillani, NPM Federal EPI	
28th April	**Day 2: Technical Meetings**		
Consultation with Federal Stakeholders			
10:00 am	National Legislation & Policy	Dr. Michele Forzele Ms. Clio Stoidou Mr. Khashi Ur Rehman, Additional Draftsman, Ministry of Law & Justice Dr. Sabeen Afzal Mo/NHSRC	Mo Law & Justice S Block , Pak Secretariat
10:45 am	Chemical Events	Dr. Sohel Saikat Mr. Irfan Tariq , DG Climate Change, Mo Climate Change,	Mo Climate Change, LG&RD Plaza 4th Floor,

		Dr. Jamal Nasir Focal Person/ Dr. Faheem Tahir, Environmental Health	G 5/2 Islamabad
11:30 am	Radiation Emergencies	Dr. Wael Khouli Brig Amer Ikram Dr. Ameena Bano Dr. Tahir Kazmi, Pakistan Atomic Energy Commission Mr. Rana Iftikhar, Principal Scientist, Chashma NPP Dr. Jamil Ahmed Ansari NIH Dr.Farah Sabih WHO	Committee Mo NHSR&C / PNRA Islamabad
11:30am	Food Safety	Dr. Sareen Shashi Syed Moazzam Ali, Joint Secretary, Ministry of Food Security Dr. Mumtaz Ali Khan FEDSD NIH	Ministry of Food Security B-Bloch Pak Secretariat , Islamabad
11:30am	Meeting with KPK & Balochistan EPI Program Managers	Dr. Hamid Jafri Dr. Kashef Ejaz Dr. Saqlain Gillani NPM Dr. Quamrul Hasan, WHO	Federal EPI Building Chak Shehzad, Islamabad
28th April		**Day 2: Federal Site Visits**	
10 am --- 12:00 am Noon	National Institute of Health (Virology Lab; Federal Disease Surveillance Response Unit; Federal Epidemiology Lab Training Program; Bio Safety Lab3	Dr. Wayne Dimech Dr. Farnaz Malik, ED NIH Dr Arshad Mumtaz Chief PHLD NIH Dr. Sohail Zaidi, Principal Virologist, NIH Dr. M Salman, National IHR / AMR Focal Point, NIH Dr. Uzma Bashir, Virologist	NIH, Chak Shehzad, Islamabad
10 am - 12:00 am Noon	TB Surveillance Lab	Dr. Mika Salminen Dr. A Khalique Ghauri, SPO, NTP Dr. Sabira Tehseen NTP	Federal Government Hospital, Chak Shehzad, Islamabad
10 am- 11.00 am	Directorate CHE	Khalid Abu Hamaid Dr. Nasir Mohi Uddin, Director CHE Dr. Irfan Tahir Airport Health Officer Dr. Jamil Ansari NIH	NHEPRN Building, NIH, Chak Shehzad, Islamabad
11 am - 12:00 am Noon	NHEPRN	Khalid Abu Hamaid DG NEPHRN Dr. Munir Ahmed Mangrio, Dr. Attyia	NHEPRN Building, NIH, Chak Shehzad, Islamabad

		Dr. Jamil Ansari NIH Dr. Samra Mazhar	
12:30 – 02:00 pm	National Disaster Management Authority (NDMA)	Khalid Abu Hamaid Chairman, NDMA DG NEPHRN Dr. Munir Ahmed Mangrio Dr. Jamil Ansari NIH Dr. Samra Mazhar	NDMA Office, PM Secretariat, Islamabad
29th April	**Day 3: Meeting with Federating Areas (AJ&K, FATA, GB)**		
9:30 am – 11:30 am	Meeting with Federating area (ICT, FATA, AJK, GB)	JEE Team	M/o NHSR & C
11.30 am-12.30 pm	Demonstration of Dashboard: Pakistan Health Information System	JEE Team Dr. Ahsan Ahmed Epidemiologist	Health Planning System Strengthening & Information Analysis Unit, Mo NHSR&C
30th April	**Day 4: JEE Members Internal Discussion**		
10.00 am-3.00 pm	Internal Deliberations Review and Planning of Provincial Visits	Focal Point GHSA/Country Planning Team, JEE Mission Team	WHO Country Office, NIH
1st May	**Day 5: Travel of Technical Teams to Provinces**		
2nd May	**Day 6: Site Visits-Federal team of Mission**		
Time	Agenda Item	Facilitator	Venue
10:00 am – 4:00 pm	Food Security Grain Testing Lab Food & Poultry Processing Plant	Dr. Sareen Shashi Dr. Saeeda Raza, Food Quality Department NARC Dr. Sabeen Afzal Dr Farah Sabih	NARC Chak Shehzad Islamabad
3rd May	**Day 7: Site Visits- Federal team of Mission**		
10:00 am – 4:00 pm	Zoonosis National Agricultural Research Center (NARC)	Dr. Karen Silter Dr. Athar Abbas/ Dr. Naila Siddiqui, NARC Dr. Sabeen Afzal Dr. Farah Sabih	NARC Chak Shehzad Islamabad
	Animal Science Institute/ National Reference Lab for Poultry Diseases	Dr. Karen Silter Dr. M Azeem Khan, DG, NARC Dr. Sabeen Afzal Dr. Farah Sabih	NARC Chak Shehzad Islamabad
2nd & 3rd May	**Day 6 & 7: Provincial Meetings & Site Visits-Provincial team of Mission**		
10.00 am-4.00 pm	Meetings and Provincial Site Visits	Province Wise Details of JEE Teams	Annex A

4th May	**Day 8: Provincial Debriefing-Provincial team of Mission**		
Time	Agenda Item	Facilitator	Venue
9:30 am – 11:30 am	Debrief to Provincial Department of Health & Other Line Departments	JEE Team Member	Department of Health
2:00 pm	Travel back to Islamabad		
5th May	**Day 9: Collation & Consolidation of Assessment Feedback**		
9:30 am – 4:00 pm	Collation and Consolidation of JEE Assessment Report	JEE Team	WHO Country Office
7:00 pm	Dinner Hosted by M o NHSR&C		Venue to be decided
6th May	**Day 10: National Debrief**		
Time	Agenda Item	Facilitator	Venue
10:00 am – 1:00 pm	Mission Debrief to Country	Ministry of National Health Services Regulations & Coordination & Line Ministries & Other Partners	Committee Room Mo NHSR&C

PROVINCIAL TECHNICAL AREAS AND PROPOSED SITES

Punjab (Lahore)				
Technical Areas	IHR Coordination and Communication, Laboratory and Bio Safety and Bio Security, Surveillance, Zoonosis, POE, EOC			
Sites for Visit	Provincial IHR Focal Point, DSRU, IPH, University of Veterinary & Animal Sciences (UVAS), Lahore Airport, Wahga Border, Immunization, Shaikh Zayed Hospital (SZH) Sentinel Site, Mayo Hospital			
Dates:	**International Members**	**National Members**	**Primary Technical Area**	**Additional Area**
2nd-4th May	Ghazi Kayali	Safi Malik	Zoonosis (University of Veterinary & Animal Sciences; Livestock Department)	
	Mohammed Moussif	Jamshaid Ahmed Amna Saqib	POEs (Airport & Wahgah Border)	
	Abdullah Assiri	M Salman	Infection Control (Shaikh Zayed)	AMR (Shaikh Zayed Hospital)
	Wayne Dimech	M Salman	Labs (IPH Lab; Shaikh Zayed)	Biosafety Security (IPH Lab; Shaikh Zayed; Mayo Hospital)
	Christina Banluta	Asim Altaf	Risk Communication (Office of IHR Focal Point)	
	Hamid Jafari	Jawad Asghar	Immunization (EOC, EPI/ Lahore)	

	Kashif Ijaz	Jawad Asghar	Workforce Development (PDSRU)	Immunization (EOC, EPI/ Lahore)
Baluchistan (Quetta)				
Technical Areas	Zoonosis, Immunization, Surveillance, Preparedness, EOC, POE			
Sites for Visit	Livestock Laboratory; Public Health Lab Bolan Medical College (BMC), EOC, PDMA, Quetta Airport, PDSRU			
Dates:	**International Members**	**National Members**	**Primary Technical Area**	**Additional Area**
2nd-4th May	Irshad Shaikh	Uzma Bashir (Public Health Lab BMC and Livestock)	Epidemiology & Surveillance (DGHS; IHR Focal Point; PDSRU	POE (Quetta Airport)
	Nirmal Kandel Khalid Abu Hamaid	Daud Riaz	IHR Coordination (DGHS; IHR Focal Point) Preparedness & Emergency Response (PDMA;EOC)	Capacity Assessment Mass Gathering & Disaster Management (PDMA; EOC)
KP (Peshawar)				
Technical Areas	Zoonosis, IHR Coordination and Communication, Laboratory, Surveillance, Preparedness, Risk Communication			
Sites for Visit	Isolation Unit Hayatabad Medical Complex (HMC), Khyber Teaching Hospital (KTH); PDSRU/ IDSR, PDMA, Immunization Program, Livestock & Dairy Department; TB Provincial Reference Lab			
Dates:	International Members	National Members	Primary Technical Area	Additional Area
2nd-4th May	Thomas Hofmann	M Salman	IHR Coordination (DGHS, KP; FATA Secretariat; PDMA)	Preparedness & Response, Surveillance
	Wayne Dimech		Labs (HMC & KTH)	Biosafety Security (HMC & KTH)
	Christina Banluta	Irfan Shah	Risk Communication (DGHS; IHR Focal Point)	
	Ghazi Kayali	Jamal A Nasir	Zoonosis (Livestock & Dairy Development Department/ Assad Ali)	Zoonotic Surveillance(Livestock & Dairy Development Department
	Mika Salminen	Sardar Hayat	Surveillance & Reporting (PDSRU; IDSR)	Infectious Diseases
	Abdullah Assiri	M Salman	Infection Control, HMC	AMR, HMC
Sindh (Karachi)				
Technical Areas	Zoonosis, Food Safety, Laboratory and Bio Safety and Bio Security, Immunization, Surveillance, Workforce Development, EOC, Risk Communication, POE, Chemical Hazards			

Sites for Visit	JPMC (Poison Control Center), PDSRU, Immunization Program, EOC, Karachi Sea Port, Quarantine Facilities at Airport , Sindh Poultry Vaccine Production Center, Korangi			
Dates: **2nd-4th May**	**International Members**	**National Members**	**Primary Technical Area**	**Additional Area**
	Hamid Jafari & Kashif Ijaz	Saqlain Gillani	Immunization (EOC, EPI/ Karachi)	
	Mohammed Moussif	Jamil Ansari	POEs (Sea Port; Quarantine Facilities)	
	Sohel Saiket	Sara Salman Jamil Ansari	Chemical (JPMC, Poison Center)	
	Karen Sliter	Sara Salman	Zoonosis (Sindh Poultry Vaccine Production Center, Korangi)	
	Mika Salminen	Jamil Ansari Khalid Khan Laghari	PDSRU, Food Analysis Lab Hyderabad	Agricultural University Tando Jam

ANNEX 5: NOTIFICATION OF TECHNICAL WORKING GROUP FOR NAP

Government of Pakistan
Ministry of National Health Services Regulations & Coordination
LG&RD Complex, Sector G-5/2, Islamabad
*****

Islamabad, the 22nd August, 2016

NOTIFICATION

F. No.4-71/2015-GHSA (Vol-I) The Secretary, Ministry of National Health Services, Regulations and Coordination (NHS,R&C), Islamabad has been pleased to constitute a road map committee of Technical Working Group with the Ministry of NHSR&C, Islamabad in order to implement the recommendations received from provinces and regions on final Joint External Evolution Report with following composition and Terms of References:-

Composition:-

• Director HPSIU, Focal unit for IHR&GHSA	**Chairman**
• Deputy Director HPSIU, Focal unit for IHR&GHSA	Member/ Secretary
• Provincial / Area IHR Focal Persons	Member
• Representative of WHO	Member
• Representative of NIH	Member
• Representative of CDC	Member
• Representative of PHE	Member
• Representative of M/o Food Security	Member
• Any other Co-Opted Member	

ToRs:

- To prepare zero draft
- Review relevant document
- To engage provincial / national /regional/ stakeholders both health and non-health (One Health)

(Dr. Sabeen Afzal)
Deputy Director

Distribution:-

- All concerned.

Copy to:-

1. Sr. PS to Secretary, M/o NHS, R&C, Islamabad.
2. PS to DG Health, M/o NHS, R&C, Islamabad.

Annex 6: National Consultative Meeting for the Finalization of 5 Year National Action Plan for Health Security: Summary and Recommendations 30th Nov – 1st Dec 2016

National Consultative Meeting
Summary and Recommendations
The Finalization of 5 Year National Action Plan for Health Security
30 November - 1 December 2016; Islamabad

Context

The magnitude and frequency of disease outbreaks due to new emerging risks such as Zika, the expansion of known diseases like Cholera and Ebola with re-emergence of malaria, dengue and yellow fever and continuing outbreaks of cholera, measles, and rota virus pose a persistent challenge. The infectious diseases and other public health hazards and emergencies are often associated with high morbidity, mortality, and considerable socio-economic impact and demonstrate the urgent need for sustained preparedness and national capacity building in WHO Member States.

Pakistan along with all Member States has been a signatory to International Health Regulations (IHR) 2005 which calls for the countries to work together to prevent, detect and respond to public health emergencies under the IHR (2005). The signatory countries have also agreed to work towards Universal Health Coverage and to build resilient health systems which can adapt and respond to the challenges posed by outbreaks and other health hazards and emergencies of national and international concern.

WHO Member States had been following the practice of annual self-reporting for monitoring IHR implementation since 2007. The global threat of Ebola precipitated the need to review and revisit the practice of exclusive self–evaluation, resulting in development and subsequent endorsement of revised IHR Monitoring and Evaluation Framework (69th World Health Assembly) in 2015. The new approach was adopted by EMRO in October 2015 (62nd session of the WHO Regional Committee for the Eastern Mediterranean (EM) Region EM/RC62/R.3); and, in line with the recommendation of IHR Review Committee on Second Extensions in WHA 68/22 Add.1 (Ref: 62nd session of the WHO Regional Committee for the EM Region EM/RC62/R.3), the Government of Pakistan also adopted the new approach of Joint External Evaluation (JEE) for monitoring and assessment of IHR implementation.

Pakistan is the first country in the EM Region and fourth globally to volunteer for JEE. The Government of Pakistan under the overall lead of the Ministry of National Health Services Regulations & Coordination (NHSR&C) conducted the JEE from 27th April to 6th May 2016. The process included comprehensive collaboration between the Federal & Provincial/Federating Areas' involving both Health and non-Health Sectors. The evaluation of national IHR core capacities was derived from joint discussions between external experts and government peers/counterparts for the 19 technical areas in the JEE Tool.

The JEE results and recommended priority actions have guided Pakistan in developing the 5 Year National Action Plan for Health Security with the aim to establish a strong public health system to meet the standards for IHR core capacities.

The JEE was followed by strengthening and establishment of coordination mechanisms with National IHR Task Force re-designated as the National Multi-sectoral Taskforce for IHR (2005) and GHSA; nomination of focal persons from Federal non-Health Ministries; notification of HPSIU as

focal point for IHR-GHSA and counterpart notifications of Provincial IHR Task Force in four major provinces.

The development of Draft 5 Year National Action Plan for Health Security commenced with formulation of a technical working group (TWG) by the MoNHSRC. An extensive and comprehensive process was then undertaken with involvement and participation area relevant technical experts and focal persons from Health and nonHealth sector at the Federal & Provincial/ Federating Areas in six consultative workshops through Oct- Nov 2016. The draft 5 Year National Action Plan for Health Security defined the goal, objectives and key activities under each of the 19 technical areas.

Pakistan National Consultative Meeting

The main objectives of the consultative meeting were final endorsement of 5 Year National Action Plan for Health Security with alignment of all relevant stakeholders in the context of One Health and multi-sectorial approaches; commencement of costing exercise for determining the financial resource allocation through national and development partners mapping; define timelines and M&E framework for National Action Plan implementation; and, endorsement of national AMR framework

The National Action Plan development for each technical areas included defining the goal, objective setting with broad activity areas derived from the priorities and recommendations, indicators and identified areas of strengthening in the JEE Report, National Health Vision, Draft AMR Framework and OIE PVS Assessment report. The action plan has focused on ensuring the One Health Approach, and has been aligned with the ongoing relevant initiatives and activities within the government sector as well as through the various HDPs involved in and contributing to developing competent health systems for implementation of IHR in Pakistan.

Over 70 participants attended the consultative meeting organised by the Ministry of National Health Services Regulations & Coordination, Government of Pakistan from 30th Nov to 1st Dec 2016. The Secretary and Director General of MoNHSRC graced the inaugural session which was co- chaired by the WHO and OIE delegate in Pakistan. Provincial Director Generals of relevant departments, important line ministries such PD&R Division, Ministry of Finance, Ministry of National Food Security and Research, Ministry of Law and Justice, Ministry of Climate Change, Ministry of Foreign Affairs, Ministry of Commerce, Ministry of Industries and Production, Ministry of Port & Shipping, Ministry of Federal Education and Professional Training, Ministry of Interior and Narcotic Control, GHQ & Strategic Planning Division, Pakistan Nuclear Regulatory Authority, Pakistan Atomic Energy Commission, Civil Aviation, NDMA. The honourable Minister of NHSRC closed the workshop expressing her support for implementation of the action plan.

Representatives from UN agencies (WHO, FAO), and donors and other technical partners USAID, WB, CDC, DfID, PHE, JICA, also attended the meeting.

The meeting highlighted the commitment of the government of Pakistan to strengthen health security, and the important role of coordination between MoNHSRC, other line Ministries and provincial departments in national financing for sustainability in IHR implementation. The meeting further emphasised strong country ownership, WHO leadership and active partnership to develop and implement the 5 Year National Action Plan for Health Security for building resilient health systems in Pakistan.

The main outcome of the meeting was agreement on the 5 Year National Action Plan for Health Security, with key priorities and drivers identified for detailed costing, time lines, intra/inter-

linkages, performance indicators for a phased implementation. Funding gaps and potential funding sources were also identified, including domestic funding (public and private), potential donor investments and requisite resource availability.

The 5 Year National Action Plan for Health Security will be a coordination platform to map and ensure interplay between multiple sectors and other existing plans at all administrative levels of the country. The MoNHSR&C along with relevant Provincial Departments will be the custodian of the plan for providing close coordination and collaboration for implementation. The Multi-sectoral National IHR Taskforce with representation of all the relevant line ministries, and HDPs will be responsible to provide oversight on the plan, and monitor and evaluate its implementation.

Thee meeting was concluded with consensus of the Federal & respective Provincial Health and non-Health Departments, donors and technical partners on the 5 Year National Action Plan for Health Security as a reflection of solidarity and commitment to supporting and taking forward the national commitment of IHR implementation in Pakistan.

Recommendations

Government of Pakistan:

1. Formalize and ensure the functionality and oversight role of the National Multi-sectoral Taskforce for IHR encompassing GHSA. Establish and notify TWGs and Focal Points in the Health & Non Health Sectors through National Multi-sectoral Taskforce for IHR and GHSA;
2. Oversight and involvement of Inter-Ministerial Meeting for endorsement of National Action Plan for Health Security;
3. Identify any gaps in the legal framework and processes with One Health Approach and its institutionalization;
4. Strengthen coordination mechanisms between Health and non-Health sectors, Federal & Provincial Governments and collaboration with health development partners (HDPs) to jointly ensure advocacy and relevant capacity building for implementation of IHR core capacities;
5. Develop robust and transparent monitoring and evaluation mechanisms to ensure timely and effective implementation of planned activities and targets in the National Action Plan, regular reporting with documentation and sharing best practices;
6. Advocate with the political leadership, Finance and PD&R Division, Provincial P&D and Finance Departments for sustainable domestic financing and required allocation with equity for National Action Plan implementation;
7. Review the existing national and international funding investments and work plans such as Gavi, Global Fund, USAID, WB, etc. to align the activities and utilization of these funds to support activities in the National Action Plan.
8. Take steps to develop polio transition plan to support Health Security.

WHO and Health Development Partners:

1. Jointly support the Government of Pakistan in the implementation of the 5 Year National Action Plan for Health Security;

2. Advocate with Government for national and external financing and assistance for the national action plan;
3. Provide technical guidance to help harmonize the implementation of the various initiatives, plans and tools;
4. Support Multi-sectoral National Task Force for IHR encompassing GHSA for joint progress review of 5 Year National Action Plan for Health Security.

Next Steps

1. Finalize IHR National Action Plan for Health Security including an M&E framework December 16 / January 2017
2. Share 5 Year National Action Plan for Health Security for endorsement in the Inter-Ministerial meeting by December 16 /Jan 2017
3. Share the 5 year National Action Plan with Prime Minister (PM) & Chief Minster (CM) offices for their ownership and resources
4. Establish functional executive committees at Highest levels .i.e. PM/CM levels, for the oversight & implementation of the Plan - by January 2017;
5. Finalize the costed 5 Year National Action Plan for Health Security by end of March 2017 in consideration of;
    a. Refinement to include any modifications including review of prioritization
    b. Identify and complete sub-activities to enable costing
    c. Determine co-dependencies, complementarity/synergies between technical areas and activities for greater impact
    d. Realistic target setting for subsequent M&E
    e. Costing of the finalized plan
6. Presenting detailed costing of 5 Year National Action Plan for Health Security with health development partners for resource mobilization with SPP by April 2017;
7. Development of PC 1 at Federal & Provincial levels
8. Launching of 5 Year IHR National Action plan for Health Security by July 2017
9. Implementation of 5 Year National Action Plan for Health Security began July 2017

ANNEX 7: CONSOLIDATED SUMMARY OF TOTAL COST BY PRIORITY/FIELDS

S No.	Priority/Fields	Year I	Year II	Year III	Year IV	Year V	Total In PKR (In Million)	Total In Dollar (In Million)
1	**National Legislation, Policy and Financing**	187.47	90.78	50.78	38.01	38.01	405.04	**3.89**
2	**IHR Coordination**	193.29	193.40	164.15	164.15	163.04	878.03	**8.44**
3	**Antimicrobial Resistance (AMR)**	380.96	273.77	195.61	185.44	164.89	1200.68	**11.55**
4	**Zoonotic Diseases**	7396.40	1105.92	765.18	677.98	697.98	10643.47	**102.34**
5	**Food safety**	3105.21	1194.76	561.98	643.03	457.63	5962.61	**57.33**
6	**Biosafety& Biosecurity**	5415.09	1480.09	224.96	445.44	196.34	7761.93	**74.63**
7	**Immunization**	17698.60	3553.30	4465.90	3553.30	3565.90	32837.00	**315.74**
8	**National Laboratory System**	4150.75	919.46	830.56	826.86	800.98	7527.40	**72.38**
9	**Surveillance**	3814.99	1110.56	984.50	810.11	810.11	7530.27	**72.41**
10	**Reporting**	1126.06	169.72	166.72	165.72	166.72	1794.95	**17.26**
11	**Workforce Development**	10593.42	252.15	331.35	209.70	297.90	11684.54	**112.35**
12	**Preparedness**	5220.82	410.75	1244.13	271.15	1236.44	8383.29	**80.61**
13	**Emergency Response Operations**	305.23	160.35	299.50	130.43	268.64	1164.15	**11.19**
14	**Linking public health& security Agencies**	127.43	0.79	0.79	0.79	0.79	130.59	**1.26**
15	**Medical Countermeasures and Personnel Deployment**	**137.45**	**84.65**	**37.12**	**37.12**	**41.36**	**337.70**	**3.25**
16	**Risk Communication**	258.99	86.91	78.23	78.23	78.23	580.61	**5.58**
17	**Point of Entries (POEs)**	2490.16	354.54	322.45	224.63	225.63	3617.41	**34.78**
18	**Chemical Events**	8181.05	156.43	156.43	114.96	114.96	8723.84	**83.88**
19	**Radiation Emergencies**	38.43	16.03	18.43	16.03	18.43	107.33	**1.03**
	Total Cost	**70821.77**	**11614.38**	**10898.79**	**8593.10**	**9343.98**	**111270.81**	**1069.91**

NOTE: Costing takes guidance from annual reporting, JEE, AAR, SimEx, PVS, pandemic flu checklist and extensive provincial consultations with all relevant stakeholders.

ANNEX 8: CONSOLIDATED SUMMARY OF TOTAL COST BY PROVINCES/FEDERATING UNITS

S No.	Province/ Federating Unit	Year I	Year II	Year III	Year IV	Year V	Total In PKR (In Million)	Total In Dollar (In Million)
1	**Federal**	1714.127	881.444	763.536	589.997	533.509	4481.413	**43.090**
2	**KPK**	8912.365	2552.189	1569.121	1166.820	1383.795	15584.292	**149.849**
3	**Punjab**	8991.398	1494.767	1666.933	1309.133	1414.098	14876.330	**143.0416**
4	**Sindh**	7733.113	1433.231	1586.677	1213.198	1400.373	13366.593	**128.5249**
5	**Baluchistan**	11914.097	1583.116	1496.238	1242.062	1316.627	17552.141	**168.7706**
6	**Fata**	11356.669	1338.899	1319.807	1068.671	1143.236	16227.281	**156.0315**
7	**AJK**	10453.314	1169.270	1252.407	1005.777	1080.342	14961.109	**143.8568**
8	**GB**	9746.689	1161.460	1244.067	997.437	1072.002	14221.654	**136.7467**

ANNEX 9: GAP ANALYSIS

	Year 1 Estimated Cost	Year 2 Estimated Cost	Year 3 Estimated Cost	Year 4 Estimated Cost	Year 5 Estimated Cost	Total Cost PKR (In Million)	Total Cost Dollar (In Million)
Share of Government of Pakistan	13,452.06	4,749.20	5,446.15	4,607.22	4,595.73	32,850.37	362.06
Funding Gap	57,369.71	6,865.18	5,452.63	3,985.87	4,748.25	78,421.64	707.85
Total Cost	70821.77	11614.38	10898.79	8593.10	9343.98	111270.81	1069.91

ANNEX 10 MINUTES OF PAKISTAN HEALTH & POPULATION INTERAGENCY COORDINATION CONSORTIUM

PAKISTAN HEALTH AND POPULATION INTERAGENCY COORDINATION CONSORTIUM

MINUTES OF THE MEETING

Meeting of Pakistan Health and Population Interagency Coordination Consortium was held in committee room of M/o NHSR&C at 2:00 pm on 16th August, 2017. Director General Health, M/o NHSR&C chaired the meeting. Representative of EAD, P&D and Provincial Health and Population Department and Health Develop Partners including USAID, World Bank, DFID, DAFT, German Embassy, WFP, UNFPA, UNAIDS WHO and UNICEF participated in the meeting. List of participants is places at **Annex-I**

Agenda:

1. Progress of previous minutes
2. Sharing of WHO RC meeting dates
3. Plan of Government post FP2020
4. Sharing of Costed IHR-GHSA Action plan

Proceeding:

1. Review of previous minutes / Sustainable Development Goals

- Meeting started with recitation from Holy Quran followed by introduction of participants.
- All DHIS indicators have been reviewed for Sindh.
- Dr Nabila Ali (JSI) noted that think tank has been conducting meeting and it is collaborating all SDG efforts in the country along with the HPSIU at the Ministry
- DG (NHSRC)s further added that HPSIU is taking the overarching lead on SDG 3 and has developed linkages with the provinces
- Dr Assai (WR-WHO) added that the WHO work plan 2018-19 is SDG oriented and is currently being proceeded upon

2. WHO Regional Committee (RC) Meeting

- Pakistan will be hosting the RC meeting after 21 years. The meeting will be headed by Health Ministers of regional countries. Full technical program is being developed, high level policy decisions for regional level are also on the agenda. The new Regional Director (RD) and Director General (DG) will also be in attendance.
- Next Executive Board (EB) meeting of the WHO will be held in Islamabad preceding the RC meeting on 7th October 2017. This will be the first EB meeting held outside of Geneva and will be presided over by the WHO DG along with 5 vice-chairs.

3. Government's Plan post FP2020

- The FP taskforce has already been established
- Draft policy has been developed with UNFPA support (hiring of consultant)
- Decision to move for resource allocation by provincial PPW

- Dr Aliya (World Bank) noted that while costed implementation plan has been developed by the provinces, implementation thus far has been poor
- Dr Nabila Ali (JSI) added that recent census findings should also be taken into consideration
- DG NARC added that better planning and increased resources are needed for proper implementation
- Dr Isa (USAID) noted that no FP policy has been rolled out for the last 20 years, an accelerated plan is necessary if the targets of FP 2020
- Additional Secretary Population Welfare Department noted that Sindh has been the first to develop the CIP. The PC-1 is being revised now to cover the all 29 districts of the province. Functional integration has been done in DoH & PPW providing full range of services. 2000 Health Practitioners in DoH have been trained, DoH has been providing more services than PPW. However, method mix has never been changed in Pakistan. Free of cost contraceptive from private sector as well
- DG (NHSRC) also added that pooled procurement has been tried in EPI and costs have been brought down. Similar mechanism for procuring contraceptives may be explored
- Dr Naseer (Director PPW) noted suggested that costs need to be reviewed, revised and will be considered in next Technical Working Group (TWG) meeting. He also noted that increasing expenditures will also increase availability and accessibility. Provincial government are taking up the accelerated plan and are incorporating it into PC-1s currently under development. He also agreed that the pooled procurement mechanism should be taken up in the next TWG. He also recalled that prior discussions on the pooled procurement mechanism had noted that different provinces have different fund flow and procurement policies which will need to be accounted for in a pooled mechanism.
- Dr Assai (WR-WHO) reiterated that FP is one of the most important issues facing Pakistan. It is a common goal for both maternal and children's health and should be taken forward as a national commitment. Closely coordinated intervention is needed for taking FP forward in an integrated manner
- Dr Sangeeta (USAID) also noted the need for an accelerated plan and suggested that the matter also be discussed at the next think tank meeting. Malnutrition also remains a critical challenge (45%) that does not seem to be improving despite multiple investments and coordination forum. Hence integration of malnutrition programs within the FP2020 framework may be considered. Furthermore, attention to family planning can help in achieving SDGs. Preliminary census data is rather disturbing and reveals a need for more accelerated action, potentially even multi-sectorally, and with a strong FP champion within the GOP

4. Sharing of Costed IHR-GHSA Action plan
    - A presentation on the IHR-GHSA action plan's costing was given by Dr Safi (Director Programs) along with Mr Faheem (Costing Consultant)
    - Dr Naseer (Direcetor PPW) enquired as to what will be the coordination mechanism for interfacing between different ministries and departments and whether M/o Finance is onboard going forward. Dr Programs responded by apprising meeting of the TWG for IHR which has already been notified. Plans will be endorsed by the TWG before appropriate submissions to Finance
    - Dr Kashif (CDC Atlanta) raised similar concerns relating to linkages and sharing of the current planning with M/o Finance. He addressed this within the larger context of GoP's commitment to the GHSA agenda. He also recommended mapping donors for support in this regard to better focus all resource inputs in realizing this important action plan
    - EPI raised the point that vaccine costs have been included in both Federal and Provincial PC-1s and the National Plan should reflect that input
    - Dr Isa (USAID)also raised the issue that the current budget does not reflect which donor is extending support for which area and this break up should also be included
    - Dr Lamia (UNICEF) queried whether the budget was adjusted for inflation, and was informed that this budgeting did not account for inflation but PC-1s developed subsequently will adjust for inflation. She also asked whether a tool to assess impact was also used in budgeting; it was not
    - Dr Aliya (World Bank) asked for clarity on the budget, requesting break up of Federal and Provincial allocation. This will be shared in due course
    - Dr Nabeela (USAID) commended the ministry but highlighted the need to bear in mind the government's project cycles to ensure that PC1s are rolled out in time for budgetary allocation next year

Meeting ended with vote of thanks

List of Participants

1. Mrs. Saira Afzal Tarar, MOS, M/o NHSR&C
2. Mr. Muhammad Ayub Sheikh, Secretary, M/o NHSR&C
3. Dr. Assad Hafeez, Director General Health, M/o NHSR&C
4. Dr. Shafat Javed Sheikh, DG Population M/o NHSR&C
5. Mr. Qamar Abbas, Chief Population, Planning Commission
6. Dr. Malik. M. Safi, Director Program, M/o NHSR&C
7. Mr. Haroon Mahmood, Deputy Secretary (WB), EAD
8. Dr. Muhammad Ishaq Khan, AD, DG Health office, Peshawar, KP
9. Ms. Shereen, Population Department , Punjab
10. Dr. Farahat Shaheen, ADHS-DG Health office, AJK
11. Dr. Ashfaq Mir, Deputy Director, PWD, AJ&K
12. Dr. Sabeen Afzal, Deputy Director P-I, M/o NHSR&C
13. Dr. Samara Mazhar, Deputy Director P-II, M,/o NHSR&C
14. Dr. Saira Ashraf, AD PMDC, M/o NHSR&C
15. Dr. Muhammad Qaiser Khan, Assistant Chief Health , Planning Commission
16. Dr. Haseeb Shabaz, Section Officer, EAD
17. Mr. Nazeer Ahmed, Assistant Chief , Nutrition M/o PD&R
18. Dr. Ali Ahmed Khan, NPO SUN, M/o PD&R
19. Mr. Ahmed Hussain, PS to MOS, M/o NHSR&C
20. Dr. Michele Thieren, WR WHO, Pakistan
21. Dr. Zulfiqar Khan, WHO
22. Dr. Farah Sabih, WHO
23. Dr. Tania Glodner, Health Chief, UNICEF
24. Dr. Sangita Patel, Director health USAID
25. Dr. M. Isa, USAID
26. Mr. David Preston, Australian High Commission, Islamabad
27. Dr. Chris Athayde, Team Leader / Senior Health Adviser, DFID Pakistan
28. Ms. Ingeborg Dorn, EU
29. Dr. Tayyab Masud, Senior Health Specialist, World Bank
30. Dr. Aliya Kashif, Health Specialist, World Bank, Islamabad
31. Mr. Stephen Gluning, Acting director WFP
32. Dr Masood Abbas, WFP
33. Dr. Rajwal Khan, Strategic information Advisor, UNAIDS
34. Dr Zulfiqar Khan, HSS coordinator, WHO
35. Dr Hassan Mohtashami, Country Director UNFPA
36. Dr Jameel Ahmed Chaudhary, program and technical specialist, UNFPA
37. Mr. Asim Khattak, Project officer, JICA
38. Ms. Meha Ghaina, German Embassy

ANNEX 11: MINUTES OF MEETING OF NATIONAL IHR TASK FORCE

Minutes of Meeting National IHR Taskforce Meeting
Ramada Hotel, Islamabad

The 1st Meeting of National IHR Taskforce was held under the chairmanship of Director General (Health) on the 20th of February 2018 at the Ramada Hotel, Islamabad. (List of participants is placed at Annex A).

Proceedings:

1. The meeting began with a brief introduction to International Health Regulations (IHR) by the Deputy Director (Programs I) which provided essential background to IHR. She informed that Pakistan is a signatory to the IHR regulations which were launched in 2005. Following the African Ebola outbreak in Africa in 2014-15, a WHO Ebola Assessment Mission was conducted which found gaps in the then extant self-reporting mechanism of IHR. This led to the development of the Global Health Security Agenda (GHSA) as a framework for IHR implementation strengthening. The GHSA derived framework for monitoring IHR technical areas is the Joint External Evaluation (JEE) which Pakistan volunteered to undergo in October 2015 at the WHO Regional Conference meeting held in Kuwait.
2. The Director (Programs) then provided greater detail on Pakistan's JEE experience and expected outcomes of the meeting. He informed the gathering that in June 2016 Pakistan had already received three extensions to a prospective IHR quarantine. Hence, Pakistan volunteered to undergo the JEE assessment soon after Pakistan's commitment for the same in RC meeting held in Kuwait in 2015. Subsequently, the JEE mission was carried out in April- May 2016 during which the JEE mission conducted field visits and meetings with concerned stakeholders in the provinces/regions before finalizing the JEE country scores. The tool itself covers 19 technical areas, segregated into 4 themes; PREVENT, DETECT, RESPOND and OTHERS, and forms a major component of the IHR Monitoring & Evaluation Framework. It utilizes a multi-sectoral, bottom-up approach to assessing IHR related technical capacities in the country with input from all IHR concerned stakeholders. The JEE assessment report was submitted by WHO in September 2016 making Pakistan the first country in the EMRO region of WHO to successfully complete the JEE process.

   The meeting was informed of the post JEE assessment steps that have been taken by the M/o NHSRC; Notification of National **IHR Taskforce** mandated to oversee implementation of the IHR-GHSA Plan, Notification of **Provincial IHR** Taskforces (Baluchistan & Sindh), An **extensive consultative process** with the provinces and **One Health** Stakeholders to develop a **5 year costed National Action Plan for IHR.** The key outcomes expected from the meeting included the following:

   i. **Notification of all Provincial / Regional IHR Taskforces**

ii. **Endorsement of IHR/GHSA NAPHS**

iii. **Resource mobilization** through PC 1 at Federal & Provincial level **(**One health Stakeholders)

iv. **Strengthen multi-sectoral coordination** mechanisms between National & Provincial levels

3. The WR WHO then addressed the meeting and offered his strong support for IHR/GHSA implementation in the country. He appreciated the ministry's efforts in bringing together a diverse set of participants from provinces, regions and health development partners. He opined that such a diverse group constitutes the best option for pushing forward implementation of the IHR/GHSA plan. He posited that the best long term solution for addressing the gaps identified in the JEE assessment is in institutionalizing the requisite capacities at the provincial level, and more importantly at the district level. The strategic direction to be adopted should bear in mind the intention of Pakistan to move towards Universal Health Coverage (UHC), as this requirement subsumes many of the requirements and capacities needed for IHR implementation as well. The need for qualified Human Resource (HR); doctors, nurses, epidemiologists etc would have to be fulfilled to implement the proposed plans. Hence the provinces and regions will have to invest in these capacities. The WR further highlighted that the 5 year National Action Plan (NAP) developed with the input of all stakeholders will need to be refined into a Provincial Action Plan (PAP) in line with the varying level of development in the respective provinces/regions. He further stressed the need for strong communication and coordination between federal and provincial levels as well as between the stakeholders and development partners as well. This coordination and communication will not be an easy task and the scores in the JEE covering this function reflect this situation. He also touched upon the need for strong advocacy for the IHR/GHSA plan in order to enable domestic resource mobilization for implementation. With IHR an important WHO mandate as well, he reiterated that the country office will continue the ongoing support for implementing this important agenda in Pakistan.
4. The Director General (DG) M/o NHSRC appreciated the WR's comments and stressed the importance of the IHR/GHSA NAP implementation for Pakistan. The DG informed the gathering that we are living in a time of major health threats. Pakistan has already faced Pandemic Influenza, Dengue, Chikungunya, while globally Ebola has caused considerable devastation in Africa recently. The DG opined that the next big epidemic / pandemic is not a question of "if" but a question of "when" and Pakistan needs to be prepared for this eventuality. He reiterated that Pakistan volunteered for the JEE assessment as there was a clear understanding that this would address our local requirements. JEE was completed successfully by Pakistan to much global acclaim, with Pakistan being one of two

countries in the world to develop a 5 year costed NAP. The DG expressed his hope that the group will continue with the same commitment and proceed on implementation with the same vigour.

The DG drew the participants' attention to the next steps that would be needed; how to generate resources for implementation (domestic/international), which tool and mechanism should be utilized for advocacy for IHR (domestically/internationally) and ensuring that the donor contributions are aligned with country's plan. Thus this plan will allow donors to align their activities to the domains listed therein and should be utilized for this purpose. He appreciated the strong coordination conducted between the federal and provincial levels as well as between the line ministries, departments at all levels. He recommended that this coordination should be maintained in other health and non-health subjects as well.

The DG also suggested that the experience of creating a multi-sectoral forum, the dynamics of coordination and lessons learnt during this involved process conducted for IHR be documented for local and international consumption. He urged the participants to continue to work to bring synergies to government activities and take along all stakeholders in implementation by catering to their sensitivities as well.

5. The National IHR Focal Person (NFP) provided a more in depth presentation on IHR including the various threats that it addresses. In addition to the traditional concerns of disease outbreaks, globalization related massive increase in air travel as well the threat of terrorism related biological and chemical stacks have also become a concern in recent years. The impact of increased travel in particular has increased the threat of cross border transmission of disease. In this context, he described the evolution of the original International Sanitary Regulation (1951) into the IHR (2005) following multiple consultations. These consultations achieved a balance between a country's sovereignty concerns and international He described the increased scope of the IHR (2005) which is now focuses on Public Health Emergencies of International Concern (PHEIC) instead of a few diseases and is meant to enable adapted response to outbreaks of disease in the country and not just at Points of Entry (PoEs). The implications of not implementing this legally binding protocol, include disruption of trade, tourism and travel as well as quarantines, which can have significant economic consequences for resource constrained countries.

   The current IHR conception is more operationally oriented and is intended to strengthen management of PHIECs. He described the reporting mechanism in some detail with the National IHR Focal Point (Government appointed) is in communication with WHO Global Event Portal and can notify them about any disease outbreak. WHO subsequently verifies the report and can initiate actions in support

of the affected country, while also informing the NFPs of other countries of the threatened outbreak. The DG WHO subsequently consults with the relevant area experts before deciding on the need for restrictions for the country in question. This decision also hinges on a WHO decision tool which estimates the Public Health impact of the PHEIC, risk of spread and implication of possible restriction for travel and trade. It is also important to note that the WHO will find out about any outbreak from other sources if not notified by the NFP for e.g. through the WHO Digital Disease Reporting Platform. In such an event the country may have to verify the PHEIC within 24-48 hours; in the event of no response an independent Risk Assessment may be initiated. In the same context, it should be noted that the self-reporting format for IHR has not been particularly effective and beyond 2016 WHO has also been involved in supporting and monitoring countries' implementation of the IHR/GHSA activities.

The NFP further shared that the IHR/GHSA mandated core capacities can play a significant role in dealing with PHEIC. The response would, however, be multi-sectoral in nature as multiple systems from different departments and ministries will need to be involved. IHR provides a mechanism for linking these different responders and building their capacities to manage such events. Furthermore, the institution of these IHR capacities would allow Pakistan to respond to PHEICs as a responsible member of the international community. This is important as Pakistan is already on the restriction list due to Polio, while recent outbreaks such as Influenza, Ebola and Zika have also been of concern in the country.

With respect to the subsequent monitoring of progress of the IHR/GHSA NAP, the NFP also enlisted the Monitoring and Evaluation Framework modalities currently being used. These include Self Reporting (scoring done by independent mission), Self-Assessment (Scoring done by country), Joint External Evaluation, After Action Reviews and Simulation Exercises. The NFP provide updates regarding the 19 technical areas and work achieved under each theme. He closed his presentation by highlighting the need for additional focal points by designation for key areas to ensure relevant persons are engaged for the NAP implementation while maintaining institutional memory of work performed

6. The Director (Programs) M/o NHSRC provided a detailed presentation on JEE scoring that Pakistan had obtained. He highlighted that this scoring forms an excellent baseline to assess future progress on this important agenda. He proceeded to recap the origin of the IHR/GHSA mechanism and highlighted that Pakistan is one of the 17 countries being supported by CDC for implementation. He further pointed out the considerable efforts being put into NIH, which is the intended National Public

Health Institute (NPHI) and will cover many roles under the IHR/GHSA NAP. In addition to the NIH, PoEs are an important focus of action as well.

After sharing the JEE scores on each individual area, the Director briefed the participants on the 5 key recommendations obtained from the report:

i. Need for a multi-sectoral coordination between Federal & Provincial levels
ii. Development of mutually agreed & funded 5 year NAP IHR
iii. Establishment of surveillance & laboratory systems with a ''One Health Approach''
iv. Development of uniform regulatory standards - all areas of food security
v. Comprehensive national cross-sectional approach towards AMR**.**

The details of the costing of the NAP were also described to the participants. It was stressed that such a costing exercise had never been attempted before and it should be understood that the current costed plan developed with extensive provincial input is a living document. The costs may well be revised (increase or decrease) in light of actual implementation on the ground. The costing of the plan will be uploaded to the M/o NHSRC website shortly.

Discussion

1. *Dr Qaiser Khan, M/o Planning, Development & Reform:*

   A query was raised regarding the mechanism of funding the proposed IHR Plan. Whether the costing done is segregated by health / other departments; this will make the processing of the proposed PC-1s easier for the Planning Commission. Director (Programs) responded by clarifying that the costing document may be considered a mother document which is also a living document that will see revisions as and when appropriate. He further explained that all activities in the plan are segregated by functional component and responsible ministry / department. There is the possibility of segregating health section of the costed plan and sending it to Planning Commission separately from the rest of activities if that would streamline the PC-1 approval process. Other line ministries may similarly segregate their components / activities and submit them separately. The process more likely to facilitate the Planning Commission would be preferred. Executive Director NIH also endorsed this mechanism as all activities are segregated by technical area and responsible ministry/department.

2. *Dr Anissa Afridi, IHR Focal Person FATA:*

   IHR Focal Person FATA asked for details for the under process activities for Points of Entries (PoEs) and whether ground crossings in FATA will be covered and if so whether FATA will get funds directly for PoE strengthening in their region. It was clarified that PoEs are the responsibility of Central Health

Establishment (CHE) and being a federal subject funds for FATA will flow from the federal PC-1 for PoEs. The IHR Focal Person also informed the gathering that FATA has notified their Regional IHR Taskforce and the notification for this was requested to be shared with the Ministry.

3. *Dr Sabir Abbasi, IHR Focal Person AJK:*

   IHR Focal Person AJK also raised the question of fund flow mechanism for AJK; will be be budgeted and disbursed directly to AJK or will it be routed through federal budgeting mechanism. It was clarified that the activities and costing for the same may be approved by AJK and sent to the Ministry, which will subsequently route the resulting PC-1 to PD&R. In the eventuality of the PC-1 being sent to CDWP or ECNEC, then M/o NHSRC will support for approval. IHR Focal Person AJK also requested that inclusion of ground crossing points (3 officially designated crossings) situated in AJK should be assured in PoE plan.

4. *Dr Shaheen Afridi, IHR Focal Person KP:*

   IHR Focal Person KP appreciated the detailed presentation provided to the gathering including the updates under each technical areas; knowledge about the current progress across the country is instructive for provinces. Query was raised regarding what will be the next steps in moving the implementation forward. She put forward 3 possibilities for the next steps:

   i. <u>Advocacy</u>:

      The need is to engage senior representatives of Federal and Provincial governments. The higher policy level needs to be engaged and in line with One Health approach. This would require closer coordination between Federal/Provincial governments. Director (Programs) NHSRC suggested that the provincial IHR focal points should begin advocacy at their level soon so that such efforts at Federal / Provincial level may contribute to each other. He also highlighted the Pakistan Health & Population Strategic Forum as a useful venue for driving advocacy, where IDSR developments were recently presented. It provides a platform for engaging Chief Secretaries; their engagement may help in engaging other Provincial level Secretaries. Furthermore, the Federal Secretary may also brief the other Federal Secretaries or Prime Minister as the need arises. IHR Focal Person further added that in addition to this, Polio Eradication Initiative's (PEI) advocacy model may be explored as well, including parliamentarian briefings as conducted there.

   ii. <u>Develop resource generation / fund mobilization mechanisms</u>:

This would need prioritization of technical areas, defining which needs to be proceeded on immediately. This will necessarily align with advocacy efforts described above. IHR Focal Person KP further stated that the experience of DEWS should not be repeated where lack of resources had implications for sustaining the program. Hence, provincial level advocacy for fund mobilization should be a priority.

iii. Share prioritized areas for implementation:

The prioritization of provincial level activities would be better served by decision at that level. Director (Programs) NHSRC suggested that Provincial IHR Taskforces need to be notified where not already done and shared with the Ministry. These provincial taskforces should meet soon and set their priority at their own level to ensure ownership. Of the 19 areas, IDSR and Public Health Laboratories are already under process and may be taken up as the initial priority.

5. *Dr Mohd Akram, Assistant Animal Husbandry Commissioner, M/o National Food Security & Research:*

AAHC noted that M/oNHSRC is the lead agency in IHR implementation and all coordination is routed through the ministry. In this regard, he raised the possibility of one PC-1 for all activities instead of multiple PC-1s. He also suggested that the "umbrella" PC-1 may be developed by the M/o NHSRC. To this M/o PD&R representative responded that their previous experience with such "umbrella" PC-1s are not positive. The issue of ownership of activities under such an arrangement is problematic, besides Health Development Partners / Donors may have different priorities as well. Deputy Director (Programs) further elaborated, that the work under IHR is envisaged to be undertaken by the respective ministries and departments at provincial/federal levels. This would be in line with constitutional mandate as per 18th Amendment; subjects falling under the Federal Legislative Lists will be Federal Mandate, whereas subjects that have been devolved (especially policy matters for the same) are a Provincial mandate. CHE's PoE functions versus Health Workforce Development are examples of Federal and Provincial mandates respectively.

6. *Mr Emaad Hussain, Deputy Country Director CDC:*

The DCD CDC suggested that interagency forums should also be utilized for fund mobilization and advocacy. In addition, he also recommended that it may be useful to present some manner of cost benefit analysis for IHR related activities; e.g. defining economic burden of pandemics or effect of the same on GDP of the country. He also pointed out that different ministries/departments have different areas of focus and this should also be taken into account. For example cost of dengue to economic

productivity, cost of zoonotic disease to agriculture or food security, lack of FETP fellows in system on provincial health department performance.

7. *Dr Roomi Aziz, Chief Technical Officer, Punjab Public Health Authority*

   The representative of the IHR Focal Person Punjab, described the formation of PPHA which aligned many of its functions to the IHR/GHSA plan requirements and the PC-1 for this body has already been approved. She further elaborated that no IHR taskforce currently exists at the provincial level, but they do possess have an alternate forum with a similar mandate; the Provincial Health Protection Committee. Deputy Director (Programs) suggested that there is no need for duplication and if the ToRs of the IHR taskforce are incorporated into this forum this would be adequate.

8. *Dr Assai Ardakani, WR WHO*

   The WR reiterated the stress laid on advocacy for IHR implementation and stated that this function should be a part and parcel of the roles and responsibilities of all stakeholders involved and must be sustained. He further highlighted the role that media may play in advocacy especially in educating the public at large. The flip side of this would be to educate the media as well as to the importance of health issues including IHR. Modern media may also serve as viable conduit to sensitize community leaders by relating the success stories in the area of health. He also stressed that the range of developmental activities being undertaken implies that Pakistan's health system will change; a corollary to this is that the approach to Health Care Providers to service delivery will need to change completely. For example epidemic response as envisaged under IHR will need that district capacities to respond will need building up. A good example of this that he shared was the Dengue response carried out in KP province which included a significant component of community mobilization. He also noted that Pakistan is currently leading the world in IHR/GHSA mechanism and should document their successes and lessons learnt for the benefit of all.

9. *Dr Muhammad Issa, Health Advisor, USAID:*

   The Health Advisor, USAID raised an important point regarding the need to take stock of fragmentation which results from poor coordination with donors and Health Development Partners. He pointed out that different agencies are involved in supporting the GoP in IHR implementation covering different areas. The cost outlays should take into account current donor support already being provided and provide some measure of segregation of what is the donor envelope and what is the government's envelope. To this the Deputy Director (Programs) responded by clarifying that the costed document was developed in 2017 and reflects donor contributions to the system till that date. This is reflected in the cost segregation in the NAP by government and donor funding. However, the

costed NAP is a living document and will be updated as implementation proceeds and account for future donor contributions as well.

10. *Dr Mohammad Salman, National IHR Focal Person, NIH:*

    The National IHR Focal Person stressed the need for better coordination between Provincial IHR Focal Persons and NIH, which is the officially designated IHR Focal Point for Pakistan. This would allow information sharing regarding steps taken by the provinces and line ministries at their respective levels. He also suggested that nominations of Provincial Focal Points be by designation to permit institutional knowledge to be retained and continuity to be maintained.

11. *Dr Farah Sabih, NPO World Health Emergencies, WHO*

    The NPO WHE reiterated that NIH is the formally notified focal point for Pakistan and should be kept apprised and in the loop regarding all activities, in addition to the M/o NHSRC. She also noted that a forum as large as the National IHR Taskforce may not be able to meet regularly, hence smaller area focused Techncial Working Groups may be considered by the Ministry.

12. *Mr Saleem Khattak, Deputy Secretary, M/o Climate Change:*

    The DS Climate change appreciated the involvement of his ministry in the Taskforce, highlighting that Pakistan is very vulnerable to climate change and resulting emergencies may impact health significantly. He hoped that Climate Change related health issues are included in the NAP. National IHR Focal Person seconded this and informed the gathering that MoU with M/o CC already exists and the availability of the One Health Hub at NIH can coordinate climate related emergencies affecting humans, animals and agriculture sectors. Another point raised was that every line ministry or department involved with IHR implementation should designate a focal person to deal with matters relating to this important subject.

Decisions:

- The 5 year costed NAP document stands endorsed
- PC-1 development in their sectors should be initiated by all concerned Provincial and Federal entities as per NAP
- All Provincial/regional IHR taskforces should be notified and the M/o NHSRC informed in writing. These taskforces should reflect the multi-sectoral composition seen in the National Taskforce and each taskforce member should be nominated by designation. These taskforces should start meeting regularly with updates being shared with all stakeholders, including the M/o NHSRC.
- Focal persons for each technical area should be identified and notified along the lines described above, i.e. in writing and by designation

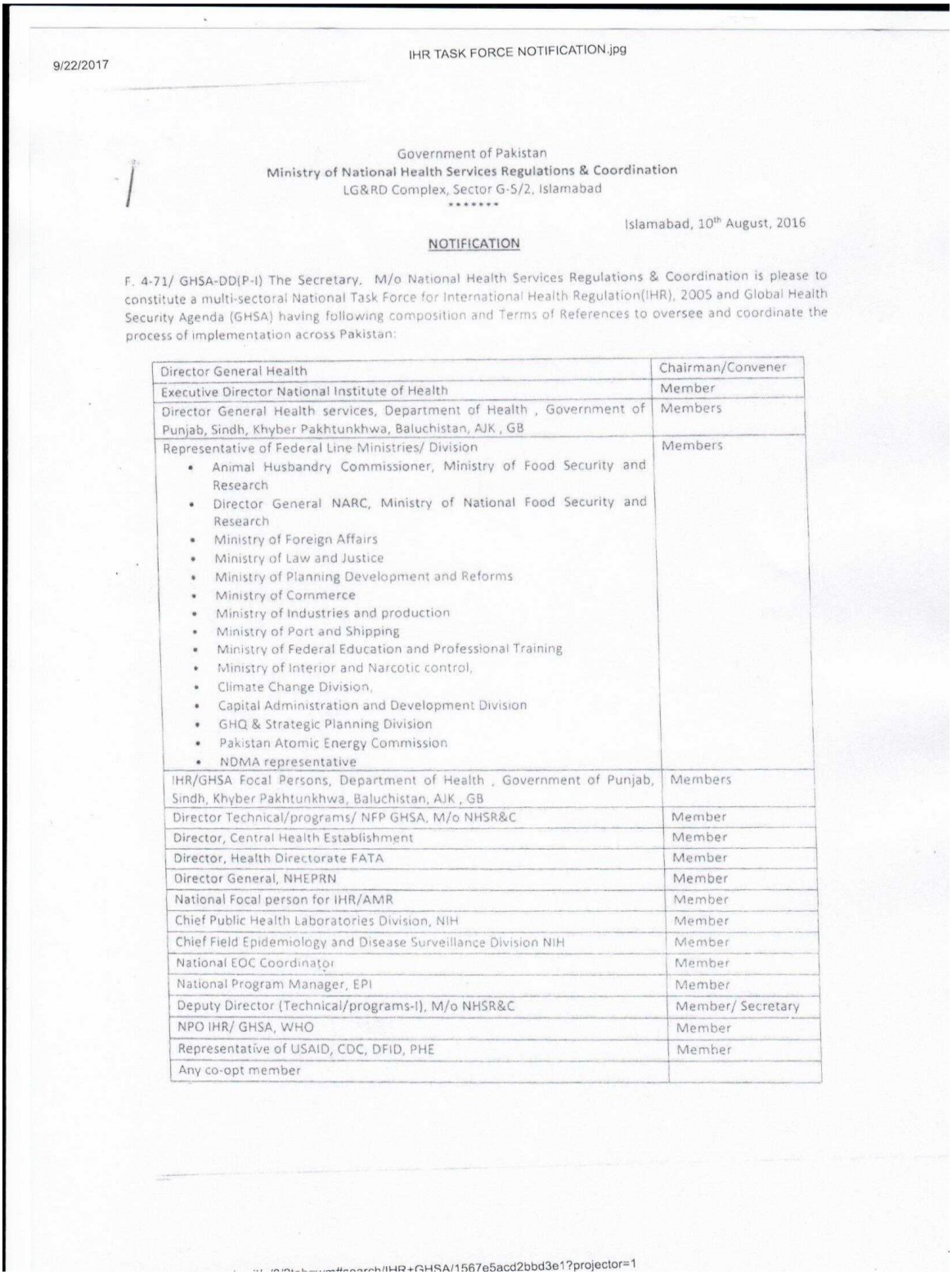
- Advocacy efforts should be prepared and instituted at provincial and federal level. The M/o NHSRC shall play its role in facilitating such efforts at every level.
- Meeting ended with note of thanks to all participants and agreement on participating in subsequent planning meetings to ensure all aspects IHR/GHSA Action Plan are covered.

Annex A: List of Participants:

S. No.	Name	Designation
7.	Dr. Assad Hafeez	Director General Health
8.	Dr. Aamir Ikram	Executive Director NIH
9.	Dr. Assai Ardakani	WR, WHO country office
10.	Dr. Malik M. Safi	Director Program
11.	Dr. Sabeen Afzal	Deputy Director Program
12.	Syed Muhammad Shafi	Associate Director
13.	Dr. M. Athar Abbas	SSO / OH Coordinator
14.	Dr. Waheed Ahmed	ADP-I M/o NHSR&C
15.	Rana Iftikhar Ahmed	Principal Scientist, Chashma
16.	Dr. M. Khurram	Inch. Medical Services Civil Aviation Authority
17.	Dr. Ameena Bano	SPMO/ Director (PNRA)
18.	Dr. Anisa Afridi	IHR FP / Coordinator MNCH (KP)
19.	Dr. Muhammad Akram	Assitant Animal Husbandry Commissioner
20.	Dr. Muhammad Javed Arshad	SSO/AMR focal person
21.	Dr. Zaeem Zia	Director Health Information
22.	Dr. Muneer Ahmed Mangrio	DG NHEPRN
23.	Dr. Mobin Ahmed	Director DG HS Sindh
24.	Muhammad Moosa Qazi	Assistant Dir. DG HS Sindh
25.	Dr. Muhammad Hayat Rangho	Director PH / IHR Focal Person (BLN)
26.	Dr. Shaheen Afridi	Director PH (KP)
27.	Dr. Farah Sabin	NPO IHR
28.	Zarar Haider	J.S Industries Division
29.	Dr. Aminah Khan	PH Consultant (PPHA)
30.	Dr. Roomi Aziz	Chief Tech. Officer (PPHA)
31.	Dr. Rana Jawad Asghar	Resident Advisor CDC FELTP
32.	Dr. Mustafa Tahir Kazmi	Director Hospital PAEC Chashma/SPD
33.	Dr. Laeeq Daraz Khan	Director Trade Dispute Resolution Organization, M/o Commerce
34.	Lt.Col. Dr. Dawood Ahmad	Focal Person of AFIP
35.	Dr. Sabir Abbasi	DHS Health AJK
36.	Gul-e-Afshan	Econ Specialist US Embassy

37.	Dr. Muhammad Salman	Focal Person IHR NIH /AMR FP NIH
38.	Dr. Jamil Ansari	Chief FEDSD NIH
39.	Emaad Hassan	Deputy Country Director, CDC
40.	Ahmed Liban	Country Director, CDC
41.	Rhiannon Bramer	US Embassy
42.	Dr. Saqlain Gilani	NPM EPI
43.	Dr. Ayesha Rasheed	Sr Health Advisor PHE
44.	Dr. Muhammad Qaiser Khan	Deputy Chief (Health) M/o PD&R
45.	Dr. Muhammad Ahmed Isa	Sr. Tech. Advisor USAID
46.	Dr. Minhaj us Siraj	DDG Health CADD
47.	Ismat Hassan	Dir (EC&R)
48.	Omar Mahar	PIO / SO
49.	Abdul Razaq	SO M/o Commerce
50.	Ali Saeed Mirza	IHR Coordinator, HPSIU
51.	Urooj Aqeel	Research Assistant
52.	Dr. M. Ayub Rose	DG Health KPK
53.	Dr. Nadeem Hassan	National Manager, JSI
54.	Mohammad Salim Khattak	DS M/o Climate Change
55.	Barrister Zahoor Ahmed	Assistant Consultant M/o Law & Justice

ANNEX 12: NOTIFICATION OF NATIONAL IHR TASK FORCE



9/22/2017 IHR TASK FORCE NOTIFICATION.jpg

Government of Pakistan
Ministry of National Health Services Regulations & Coordination
LG&RD Complex, Sector G-5/2, Islamabad
****

Islamabad, 10th August, 2016

NOTIFICATION

F. 4-71/ GHSA-DD(P-I) The Secretary, M/o National Health Services Regulations & Coordination is please to constitute a multi-sectoral National Task Force for International Health Regulation(IHR), 2005 and Global Health Security Agenda (GHSA) having following composition and Terms of References to oversee and coordinate the process of implementation across Pakistan:

Director General Health	Chairman/Convener
Executive Director National Institute of Health	Member
Director General Health services, Department of Health , Government of Punjab, Sindh, Khyber Pakhtunkhwa, Baluchistan, AJK , GB	Members
Representative of Federal Line Ministries/ Division • Animal Husbandry Commissioner, Ministry of Food Security and Research • Director General NARC, Ministry of National Food Security and Research • Ministry of Foreign Affairs • Ministry of Law and Justice • Ministry of Planning Development and Reforms • Ministry of Commerce • Ministry of Industries and production • Ministry of Port and Shipping • Ministry of Federal Education and Professional Training • Ministry of Interior and Narcotic control, • Climate Change Division, • Capital Administration and Development Division • GHQ & Strategic Planning Division • Pakistan Atomic Energy Commission • NDMA representative	Members
IHR/GHSA Focal Persons, Department of Health , Government of Punjab, Sindh, Khyber Pakhtunkhwa, Baluchistan, AJK , GB	Members
Director Technical/programs/ NFP GHSA, M/o NHSR&C	Member
Director, Central Health Establishment	Member
Director, Health Directorate FATA	Member
Director General, NHEPRN	Member
National Focal person for IHR/AMR	Member
Chief Public Health Laboratories Division, NIH	Member
Chief Field Epidemiology and Disease Surveillance Division NIH	Member
National EOC Coordinator	Member
National Program Manager, EPI	Member
Deputy Director (Technical/programs-I), M/o NHSR&C	Member/ Secretary
NPO IHR/ GHSA, WHO	Member
Representative of USAID, CDC, DFID, PHE	Member
Any co-opt member	

2 TASK FORCE.jpg

9/22/2017

The Terms of References are as under:

a. To act as an advisory and oversight body for IHR and GHSA implementation in Pakistan
b. To review the progress of implementation status of IHR Core capacities and GHSA action Packages and advise on strengthening IHR core capacities
c. To address IHR requirements on surveillance and response for public health emergencies of national and international concern including zoonotic diseases for compliance to One Health Approach
d. To provide feedback on monitoring and evaluation frame work tools developed by WHO and other technical agencies as and when required.
e. To advise on GHSA/IHR road map and strategic action plan based on JEE recommendations for 19 technical areas and their endorsement and review progress on implementation or the road map

3. The Task force shall meet annually and shall function through constitution of executive committee and sub committees

(DR. Malik M. Safi)
Director (Programs /HPSIU: IHR/GHSA)
Phone: 051-9245576

Distribution: To all members

Cc:

1. PS to MOS, NHSR&C, Islamabad
2. Sr. PS to Secretary NHSR&C, Islamabad

ANNEX 13: RESULT BASED MONITORING INDICATORS

Capacities	Indicators	Score	
		Baseline 2016	Target 2022
National legislation, policy and financing	P.1.1 Legislation, laws, regulations, administrative requirements, policies or other government instruments in place are sufficient for implementation of IHR	2	4
	P.1.2 The state can demonstrate that it has adjusted and aligned its domestic legislation, policies and administrative arrangements to enable compliance with the IHR (2005)	3	4
IHR coordination, communication and advocacy	P.2.1 A functional mechanism is established for the coordination and integration of relevant sectors in the implementation of IHR.	3	5
Antimicrobial resistance	P.3.1 Antimicrobial resistance (AMR) detection	1	3
	P.3.2 Surveillance of infections caused by AMR pathogens	1	3
	P.3.3 Healthcare associated infection (HCAI) prevention and control programs	1	3
	P.3.4 Antimicrobial stewardship activities	1	3
Zoonotic diseases	P.4.1 Surveillance systems in place for priority zoonotic diseases/pathogens	3	4
	P.4.2 Veterinary or Animal Health Workforce	3	4
	P.4.3 Mechanisms for responding to zoonosis and potential zoonosis are established and functional	2	3
Food safety	P.5.1 Mechanisms are established and functioning for detecting and responding to foodborne disease and food contamination.	2	3
Biosafety and biosecurity	P.6.1 Whole-of-Government biosafety and biosecurity system is in place for human, animal, and agriculture facilities	2	3
	P.6.2 Biosafety and biosecurity training and practices	2	3
Immunization	P.7.1 Vaccine coverage (measles) as part of national program	2	4
	P.7.2 National vaccine access and delivery	4	5
National laboratory system	D.1.1 Laboratory testing for detection of priority diseases	4	5
	D.1.2 Specimen referral and transport system	3	4
	D.1.3 Effective modern point of care and laboratory based diagnostics	2	3
	D.1.4 Laboratory Quality System	2	3
Real-time surveillance	D.2.1 Indicator and event based surveillance systems	3	4
	D.2.2 Inter-operable, interconnected, electronic real-time reporting system	2	3
	D.2.3 Analysis of surveillance data	2	3
	D.2.4 Syndromic surveillance systems	4	5
Reporting	D.3.1 System for efficient reporting to WHO, FAO and OIE	2	4
	D.3.2 Reporting network and protocols in country	2	4
Workforce development	D.4.1 Human resources are available to implement IHR core capacity requirements	3	5
	D.4.2 Field epidemiology training programme or other applied epidemiology training programme in place	3	4
	D.4.3 Workforce strategy	2	4

Preparedness	R.1.1 Multi-hazard National Public Health Emergency Preparedness and Response Plan is developed and implemented	1	3
	R.1.2 Priority public health risks and resources are mapped and utilized	1	3
Emergency response operations	R.2.1 Capacity to activate emergency operations	2	3
	R.2.2 Emergency Operations Centre operating procedures and plans	2	3
	R.2.3 Emergency operations programme	3	4
	R.2.4 Case management procedures are implemented for IHR relevant hazards	2	3
Linking public health and security Authorities	R.3.1 Public health and security authorities (e.g. law enforcement, border control, customs) are linked during a suspect or confirmed biological event	3	5
Medical countermeasures and personnel deployment	R.4.1 System is in place for sending and receiving medical countermeasures during a public health emergency	4	5
	R.4.2 System is in place for sending and receiving health personnel during a public health emergency	4	5
Risk communication	R.5.1 Risk communication systems (plans, mechanisms etc.)	1	3
	R.5.2 Internal and partner communication and coordination	2	3
	R.5.3 Public communication	2	3
	R.5.4 Communication engagement with affected communities	2	3
	R.5.5 Dynamic listening and rumor management	3	4
Points of Entry (PoE)	PoE.1 Routine capacities are established at PoE.	2	3
	PoE.2 Effective public health response at Points of Entry	2	3
Chemical events	CE.1 Mechanisms are established and functioning for detecting and responding to chemical events or emergencies	2	3
	CE.2 Enabling environment is in place for management of chemical events	2	3
Radiation emergencies	RE.1 Mechanisms are established and functioning for detecting and responding to radiological and nuclear emergencies	5	5
	RE.2 Enabling environment is in place for management of radiation emergencies	5	5

No Capacity – 1: Attributes of a capacity are not in place Color Code: **Red**
Limited Capacity -2: Attributes of a capacity are in development stage (some are achieved and some are ongoing; however, the implementation has started). Color Code: **Yellow**
Developed Capacity – 3: Attributes of a capacity are in place; however, there is the issue of sustainability is measured by lack of inclusion in the operational plan in National Health Sector Planning (NHSP) and/or secure funding. Color Code: **Yellow -**
Demonstrated Capacity – 4: Attributes are in place, sustainable for a few more years and can be measured by the inclusion of attributes or IHR (2005) core capacities in the national health sector plan. Color Code: **Green**
Sustainable Capacity – 5: Attributes are functional, sustainable and the country is supporting other countries in its implementation. This is the highest level of the achievement of implementation of IHR (2005) core capacities. Color Code: **Green**

Baseline: JEE Report 2016
Target: JEE Report 2022