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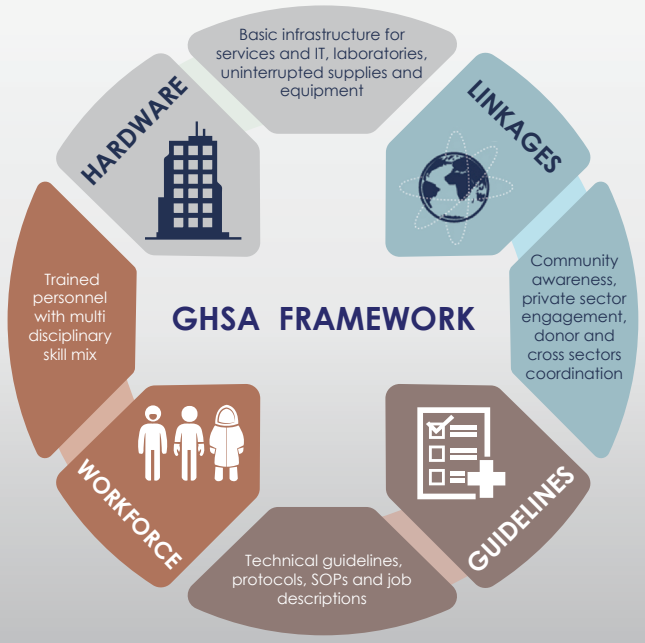
GHSA & Journey to Self Reliance

Building Health Secure Communities in Pakistan

Context

Pakistan, like rest of developing world, is confronted with dual burden of diseases, where communicable diseases have exponential potential to spread into outbreaks and epidemics. Existing gaps in health system leads to no or delayed response to preventable sufferings of the people from communicable diseases. Nonexistence of active surveillance, minimal capacity of healthcare infrastructure, deficient and unskilled workforce, and non-standardized technical protocols and guidelines, have all weakened the effectiveness and efficiency of health systems. Deficiencies in disease surveillance and response systems are persistently triggering undeterred reservoir of infections – posing threat to healthy individuals and communities. Resultantly, the existing mechanisms are failing to fully represent the disease burden or trends. The country mainly relies on fragmented surveillance, failing in epidemic detection related to emerging infectious disease threats, thus posing challenges in achievement of Global Health Security Agenda (GHSA), Sustainable Development Goals and International Health Regulations (IHR) 2005.



Technical Approach

USAID's Integrated Health Systems Strengthening and Service Delivery (IHSS-SD) Activity is supporting the federal and provincial governments in achieving GHSA in Pakistan. In line with USAID/Pakistan's Country Development Cooperation Strategy (2018-23), the aim of this assistance is to strengthen a system that can detect, report and respond to public health events within quickest possible time to minimize the associated morbidity and mortality. The 1st step for initiating this support was to conduct 'situation analysis' for catering the geographic disparities and varying readiness of health systems for GHSA across Pakistan and findings of Joint External Evaluation (JEE) Report. Based on the situation analysis, 2nd step was development of a 'plan of action' focusing on GHSA components. As a 3rd step, this plan of action was translated into activities, sub-activities and tasks for 'implementation'. IHSS-SD Activity team worked in close coordination with government counterparts, donors, development partners and academia to ensure that disease surveillance and response activities are targeted, collaborative and integrated.

Stepwise Approach of GHSA Implementation

Step I
Situation Analysis
- Institutional Review/Assessment
- Readiness Appraisal
- Stakeholders Mapping
- Resource Documentation

Step II
Plan of Action
- Hardware
- Guidelines
- Workforce
- Linkages

Step III
Implementation
- Disease Surveillance
- Emergency Preparedness & Response
- Coordination & Risk Communication

Description of GHSA Implementation

Disease Surveillance

– Institutional review and strengthening of Provincial Disease Surveillance and Response Units (PDSRUs) in Sindh, Punjab and Khyber Pakhtunkhwa

– District Disease Surveillance and Response Units (DDSRU) within M&E Cells – followed by nomination and training (by FELTP) of DDSRU in-charges – **Number of managers/staff being trained as frontline workers: 150 (50 in Sindh, 50 in KP and 50 in Punjab)**

– Technical assistance for development of Punjab's PC-1 for Integrated Communicable Disease Control (I-CDC)

– Outreach activities for active case detection for TB through Mobile Health Services Units in Sindh and KP

– Use of smartphone application for active surveillance, alerts generation, real-time notification and access to technical guidelines – HealthAlert®

– Support to Directorates General of Health Services in Punjab and Sindh (in Sindh through Infection Prevention and Control Committee) for promulgation of Public Health Act and notification/revision of List of Priority Notifiable Diseases

Emergency Preparedness and Response

– Priority diseases readiness matrix for all notifiable diseases of Sindh (32) and Khyber Pakhtunkhwa (14) focusing on individual disease-specific readiness parameters and disease categorization

– SOPs and protocols – case definitions (suspected, probable and confirmed cases), case management and training of healthcare providers in selected districts of Sindh and Khyber Pakhtunkhwa – **Number of care providers being trained:**

On IDSR: 200 (60 in Sindh; 110 in KP; 30 in Punjab)

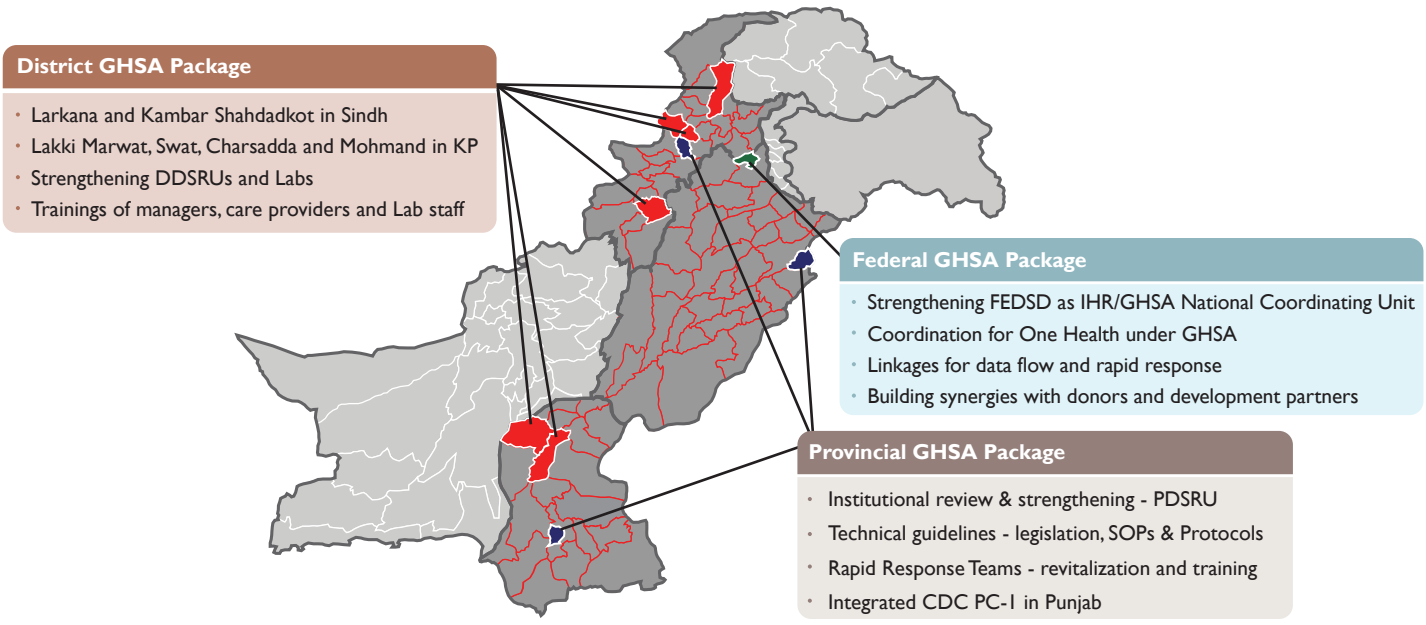
On case management protocols: 350 (125 in Sindh; 200 in KP; 25 in Punjab)

On Infection Prevention & Control (IPC) Protocols: 200 care providers and 2, 800 LHWs in KP

– Priority Diseases Information Charts with information on disease agent, alert/outbreak thresholds, case definition and reporting timelines – designing/display across Sindh

– Rapid Response Teams (RRT) for multi-sectors approach to outbreak prevention and control – Notification of RRT in Sindh and revitalization of RRT in Khyber Pakhtunkhwa and Punjab followed by their training – **Number of RRTs being supported: 3 provincial and 6 district RRTs with 120 managers being trained (60 in KP, 40 in Sindh and 20 in Punjab)**

– Strengthening of laboratories through their assessment, refurbishment and training of lab staff in selected districts of Sindh and Khyber Pakhtunkhwa – **Number of lab staff being trained: 150 (50 in Sindh; 100 in KP)**



Coordination and Risk Communication

– Strengthening of Field Epidemiology & Disease Surveillance Division (FEDSD) as IHR/GHSA National Coordinating Unit and linkages between FEDSD, PDSRUs and DDSRUs across Pakistan for risk communication – **Number of managers being trained on risk communication: 100 (30 in KP, 30 in Sindh, 40 in Punjab)**

– Coordination for One Health under GHSA (livestock, agriculture, climate change and relevant sectors)

– Linkages for data flow and rapid response at NIH

– Engagement of development partners and academia for building synergies – CDC-accredited FELTP's frontline workers trainings, Fleming Fund for labs strengthening on AMR, Public Health England for IDSR trainings and WHO for joint technical reviews of SOPs and guidelines