DEVELOPMENT OF A COSTED NATIONAL ACTION PLAN FOR HEALTH SECURITY IN PAKISTAN: LESSONS LEARNED

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In order to assess progress toward achieving compliance with the International Health Regulations (2005), member states may voluntarily request a Joint External Evaluation (JEE). Pakistan was the first country in the WHO Eastern Mediterranean Region to volunteer for and complete a JEE to establish the baseline of the country's public health capacity across multiple sectors covering 19 technical areas. It subsequently developed a post-JEE costed National Action Plan for Health Security (NAPHS). The process for developing the costed NAPHS was based on objectives and activities related to the 3 to 5 priority actions for each of the 19 JEE technical areas. Four key lessons were learned during the process of developing the NAPHS. First, multisectoral coordination at both federal and provincial levels is important in a devolved health system, where provinces are autonomous from a public health sector standpoint. Second, the development of a costed NAPHS requires engagement and investment of the country's own resources for sustainability as well as donor coordination among national and international donors and partners. Engagement from the ministries of Finance, Planning and Development, and Foreign Affairs and from WHO was also important. Third, development of predefined goals, targets, and indicators aligned with the JEE as part of the NAPHS process proved to be critical, as they can be used to monitor progress toward implementation of the NAPHS and provide data for repeat JEEs. Lastly, several challenges were identified related to the NAPHS process and costing tool, which need to be addressed by WHO and partners to help countries develop their plans.

Keywords: Joint External Evaluation, International Health Regulations, Pakistan, Public health preparedness and response

IN FEBRUARY 2016, THE World Health Organization (WHO) launched a Joint External Evaluation (JEE) tool with inputs from WHO regions, incorporating various regional and partner initiatives like the Global Health Security Agenda (GHSA). Using the JEE tool, countries

conduct a self-assessment that is followed by an external evaluation by a WHO-led multidisciplinary team of experts. After the completion of external evaluation, the JEE report is shared with the country for review and published online, and the country is encouraged to lead the development

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and costing of a National Action Plan for Health Security (NAPHS).^{1,2} To ensure sustainability, the plan should be country-owned and the country should demonstrate commitment by allocating its own resources. However, the plan should also be available to potential partners and donors for assistance in addressing the gaps and provision of technical or financial assistance for implementation.³

The Islamic Republic of Pakistan is the sixth largest country in the world, with an estimated population of 207.8 million.⁴ Pakistan has a per capita yearly income of US\$1,560. The budgetary allocation for the health sector has consistently remained below 1% of gross domestic product.⁵ Pakistan is a signatory to the International Health Regulations (IHR 2005) and has been strengthening capacities to prevent, detect, and respond to public health events. However, it has not achieved the optimum level of core public health capacities, which can affect its ability to respond to public health events, including biological, radiological, chemical, or nuclear, whether naturally occurring or deliberate. Therefore, there is an urgent need to strengthen capacities, since the country has faced both infectious disease events and humanitarian disasters in the recent past.⁶ This will also help ensure the country's economic development, trade, and travel.

Pakistan has a federal system comprising 4 provinces—Baluchistan, Khyber Pakhtunkhwa, Punjab, and Sindh—and 4 federated areas: Gilgit-Baltistan (GB, province-like status under 2009 presidential ordinance), Islamabad capital territory (ICT), State of Azad Jammu and Kashmir (AJK), and federally administered tribal areas (FATA). These provinces/administrative areas vary in their level of development.⁷ In Pakistan, overarching priorities, coordination, and regulation of the health sector are conducted at the national level, but operational responsibility lies at the provincial level, which poses challenges for implementing and assessing national programs and policies. On June 30, 2011, the 18th amendment to the constitution of Pakistan abolished the Federal Ministry of Health and devolved health issues to the provincial level.⁸ The Ministry of National Health Services Regulations and Coordination (MoNHSR&C) was established on May 4, 2013. In its stewardship role, the ministry is responsible for developing a vision for the health sector, interprovincial coordination, regulation in medical and allied education, research, national reporting for the health sector, establishing quality standards, and meeting international obligations, including United Nations Sustainable Development Goals and IHR. The development and implementation of health sector strategies and plans are, however, a provincial responsibility.

Following resolution EM/RC62/R.3 of the Regional Committee WHO Eastern Mediterranean to assess and monitor the implementation of the IHR (2005), Pakistan was the first country in the WHO Eastern Mediterranean Region (EMRO), and the fourth globally, to volunteer for and complete a JEE.^{3,9,10} The JEE in Pakistan focused on assessing capacities at both the national level and in the provincial and federated areas.¹¹ Throughout the evaluation, the commit-

ment of all sectors to work together to improve the health of the population was evident at all levels of governance structure.

To date, although 81 JEEs have been completed globally, a relatively small proportion of countries have developed and costed their NAPHS. Here we describe Pakistan's experience and lessons learned in developing its costed NAPHS.

PROCESS

The process for developing and costing of the NAPHS in a devolved health system, where provinces are autonomous from a public health sector standpoint, was implemented using the WHO guidance and template.¹² The Health Planning and Systems Integration Unit (HPSIU) of MoNHSR&C was designated as the lead for development of the post-JEE NAPHS. The HPSIU began the process of developing NAPHS in August 2016, just a couple of months after completion of the JEE.

Formation of Working Group

A 6- to 8-member national IHR technical working group was formed prior to the JEE self-evaluation, with the specific task of focusing on coordination and oversight of the JEE as well as the development of a 5-year costed NAPHS through a consultative and consensus-building process. The technical working group reported to the director general for health in the MoNHSR&C and also kept the multisectoral national taskforce for IHR informed. WHO assisted by working with the group prior to the JEE self-evaluation, and later 2 consultants were also hired as contractors with assistance from the WHO country office to help with the development of the draft NAPHS.

Sensitization and Orientation

Prior to the beginning of the JEE and the self-evaluation phase, sensitization and orientation workshops were held from April 4-9, 2016, for all national stakeholders, both at federal and provincial levels. These workshops helped with the overall understanding of the goal and overview of IHR (2005) as well as the entire JEE process and its intended goals and benefits for the country.¹ The planning template and key planning principles were introduced to all provinces during these workshops. This also proved to be extremely helpful in successful completion of the JEE self-evaluation phase, as it ensured inclusion of provincial-level data and input in the JEE process.^{1,3}

Ensuring Engagement

On July 11, 2016, shortly after the JEE was conducted by the external evaluation team, IHR focal persons were nominated from federal non-health ministries and department directors, including the Department of Livestock and

Fisheries, Ministry of Defense, and the National Disaster Management Agency. This was followed on August 10, 2016, by renotification and renaming of the national IHR taskforce as the Multisectoral National Taskforce for IHR (2005). This also included a One Health approach to ensure engagement from both human health, animal health, and other relevant non-health sectors. Additionally, in order to ensure provincial-level active engagement, provincial IHR taskforces were formed by each province and requested notification on August 12, 2016.

Development of Costed NAPHS

The costing process was divided into 2 phases; the first phase had the goal of developing a draft NAPHS, and the second phase sought to develop a costing process and model for the NAPHS. The National IHR Technical working group initiated the first phase by developing the preliminary draft, termed as zero draft, for NAPHS by holding a technical consultation September 26-28, 2016. The purpose of the consultation was to review and deliberate on development of goals, objectives, and main activity areas for the zero draft. In order to ensure consensus building and ownership in a post-devolution environment, both national and provincial consultative meetings were initiated. There were a total of 6 national and provincial consultative meetings convened that included multisectoral stakeholders at both federal and provincial level meetings in each province. The zero draft was derived from the JEE report as well as the GHSA action plan.¹³ A national consultative meeting for final endorsement of the NAPHS was convened at the end of November 2016. During the consultation, indicative cost drivers were also defined for NAPHS to develop and sustain IHR core capacities in Pakistan. At the conclusion of the meeting, there was agreement on the NAPHS by all relevant stakeholders in the health and nonhealth sectors in terms of their role in advocacy, action, and accountability. They also agreed on timelines, performance targets, and monitoring indicators for the activities. There was overall consensus to support NAPHS implementation.

Following the development of the country-led consensus-driven NAPHS, the National IHR Technical working group began to work on the development of costing each of the technical areas for the NAPHS in January 2017. The costing for the NAPHS was done for each province and technical area, and this was combined into a single comprehensive 5-year costed NAPHS.

Selecting Costing Tool and Consultation

There were no standard WHO costing tools available or recommended for the NAPHS. The country decided to develop its own process, using MS Excel for costing of the NAPHS. The MoNHSR&C, with the support of WHO, hired an economist as costing consultant to work on the process that included the steps outlined below. The costing

consultant also had a consultation call with a health economist and costing experts at CDC and Georgetown University to get input and suggestions related to the process for costing of the NAPHS.

Costing Methodology

Customized MS Excel spreadsheets were developed, with each technical area having a separate spreadsheet. In addition, each activity was costed separately according to the needs of the relevant departments. This worksheet was linked with each activity based on the costing requirement of the activity. Costing was based on key cost drivers, including technical assistance; equipment costs; workshops, meetings, and seminars; hiring of staff; civil work and infrastructure; and travel costs related to monitoring and evaluation, including government of Pakistan standard per diems.

Development of costing estimates was done at provincial levels as well as at the federal level, including federally administered areas, which resulted in developing a consolidated summary of total cost by each province and federated areas by year for the 5-year NAPHS. The spreadsheet captured the province-specific costing estimates for each activity and technical area separately also. Development of the costing component also entailed engagement with representatives from Ministry of Finance (Economic Affairs Division) and the Ministry of Planning and Development. The costed items were carefully reviewed and validated from the country perspective based on local cost and not global averages to make sure that they were adequately captured.

Funding Gap Analysis

The government's share and contribution toward the costed NAPHS were also captured in the costing model, including the present funding from donors and partners, as well as the amount requested by the government through the internal planning commission process. The funding gap analysis was based on the total estimated amount required over 5 years minus what the government currently funds (including expanded program for immunization and majority of polio eradication initiative, zoonotic, food safety, preparedness, and biosafety and biosecurity funds) and what the government plans to request. The remaining was determined to be the funding gap that needs to be addressed with assistance from donors and partners, including both technical assistance and funding.

Launching and Sharing the Costed NAPHS

The final draft of the costed NAPHS was launched and shared at the consultation meeting in Islamabad on August 16, 2017. Federal and provincial multisectoral representatives from ministries of health, finance, foreign affairs, planning development and reform, and department of livestock and fisheries were present. Additionally, representatives from the World Bank country office in Pakistan, the US Centers for Disease Control and Prevention (CDC), Public

Health England, and the WHO Representative for Pakistan also participated in the meeting. Audience participation included discussion of Pakistan's efforts in developing a costed NAPHS and setting an example not only in the region but also globally.

LESSONS LEARNED

Pakistan's JEE and subsequent development of the NAPHS are foundational elements to building the nation's health security and provide an opportunity for other countries to learn from their experience. Pakistan's country-led, country-driven, and country-owned NAPHS is a critical step in the JEE continuum that needs attention for the success of sustained global health security. Based on Pakistan's experience, there were 4 key lessons learned, outlined below.

First, a large, developing country like Pakistan with a devolved health sector, where provinces are autonomous from the public health sector standpoint, required multi-sectoral coordination and participation of appropriate health- and nonhealth-related ministerial and departmental representatives at both the federal and provincial levels. The absence of a costing tool and guidance required more time for the development and costing of the plan. The formation of a national IHR technical working group proved to be essential in ensuring systematic coordination, participation, and collaboration across all sectors at the federal and provincial levels. This was extremely important because it helped get support and "buy-in" from all levels in the government. Also, creation of a plan alone is insufficient; planning can be more effective when all the stakeholders come together and develop their own roles and responsibilities for the implementation of the plan.¹⁴

Second, the development of the costed NAPHS is the beginning of the process for implementation of prioritized activities outlined in the plan.^{1,12} This requires engagement and investment of the country's own resources for sustainability as well as donor coordination among national and international donors and partners to address the identified gaps.¹² Pakistan has initiated the internal planning commission process to commit and invest its own additional resources for implementation. The donor coordination should be done by the country with the support of WHO's representative in the country, given its central role as the convener. The donors should also ensure that their current and future activities are aligned with the priority areas outlined in the plan. Additionally, donor-supported activities should be coordinated not only among themselves but also with the key government stakeholders.

Third, based on the JEE recommendations, the prioritization of activities by year and development of realistic country-specific goals and targets for NAPHS proved to be critical for country ownership of the plan and its implementation. This will also help in conducting periodic ongoing monitoring and evaluation for the implementation

of the plan. Areas that may be lagging and needing attention can be identified in a timely manner and addressed or modified accordingly.

Fourth, although Pakistan developed a costed NAPHS, the country encountered several challenges with the overall NAPHS process, including costing, which WHO and partners could address to help countries develop their own plans. First, the WHO guidance for development of an NAPHS needs to be simple, brief, flexible, and easy to follow, so that countries do not find the process too prescriptive, rigid, and overwhelming in terms of following the guidance as well as the time requirements to develop the plan. Second, the availability of short-time consultants from WHO or partners to support the country in the process of developing and costing of NAPHS following the completion of a JEE can expedite the NAPHS development process. This is important because the countries usually do not have staff at their health ministry who are familiar with the process, and they become overwhelmed. Third, the absence of a WHO-recommended user-friendly costing tool challenged Pakistan to initiate a costing process. Pakistan also had to recruit a costing consultant and then develop the costing tool and process themselves, which contributed to the delays in finalizing the plan. A simple, user-friendly WHO-recommended costing tool could have facilitated and expedited costing of the plan. WHO is currently in the process of developing and evaluating such a tool for future use by member states. Fourth, the availability of monitoring and evaluation indicators with specific milestones for countries is critical. The JEE tool divides each technical area into a set of indicators with capacity scores ranging from 1 to 5. However, there are no milestones to help guide planning efforts to move from one capacity level to the next. Incorporation of milestones would offer countries intermediate steps to work toward as countries develop activities and assess progress in moving from one JEE capability level to the next in each JEE technical area.¹⁵ WHO has recently worked on developing and adopting benchmarks to facilitate country-level planning efforts and monitoring progress in JEE technical areas. WHO has also recently rolled out basic training on monitoring and evaluation for IHR (2005) in the regions, and it might be helpful to make this training available especially to those countries that have completed a JEE. Lastly, facilitating the engagement and coordination of global donors and partners to assist with implementation is needed at an early stage of conducting the JEE and then immediately following the development of the NAPHS. This will help make them aware of the gaps in technical areas needing assistance and prompt engagement with the post-NAPHS implementation process. Pakistan did this at an early stage and has also engaged with the World Bank.

In conclusion, it is important to initiate the process for development of NAPHS immediately upon completion of the JEE process. WHO and partners have developed the process for developing the NAPHS, but delaying this process

risks losing vital momentum from the JEE. Although the development of the NAPHS in Pakistan took some time, Pakistan is the first country in EMRO and one of the few globally who have completed this process. Pakistan's experience and key lessons learned may help other countries in developing their NAPHS in a timely manner.

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