PAKISTAN PREPAREDNESS & RESPONSE PLAN COVID-19

Government of Pakistan

Table of contents

Acronyms

AAR	After Action Review
AJK	Azad Jammu and Kashmir (Pakistan Administered Kashmir)
CAA	Civil Aviation Authority
CDC	Centers for Disease Prevention & Control
CFR	Case Fatality Rate
CHE	Central Health Establishment
COVID-19	Coronavirus Disease 2019
DOH	Department of Health
DRAP	Drug Regulatory Authority of Pakistan
EOC	Emergency Operating Centre
FDSRU	Federal Disease surveillance & Response Unit
FELTP	Field Epidemiology Training Program
GHRP	Global Humanitarian Response Plan
HDU	High Dependency Unit
HDF	Health Declaration Form
IDIMS	Integrated Disease Information Management System
IEC	Information, Education and Communication
IPC	Infection Prevention & Control
ISPR	Inter-Services Public Relations
KP	Khyber Pakhtunkhwa
Mo NHSR&C	Ministry of National Health Services, Regulation & Coordination
MERS-CoV	Middle East Respiratory Syndrome
Mo C	Ministry of Commerce
Mo CC	Ministry of Climate Change
Mo H	Ministry of Health
Mo I	Ministry of Interior
Mo IB	Ministry of Information, Broadcasting,
MTAs	Material transfer agreement
NAP	National Action Plan
NCC	National Coordination Committee
NDMA	National Disaster Management Authority
NIH	National Institute of Health
NITB	National Information Technology Board
N-STOP	National Stop Transmission of Polio
OCHA	Office for Coordination of Humanitarian Affairs
PCR	Polymerase Chain Reaction
PDMA	Provincial Disaster Management Authority
PDSRU	Disease surveillance & Response Unit
PEI	Polio Eradication Initiative
PEMRA	Pakistan Electronic Media Regulatory Authority
PHEOC	Public Health Emergency Operational Centre
PHE	Public Health England
PHEIC	Public Health Emergency of International Concern
PoEs	Point of Entries
PPEs	Personal protective equipment
PPRP COVID-19	Pakistan Preparedness and Response Plan COVID-19
PSS	Psycho-social support
RCCE	Risk Communication and Community Engagement
RRT	Emergency Rapid Response Teams

SARI/ ILI	Severe Acute Respiratory Illness/ Influenza Like Illness
SARS-CoV	Severe Acute Respiratory Syndrome
SOPs	Standard Operating Procedures
SPRP	Strategic Preparedness and Response Plan
TORs	Terms of References
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNIDO	United Nations International Development Organization
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

There is an ongoing pandemic of Novel Coronavirus (COVID-19) in Pakistan which was first notified on 26 February 2020. As of 14 April 2020, over 5,719 cases with 96 deaths (CFR 1.68%) had been reported. The pandemic has spread to all provinces in Pakistan with over 115 districts affected, largely in Punjab and Sindh. The Government of Pakistan with support from partners have responded to the pandemic by strengthening coordination, case management, disease surveillance, laboratory, community mobilization and sensitization.

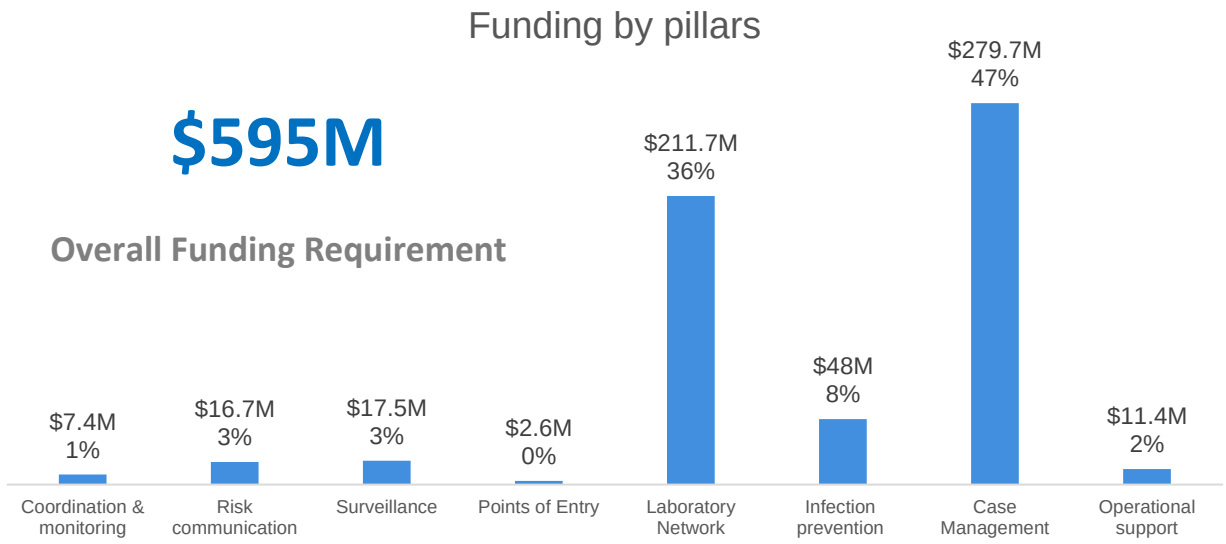
The COVID-19 Pakistan Preparedness and Response Plan (PPRP) outlines the international assistance required by the Government of Pakistan (GoP) to stop the transmission of the pandemic and respond to the emerging public health needs in Pakistan. It is created in line with the Pakistan National Action Plan. It aims to steer a coordinated international effort in consultation with Ministry of Foreign Affairs (MoFA) to support the Ministry of Health Services, Regulations and Coordination (M/O NHSRC), National Disaster Management Authority (NDMA) and Provincial Departments of Health, PDMAs under the overall efforts of the Government of Pakistan (GoP). It is prepared with the support of the UN and is guided by the WHO Strategic Preparedness and Response Plan (SPRP).

This plan will strengthen and reduce gaps in coordination at all levels, support disease surveillance and laboratory diagnosis, enhance case management, ensure implementation of infection prevention and control and lastly mobilize community for control of the outbreak.

The approach is dynamic, enabling resources to be adapted to support the most effective public health interventions as more is learnt about the virus and the key risk groups, with emphasis remaining on supporting the most vulnerable people. The primary focus of the plan continues to be prevention, preparedness and treatment of the COVID-19 outbreak.

Central to the plan is the following overall objective: **To help prevent and limit the spread of COVID-19 in Pakistan, and reduce the related morbidity and mortality due to the pandemic in the country**

The Plan seeks US$ 595 million as an overall funding requirement for a period of 9 months from April to December 2020.



GENERAL

The PPRP outlines the international assistance required by the Government of Pakistan (GOP) in support of actions to stop transmission of novel corona virus 2019 (COVID-19). It notes the, situation, international plans, outlines the assistance required, coordination mechanisms and reporting arrangements.

RELATIONSHIP WITH OTHER PLANS

This plan supports the National Action Plan.[1]

There are three international initiatives that address the COVID-19 pandemic and its consequences.

1. Strategic Pakistan Preparedness and Response Plan (PPRP)[2] aims to stop transmission of COVID-19. The tracking of assistance and actions is done through the COVID-19 Partners Platform[3]. It was prepared by the Ministry of Health and NDMA in consultation with member states and IFI with the technical support of WHO and UN Partners.
2. The Global Humanitarian Response Plan (GHRP)[4] addresses the direct public health and indirect immediate humanitarian consequences of the pandemic. It currently covers those countries that already have a Humanitarian Response Plan or a Regional Refugee Plan. Tracking of assistance is done through the Financial Tracking System (FTS). It is facilitated by Office of Coordination of Humanitarian Assistance (OCHA).
3. 'Shared responsibility, global solidarity: Responding to the socio-economic impacts of COVID-19'[5] is a set of recommendations to mitigate the socio-economic consequences of the pandemic.

The PPRP is aligned with the SPRP and so aims to stop transmission of COVID-19. It does not seek to address the humanitarian or socio-economic consequences of the epidemic, the GOP is preparing two other plans to address that.

ASSISTANCE COVERED BY THE PPRP

The aim of the PPRP is to ensure a coordinated international support in consultation with Ministry of Foreign Affairs (MoFA) to the Ministry of Health Services, Regulations and Coordination (M/O NHSRC), National Disaster Management Authority (NDMA) and Provincial Departments of Health (PDMAs), to stop transmission of COVID-19. Further this plan ensures that international assistance to the GOP is coordinated, efficient and transparent:

The PPRP covers:

- Assistance by all sovereign states and International Financial Institutions (IFI).
- All forms of assistance; in-kind, grants, loans and the repurposing of existing aid instruments.
- Assistance provided up to but not beyond the end of 2020.
- Implementation by the GOP, UN and Non-Government Organisations (NGO).

The plan regroups various international assistance, including the following non-comprehensive list:

1 https://www.nih.org.pk/wp-content/uploads/2020/03/COVID-19-NAP-V2-13-March-2020.pdf
2 https://www.who.int/docs/default-source/coronaviruse/covid-19-sprp-unct-guidelines.pdf
3 https://www.covid-19-response.org
4 https://www.unocha.org/sites/unocha/files/Global-Humanitarian-Response-Plan-COVID-19.pdf
5 https://www.un.org/sites/un2.un.org/files/sg_report_socio-economic_impact_of_covid19.pdf

- The plan refers to and includes actions covered under the agreements of the World Bank (WB)[6], the Asian Development Bank (ADB), the Islamic Development Bank (IDB) and the Asian Infrastructure Development Bank (AIDB) with the GOP on COVID-19.
- The plan covers existing UN international appeals for COVID-19 such as; the UNICEF Humanitarian Action for Children 2020 appeal for COVID-19[7], the UNDP Integrated Response[8], the IOM COVID-19 Global Strategic Preparedness and Response Plan.[9]
- UN administered pooled funds will be used for implementation. The Pakistan Humanitarian Pooled Fund has been reactivated and will be used with a view to supporting NGOs in particular, and UN when needed. The Central Emergency Response Fund (CERF) is available to finance UN agencies.

The importance of the emergency financing from the International Monetary Fund (IMF) now under discussion with the GOP is recognised however the activities thereby financed will not be monitored by this plan.

EPIDEMIOLOGY OF THE OUTBREAK

The pandemic of COVID-19 was first notified on 31 December 2019 in Wuhan City, Hubei Province of China. As of 14 April 2020, the disease had infected over 1,812,734 people with 113,675 deaths (CFR 6.27%). Over 185 countries from all continents have reported at least one case.

The first 2 cases of COVID-19 in Pakistan were notified on 26 February 2020. As of 14 April 2020, over 5,719 cases with 96 deaths (CFR 1.68%) have been reported. One case was notified in Karachi while the other case was reported in Islamabad City Territory. The outbreak has now spread to all provinces and regions of Pakistan. The most affected province is Punjab with 2,826 cases and 24 deaths (CFR 0.84%), followed by Sindh with 1,452 cases and 31 deaths (CFR 2.13%). The least affected region is AJK/PAK with 43 cases and no deaths (CFR 0%). See details in the map 1. below.

The daily incidence has increased from 2 cases on 26 February to 342 cases as of 14 April 2020. Five hundred seventy-seven (577) is the highest number of cases reported on 6 April 2020. See figure 1 showing the daily incidence of cases in Pakistan and figure 2 showing cumulative number of cases being reported daily.

Male (75%) are affected more than the females (25%). The most affected age group ranges from 20 to 49 years (45%). In Pakistan only 28% of the affected population is over 50 years of age. This figure is not in line with what is reported in USA, Italy and China. See figure 3 showing the distribution of cases by sex and age group.

Over 115 districts in Pakistan have reported at least one case of COVID-19. See map 2 showing the distribution of number of cases of confirmed COVID-19 in Pakistan by district.

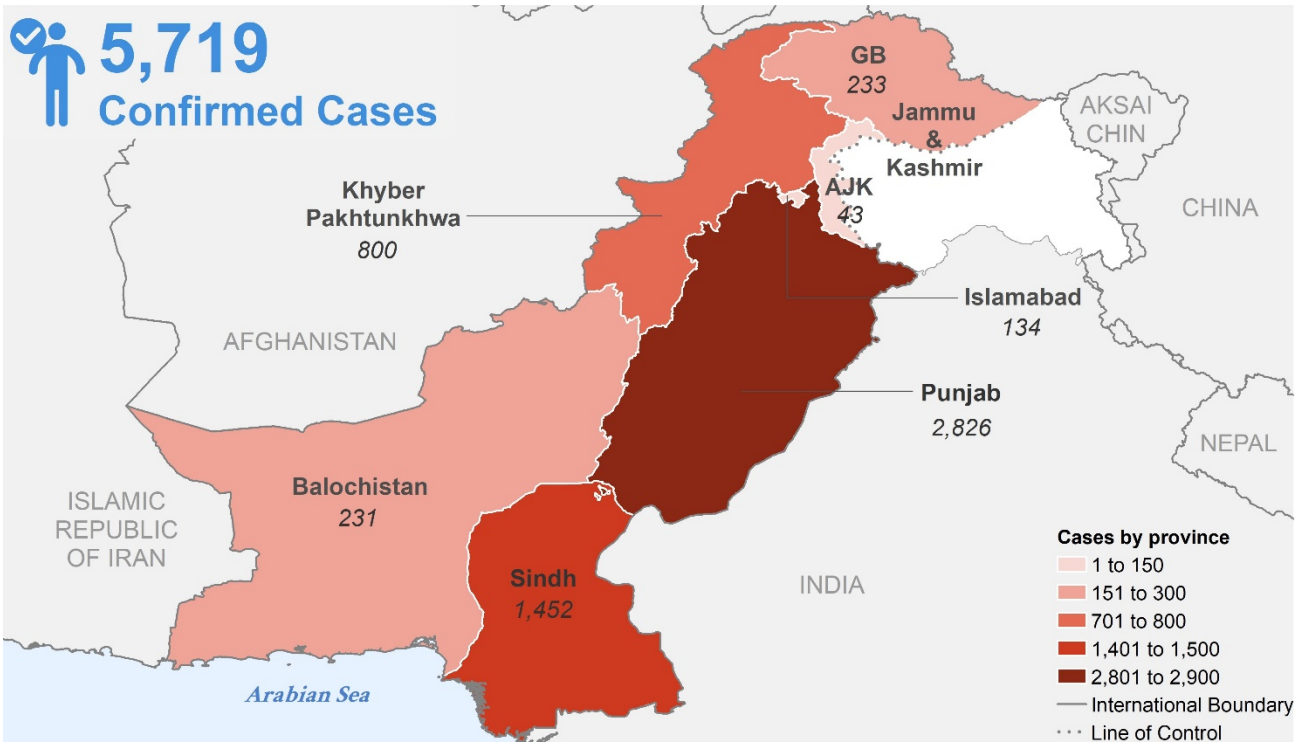
6 Project appraisal document on a COVID-19 Strategic Preparedness and Response Program and proposed 25 projects under phase 1 using the multiphase programmatic approach with an overall financing envelope of up to $4 billion for health financing (upto US$ 1,300 million IDA and up to US$2.7 billion under the IBRD) Human Development Practice Group, April 2, 2020

7 https://www.unicef.org/appeals/covid-2019.html

8 https://www.undp.org/content/dam/denmark/docs/COVID-19%20Response%20Plan.pdf

9 https://crisisresponse.iom.int/sites/default/files/uploaded-files/IOM%20Covid-19%20Appeal%202020_final_0.pdf

MAP I: SHOWING THE DISTRIBUTION OF COVID-19 CASES BY PROVINCE- 4 APRIL 2020



MAP II: SHOWING THE DISTRIBUTION OF COVID-19 CASES BY DISTRICTS

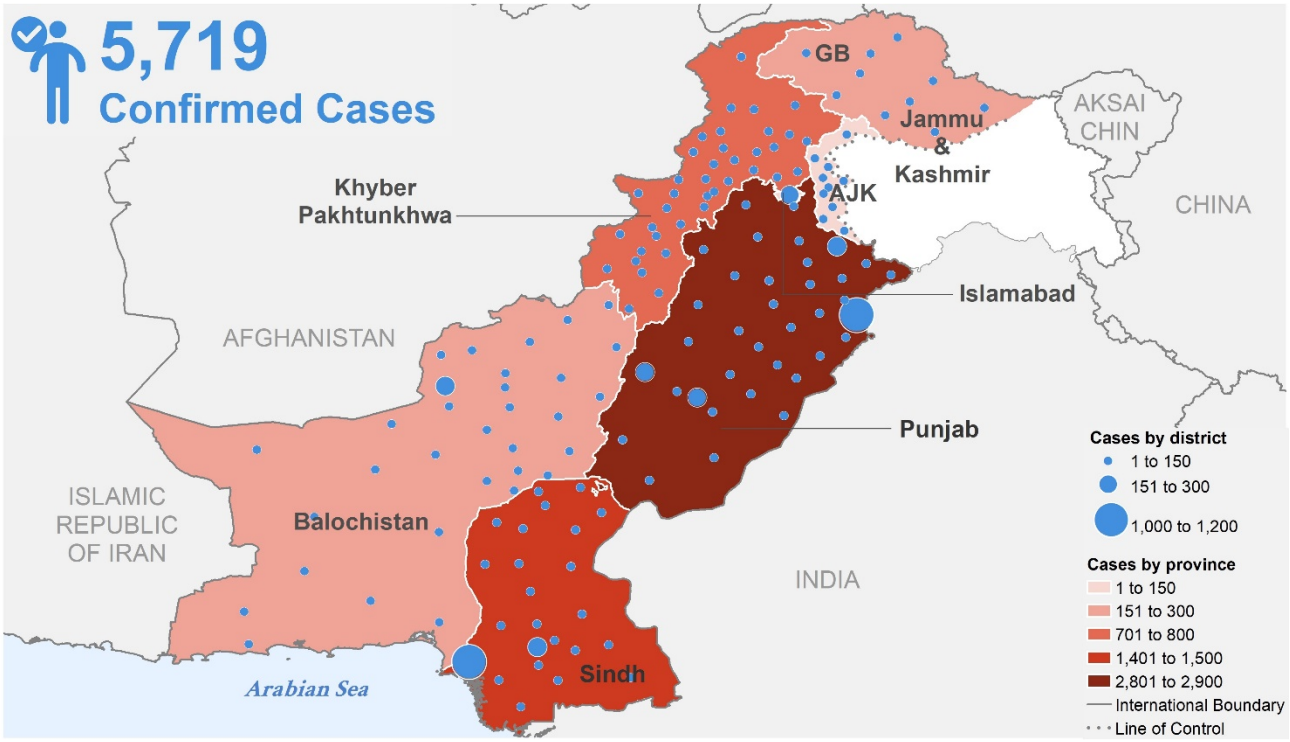


Fig 1: Daily incidence of COVID-19 in Pakistan
(19 March to 14 April 2020)

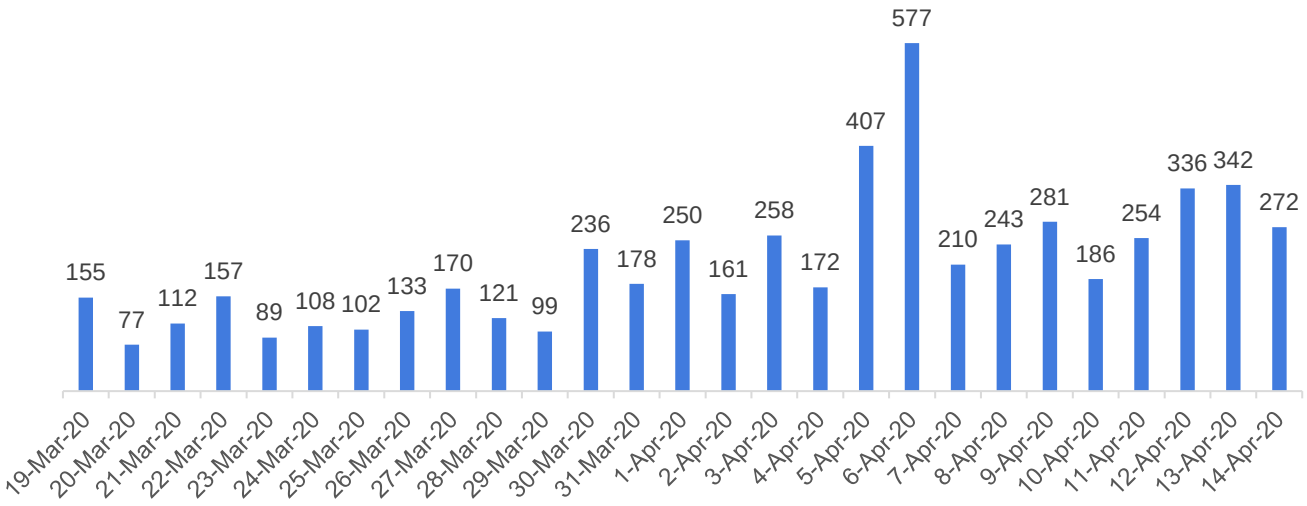


Fig 2: Cumulative Number of Cases of COVID-19 in Pakistan
by Province and by Date
(19 March to 14 April 2020)

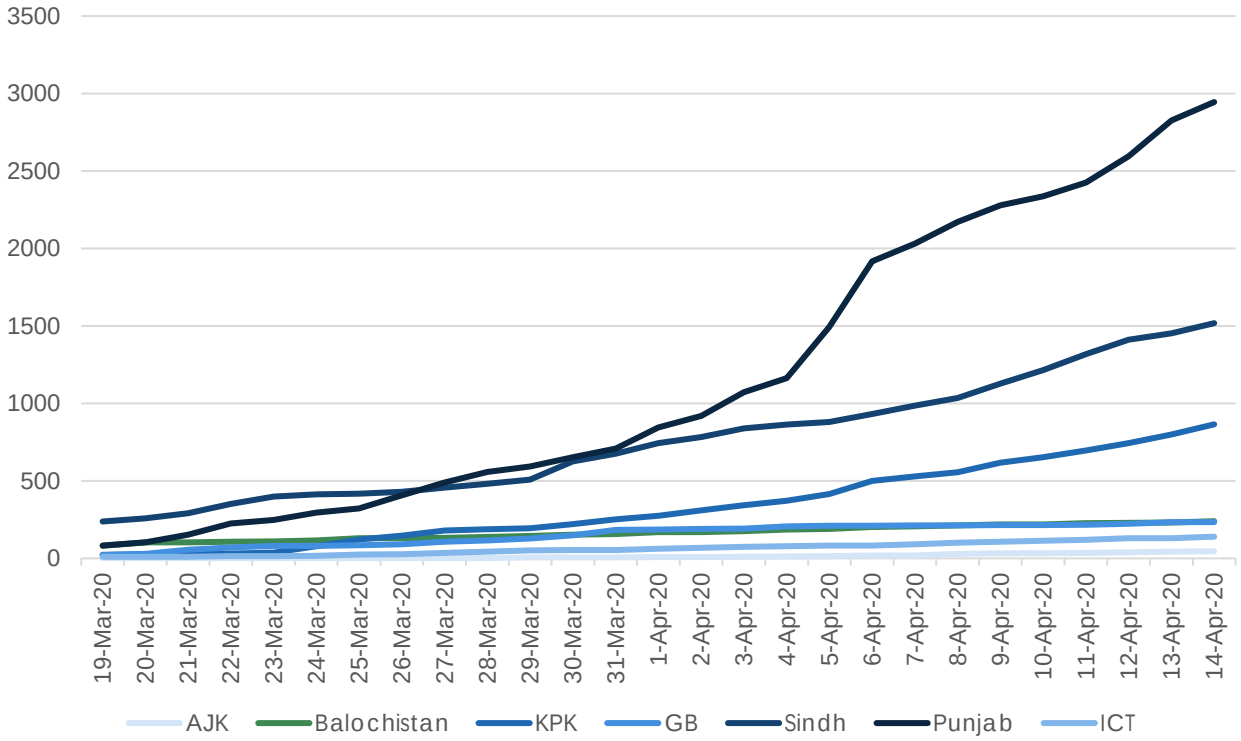
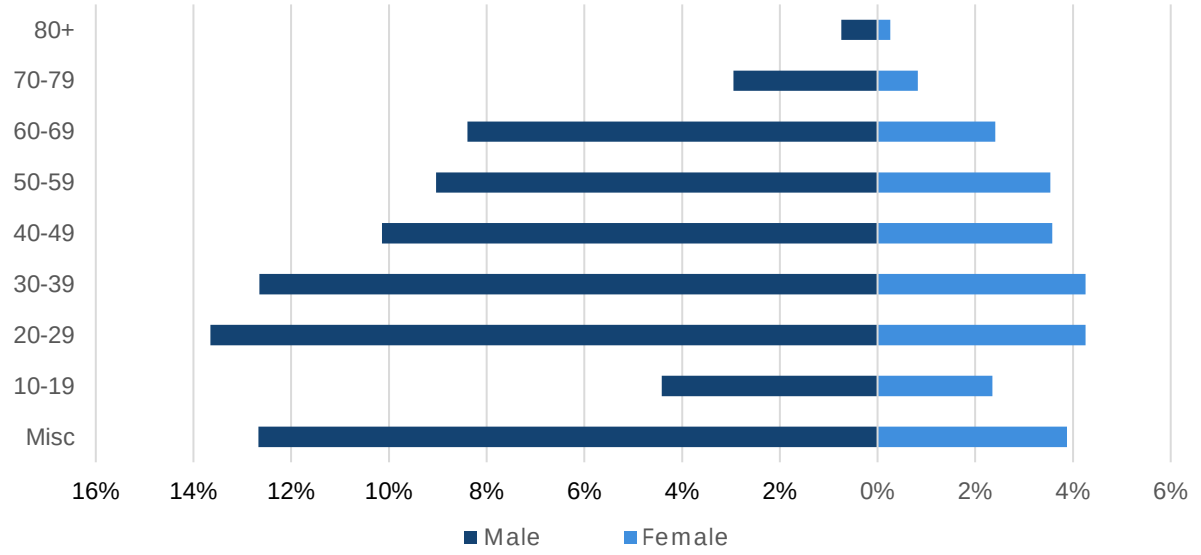


Fig 3: Proportion of COVID-19 Cases by Age and Sex



GOVERNMENT RESPONSE

On the 13th March 2020 the National Security Committee of the GOP constituted a National Coordination Committee, chaired by the Special Advisor to the Prime Minister for Health to formulate and implement a comprehensive strategy to stop the transmission of the virus and mitigate its consequences. This committee comprises of all relevant Federal Ministers, Chief Ministers and Provincial Health Departments and has designated the National Disaster Management Agency (NDMA) as the leading operational agency.

A National Command and Control Centre has been established to ensure effective coordination between the federal and provincial governments. At each provincial level, Task Force chaired by Chief Minister on COVID-19 has been formed. The National Disaster Management Authority with Provincial Disaster Management Authorities are the leading operational agency for COVID-19 response.

During the early phase of the pandemic, the major threat was importation of cases of COVID-19. To that effect, on the 23 January 2020, the government of Pakistan started screening passengers at Islamabad airport. Subsequently, the screening was expanded to include all types of points of entry (sea, land crossings and airports). Training of additional health and airport staff, provisions of equipment and other supplies and establishment of information desks at the airport for information and general awareness to travellers was undertaken. Over one million (1,102,562) passengers were screened between 23 January and 20 March 2020 when all points of entry were closed. Additionally, the government has established 294 quarantine facilities with 139,558 beds to segregate people who had contacts with a confirmed COVID-19 case but are not yet ill. In addition, 566 hotels with 16,336 beds have also been identified for the same purpose.

In view of escalation in the reported cases as a result of local transmission, the government has strengthened disease surveillance at health facility and community level using existing surveillance mechanism including Polio surveillance officers. Currently over 444,509 contacts have been traced by the same team. Confirmed cases are managed in isolation facilities designated for the confirmed cases. In this regard, strengthening of isolation facilities for Infection Prevention and Control and case management is the major component of health facility preparedness for COVID response. Infection Prevention and Control

is cross cutting and the mainstay of infectious disease management. There has been renewed focus on implementing IPC including provision of PPE and other IPC supplies and training of health care workers on various IPC and case management protocols. A total of 217 isolation facilities with 119,778 beds are already designated for case management in Pakistan. Strengthening IPC and case management in the designated facilities has assumed greater significance in view of initiation of community transmission and continuous escalation of confirmed COVID cases in the country.

Awareness and information material on hand hygiene, SOPs on standard and transmission precautions, correct and rational use of mask and PPEs, social distancing and environmental cleaning were developed and disseminated widely. Help lines have been established for public facilitation.

The National Institute of Health, as the national reference public health laboratory acquired the requisite capability for COVID-19 diagnostics on 1 February 2020. Since then the government has established 18 centres in all provinces and regions across Pakistan that can perform Real time PCR testing for COVID-19. Over 30 technical staff has been trained on the testing protocols, and now the current testing capacity is 2500-3000 tests/day. The Technical Working Group on laboratory has developed the following key guidance documents for laboratory:

1. National Guidance on sample collection, storage and transport of suspected COVID-19 samples
2. National recommendations for priority COVID-19 testing
3. Recommendations for COVID-19 Laboratory Diagnostics

Over 69,928 samples have been tested at these laboratories, of which over 5716 positive cases have been identified from all provinces and regions [approx. 8% positive rate). At the current detection rate of 8%, there is need to enhance the testing capacity to 2 million tests.

The predicative analysis of expected cases based on the attack rates from other countries indicates that there are likely to be approx. 196,421 total cases in Pakistan. Of these 157,137 (80%) will be mild, 29,463 will be moderate to severely ill (15%) and approximately 10,000 (5%) critical cases that will require ventilator/Highly Dependent Unit support. This projection is based on the present available epidemiological data on COVID-19 and will change depending on the response instituted. There is a need to regularly monitor the trend of the outbreak and revise the plan accordingly.

In view of the predicted increased testing requirements for COVID-19 testing across Pakistan, there is urgent need to clearly map and expand the lab detection capacity to high case burden areas, linking the laboratory network to designated quarantine and health/isolation facilities to ensure early case finding, case isolation, contact tracing and management of confirmed cases.

TOTAL NUMBER OF TESTS BY PROVINCE AND POSITIVE CASES

Province/Region	Test Performed	Test Positive	Positivity Rate (%)
ICT	3,883	134	3%
Punjab	32,638	2826	9%
Sindh	13,595	1452	11%
KPK	4,075	800	20%
Balochistan	3,463	231	7%

AJK / PAK	1,006	43	4%
Gilgit Baltistan	1,528	233	15%
Total	60,188	5,719	10%

**As of 14 April 2020*

CHALLENGES AND GAPS

There is a formal coordination structure within the government that has been established to provide coordination of the response at all levels however, the linkage between the central and provincial/regional level coordination is not well defined and needs to be streamlined. The provincial coordination structure which is mandated by the constitution needs to be supported to provide oversight to the response.

The disease surveillance system is weak and fragmented, and the sentinel surveillance and event-based surveillance is not functional. The Severe Acute Respiratory Illness/ Influenza Like Illness (SARI/ILI) sentinel surveillance which can be used as a proxy is not fully functional. Over 70 Rapid Response Teams (RRTs) have been constituted and trained in many of the provinces however, this number is very small given the fact that we need at least one RRTs in each of the 154 districts in Pakistan. The response to call by the RRTs for case investigation is weak as they are few and lack infection prevention and control equipment and supplies. The data collection, analysis, reporting and dissemination of health data is weak and fragmented at all levels. There is an urgent need to strengthen all aspects of disease surveillance.

Confirmation of COVID-19 is another challenge. There are limited number of laboratories with inadequate capacity to confirm COVID-19 cases. Currently, there are 18 laboratories in Pakistan with the capacity to confirm COVID cases. The total PCR tests available in the country are approximately 45,000-50,000 in the public and private sectors with daily testing of up to 3,000 tests/day. There are inadequate supplies of viral RNA extraction kits and automated extractors in the country which affects the overall testing output. Majority of the laboratories are in major cities. As a result, only 35,875 tests have so far been conducted representing 142 tests per 1,000,000 people. Given the current positivity rate of 8%, there is need to conduct 2 million tests to reach the projected 9,049 tests per 1,000,000. There is a network of TB labs with Genexpert systems for PCR, but the testing cartridges are not available, and only 15-20 labs have biosafety equipment required for COVID-19 sample handling.

The isolation and quarantine facilities are inadequate in number and the infrastructure is inappropriate for isolation and quarantine. The standard operating procedures (SoPs) are not implemented at both the isolation and quarantine facilities. The facilities also lack human resources, technical expertise, supplies, equipment and proper management. The people quarantined or isolated are not properly briefed on the importance of social distancing and hygiene. This was partially responsible for the spread of COVID-19 at Taftan border and may continue to be a factor in spread of COVID in new quarantine sites being established. Balochistan has a highly porous border with Iran and Afghanistan that potentially puts at risk its population to the pandemic. There is a need to put in place adequate facilities and technical expertise at all points of entry while ensuring that borders are sealed. Weak surveillance capacity and scattered population may lead to inaccurate depiction of the exact situation in Balochistan.

The current number of isolation facilities and beds are few (217 isolation facilities with 119,778 beds) whereas the estimated number of total beds requirement is 196,421 as per the current projection based on available data. There is urgent need to support the government through training of staff, provision of necessary female staff with essential medicines and other medical supplies.

Case management facilities are inadequate and lack trained staff, required equipment and supplies. Infection prevention and control is weak at all levels (community, facility, surveillance and laboratory) in

terms of competent human resources, supplies, availability of required structures and implementation of protocols.

The COVID-19 outbreak has the potential to reverse the reproductive health gains achieved so far and make existing vulnerabilities worse, limiting women's access to lifesaving maternal health services as a result of movement restrictions, combined with the fear and household tensions. This is coupled with fragile reproductive health facilities, which have been in need of significant investments in human capital, supplies and infrastructure even before the outbreak. Currently, about 66 percent of the deliveries occur in health facilities. Therefore, ensuring continuity of life-saving maternal health services and interventions to attend the 66 percent facility-based deliveries (more than one million deliveries in next three months constitutes) a tremendous public health concern, considering the fact that around 15 percent of women experience delivery complications. The weak health system is evidenced by high lifetime risk of maternal death, which is at 1 in 180 (the third highest in the Asia Pacific region, with an estimated number of maternal deaths of 8300 in Pakistan) and the maternal mortality ratio of 140 per 100,000 live births, with wide variation between provinces.

Technical awareness messages have been developed and need to be disseminated widely. However, community mobilization and sensitization activities are weak, and risk communication and community engagement strategy still need finalization and dissemination.

STRATEGIC PREPAREDNESS AND RESPONSE

GOAL

Reduce risk of COVID-19 pandemic to the population of Pakistan by prevention, detection and response at all levels

STRATEGIC OBJECTIVE

To help prevent and limit the spread of COVID-19 in Pakistan and reduce the related morbidity and mortality in the country.

RESPONSE PRIORITIES

Pillar 1: Country-level coordination, planning and monitoring	
Step	**Priority Actions/Activities**
1	Activate multi-sectoral, multi-partner coordination mechanisms to support preparedness and response at national and provincial level
	Engage with national authorities and key partners to develop a country-specific operational plan with estimated resource requirements for COVID-19 preparedness and response
	Conduct initial capacity assessment and risk analysis, including mapping of vulnerable populations by adapting human rights approach and intersectional analysis that would also form the basis of the socio-economic impact analysis
	Begin establishing metrics and monitoring and evaluation systems to assess the effectiveness and impact of planned measures
2	Establish an incident management team, including rapid deployment of designated staff from national and partner organizations, within a public health emergency operation centre (PHEOC) or equivalent if available
	Identify, train, and designate spokespeople

	Establish an incident reporting mechanism for addressing GBV incidents within communities or and link with essential services
	Engage with local donors and existing programmes to mobilize/allocate resources and capacities to implement operational plan
	Review regulatory requirements and legal basis of all potential public health measures
	Monitor implementation of PPRP based on key performance indicators in PPRP
3	Conduct regular operational reviews to assess implementation success and epidemiological situation, and adjust operational plans as necessary
	Conduct After Action Reviews in accordance with IHR (2005) as required
	Use COVID-19 outbreak to test/learn from existing plans, systems and lesson-learning exercises to inform future preparedness

Pillar 2: Risk Communication and community engagement

Step	Priority Actions/Activities
1	Implement national risk-communication and community engagement (RCCE) plan for COVID-19, including details of anticipated public health measures
	Conduct regular rapid behaviour assessment to understand key target audience, perceptions, concerns, influencers and preferred communication channels
	Prepare local messages and pre-test through a participatory process, specifically targeting key stakeholders and at-risk groups
	Identify trusted community groups (local influencers such as community leaders, religious leaders, health workers, community volunteers) and local networks (women's groups, youth groups, business groups, traditional healers, etc.)
2	Utilize the clearance processes through the Government notified Risk Communication and Community Engagement task force for timely review and dissemination of messages and materials in local languages and adopt relevant communication channels
	Engage with existing public health and community-based networks, media, local NGOs, schools, local governments and other sectors such as healthcare service providers, education sector, business, travel and food/agriculture sectors using a consistent mechanism of communication
	Utilize two-way 'channels' for community and public information to detect and rapidly respond to and counter misinformation
	Leverage community networks and influencers for social and behaviour change approaches to ensure preventive community and individual health and hygiene practices, including stigma prevention, in line with the national public health containment recommendations
3	Systematically establish community information and feedback mechanisms
	Ensure changes to community engagement approaches are based on evidence and needs, and ensure all engagement is culturally appropriate and empathetic
	Document lessons learned to inform future preparedness and response activities

Pillar 3: Surveillance, rapid response teams, and case investigation

Step	Priority Actions/Activities
1	Update and disseminate case definition in line with WHO guidelines and investigation protocols to healthcare workers (public and private sectors)
	Activate active case finding and event-based surveillance for influenza-like illness (ILI), and severe acute respiratory infection (SARI)
	Assess gaps in active case finding and event-based surveillance systems
2	Enhance existing surveillance systems to enable monitoring of COVID-19 transmission and adapt tools and protocols for contact tracing and monitoring to COVID-19
	Undertake case-based reporting to WHO within 24 hours under IHR (2005)

	Actively monitor and report disease trends, impacts, population perspective to global laboratory/epidemiology systems including anonymized clinical data, case fatality ratio, high-risk groups (pregnant women, immunocompromised) and children
	Train and equip rapid-response teams to investigate cases and clusters early in the outbreak, and conduct contact tracing within 24 hours
3	Provide robust and timely epidemiological and social science data analysis to continuously inform risk assessment and support operational decision making for the response

Pillar 4: Points of entry

Step	Priority Actions/Activities
1	Develop and implement a points of entry public health emergency plan
2	Disseminate latest disease information, standard operating procedures, equip and train staff in appropriate actions to manage ill passenger(s)
	Prepare rapid health assessment/isolation facilities to manage ill passenger(s) and to safely transport them to designated health facilities
	Communicate information about COVID-19 to travellers
3	Regularly monitor and evaluate the effectiveness of readiness and response measures at points of entry, and adjust readiness and response plans as appropriate

Pillar 5: Laboratory network

Step	Priority Actions/Activities
1	Establish access to a designated international COVID-19 reference laboratory
	Adopt and disseminate standard operating procedures (as part of disease outbreak investigation protocols) for specimen collection, management, and transportation for COVID-19 diagnostic testing
	Identify hazards and perform a biosafety risk assessment at participating laboratories; use appropriate biosafety measures to mitigate risks
	Adopt standardized systems for molecular testing, supported by assured access to reagents and kits
2	Ensure specimen collection, management, and referral network and procedures are functional
	Share genetic sequence data and virus materials according to established protocols for COVID-19
	Develop and implement plans to link laboratory data with key epidemiological data for timely data analysis
	Develop and implement surge plans to manage increased demand for testing; consider conservation of lab resources in anticipation of potential widespread COVID-19 transmission
3	Monitor and evaluate diagnostics, data quality and staff performance, and incorporate findings into strategic review of national laboratory plan and share lessons learned
	Develop a quality assurance mechanism for point-of-care testing, including quality indicators

Pillar 6: Infection prevention and control

Step	Priority Actions/Activities
1	Assess IPC capacity at all levels of healthcare system, including public, private, traditional practices and pharmacies.
	Assess IPC capacity in public places and community spaces where risk of community transmission is considered high
	Review and update existing national IPC guidelines
	Develop and implement a plan for monitoring of healthcare personnel exposed to confirmed cases of COVID-19 for respiratory illness

	Develop a national plan to manage PPE supply (stockpile, distribution) and to identify IPC surge capacity (numbers and competence)
2	Engage trained staff with authority and technical expertise to implement IPC activities, prioritizing based on risk assessment and local care-seeking patterns
	Record, report, and investigate all cases of healthcare-associated infections
	Disseminate IPC guidance for home and community care providers
	Implement triage, early detection, and infectious-source controls, administrative controls and engineering controls; implement visual alerts (educational material in appropriate language) for family members and patients to inform triage personnel of respiratory symptoms and to practice respiratory etiquette
	Support access to water and sanitation for health (WASH) services in public places and community spaces most at risk
3	Monitor IPC and WASH implementation in selected healthcare facilities, quarantine and isolation centres and public spaces
	Provide prioritized tailored support to health facilities based on IPC risk assessment and local care-seeking patterns, including for supplies, human resources, training
	Carry out training to address any skills and performance deficits

Pillar 7: Case management

Step	Priority Actions/Activities
1	Map vulnerable populations and public and private health facilities (including traditional healers, pharmacies and other providers) and identify alternative facilities that may be used to provide treatment
	Identify Intensive Care Unit Capacity /Quarantine/Isolation Facilities
	Continuously assess burden on local health system, and capacity to safely deliver primary healthcare services
2	Ensure that guidance is made available for the self-care of patients with mild COVID-19 symptoms, including guidance on when referral to healthcare facilities is recommended; Enhance national healthcare capacity
	Establish dedicated and equipped teams and ambulances to transport suspected and confirmed cases, and referral mechanisms for severe cases with co morbidity
	Ensure comprehensive medical, nutritional, and psycho-social care for those with COVID-19
	Evaluate implementation and effectiveness of case management procedures and protocols (including for pregnant women, children, immunocompromised), and adjust guidance and/or address implementation gaps as necessary

Pillar 8: Operational support and logistics

Step	Priority Actions/Activities
1	Map available resources and supply systems in health and other sectors
2	Review supply chain control and management system
	Review procurement processes (including importation and customs) for medical and other essential supplies
	Assess the capacity of local market to meet increased demand for medical and other essential supplies, and coordinate international request of supplies through regional and global procurement mechanisms
3	Identify and support critical functions that must continue during a widespread outbreak of COVID-19

OUTCOMES

1. Strengthened national emergency prevention, preparedness, response and rehabilitation for COVID-19 pandemic in Pakistan through implementation of public health preparedness and response plan
2. Defined and coordinated sectoral and technical roles, responsibilities and functions of all stakeholders involved in emergency management of COVID-19 with NDMA
3. Robust pandemic prevention, preparedness, detection and response mechanisms established
4. Strengthened monitoring and evaluation coordination mechanisms for strategic, technical and operational support
5. Increased financial and other resources advocated and mobilized for national emergency preparedness, detection, response and recovery
6. Local community engaged for COVID-19 prevention, preparedness, detection and response through a robust risk communication and community engagement strategy

IMPLEMENTATION ARRANGEMENT

This plan will be jointly implemented through the National Disaster Management Authority and Ministry of National Health Service, Regulation and Coordination NHSRC, the Provincial and District health department alongside Provincial Disaster Management Authorities in order to strengthen/build local capacity for sustainable interventions. Partners will provide technical and financial support to the project. However, provisions for direct implementation of some activities like training of health workers and the community can be conducted directly by the supporting partners. Under such circumstances the NHSRC, the Provincial Health Department and the District Health Office will be partners in the activity to ensure quality of the activity. national guidelines for such activities will be used for the training purpose.

COORDINATION MECHANISM

Coordination of international assistance will be carried out at the national level and in the provinces. National coordination will take place with NDMA, MO NHSR&C, Ministry of Foreign Affairs, contributing sovereign states, IFI, UN and NGOs in:

- Strategic Coordination Forum convened by the NDMA with the support of OCHA.
- Pilar working groups chaired by the relevant government focal point, supported by the relevant UN agency.

Provincial coordination will take place with relevant departments of the Government of Pakistan including Department of Health, Provincial Disaster Management Authority, UN and Non-Government Organisations (NGO) in:

- General Coordination Meetings convened by the Provincial Disaster Management Agencies (PDMA) with the support of OCHA.
- Pillar working groups chaired by the relevant GOP focal point, supported by the relevant UN agency.

MONITORING, EVALUATION AND REPORTING

The PPRP will be monitored through the COVID-19 Partner Platform[10]. This will track aid commitments and actions under the pillars at National, Provincial and District level. Ministry of Economic Affairs Division (EAD), WHO and OCHA will facilitate this.

[10] www.covid-19-response.org

Based on the guidelines, NDMA and NHSRC has developed detailed implementation activities and sub-activities along with indicators, implementer, and budget with timeframe to be determined for priority actions. The detailed plan is as follows:

BREAKDOWN OF ACTIVITIES AND FUNDING REQUIREMENT

Pillar	Pillar	Funding Request	Percentage of Total
Pillar 1	Country level coordination, planning & monitoring	$7.4M	1%
Pillar 2	Risk communication & community engagement	$16.7M	3%
Pillar 3	Surveillance, rapid response teams & case investigation	$17.5M	3%
Pillar 4	Points of Entry	$2.6M	0%
Pillar 5	Laboratory Network	$211.7M	36%
Pillar 6	Infection prevention and control	$48.0M	8%
Pillar 7	Case Management	$279.7M	47%
Pillar 8	Operational support & logistics	$11.4M	2%
	Total	$594.9M	

Detailed activities by pillar

Pillar 1: Country-Level Coordination, Planning, and Monitoring

Step	Priority Actions/Activities	Sub-Activities	Indicators	Implementer	Budget (USD)
1	Activate multi-sectoral, multi-partner coordination mechanisms to support preparedness and response at national and provincial level	• Establishment and functionality of national and provincial / regional coordination committee • Modelling of the outbreak trajectory • Establishment of a technical working groups at national and provincial level • Activate National Emergency Operations at	• Notification of the committees • Coordination mechanism developed at national and provincial level • NEOCs activated in Mo/NHSRC, NDMA, PDMA and provincial health departments	M/o NHSRC Provincial and Regional DoH NDMA PDMA OCHA WHO UN / Partners	800,000

		Federal and Provincial Levels • Meetings key stakeholders to develop a comprehensive coordination mechanism between key agencies for COVID-19 preparedness and response • Map existing and potential partners • Produce weekly SitReps	• Number of meetings conducted, and actions taken • SitReps developed and shared		
	Engage with national and provincial authorities and key partners to develop a country-specific operational plan with estimated resource requirements for COVID-19 preparedness and response	• Develop national emergency preparedness and response plan COVID-19 for Pakistan • Translate National PPRP COVID-19 Plan into provincial and regional operational preparedness and response plans	• COVID-19 National Emergency preparedness and response plan prepared and shared • Financial outlay of the plan developed and shared	M/o NHSRC Provincial and regional DoH NDMA PDMA, OCHA WHO UN / Partners	800,000
	Conduct initial capacity assessment and risk analysis, including mapping of vulnerable populations by adapting human rights approach and intersectional analysis that would also the form the basis of the socio-economic impact analysis	• Conduct assessment of national (federal and provincial) health capacity and resources to inform response actions (both public and private) • Map vulnerable areas/population segments • Establish procedures to share data and risk assessment findings with	• Capacity assessment and risk analysis conducted, and report shared • Mapping of vulnerable populations conducted and shared through a report • Process/mechanism to share findings established	M/o NHSRC Provincial and regional DoH Planning Commission NDMA PDMA OCHA	520,000

		national and international stakeholders • Conduct a regularly updated, multi-sectoral gender analysis with sex, age and disability disaggregated data collection to identify inequalities, gaps, and capacities to assess the specific impacts of the crisis on the women, girls, men and boys of the affected population • Conduct Socio-economic Impact Assessment of COVID-19 on Vulnerable Population in Pakistan	• Assessment findings generated and utilized for planning socio-economic analysis	WHO UN / Partners	
	Begin establishing metrics and monitoring and evaluation systems to assess the effectiveness and impact of planned measures	• Establish M E oversight bodies at the national and provincial level • Devise a monitoring and evaluation system/process • Develop indicators to track progress	• Notification of M&E oversight bodies • M&E system developed • M&E Indicators developed	M/o NHSRC Provincial and regional DoH NDMA PDMA OCHA WHO UN / Partners	50,000
2	Establish an incident management team, including rapid deployment of designated staff from national and partner	• Establish/ Strengthen Incident Management/Incident Command and Control	• Incident Command and Control/Incident Management System established at the	M/o NHSRC Provincial and regional DoH NDMA	600,000

	organizations, within a public health emergency operation centre (PHEOC) or equivalent if available	Centre at the national and provincial level • Training and Capacity building of EOC staff • Development of SOPS and tools • Logistics and operational support for management of EOC (HR cost, support mobility for M&E, IT equipment, printing, PPEs, etc.)	national and provincial level • Tools developed (HR cost, support mobility for M&E, IT equipment, printing, PPEs, etc.	PDMA OCHA WHO UN / Partners	
	Identify, train, and designate spokespeople	• Designate senior management spokesperson at national and provincial/regional level • Orientation of spokesperson on COVID19 management and response	• Senior National and provincial spokesperson designated	M/o NHSRC Provincial and regional WHO and DoH	110,000
	Establish an incident reporting mechanism for addressing GBV incidents within communities, isolation facilities, quarantine facilities and health care facilities and link with essential services	• Establish Case Management system linked with appropriate helplines and social services	• GBV Incident record and management system established • Provinces required to establish a multi-sectoral coordination mechanism to prevent and respond to GBV during COVID-19 that link districts to provincial and federal teams	NDMA PDMA UNFPA UN Partners	50,000

	Engage with local donors and existing programmes to mobilize/allocate resources and capacities to implement operational plan	• Resource mapping at national and provincial/regional level to identify needs • Conduct meetings with stakeholders to mobilize resources for implementation of humanitarian response plan	• Resources mobilized in line with humanitarian response plan and needs identified	M/o NHSRC Provincial and regional DoH WHO UN / Partners	200,000
	Review regulatory mechanisms including private and public partnership to assist with capacity problems	• Engage team for finalizing relevant laws (public health legal experts) • Conduct consultative process at the national and provincial level for consensus to finalize public health • Finalize the relevant public health legislations for approval from the parliament (public health surveillance, IPC, waste management) • Enactment of the law	• Legal teams hired at National and provincial level • Approval and endorsement by parliament	M/o NHSRC Ministry of Law and justice division WHO UN / Partners	1,000,000
	Monitor implementation of PPRP based on key performance indicators in PPRP	• Assign focal points for monitoring and evaluation • Monitoring visits • Produce monitoring reports	• Monitoring and Progress reports shared	M/o NHSRC Provincial and regional DoH NDMA PDMA OCHA WHO UN / Partners	2,000,000

3	Conduct regular operational reviews to assess implementation success and epidemiological situation, and adjust operational plans as necessary	• Conduct weekly meetings with all relevant stakeholders • Review of operational plans	• Minutes of meeting shared • Monthly operational review report shared • SitReps generated	M/o NHSRC Provincial and regional DoH NDMA PDMA OCHA WHO UN / Partners	50,000
	Conduct After Action Reviews in accordance with IHR (2005) as required in consultation with partners (Public Health England, USAID etc)	• After Action Review (AAR) at national and provincial level using validated WHO tools within a month of declaration of the end of the outbreak (or earlier)	• AAR Report developed at national and provincial level and shared • Development of the revised plan for future based on the recommendation	M/o NHSRC Provincial and regional DoH NDMA PDMA OCHA WHO UN / Partners	1,000,000
	Use COVID-19 outbreak to test/learn from existing plans, systems and lesson-learning exercises to inform future preparedness	• Review and update hazard mapping and risk profiling on all hazards approach at national and provincial level led by government with support from WHO • National multi-sectoral emergency preparedness and response strategic framework on all hazards approach • Consultative process and finalization of National Pandemic Preparedness plan	• Report on hazard mapping developed at national and provincial level • Plan developed	M/o NHSRC Provincial and regional DoH NDMA PDMA OCHA WHO UN / Partners	200,000

	Sub-Total (Pillar 1)				**7,380,000**

Pillar 2: Risk Communication and Community Engagement

Step	Priority Actions/Activities	Sub-Activities	Indicators	Responsible	Budget
1	Implement national risk-communication and community engagement (RCCE) plan for COVID-19, including details of anticipated public health measures	• Ensure commitment of government authorities to risk communication and community engagement at national and provincial level • Develop a RCCE plan for COVID-19	• Adequate budget allocated and secured for nation-wide communication campaign • RCCE plan developed and incorporated in the response plans of Mo/NHSRC and NDMA	M/o NHSRC Provincial and regional DoH NDMA PDMA OCHA WHO and UNICEF UN / Partners Ministry of Information & Broadcasting	2,000,000

				ISPR	
	Conduct regular rapid behaviour assessment in collaboration with partners (NGOs, academic institutions etc) to understand key target audience, perceptions, concerns, influencers and preferred communication channels	• Develop a comprehensive RCCE plan at national and provincial level • Map and utilize data to inform communication response • Training and capacity building of teams of risk communication engagement	• RCCE plan developed at national and provincial level and incorporated in the response plans of Mo/NHSRC and NDMA	M/o NHSRC Provincial and regional DoH NDMA PDMA OCHA WHO and UN/Partners	300,000
	Prepare local messages and pre-test through a participatory process, specifically targeting key stakeholders and at-risk groups	• Prepare key messages in local languages at national and provincial level • Conduct RCCE sessions of community stakeholders (schools, religious bodies, flight crew, security personnel, media etc. on COVID-19 • Ensure that crisis and risk communication targets and reaches women, persons living with disabilities and marginalized groups,	• Key messages and prepared at national and provincial level • Digital Application prepared • Number of community stakeholders and at-risk groups oriented on COVID-19 • Number of persons with disabilities received information and awareness on COVID-19 • Number of women and other marginalized groups living in remote communities received information and awareness on COVID-19 • Number of women and other vulnerable groups reached through key	M/o NHSRC Provincial and regional DoH NDMA PDMA OCHA WHO and UNICEF UN / Partners	300,000

			messages and accessed services like helpline		
	Identify trusted community groups (local influencers such as community leaders, religious leaders, health workers, community volunteers) and local networks (women's groups, youth groups, business groups, traditional healers, etc.)	• Identify trusted groups in the communication and community engagement plan through electronic and print media at national and provincial level • Define strategies for maximum outreach • Develop material which is sensitive to needs of persons with disability, like sign language and brail • Engage community-based health workers • Encourage partners (RSPN) for maximum engagement of LSOs/CSOs • Ensure community and women networks actively participate in awareness raising and community empowerment	• RCCE plan developed and incorporated in the response plans at national and provincial level • Strategies identified and incorporated for implementation • Youth, community and women networks integrated in overall implementation	M/o NHSRC Provincial and regional DoH NDMA PDMA OCHA WHO and UNICEF UN / Partners	1,300,000
2	Utilize the clearance processes through the Government notified Risk Communication and	• Establishment of Media strategy committee (Mo/NHSRC, MoI, ISPR)	• Dissemination of messages through various channels	M/o NHSRC Provincial and regional DoH NDMA	200,000

	Community Engagement task force for timely review and dissemination of messages and materials in local languages and adopt relevant communication channels	• Development of messages in all languages		PDMA OCHA WHO and UN/Partners	
	Engage with existing public health and community-based networks, media, local NGOs, schools, local governments and other sectors such as healthcare service providers, education sector, business, travel and food/agriculture sectors using a consistent mechanism of communication	• Improve risk communication capacity • Integrate risk communication guidelines in all pillars • Integrate personal protection and infection prevention guidelines in routine health education	• Focal persons nominated from other sectors in existing structures • Focal persons trained on risk communication	M/o NHSRC Provincial and regional DoH District Administrations NDMA PDMA OCHA WHO and UN/Partners	200,000
	Utilize two-way 'channels' for community and public information to detect and rapidly respond to and counter misinformation	• Establish hotlines/helplines • Radio shows • Establish a responsive SMS service • Press releases and press conferences by designated focal points (ISPR, MoI) • Social media platforms	• Hotline/Helpline established • Responsive service for community engagement established	M/o NHSRC Provincial and regional DoH District Administrations NDMA PDMA OCHA WHO and UNICEF UN/Partners	3,000,000

				Ministry of Information & Broadcasting ISPR Telecoms	
	Leverage community networks and influencers for social and behaviour change approaches to ensure preventive community and individual health and hygiene practices, including stigma prevention, in line with the national public health containment recommendations	• Conduct community engagement and social behaviour change training and awareness raising sessions, preferably by remote, at national and provincial level • Develop and disseminate IPC IEC guidance for healthcare, workers, offices, public spaces, homes, and home care takers of patients through various channels • Run robust RCCE campaign through print, electronic and social media • Support vigilant media monitoring for identification of misinformation • Design and run communication and engagement camping that addresses harmful gender norms, discriminatory practices and inequalities during crisis highlighting	• Number of RCCE trainings/Awareness sessions conducted with key target groups at national and provincial level • Reports shared with all stakeholders • IPC IEC material developed and disseminated • Frequency of media messages run through campaign • Number of messages of misinformation reported to PEMRA • Number of key messages addressing positive social, cultural and gender norms to enhance people's safety, dignity and rights.	M/o NHSRC Provincial and regional DoH NDMA PDMA OCHA WHO and UNICEF UN/Partners Ministry of Information & Broadcasting ISPR	8,000,000

		the importance of recognizing that social, culture and gender norms, roles, and relations influence women's and men's vulnerability to infection, exposure, and treatment differently. • Disseminate stigma prevention messages, stress management and self-care during the pandemic			
3	Systematically establish community information and feedback mechanisms	• Conduct surveys of community perceptions, knowledge and attitude • Conduct direct dialogues and consultations through different channels	• Number of surveys conducted • Number of dialogues/consultations conducted	M/o NHSRC Provincial and regional DoH NDMA PDMA OCHA WHO and UNICEF UN/Partners	700,000
	Ensure changes to community engagement approaches are based on evidence and needs, and ensure all engagement is culturally appropriate and empathetic	• Develop culturally sensitive messages • Follow guidelines of WHO when developing the RCCE plan	• RCCE plan contextualized based on local needs	M/o NHSRC Provincial and regional DoH NDMAPDMA OCHA WHO and UNICEF UN/Partners	600,000

	Document lessons learned to inform future preparedness and response activities	• Document and develop reports based on monitoring reviews and implementation reports	• Lessons learnt documented and shared through a report after M&E of the campaign	Mo/NHSRC NDMA, PDMA	60,000
	Sub-Total (Pillar 2)				**16,660,000**

Pillar 3: Surveillance, Rapid Response Teams, and Case Investigation

Step	Priority Actions/Activities	Sub-Activities	Indicators	Responsible	Budget
1	Update and disseminate case definition in line with WHO guidelines and investigation protocols to healthcare workers (public and private sectors)	• Adapt WHO case definitions, tools, SOPs, and protocols for surveillance, case reporting, case investigation, contact tracing, and follow-up	• Number of health facilities which have received the necessary surveillance tools	Mo/NHSRC WHO	600,000
	Activate active case finding and event-based surveillance for influenza-like illness (ILI), and severe acute respiratory infection (SARI). Leverage on the Polio network, JSI and USAID projects where applicable	• Identify and train surveillance focal persons at health facilities • Designate/hire surveillance coordinators at national, provincial and district level • Devise mechanism for mapping of COVID-19 cases • Engage, train and equip staff for case finding, contact tracing and follow-up • Activate Federal and District Surveillance and response Units	• Number of staff trained on case investigation and contact tracing • Number of contacts traced and followed up • Number of cases investigated and tested •	NDMA, PDMA Mo/NHSRC	1,200,000
	Assess gaps in active case finding and event-based surveillance systems				-

2	Enhance existing surveillance systems to enable monitoring of COVID-19 transmission and adapt tools and protocols for contact tracing and monitoring to COVID-19	• Develop/adopt case investigation and reporting tools • Devise mechanism for mapping of COVID-19 cases • Define guidelines for SARI/ILI/COVID surveillance • Develop and implement software-based system for online reporting with IT support • Expand COVID surveillance to include private sectors HCF	• Protocols & guidelines developed • Standardized data collection & reporting tools available • Number of private HCF reporting on COVID cases	Mo NHSR&C NIH PDSRUs NITB PITB	10,000,000
	Undertake case-based reporting to WHO within 24 hours under IHR (2005)	• Provide HR support for regular data compilation and sharing with WHO • Ensure availability of sex, age and disability disaggregated data, • Advocate with senior management at national and provincial level for regular and complete and timely sharing under IHR	• Timeliness of reporting to WHO	Mo/NHSR&C NIH	100,000
	Actively monitor and report disease trends, impacts, population perspective to global laboratory/epidemiology systems including anonymized clinical data, case fatality ratio, high-risk	• Deploy HR for data management (Analysis and reporting) • Develop daily & weekly epidemiological reports for COVID-19 with analysis for sharing with stakeholders	• HR hired • Report developed weekly and shared	Mo/NHSR&C WHO	1,100,000

	groups (pregnant women, immunocompromised) and children	• Develop spot maps for COVID19 cases • Continuously analyse and monitor the impact of COVID19			
	Train and equip rapid-response teams to investigate cases and clusters early in the outbreak, and conduct contact tracing within 24 hours	• Conduct training sessions of RRT • Designate and train rapid response team (RRT) • Equipment & logistics support to RRTs for reporting and mobility • Provide priority support to women on the frontlines of the response, for instance, by improving access to women-friendly personal protective equipment and menstrual hygiene products for healthcare workers and caregivers, and flexible working arrangements for women with a burden of care • Ensure flexible working arrangement for women with a burden of care	• Number of trainings conducted • Number of teams trained as RRT • Number of Women frontline health workers received women friendly PPES	Mo/NHSR&C WHO	4,300,000

3	Provide robust and timely epidemiological and social science data analysis to continuously inform risk assessment and support operational decision making for the response	• Create and establish an expert think tank to review and analyse all epidemiological & socio-behavioural reports for deriving policy decisions and guidelines • Provide technical expert support for conducting in-depth epidemiological, social data etc. analysis	• Evidence based policy actions taken	Mo/NHSR&C FBS WHO and UNICEF UN / Partners	200,000
	Sub-Total (Pillar 3)				**17,500,000**

Pillar 4: Points of Entry

Step	Priority Actions/Activities	Sub-Activities	Indicators	Responsible	Budget
1	Develop and implement a points of entry public health emergency plan	• Conduct Rapid assessment of the current capacity at the health desk at three airports open for international flights, railway stations and ground crossings • Review and update PoE public health contingency plan	• Rapid assessment conducted • PoE public health emergency plan developed	Mo/NHSRC WHO	100,000
2	Disseminate latest disease information, standard	• Develop SOP and operational guidelines for	• Number of airports, railway stations and	Mo/NHSRCH	200,000

	operating procedures, equip and train staff in appropriate actions to manage ill passenger(s)	screening and management of COVID19 cases at PoE • Establish data management system at point of entries including linkages with relevant entities at the national and provincial level • Liaise and coordinate with relevant authorities at PoE for effective screening of travellers • Sharing daily PoE data with Epidemiological hub at NIH • Conduct trainings of staff deployed at PoEs	ground crossing PoEs targeted • Daily Report of PoE data at NIH • Number of trainings conducted • Number of travellers screened for COVID19 cases	WHO UN / Partners	
	Prepare rapid health assessment/isolation facilities to manage ill passenger(s) and to safely transport them to designated health facilities	• Establish protocols based on WHO guidelines for ill passengers and their transport to health facilities and referral protocols • Hire or Orient staff designated at PoEs for all protocols through training sessions • Provide PPEs and IPC supplies in PoEs and their attached isolation rooms staff	• Number of PPEs utilized by PoE staff for screening travellers • Number of COVID19 suspected identified at PoE • Number of ambulances provided • Number of RRTs trained • Number of simulation exercises conducted	Mo/NHSRC NDMA, PDMA WHO	2,000,000

		• Provide referral ambulance • Provide equipment for screening passengers at PoE (thermal scanners etc.) • Trained Rapid Response Teams (RRTs) for suspected cases from POE to designated hospitals. • Conduct simulation exercises at POE			
	Communicate information about COVID-19 to travellers	• Orient and engage flight crew for disseminating flight information • Orient railways staff for relaying information to travellers • Orient local transport networks • Print and disseminate standard IEC materials and protocols for distribution at all PoEs	• Number of health declaration forms correctly filled Number of IPC messages distributed to passengers	Mo/NHSRC WHO CAA	200,000
3	Regularly monitor and evaluate the effectiveness of readiness and response measures at points of entry, and adjust readiness and response plans as appropriate	• Central Health Establishment (CHE) to develop monitoring mechanism at PoEs (Airports, land crossing and seaports) and ensure strict compliance • Develop monitoring indicators and SOPs and establish linkages with relevant entities	• Number of monitoring visits conducted • Develop and share monitoring report	Mo/NHSRC WHO	100,000

	Sub-Total (Pillar 4)				**2,600,000**

Pillar 5: Laboratory Network

Step	Priority Actions/Activities	Sub-Activities	Indicators	Responsible	Budget
1	Establish access to a designated international COVID-19 reference laboratory	• Continue to provide technical and financial support to the national central testing facility at NIH • Conduct a rapid assessment of lab capacities in all provinces and regions for specimen referral and quality assurance at NIH	• Main testing facility established at NIH • Number of additional testing facilities established across the country • Mobile testing lab facility established at Taftan border • Report of rapid assessment shared	Mo/NHSRC NIH WHO	2,000,000
	Establish laboratory network	• Based on results of the assessment on the laboratory strengthen public health laboratory network at all levels	• Number of new laboratory network established	Mo/NHSRC WHO	1,000,000
	Adopt and disseminate standard operating procedures (as part of disease outbreak investigation protocols) for specimen collection, management, and transportation for COVID-19 diagnostic testing	• Develop protocols based on WHO guidelines and share with provincial departments of health, designated facilities and surveillance teams • Training of key personnel for sample collection, storage, packaging and transportation	• Number of health facilities with established protocols • Number of staff trained for sample collection, storage, packaging and transportation • Number of permits and agreements secured with international labs	Mo/NHSRC NIH WHO	100,000

		• Identify a courier service with service agreement for sample transportation to provincial labs, NIH and International reference labs • Complete all documentary requirements: export permits, material transfer agreement (MTAs) with international reference labs	• Protocols established in NAP of Mo/NHSRC		
	Identify hazards and perform a biosafety risk assessment at participating laboratories; use appropriate biosafety measures to mitigate risks	• Establish protocols and disseminate to laboratories • Bio risk assessment in labs as part of the complete lab assessment for testing	• Number of laboratories targeted	Mo/NHSRC NIH WHO	100,000
	Adopt standardized systems for molecular testing, supported by assured access to reagents and kits	• Establish protocols and adopt measures for validation of the diagnostic kits and equipment that become available • Review and update the diagnostic algorithm • Assessment of the laboratory surge capacity for testing using the recommended test lab authorities • Establish protocols and adopt measures to procure and distribute the relevant equipment,	• Protocols developed and incorporated in NAP of Mo/NHSRC • Standardized protocols adopted at national and provincial level • Recommended diagnostic equipment and kits procured • Number of PPE procured and distributed	Mo/NHSRC NIH WHO	70,000,000

		• reagents and kits • Secure procurement of Synthesizer for production of primers by NIH • Procure PPE for all laboratory staff			
2	Ensure specimen collection, management, and referral network and procedures are functional	• Establish protocols based on WHO guidelines • Procure and distribute sample collection kits including viral transport media and packaging materials • Monitor the facilities and referral network	Protocols developed and incorporated in NAP of Mo/NHSRC • Monitoring report shared	Mo/NHSRC NIH WHO	8,000,000
	Share genetic sequence data and virus materials according to established protocols for COVID-19	• Develop full genome sequencing capacity at national and provincial level • Procurement of Next Generation sequence (NGS) technology at NIH and provincial public health labs along with required equipment and kits • Implement sequencing of representative specimens' samples from all provinces/regions • Upgrade the bioinformatics pipeline to support the NGS outputs (logistic and technical support)	• Full genome sequencing established at national and provincial level • Equipment and supplies procured for NGS • Bioinformatics capacity upgraded for NGS analysis • Number of COVID19 sequences generated and shared	Mo/NHSRC NIH WHO	79,000,000

		• Share genetic sequence data on the GISAID and other platforms			
	Develop and implement plans to link laboratory data with key epidemiological data for timely data analysis	• Develop and expand web based epidemiological data reporting system • Develop and expand lab information system and link it to the epidemiological data reporting system • Hiring of IT staff	• Data platforms developed • Data platforms integrated • Number of HR recruited	Mo/NHSRC NITB NIH WHO	20,000,000
	Develop and implement surge plans to manage increased demand for testing; consider conservation of lab resources in anticipation of potential widespread COVID-19 transmission	• Increase the existing network of 16 laboratories to 50 • Procure PCR testing equipment and sampling kits to increase capacity of testing to 30,000 per day • Hiring of lab technical staff to conduct COVID19 testing • Establish a network of and build capacity of private labs to increase national capacity	• Number of labs established • Number of HR recruited • Number of private labs included in the network	Mo/NHSRC NIH WHO	30,000,000
3	Monitor and evaluate diagnostics, data quality and staff performance, and incorporate findings into	• Develop M&E tool	• Tool developed and staff trained	Mo/NHSRC NIH WHO	500,000

	strategic review of national laboratory plan and share lessons learned	• Identify and train the monitoring staff on the tool • Conduct monitoring visits for periodic evaluation	• Monitoring visit report developed • Laboratory diagnostic plan in NAP of Mo/NHSRC reviewed and modified according to M&E results		
	Develop a quality assurance mechanism for point-of-care testing, including quality indicators	• Develop mechanism and indicators for quality assurance of point of care testing equipment and facilities • Implement external quality assurance program (EQAP) for standard and point of care testing at national and provincial facilities in public and private sectors	• Mechanism developed and incorporated in NAP of Mo/NHSRC • EQA program established	Mo/NHSRC NIH WHO	1,000,000
	Sub-Total (Pillar 5)				**211,700,000**

Pillar 6: Infection Prevention and Control

Step	Priority Actions/Activities	Sub-Activities	Indicators	Responsible	Budget
1	Assess IPC capacity at all levels of healthcare system, including public, private, traditional practices, pharmacies and IPC during referral of suspected/confirmed COVID-19 cases	• Conduct rapid assessment of IPC capacity at national and provincial level including designated isolation facilities • Develop health care facility improvement plans based on	• Rapid assessment conducted • Action Plan developed for priority / high burden districts/facilities • National/provincial IPC guidelines updated	Mo/NHSRC WHO and UNICEF	10,100,000

		assessment findings on priority/high burden COVID19 districts/facilities • Ensure minimum requirement of IPC including functional triage system, isolation rooms, case deduction, trained staff (for early detection and standard principles for IPC) with sufficient availability of IPC materials, including personal protective equipment (PPE) • Ensure IPC and WASH services are maintained at essential health care standards with solid waste management • Procurement and staffing for routine dis-infection • Procure and install hand sensitization facilities • IPC during referral of suspected/confirmed COVID-19 cases	• IPC improvement plans developed • Number of health facilities assessed for IPCs		
	Assess IPC capacity in public places and community spaces where risk of community transmission is considered high	• Promote and install hand washing facilities at public places • Advocacy through IEC material on hand hygiene,	• Assessment of community risk for IPC • IEC material developed and disseminated	Mo/NHSRC WHO UNICEF	1,000,000

		respiratory etiquettes, infection prevention and control practices • Dis-infection of public spaces, in particular urban slums, congested areas, markets etc in line with guidance from MoH	• Essential requirements at public places and PoE procured and distributed		
	Review and update existing national IPC guidelines	• Disseminate National IPC guidelines • Development of SOPs based on WHO/National IPC guidelines and disseminate at all levels of care • Train IPC teams and other staffs on SOPs at National and provincial level • Refresher Trainings and hands-on sessions of IPC team at National and provincial level • Periodic review of national IPC guidelines	• Protocols based on WHO guidelines incorporated in NAP of Mo/NHSRC and Preparedness and Response Plan of NDMA	Mo/NHSRC WHO and UNICEF	1,000,000
	Develop and implement a plan for a monitoring of healthcare personnel exposed to confirmed cases of COVID-19 for respiratory illness	• Develop IPC audit and monitoring plan with protocols for case management of handling the confirmed cases of COVID-19 in healthcare personnel	• Health Care associated infection recorded and reported • Improvement plan developed, implemented and incorporated in the NAP of Mo/NHSRC	Mo/NHSRC WHO	100,000

	Develop a national plan to manage PPE supply (stockpile, distribution) and to identify IPC surge capacity (numbers and competence)	• Develop a procurement plan of essential stockpiles in line with the country trends and projections and subsequent requirement	• Procurement plan developed	Mo/NHSRC NDMA, PDMA UNICEF	1,000,000
2	Engage trained staff with authority and technical expertise to implement IPC activities, prioritizing based on risk assessment and local care-seeking patterns	• Carry out disinfection of public places, quarantine and isolation facilities • Train & re-train health care workers on safe IPC practices at national, provincial and district levels • Conduct simulation exercises / mock drills on emergency response. • Conduct mandatory training of using PPE IPC at PoE: -Implement standard and droplet precautions at PoE Health desks with staff orientation. - Train the staff on IPC guidelines, and ensure implementation - Monitor the application of IPC practices by PoEs staff- IPC at Health Facilities:	• Number of places disinfected across the country • Number of staff trained at PoE and Health facilities • Number of simulation exercises conducted • ToT on IPC and precautionary measured training conducted for SRH care providers • Number of trainings conducted on PPE • Required IPC equipment and supplies procured	Mo/NHSRC	1,000,000

		-Train healthcare workers on standard precaution, contact and droplet precautions. IPC Training for health care workforce engaged in the RMNCH services -Provide IPC guideline and SOPs to health facilities. -Monitor the implementation of IPC measures. Ensure sustained availability of IPC equipment and supplies.			
	Record, report, and investigate all cases of healthcare-associated infections on health care workers (COVID-19)	• Carry out regular monitoring of health care personnel	• Weekly report of the health status of healthcare personnel compiled and shared	Mo/NHSRC WHO	200,000
	Disseminate IPC guidance for home and community care providers	• Develop protocols for home care of COVID-19 patients and disseminate through various channels	• Key target population, places and channels used to disseminate information	Mo/NHSRC NDMA, PDMA	300,000
	Implement triage, early detection, and infectious-source controls, administrative controls and engineering controls; implement visual alerts (educational material in appropriate language) for family members and patients to inform triage personnel of respiratory	• Establish strict screening, surveillance and detection protocols • Integrate IPC into all educational material and IEC for healthcare facilities and public places • Disseminate IEC material and ensure prominent display of all material for public	• Protocols established and incorporated in NAP of Mo/NHSRC and Preparedness and Response Plan of NDMA • IEC material developed, printed and distributed • Number of PoE, health facilities,	Mo/NHSRC NDMA, PDMA	2,500,000

	symptoms and to practice respiratory etiquette	• Encourage respiratory etiquette through public service campaigns and during all trainings	public places and other place with visibly displayed IEC material		
	Support access to water and sanitation for health (WASH) services in public places and community spaces most at risk	• Improve WASH facilities in PoEs, designated health facilities, quarantine, isolation centres and public places including solid waste management	• Number of WASH facilities increased at high-risk places	UNICEF Mo/NHSRC NDMA, PDMA MoCC	15,000,000
3	Monitor IPC and WASH implementation in selected healthcare facilities, quarantine and isolation centres and public spaces	• Use WHO's Infection Prevention and Control Assessment Framework, the Hand Hygiene Self-Assessment Framework, Hand hygiene compliance observation tools and the WASH Facilities Improvement Tool to monitor the implementation	• Report generated against each tool and shared	Mo/NHSRC WHO and UNICEF UN/Partners	60,000
	Provide prioritized tailored support to health facilities based on IPC risk assessment and local care-seeking patterns, including for supplies, human resources, training	• Mo/NHSRC and WHO to provide support requirement to NDMA for procurement of supplies • Devise mechanism for enhancing human resource capacity at healthcare facilities and subsequent training like: - Induct Volunteers from Medical institutes, universities etc.	• Procurement requirement list shared with NDMA • Options for increasing Human Resource at healthcare facilities chalked out and shared with stakeholders • Number of trainings conducted to enhance national capacity of healthcare workers	Mo/NHSRC WHO	15,500,000

		- Integrate Polio Teams for screening / early detection / distribution of Information, Education and Communication material - Privatization of medical facilities to enhance national capacity			
	Carry out training to address any skills and performance deficits	• Conduct regular monitoring and evaluation of IPC protocols to identify gaps, lessons learnt	• Number of trainings conducted to identify gaps	Mo/NHSRC WHO, UNFPA	200,000
	Sub-Total (Pillar 6)				**47,960,000**

Pillar 7: Case Management

Step	Priority Actions/Activities	Sub-Activities	Indicators	Responsible	Budget
1	Map – a vulnerable populations to the nearest health facility and ensure they have access to health care and b) public and private health facilities (including traditional healers, pharmacies and other providers) and identify alternative facilities that may be used to provide treatment	• Conduct capacity assessment on WHO tool • Prepare consolidated report for providing information for planning purposes • Identify and map vulnerable population including women and young girls, persons with disabilities, transgender	• Capacity gaps identified • Mapping conducted for vulnerable population at risk of COVID-19 and GBV	Mo/NHSRC WHO UN / partners	125,000

		community and youth/adolescents			
	Identify and build capacity of intensive care units	• Identify and map ICU capacity/facilities • Develop hospital emergency preparedness plans including surge capacity • Training of health care providers in management of ICU cases • Support designated hospitals for ICU/ including procurement of medical facilities required • Establish state of the art isolation hospital at the national and provincial levels on WHO design • Procurement of essential PPEs, IPC supplies, ICU equipment and essential medicines as per WHO/standards specifications •	• Number of health care (nurses and doctors) staff designated per ICU bed • Plans developed • Number of ventilators in ICU	Mo/NHSRC NDMA, PDMA WHO, UNFPA and UN / Partners	70,000,000
	Identify and build capacity of quarantine	• Identify and map quarantine facilities in the country • Support designated quarantine facilities	• Number of health care staff designated per quarantine facility	Mo/NHSRC NDMA, PDMA WHO, UNFPA and UN / Partners	25,500,000

		including procurement of medical supplies required • Procurement of essential PPEs, IPC supplies, and essential medicines as per WHO/standards specifications • Provision of logistic support for quarantine centres	• Number transport vehicles provided for management of quarantine centres		
	Identify and build capacity of isolation facilities	• Identify and map ICU beds in isolation facilities at all levels • Develop hospital emergency preparedness plans including surge capacity • Support designated hospitals for ICU facilities including procurement of medical facilities required • Establish state of the art isolation hospital at the national and provincial levels on WHO design (new 10,000 ICU beds) • Procurement of essential PPEs, IPC supplies, ICU equipment and essential medicines as per WHO/standards specifications	• Number of health care staff designated per ICU bed • Plans developed • Number of equipment's supplied • Number of women at Quarantine and Isolation centres received hygiene kits • Number of logistical support provided to quarantine centres	Mo/NHSRC NDMA, PDMA WHO and UN / Partners	90,750,000

		• Provision of logistical support for isolation facilities			
	Continuously assess burden on local health system, and capacity to safely deliver primary healthcare services	• Ensure continuity of essential services for high priority service delivery (communicable diseases, vaccination, nutrition, reproductive health including child health and vaccination, care of vulnerable populations and provision of medications and supplies for chronic diseases) • Provision of essential medicines for chronic diseases, child and maternal care	• Continuity of routine of immunization services and nutrition, pregnancy care	Mo/NHSRC NDMA, PDMA WHO, UNFPA and UN / Partners	125,000

2	Ensure that guidance is made available for the self-care of patients with mild COVID-19 symptoms, including guidance on when referral to healthcare facilities is recommended Enhance national healthcare capacity	• Disseminate regularly updated information for clinical management of COVID-19 cases • Designate and train emergency medical teams (EMT) • Train, and refresh medical/ambulatory teams for management on SARI and COVID 19-specific protocols based on international standards and WHO clinical guidance • Set up triage and screening areas at all healthcare facilities • Engage private sector in management of COVID-19 cases • Define and establish mechanisms for DRAP to ensure emergency user authorization for critical care supplies as per SRA & ICH countries standards for COVID-19 & other essential medicines & supplies • Strengthen and empower DRAP for Risk based registration, (user	• Number of targeted places for dissemination of information on COVID-19 • Number of trained EMTs in hospitals • Number of medical and ambulatory teams refreshed the management of severe acute respiratory infections and COVID 19-specific protocols • Number of healthcare facilities set up with triage and screening measures • Number of fast track users authorization given by DRAP • Enlistment of suppliers /manufacturers • DRAP SOPS for emergency authorisation of medical products, treatments & IVD developed & disseminated • Adoption of standards for PPE, Hand sanitizers s& other supplies for critical & intermediate care	Mo/NHSRC, DRAP NDMA, PDMA WHO and UN / Partners	80,000,000

		authorization & quality inspection to ensure quality & availability of essential medicines and supplies) • Set up capacities & standard operating procedures for DRAP oversight to handle resources, capacities and API of treatment regimen & supplies to avoid shortages in responding to pandemics & disasters • Training DRAP staff for adoption of standard specification as per WHO & ICH guidelines fixation & publicize • Hand sanitizer regular quality monitoring & risk based lab testing (WHO prequalified labs or ISO17025 -2017LABs) for QA by DRAP	• Number of Regulators trained for risk-based post marketing surveillance • Number of samples of Alcohol base hand sanitizer tested & regulatory action taken against suboptimal products		
	Establish dedicated and equipped teams and ambulances to transport suspected and confirmed cases, and referral mechanisms for severe cases with co morbidity	• Procure need based ambulances for critical care of COVID19 cases • Equip ambulance for emergency care and ambulance staff for safe transportation of COVID19 cases	• Number of ambulances procured and equipped for emergency care	Mo/NHSRC NDMA, PDMA WHO and UN / Partners	8,000,000

		• Define functional referral linkages for timely transportation and management of COVID19 cases at all levels of care • Establish linkages with already existing emergency services (EDHI, RESCUE 1122 etc.) for safe transportation of COVID19 cases			
	Ensure comprehensive medical, nutritional, and psycho-social care for those with COVID-19	• Devise and plan coordination mechanism for provision of adequate medical, nutritional and psycho-social support for COVID-19 cases • Designate and train medical, nutritional and psychosocial care teams at all levels • Develop training package for psycho-social care and first aid in the context of COVID-19 • Coordinate mechanism to provide families and children of care givers and contacts with psychosocial services at community level,	• Establish PSS mechanism • Number of trained teams providing medical, nutritional and psycho-social support to COVID19 cases • Number of beneficiaries reached with PSS at community levels • Number of beneficiaries reached with services including PSS in quarantine / isolation centres	Mo/NHSRC Nutrition Section WHO and UNICEF, UNFPA UN / Partners	5,000,000

		including digital PSS sessions • Provide psychosocial first aid support including counselling through medical social welfare officers located in hospitals, quarantine /isolation centres, including digital PSS sessions • Provision of mental health and psychosocial support for affected individuals, families, communities and health workers			
	Evaluate implementation and effectiveness of case management procedures and protocols (including for pregnant women, children, immunocompromised), and adjust guidance and/or address implementation gaps as necessary	• Develop checklist and monitoring tools for assessment of quality of case management of COVID-19 • Provide refresher training on case management based on identified COVID-19 case	• Number of corrective actions taken • Number of refresher trainings conducted	Mo/NHSRC NDMA, PDMA WHO and UN Partners	200,000
	Sub-Total (Pillar 7)				**279,700,000**

Pillar 8: Operational Support and Logistics

Step	Priority Actions/Activities	Sub-Activities	Indicators	Responsible	Budget
1	Map available resources and supply systems in health and other sectors	• Conduct in-country inventory review of supplies	• Inventory review conducted and data of requirement compiled	Mo/NHSRC NDMA, PDMA WHO	200,000
2	Review supply chain control and management system	• Review stockpiling, storage, security, transportation and distribution arrangements for medical and other essential supplies • Develop a central stock reserve for COVID-19 case management based on WHO's Disease Commodity Package (DCP) & COVID19 critical items (WHO list) in coordination with DRAP after gauging internal capacities of DRAP • Contingency planning for strategizing availability and responsible use of hand hygiene, PPE, environmental cleaning and ICU supplies	• Procurement and distribution mechanism devised • Use of software for logistics supply chain management	Mo/NHSRC NDMA, PDMA WHO, UNICEF DRAP	100,000

		• Prepare procurement and distribution mechanism			
	Review procurement processes (including importation and customs) for medical and other essential supplies	• Prepare procurement mechanism and storage space for medical and other supply management	• Procurement mechanism devised • Storage space identified	Mo/NHSRC NDMA, PDMA WFP, UNICEF	300,000
	Assess the capacity of local market to meet increased demand for medical and other essential supplies, and coordinate international request of supplies through regional and global procurement mechanisms	• Strengthen DRAP for Price monitoring/shortage • of medicines in time reporting of API & testing kits, ventilators & other supplies for case management • Support the local market for production of more supplies through providing technical standards & incentivising them by TAX exemption • Support the local industry in terms of design and product development of personal protective and medical care equipment through facilitating international collaborations , joint ventures and technology transfer and enhance the capacities of the	• Number of post marketing visits conducted by DRAP & action taken against over pricing • Exemption of import No of local medical products/ equipment launched in the market to meet the demand. • No of local manufacturing industries involved in development of medical equipment capacitated	Mo/NHSRC DRAP, WHO Science & Technology, UNIDO	800,000

		manufacturing industry through engaging international experts to adopt the procedures and best practices involved in manufacturing of the medical equipment whilst ensuring its compliance with the international and locally approved medical standard including CE mark certification for PPEs provide technical assistance to innovators/start-ups in assessing the market needs, technology trends, piloting and following innovative approaches for scaling up /commercialization e.g. indigenous development of equipment, devices e.g. Incubators, PPE, testing kits etc			
3	Identify and support critical functions that must continue during a widespread outbreak of COVID-19	• Routine immunization, • Polio campaign • RMNCH (ANC, PNC etc.) delivery	• Number of Frontline workers trained and provided with basic PPE (hand gloves and	Mo/NHSRC NDMA, PDMA WHO, UNFPA UNICEF	10,000,000

		contraception/FP, CEmOC • Continuity of preventive programs e.g. TB, AIDS, malaria • Chronic diseases & terminally ill patients • Basic PPE items and training for frontline workers • Care of vulnerable population	face masks) to sustain service continuity	UN / Partners	
	Sub-Total (Pillar 8)				**11,400,000**
GRAND TOTAL					**595,900,000**