Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

Pakistan Mission Report

6–8 September 2017

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Note from the Secretariat as at 15 January 2018: this is an updated version of the report originally posted on 4 October 2017.
Acknowledgements

The members are grateful to the government of the Islamic Republic of Pakistan for hosting the visit of the Independent Oversight and Advisory Committee (IOAC) and to WHO Headquarters, the Regional Office for the Eastern Mediterranean and the Country Office in Pakistan for their part in making this a successful mission.

The IOAC Mission members would, in particular, like to thank all the national technical experts, the partners and WHO staff who gave so freely of their time during the Mission, and spoke so openly to members of the IOAC team so that the members were able to give their frank assessment of the WHO Health Emergencies Programme in Pakistan.
1. Introduction

1.1 Background

From the last report of IOAC\(^1\) to the WHA70 in May 2017, a priority for the IOAC Committee over the past six months leading to the Executive Board is an assessment of the WHO Health Emergencies (WHE) Programme’s performance in supporting member states with International Health Regulations (IHR 2005) implementation, including Joint External Evaluations (JEEs) and post-JEE development of National Action Plans for Health Security (NAPHS). Pakistan was the first country in the WHO Eastern Mediterranean Region (EMRO) to volunteer for a JEE and the second country to develop a NAPHS among the 56 countries\(^2\) worldwide that completed the JEE process between February 2016 and September 2017. JEEs are carried out to assess countries’ capacity to prevent, detect and rapidly respond to public health threats.

Pakistan is the sixth most populated country worldwide, with a population exceeding 200 million people. The country shares borders with Afghanistan, China, India and Iran. It is a diverse country with variations between provinces in terms of geography, ethnicity, language, economy and development. Pakistan is a lower-middle-income country with a per-capita yearly income of US$1560 (Economic Survey of Pakistan, 2015–2016). The budgetary allocation for the health sector has consistently remained below 1% of gross domestic product. The country has a federal system comprising four provinces: Baluchistan, Khyber Pakhtunkhwa, Punjab, and Sindh; and four federating areas: Gilgit-Baltistan, Islamabad capital territory, State of Azad Jammu and Kashmir, and the federally administered tribal areas (FATA).

Pakistan has experienced large-scale displacement of its population as a result of conflicts and natural disasters. It is graded level 1 for a dengue outbreak and is also one of the three countries in the world with active poliovirus transmission. Pakistan was chosen to ascertain the operationalisation of the WHE Programme at country level because of the commitment of the Government of Pakistan to strengthening its national capacities and progress in IHR (2005) capacity development, as well as management of ongoing public health challenges.

1.2 Mission objectives and activities carried out (see Annex for detailed programme)

The Committee objectives for the visit to Pakistan were to review the WHE Programme’s implementation status in terms of:

- The effectiveness of WHO’s support to the national response to emergencies and partnership on the ground
- The effectiveness of the tools and processes used for JEEs and development of NAPHS
- WHO’s support to the national response to polio and the plans for a post-polio transition of key assets

\(^1\) A70/8 http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_8-en.pdf  
\(^2\) As of 8 September 2017
The IOAC mission was planned in consultation with the Ministry of National Health Regulations & Coordination (MNHS&R) and WHO, and took place over 3 days between 6 and 8 September 2017. The IOAC team met with numerous representatives of key stakeholders including the MNHS&R, the National Disaster Management Authority (NDMA), the National Institute of Health, provincial health authorities, key UN agencies, representatives of the US Centers for Disease Control and Prevention (CDC), Public Health England, the WHO Country Office (WCO) in Islamabad and its sub-office in Peshawar.

In addition, the mission included a field trip to Khyber Pakhtunkhwa province to visit the provincial government and the FATA secretariat, both located in Peshawar. IOAC members also visited the Emergency Operational Centre for Polio, to better understand the overall polio infrastructure in the country in relation to surveillance, response, community engagement and partnerships. The members also scheduled interviews with key WHO staff including the WHO Representative (WR) to Pakistan, members of the polio team and the administrative officer.

1.3 High-level summary of findings

WHO’s role in providing technical support and convening various stakeholders was well understood and appreciated by both the national and local government, and the partners. Although national counterparts, national and local partners are not aware of WHO’s reform nor development of the WHE Programme, they have nonetheless noted positive improvements in WHO’s engagement and support to them over the last few months.

In Pakistan, the WHE Programme is yet to be fully developed in terms of staff recruitment and skills, adoption of the revised standard operating procedures (SOPs) on delegation of authority for decision making, and improved communication between the three levels of WHO. This is limiting the capacity of the WCO to meet the country’s needs. For example, the “no regrets” policy has not been fully implemented and delegation of authority in decision making on new contracts and disbursements of funds seems still to be following the old protocols. Simplified procedures, proactive communication and staff training across the three levels has not been carried out. Additionally, the WCO organogram and country business model were not clear, and IOAC would have expected to see them better reflect both the country’s situation and the WCO’s priorities and capacity.

IOAC members were also concerned that WHO needs to be realistic about the availability of locally available donor funding. The IOAC committee was informed that official development assistance related to health crises in Pakistan is reducing. UN organisations highlighted the current level of difficulty in attracting donor contributions to Pakistan due to the high level of humanitarian need and funding required across EMRO. The WCO should therefore be adequately resourced and should continue to be supported by Headquarters (HQ) and the Regional Office (RO) to fulfil resource mobilization expectations.
Authorities at both central and provincial levels acknowledged WHO’s coordination and the technical support provided in preparing for the JEE, support to the JEE self-reporting, the conduct of JEE and the post-JEE NAPHS development. IOAC considered that Pakistan’s success with the JEE and NAPHS is owed to the country’s strong ownership of the process and high-level political commitment. The Ministry of Health took a broad cross-governmental, One Health approach, engaging colleagues from all relevant ministries and a broad stakeholder group. All provinces and federal territories were brought together for round-table discussions and the many sectors were encouraged to collaborate under the JEE. The benefit of such a broad approach both across the federal and provincial governments was clearly evident from the discussions with both the governments and stakeholders. The WCO played a strong part in working closely with the Ministry of Health and lessons from Pakistan’s experience would doubtless be useful for many countries developing their JEEs and NAPHSs, especially those with decentralized public health administrations.

As shown by Pakistan, a NAPHS should be developed at the country’s own pace, ensuring comprehensiveness and ownership at all levels of government and with stakeholders for successful implementation. Further clarity and technical support should be provided by the WHE Programme, especially with regard to development of monitoring frameworks and reporting systems for NAPHS implementation.

The success of the polio and dengue response is equally attributable to the governments’ ownership and the national capacity at the federal and provincial level. The CDC-supported Field Epidemiology & Laboratory Training Program (FELTP) is a successful model for building national workforce capacity, whereby trainees are employed by the federal and provincial governments, developing their surveillance capability; this is again a model that might be of benefit to other countries.

Whilst Pakistan has been focusing on polio eradication, there is a consensus both at the federal and provincial level that polio assets in terms of trained dedicated staff and infrastructure should not be lost, but must be utilized to strengthen both routine immunization programmes across Pakistan, and other public health activities, particularly outbreak management.

Health is at the very centre of natural disasters and humanitarian crises: expectations of WHO and the WHE Programme from both the federal and provincial government and partners is increasing, and will bring new challenges to WHO beyond the WHE Programme. In particular, there is a need for clearer direction and further technical support from WHO to enable WCOs to provide timely advice to governments on both evidence-based messages that can be disseminated in emergencies, and appropriate responses.

The situation with returning people in FATA warrants particular attention. There is a level of unease identified among responsible provincial authorities due to the destruction of basic infrastructure, including health infrastructure. A reconstruction programme should be in place to mobilise essential health services and develop capacities for disease surveillance and emergency preparedness and response. A health sector/service needs assessment is urgently needed for FATA.
2. Specific findings, observations and recommendations

2.1 WHE implementation

WHO is seen as the provider of normative health guidance and technical support to the country and is respected by the health authorities at all levels. Partners perceive WHO as a credible voice to the national authorities that can facilitate discussions with the government. They also acknowledged WHO’s power in convening stakeholders. These positive perceptions of WHO’s roles serves the WHE Programme well in responding to health emergencies and natural disasters in Pakistan.

Both the country and partners acknowledge a good working relationship with the WCO. The IOAC team was repeatedly told by government officials that communication has further improved over the last few months. However, this improvement is not directly attributable to the roll-out of the WHE Programme.

The WCO is based in Islamabad and there are four sub-country offices, with a total of 819 staff including 718 dedicated to polio elimination; 750 are national and 69 international staff. The WCO budget has received about US$270 million for the current biennium 2016–17; that includes the budget for polio elimination.

The WHE Programme was introduced to the WCO at the beginning of 2016 and the HR implementation strategy is currently underway. Five staff members, consisting of one international and four national staff, are assigned to the WHE Programme, but, with the exception of a Health Cluster Coordinator position, the four other positions are funded by other programmes. The WHE Programme has recently been introduced under category 12. As a WHE priority 2 country, the proposed HR allocation for the WCO is between nine and 13 staff members, but this is subject to funding availability.

The IOAC noted that concerns have been raised with regard to HQ/RO Directives for the organogram, since proposed positions for ensuring the main functions of the WHE may not necessarily match the country’s priorities. Local adjustment is necessary according to country need and it is recommended that the WR should lead the process in consultation with the WCO, RO and HQ.

The IOAC members advised that WCOs should invest in an optimum structure of staffing required to deal with the varied needs of the country. Cross-cutting positions such as administration, communication, resource mobilization and security are an essential part of the WCO structure and should be budgeted appropriately. If the WHE requires dedicated capacity or unique HR positions which other programmes do not demand, such additional components should be covered by the WHE Programme.

Although approval has been given to recruit additional WHE staff members, there is no guarantee or clarity on how much funding will be provided to the WCO. Mobilizing resources locally is challenging because of the competition for donor support with other countries in the region where major humanitarian crises are ongoing. Therefore, the recruitment of WHE positions will depend on
funding availability, but there needs to be a clearer plan agreed between WCO, RO and HQ. The WCO will need help from the RO and HQ in mobilizing resources for filling service-critical positions. The IOAC members recognized that the WR has been actively engaging the embassies of potential donor countries for bilateral funding. Further technical support and capacity for resource mobilization should be provided to the WCO to enable them to raise funds at the country level.

With regard to the consultation among three levels of offices, the IOAC members were surprised to note that no WHE staff members had visited Pakistan from either HQ or the RO in the previous 6 months. This may have contributed to the above situation. There needs to be a closer working relationship between HQ, the RO and CO.

Key staff at the WCO are aware of the WHE Programme, but the lack of information sharing has caused a certain degree of anxiety among staff members. The government and partner agencies acknowledge WHO’s function in emergencies but are uninformed about the WHE Programme and relevant changes within the Organization. WHO is encouraged to make further efforts to embed transparent and proactive communication in the Organization, for both internal and external audiences with regard to the structure, function and deliverables of the WHE Programme. WCO staff involvement and engagement will ensure the success of the reform. Further collaboration within the Organization is also recommended, namely consultation across the three levels of the Organization, stronger regional presence at the country level and inter- and intra-regional cooperation, especially between countries with shared borders.

Staff members in the WCO have noticed some progress in terms of new SOPs for emergencies and delegation of authority. However, these instruments have not been fully understood or implemented. **Staff training at all three levels and a simplified manual and e-learning opportunities are required.** The current systems and funding availability seem inadequate to operationalize delegation of authority. For example, hiring a consultant under Agreements for Performance of Work, even for trifling amounts, require EMRO’s approval of the terms of reference and its subsequent electronic approval via the GSM workflow. This has caused a delay in deployment of entomologists for responding to the current grade 1 dengue outbreak. The SOPs for hiring consultants in emergencies require further revision to ensure that the WCO can provide timely support. **A greater level of authority should be given to the WR to allow him to deliver his functions effectively.** Currently the WR is allowed to approve a maximum of US$25 000 for purchasing goods or services, which is too modest an amount for emergencies.

Security is one of the priorities of the WCO and, thanks to polio, the team is well equipped compared to other WCOs, with a total eight staff—two international and six national officers. The cost of security staff is covered by the polio programme, and accounts for more than 85% of the total WCO funds.
2.2 Joint External Evaluation (JEE) and national action plan for health security (NAPHS)

A JEE mission was conducted in Pakistan between 27 April and 6 May 2016\(^3\) following an intense 6-week preparation period supported by WHO HQ, RO and CO that included orientation workshops and self-reporting. The IHR is well known to the Government and there are the national focal points at both federal and provincial levels. The JEE process was led by the MNHS&R with WHO’s technical support and involved more than 120 government officers from a range of government ministries, various sectors and all provinces and territories; these officers played key roles throughout the preparation process and the JEE itself. The IOAC team members noted the multi-sectoral participation, namely representatives from the Armed Forces, the Economic Affairs Division which oversees donor relations, the Ministry of Climate Change, the Environmental Protection Agency, the NDMA, the Ministry of Finance, the Ministry of National Food Security and Research which includes the Agriculture and Veterinary sector, the Pakistan Nuclear Regulatory Authority (PNRA), and the Planning and Development Division.

Positive feedback and enthusiasm were noted from both the federal government and provincial authorities throughout the JEE process. The JEE process revealed areas requiring improvement and coordination at both federal and provincial levels by bringing all provinces, federating areas and multiple sectors together. This was clearly perceived by Pakistan as an added value of the JEE, given that the country has a decentralized government. The discussion at central and provincial levels highlighted vital technical support, coordination and management provided by WHO in the preparation for, and conducting of, the JEE.

In September 2016, immediately after the JEE, Pakistan started developing a NAPHS in consultation with the relevant sectors at all levels. The plan was endorsed during 29 November – 1 December 2016, followed by a costing exercise that lasted 5 months, from January 2017 to May 2017. The MNHS&R presented the NAPHS to the Health & Population Donors Consortium, which includes the Directors General of Health of four provinces and UN partners, on 24 August 2017. The NAP was to be presented to the Prime Minister’s office for advocacy and facilitation for required domestic budget allocation. The total cost of the 5-year plan is estimated at US$1 billion, of which 35% could be sourced from domestic funding; 65% would need to be funded externally.

The IOAC members noted that the country has already implemented some key recommendations at the provincial level. For example, following the JEE, Khyber Pakhtunkhwa province moved ahead to develop public health legislation that requires a One Health approach and provides underpinning for the surveillance system to address the issues raised during the evaluations. The impact of the legislation and the strengthened surveillance capacity is already proving to be an asset in the current dengue outbreak.

Despite the anxiety over a timely launch of the NAHSP by the MNHS&R, there is a strong consensus among the national authorities that development of the plan benefitted from the consultative, inclusive and comprehensive process that was undertaken, which included participation and involvement of stakeholders beyond the health sector.

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The IOAC team recognizes the strong country ownership and leadership of the MNHS&R in implementing the NAPHS using a whole-of-government approach. However, further clarity and agreement will be required to define a monitoring and evaluation framework and reporting mechanism. It will also be critical to strengthen multi-sectoral country coordination mechanisms between the federal government and local governments in implementation by enabling the Federal Ministry to oversee implementation.

The IOAC team emphasized the importance of the NAPHS as a good mechanism to accelerate achievement of universal health coverage across the country, to address the much needed strengthening of health systems in the FATA following humanitarian crises, and to immediately improve health service delivery within FATA.

2.3 Response to the dengue outbreak

Transmission of dengue fever has intensified in Pakistan, with increased incidence and geographic expansion. In the current epidemic, 14,783 cases of suspected dengue have been reported from various districts of Khyber Pakhtunkhwa province, of which 3,685 tested positive for dengue virus, with 17 deaths. The health authorities are leading the response at both federal and provincial level, including public awareness-raising campaigns for risk mitigation, strengthening surveillance and general preventive measures, providing a dengue helpline, improving clinical management of patients and implementing targeted vector control activities.

The health authorities identified surveillance capacity, data reporting systems and risk communication as key components for a successful disease outbreak management.

The FELTP in Pakistan has demonstrated sustainable impact on capacity building, not only for polio but also for management of outbreaks, including dengue. The FELTP graduates play a key role in the Disease Surveillance and Response Units in the districts, although with limited access to some of the affected provinces. The FELTP has also emphasized the need for a career development pathway for epidemiologists and other public health officers within the government.

The process for grading dengue as a level 1 emergency was efficient and consultative and the dengue outbreak reaffirmed WHO’s strength in setting standards—for instance case definition and surveillance guidelines—and for providing country support such as deployment of entomologists to the affected areas. However, the IOAC noted that an incident management system is yet to be fully operationalized at the country level and WHO’s leadership in the Health Cluster for the dengue response was not very visible and needs to be further strengthened. IOAC also heard that support would be welcome on risk communication to provide timely advice to governments on both evidence-based messages that can be disseminated in emergencies, and appropriate responses (e.g. any necessary restrictions, screening).
2.4 Polio response and transition

Pakistan is classified by the IHR as a state infected with WPV1, cVDPV1 or cVDPV3, with a potential risk of international spread, and as a state infected with cVDPV2, with a potential risk of international spread.\(^4\)

Pakistan has made tremendous progress towards polio eradication, with only four cases of WPV1 confirmed currently. However, in high-risk areas of the country, routine vaccine coverage remains low and there are huge operational challenges due to security and access constraints.

More than 600 staff in the WCO are dedicated to polio eradication in Pakistan. National Stop Transmission of Polio officers have been trained by the FELTP. On national immunization day approximately 250,000 front-line workers are engaged to cover 38 million children under the age of five across the country through house-to-house visits.

While the government is highly focused on eradication of polio, and transition planning has not started yet, there is a strong consensus among government officials that polio assets should not be lost and that the resources (both HR capacity and assets) should be transferred to the routine immunization programme and other disease and health emergencies management. Government leaders in the Khyber Pakhtunkhwa province have already reached out to WHO and the Bill & Melinda Gates Foundation to highlight the need for polio transition planning.

2.5 New challenges for WHO

The NDMA has a deep understanding of the health impact of natural disasters such as earthquakes, landslides and floods, and emphasized the importance of close collaboration with the Ministry of Health in response and recovery efforts. WHO’s support in response and recovery efforts was highly appreciated but the IOAC team noted that because climate change is seen as a trigger of natural disasters, there is now a high expectation and great need for WHO’s support to expand beyond its traditional role to provide technical guidance on diseases related to climate change, country-specific risk assessment and readiness to respond. Also there is high expectation on WHO as Health Cluster lead for supporting recovery after humanitarian crises, including in FATA.

3 Conclusion

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

Pakistan’s ongoing success in dengue and polio response are also attributable to the country ownership and capacity of the provincial and district governments.

To support the government’s response and political commitment, it is critical that the WHE Programme in Pakistan is allocated the human resources necessary. It is also urgent for the WHE Programme in Pakistan to be constructed based on the particular needs of the country’s response to health emergencies, not on a blueprint developed in the RO or HQ. Staff members at the country level should be consulted and engaged in the ongoing WHE reform process and provided with training to enable them to perform their duties and to lead WHO’s “no regrets” policy. Also, better communication within the WHE Programme across all three levels is necessary so that staff are aware of changes and developments and the strength of the WHE Programme. Communication and outreach to stakeholders about the changes brought about through the WHE reform also needs to be significantly improved.

WHO’s support of national and provincial governments in risk communication and management needs to be strengthened to ensure that the governments’ actions and communications are based on the most up-to-date evidence so that they can provide a proportionate response in a timely manner.

Lastly, the WHE Programme is not a stand-alone entity but must continue to develop stronger links to other WHO programmes. Given the increasing need and expectations on WHO with regard to health impacts from climate change and environmental issues, further collaboration within WHO is desired to provide organization-wide support.
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| Tuesday 5 Sept| 08:30 – 10:45 | Arrival of the Mission team in Islamabad, Marriott Hotel Members’ pre-meeting at the hotel  
Dr Geeta Rao Gupta, IOAC  
Dr Felicity Harvey, IOAC  
Dr Hiroki Nakatani, IOAC  
Ms Munjoo Park, IOAC Secretariat  
Ms Dalia Samhouri, WHO/EMRO  
Dr Sohel Saikat, WHO/HQ  
Visit the WCO office Pakistan  
Security briefing (Mr Daudi)  
Meeting with WCO team including  
Mohammad Assai Ardakani (WR Pakistan)  
Dr. Michael Lukwiya Health Cluster Coordinator  
Dr. Farah Sabih NPO HSS – IHR |
|               | 10:45 – 11:30 | Meeting Partners CDC/FELTP  
Meeting in NHEPRN in presence of:  
Dr. Muneer Ahmed Mangrio, DG NHEPRN  
Dr Ahmed Leban, Acting Director CDC  
Dr. Rana Jawad Asghar, Resident adviser for FELTP |
|               | 11:30 – 13:00 | Meeting UN and UNOCHA  
Mr. Neil Buhne Humanitarian/Resident Coordinator  
Mr Tareq Talahma, OCHA Deputy head of Office  
Ms. Heli Usekyla, Country Head UNOCHA  
Ms Cris Munduate, Acting UNICEF Rep  
Ms Anna Wilson, PHE Rep  
Ms Sangita Patel- USAIDS |
|               | 13:00 – 14:00 | Lunch |
|               | 14:00 – 16:00 | Meet Ministry of National Health Services, Regulation and Coordination (MNHS&R) authorities  
Dr. Assad Hafeez DG Health  
Dr. Malik Muhammad Safi Director Programme  
Dr Brig. Amir Ikram, ED NIH  
Dr Munir Ahmed Mangrio (DG NHEPRN)  
Dr Muhammad Salman (National IHR focal point) |
|               | 19:00 – 20:30 | Working dinner at Marriott Hotel, Nadia coffee shop 7:30 pm with representatives from  
**UN:** Mr. Neil Buhne Humanitarian/Resident Coordinator, Ms. Heli Usekyla, Country Head UNOCHA, Ms Angela Kearney, UNICEF Rep, Ms Anna Wilson, PHE Rep, Dr Ahmed Liban CDC, Dr Rana Jawad Asghar CDC/ FELTP, Dr Muhammad Salman/ NIH  
**Moh:** Dr. Assad Hafeez DG Health, Dr. Malik Muhammad Safi Director Programme, Dr Brig. Amir Ikram, ED NIH, NIH, Dr Munir Ahmed Mangrio (DG NHEPRN)  
**WHO:** Dr Mohammad Assai Ardakani(WR), Dr. Michael Lukwiya Health Cluster Coordinator, Dr. Farah Sabih NPO HSS – IHR |
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<td>Thursday 7 Sept</td>
<td>06:00</td>
<td>Departure from the hotel / Travel by road</td>
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<td>09:30 – 13:30</td>
<td><strong>Meeting with Secretary of Health of Provincial Khyber Pakhtunkhwa</strong>&lt;br&gt;Mr. Abid Majeed, Secretary Health Khyber Pakhtunkhwa&lt;br&gt;<strong>Meeting with the Director General of KP Health Authorities and her team:</strong>&lt;br&gt;Dr. Shabina Raza, DG Health Khyber Pakhtunkhwa&lt;br&gt;Mr. Amir Afaq, DG Provincial Disaster Management Authority Khyber Pakhtunkhwa&lt;br&gt;Health Cluster Partners</td>
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<td>13:30 – 14.30</td>
<td><strong>Group lunch</strong></td>
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<td><strong>Meeting with FATA authorities:</strong>&lt;br&gt;Secretary Social Sector FATA&lt;br&gt;Dr. Jawad Habib, Director Health Services FATA (and his team)&lt;br&gt;Mr. Khalid Rehman, DG FATA disaster management authority</td>
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<td>15.00 – 16.30</td>
<td>Visit to UNOCHA and meeting with partners:</td>
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<td>Departure toward Islamabad</td>
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<td>Friday 8 Sept</td>
<td>09:00 – 11:00</td>
<td><strong>Meeting with polio partners EOC</strong></td>
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<td>11.00 – 12.00</td>
<td><strong>Meeting with the Chairman of National Disaster Management Authority at the Prime Minister’s Office</strong></td>
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<td>12:00 – 14.00</td>
<td><strong>Meeting with representatives from the three provinces</strong>&lt;br&gt;Balochistan: Dr Rasool Zehri, Dr Muhammad Hayat&lt;br&gt;Sindh: Dr Waqar Mahmood Memon, Dr Mobin Ahmed&lt;br&gt;Punjab: Dr Qais Mahmood Sikandar, Dr Muhammad Imran Bashir, Dr Shakeel Ahmed Gondal</td>
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<td><strong>Working Lunch at the WCO</strong></td>
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<td>14:30 – 15:00</td>
<td>Interview with WCO staff&lt;br&gt;Mr Nigel Bond&lt;br&gt;Polio team</td>
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<td>15:30 – 16:30</td>
<td><strong>Debriefing with representatives from MoH at NIH</strong>&lt;br&gt;Dr. Malik Muhammad Safi Director Programme&lt;br&gt;Dr Brig. Amir Ikram, ED NIH&lt;br&gt;Dr Munir Ahmed Mangrio (DG NHEPRN)&lt;br&gt;Dr Muhammad Salman (National IHR focal point)</td>
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<td>17:00 – 18:00</td>
<td><strong>Debriefing with the WR in participation of the EMRO/RED via phone</strong></td>
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