

## **Programmatic priorities (section 2.2)**

Past focus and spendings on AMR have mostly been on understanding drug-resistance and surveillance. As a result, from being an unrecognized and silent threat, a clearer picture of the burden of AMR is emerging. However, substantial gains could be made from preventing infections in the first place. Hence, future spendings could be directed to preventing infections, raising awareness, risk communications and community engagement to address AMR and making sure existing antibiotics are used appropriately and judiciously. Focus on interventions for promoting antimicrobial stewardship including surveillance for antimicrobial use and monitoring of consumption, capacity building efforts for implementation of IPC and stewardship programs will help sustain the effectiveness of existing antimicrobials. Safeguarding antimicrobials and ensuring that they are equitably available to all are essential aspects of comprehensive pandemic prevention, preparedness, and response.

## **Community and civil society engagement: (Section 6.3)**

### **Strong points:**

1. “The Pandemic Fund is dedicated to strengthening civil society engagement...”
2. “Creating formal processes for supporting communication between representatives and their constituencies...”

### **Weak/missing:**

The pandemic fund strategic plan to specify support to,

1. targeted approach and interventions for and by vulnerable people groups and at-risk population – minorities, marginalized including disabled people and migrants (3M) towards equity, community protection and resilience (e.g. preparedness and response initiatives planned and implemented by persons with disabilities)
2. In addition to supporting communication between representatives and their constituencies (mentioned in the draft), initiative and innovations towards institutionalizing systems, structures & process at local government level to sustain engagement (representation, participation, empowerment) of vulnerable groups (e.g. ‘vulnerable group liaison’ in the municipalities and health facilities).

### **Clinical readiness - rehabilitation:**

1. Support to continuum of care beyond acute response, to include post acute sequelae as well (e.g. Post COVID-19 Conditions, post viral arthritis – Chikungunya etc.)
2. Towards that, service availability and readiness assessment for rehabilitation during recovery phase for better ‘functioning’ to return to school, return to work etc.

## **Appendix C - Health workforce**

1. A fit for purpose health workforce that prioritizes safety and quality of care. This includes:
  - 1.1. health facility and community based staff that are trained in infection prevention and control including all transmission based precautions, and;
  - 1.2. health facility and community practitioners that have received training in the care and treatment of notifiable diseases and syndromic surveillance. Treatment based on syndromic surveillance must be linked to laboratory systems for effective response planning and validation of syndromic signals.

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- 1.3. Treating health professionals play an important role in linking syndromic surveillance to laboratory. Diagnosis based upon syndromic surveillance must be confirmed by laboratory testing of specimens to alerts and enable timely response planning and implementation of control measures. This proactive approach can help contain outbreaks and mitigate their impact on public health emergencies, particularly in health facilities and communities.
2. Referring to the “surge workforce capacity”, what was explicitly mentioned in the document was the surge for deployment. It is equally important to think about surge capacity of “receiving or referral health facilities” which requires designated referral hospitals to have preparedness plans in place which includes but not limited to, guidance on how to handle higher than usual surge of patients, support for surge health workforce from other entities, hospital incident management or command system, etc.