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SECOND INTERNATIONAL PUBLIC HEALTH CONFERENCE

Public Health Innovations For A Healthier Nation

PESHAWAR, PAKISTAN

25TH- 27TH FEBRUARY 2020

Introduction

This was the second Annual International Public Health Conference in Khyber Pakhtunkhwa (KPK), Pakistan organised by Khyber Medical University (KMU) with attendees from 4 continents.

Pakistan government's Special Assistant on Health, Dr Zafar Mirza and Special Assistant on Poverty Alleviation and Social Safety, Dr Sania Nishtar were due to speak but were unable to so due to the COVID 19 crisis. The conference was organised by Dr Zia Ul Haq, Dean Faculty of Public Health Social Sciences at KMU.

The UK Faculty of Public Health's (FPH) Pakistan Special interest group (SIG) was invited to contribute to the conference and was attended by:

- Prof. Zafar Iqbal (Chair FPH SIG)
- Dr Samia Latif (Vice Chair FPH SIG)
- Dr Waseem Gill (Associate Member SIG)

Some of the highlights of the conference included:

- Workshop on developing exemplary Public Health systems in Pakistan; A UK Pakistan comparison. This was led by Prof Zafar Iqbal with contributions from Dr Samia Latif and Dr Waseem Gill
- Keynote Talk on Lessons in Public Health Leadership – Dr Samia Latif
- Keynote Talk on Public Health Innovations in the Management of Non-Communicable Diseases – Prof Zafar Iqbal
- Smokeless tobacco control policy, challenges and way forward – Dr Kamran Siddiqui
- Primary Care Diploma – Dr Jalil Khan
- Meeting with the Health Secretary KPK
- Institutional Membership of the UK's Faculty Public Health Offer announced – Dr Samia Latif
- Discussion on developing KMU's Undergraduate Public Health Curriculum – Dr Samia Latif

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- Public Health innovations needed to to face the multiple morbidity challenges in developing countries – Prof Saeed Farooq

Workshop on Public Health systems in Pakistan and UK

Professor Iqbal chaired the workshop and was supported by Dr Samia Latif and Dr Waseem Gill.

The aim of the session was to explore what an exemplary PH system might look in Pakistan through a comparison with the UK PH systems. The session explored the history of Public Health, training and curriculum, structures, organisations, responsibilities of Directors Public Health, health protection, health service systems, professional development, standards e.g. NICE, and research.

A number of questions were posed such as what are the major PH challenges faced by Pakistan? What leadership is required? What structures are required at local/national level? What skills competencies are required for PH professionals?

Dr Samia Latif spoke about health and Public Health and the different domains of public health i.e. health protection, health improvement, healthcare in terms of ensuring effective, efficient and accessible healthcare and academic public health (research and teaching).

She mentioned that in the UK 15 million people and a further 5.4 million unpaid carers in the UK are occupied outside the core public health workforce and have the ability or opportunities to make a significant contribution to the health and well-being. She explained in terms of training the Faculty of Public Health set the standards as part of the Royal College of Physicians (RCP) and the General Medical Council (GMC) approved the curriculum training programmes, training sites and trainees. The competency framework has 89 learning outcomes in 10 key areas. She gave acknowledgements to David Chappel Academic registrar UKFPH for his input into this information.

Dr Gill, General Practitioner, talked about primary care in the United Kingdom, its origins the changes over the years and the future of primary care in Pakistan. He emphasised the social model of care and the fact that the primary care consists of an extensive team and not just

family doctors-dentists, pharmacists, nurses, health visitors, midwives, opticians, family planning and others. The importance of the gatekeeper role and the importance of providing controlled access to secondary and tertiary care was emphasised.

The philosophy and ethics of the NHS in terms of the goodwill and social value system was also highlighted with the important fact of care being free at the point of entry and no financial transactions between the doctor and patient. The post-war origins of the NHS and the current costs were noted and the original roll being a reactive service to the current more preventative service was emphasised. The ability to provide a cost-effective national health service with 90% of care being delivered in primary care showed a changing strategy from the early inception of the NHS which at the outset was consultant led to a more managerial general practitioner led service in the 1990s. The recent advances in therapeutic breakthroughs with the IT revolution, an ageing population and increasing costs was also highlighted as was the need to retain an all-round general physician with a holistic approach to patient care.

Dr Gill also mentioned the cornerstone of the recent reforms in primary care was seen as one of the main agents for public health messages through the quality and outcomes framework in the early 2000s imparting messages to patients on smoking, exercise, weight loss, nutrition, alcohol and mental health.

He concluded by arguing the importance of the trained general practitioners as the last true bastions of the general physician in the west as part of a wider extensive team and this should not be lost in developing countries such as Pakistan as systems increase funding and often invest in more specialised services with the loss of a generalised approach. The primary care team has the potential to do be the comprehensive system wide horizontal lattice to gel the vertical components together, a lack of which was a significant factor in why the Millennium Development Goals were poorly attained due to funding interventions that were vertical, selective and disease orientated.

Some of the conclusions of the workshop included:

1. There is a need for a system wide role equivalent to an independent Director of Public Health. They would have wide ranging responsibilities and the post-holder would be expected to influence change at grassroots level by working with political leaders, community stakeholders, religious institutions, law enforcement agencies, the health sector and educational establishments to ensure that prevention is embedded in all settings. This would be achieved by:
    - ❖ Building public health capacities of local government systems
    - ❖ Creating a workforce cadre that could affect change at grassroots level

- ❖ Act with integrity and free of undue political influence

2. There is an urgent need for a primary care system to provide Public Health interventions for non-communicable diseases. Best use of workforce was questioned particularly lady health workers and lady health visitors (currently 90% of their work is immunisation) and they could be used in managing to help non-communicable diseases. If so there would be a need to look at expanding their role and increasing capacity.
3. The secondary care system is under immense strain. Public Health funds 30% care in Pakistan, Private Healthcare funds 70%. A local example of poor management was Lady Reading hospital in Peshawar which sees over 5000 people daily, 80% of which could be managed in primary care. Inappropriate referrals/gateway system to secondary care needed to be developed to stem the inappropriate utilisation of secondary care services. This requires a cadre of family health practitioners. Finance system for healthcare needed to be reviewed as well as the incentives to provide quality healthcare. There is also need for quality assurance systems in secondary care.
4. The SIG could support continuing medical education, CPD, standards in public health, regulation and revalidation, including the local regulating bodies, PMDC/HEC/College of Physicians in Surgeons and look at helping in their joint working.

Leadership

On the 26th of February Dr Samia Latif was the first speaker at the conference and spoke about lessons in public health leadership. She spoke about the changing landscape in Public Health, systems leadership in public health, wicked problems, leadership competencies, enablers and barriers and leadership legacy. She mentioned the changing nature of public health was dependent on several factors including global politics, global climate change, funding, conflict, media, anti-microbial resistance (AMR), emerging infectious diseases, workforce capacity, food security and equality of access.

Dr Latif explained systems leadership in public health meant negotiating the complexity of leading across and beyond organisational boundaries, leading without power or authority, boundary spanning, creating change whilst not being in charge, addressing crosscutting 'wicked' problems. By wicked problems she meant cross cutting public health issues such as air pollution, NCDs, war and peace, AMR, vaccine preventable diseases, emerging infectious diseases

She mentioned the social determinants of health and the importance of freedom, justice and equity. Specific issues being Ebola, 'anti vaxxers ', climate change and coronavirus. She explained Systems architecture through a diagram with an inner ring with capacities required of systems leaders, middle ring of wider characteristics of system leadership and an outer ring-the public service contact. Some examples of leadership competencies being: ways of feeling, perceiving, thinking, relating, doing and leading self. Dr Latif emphasised that a systems thinker focuses on the forest rather than the details of any one tree.

The final challenge to the audience was What would be your leadership legacy? "Leaders develop followers, great leaders develop the leaders".

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Innovations in the Management of Non-Communicable Diseases

On the 27th February Professor Iqbal, in a keynote speech, spoke about non-communicable diseases (NCDs) and looked at public-health innovations in the management of NCDs. These included,

prevention programmes, disease registers, structured care and digital technologies. In terms of prevention he highlighted that the greatest UK public health achievement of the 21st-century according to public health experts, was the ban on smoking in public spaces with this practice being de-normalised. he mention the significant increase in the obesity from 1995 to 2017 and that and a levy in 2017 on soft drinks led to a 29% decrease in the amount of sugar they contained.

Some of the preventative measures included the national health check programme for 40 to 75-year-olds which is probably one of the largest CVD prevention programmes in the world. He touched upon the increasing prevalence of diabetes in the last 20 years. Type II diabetes could be prevented or delayed with appropriate PH measures. The role of the primary care system in the UK was explained and how the GP acts as a gatekeeper and conduit to secondary care whilst providing the important facet of continuity of care. A truly great historic Public Health figure was a GP who worked as Tudor Hart a GP in the Welsh Valleys over 50 years ago. He introduced the concept of disease registers for NCDs which allowed structured care and measurement of patient outcomes.

Professor Iqbal mentioned Pakistan's vision for health - that governments will be working to improve the coverage and functionality of primary and preventative health services while ensuring essential service packages for family medicine, new-born services, birth spacing and contraceptive services, NCDs, mental health, poor nutrition, disabilities, problems of the ageing population. Quality of the services would be set by implementing minimum standards for delivery and service at all levels. He

concluded by speaking about innovations and IT with particular reference to the mobile apps which are now available for health monitoring.

Smokeless Tobacco

Professor Kamran Siddiqi spoke about smokeless tobacco. He defined smokeless tobacco as a number

of products containing tobacco, which are consumed without burning through the mouth or nose. Local and regional examples in Pakistan were given e.g. Nasal Snuff in KPK or Tobacco-Paan in Sindh (a betel leaf with various ingredients and flavourings). Looking at the overall uses of tobacco the current tobacco smokers were 10 to 15% of Pakistan's population with the current smokeless tobacco users between 5 and 10%. He mentioned that it needed special attention to look at the diversity of its range, its demand, harms, supply chain and policy gap. What mattered was the tobacco plant, storage, curing, processing and additives (including carcinogens). Common cancers from smokeless tobacco were pointed out specifically cancer of the mouth, oesophagus and pancreas.

In terms of policies, Professor Siddiqi mentioned the bar is much lower for smokeless tobacco, with little regulation across the region, smokeless tobacco taxes are lower than cigarette taxes and health warnings for smokeless tobacco are less strict than for cigarettes. With respect to implementation the compliance is poor, despite bans products are promoted at the point of sale and via the media.

Professor Siddiqui showed a comparison study between smokers and smokeless tobacco users and the way they were responded to for advice to help reduce their habit. It showed showing that smokeless tobacco users were much less likely to be advised and given support or medication to reduce their behaviour despite having visited healthcare workers as frequently as tobacco users in previous 12 months of the study.

A comprehensive implementation of the World Health Organisation Framework on Tobacco Control (WHO FCTC)

Applying uniform tax on all tobacco including smokeless tobacco
Extending bans on advertising inclusive of points -of-sale, promotion and sponsorship to smokeless tobacco
Standardising package with pictorial warnings
Smokeless tobacco specific mass media campaigns

Preventing children from buying and selling smokeless tobacco
Regulating ingredients of smokeless tobacco products
Offering support to those who wish to quit

Primary Care Diploma

Dr Jalil Khan launched a new Family Medicine online diploma with the support of 6 leading Medical institutions in Pakistan. This is major step forward to develop primary care in Pakistan. The goal is to train 10,000 Family Medicine doctors. There was an awards ceremony to present certificates to the doctors successfully completing the programme. There is recognition that Primary Care is crucial to addressing many of the Public Health challenges in Pakistan and reducing reliance on secondary care.

Meeting with the Health Secretary KPK

A meeting was held with Jamil Farook who is the Health Secretary for KPK and Prof Zafar Iqbal. There were wide ranging discussions on how the FPH Pakistan SIG could support Pakistan. He welcomed the offer from the SIG to support Health Policy Development in KPK. He proposed that the SIG works with the KPK Health Policy Reform Unit to inform policy development.

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Institutional Membership offer by the UK Faculty Public Health

The UK FPH have launched a unique bulk membership offer for KMU as an institution. The offer is for 100 individual members for a nominal fee. This is first offer of bulk membership by the FPH anywhere in the world and was negotiated by Dr Samia Latif who is the Assistant Academic Registrar for the FPH and Dr Zia Ul Haq on behalf of KMU. This initiative will be piloted in KMU and subject to an evaluation may be rolled out to other parts of the world.

KMU Undergraduate Public Health Curriculum

Dr Zia Ul Haq has initiated a review of the KMU Undergraduate Public Health Curriculum and has requested the FPH SIG support. Dr Samia Latif is coordinating the FPH SIG input into this review.