

Pakistan's Pandemic Governance Framework: FAFEN's Monitoring and Assessment of the Government's COVID-19 Response

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ABOUT THIS REPORT

This report aims to contextualize the findings of FAFEN's observation and monitoring of the government's COVID-19 response (carried out from October 2020 to February 2021) and the official data of the pandemic up to April 14, 2021, in the larger framework of Pakistan's pandemic governance.

Key informant interviews (KIIs), observation checklists, and media monitoring at national, provincial, and district levels were used as data collection tools, and the collected data is substantiated with the help of secondary sources and media monitoring. KIIs were carried out at the district level with key government officials, including Deputy Commissioners, District Disaster Management Authority representatives, District Health Officers, Executive District Officers, heads of doctors' and paramedics' associations, those of local civil society organizations, local journalists, beneficiaries of health institutions, and direct observation of health facilities. Press releases, statements, and opinion pieces were monitored at both national and district level. Considering the vaccination drive a critical part of the COVID-19 response, 30 representatives of district administration, 33 doctors, and 33 paramedics were asked about their perspectives on vaccination.

The current report is based on primary data collected between October 10, 2020, to February 28, for checklists and 1 to 8 from 35 project districts. Checklists 9 and 10 were introduced in February 2021, and data against these checklists were collected from February 10, 2021, to March 10, 2021, from 54 district-level officials and 60 healthcare workers in 33 districts.

Discussion in this report is based on data collected against all the ten checklists, including, but not limited to interviews of 150 district health/administration officials, 153 representatives of doctors' associations, 150 representatives of paramedics' associations, 528 health institution beneficiaries, 158 CSO representatives, 221 journalists, and observation of 341 healthcare facilities. 1,198 media pieces were also monitored during the above-mentioned period.

To better reflect on the impact of the trends observed, the numbers for cases, mortality, and positivity ratio ending April 15, 2021, are accounted for.

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List of Acronyms

ADB	Asian Development Bank
AVC	Adult Vaccine Centers
BISP	Benazir Income Support Program
COVID-19	Coronavirus Disease 2019
COVAX	COVID-19 Vaccines Global Access
CSO	Civil Society Organization
DC	Deputy Commissioner
DDMA	District Disaster Management Authority
DMA	District Management Authority
DRAP	Drug Regulatory Authority of Pakistan
ECC	Economic Coordination Committee
ECP	Election Commission of Pakistan
EDO	Executive District Officer
FAFEN	Free and Fair Election Network
GAVI	Global Alliance for Vaccine Immunization
GDP	Gross Domestic Product
HSA	Health Services Academy
HPSIU	Health Planning System Strengthening & Information Analysis Unit
ICT	Islamabad Capital Territory
ICU	Intensive Care Unit
KP	Khyber Pakhtunkhwa
MoH	Ministry of Health
MoNHSR&C	Ministry of National Health Services Regulations and Coordination
NADRA	National Database and Registration Authority
NCC	National Coordination Committee
NCOC	National Command and Operation Centre
NDMA	National Disaster Management Authority
NGO	Non-Governmental Organization
NHS	National Health Services
NHEPRN	National Health Emergency Preparedness and Response Network
NIH	National Institute of Health
NIMS	National Immunization Management System

NSC	National Security Committee
PAC	Public Accounts Committee
PDM	Pakistan Democratic Movement
PDMA	Provincial Disaster Management Authority
PEMRA	Pakistan Electronic Media Regulatory Authority
PIMS	Pakistan Institute of Medical Sciences
PM	Prime Minister
PMA	Pakistan Medical Association
PPE	Personal Protective Equipment
PPRP	Pakistan's Preparedness and Response Plan
RT-PCR	Reverse Transcription Polymerase Chain Reaction
SAPM	Special Assistant to the Prime Minister
SOP	Standard Operating Procedure
TDEA	Trust for Democratic Education and Accountability
TIP	Transparency International Pakistan
USAID	United States Agency for International Development
VIP	Very Important Person
WB	World Bank
WHO	World Health Organization

Executive Summary

More than a year since Pakistan reported its first confirmed case of Coronavirus disease 2019 (COVID-19), the country's response has been largely revolving around the impact of this disease on the health sector capacity that comprises of critical care and resources such as provisions of personal protective equipment, tests, vaccines, etc. An indifferent attitude, however, was observed related to legal, institutional, and implementation issues that also impact Pakistan's capacity to respond to pandemics and other health emergencies. To make up for the lost time, there is a need for a two-pronged strategy for sustainable and effective pandemic governance that can tackle the current COVID-19 pandemic whilst laying the structural and functional foundations for similar challenges in the future.

FAFEN's monitoring and observations of governance of COVID-19 response from October 10, 2020, to April 14, 2021, paints a worrying picture of the country's overall health governance system. Even though the country is undergoing the third wave of the COVID-19 pandemic, the legislature, which is the first pillar of the governance system, has largely ignored the issue of the pandemic and the healthcare system. Careful monitoring of legislative activity has highlighted two aspects. First, there has been only been minimal interest in the pandemic in the country's legislative bodies, with none of them giving the importance COVID-19 needed as a national health emergency. The issue has been generating an exchange of political statements until recently when there has been some seriousness in parliamentary decision-making during the third wave of the pandemic.

Second, the institutional framework required to deal with a pandemic under a national response is missing. Even though health is a provincial subject in the context of the post-18th amendment, all three waves of COVID-19 illustrated that the devolution is far from being complete while the required national-level coordination had to be established through ad-hoc measures. The cumulative impact of the gaps in health and pandemic governance registers themselves in the findings of FAFEN's successive monitoring reports. Reviewing the observation and assessment of the government's COVID-19 response over the last six months establish several points for thoughtful considerations by the concerned stakeholders.

- With varying testing numbers over the months, Pakistan's COVID-19 testing capability remains a dilemma yet to be solved. The testing per capita numbers remained the lowest in the region, showed erratic trends, that did not reflect any urgency regardless of the intensity of the pandemic. Furthermore, where a majority of the health institution beneficiaries did not face any difficulty getting tested for the virus, there has been significant variation in the cost of the test, which involved engagement of the private sector. This finding points towards the room for public-private partnerships in health on one hand and reinforces the need for regulations in such partnerships on the other hand.
- Lack of personal protective equipment (PPE) has been making headlines at the onset of the first wave of the pandemic, and the issue persists in a sizable number of districts monitored. Where the availability of PPE has improved for doctors, the number of paramedics reporting adequate availability of PPE has been on the decline. Comparison of statements of district officials about the PPE available to be disbursed across district level shows discrepancies in either supply chain, or coordination of the stakeholders, or both parts of the health governance system.
- Doctors and paramedics, the frontline warriors of the war against the pandemic, reported that they could not deal with the situation. Where the number of such healthcare staff who reported them not being ready to deal with the pandemic decreased, the number soared up again in the face of the onset of the overwhelming third wave.
- Field monitoring shows that the dominant majority of doctors and paramedics feel that the vaccination shall help them to provide care to the COVID-19 patients and trust the process of selection for receiving the vaccine. It was also noted that federal bodies are involved in the overall management of the vaccination drive in a few districts.

In the absence of any meaningful debate in the political circles, the role of media acquired added significance. Media, being an important pillar of governance and oversight systems, has not been either ready, or prudent to observe, report, and comment on the state of health governance in Pakistan. National and local level media monitored at

district levels, and data collected from journalists at district levels shows that these stakeholders lacked the capacity of evidence-based reporting. With its focus towards operationalization of response, the role of Pakistani media improved gradually since the start of the pandemic as it started using evidence-based reporting and demanding legislature to behave more responsibly in face of the third wave of the deadly virus.

Due to these shortcomings and inconsistencies in the system, there has been a general lack of trust in the government's COVID-19 response among the public. A consistent reading of lack of compliance with SOPs through all the waves of the pandemic even at public offices and health facilities is a clear example of the trend. A more recent expression of lack of trust in the government's decision-making regarding the pandemic is the lowest number of vaccinations against COVID-19 in Pakistan when compared to the neighboring countries. This again is an expression of the fact that when the system of governance is reactive, lacks transparency, and is inconsistent in its decisions like implementation of lockdown, its credibility suffers a significant and perhaps irreparable loss.

The government's COVID-19 response has to make up for the lost ground with a strategic approach to cover the gaps, especially in setting up a structural platform that establishes close coordination at various tiers of government, a robust legislative engagement, and oversight that imparts an inclusive and representative character to all measures needed and lastly, to build public knowledge and understanding that makes compliance with safety guidelines more voluntary than enforced.

From the First to the Third Wave

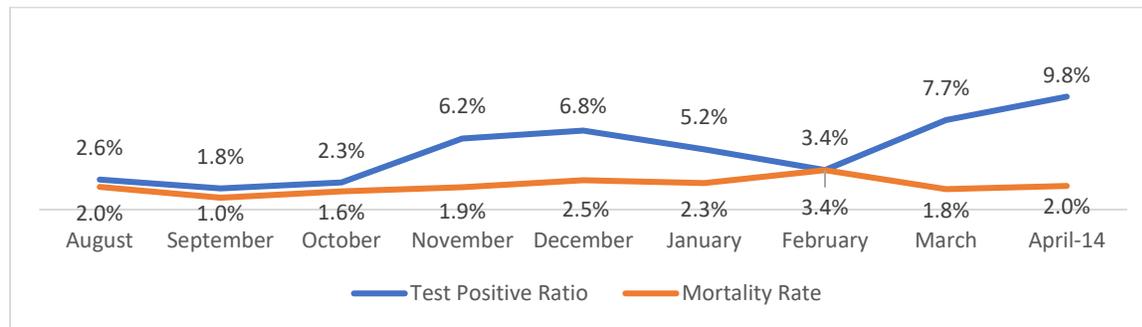
Since the last week of February 2021, Pakistan is undergoing the third wave of the COVID-19 pandemic. Almost a year ago, the country reported its first case of COVID-19 in February 2020. Taking a proactive approach then, the government announced and implemented a series of measures, including, travel restrictions, the closing of education institutions, a ban on public events, and varying levels of lockdown to curtail the spread of the pandemic. The measures largely remained in place till August—a month after the first wave had dissipated in July 2020.

Two months after the lifting of lockdown restrictions in August, the second wave of infections hit Pakistan in October. The wave followed the decreasing public compliance with SOPs, driven by the government’s reactive decision-making and its confused risk communication strategy. As the number of infections increased, the government responded with restrictions but avoided the imposition of country-wide lockdown like it did in response to the first wave.

Despite warnings from civil society organizations, including FAFEN, the government announced ease in restrictions on February 24, 2021. Around the same time, the trends were showing an increase in infections and positivity rate. Hardly a week had passed when the government backtracked from its decision and announced the onset of yet another wave with the re-imposition of several restrictions. The third wave had found its foothold by then.

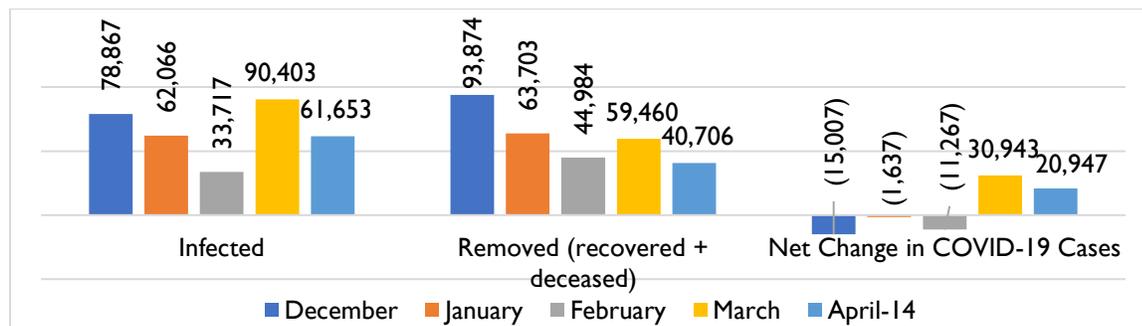
As shown in Figure 1, the test-positivity ratio reflects a steep increase, changing from 3.4 percent in February to 7.7 percent in March and accelerating further to 9.8 percent by the end of the second week of April. The mortality rate, on the other hand, declined from 3.4 percent in February to 1.8 percent in March. However, the absolute number of deaths went up, and 1,592 casualties in March were the second-highest since October.

Figure 1: Monthly Test Positivity Ratio and Mortality Rate



Beyond positivity ratios and mortality rates, trends in other critical indicators in the third wave paints a more worrying picture than at any other time since the first COVID-19 case was recorded in February 2020. As Figure 2 reflects, the total number of new infections experienced a dramatic change from February to March. A total of 90,403 patients were added to the health system. More worrying is the unabated acceleration in new infections as more than 60 thousand positive cases were recorded in the first two weeks of April alone.

Figure 2: Comparative Reading of COVID-19 Cases



The aggravating pandemic situation in Pakistan comes in the wake of persisting governance gaps that threaten to derail the gains made in the first wave of the pandemic. Throughout the second wave and the beginning of the third

wave, continued vigilance and oversight of the pandemic took a backseat to the ongoing political wrangling that displaced the pandemic from the government's priority. More consequentially, the environment fostered a lack of compliance among the citizens with what appeared as a return to the country's normal political discourse.

While the reactive mode of pandemic governance since the end of the first wave has deprived the country of a meaningful discourse on reforming the structural, policymaking, and implementation aspects of pandemic governance, the issue remains of critical importance that demands a robust review and measures commensurate with the scale and scope of the damage and disruption caused by the COVID-19 and future pandemics of similar scope and nature.

Pakistan's Pandemic Governance: An Overview of the COVID-19 Response

COVID-19 was declared a public health emergency of international concern by the World Health Organization (WHO) in January 2020.¹ By April 14, 2021, more than 138 million individuals across the world had been infected with COVID-19, resulting in around 3 million deaths. On a national level, Pakistan had reported 739,818 cases of COVID-19 and 15,872 deaths amongst its population.²

Pakistan is the fifth populous country in the world, housing a population of 232 million in 2021, along with additional 1.4 million registered Afghan refugees. More than 80 million of the population lives in urban areas, with a higher risk of getting COVID-19 infection, as opposed to those that reside in the rural areas. Despite many people at high risk for getting infected, Pakistan's performance to control the COVID-19 epidemic so far looks promising in comparison to its neighboring countries, and fares much better than many developed nations. As of March 15, 2021, Pakistan is facing a rising third wave of the epidemic and its response as compared to that seen in Iran and India is shown below in table 1.

Table 1: Comparison of COVID-19 Statistics in Pakistan with Iran and India (On March 15, 2021)³

Indicator	Pakistan		Iran		India	
	Number	Rank	Number	Rank	Number	Rank
Total reported cases	607,453	31	1,754,933	15	11,409,595	3
Total reported deaths	13,537	30	61,330	11	158,882	4
Cases per 1 M population	2,713	146	20,708	90	8,211	125
Deaths per 1 M population	60	137	724	49	114	118
Total tests	9,529,763	25	11,781,317	19	227,407,413	2
Tests per 1 M population	42,564	156	139,018	119	163,200	114

Using the data against the six indicators available till January 9, 2021, Lowy Institute provided a ranked comparison of the performance of 98 countries in managing the COVID-19 pandemic in the 36 weeks following their hundredth confirmed case of the virus. The composite score of Pakistan was 36.9 (rank 69), Iran with a score of 24.3 (rank 86), and India with a score of 15.9 (rank 95).⁴ The ranking depicted better performance of Pakistan in handling the COVID-19 pandemic than its neighbors.

BMJ Global Health concludes that readily available data supports transparently generated rankings of countries' performance against COVID-19 based on doubling times of cases and deaths. By days 65 and 135, the performance showed a large (and increasing) cross-country variation, and rankings of countries by performance became meaningful. Good performance was identified in countries with both high and low levels of income.⁵ The study scored Pakistan's performance at 8 amongst 35 countries, compared to a score of 30 for Iran and 21 for India. Significantly better performance in Pakistan demonstrates the value of timely and appropriate policy measures that were taken

¹ COVID-19 as a Public Health Emergency of International Concern (PHEIC) under the IHR. (2020, May). World Health Organization. <https://extranet.who.int/sph/covid-19-public-health-emergency-international-concern-pheic-under-ihp>

² Situation Reports. (2021, April 15). National Command and Operation Center (NCOC). <https://ncoc.gov.pk/sitrep.php>

³ Reported Cases and Deaths. (2021, March 15). Worldometer. <https://www.worldometers.info/coronavirus/>

⁴ Covid Performance Index. Lowy Institute. <https://interactives.lowyinstitute.org/features/covid-performance/#rankings>

⁵ Jamison, D.T., Lau, L.J., Wu, K.B., & Xiaong, Y. (2020, December). Country performance against COVID-19: rankings for 35 countries. BMJ Global Health. <https://gh.bmj.com/content/5/12/e003047.info>

at the outset of the pandemic. However, in the absence of an adequate health sector infrastructure and regulation, these gains may not be sustainable.

At present, most health outcome indicators of Pakistan are among the worst in the region, being just ahead of Afghanistan.⁶ For instance, global spending on health extended up to 10 percent (US\$8.3 trillion) of global GDP in 2019 and the share of out-of-pocket spending in total health spending remained above 40 percent in both low and lower-middle-income countries.⁷ Yet, in comparison, Pakistan's performance is very poor in total spending (both public and private) on health at 3.2 percent of GDP, with out-of-pocket expenditure amounting to 57.6 percent of the total health expenditure.⁸ These figures are broadly indicative of the lack of the healthcare sector's capacity to absorb and withstand the onslaught of a widespread pandemic such as COVID-19.

It is therefore important to understand additional contextual factors including, but not limited to, legal, institutional, and implementation levels that may have affected Pakistan's capacity to respond to COVID-19 and may offer insight for tackling health emergencies and epidemics in the future.

Pandemic Governance Framework on the Eve of COVID-19

Pakistan underwent a massive transformation in its health governance after the passage of the 18th Constitutional Amendment in 2010. The abolition of the 'concurrent list' and its devolution to provinces radically altered the federal structure of Pakistan and led to the greater provincial autonomy. Along with other governance systems, the health mandate was also transferred to provinces which assumed more responsibilities for key health governance functions such as planning, legislation, financing, and service delivery.

The devolution opened up new opportunities for improving health governance but the abrupt transition of power from the center to provinces posed further problems and challenges that included fragmentation in national coordination, institutional constraints and incapacities, uneven implementation of norms and regulations, and resource division issues. Moreover, the delegation and transfer of ministries and departments also left enduring gaps and confusion with regards to the roles, authorities, and responsibilities that were to be exercised by respective federal and provincial ministries and departments.

As the Federal Ministry of Health (MoH) was dissolved in 2011 and federal roles in "health" parked in various divisions, existing staff was either sent back to their parent organizations or other divisions. There was, however, scant discussion and planning undertaken by the ministry with provinces, which were burdened with additional responsibilities but in practice were unable to dispense with the same on account of institutional capacity constraints.⁹

Earlier in 2011, the then Ministry of Health established National Health Emergency Preparedness and Response Network (NHEPRN) to fill the health gap in disaster management. Under the National Disaster Management Act in 2010, a robust disaster management system spread over the entire country with the establishment of its national, provincial, and district chapters. However, the component of health in this effort was not seriously addressed. NHEPRN was the first step towards institutionalizing the concept of Health Emergency Preparedness, Response, and Recovery in Pakistan. After devolution under the 18th Amendment, NHEPRN was transferred to the Cabinet Division and since 2013 it has been a subordinate office of the Ministry of National Health Services Regulations and Coordination (MoNHSR&C).¹⁰

The ministry of health was reinstated sensing the administrative gap in health sector governance as a federal entity for health-related functions under federal legislative I and II. Renamed as the Ministry of National Health Services Regulation and Coordination (MoNHSR&C), the apex health body was created in 2013 accordingly. Gradually, federal health functions were centralized under the ministry. The centralization, however, was conducted without any major organizational reform in the newly established ministry, which lacked capacity and expertise for its new

⁶ *Health, Nutrition and Population*. The World Bank. <https://datatopics.worldbank.org/health/available-indicators>

⁷ *Global spending on health: Weathering the storm*. (2020, December). World Health Organization. <https://www.who.int/publications/i/item/9789240017788>

⁸ *National Health Accounts Pakistan 2015-2016* (2018, June). Pakistan Bureau of Statistics. <https://www.pbs.gov.pk/content/national-health-accounts-pakistan-2015-16>

⁹ Zaidi, S.A., Bigdeli, et al. (2019). *Health systems changes after decentralization: progress, challenges and dynamics in Pakistan*. BMJ Global Health. <https://gh.bmj.com/content/4/1/e001013>

¹⁰ *About NHEPRN*. National Health Emergency Preparedness & Response Network (NHEPRN) Government of Pakistan. <https://www.nheprn.gov.pk/Detail/YzE4NjRmODMtYTlmYy00YWU5LTg5YWQ0tNjY2NTRkNWExYTc0>

role of coordination and regulation across the diverse provinces amidst a struggle to recover legitimacy in the face of opposition from both provinces and the federal entities that had to return the functions.¹¹ Hence, the process of re-centralization started in the early years of devolution, but the remits of new central structures remained vague and unsettled.

When the new Ministry of NHR&C was reinstated, technical positions were not created appropriately, whereas gradually more functions from other divisions were transferred to the ministry considering a coordinated and integrated response. Being a technical ministry with a serious shortage of technical expertise and imbalance with non-technical staff, this deficiency is causing difficulties in coordinating effective national response and strategic oversight. To address this, a proposal for restructuring of the Ministry of NHR&C was developed in consultation with establishment and finance divisions in 2019. The proposal was reviewed by the implementation committee on restructuring the federal government and finally presented to the cabinet in January 2020.¹² However, before its implementation, the attention diverted towards the COVID-19 pandemic. The pandemic again elevated the need for an urgent restructuring of the ministry, and this became a priority agenda in the anti-COVID-19 action plan (short term; Jun & Jul 2020).¹³ Yet, the matter is still under discussion and review.

Tailoring Response to COVID-19: Pandemic Governance on the Go

The governance problems that beset the health sector, in particular, were brought to stark light with the onset of the COVID-19 pandemic in Pakistan. In the absence of formal governance and institutional framework, the government response throughout the pandemic was marked by confusion and contradictions. This was initially seen most visibly in vacillation over declaring a national health emergency and imposing lockdowns as the legal basis for such measures did not exist. The differences in approaches between provinces and federal over strategy and oversight were also manifested in the lives versus livelihood debate, not wanting complete lockdown and shutting down the life-critical economy.

February 26, 2020, marks the date when Pakistan reported its first two imported cases of COVID-19. A week earlier, Pakistan had decided to shut its border with Iran, as the latter reported 19 people succumbing to the virus. Fortunately, Pakistan had made the quick decision to close its border with China, with the government later taking a well-informed step of stopping all flights from China.

The erstwhile mechanism between National Disaster Management Authority (NDMA) and NHEPRN for health-related emergencies was in place before the COVID-19 pandemic but was not strong enough for the overall disaster risk management agenda. During COVID-19, the performance of NHEPRN was not significant primarily due to existing capacity constraints. On an ad-hoc basis, this role was played by the Health Services Academy (HSA), Health Planning System Strengthening & Information Analysis Unit (HPSIU), National Institute of Health (NIH), National Emergency Operation Centre (polio), and experts from the private sector under the supervision of MoNHR&C and National Command and Operation Center (NCOC).

Soon after the start of the epidemic in Pakistan, the government formulated a crisis management team, under the leadership of Special Assistant to Prime Minister (SAPM)/ Minister of State for Health and SAPM for National Security to coordinate an early and effective response. Immediate measures were taken, with the development of a national action plan, establishing 1166 helpline, risk communication, containment and mitigation measures that included quarantines and border closures, international and domestic travel restrictions, closure of educational institutions, banning of public events, social distancing, and varying levels of lockdown, etc.

The Ministry of National Health Services, Regulations & Coordination (MoNHR&C) established a coordination mechanism that ensured proper forums and a uniform response to the COVID-19 threat. The ministry established a COVID-19 surveillance system using the existing surveillance mechanism of Polio. Using the evidence, critical health system needs were identified, and necessary standard operating procedures/ guidelines were issued, and accordingly dissemination of information started. The National Institute of Health (NIH), the national reference public health laboratories acquired the requisite technical capacity for COVID-19 diagnostics on February 1, 2020. Since then, the diagnostic centers have gradually found their footing across Pakistan, in all provinces and federating areas.

¹¹ Zaidi, S.A., Bigdeli, et al. (2019). *Health systems changes after decentralization: progress, challenges and dynamics in Pakistan*. BMJ Global Health. <https://gh.bmj.com/content/4/1/e001013>

¹² Ministry of NHR&C, Jan 2020; Summary for reforms in the M/o NHR&C

¹³ Ministry of NHR&C, 2020, National Anti-COVID-19 Action Plan for the Period June & July 2020

In early April 2020, a decision was taken to adopt the “One Government” approach to articulate a holistic response to the crisis. A high-level National Coordination Committee (NCC) chaired by the Prime Minister was established. The Committee comprised all relevant Federal Ministers, Chief Ministers, and Provincial/ area governments, and was tasked with overall coordination of the COVID-19 response in the country.

Faced with the issues of operational coordination between federal and provinces (e.g. between The NDMA and its provincial counterparts) it announced the creation of the NCOC to evolve a unified response. This was in line with the past practices in that rather than being sustained, the federal-provincial coordination is spurred usually when health or other calamities (e.g. polio and dengue outbreaks or flooding and earthquake) grip the country.¹⁴ This was aided by the organization of Task Forces on COVID-19 at provincial/ area levels that were chaired by the respective Chief Ministers. The National Disaster Management Authority (NDMA) and Provincial Disaster Management Authorities (PDMA) were assigned to lead operational issues for overall COVID-19 response.

While the NCOC did resolve some of the issues emanating from the lack of effective coordination, its emergence reflected the inadequacy of the existing formal governance framework. This short-term policy could hardly serve as an alternative to well-organized and pre-established institutional coordination mechanisms that were needed to meet the challenges of the COVID-19 health emergency. Reflecting the ad-hoc approach, to further strengthen the structural and functional capacity for pandemic response, an ordinance to re-organize the National Institute of Health (NIH) was promulgated on 17 December 2020 to provide for an autonomous body to operate and manage institutes and centers for carrying out research and for the prevention of the spread of infectious diseases and health emergencies in Pakistan.¹⁵ The following institutes and centers for health and disease control shall be set up and operate under the control and authority of the NIH:

- (a) Centre for Disease Control; (b) Health Research Institute; (c) National Health Laboratory; (d) Health Data Centre; (e) Institute of Nutrition and Health; (f) Vaccine and Biological Products Centre; and (g) Centre for environmental and occupational health.

To tackle pandemics and health emergencies, this was a major reform enacted through a Presidential Order. However, if not presented to, and approved by the Senate and the National Assembly within the stipulated time, these efforts may not be sustainable in the long run. On the other hand, health-related legislation in the recent past has remained poor. A divided parliament, where the opposition and the ruling party have majorities in the Senate and National Assembly respectively, a charged political environment, and the nuanced understanding and approach to health legislation in the post-18th amendment scenario, are some of the factors that have contributed to the relegation of health governance from the legislative agenda. Combined with the federal government’s preference for management through executive measures, the country’s COVID-19 response has been reliant on a host of other ad-hoc measures without meaningful parliamentary deliberations and approvals.

The structural adjustments in the relevant health departments and institutions were supplemented with COVID-19 response plans. On April 23, 2020, the Government of Pakistan launched Pakistan’s Preparedness and Response Plan (PPRP) in a bid to suppress and mitigate the spread of COVID-19. The initial Response Plan of US\$ 595 million, was intended to strengthen Pakistan’s capacity in emergency prevention, preparedness, response, and relief and build health systems for a period of 9 months from April to December 2020. The response plan called on all partners to act together and utilize their resources and expertise to help implement a coordinated response across the country at federal and provincial levels towards:

1. Scaling-up emergency response mechanisms to ensure a whole-of-country and whole-of-society approach;
2. Launching mass public awareness campaigns on COVID-19;
3. Delivering essential case finding, contact tracing, and management in quarantine and isolation facilities;
4. Expanding surveillance to capture and monitor disease outbreak trends;
5. Delivering essential public health measures to contain the spread of the virus such as social distancing;
6. Delivering essential laboratory equipment and capacity building to adequately test for the virus;

¹⁴ About NHEPRN. National Health Emergency Preparedness & Response Network (NHEPRN) Government of Pakistan. <http://www.nheprn.gov.pk/Detail/YzE4NjRmODMtYTlmYy00YWU5LTg5YWQeNjY2NTRkNWExYTc0>

¹⁵ Ordinance No. XVIII of 2020. An ordinance to re-organize and create National Institute of Health. National Assembly of Pakistan. http://www.na.gov.pk/uploads/documents/1612362126_696.pdf

7. Enhancing the capacity of the health system to cope with the surge in patients through the delivery of medical supplies and implementation of surge plans;
8. Providing emergency cash transfers, food rations, and support educational activities.

From the outset, the provision of essential health services, an important component, was missed, which was added later. This component emerged as a critical area; for, as predicted, the lives lost due to disruption of essential health services were beyond the number of deaths because of the COVID-19. The provision of essential health services to all people is not up to the desired level in the country and the impact is an annual loss of around 9,500 maternal lives and half a million children's lives. Using the LiST model and considering the average disruption experienced in March-July 2020, it was estimated that the disruption of essential health services delivery for five months, caused an additional loss of 48,062 additional children (including 20,874 newborn lives) and an additional 440 maternal lives.¹⁶

Where such lapses yielded negative results, there were several silver linings in the government's efforts in related sectors. One, the same study that provided an estimated figure for the lives lost due to non-provision of essential health services, concluded that reinstating essential services saved more lives than were lost due to additional deaths caused by the COVID-19 as acquired during contacts with the health system.¹⁷

Two, Pakistan was able to avert most of these additional deaths and the two factors which played a critical role included the involvement of the private sector health providers/ general practitioners and the use of digital technologies. A good example of working with the private sector is polymerase chain reaction (PCR) testing and regular reporting to the government for disease surveillance.

Three, to support the response to mitigate COVID-19, the State Bank of Pakistan (SBP) expanded the scope of existing refinancing facilities and introduced three new measures to (i) support hospitals and medical centers to purchase COVID-19 related equipment (43 hospitals, PKR 10.1 billion); (ii) stimulate investment in new manufacturing plants and machinery, as well as modernization and expansion of existing projects (487 new projects, PKR 430 billion); (iii) incentivize businesses to avoid laying off their workers during the pandemic (2,958 firms, PKR 238 billion). These facilities were extended beyond their original deadline of June 2020 to September or December 2020.¹⁸ The measures helped alleviate the acute shortage of facilities and services on the one hand and helped partially mitigate the impact of lockdown on employees and employers.

Fourth, the effort to generate resources for focused and related aspects of the COVID-19 response bore satisfactory results. By mid-March 2021, a total of US\$ 694.19 million were committed by donors for COVID-19 response, of which loans of US\$357 million (\$158m from World Bank (WB) and US\$ 199 million from Asian Development Bank (ADB)) have been earmarked for the purchase of COVID-19 vaccine. Also, the COVAX facility of the Global Alliance for Vaccine and Immunization (GAVI) has committed to cover 20 percent of the vaccine needs in Pakistan, whereas China has also provided 1.2 million doses of vaccine as a grant in kind.¹⁹

So far, WB has funded US\$ 38 million of loans and US\$ 15 million of grants (in addition to loans allocated for the vaccine) have been utilized for the purchase of personal protective equipment (PPE) and equipment. In addition to ADB support for the COVID vaccine, US\$56 million (including a US\$ 50 million loan and remaining as a grant) has been utilized for commodities, supplies, and capacity development. In addition to the loan committed for the vaccine, a PC-I amounting to US\$ 100 million (loan from ADB) along with US\$ 20 million (loan from Agence Française de Développement) is in process of development. A PC-I with the support of Islamic Development Bank (IsDB) amounting to US\$ 70 million loans has been returned from Planning Commission with observations. Grant assistance from China (US\$ 4 million), the United States Agency for International Development (US\$ 17.85 million), and the Government of Japan (US\$ 15.6 million) are also available and under implementation or in the approval stage at Planning Commission.

Despite the numerous notable measures, the government's COVID-19 response has largely remained reactive and would need to be reviewed for enhanced response in the future. The first challenge for a better response would

¹⁶ *Measuring Impact of Mitigation Measures during COVID-19 Pandemic in Pakistan: Maternal, New-born and Child Lives Lost and Saved.* (2021). Ministry of NHSR&C and WHO.

¹⁷ Ibid

¹⁸ *Policy Responses to COVID-19.* (2021, April). International Monetary Fund. <https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19>

¹⁹ Monitoring reports on investments during COVID-19 pandemic in Pakistan. (2021, March). Ministry of NHSR&C – HPSIU.

require a more sustainable and robust pandemic governance framework building on the lessons learned from the existing ad-hoc arrangements. To date, the government has resorted to ad-hoc measures and short-term policies to articulate a concerted response effort. A brief look at the events in the context of the third wave reflects the need for more proactive and considerate decision-making.

March 2021 witnessed an unprecedented surge in COVID-19 cases, leading to the official declaration of the third wave of the pandemic in the country. On February 24, 2021, the government had announced a relaxation of its COVID-19 related restrictions on public gatherings. The announcement came as a surprise for observers looking at the increasing numbers of positive cases in the same week of February. On March 4 the Pakistan Medical Association (PMA) had expressed its concern over the government's decision to relax COVID-related restrictions. Terming it a "hasty" decision, the PMA had warned the situation might worsen in the country as the vaccination campaign was moving at a slow pace. It had suggested that the restrictions not be lifted till 70 percent of the country's population was vaccinated against the virus. However, despite these warnings, Prime Minister Imran Khan stayed firm that the government wanted to adopt a balanced policy where the spread of the virus could be prevented without affecting the poor man and the country's economy.

Furthering this wave of confusion and lack of unanimity among the stakeholders, on March 10, NCOC re-imposed several restrictions that had been in force in the country before February 24. As a result, the center announced a two-week spring vacation in educational institutions in 10 cities whereas Balochistan and Sindh were advised to limit attendance to 50 percent. With the aim to ensure strict compliance with SOPs, it was decided to continue smart, and micro smart lockdowns, re-implement 50 percent work from home policy, and a time limit of 10 pm on all commercial activities with immediate effect. NCOC, which had announced relaxation in several COVID-related restrictions on February 24, itself revealed on March 16 that the number of active cases had increased by about 50 percent in three weeks.

As a sign of further confusion on the part of NCOC, the Election Commission of Pakistan (ECP) was given a go-ahead to hold local bodies and cantonment board elections by the end of May or early June. Days later, on March 24, the NCOC extended the closure of educational institutions till April 11 in Islamabad as well as in selected districts of Punjab and Khyber Pakhtunkhwa where virus prevalence was high. On the other hand, Sindh Education Minister Saeed Ghani, however, announced that all educational institutions across the province would remain open as usual since the situation was still under control in Sindh. However, the ominous development of a considerable number of children contracting the virus necessitated a rethink. A four-day-old baby contracted a virus from her mother and was put on an oxygenated bed at the Pakistan Institute of Medical Sciences (PIMS) in Islamabad on March 29. As many as 43 children from newborn to 10 years were found corona positive in Islamabad alone.

In a catching up act, on March 28, the NCOC imposed a ban on all kinds of gatherings with immediate effect in cities where the infection rate was more than eight percent. It also suggested a reduction in inter-provincial transport and advised the provincial governments to expedite the vaccination process. This came in response to reports of 4,368 positive cases in a day on March 26—the highest single-day count since July 2020. Within days of the news, on March 30, Pakistan reported 100 deaths within just 24 hours which was the current year's highest death toll in a single day. Equally worrying was news of 80 percent oxygen bed occupancy and reports of PIMS and Polyclinic Hospital having exhausted their capacity.

Confusions in the government announcements, however, were not the only issue. On March 25, five days after being tested positive for COVID-19, Prime Minister Imran Khan presided over a meeting of his media team at his *Banigala* residence. The picture of the Executive presiding over the meeting came at a time when the newspapers were also reporting arrests and imposition of a fine on people in various cities for not observing the SOPs. National English daily Dawn in its March 27 editorial questioned the action of the Prime Minister and questioned NCOC on the operational level management of the third wave in the country, expressing disappointment over the NCOC for its failure to come out with a practicable strategy to ensure strict implementation of the SOPs. In terms of damage to public trust and compliance with SOPs, the lapse on the part of the PM only added to suspicions of the circumspect citizenry that have increasingly abandoned the safety protocols and view vaccination with suspicion.

Missing Legislation and Limited Oversight

The government's inclination towards ad-hoc measures was only matched with a lack of interest on the part of the legislatures to review the situation, demand answers, and deliberate a legal framework for Pakistan's pandemic governance. The National Assembly held a total of 24 and the Senate 27 sittings during the past six months, starting

from October 2020. However, there had been no input from either of the two houses regarding the government's measures to deal with the pandemic and procuring the vaccines.

On October 9, 2020, officials of the Ministry of Interior briefed the members of the Senate Standing Committee on Interior on "the preparations/preventive measures about the potential spread of COVID-19 (Phase-II)." Later in the month, on October 26, the National Assembly was informed through a written reply that an amount of Rs 4.84 billion was lying unutilized in the account created for receiving donations and funds from the public and overseas Pakistanis for the fight against COVID-19. However, no member raised any supplementary question and it remained unnoticed by the lawmakers even if there had been general demand for resources to combat the pandemic at both provincial and district level.

There was no session of the National Assembly during November and December 2020. The 28th regular session of the National Assembly was scheduled to start in the third week of November, but the government did not convene it due to the COVID-19 situation as well as the opposition's aggressive agitation campaign. Most of the committee meetings were also canceled due to the pandemic.

The Senate chairman convened the sitting of the Senate on December 31, 2020, on the requisition of the opposition, but there was no mention of COVID-19 on the agenda as the opposition was only interested in holding a debate on the political matters, like the role of the National Accountability Bureau.

In one of its meetings in December 2020, the National Assembly Standing Committee on Overseas Pakistanis and Human Resource Development discussed the sufferings of the overseas Pakistanis due to COVID-19. The committee was informed that 76,968 Pakistani workers had returned to Pakistan since the outbreak of the pandemic. However, there was no discussion on the impact of this mass return on the Pakistani economy and the socioeconomic well-being of these individuals.

A meeting of the sub-committee of the Special Parliamentary Committee on COVID-19 under the convenorship of Senator Shibli Faraz was also scheduled to be held on January 28, but it was canceled without assigning any reason.

On January 29, a Calling Attention Notice, moved by Pakistan Peoples Party's Sherry Rehman and Pakistan Muslim League-Nawaz's Ayesha Raza Farooq, "drawing the attention of the Minister for National Health Services, towards the COVID-19 vaccination plan of the government to ensure early and equitable access to the vaccine" was taken up in the Senate. The opposition senators had inquired about the prioritization of vaccine subjects and asked the government to explain the vaccine procurement policy. In response, Minister of State for Parliamentary Affairs, Ali Muhammad Khan, assured the House that no elite group would be prioritized for COVID-19 vaccination; priority would be given only to the high-risk category including frontline healthcare professionals, elderly, and teachers. However, no details were shared on details of the procurement policy.

In February 2020, some of the members had asked written questions about the pandemic data during the assembly session which were adequately responded to by the concerned minister.

A meeting of the Senate Standing Committee on National Health Services was scheduled to meet on February 17 to take up a Calling Attention Notice moved by an opposition member regarding the government's COVID-19 vaccination plan ensuring early and equitable access to the vaccine and the mechanism of administering the vaccine, but the meeting was called off without assigning any reason.

The issue of the procurement of the vaccines had come under the scrutiny of the PAC in its meeting on Feb 4 as well, but no major decisions were taken in it and Auditor General Javed Jahangir briefed the PAC members on audit reports for the first phase of COVID-19 spending up to June 30, 2020.

Senate elections held in the first week of March dominated the country's politics as well as the parliamentary proceedings throughout the month. There was no meaningful discussion in the parliament on either *policy* (transparency of procurement, selection of vaccine among the available options, financing, and communication with the public on the issues of safety of the vaccine), neither technical issues related to COVID-19 vaccines (such as results of clinical trials, the physical infrastructure required for the vaccination drive, opinions of medical experts on the effectiveness of vaccines, and capacity building of healthcare staff to administer the vaccine).

The National Assembly held only five sittings, whereas the Senate met for four days during March. However, the members of both the houses during their speeches preferred highlighting political issues only, turning their faces away from the prevailing pandemic situation in the country. Interestingly, instead of demanding a parliamentary oversight over the government policies to handle the pandemic, the opposition members criticized the government for convening the session during the pandemic.

Parliamentary oversight over the government response to COVID-19 showed some sign of improvement in March as the third wave of the pandemic accelerated. In over 50 meetings of various committees and sub-committees of the National Assembly that took place during March 2021, the COVID-19 issue came under discussion on March 4 during the 46th meeting of the Public Accounts Committee (PAC) that had been convened “to examine the audit paras of the Ministry of National Health Services and the National Institute of Health (NIH) for the year 2019-20. Furthermore, several individual lawmakers raised questions on the government’s COVID-19 response. However, the required effective oversight from the legislators and parties remained significantly lower than expected.

Viewed in the larger regional and global context, the legislatures in Pakistan surprisingly maintained an inexplicable distance from an issue that in its wide-scale impact has acquired a priority in the national politics of most countries. The results of the inaction are not merely limited to a lack of transparency and inclusivity. It can be argued to have contributed to the lack of seriousness on the part of key stakeholders and perhaps more importantly to the public’s lack of seriousness towards the pandemic itself. A more proactive role of the legislators in guiding the long-term plan for efficient and effective pandemic governance would have helped enhance public confidence in a more transparent, robust, and inclusive COVID-19 response—a critical gap in the current effort to date.

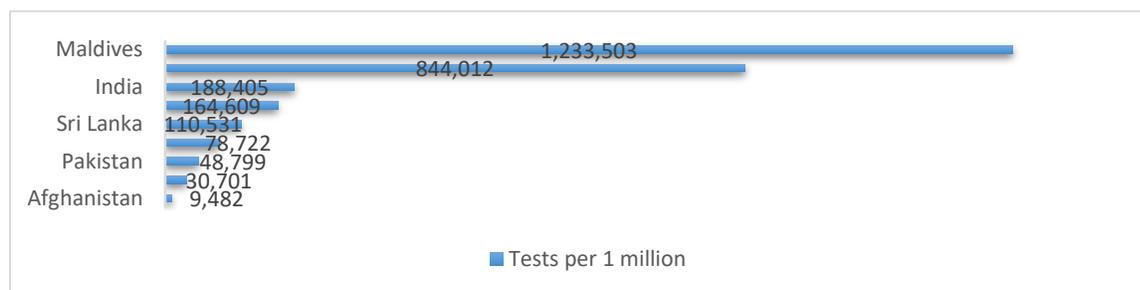
COVID-19 Response: Observation and Assessment at the District Level

The aforementioned institutional and governance gaps in the health sector were also registered in day-to-day operational issues, as highlighted by the district-level observation and monitoring data obtained for this project. These operational aspects involved testing of patients for COVID-19, availability of critical infrastructure (PPEs, etc.), technical readiness and capacity of healthcare workers and local journalists, vaccine roll-out and administration, and implementation of key SOPs at public offices, health facilities, and among the public at large.

Testing

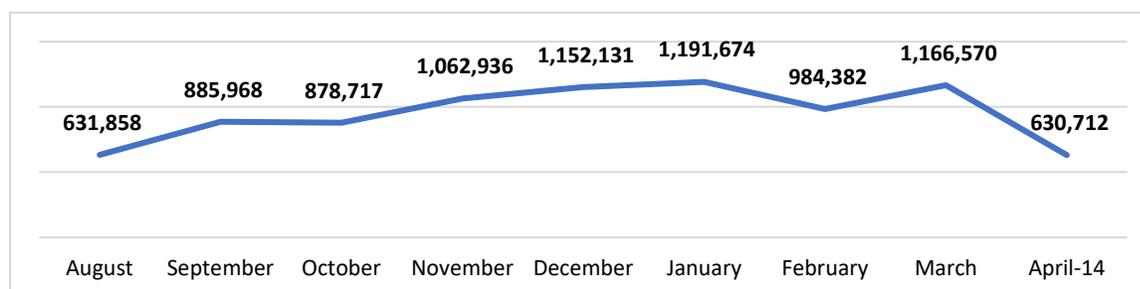
The challenges in this area included shortage of testing kits, capacity building of healthcare workers to test, quality and pricing mechanisms in the private sector, and low utilization rate of available testing capacity. Pakistan's testing rate has been shallow since the beginning of the pandemic, with its per capita testing rate among the lowest in the region.

Figure 3: Tests per One Million Population²⁰



Moreover, the monthly tests conducted showed erratic trends that hardly reflected the pace, intensity, and severity witnessed in different stages of the pandemic. This was most notably experienced in the months following October and February, which marked the beginning of the second and third waves of the pandemic respectively.

Figure 4: Monthly COVID-19 Tests



The COVID-19 experience also unveiled regulation gaps in the private sector that dominates Pakistan's health system. During the pandemic, the private laboratories provided 50 percent of the overall testing capacity, but government authorities were reluctant to effectively regulate the pricing mechanism and quality of COVID-19 tests in the private sector.²¹ In neighboring countries such as India, state authorities imposed varying price caps on COVID-19 tests conducted by private facilities. Following the central government's move in December 2020 to slash COVID-19 testing prices charged by private facilities, several other states followed suit and reduced maximum testing costs to less than INR 1000 (PKR 2160) for both RT-PCR and rapid antigen tests. For example, the Odisha and Uttar Pradesh governments capped the RT-PCR tests at INR 400 and 600 (PKR 864 and 1296), respectively.²²

²⁰ Reported Cases and Deaths. (2021, April 15). Worldometer. <https://www.worldometers.info/coronavirus/>

²¹ Zaidi, S. (2020, December 26). Covid & public-private partnerships. Dawn. <https://www.dawn.com/news/1597881>

²² Covid-19: How much does RT-PCR test cost? Find state-wise price here. (2020, December 2). Times Now Digital. <https://www.timesnownews.com/india/article/covid-10-how-muc-does-rt-pcr-test-cost-find-state-wise-price-here/686056>

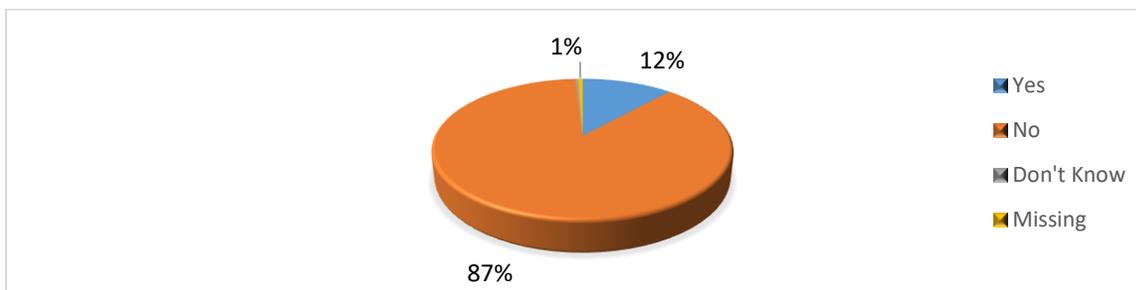
In the absence of satisfactory pricing caps on testing in Pakistan, private laboratories charged patients arbitrary prices for the COVID-19 test. In Pakistan, a coronavirus test at an average costs more than Rs. 6,000.²³ This was unaffordable for the marginalized sections of society and those from low-income households constituting the bulk of Pakistan’s society and who were relatively more exposed to risks posed by COVID-19. That said, the engagement of the private sector and effective public-private partnerships (e.g. in Sindh) played a critical role in alleviating the burden of the pandemic on the public health sector; however, its potential in terms of supplying critical health expertise, required human resources, and infrastructural capacity was not fully harnessed.²⁴

The consolidated data gathered for this report from October 10, 2020, to February 28, 2021, highlighted these issues of testing access and pricing. Over this period, the team collected the responses of 528 patients or their attendants for quantitative and qualitative questions to evaluate if they had access to COVID-19 testing or afford testing costs. The following section will present the consolidated findings in detail.

Testing Access

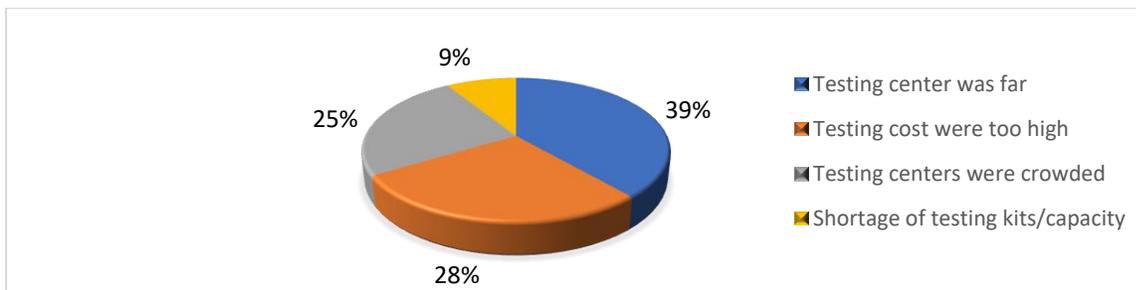
Patients/their attendants were asked if they/their patients faced any difficulty during COVID-19 testing. Twelve percent of them percent said yes, 87 percent said no, while data for one percent was reported missing.

Figure 4: Difficulties Faced in Getting Tested for COVID-19



Those who answered in the affirmative were asked to comment on the problems they faced during their test. Accounting for 39 percent of the total responses, distance from the testing center was the most frequently mentioned problem. It was followed by high testing costs and crowded testing centers which were mentioned in 28 percent and 25 percent of the responses. Lastly, in nine percent issues of shortage of testing kits/capacity were highlighted.

Figure 5: Problems Faced During the COVID-19 Test

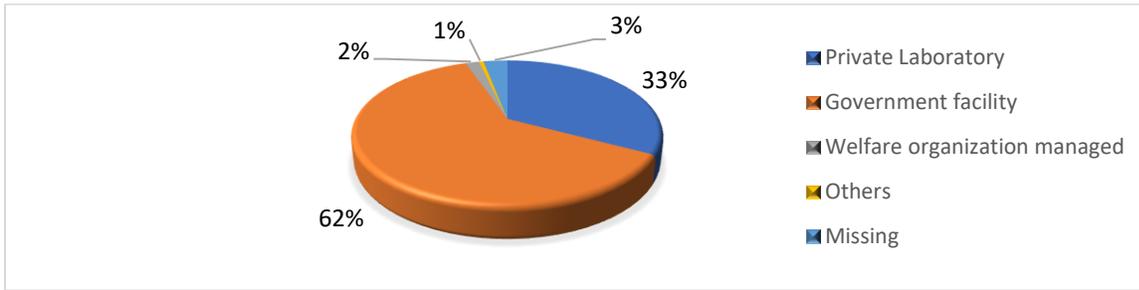


As for facilities at which the COVID-19 test was conducted, 62 percent said government laboratory, 33 percent said private facility, two percent mentioned welfare organization, while one percent chose ‘other’ as a category.

²³ Suleri, A.Q. (2021, January 7). *Pakistan in 2021*. The News. <https://www.thenews.com.pk/print/770226>

²⁴ Zaidi, S. (2020, December 26). *Covid & public-private partnerships*. Dawn. <https://www.dawn.com/news/1597881>

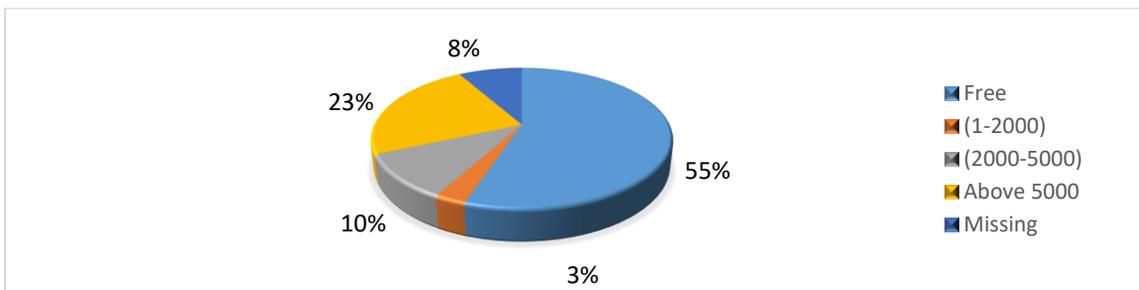
Figure 6: Facilities at Which COVID-19 Test Was Conducted



Testing Cost

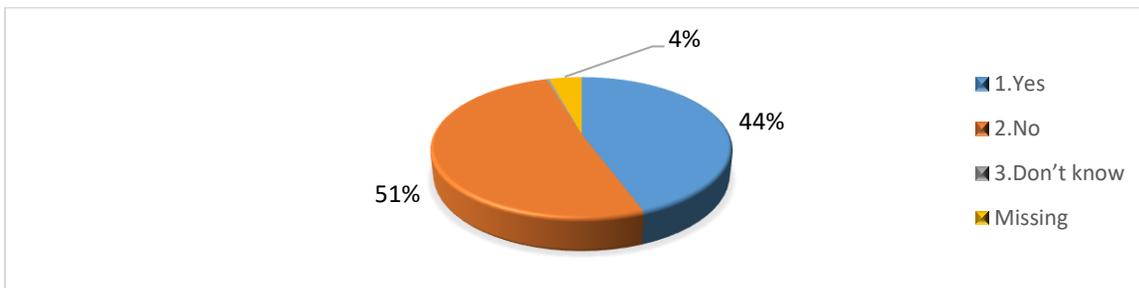
In response to a question on the testing cost, 55 percent said they got it for free, 23 percent said they were charged more than Rs. 5000, whereas 10 percent said it cost them between Rs. 2000 to 5000. Lastly, three percent were charged less than Rs. 2000, while responses for eight percent were reported missing.

Figure 7: Cost of COVID-19 Test



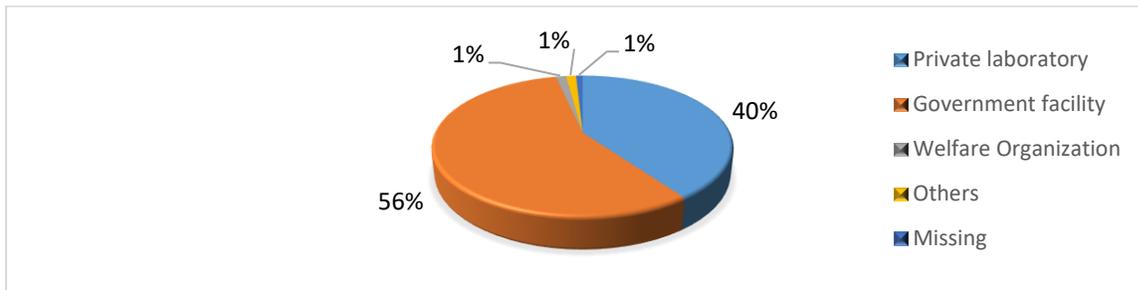
When asked whether patients got a second test, 51 percent responded no, 44 percent said yes, while responses for four percent were not ascertained.

Figure 8: Second COVID-19 Test



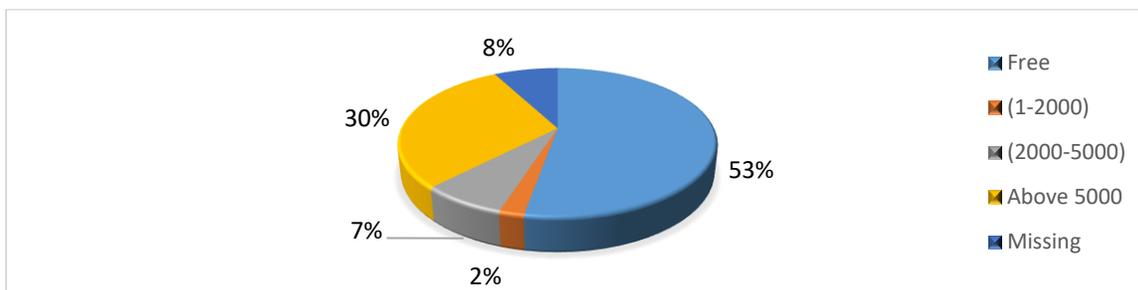
Fifty-six percent of those who got a second COVID-19 test went to a government facility, 40 percent visited a private facility, one percent were assisted by a welfare organization, with another one percent choosing 'other' as a category.

Figure 9: Facility at Which Second COVID-19 Test was Conducted



Fifty-three percent of those getting tested twice were not charged any fee, 30 percent were charged more than Rs. 5000, whereas for seven percent it cost them between Rs. 2000 to 5000. Finally, two percent said less than Rs. 2000, while responses of eight percent could not be ascertained.

Figure 10: Cost of Second COVID-19 Test



These variations in the testing costs express the differences in amounts charged by public facilities and private laboratories. In February, for instance, customers were charged on average around Rs 5,500 per test at private testing facilities. On the other hand, the amount was as high as Rs 8000 to Rs 9000 per test in a few cases. The situation at government hospitals remained entirely different. As per the respondents' data, these facilities provided subsidized or free testing. Overall, the consolidated findings suggest that the testing strategy was partial and limited in equity and inclusiveness, especially insofar as testing costs at private facilities are concerned, which reportedly put the society's have-nots at disadvantage, made it difficult for them to get tested, and were consequently left out of the testing net.

Infrastructure

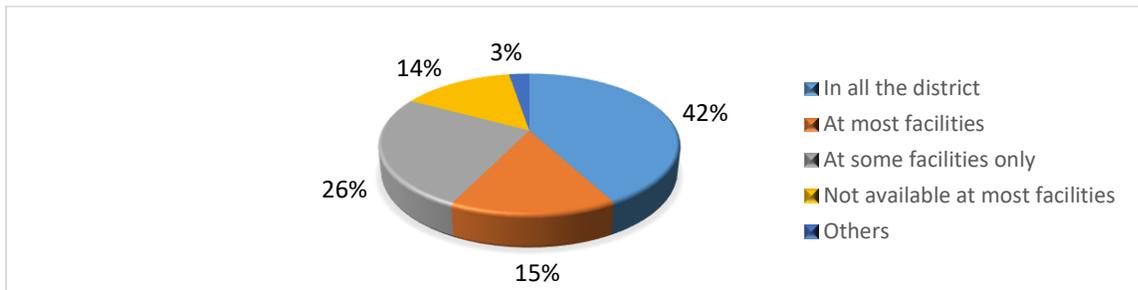
The critical governance principles of effectiveness, efficiency, equity, and inclusiveness were also missing in other aspects of Pakistan's pandemic response. On the one hand, healthcare workers faced an acute shortage of critical resources and equipment such as Personal Protective Equipment (PPE), Intensive Care Unit (ICU), beds, etc.; on the other hand, they lacked the requisite skills, training, and capacity in handling the pandemic. Besides, as FAFEN's monthly reports have shown, there were disparities and inequities between districts in terms of resource allocation for tackling the pandemic, including the provision of critical care specialists, ventilators, beds, etc.

Availability of PPE

PPE is the first and foremost requirement for healthcare professionals dealing with COVID-19 patients. Its availability varied over time in the project districts. Over different months, some district healthcare workers reported overall adequacy of PPE in district health facilities, while others reporting its inadequacy in the same district. These issues of adequacy or lack thereof were highlighted in the consolidated responses of 152 doctors and 148 paramedics interviewed from October 10 to February 28.

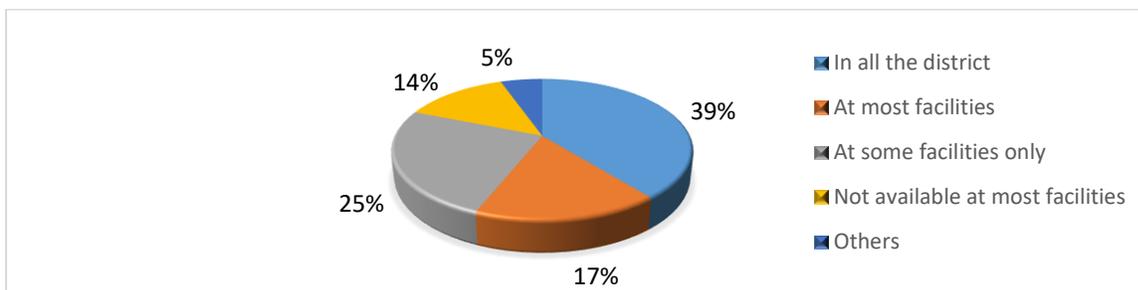
Only 42 percent of doctors reported the availability of PPE at all the district health facilities. According to 15 percent the safety equipment was available at most health facilities, 26 percent thought it was available at some health facilities only, while 14 percent said it was not available at most health facilities.

Figure 11: Availability of PPEs – Head of Doctors’ Association



On the other hand, of paramedics, 39 percent reported PPE availability at all district health facilities. Another 17 percent said at most facilities, 25 percent said at some health facilities only, with as many as 14 percent paramedics reporting non-availability of PPE at most facilities.

Figure 12: Availability of PPEs – Head of Paramedics’ Association



These varying trends in the availability of PPE across the district can be indicative of either lack of PPE procured for the healthcare staff or significant margins for improvement in the supply line of this basic commodity for the frontline warriors of the pandemic. The situation seems to be worse for the paramedics as a higher proportion of these healthcare workers reported a lack of PPE at all the health facilities.

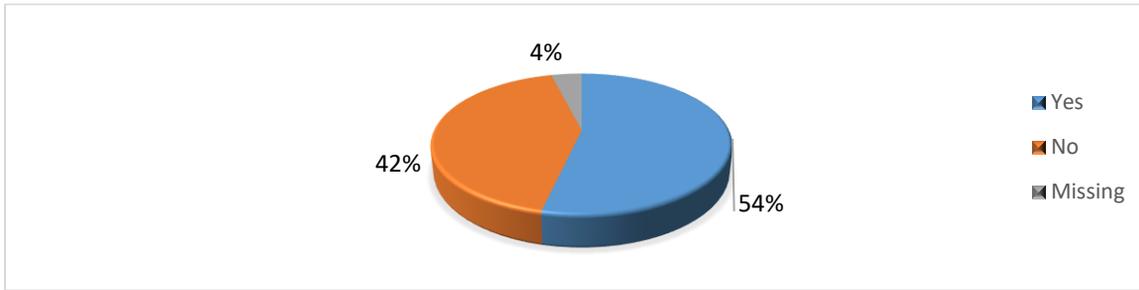
Stakeholders’ Capacity to Deal with the Pandemic

The consolidated findings in this area reflected governance gaps in the quality, training of human resources in the healthcare system, and their effective utilization during times of emergency. Throughout the period observed for this project, healthcare workers were found lacking in capacity and training in tackling pandemic-related issues. As the findings show, a few orientations or capacity-building sessions were held to enhance their capacity. Furthermore, healthcare workers consistently emphasized the need for further training/awareness in key areas such as compliance with SOPs, technical knowledge about the use of equipment, testing, among others. Aside from healthcare workers, local press/media faced capacity issues which hindered it in playing its critical role with regards to increasing public awareness regarding the pandemic/SOPs, overseeing mechanisms and processes laid out by local government/administration to meet the challenge of the pandemic, and enhancing accountability and transparency process at the district level.

Doctors and Paramedics

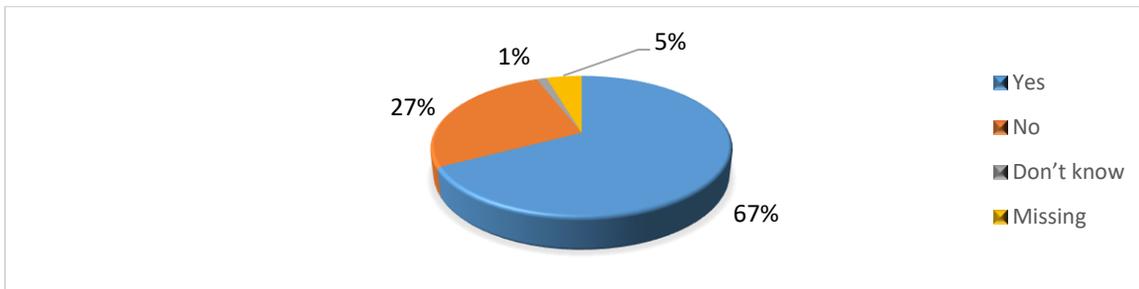
The team collected the responses of 153 representatives of doctors’ associations and 150 representatives of paramedics’ associations to evaluate their technical expertise and readiness to deal with the pandemic. Only 54 percent of representatives of the doctors’ association were trained enough to deal with pandemics, with 42 percent reporting training inadequacy in dispensing with their duties during the pandemic.

Figure 13: Technical Readiness to Deal with the Pandemic – Head of Doctors’ Association



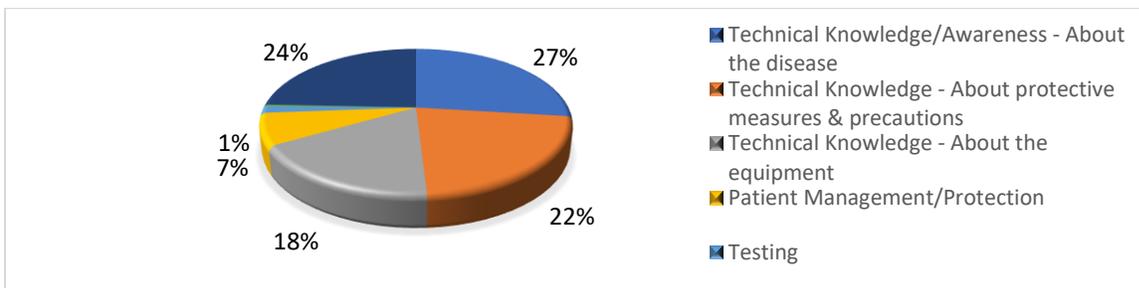
Sixty-seven percent needed further training to enhance their capacity, while 27 percent said they did not require any further capacity-building sessions. Lastly, one percent of them were unsure about the need for training whereas a response for five percent was missing.

Figure 14: Training Need for Doctors



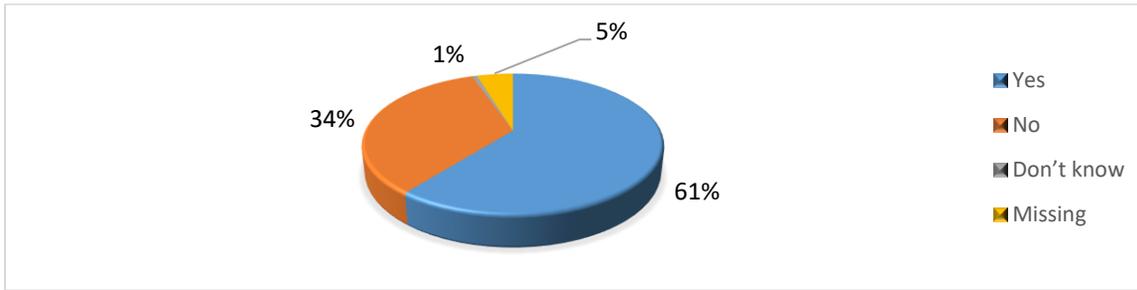
When doctors were asked about the areas in which they needed further training, awareness about the disease, technical knowledge about SOPs, and knowledge about the equipment used were the three most frequently mentioned areas, which respectively accounted for 27 percent, 22 percent, and 18 percent of all the responses. Furthermore, seven percent of responses stressed the need for training on patient management, whereas one percent emphasized orientations on testing. A big chunk, 24 percent, were miscellaneous responses.

Figure 15: Training Requirement for Doctors



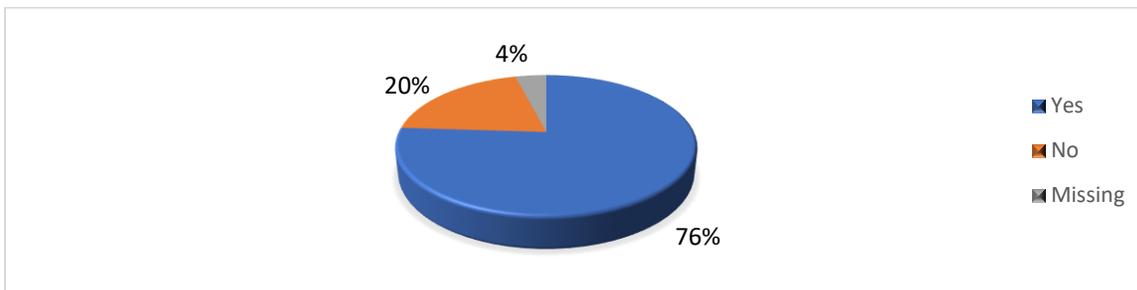
On the other hand, 61 percent of paramedic staff stated that they had received adequate training, while 34 percent said they had not received any such training and were unprepared to deal with the pandemic.

Figure 16: Technical Readiness to Deal with the Pandemic – Head of Paramedics’ Association



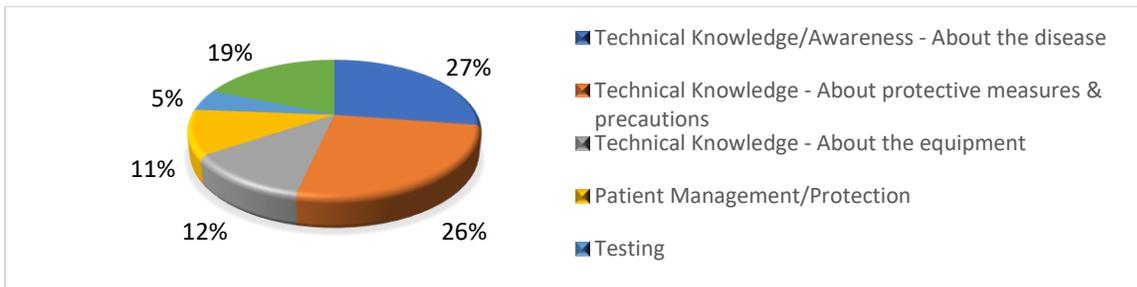
Likewise, 76 percent of paramedics called for further capacity-building sessions, while 20 percent reported needing no further training sessions in handling the pandemic.

Figure 17: Training Need for Paramedics



Similarly, paramedics’ representatives also identified awareness about the disease, technical knowledge about SOPs, and knowledge about equipment as the three most critical areas in which they needed further training. Of the mix of total responses, 27 percent, 26 percent, and 12 percent respectively underlined training need in the said areas. Moreover, 11 percent of responses emphasized the need for training on patient management, whereas five percent emphasized orientations on testing. Lastly, 24 percent of the responses were miscellaneous.

Figure 18: Training Requirements for Paramedics



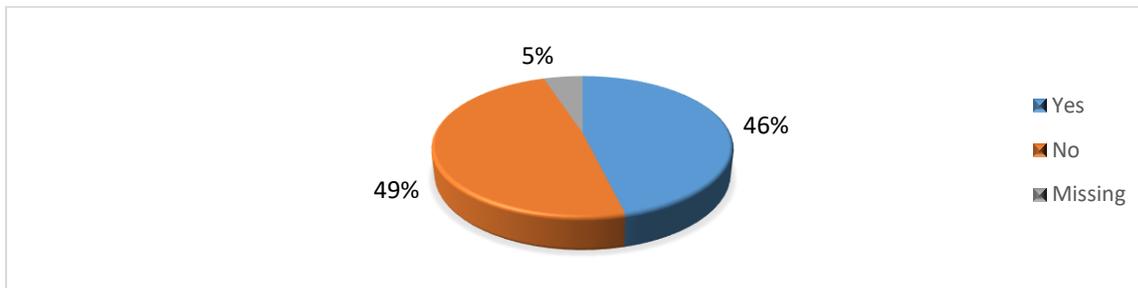
The fact that a significant majority of doctors (67 percent) and paramedics (76 percent) called for further training sessions reveals that not enough efforts have been made by the authorities to meet the challenge of the pandemic. The persistent lack of progress in this critical area (lack of awareness) should be a matter of serious concern for policymakers, as with ill/miss-informed and ill-equipped healthcare workers, the country will continue to face serious difficulties in sailing through the pandemic.

CSO and Media

Civil society organizations (CSOs) and local press/media journalists also faced constraints in playing their relevant roles during the pandemic. From October 10, 2020, to February 28, 2021, responses were collected from a total of 158 local CSO representatives and 221 local journalists.

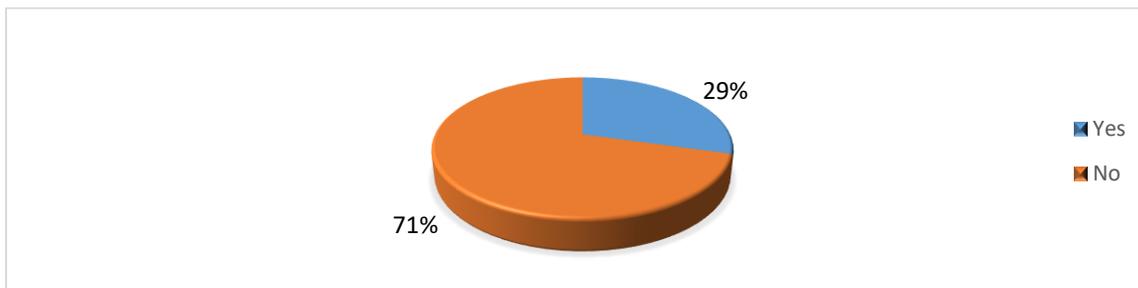
Forty-six percent of representatives of CSOs said they faced hurdles during their relief work, 49 percent said they did not face any difficulty, whereas responses for five percent could not be collected.

Figure 19: Problems Faced by CSOs in Extending Relief



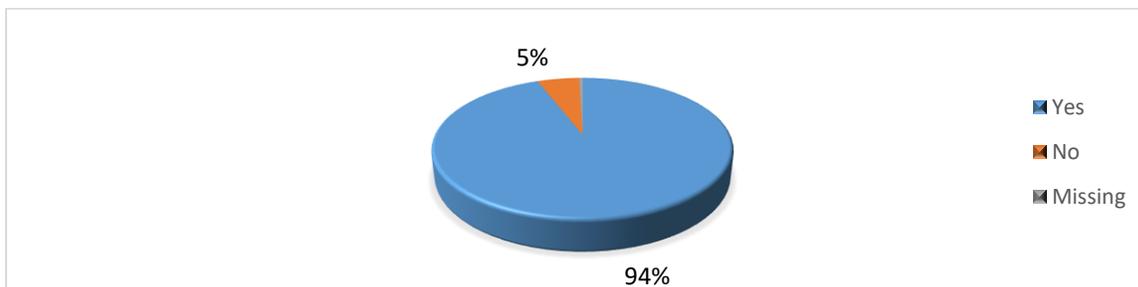
On the other hand, consolidated data of local journalists collected reflected a lack of expertise in capacity and skills for effective reporting on the COVID-19 pandemic. For instance, 71 percent of local journalists did not have the requisite skills to report COVID-19 pandemic-related stories.

Figure 20: Training Adequacy of Local Journalists



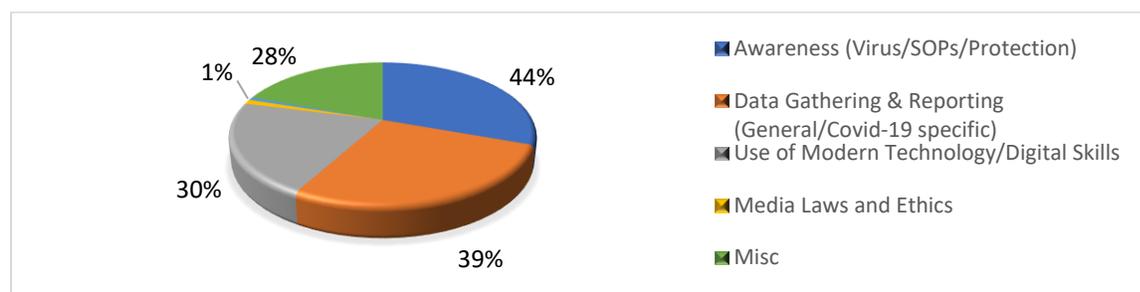
Furthermore, 94 percent of journalists underlined the need for training/orientation sessions to increase their COVID-19-specific reporting skills, whereas five percent said they did not need any training.

Figure 21: Training Need of Local Journalists



When local journalists were asked about the areas in which they needed further training, awareness about the virus/SOPs, data gathering and reporting (general/COVID-19 specific), and use of modern technology were the three most frequently mentioned areas, which respectively comprised 44 percent, 39 percent, and 30 percent of all the responses. Furthermore, one percent of responses stressed the need for training in media laws and ethic, whereas 28 percent were miscellaneous

Figure 22: Training Requirements for Local Journalists



It should also be pointed out that given that a highly significant section of youth is digitally networked via social media, which is fast becoming the dominant medium of absorbing information, local journalists should be equipped with the relevant skills so that they can effectively reach the public and inform them about the ways to protect against the disease. It is high time that journalists shall be imparted digital as well as reporting skills as part of evolving a concerted COVID-19 response.

Implementation of Standard Operating Procedures (SOPs)

Compliance with SOPs is the first line of defense at the individual level. To an extent, it also indicates the level of public trust in the government as well as their understanding of the issues. During the pandemic, the awareness campaign remained lackluster and spotty at best, with the result that the contradicting information and confused risk-communication can be argued to have led to an increased disregard for safety guidelines. The opposition parties have publicly pointed out the lack of compliance by government functionaries to justify their public meetings.

With the onset of the third wave of the pandemic, the government has started prioritizing the imperative of setting in place a nationwide risk communication strategy and ensuring public compliance with the SOPs. On March 26, for instance, the Economic Coordination Committee set aside one billion rupees for the Ministry of Broadcasting and Information to launch a sensitization and education campaign regarding the third wave of the pandemic.²⁵ However, aside from imposing smart lockdowns and forceful implementation of the SOPs, other necessary measures have not been taken so far to that effect, viz. widespread public education for ensuring voluntary compliance with the SOPs.

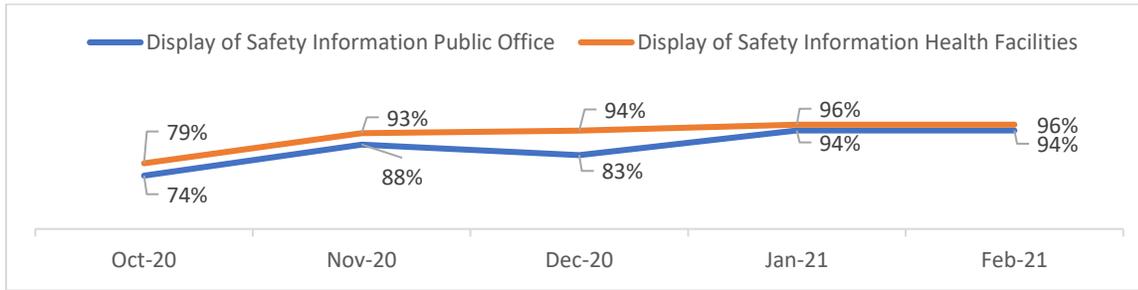
To substantiate the monitoring observations, starting from October 2020, 19, 32, 35, and 32 public offices were observed over the last five months. On the other hand, 24 health facilities were monitored in October, 67 in November, 79 in December; while 82 health facilities were observed in January, and a similar number, i.e., 82 in February.

Display of Safety Information

Display of safety information at health facilities followed an upward trend for October and November and became steady onwards. At the start of the observation period, a total of 79 percent observed health facilities were displaying safety information. The percentage rose to 93 percent in November and remained almost uniform from that point onwards. In February, 96 percent of observed health facilities were displaying safety information.

²⁵ ECC approves Rs 1 bln to education people about Covid-19 3rd wave. (2021, March 26). Radio Pakistan. <https://www.radio.gov.pk/26-03-2021/ecc-approves-rs-1-bln-to-educate-people-about-3rd-wave-of-covid-19>

Figure 23: Longitudinal Analysis of Display of Information



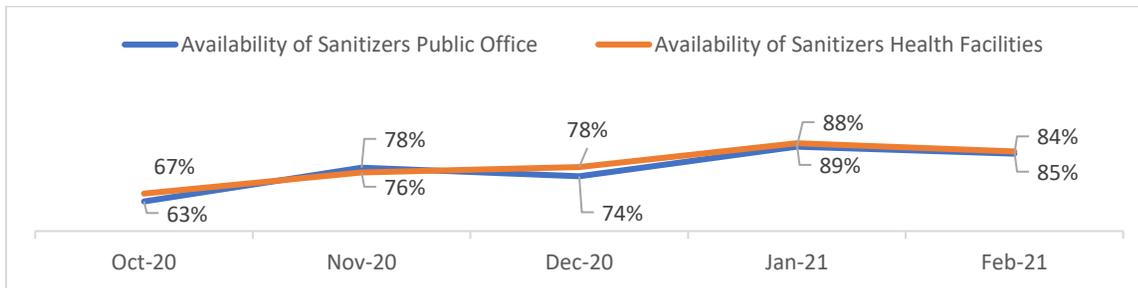
On the other hand, at the offices of EDO/DC/DDMA, the safety information was displayed at 74 percent of offices initially and reached a maximum of 94 percent in February. While the period from November to December saw a five-point decline (from 88 percent to 83 percent), compliance with this SOP rose by 11 points and reached 94 percent in January 2021, remaining constant thereafter as the threat of the third wave of COVID-19 loomed.

Availability of Sanitizers

The use and availability of hand sanitizers at all public places is the second SOP observed by the TDEA-FAFEN observers at the public offices and health facilities. A somewhat similar was observed in both types of facilities/establishments.

In October sixty-seven percent of the health facilities provided hand sanitizers. The number gradually rose to its highest 88 percent in January and dropped down to 84 percent in February. This decline in the provision of hand sanitizers can be due to the lack of budget allocations with the apparent decline in the number of COVID-19 cases, or due to lack of diligence in the management of the health facilities.

Figure 24: Longitudinal Analysis of Availability of Sanitizers

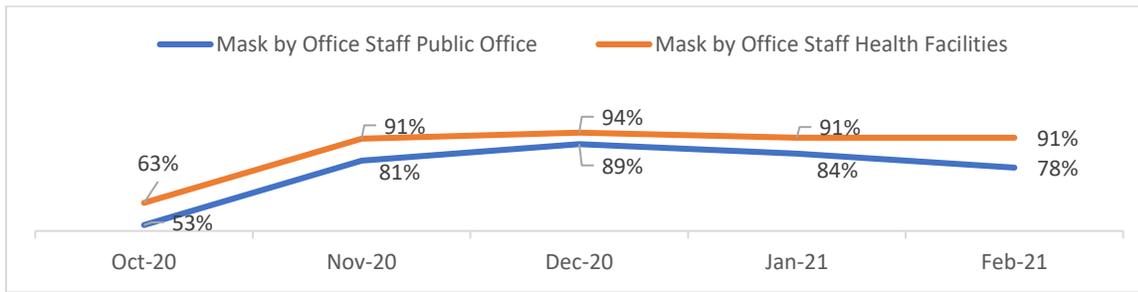


In October, hand sanitizers were available at 63 percent of public offices. This number rose to 89 percent in January, but dropped by an equal four points in February, reaching 85 percent. This number is still higher than the one observed at the start of the observation period. However, one should not equate the availability of hand sanitizers with their usage and it shall be useful to look at other SOPs.

Mask by Staff

Wearing masks is one of the key, critical SOPs to curtail the spread of the deadly COVID-19 virus. At health facilities, in October, only 63 percent of the staff was wearing masks. The number, however, underwent a sharp increase to 91 percent in November, reached its highest 94 percent in December, and dropped to 91 percent in February.

Figure 25: Longitudinal Analysis of Masks by Office Staff

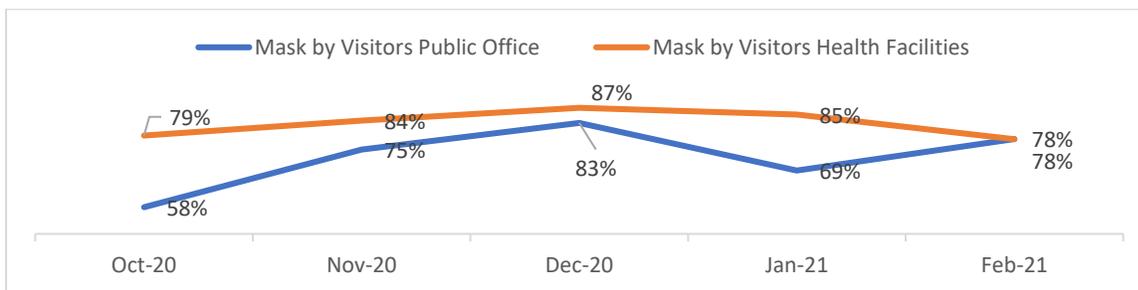


On the other hand, although the graph plotted for the number of staff wearing masks at the public offices overall followed the same trend, the corresponding percentages of the staff complying with this SOP remained lower than that of staff at health facilities. Only 53 percent of the staff at the public offices wore masks in October. This number reached its highest 89 percent in December, from where it started following a downward trend and 78 percent of the public offices' staff was reported wearing face masks in February.

Mask by Visitors

Only 58 percent of visitors at health facilities wore masks in October, improving with time till December when 83 percent of the total visitors at public facilities were observed to be wearing masks. In January, however, it declined to 69 percent and rose to 78 percent in February, becoming equal to that of visitors at public offices the same month.

Figure 26: Longitudinal Analysis of Masks by Visitors

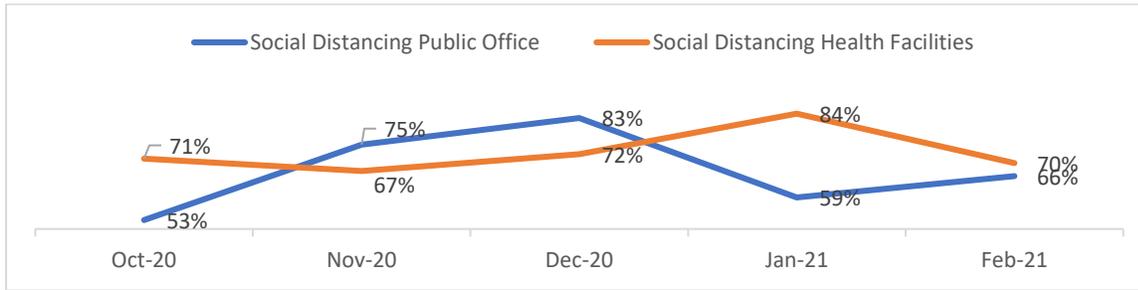


Overall the visitors at public offices were more cautious than those at health facilities. With 79 percent of public office visitors wearing face masks in October, their number kept increasing and they were observed to be exercising the highest level of caution in December (87 percent). However, in February, 78 percent of visitors to health facilities were wearing masks, showing a decline of seven points from 85 percent in January.

Social Distancing

Social distancing compliance was observed at 71 percent of public offices in October. It followed a decline in November to 67 percent but increased to 72 and 84 percent respectively in December and January. In February, there was a sharp decline in social distancing at public offices with only 70 percent of such facilities complying with this SOP. This is lower than the initial observation of 71 percent in October, indicating that the public's attitude towards this SOP was negligent.

Figure 27: Longitudinal Analysis of Social Distancing

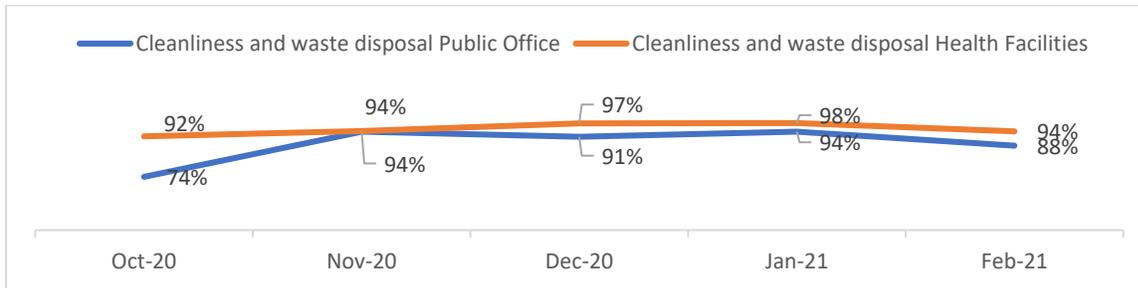


Considering COVID-19 a health emergency, and given the recent spike in new infections, 66 percent of health facilities reported compliance with social distancing is still a cause for concern, notwithstanding the uptick of 13 percentage points from the last month.

Cleanliness and waste disposal

Cleanliness and waste disposal at health facilities were observed to be positive since October when 92 percent of offices were following this SOP. The trend went only upward from this point onwards with 98 percent of health facilities complying with this SOP in January. The following month, however, compliance with this SOP declined to 94 percent.

Figure 28: Longitudinal Analysis of Cleanliness and Waste Disposal



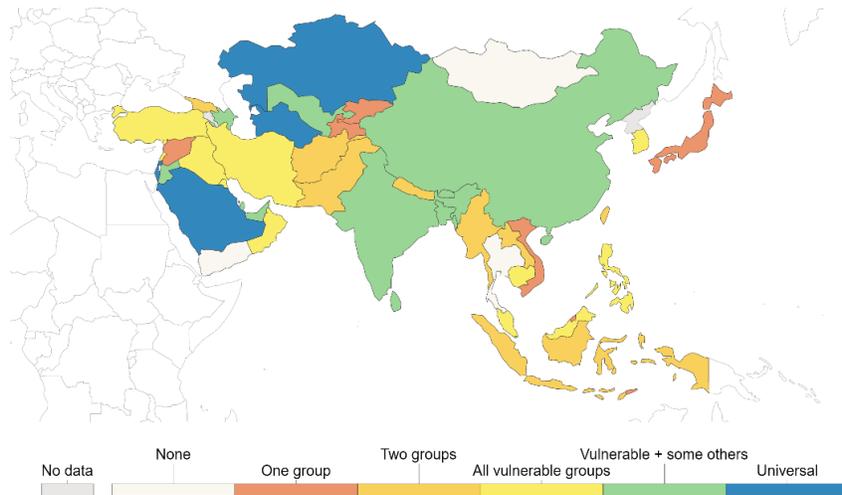
On the other hand, initially, 74 percent of public offices were following SOPs regarding cleanliness and waste disposal. Following an uptick of 20 points in November, 94 percent of offices were observed compliant with this SOP; the same percentage was also witnessed in January. However, only 88 percent of health facilities followed this SOP in February.

Vaccination

Pakistan formally launched the coronavirus vaccination drive on February 3, 2021. Like some other countries, its vaccination policy is targeted at the two most vulnerable groups of the society, namely frontline healthcare workers and elderly people above the age of 60. Gradually, the vaccination net is to be expanded to include people of other age categories.

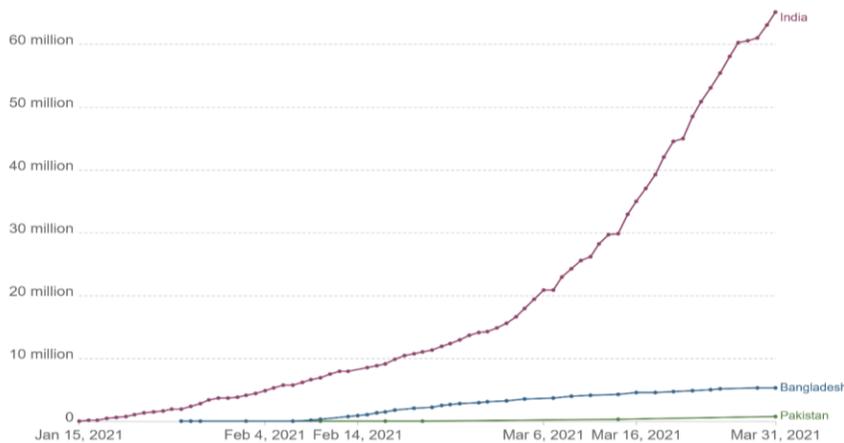
In terms of vaccine roll-out, however, Pakistan lagged behind such regional countries as India and Bangladesh as both of these countries kicked off their vaccination drives in January. Besides, its vaccination coverage is very low so far and falls behind that of India – a neighbor with a greater population and more resources – and Bangladesh, which is less populated and has comparatively lesser resources. As of March 31, Pakistan had cumulatively administered 800,000 vaccine doses to its target population (key healthcare workers and elderly people), whereas the corresponding figures for India and Bangladesh were 65.12 million and 5.37 million respectively. In India, aside from key healthcare workers and clinically vulnerable groups (elderly people), other social groups and people of select ages are also being inoculated.

Figure 29: COVID-19 Vaccination Policy in Asian Countries in Terms of Vaccine Delivery for Different Groups²⁶



The low vaccine coverage can be attributed to the lack of institutional frameworks, the minimal interest exhibited by the legislature, the low oversight by the media, and the lack of transparency and concerns about the efficacy as well as side effects of the vaccine, which gave rise to disinformation and rumors.²⁷ Thus despite the designation of 582 adult vaccination centers (ACVs),²⁸ a vast majority of the Pakistani population is reluctant to get vaccinated;²⁹ this also includes frontline healthcare who are also ‘less than enthusiastic about getting vaccinated’.³⁰

Figure 30: Cumulative COVID-19 Doses Administered in India, Pakistan, and Bangladesh³¹



This lack of trust among the public in government remained persistent throughout the three waves of COVID-19, each more lethal, and creating fewer ripples in the pond of the legislature, than the preceding one. Non-compliance with SOPs was one indication public not paying heed to the government’s advice; lack of interest in getting vaccinated is a continuation of this phenomenon, leading to slower rates of vaccination in Pakistan. Such public attitude and

²⁶ COVID-19 Vaccination Policy, Apr 15, 2021. Our World in Data. <https://ourworldindata.org/covid-vaccination-policy>

²⁷ Hashim, A. (2021, March 5). Vaccine hesitancy in Pakistan heightens risk of COVID resurgence. Aljazeera. <https://www.aljazeera.com/news/2021/3/5/in-pakistan-vaccine-hesitancy-heightens-risk-of-covid-19-resurge>

²⁸ Guidelines for Adult Vaccination Counters (AVCs) in Pakistan. (2021, January). National Institute of Health. https://www.nih.org.pk/wp-content/uploads/2021/01/20210128-Guidelines-for-Adult-Vaccination-Counters-in-Pakistan_5701.pdf

²⁹ Goraya, J.M. (2021, April 8). What is Pakistan’s COVID-19 vaccination plan? Geo News. <https://www.geo.tv/latest/344144-what-is-pakistans-covid-19-vaccination-plan>

³⁰ Vaccine hesitancy. (2021, February 13). Dawn. <https://www.dawn.com/news/1607104>

³¹ COVID-19 vaccine doses administered. Our World in Data. <https://ourworldindata.org/grapher/cumulative-covid-vaccinations>

mistrust in government need a long-due overhaul in the health governance system of the country to avoid losses of massive scale and scope.

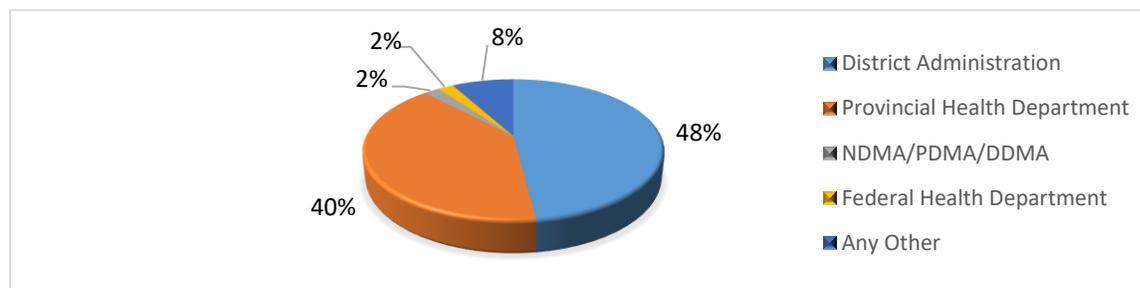
Furthermore, Pakistan’s vaccine strategy was also marked by controversies of allowing private import of vaccines. In other countries, vaccination is considered a public good; but the government's decision to commercialize the vaccination strategy could create inequities between the ‘haves’ and ‘have-nots’, and may harm the whole vaccination process.³² Lastly, at the district level, the key gap was observed in the demand and supply of vaccines—an issue that was also highlighted in FAFEN’s last report.³³

Administration of Vaccine at the Districts Level

With the start of the vaccination drive, two additional checklists were collected in February and March from key stakeholders, including 50 district officials, 60 doctors, and 60 paramedics. The project team consolidated the views of these stakeholders on different aspects of the district-level vaccination drive.

Concerning the question as to which relevant department was responsible for the vaccination drive in the district, 48 percent of the officials mentioned district administration, 40 percent named provincial management, two percent said disaster management authority, while another two percent stated that federal authorities were managing the vaccination drive in their district. Lastly, eight percent of respondents identified other departments as being responsible for vaccination in the district.

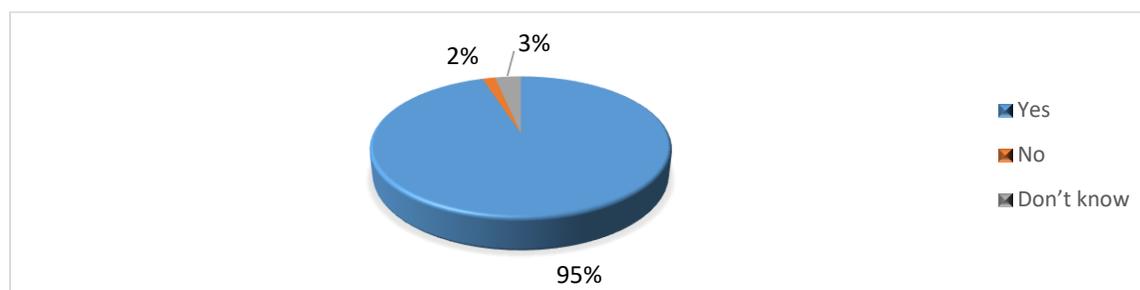
Figure 31: Responsibility of Vaccination



Perception Among the First Responders

Among the doctors, 95 percent doctors agreed that vaccination shall help them in better performing their duty of caring for the infected patients, two percent disagreed, while three percent did not have any opinion on the subject matter.

Figure 32: Contribution of Vaccine in the Performance of Doctors

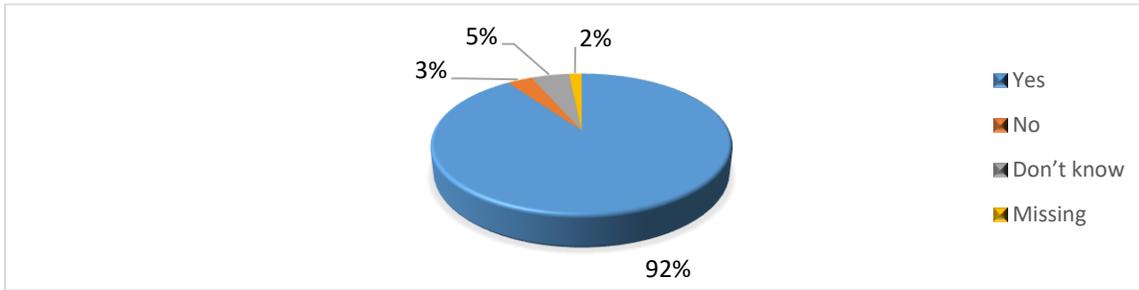


Likewise, 92 percent of paramedics stated that they feel that the vaccine shall help them perform their jobs in a better way, while three percent of them disagreed with the statement.

³² Mirza, Z. (2021, March 30). COMMENT: Covid-19 vaccines: public health, private interests. Dawn. <https://www.dawn.com/news/1615428/comment-covid-19-vaccines-public-health-private-interests>

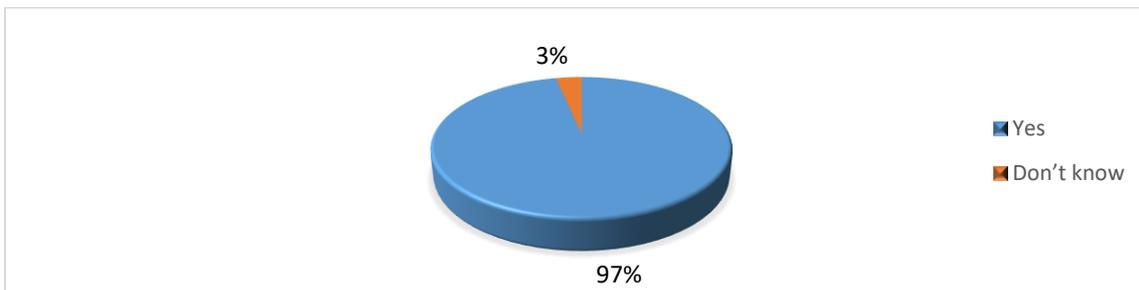
³³ COVID-19: Monitoring and Assessments of Pandemic Governance. (2021, March). Free and Fair Elections Network (FAFEN). <https://fafen.org/wp-content/uploads/2021/04/COVID-19-Response-and-Relief-Governance-Monitoring-Report-Mar.pdf>

Figure 33: Contribution of Vaccine in the Performance of Paramedics



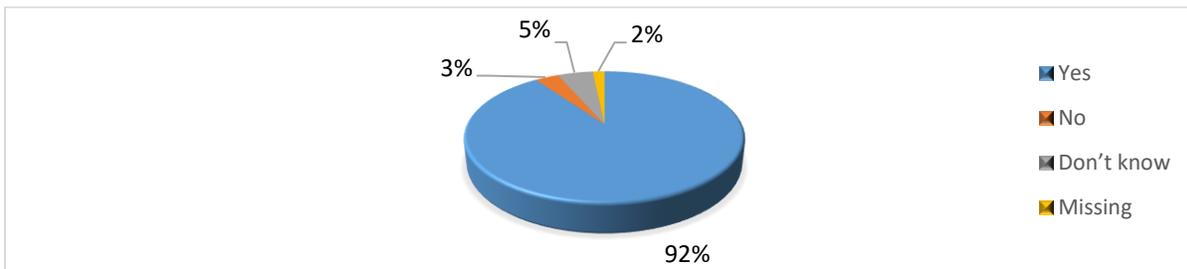
On the prioritization of medical staff for vaccination, 97 percent of doctors stated that they were satisfied with the selection process, while three percent of doctors were uncertain about the question.

Figure 34: Perception of Doctors About the Selection Process of Vaccination



Similarly, 92 percent of paramedics were satisfied with the selection process, three percent were unsatisfied, whereas five percent were unsure about their opinion on the subject.

Figure 35: Perception of Paramedics About the Selection Process of Vaccination



The main takeaway of the district level assessments concerned the demand and supply issues regarding vaccine provision to the districts. In February, for example, there was a difference of 69,264 vials between the number of vaccines demanded by the districts and the actual number they were provided with.

Recommendations: The Way Forward

Policymakers should emphasize the importance of essential health service delivery not only as a resilient strategic approach but also as a key priority during health emergencies. There should be clear strategic roadmaps for the engagement of private sector/ general practitioners for the provision of essential health services and institutionalization of digital health.

Policy Approach

- Health to be recognized and prioritized as a key agenda for national security and economic growth. The concept of National Security is being debated afresh at a global level.³⁴ As a result of COVID-19 and other factors, Pakistan's economic activity worsened notably, with growth of -0.4 percent in FY 2020. For the first time, health was recognized not only as a key determinant towards the development of the economy of the country but also was deemed vital for national security. In Pakistan, there is a gradual shift in the primary focus of national security from just being on defense/ border/ military-related matters to that of human security, which is signified by encompassing economic, environment/ climate, education, shelter, and health security besides other allied domains. The objective is to achieve security for the life of every citizen of the state from any violent threat that has the potential to disrupt/ damage/ destroy an individual or collective lives and it is fundamental to this aim that better the physical and mental health of the citizens is facilitated.
- Continuation of essential health services during emergencies, both through the public and private sector, should be a key strategic priority – an ignored area in the initial stage of the COVID-19 epidemic.
- Engagement with the private sector/ general practitioners for the provision of essential health services and the institutionalization of digital health has proven its worth. The initiative should be expanded further to ensure the non-interrupted provision of health services to over-burdened cities as well as hard-to-reach areas.
- Best practices and capacities developed during the COVID-19 epidemic should be sustained and improved further.
- Ensuring availability, monitoring, and analysis of data for evidence-based decision-making with the engagement of different stakeholders.
- Efficient and effective use of available meager resources for health in a transparent manner during strategic priority setting, designing of schemes, and execution.

Structural and Institutional Reforms

While fully respecting the essence of empowering provinces through devolution of power, there is a need to critically review the implications of the eighteenth constitutional amendment, especially in the health sector. Following structural issues have been highlighted by the prevailing pandemic situation and need to be resolved:

- National Planning is a federal function but is linked to its approval by the Council of Common Interest (CCI). With different political views in the CCI, multiple national plans have not been endorsed. Examples include draft 12th Five Year Plan - a key multi-sectoral medium-term policy document, different health strategies and plans required at the national level including plans produced to tackle the COVID-19 pandemic in Pakistan.
- Processes for development, approval, and execution of schemes should be speedy especially during health emergencies while ensuring transparency and objectivity. An important reason for the delay in the development, approval, and execution of new schemes comes down to procedural delays. Many PC-Is submitted to the Planning Commission are returned with objections such as 50 percent contributions from provincial governments, objections on purchase of vehicles, and implications on the recurrent budget after completion of projects or capacity constraints in the health sector, etc. The process of development and approval of schemes in the public sector needs to be thoroughly reviewed to document reasons for the same and suggest corrective measures. The federal government has also announced PKR 70 billion stimulus package for health after the COVID-19 pandemic, but no funds have been utilized so far, as schemes proposed are not approved.
- Emergency response should not be a 'Knee Jerk' reaction – there is a need to maximize capacities for core public health functions on a sustainable basis along with legal and governance reforms.
- Strengthening of coordination mechanisms, regulatory bodies, institutions, and organizations for a resilient health system. The federal ministries, provincial departments, and district authorities need more effective coordination mechanisms with clear common strategic priorities, which should be beyond party politics. Unfortunately, this was not the case during the COVID-19 pandemic in Pakistan. The federal ministries, provincial departments,

³⁴ Beauregard, J., & Kazemi, Roxana. (2020, April 28). *Health Security is National Security*. New Security Beat. <https://www.newsecuritybeat.org/2020/04/health-security-national-security/>

and district authorities need more effective coordination mechanisms with clear common strategic priorities, which should be beyond party politics. Unfortunately, this was not the case during the COVID-19 pandemic in Pakistan.

- The regulation of price by the Drugs Regulatory Authority of Pakistan (DRAP) is quite challenging and is subject to numerous hurdles. The authority needs capacity development and reforms to meet the expectations.
- Integrated Disease Surveillance and Response functions were also devolved to the provinces, whereas epidemics do not respect borders and the function is also linked with international coordination, collaboration, and reporting.
- The function of port quarantine, seamen's and marine hospitals, and hospitals connected with port quarantine are under the federal legislative list-I. However, the list is silent on the remaining 18 capacities related to international health regulations. In absence of a comprehensive approach, tackling health emergencies and epidemics is very challenging.
- Regular engagement of SAPM for National Security, security and law enforcement agencies, and other line ministries in COVID-19 related response was a critical factor for the success of the approach and lessons need to be learned for organizational reforms to better tackle health emergencies in the future.

Operational Level Improvements

- The awareness campaign has lagged with serious repercussions for the efforts to implement SOPs. As eluded to above, the government did set aside funds for having a better risk communication strategy for gaining public consent regarding voluntary compliance with SOPs, but this has not yet meaningfully translated into a sound strategy and plan.
- Availability and public trust in the vaccines are critical to the effort. Ensuring the availability of the vaccine is a complex operation and tough negotiations are required with the vaccine producers and their agents. Results of trials, the efficacy of vaccine, doses, unit cost, cold chain, international standards, and payment mechanisms are some of the factors, which need to be considered at a time when global demand for the vaccine is very high.
- A lesson needs to be learned on how to employ an effective approach needed to regulate quality and pricing in the private sector, along with specifying the steps that can be taken by healthcare commissions and authority to play a more effective role while dealing with health emergencies
- While the media played an important role in highlighting the discrepancy and gaps in the implementation of the government's COVID-19 response measures, there remain significant gaps. More specifically, media is well placed to play a significant role in highlighting the need for structural and policy-making reforms as well as legislative ownership and oversight of the COVID-19 response.

In summary, COVID-19 has provided an opportunity to learn lessons on health governance which needs to be further documented and reviewed. Corrective measures need to be taken to ensure that the country has a resilient health system to tackle health emergencies in the future while ensuring efficiency, value for money, and transparency. While the COVID-19 pandemic is likely to continue in Pakistan, with the possibility of new virus strains during the short- to medium-term, there is no time for complacency. Best practices and capacities developed during the COVID-19 epidemic should be sustained and improved further.