
HEALTH AND ECONOMIC POLICIES IN SOUTH ASIA IN THE CONTEXT OF COVID-19:CASES OF NEPAL, BANGLADESH, PAKISTAN AND AFGHANISTAN
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## Content

# Bangladesh in the time of COVID-19: Economic Impact

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## Introduction:

On 12 January 2020 World Health Organization (WHO) declared the spread of a novel coronavirus that caused respiratory illness among the people in Wuhan City, Hubei Province, China. The virus is (as of the time of writing this paper) spread through small droplets from coughing, sneezing and talking. The droplets are not airborne, however, those standing in close contact, within a meter length distance or 3.3 feet, may inhale them and become infected[1]. These droplets can land on objects and surfaces around the person such as tables, doorknobs and handrails. People can get infected (removed -) by touching these objects or surfaces, then touching their eyes, nose or mouth[2]. The virus was first detected in China and since then it has spread to 213 countries and territories all over the world infecting 30.8 million people (as of 19 September 2020); 22 million people have recovered and 959,000 died[3].

Movements of people and vehicles were restricted as an immediate response to stop this virus from spreading. Human life came to a standstill for few months – an unprecedented and unanticipated situation for the present society. This standstill caused adversities in the life and livelihood of people, hampered their mental and physical wellbeing, disrupted economies and influenced political decision makings. In March 2020, UN Secretary General Antonio Guterres urged for a ceasefire and requested the world to unite to fight against the common enemy, COVID 19 virus that is threatening the whole mankind. In his words- "The fury of the virus illustrates the folly of war. That is why today, I am calling for an immediate global ceasefire in all corners of the world. It is time to put armed conflict on lockdown and focus together on the true fight of our lives."[4]

The pandemic has already caused a deep economic shock for the world. The June 2020 Global Economic Prospects by the World Bank measures a 5.2% reduction in the global GDP[5]. The Covid-19 induced global economic recession will further deepen for lower investment, lack of human capital for lost work and schooling. Falling prices in energy sector has created further conflict between Russia and the Saudi Arabia. Under such circumstances, where the powerful economies are faced with multiple and adverse economic challenges, how are small countries like Bangladesh dealing with their challenges?

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Bangladesh with a huge population of over 166milion, in a small land mass, with a population density of 1265 per $km^2$ is enjoying the highest economic growth with 5.2% of GDP during the pandemic time. This paper gives a situation overview of Bangladesh by addressing the measures taken by the Government and the impact of the pandemic on the social and economic life of the people of the country.

## COVID 19 scenario in Bangladesh:

As of 6 September 2020, total number of infected people in Bangladesh is 325,157, number of death is 4,479. A total number of 1,629,312 people were tested and 221,275 people recovered from the virus attack. The fatality rate in the country is 1.32% while the recovery rate is 57.48%. The number of deaths per 1 million population is 22[6].

On 8 March 2020, Bangladesh had first 3 patients of coronavirus. 2 of them were returnees from Italy who were carrying the virus. IEDCR- Institute of Epidemiology, Disease control and Research, working under the Ministry of Health took the lead in dealing with this pandemics in Bangladesh[7]. The Government of Bangladesh sent a special flight to evacuate over 340 Bangladeshis stranded in Wuhan, the epicenter of coronavirus, in the Hubei province of China. 8 of the passengers were sent to the hospital and 312 were quarantined at the Ashkona Hajj Camp[8]. On 15 March 2020, 142 passengers came back from Italy who were sent to the Ashkona Hajj Camp. On the same day the country had the first death from COVID 19 who was a 70 year old man having underlying health problems. By the end of March, Bangladesh had recorded 51 cases with 5 deaths.

The recovery rate in Bangladesh was very low until early May. However it improved sharply to about 11% on 3 May and kept improving with time. The recovery rate improved sharply again to nearly 38% in mid-June. As of 12 July, this increased to over 50%, which means that more than half of all patients have recovered from the disease. The recovery rate in Bangladesh exceeded the recovery rate in France on 7 July. Five days later, the recovery rate exceeded 50%. It is still unclear why Bangladesh has such a high rate of recovery. The virus is more threatening for the elderly population and Bangladesh has more than 85% people under the age of 56. It can be assumed that this young population might have stronger immune system.

Bangladesh has a very weak health system. There are 3.05 physicians and 1.07 nurses per 10,000 people[9]. More than a hundred doctors died while treating patients. At the start of the pandemic people weren't properly informed about the safety measures. Symptoms of the virus varied from patient to patient. Thus, a lot of the people went to see gynecologist or to the other medical departments with the symptoms of coronavirus. For the fear of

getting isolated in the society, a lot of the infected people refused to visit a doctor or even maintain proper quarantine measures. To aware the mass, the Government of Bangladesh circulated information about the Covid-19 virus, its symptoms, and preventive and mitigating measures to take at home. Several hotline numbers have been introduced to provide medical services to the people. There are also many online and mobile services providing psychosocial counseling. The government increased the number of testing centers and improved their services. Two medical institutes were charged of fraudulence for providing fake coronavirus certificates to the migrant workers.

## Government response:

### Lockdown and general holiday

Prime Minister Sheikh Hasina addressed the nation on 25 March 2020 for the first time regarding the pandemic and requested the nation to stay inside their homes and not leave, except for emergencies. She declared a stimulus package of BDT 5,000 crore, USD 589 million, for the export oriented industries. This stimulus package was only to be disbursed for the salaries and wages of the workers and employees of the affected industries. The government imposed "general holiday" from 26 March until 4 April[10].

The “general holiday” was extended till 11 April, then subsequently extended further till 14 April, 25 April and finally till 5 May, ending the prolonged imposition of lockdowns. By the end of April the number of confirmed cases rose to 1000 with a death toll crossing 100. There were abrupt declarations of two-week or 10-day long lockdowns. Thus, a significant number of people were stuck in many places. Many people lost their jobs; regular life came to a standstill. To keep the market stable a regular flow of food items were ensured. Rice was provided to the lower income people at an affordable price in their respected communities. Citizens from all socio-economic background went out of their way and supported communities with anything they had. People donated money and goods and fed the disadvantaged for months.

### Social Distancing

The Government of Bangladesh was late in responding to the pandemic. Flights from the United States, Europe, and Far East were not screened and people were not quarantined during the initial global onset of the pandemic. First 3 patients with the virus were migrant workers from Italy who went to the doctor with fever and symptoms of the virus. After they tested positive, the government quarantined returnees at the Ashkona Hajj camp. However people complained about inadquate hygiene and quality of food in the camps. Army was deployed to ensure the maintenance of social distancing measures in the country.

On 9 April government imposed a complete lockdown on the refugee camps saying- "no entry, no exit- until the situation improves". As of 7 August 2020, 78 Rohingya refugees were tested positive and 6 died due to the virus.

**Stimulus packages:**

The government has announced 19 stimulus packages amounting BDT 103,117 crore (USD 12,138 million), 3.7% of the country's gross domestic product (GDP), according to the mid-term macroeconomic policy statement of the finance ministry.

These stimulus packages have been provided in the form of low-cost loans to the affected micro, small, medium and large industries and services, food security, social protection, special allowances and incentives as the pandemic-induced shutdown hampered the economy, destroyed millions of jobs and created new poor.

Of the stimulus packages, BDT 5,000 crore (USD 589 million) went to the export industry, Tk 20,000crore (USD 2354 million) to the micro, small and medium enterprises, Tk 30,000 crore (USD 3531 million) to large industries and services, and Tk 5,000 crore (USD 589 million) to the agriculture sector[10].

**Testing and treatment:**

At the beginning of the outbreak of the virus Bangladesh had limited facilities to test and provide medical support to the population. By the end of June, the number of daily tests rose to 18,000 per day. In July and August the number of tests per day declined to 10,000 and 14,000 consecutively. As of 6 September 2020, a total number of 1,629,320 samples tested and total number of patients are 325,157[11].

COVID-19 pandemic has largely exposed the weaknesses in the health sector of the country. Currently the country has 1,169 Intensive Care Unit beds to treat patients with COVID-19 virus, which accounts to 0.72 beds per 100,000 citizens. There are only 550 ventilators in the country.

**Impact of coronavirus:**

**Economy:**

Bangladesh has a developing market economy. With a Gross Domestic Products (GDP) of USD 348 billion and Purchasing Power Parity (PPP) of USD 860 billion in 2020, the country is the second largest financial sector in Indian subcontinent[12].

Bangladesh is classified among the Next Eleven Emerging Market Middle Income economies of the world having the world's seventh fastest growing economy with a rate of 8.2% in 2019[13]. The economy of Bangladesh is mainly dependent on the export of ready-made garments, remittances and

agricultural sector. Main export partners of the country are European Union (58%), The United States of America (16%), and Japan (3%). However, the COVID-19 pandemic has changed the situation largely.

The pandemic had hit all the three main sectors of Bangladesh's economy. Major apparel brands cancelled or delayed orders which risked livelihood of millions of garment workers. Bangladesh Garment Manufacturers and Exporters Association, BGMEA estimates a cancellation of GBP 1.4bn at the start of the pandemic[14].

Bangladesh is the 11th largest remittance recipient economy. About 10 million migrant workers together with the exports from Ready-made Garment industry helped reduce poverty of the country. From each district, 0.1% international migrant workers removed 1.7% poverty in their respective districts[15].

The country is witnessing the worst flood of the century affecting 3.3 million people and 102 upazilas. About 731,958 people were water logged with a fatality of 93 people[16].

The pandemic has increased the unemployment rate from 4.1% in 2019 to 13% in 2020[17]. There is a job cut in the lower and middle income economic class. The diaspora population is coming back to the country for the pandemic. Poverty rate in Bangladesh was 20.5% in 2019 (Bangladesh Bureau of Statistics) which rose to 35% in 2020 for the outbreak of pandemic[18].

Even though garment factories were allowed to continue operating under the country's lockdown, an estimated 1 million garment workers, or one-quarter of the workforce, were laid off due to declining orders for export[19].

The pandemic has taken a heavy toll on almost all sectors of the economy. It has caused a reduction of exports by 16.93%, imports by 17%, and also a decline of average revenue for all SMEs by 66% in 2020. Exceptionally, only remittance inflow has seen an 11% increase this year[20]. And with this rise of the inflow of remittance, Bangladesh has the highest GDP growth rate of 5.24% in Asia in this fiscal year during pandemic[21].

Bangladesh Government took some immediate response as soon as the economy started taking a downfall for the pandemic. Huge amount of stimulus packages were declared. Poor people were provided rice at a lower rate in their respective communities. Food supply chain was maintained by government intervention during the lockdown – people had regular supply of daily food items. This initiative developed trust among people. Consequently, people did not store food out of fear of food scarcity. Hence, the basic supply and demand balance could be maintained in the market.

The country celebrated two religious festivals during the time of pandemic. Public transports were open with declaration to maintain social distancing in

the last week of May. A lot of the stranded people could go back to their homes. Markets were open with social distancing guidelines to shop before Eid-ul-Fitr, the festival of sacrificing animal. The festival was celebrated nation-wide resulting in monetary exchange. Many people from all socio-economic background went out of their way and helped people at large. Hundreds and thousands of people were fed and provided safety packages from various individual/private initiatives.

The returning diaspora population brought back their savings. During the pandemic, inflow of remittance has hit a record higher. Apparel brands are coming back with their orders. Analyzing all the indicators, World Bank and Asian Development Bank are predicting a 7.1% rise of GDP in 2021.

**Education:**

Globally 1.3 billion students got affected by the pandemic, which is 68% of the total enrolled learners from 144 countries (Source: UNESCO). Since 17 March 2020, all educational institutions in the country have been closed. More than 36 million students are out of schools now and 40 million students across the country discontinued regular academic curriculum[22].

The dropout of huge number of students from the national education curriculum has been alarming. This counts not only towards the illiteracy rate of the country, but schools have also been providing some students with food, nutrition, social protection and psychosocial support. Rise of poverty and sharp decline in student enrollments in the schools will increase child labor. With a rise in the economy, increasing poverty rate and dropping school enrollments the gap between the rich poor will increase. The increasing economic division adversely affects the improvement in quality of life of the general population. To participate in the digital era, a mindful and intellectually sound population is required. Returning migrant workers need to be prepared for this new time with relevant and technical skills.

**Society:**

In July 2020, several arrests were made after Regent Hospital in Dhaka was found guilty of issuing fake coronavirus certificates to the migrant workers[23]. The alleged scams badly damaged the reputation of Bangladesh to the world, especially affecting migrant workers seeking to go abroad and whose remittances are key to Bangladesh's economy. Italy suspended flights to Rome from Bangladesh after several passengers arriving from Dhaka had tested positive for COVID-19.

Coronavirus has confined 4 billion people inside their homes worldwide. Although taken to be a protective measure, not all homes are safe for its dwellers. There has been a global increase in gender based violence. The UN WOMEN call it a "shadow pandemic"[23]. Violence against women has an economic impact. The global cost of violence against women had previously been estimated at approximately USD 1.5 trillion. This figure can only be rising as violence increases now, and continues even after lifting the imposed lockdowns.

The increase in violence against women must urgently be dealt with measures embedded in economic support and stimulus packages that meet the gravity and scale of the challenge and reflect the needs of women who face multiple forms of discrimination. The Secretary-General has called for all governments to make the prevention and remedy of violence against women a key part of their national response plans for COVID-19. Shelters and helplines for women must be considered an essential service for every country with specific funding. Significant efforts needs to be made to increase awareness about their availability[24].

Like any other country, Bangladesh is faced with multiple challenges as an impact of this global pandemic. Small economy, huge population, weak education system, backward social traditional norms, corruption and weak government institutions serve as main impediments towards the country's recovery from the pandemic-induced adversities and assimilate into the fast moving digital era. Global politics is changing rapidly; International relations between states are reshaping. During this global transition of power and politics, Bangladesh needs to act smartly, promptly and independently. The country has a huge young workforce, which is an asset. Geopolitical location of Bangladesh puts the country in a benefiting position. Although the country is being an example for many small economies for the growing GDP during the pandemic, the remittance inflow will decline in the near future. New employment opportunities need to be adopted immediately to keep the young working population motivated. Women, children and young population need to be kept at the center of any national plan, budget and projects. An overall development and steady growth are necessary for the country to stay relevant in this new post-corona world order.

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# Health Policy in South Asian Countries – A Case of Pakistan

Dr. Mehwish Raza[1]

## 1. Overview

Pakistan has a long history of bearing the burden of endemic and epidemic diseases: showcasing world's second-highest prevalence of crippling Poliovirus[2]; fifth-highest prevalence of Tuberculosis[3]; second-highest[4] prevalence of Hepatitis C Virus (HCV) that leads to chronic liver diseases; the seventh country in the region sharing 95% of the total region's Malaria burden (WHO, 2020); and HIV, although prevalence remains < 1% in the overall population, data indicates up to 40% drug users (through injections) in Punjab and Sindh are HIV infected, 10% transgender sex-workers are likely to be infected in Punjab and Sindh[5] (Sultan & Khan, 2013); recurring Dengue outbreak since 2005[6]; and seventh country for diabetes prevalence in the world. Pakistan bears a heavy burden of diseases (BoD).

Like many other developing countries, Pakistan has a fragile health support system[7] that suffers from limited infrastructure for responsiveness to disease control (diagnosis, surveillance and cure of novel diseases) – scare lab resources, weak access to precaution commodities, and limited systems in place for infection prevention (Nisar, 2018). The healthcare system of Pakistan is complicated, it devolves into eight federal units sharing a low budget of 2.61% of the GDP. The system relies heavily on prevention rather intervention.

## 2. Pandemics Preparedness and Planning in Pakistan

Outbreaks of Chikungunya, Dengue, and Crimean-Congo hemorrhagic fever have been the only viral infections experienced by Pakistan[8]. However, none of these have had a wide-range magnitude as COVID-19 that has spiked mortality rate within months while having a shattering impact on the economy and social life of the citizens of Pakistan. It is not an overstatement to say that COVID-19 is the first pandemic to touch the soil of Pakistan in a history of

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[2] Second to Afghanistan, depicting an increasing trend in the endemic, 53 cases reported in 2020, 86 cases in 2019, and 12 cases being reported in 2018.

[3] An incident rate exceeding 500,000 per year.

[4] Second to Egypt. Close to 7% of Pakistan's population is infected with HCV.

[5] Data from Karachi and Larkana region only.

[6] 127,500 cases and 709 deaths effecting 105 out of 154 districts/ agencies/ territories during 2005 to 2018 (IFRC, 2020)

[7] WHO Overall Health System Performance Index places Pakistan at 122 rank. Neighboring states ranks are: Iran 93; India 112; and Afghanistan 173 respectively.

[8] Caused by a mosquito bite, Dengue fever has claimed 257 deaths since 2010 and no deaths have been reported by Chikungunya fever. Congo fever, a zoonotic disease, resulted in 15 deaths in Pakistan between 2013 and 2016 (WHO, 2020).

seventy-three years and has served as a high-stake assessment to evaluate country's preparedness to curtail a pandemic and biological health crisis. A National Action Plan for COVID-19 was the first reaction of the state. This plan is a blueprint for guidelines and SOPs on governance, capacity building, resource utilization, multifaceted coordination mechanism, and containment protocols (MNHSR&C, 2020). The poor health infrastructure of the country heavily relied on an early identification of COVID-19 outbreaks for efficient control by spatial segmentation and mapping (Sarwar, Waheed, Sarwar, & Khan, 2020) in accordance with the three-pronged Strategic Preparedness and Response Plan (SPRP) issued by WHO on 7 March for four severity levels[1]. It was imperative for Pakistan to follow stringent measures to minimize loss of life and limit the spread of virus (WHO, 2020). On the document, the action plan to combat this pandemic sprawls on the initial guidelines for virus transmission control while seeking a funding of US$ 595 million for a period of 9 months, from April to December 2020 (PIDE, 2020).

SPRP builds on *Suppress and Sustain* policy to combat COVID-19 (MNHSR&C, 2020). The next detrimental factor, discussed in Table 1, is to gauge how effectively the procedures have been followed.

[1] The first is uninfected countries with no reported cases; countries experiencing sporadic cases with an evidence of virus being imported by travelers; cluster of cases being reported in a specific geographic region by common exposure; and infected countries with wide community transmission (WHO, 2020).

*Table 1 Measures for Suppress and Sustain Policy and their achievement status in Pakistan*

| Measure | Challenge level | Achievement level | Probable Reasons |
|---|---|---|---|
| Preparedness plan and mobilization of all govt units before COVID-19 emerged as a pandemic | High | Partial | Lack of precedent and experienced health governance |
| Mass health screening | High | Low | Low medical equipment and resources |
| Non-pharmaceutical measures | High | Partial (public awareness and adherence) | Relatively low literacy rates.<br>Late intervention by the government |
| Strict social distancing | High | Partial | Non-adherence by religious clerics [1] , general public, and traders.<br>Dense population |
| Isolation of suspected cases | High | Low | Less percentage of testing and reporting |

Despite being sandwiched between two epicenters of COVID-19 – Iran and China –Pakistan's government vehemently compromised to control border movement[2] thus seeding a catastrophe for the fragile health system and tumultuous economy of the country.

The lockdown paradox[3] delayed the suppression measures. Examples from countries like New Zealand and China assert it as the most effective policy response for breaking the chain of epidemic spread and an early eradication from a region (ECDC, 2020). The first restriction on social gathering and Educational institutions was issued by the Government of Sindh on 10 March followed by the Punjab Government on 13 March. International flights were closed on 21 March. Punjab has been the second most adversely affected

[1] Before the start of the Muslim holy month Ramadan, the GoP caved into religious clerics' pressure to keep mosques open.

[2] As of April 4, 2020 approximately six thousand Shi 'at pilgrims entered Pakistan without being properly screened for coronavirus from the Taftan border (Shabbir, 2020).

[3] Quicker the normal life shuts down, the faster the health crisis could be resolved. But, how would the poor and the vulnerable cope with a complete shutdown? (PIDE, 2020)
A complete and prolonged lockdown could force more than half of Pakistan's 220 million population into poverty (ADB, 2020).

province and imposed the lockdown in phases but lifting it on 9 May despite a spike in the virus spread (Figure 1).

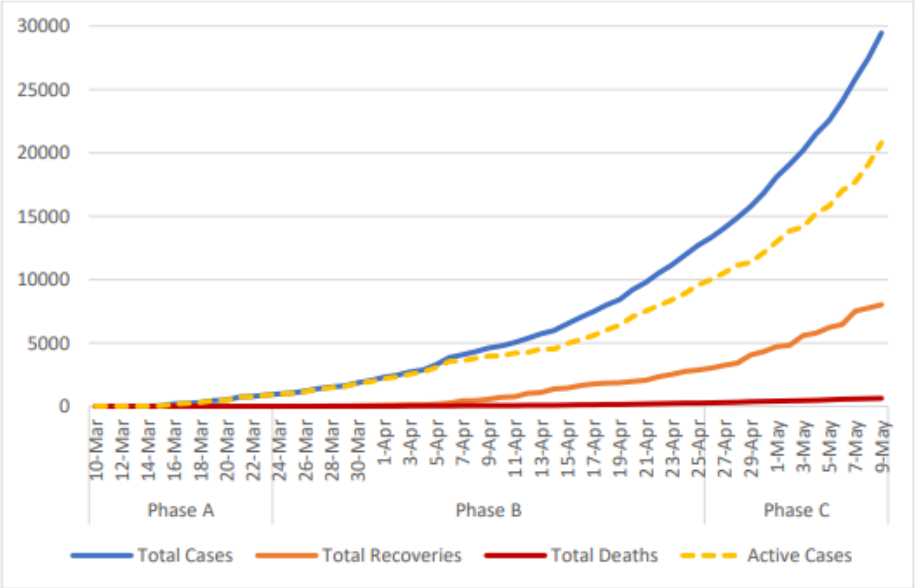


*Figure 1 Overview of COVID19 in Pakistan*

Nonexistence of a national pandemic preparedness plan and noncompliance with the plan created in the wake of COVID-19 depicts the government's blasé attitude that has costed Pakistan a loss of over four thousand lives, more than two-hundred thousand infected citizens, a heavy fiscal deficit[1], a ferocious rise in unemployment[2], and the GDP growth contracting by two to five percent (ADB, 2020).

## 3. Infectious Diseases and National Security in Pakistan

Traditionally, the national security concentrates in the analysis of threats to a country's interests, security, and sovereignty mainly of a military nature however, globally an increased concern since mid-nineteenth century about the proliferation of mass biological weapons used for bioterrorism have brought national security and public health closer in many countries (Fidler, 2003).

Pakistan Tehreek-e-Insaaf[3] has a traditional approach[4] that out rules a coalition between health and security policy, regardless of fusion of the two in

[1] Pakistan is expected to bear an estimated loss of US$ 415 million in the best-case scenario, and US $6.6–17 billion in case of an exponential outbreak (Sareen, 2020).
[2] 1.2 million to 3.2 million people are expected to lose employment between March 2020 – December 2020 (Sareen, 2020).
[3] PTI, the ruling party since 2018.
[4] National Health Policy (2016-2025) is a preventive approach to eradicate endemic (Polio & TB), improved environmental factors (clean water, sanitation, and food and drug regulation to the vulnerable) and empowering the health governance.

the recent years being recognized by policymakers, security and defence analysts in both developed and developing countries (Mirza, 2019). Despite experts [1] indicating towards this imperative alliance, an inter-ministerial collaboration or policy dialogues is rampant to prepare for a national disaster by an infectious disease such as COVID-19 and there exists no evidence in the past to advocate an integrative approach towards both streams of policy planning.

Recommendations have been made in this manuscript to build on this notion.

## 4. Critical Supply Shortages and Impact Assessment – A Case of Pakistan

Access to essential healthcare procedures, pledged under Millennium Development Goal (MDG) 8 [2], is an essential component of functioning healthcare systems. Despite yearning up to US$1 Billion (as of 2013) in medicine export[3], access to medicines and medical equipment in the local market has been a multifaceted problem often complimented by maldistribution of medical staff in Pakistan (Fatima & Khaliq, 2017). Despite having a National Medicines Policy Act, developed in 1993 and revised in 1997, the country lacks a strategic plan for impact assessment, systematic distribution procedures and monitoring in the local market. The manufacturing and distribution of medicines in Pakistan are controlled under the Drugs Act, 1976 and an implementation of this Act is ensured by the Drug Regulatory Authority of Pakistan (DRAP)[4] . A committee ensures the supply of life saving drugs in the local market but time and again Pakistan experiences medicine shortages triggered by either authentic demand-supply upheavals[5] or in many cases a fabricated shortage.

The manufacturing of life-saving medicine in Pakistan relies on raw material being imported from India and China and the regional political situation influences availability, affordability and even the export of medicines (Atif, Malik, Mushtaq, & Asghar, 2019). There has been a prevalence[6] of severe shortages of anti-tuberculosis medicines, cough and cold medicines, thyroid regulating medicines, neurological disorders medicines, and hepatitis

[1] Mirza A. Baig, CAS-TWAS President's Fellow at University of Science and Technology of China (USTC). Biomedical Health Informatics Professional, on 16 September 2019 published in Modern Diplomacy and urged policymakers to frame a National Health Security policy of Pakistan (Mirza, 2019).

[2] MDG 8: Partnership for development

[3] Afghanistan, Tajikistan and Sri Lanka are the biggest importers of medicine manufactured and distributed by Pakistan.

[4] Established under the DRAP Act, 2012

[5] Massive shortages experienced in 2005 followed by earthquake and in 2010 after the national floods and displacement of rural population (Fatima & Khaliq, 2017).

[6] Anti-rabies vaccines (ARVs) and anti-snake sera in 2017 (Atif, Malik, Mushtaq, & Asghar, 2019); insulin, pentavalent and tetanus vaccines, mumps, measles and rubella vaccines in 2020

medicines due to regulatory and supply side hurdles. In addition to medicine shortage, contamination of medicines in Pakistan[1] has been a byproduct causing failed trust in the country's medical system.

As COVID-19 unfolded in the region, Pakistan engaged aggressively in locally manufacturing the medical equipment[2] however, at provincial levels a critical supply shortage of Hydroxychloroquine (HCQ)[3] was experienced until interventions made by DRAP. Similarly, supply shortage for medicine[4] that showed some success with COVID-19 recovery cases was also experienced during the pandemic.

Data available on perpetual shortage of medical care necessities is weak and fragmented, it may be one of the main causes of lack of a robust policy and absence of impact assessment mechanisms. Recommendations have been made in the Section 8 of this manuscript.

## 5. Pandemic Emergency Financing - Pakistan

Pakistan's healthcare system is underfinanced, < 1% GDP (ADB, 2020) per annum which is not enough to meet the mandatory needs. Consequently, the development of healthcare system in the country has never been a priority. A pandemic is unprecedented for Pakistan; lack of systems in place for hazard identification, impact assessment and preparedness plan in the country paired with weak health infrastructure and limited administrative capacity caved Pakistan in seeking financing from multilateral organizations listed in Table 2.

[1] 200 people died and around 1000 became seriously ill in Pakistan in 2011 - 2012after taking contaminated cardiac medicines (WHO, 2013)

[2] COVID-19 Testing Kits prepared by National University of Science and Technology (NUST), Local version of N95 masks manufactured by Defence Science and Technology Organization (DESTO), locally manufactured ventilators VenteLight by Pakistan Airforce Foundation (PAF), PPE suits prepared in Faisalabad by the textile industry.

[3] A less toxic derivative of chloroquine, has been approved by Ministry of Health for treating auto-immune diseases.

[4] Tocilizumab and Dexamethasone.

*Table 2 Financing during COVID-19*

| PEF-Accredited Agencies | Pandemic Emergency Financing (PEF) |
|---|---|
| Asian Development Bank (ADB) | $500 million |
| International Monetary Fud (IMF) | $1.4 billion (concessionary financing to deal with economic impact of COVID-19) |
| The World Bank | $500 million |

These finances have been used to ensure provision of equipment and consumable supplies for frontline healthcare workers and COVID-19 affected groups, setting up remote infrastructure as quarantine centers[1], and economic revitalization activities[2] in the country.

Local organizations have pledged US$2.9 million[3] towards the pandemic relief fund.

## 6. Disease Outbreak and Management Strategy in South Asia

The countries in the South Asian region are politically divided but their health challenges are similar. Emergence and reemergence of infectious diseases, limited health facilities, and poor sanitation has made the SAARC countries vulnerable to disease transmission. Although People's Republic of China is not a part of the SAARC region, its presence cannot be ignored as it has been the major contributor[4] to the worldwide infectious disease burden (Wang, Wang, Jin, Wu, & Daniel, 2008). The epicenter for infectious diseases shares borders with India, Pakistan, Nepal, and Bhutan making these the most vulnerable countries in the region.

Countries in the SAARC region very well recognize that regional and global public health security cannot be fully achieved without international cooperation (Gronvall, Bland, Inglesby, & Cicero, 2018). They may lack political harmony but all are on a mutual platform of Global Health Security Agenda (GHSA) created in February 2014 with a vision to advocate *'a safe and secure world from the global health threats'*.

Pakistan is an avid member of GHSA with the first in the region to volunteer for a Joint Evaluation Exercise (JEE) in 2017, fourth country in the world, and the first in South Asia, to use JEE tools created under the platform of GHSA

1 A rough estimation of quarantine facilities across the country has exceeded US$2 million
[2] Ehsas Emergency Cash Program (EECP), US$75 per family to sustain basic living. The program is supporting 9 million families across Pakistan (GoP, 2020)
[3] PKR 500 million. Unilever Pakistan – PKR150m, Pakistan State Oil PKR50m, Engro Fertilizers PKR100m, Telecom sector (collective contribution) approx.. PKR150m, Charity Organizations approx..PKR50m (GoP, 2020).
[4] Asian Flu - 1956, Hong Kong Flu – 1966, SARS - 2002, Bird Flu (H7N9) - 2012, and COVID - 2019

and the first to announce working on national framework for biosafety (Gronvall, Bland, Inglesby, & Cicero, 2018) however, the work is still in progress[1].

Despite sharing a multilateral platform, the countries in the region, have not been able to create close working relationships for formulating a mutual health security policy due to political differences and tensions. But the COVID-19 brought the SAARC countries together in March to pledge a SAARC COVID Emergency Fund[2] for mitigation of the disease from the region. The countries came together again later in April 2020 [3] to combat the pandemic by exchanging clinical data, promising to create linkages among medical universities, academia and research institutions for a greater good.

This collation is relatively new and has re-engaged the SAARC countries while magnifying a unified approach towards region's health policy with focus on the COVID-19. The significance of regional cooperation has been further discussed under the Section 8 of this manuscript.

## 7. Economic Impact of the Pandemic:

Pakistan's debt, spending and deficits will decline by 2023. Government revenue is projected to improve from 15.1% to 17.7%. The debt-to-GDP ratio will fall from 87.2% to 78.3%. The budget deficit will be halved to 4% from the current 8%. In three years, government spending will also fall from 22.8% to 21.7%. The IMF also predicts a primary balance surplus by 2022-23. The current fiscal year growth rate is 1%. It is expected to increase by 2% next year. It may further improve in 2023. However, IMF predicted that the unemployment rate in Pakistan will rise to 5.1% in the ongoing fiscal year.

The International Monetary Fund (IMF) forecast a subdued economic growth rate for Pakistan, coupled with elevated rate of inflation and rising unemployment during the current fiscal year. IMF projected Pakistan's growth rate at one per cent, average inflation rate at 8.8pc, current account deficit at 2.5pc of GDP (gross domestic product) and unemployment rising by 0.6pc to 5.1pc during the current fiscal year. This juxtaposes the targets of 2.1pc GDP growth rate, 6.5pc inflation and 1.5pc current account deficit set by the government. IMF projected the economic growth rate recovering to 5pc of GDP by 2025.

[1] Last revised in 2005.
[2] Proposed by the Indian PM, Narendra Modi. Member states contributing US$ 2.1 million (Wikipedia, 2020).
[3] SAARc Health Ministers' video conference hosted by Pakistan on 23 April 2020 (MOFA, 2020)

## 8. Regional Cooperation as a Medium for Pandemic Response

A regional health diplomacy is critical to mitigate a pandemic while achieving SDG 3 *'Good health and well-being'* in different regions of the world (Sambala, Kenyenda, & Iwu, 2018). The political tension in the recent years within the SAARC region has kept the member states dormant however, COVID-19 re-engaged the countries into an association but the lack of trust prevails and prevents from a unified policy planning. Despite an advance medical knowledge concentration in Pakistan and India (Srinivasan, 2020) the increased political tension between these countries have largely deprived the region from building a capacity to make data-based decisions – achieving an enhanced public trust in science and mutual research; knowledge sharing for cooperative research leading to universal access to solutions; and to unify region's approach towards risk assessment and mitigation of a pandemic.

UN-DESA, in a policy brief also emphasized the need to have regional cooperation for harnessing science-policy-society interface, albeit with differences (Roehrl, Liu, & Mukherjee, 2020). Exchange of clinical data, especially for devising regional solutions to mitigate novel diseases like COVID-19, is likely to evolve the scientific and medical understanding of novel diseases in the region. India and Pakistan have a brief history of a joint medical venture[1] to combat acute liver disease, similar initiatives can promote the commitment towards regional health stability.

Regional cooperation cannot reach the fruition stage with the prevailing distrust and power struggle within the region. The ruling party in Pakistan has an outward aggressive approach towards limiting India's dominance within SAARC. Recently, Pakistan showed reservation on the SAARC COVID-19 Emergency Fund by demanding it be managed by the SAARC Secretary-General instead of India. This was followed by boycotting its presence in SAARC trade officials' video conference. Even during the pandemic, regional cooperation once again dwindles away due to Indo-Pak political rivalry. Recommendations to strengthen regional cooperation have been made under the Section 8 of this manuscript.

## 9. Recommendations

### *a. Regional-level commitments*

SAARC region is largely characterized by commonality in the public health system and economic struggle of the member states. The burden of disease (BoD) continues to increase in the region due to environmental, geological, and demographic reasons. A regional policy cannot ignore such risks to health, which could have important social and economic consequences. Some recommendations have

[1] Arranged under Lahore Chamber of Commerce and Industry and the Liver Care Society of Pakistan in 2015.

been made to strengthen strategic cooperation within the geographic region:

i. *Integrated Foreign Policy and Public Health:* All SAARC member countries are at a high risk of a severe health system crisis and the massive devastation as a result of the global pandemic ~~does not recognize borders~~. Trust in neighboring states, and cooperation and assistance in addressing public health challenges should be translated in the foreign policy to broaden partnerships and to strengthen diplomatic relationships within the SAARC region.
ii. *Collaborated Research Group:* Coordination and sharing of good practices through formation of a combined research group[1] can rejuvenate the spirit of SAARC and prepare the region in devising an effective collaborated strategy to predict and respond to any future pandemics.
iii. *Combined Supply Chain Assessment:* The member states should be mindful of dependence on each other to ensure swift pharmaceutical operations. The SAARC region should engage in periodic risk assessment to predict shortfalls in manufacturing supply chain and integrate contingencies for emergency situations.
iv. *Regional Pandemic Preparedness Plan:* Member states should re-engage in SAARC spirit and prepare a holistic regional pandemic preparedness plan to ensure biosecurity and to predict, detect, and respond to infectious disease threats.

Collaboration is likely to be effective if the countries have robust data and well-defined national-level systems in place to address such emergencies. Some suggestions particularly for Pakistan are proposed:

*b. Country-level commitments*

i. The ongoing COVID-19 pandemic has revealed many shortfalls in the health emergency preparedness of Pakistan. An immediate priority is required to integrate health policy with the national security policy to capsulate direct and indirect impact on internal destabilization, domestic unrest, and long-term deterioration of the economic viability of the country on account of effects of chemical, biological, radiological, and nuclear (CBRN) threats. A

[1] A multifaceted representation of health specialists, microbiologists, scientists and environmental biologists to infer clinical data on existing BoD and to predict large-scale health calamities in the region.

national preparedness plan should be proactively formulated building on rather than being a reaction to the pandemic.

ii. It is imperative to enhance the share of the nation's Gross Domestic Product (at least up to 5%) for empowering clinical service, research initiatives to predict supply chain shortages, and to locally manufacture medical equipment. The limited resources available for planning at national level also appear to be the reason for lack of pandemic preparedness plan. COVID-19 pandemic should be used as a case to enhance public awareness.

iii. In addition to introducing meritorious, transplant and accountable reforms, the healthcare governance should establish a sophisticated, data-driven disease prediction and surveillance system. DRAP should strengthen its role in the drug regulation on grassroot level to curb drug mafia. 1% of the gross sale from pharmaceutical firms goes for R&D which is nonexistent in Pakistan. The task of research should be reverted to the pharmaceutical industry and the progress should be monitored by the federal government.

iv. Federal and provincial should coordinate by introducing evaluation measures at federal level and the focus should be redirected to provision of technical support, upscaling the infrastructure, and discharging of responsibility instead of governing the financial controls over provincial government[1].

COVID-19, a minuscule virus, has taught the world the greatest lessons of unity, solidarity, and coexistence in identical challenges. It is above all a human crisis with severe health and long-term socio-economic consequences. The unprecedented virus has called for unprecedented solutions and despite the prevailing political tensions, the SAARC member states should unite behind science and explore their possibilities for a unified attempt for survival.

[1] The case before abolition of Pakistan's Ministry of Health post 18th Amendment.

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# Nepal's Health and Economic Policies in the Context of COVID-19

Sanghamitra Subba[1]

In recent years, Nepal has made significant progress in improving healthcare, reducing maternal and infant mortality rates, and controlling and eradicating numerous infectious diseases. However, the COVID-19 pandemic has reversed some of the country's progress in improving the health sector while also exposing its shortcomings. According to the Nepal Health Sector Support Programme III (2018), "...a majority of the policies have focused on governance followed by service delivery. The least addressed were infrastructure and equipment and pharmaceuticals and laboratories." The pandemic highlighted the aforementioned inadequate policies in terms of mismanagement and lack of testing kits, machines, quarantine facilities, isolation wards, and ventilators. This paper will review the national health policy of Nepal, discuss the intersection between regional cooperation and public health, and offer policy recommendations based on the lessons learnt from the ongoing pandemic.

## Economic Impact:

The magnitude of COVID-19 pandemic's impact on Nepal's socio-economy will depend on three fronts: first, its dependence on tourism, trade, and foreign employment – and the consequences that will propagate through the services and industrial landscape; second, if or when the spread of the pandemic overwhelms a grossly inadequate health infrastructure and antivirals or vaccine become available; and third, Nepal's heavy geo-economic reliance on India and China, and the nature of contagion in those countries. A survey of 700 businesses and 400 individuals, and consultations with over 30 private sector organizations and government agencies, conducted tenaciously during the lockdown, showed that the pandemic has disrupted supply chains, shut or threatened the survival of small and informal enterprises, and made people highly vulnerable to falling back into poverty through widespread loss of income and jobs.

World Bank's South Asia Economic Focus projects Nepal's economy to grow by only 0.6 percent in 2021, inching up from an estimated 0.2 percent in 2020 as lockdowns disrupted economic activities, especially tourism. The report forecasts a sharper than expected economic slump across the region, with

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regional growth expected to contract by 7.7 percent in 2020, after topping 6 percent annually in the past five years. Regional growth is projected to rebound to 4.5 percent in 2021. Factoring in population growth, however, income-per-capita in the region will remain 6 percent below 2019 estimates, indicating that the expected rebound will not offset the lasting economic damage caused by the pandemic.

In previous recessions, falling investment and exports led to the downturn. This time is different as private consumption, traditionally the backbone of demand in South Asia and a core indicator of economic welfare, will decline by more than 10 percent, further spiking poverty rates. A decline in remittances is also expected to accelerate loss of livelihoods for the poorest in some countries.

"The economic consequences of the pandemic and impact on livelihoods across Nepal is expected to be the most acute for informal workers or those without social security or assistance, who are more at risk of falling into extreme poverty," stated Faris Hadad-Zervos, World Bank Country Director for Maldives, Nepal and Sri Lanka. "Swift action is needed to provide incomes, social protection, and employment to support them. This includes key investment climate reforms to promote physical infrastructure and access to finance for the informal sector to shorten the transition to recovery."

Informal businesses, main source of income for most of the labor force, comprise around 50% of enterprises in Nepal. Within this, laborers employed in the urban sector along with self-employed households in the urban areas have been more vulnerable compared to rural households that are able to fall back on subsistence farming. Most informal firms operate with limited savings, and owners may feel conflicted between either staying home and fearing starvation or running their business and risk getting infected.

The report urges governments to design universal social protection as well as policies that support greater productivity, skills development, and human capital. In that effort, securing international and domestic financing will help governments fund crucial programs to speed up recovery. In the long-term, digital technologies can play an essential role in creating new opportunities for informal workers; if countries improve and support workers' digital accessibility, South Asia can become more competitive and better integrate itself into the market. "COVID-19 will profoundly transform Nepal and the rest of South Asia for years to come and leave lasting scars in its economies. But there is a silver lining towards resilient recovery: the pandemic could spur innovations that improve South Asia's future participation in global value chains, as its comparative advantage in tech services and niche tourism will likely be in higher demand as the global economy becomes more digital."

The World Bank Group has been taking immediate and broad actions to ensure that developing countries strengthen their pandemic response. It has been supporting public health interventions, working to ensure flow of critical supplies and equipment, and helping the private sector to be able to continue their operation and sustain jobs. $160 billion in financial support will be used over a 15 month period, to help more than 100 countries protect their poor and vulnerable, develop human capital, support businesses, and boost up the economic recovery. The financial support also includes $50 billion of new IDA resources in the form of grants and highly concessional loans.

## National Health Policy

Nepal's first National Health Policy established in 1991, focused on the expansion of health facilities in rural areas while that of 2014 prioritized the fundamental right to health care and free provision of basic health services. The National Health Policy 2019 has focused mainly on providing universal health services, emergency care, and public health. The National Health Sector Strategy 2016-21 (NHSS) "has adopted quality, equality, system reform, and multi-sectoral collaboration as the guiding principles to move towards universal health coverage (Ministry of Health and Population, 2018).

The Public Health Service Act, enacted in 2018, implemented the "right to get free basic health service and emergency health service." An Epidemic Outbreak Surveillance Programme has also been established under the Epidemiology and Disease Control Division.

## Health Policy and the Federal System

The transition to a federal system, in which 753 local governments will oversee more than 4,000 health facilities, is still ongoing 5 years after the promulgation of the constitution. However, due to limited resources for the local and provincial health sector and the number of fragmented health policies, there is no "streamlined service." According to Thapa et al (2019), "An umbrella health policy would standardize health reform and also allow provincial and local governments to craft their policies compatible with their needs."

The COVID-19 pandemic has also given the government an opportunity to implement Universal Health Coverage (UHC), a priority of National Health Policy 2019. The situation has also highlighted the importance of decentralization in the health sector (Vaidya et. al, 2019), especially during a pandemic.

## Pandemics Preparedness and Planning

The first case of COVID-19 in Nepal was reported on 23 January 2020 in a 32-year-old man who had returned from Wuhan, China. The patient was treated at Sukraraj Tropical and Infectious Diseases Hospital (STIDH) and his family members were also tested for COVID-19. Immediately, the government mandated health desks to be equipped with thermal cameras, thermometers, disinfectant sprays, hand sanitizers, and airport staffs needed to wear masks and gloves. Point of Entries (PoEs) between Nepal and India, and Nepal and China were also equipped with health desks.

According to the Ministry of Health and Population's Health Sector Emergency Response Plan for COVID-19 (2020), "central hospitals, provincial hospitals, medical colleges, academic institutions and hub-hospitals have been designated to provide treatment care for COVID-19 cases…"

On 24 March 2020, a country-wide lockdown came into effect and was extended until 14 June 2020 after which the second phase of the lockdown was imposed by the government. There are currently 14,046 confirmed cases of COVID-19 with 4,656 patients recovered.

One of the most prominent preparations in the government's pandemic response plan was the establishment of quarantine centers around the country, especially in border areas where Nepalis were returning from India (NPRP, 2020).

On 1st March, the government formed the 11-member High-Level Coordination Committee for the Prevention and Control of COVID-19 under the leadership of Deputy Prime Minister and Minister of Defence Ishwar Pokhrel. The Committee was given the responsibility of repatriation of Nepali citizens abroad, distribution of testing kits and PPE, facilitation of medical supplies from donor countries and organizations, creating a framework for pandemic response and managing the COVID-19 Prevention, Control and Treatment Fund. The Committee has been replaced by the Corona Crisis Management Center, a 9-member group led by Minister Pokhrel.

However, while the federal government has provided assistance in terms of supplies, local governments have spearheaded the preparations and responses to COVID-19. BK (2020) states, "Local governments took the lead in prohibiting public gatherings, establishing information centers, setting up hand-washing systems, allocating isolation beds, and instituting quarantine procedures at public and private hospitals (BK, 2020)." A model for COVID-19 preparedness is Thimi where the municipality hospital along with Nepal Red Cross Society and the Center for Molecular Dynamics Nepal established a drill for treatment of infected patients as well as for testing of locals (Karmacharya, 2020).

The COVID-19 Nepal: Preparedness and Response Plan (NPRP) was published by United Nations Nepal in April 2020 and the Health Sector Emergency Response Plan: COVID-19 Pandemic by the Ministry of Health and Population of Nepal in May 2020 to provide guidelines for health systems, officials and other involved parties.

## Critical Supply Shortages and Impact Assessment

Nepal has lagged behind in terms of testing for COVID-19 due to two main reasons: 1) The government purchased unreliable Rapid Diagnostic Tests (RDT) instead of the real-time Polymerase Chain Reaction (PCR) testing kits 2) The government bought PCR machines proved faulty and many of the test kits incompatible. Provincial hospitals that received the PCR machines have said that the National Public Health Laboratories did not check the quality of the machines before distributing them (Sapkota, 2020). As of 22 June, 181,371 PCR tests have been conducted throughout the country with plans to conduct 400,000 PCR tests in the coming months.

There were also significant price hikes for masks, disposable gloves and hand sanitizers in the beginning of March. There has also been a critical supply shortage of Personal Protective Equipment for frontline workers with most of them being donated by external organizations.

According to the Ministry of Health, Province 1 has 170 isolation beds, 88 ICU beds and 31 ventilators, Province 2 has 89 isolation beds, 26 ICU beds and 10 ventilators, Province 3 has 188 isolation beds, 69 ICU beds and 26 ventilators, Province 5 has 210 isolation beds, Province 6 has 14 ICU beds and 9 ventilators, and Province 7 has 41 isolation beds, 10 ICU beds and 6 ventilators.

## Health Policy as a Security Policy

With greater connectivity between countries and increasing globalization, the traditional concept of national security has become inadequate (Chapman & Zilinkas, 2007). As outlined by Chapman and Zilinkas, public health emergencies severely impact the country's economy, lead to social disruption, possibly destabilize governments and affect the nation's defense forces- all concerns that influence security policies and can be shaped by the existing health policy.

In the context of Nepal, health policy and security policy overlap in terms of the involvement of national defense forces during health emergencies. The government, upon recommendation from the Covid Crisis Management Center, deployed the Nepal Army to COVID-19 hotspots around the country to set up and monitor quarantine zones and even facilitate the return of migrants from neighboring countries (Giri, 2020). The Army's involvement demonstrates the intersection between national security and health crises especially during a time where the population is vulnerable.

## Pandemic Emergency Financing

The government established the COVID-19 Prevention, Control, and Treatment Fund in early March. On 28 May 2020, the government unveiled a budget of Rs. 6 billion for the control and management of COVID-19, and Rs. 12 billion for expanding and upgrading the country's healthcare capacity. The overall budget of the Ministry of Health is currently Rs. 90 billion. The EU has offered a $84 million aid package to Nepal, the IMF has signed a $214 Million Disbursement agreement with the government, the World Bank has agreed to fund a $29 million COVID-19 Emergency Response and Health Systems Preparedness Project and various countries have pledged to donate or have already donated significant monetary funds to support Nepal's COVID-19 relief.

According to the Policy Based Costing to Respond the COVID-19 (MoHP et. al, 2020), "For treating the diseases in mild condition, the cost per day per person is Rs 14,506, for moderate condition it is Rs 23,993 whereas the severe case requires Rs 38,118. In case of reimbursement done including PPE, it will require Rs 11,219 to treat a person per day for mild conditions, Rs 19, 083 for moderate cases and Rs 31,790 for severe cases."

## Regional Cooperation as a Medium for Pandemic Response

India's decision to convene a video conference with the leaders of member states can be seen as a push towards reviving the almost defunct organization. SAARC member states shared their country's tackling of the pandemic and proposed a fund to support each other with India pledging $10 million to the SAARC COVID-19 emergency fund (The Wire, 2020).

Regional cooperation for the control and management of the COVID-19 pandemic is of utmost importance in the South Asian region with many of the countries sharing a border. In particular, since Nepal and India share a porous border, asymptomatic carriers can easily transmit the virus from one country to another. If both countries create a framework to establish proper and effective health posts in checkpoints, sharing of information and resources for contact tracing along the border, cases can be managed better.

Prime Minister Modi's proposal to create a research platform to tackle COVID-19 in the South Asian region is also not only beneficial from a health research point of view, but also from the perspective of improving diplomatic ties among SAARC member states. Given the current circumstances, cooperation during the pandemic is an opportunity to not only revive SAARC, but strengthen the organization.

## Policy Recommendations

The COVID-19 pandemic has shown that the health policy of Nepal needs to be reformed to incorporate information communication and technology tools, manage multi-faceted and inter-related public health emergencies, improve coordination between the public and private health sector and put greater emphasis on the importance of disseminating reliable and scientifically proven information by the government in terms of healthcare.

Contact tracing and surveillance strategies are likely to be very effective in tracking possible COVID-19 carriers in Nepal where preventive care is more feasible than treatment. Adopting a rigorous digital tracing framework under the National Health Policy in Nepal is plausible since 96% of households own a cell phone or with 61.5% owning smartphones, according to Sharecast Initiative's Nepal Media Survey (2019). For contact tracing, personnel should be trained to effectively communicate with the persons contacted and made aware of cultural sensitivities as well as comprehensible medical terms.

COVID-19 also demonstrated the need for policy reforms in the health sector to manage multi-faceted and inter-related public health emergencies. Kidney patients (Dhiren, 2020) and expecting mothers (UNFPA, 2020) were severely impacted by the lockdowns imposed to curb the spread of COVID-19. With no policies in place to deal with an emergency medical situation during a public health crisis and the subsequent lack of infrastructure to conduct rescue and relief, Nepal had a 200% increase in maternal mortality just between March and May (Poudel, 2020). To ensure that this situation does not repeat itself, the government needs to create a framework and allocate designated resources to handle secondary health emergencies during such situations. This requires immediate attention with the rise of dengue during the upcoming monsoon season and influenza in the winter.

In regards to an umbrella policy in the case of public health emergencies like epidemics, there needs to be better coordination and communication between the Department of Health Services, National Public Health Laboratory, Epidemiology and Disease Control Division, Epidemiology and Epidemic Management Section, and Teku Hospital and Animal Disease Investigation and Control Division.

Policies to improve public-private partnerships in the health sector during public health crises should also be considered by the government.

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# Health Policy and COVID-19: Afghanistan

Dr. Shanthie Mariet D'Souza[1]

In May 2019, addressing the healthcare providers, the then Chief Executive and the current lead person of the High Council for National Reconciliation (HCNR), Dr. Abdullah, summed up the state of healthcare in the country in the following words. "With what we spend on a single day of war, we could build a state-of-the-art hospital."[2] Years of war and lack of resources have ruined the health facilities in the country. Yet, much of international reportage on Afghanistan has remained focused on the state of insecurity and violence in the country. The Covid-19 pandemic, however, has brought back the attention on the challenges confronting the Afghan government to keep the country safe from the virus and how without timely international assistance, the country could be on its way to become a major hotspot.

## Health Service Sector: State of Play

In 1991, health services covered only 25 percent of the Afghan population[3] and the vast rural areas of the country remained outside the focus of the urban based curative focused health system. More than 58 percent of the hospitals under the Ministry of Health were in Kabul, along with 43 percent of the government pharmacies, 58 percent of the x-ray units, and more than 78 percent of the family guidance clinics. The entire country had only 2400 physicians, 1270 nurses, 441 midwives and 326 laboratory technicians, two thirds of whom were based in Kabul. Not surprisingly, Afghanistan had the lowest child survival rate in the developing world, and only 70 percent of the newborns survived till the age of five. Maternal mortality was 640 per 100,000 live births. Life expectancy at birth was only 40.5 to 42 years.

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[2] Ali M Latifi, "Years of war and poverty take toll on Afghanistan's healthcare", Al Jazeera, 25 May 2019, https://www.aljazeera.com/news/2019/05/years-war-poverty-toll-afghanistan-healthcare-190525101842119.html. Accessed on 25 June 2020.

[3] World Health Organisation, Master Plan for Reconstruction and Rehabilitation of the Health Situation, May 1991, https://apps.who.int/iris/bitstream/handle/10665/61965/REL_AFG_91.4.pdf?

By 2003, the statistics worsened. Maternal mortality rate had dipped to 1600/100,000 live births and under-5 mortality to 230/1,000 live births. Infant mortality was at 140/1000 live births and only 14.3 percent of the births were attended by skilled personnel. In early 2002, Afghanistan, with the assistance of the World Health Organisation, published its Master Plan for Reconstruction and Rehabilitation of the Health Situation 2002-2006, to find 'ways and means for the reconstruction and rehabilitation of the health delivery system'. The plan, among other things, wished to emphasize on establishing health centers at the *alakadari* (sub-district) level to bring health services nearer to the rural population. As the international donors met in Tokyo to commit to a major recovery plan for Afghanistan in January 2002, the estimate for a combined head of social protection, health and education was US$260 million for the first year and US$2.2 to 2.6 billion for 10 years. Among the specific action proposed were rehabilitation of hospitals, health centers, and women's clinics. And during 2002-04, the Ministry of Public Health claimed to have made impressive achievements in the five areas: 'information gathering, disease prevention, health reforms, donor coordination and physical construction'.

In 2004, Afghanistan signed up for the Millennium Development Goals (MDGs) and decided to 'extend the period of achieving the MDGs until 2020 and to use baseline data from 2003 since data from the time during the conflict are not available.'[1] By 2020, the country aimed to reduce under-five mortality to 77 and infant mortality rate to 47 per 1000 live births. Similarly, maternal mortality was aimed to be reduced to 400 per 100,000 live births and proportion of births attended by skilled personnel was sought to be increased to 75 percent. Further, in 2005, Afghanistan unveiled its five-year National Health Policy 2005-09[2] based on the following core values: Right to a healthy life; greater equity; concern for women, children and other socially disadvantaged groups; and the need to address the problem of poverty by being pro-rural.

In 2008, the Ministry of Public Health (MoPH) produced its Health and Nutrition Survey (2008-2013) and in 2011, it brought out its first Strategic Plan (2011-

[1] Ministry of Public Health, Islamic Republic of Afghanistan, *National Health Policy 2005-2909 and National Health Strategy 2005-2006*, September 2005, https://extranet.who.int/nutrition/gina/sites/default/files/AFG%202005%20National%20Health%20Policy%20and%20National%20Health%20Strategy%20.pdf. Accessed on 20 June 2020.
[2] ibid.

2015)[1]. The Strategic Plan aimed to guide the MoPH management and staff and related stakeholders, in their operational/work planning processes over the next five years. In 2015, a new National Health Policy (2015-2020) and in 2016, a new Strategy (2016-2020) were promulgated. The Heath Policy focused on five key areas: 'governance, institutional development, public health, health services and human resources'.

According to the World Health Organization (WHO), in 2018, a total of 3,135 health facilities including 242 mobile clinics were functional throughout the country, ensuring access to almost 87 percent of the population within two hours distance. Life expectancy at birth had increased to 64 years in 2012. By 2014, 57 percent of the population had access to a health facility less than one hour from their home, and nearly 87 percent had access to health services within a two-hour distance by any means of transportation. By 2019, the country had 31 specialised hospitals, 34 provincial hospitals, six regional hospitals, and 82 districts hospitals.

The journey from 1991 was impressive, but continued to be marred by challenges. In 2017, the World Bank pointed out the low usage of family planning in the country, resulting in high fertility rates. 'Malnutrition remains a serious problem that is exacerbated by declining levels of exclusive breast feeding and poor infant and child feeding practices. The maternal mortality ratio remained unacceptably high. The quality of services in many public hospitals has stagnated at low levels'[2]. Moreover, the country remained affected by 'a fragile political settlement, continued threats from insurgencies and local power holders, military stalemate, economic downturn, diminishing aid flows, widespread corruption, and regional relationships that continue to exacerbate conflict.'[3] Targets of insurgent attacks included hospitals. Worse still, Afghanistan remained completely dependent on external assistance, with more than 80 percent of the expenditure in the health sector coming from the

[1] *Strategic Plan for the Ministry of Public Health (2011-2015)*, Government of the Islamic Republic of Afghanistan, https://www.gfmer.ch/country-coordinators/pdf/Ministry-Public-Health-Strategic-Plan-2011-2015-Afghanistan.pdf. Accessed on 30 June 2020.

[2] 'Strong Progress but Challenges Remain in Health Sector in Afghanistan', *Word Bank*, 1 June 2017, https://www.worldbank.org/en/news/press-release/2017/06/01/strong-progress-but-challenges-remain-in-health-sector-in-afghanistan. Accessed on 29 June 2020.

[3] National Health Strategy 2016–2020: Sustaining Progress and Building for Tomorrow and Beyond, Ministry of Public Health, Islamic Republic of Afghanistan, September 2016, https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/afghanistan/afghanistan_mophstrategy2016-2020_final09september20161112016145089505533253 25.pdf. Accessed 30 May 2020

donor communities. Even the money for health sector was hardly utilized fully, having been siphoned off by corrupt officials and politicians.

**State Response**

The fact that Afghanistan's achievements have been fragile and is dependent of external assistance has been highlighted by the Corona pandemic. The International Organization for Migration, in the first week of May, projected that the country could be on its way to have one of the highest Covid-19 infections in the world. The projection was made after results of a randomized sample of 500 people in Kabul, which so far has been the worst affected, showed an alarming infection rate of 50 percent. Cases of infections have been reported from all the 34 provinces of the country. The Health Minister Ferozuddin Feroz, who contacted infection, had to be replaced. Fears have already been expressed that the Covid-19 pandemic may prove to be a more dangerous killer than 18 years of war.

According to the country's National Statistics and Information Authority, there are only 536 hospitals with approximately 15,000 beds and roughly three doctors for every 10,000 patients in the entire country. In April 2020, the MoPH said that there are only 300 ventilators in the whole country. Testing kits are in short supply and the hundreds of infected refugees returning from Iran to all provinces of the country added to the crisis. The BBC reported that oxygen cylinders are in short supply and the patient's families 'having to "fight for oxygen" when cylinders arrived, before bringing it to the intensive care unit themselves.'[1] Provinces sharing border with Iran, such as Herat, are projected as the hotspots.

The Government in Kabul has delegated some financial authorities to the provincial governments enabling them to buy equipment and boost the health facilities. It has helped in organizing local response to the pandemic. However, given the unknown nature of the spread of the pandemic due to low testing, it is unclear if such limited delegation would be effective. In Kabul as well as some of the major cities of the country, the ability of the health sector to conduct extensive testing and the government's appeal for self-quarantine have been largely unsuccessful. Likewise, awareness measures and enforcing strict lockdown have not yielded optimal results. Internally displaced people have particularly been affected by the pandemic, particularly those in crowded camps on the outskirts of cities living in unhygienic conditions and without access to healthcare. According to a 2019 Gallup study, Afghanistan is a very

[1] Secunder Kermani, Coronavirus overwhelms hospitals in war-ravaged Afghanistan, *BBC*, 30 June 2020, https://www.bbc.com/news/world-asia-53198785. Accessed on 30 June 2020.

poor country, with more than half of Afghans living with less than US$1 a day. The pandemic has further worsened the situation by steep increase in food prices and rising levels of unemployment.

## Health Policy as Security Policy

The Taliban took apparent advantage of the pandemic, as highlighted by reports, by launching public health awareness campaigns in the Logar and Nangarhar in the east; and Herat and Jawzjan provinces in the west. Taliban teams reportedly have spoken to people of the region of the benefits of washing hand with detergent and have distributed pamphlets, hand sanitizers, and masks among them. The group claimed that its fighters are traveling to remote villages via motorcycles to distribute leaflets, soap bars, and hand sanitizer. In the provinces where the Taliban have shadow governments, new directors of Public Health have been appointed by the group. The group has even accessed testing kits from undisclosed sources, which is apparently in short supply in the government.

The government departments, in turn, are appreciative of such gestures and have welcomed whatever assistance they can get in terms of raising awareness of the people regarding the virus. This has led some to predict that the pandemic can help build trust between the two warring sides. The Human Rights Watch even opined that both the government and the insurgents should 'work together with the UN and humanitarian agencies to ensure that aid reaches the whole country, or a dire situation will become catastrophic.'[1] However, it is difficult to foresee how such gestures by the Taliban can translate into a joint policy response, especially when deadly clashes between the government forces and insurgents belonging to various groups haven't stopped.

## Preparedness and MDGs

There are two ways to interpret Afghanistan's state of preparedness. At one level, the ongoing conflict and resource crunch limits the government's ability to upgrade the health sector. On the other, widespread and persisting corruption dents the prospects of the government achieving the optimistic MDGs. As evident from the data, even before the pandemic, the country's healthcare system was already under resourced. Thousands of Afghans often travel to neighboring Pakistan or India for treatment if they could afford it. The number of patients from Afghanistan to India, for example, were 27,505 in 2015, 61,231 in 2016 and 55,681 in 2017. Not only that, government hospitals in Afghanistan lacked staff and equipment; media reports have

[1] Human Rights Watch, 'Afghanistan: Leaders Bicker Amid COVID-19 Crisis', 30 March 2020, https://www.hrw.org/news/2020/03/30/afghanistan-leaders-bicker-amid-covid-19-crisis. Accessed on 19 May 2020.

suggested that ventilators have been stolen from the MoPH and smuggled to Pakistan for sale. In another case, an employee of the health department was arrested for allegedly demanding an US$80,000 bribe in order to complete a contract with a company producing protective equipment for medical staff.[1] In spite of the complaints, the government in Kabul has not been able to control such endemic corruption, which not only undermines its ability to achieve the MDGs, but also undermines its credibility.

**Impact on the Afghan Economy:**

COVID-19 pandemic has set back Afghanistan's economic growth by several years. It exposed structural and resource gaps in responding to unforeseen events such as pandemics. The country had to reallocate resources from long-term development priorities to fighting this health crisis.

Recent simulations from a single-country computable general equilibrium model (CGE) developed by UNDP estimates that due to a combination of external and internal shocks, the Afghan economy will contract by around 6 percent in 2020. Assuming the recovery starts in 2021 and growth performance to be positive between 2021 and 2024, it will be moderate, and well below the pre-pandemic level. Without well thought-out recovery-oriented policies, this amounts to a cumulative loss of around 12.5 percent in real GDP by 2024.

Based on the findings of the Note, Afghanistan witnessed a sharp decline in revenues in 2020 due to low economic activity, trade disruption and weaker compliance brought on by the pandemic. The government had to adjust the revenue estimates downwards from Afs 209 billion (USD 2.71 billion) in 2019 to Afs 144 billion (USD 1.87 billion) during the mid-year budget review. UNDP CGE model simulations estimate an average of 17 percent decline in corporate tax revenue and 18 percent decline in personal income tax revenue. Tax on international trade will be the worst hit and revenues may decline to as low as 19 percent due to the decrease in imports, while tax revenue on goods and services might decline by 10 percent. The fiscal deficit is expected to increase to around 4 percent of GDP in 2020.

The Government of Afghanistan needs to opt for policies and programmes to generate more revenue to address the fiscal deficit. Given the economic slowdown, a second wave of the pandemic, continued conflict, and an uncertain peace process and political environment, the country will continue to need grant support from the international community to address the fiscal deficit and maintain its current level of expenditure on basic services. Additional grants need to be directed at driving and implementing reforms

[1] Secunder Kermani, Coronavirus overwhelms hospitals in war-ravaged Afghanistan, op.cit.

to improve the business regulatory environment, improve governance, encourage investment and strengthen the private sector.

UNDP's socio-economic recovery offer to fight against COVID-19 aims to enable national and sub-national authorities to address the immediate fiscal impact of the pandemic in the short-run and help reverse its negative effects on the country's development agendas and attainment A-SDGs in the medium and the long run. UNDP, along with other development partners, has been supporting the government of Afghanistan in the run up to, and after, the pledging conference by presenting donors and friends of Afghanistan with evidence-based research and a clear picture of the situation to ensure the international community continues to support Afghanistan to address its fiscal needs and its recovery path from the COVID-19, that is informed by data and research.

**Policy Options**

It is indeed difficult to see how the country will be able to emerge from such morass, as large scale violence continues to wrack the country. Without substantial international aid and intervention, the Central government's task will become even harder. As international assistance dries up and too many countries vie for assistance to deal with the pandemic, suggestions have already been made 'to let the virus run its course in Afghanistan until enough people have survived the infection to create herd immunity'[1]. There is no certainty that this natural immunization will be successful and in fact, may end up proving to be devastating for the people.

However, dependency cannot be a policy option for the country. Being pitted against heavy odds, Afghanistan has to strive to build onto its achievements made since 1991. There are several steps that it can take at home to make the best utilization of the available international aid. First and foremost, Afghanistan has to address the issues of overstretched heath sector and payment of medical staff. Secondly, it needs to build an outreach strategy and free testing facility with donor funding; it will be critical for donors to provide health emergency funding for Afghanistan for testing and treatment. There is a need to have greater delegation of authority to the provinces and provide healthcare services away from the capital to prevent people from moving to Kabul. While security is an issue, initiatives can be taken to extend mobile health services in far-fetched and insecure provinces. More importantly, Afghanistan will need a coherent pandemic and health emergency policy with

[1] Abdullah Ahmadzai, 'Afghanistan's Covid-19 Bargain', Asia Foundation, 24 June 2020, https://asiafoundation.org/2020/06/24/afghanistans-covid-19-bargain/. Accessed on 30 June 2020.

delegation of authority. In fact, the response to the Covid-19 pandemic could potentially shape Afghanistan's health policy in the coming years.

As Afghanistan traverses through a fragile transition, other South Asian countries need to provide assistance as needed to effectively deal with this crisis. This could indeed be a time to demonstrate South Asian solidarity and strength by extending help towards Afghanistan, enabling it to overcome the challenge through regional cooperation mechanism. As a SAARC member, Afghanistan could potentially benefit from the SAARC emergency fund and disaster relief assistance. This could be an effective mechanism for minimizing competition and increasing cooperation for South Asian countries in Afghanistan which would be beneficial for conflict affected country. The onus, hence, is not just on Afghanistan, but also on other regional countries to help prevent the further spread of the pandemic.