

Impact of the COVID-19 pandemic on primary health care reform in Pakistan

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Abstract

Background: Primary health care reform in low- and middle-income countries involves complex processes of prioritisation and agenda-setting. Evidence remains limited on how the COVID-19 pandemic influenced these processes at the subnational level.

Aim: To examine how COVID-19 affected primary health care reform in Khyber Pakhtunkhwa, Pakistan.

Methods: We conducted semi-structured interviews with 14 key informants, including provincial health leaders, provincial political leaders and their advisers, and representatives of national and international organisations, and reviewed relevant supporting documents. We analysed the data inductively through thematic coding and process tracing across data sources.

Results: Most of the respondents agreed that the pandemic facilitated the implementation of reforms at the primary health care level, by strengthening advocacy and political influence. The reforms began around August 2020 and included improved financial management and allocation of resources, establishment of primary health care management committees, increased budget for essential medicines, recruitment of additional frontline clinical staff, and outsourcing of selected support services. Investments in public health increased through an almost 40% increase in the health budget between the 2019/2020 and 2022/2023 financial years.

Conclusion: COVID-19 created an opportunity to advance primary health care reform at the provincial level in Khyber Pakhtunkhwa, Pakistan. There is a need to sustain and improve on these reforms to strengthen primary health care services and advance towards the longer-term health goals and Universal Health Coverage.

Keywords: COVID-19, primary health care, health reform, health policy, UHC, Pakistan

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Background

Primary health care (PHC) is central to improving access to essential services and advancing progress towards Universal Health Coverage (1–3). The COVID-19 pandemic had a significant impact on health systems and may have accelerated changes in the organisation and functioning of PHC systems (4–7). While the long-term implications of COVID-19 for PHC remain uncertain, early stages of the policy process, namely reform prioritisation, are likely to reveal indirect effects of the pandemic.

Evidence on the impact of COVID-19 on PHC systems in low- and middle-income countries (LMICs) remains limited. Existing literature has largely focused on the immediate impact on service delivery during emergency response, or on selected priority areas such as childhood immunisation, maternal and child health care, and the scale-up of emergency services (4,6–11). Fewer studies have examined the indirect effects of the pandemic on health system reform processes, although emerging evidence from India suggests that COVID-19 influenced policy priorities beyond the acute response phase (12).

Policy process theory offers analytical tools for examining how reform priorities emerge and change. Kingdon's Multiple Streams Framework (MSF) is widely applied in policy analysis and conceptualises agenda-setting as the convergence of problem, policy and political streams, often triggered by a focusing event that opens a policy window (13). Large-scale shocks may alter perceptions of health system performance or political feasibility, thereby creating opportunities for reform. The COVID-19 pandemic may therefore have functioned as a focusing event, reshaping primary health care reform priorities within different institutional and governance contexts.

Path dependency further highlights how past policy decisions shape subsequent reform trajectories. Policy Feedback Theory (PFT) applies this concept to explain how existing policies influence political dynamics and future change (14,15). However, path dependency has rarely been integrated explicitly into MSF-based analyses. An exception is a modified MSF incorporating PFT and path dependency, developed by Spohr and applied in analyses of European labour market policies (16). This integrated

perspective highlights how reform priorities may shift following a major health system shock.

In Pakistan, a lower-middle-income country with a Gross Domestic Product of US\$1597 per capita, such shifts occurred in the context of PHC reform during the COVID-19 pandemic (17). Before that, the leading causes of mortality included neonatal conditions and non-communicable diseases (18). In 2021, COVID-19 became the leading cause of death (19). Khyber Pakhtunkhwa, the third largest province in Pakistan, has a population of 41 million and has experienced recurrent natural disasters and conflict, contributing to population displacement and increased communicable disease transmission (20–22). The provincial department of health comprises 887 basic health units (BHUs) and rural health centres (RHUs) delivering essential preventive and curative services (23). Key pre-pandemic reforms included the devolution of health system governance to the provincial level in 2010 and initiatives to outsource management of selected PHC facilities.

Pakistan's response to the COVID-19 pandemic has been described as relatively effective (11,24,25). In Khyber Pakhtunkhwa, a PHC reform agenda was developed in August 2020, following the initial emergency response. This case study examines how COVID-19 influenced PHC reform prioritisation in Khyber Pakhtunkhwa by comparing pre-pandemic and post-emergency reform

agendas and analysing the drivers shaping reform decisions within a devolved health system.

Methods

Study design

This study used a qualitative case study design. Data were derived from semi-structured interviews with key informants and complemented by analysis of supporting documents using a clear audit trail. A narrow definition of PHC was applied, focusing on public sector formal health facilities providing first contact health care, including BHUs and RHUs (26).

Semi-structured interviews

Fourteen interview participants were identified through stratified purposive sampling (Table 1). Stakeholders included provincial department of health leaders, members of provincial political leadership and their advisers, and representatives of national and international organisations. Sampling aimed to achieve saturation among decision-makers directly involved in steering the provincial COVID-19 response. Saturation was considered reached when interview data became repetitive and no substantively new themes emerged. This assessment was confirmed through iterative review among the co-authors.

Table 1 Characteristics of semistructured interview participants

| No. | Date and location of interview | Role | Organisation type | Engagement in COVID-19 response |
|-----|------------------------------------|--------------------|----------------------------|--|
| 1 | December 2022, Peshawar, Pakistan | Director | Provincial government | Led COVID-19 response for the department of health at district level, later appointed at director level during pandemic; involved in PHC reform design |
| 2 | December 2022, Peshawar, Pakistan | Director | Provincial government | Member of the team leading the COVID-19 response at provincial level; involved in PHC reform design |
| 3 | December 2022, Peshawar, Pakistan | Executive Director | Provincial government | Led the department of health response during part of the COVID-19 pandemic; involved in PHC reform design |
| 4 | December 2022, Peshawar, Pakistan | Deputy Director | Provincial government | Member of the team leading the COVID-19 response at provincial level; involved in PHC reform design |
| 5 | December 2022, Peshawar, Pakistan | Director | Provincial government | Member of the team leading the COVID-19 response at provincial level |
| 6 | December 2022, Peshawar, Pakistan | Leader | Provincial government | Political leader responsible for the COVID-19 response within the provincial government |
| 7 | December 2022, Peshawar, Pakistan | Adviser | Provincial government | Adviser to political leadership for the COVID-19 response at provincial level |
| 8 | December 2022, Peshawar, Pakistan | Director | Provincial government | Led the COVID-19 response for the department of health at district level |
| 9 | December 2022, remote (video call) | Executive Director | Provincial government | Led department of health response during part of the COVID-19 pandemic, involved in PHC reform design |
| 10 | December 2022, remote (video call) | Adviser | Provincial government | Adviser to political leadership for the COVID-19 response within the provincial government |
| 11 | March 2023, remote (video call) | Adviser | International organisation | Adviser to provincial government COVID-19 response |
| 12 | March 2023, remote (video call) | Adviser | International organisation | Adviser to provincial government COVID-19 response |
| 13 | March 2023, remote (video call) | Adviser | National organisation | Adviser to provincial government COVID-19 response and PHC reform design |
| 14 | April 2023, remote (video call) | Adviser | International organisation | Consultant supporting PHC reform design |

Interviews were conducted in person or remotely through video calls between December 2022 and April 2023 by the lead author. A second author independently reviewed 2 interview transcripts to ensure consistency of coding and interpretation.

Review of supporting documents

Supporting documents were identified through recommendations from interview participants, complemented by a search of publicly available sources. In total, 9 documents were reviewed, including 5 non-public documents provided by interview participants and 4 documents in the public domain. Document analysis was conducted using a process tracing approach, with data extracted using the READ (Read, Extract, Analyse, Distil) framework, aligned with the temporal focus of the research questions (27,28).

Data analysis

Interview transcripts and supporting documents were coded to inform the development of analytic memos for each interview. Inductive thematic coding of health system-related themes was conducted by the lead author using ATLAS.ti (29). Memos prepared in Microsoft Word were combined with field notes and data extracted from document analysis to identify recurrent patterns and potential causal mechanisms (30). These were iteratively examined and refined through subsequent interviews using an explaining-outcome process tracing approach to assess causal pathways.

Results

Pre-COVID-19 and early COVID-19 priorities

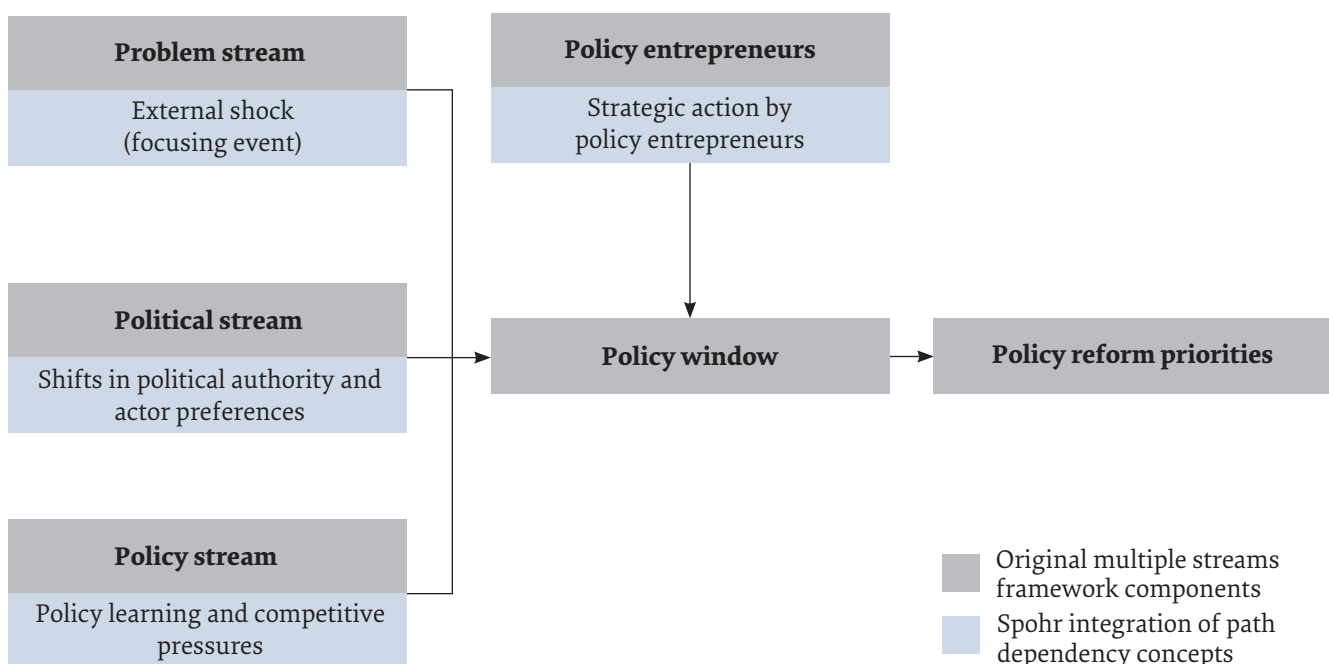
Interview participants with technical backgrounds said that pre-COVID-19 priorities were largely driven by external influences and reactive agenda-setting. These included donor priorities linked to international commitments and heightened public attention following negative media coverage, such as localised outbreaks of dengue fever (31). One respondent said:

“TB and HIV are global commitments, and the Global Fund puts its resources there. To match those resources, the provincial government is compelled to invest as well.”
(Provincial department of health official)

Participants with political backgrounds described a different set of priorities, focusing on the construction of new health facilities, often within the constituencies of influential politicians, and the expansion of human resources. Across both technical and political groups, pre-COVID-19 priorities were shaped by 3 dominant factors: donor and international expectations, negative media coverage, and perceptions of voter preferences (Figure 2).

The early COVID-19 emergency response from March 2020 to August 2020 prioritised hospital-based and public health interventions. During this period, the PHC system played 2 main roles. First, it served as a source of human resources, with PHC doctors seconded to hospitals that were rapidly expanded to manage early COVID-19 waves. Second, PHC staff supported rapid response teams involved in COVID-19 track-and-trace activities in Khyber Pakhtunkhwa.

Figure 1 Conceptual framework integrating the multiple streams framework with temporal and path-dependent elements (16)



Emergence of new primary health care reform priorities

The main priorities of the PHC reform agenda developed around August 2020 focused on areas requiring additional financial allocation. These included devolving aspects of financial management to BHUs and RHCs through the establishment of PHC management committees, increased budget for essential medicines, recruitment of additional frontline clinical staff through contract arrangements, and outsourcing of selected support services.

Interview respondents described changes in performance management practices, including more frequent operational and performance review meetings led by senior department of health officials and supported by digital communication and data systems (Figure 2).

Although participants reported that many reform ideas pre-dated COVID-19, views differed on whether the pandemic itself constituted a focusing event. However, there was broad agreement that the pandemic facilitated the implementation of the reform agenda by increasing urgency, addressing performance gaps, strengthening the political influence of reform advocates, and allowing reforms to be tested during the emergency response (Figure 2).

Participants reported that reform discussions fluctuated with the rise and fall of COVID-19 cases. One respondent said:

“Whenever the wave was rising, nothing else was discussed. Whenever the number of cases decreased, there was a discussion about potential areas of primary and secondary health care reform, not from the COVID learning or

compliance, but from a general desire of the provincial government to improve primary and secondary health care.” (Provincial political adviser)

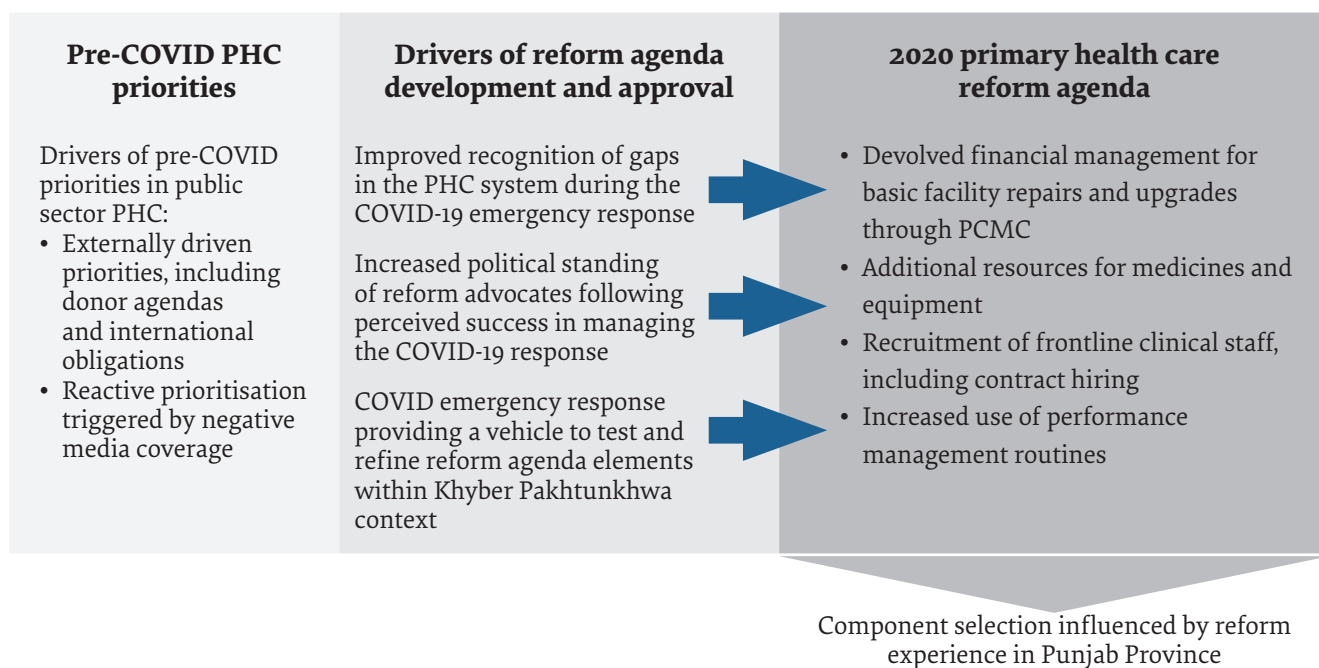
Most participants identified neighbouring Punjab Province as a key source of reform ideas, reflecting reforms implemented there from 2016. Participants also linked COVID-19 experiences to the feasibility of reform implementation in Khyber Pakhtunkhwa. For example, financial devolution to hospitals during the early emergency response, combined with experience from the medical teaching institution initiative at the tertiary level, informed reform design at the PHC level. COVID-19 was also described as having exposed system weaknesses and increased urgency for reform. A provincial department of health official said:

“COVID showed us where the health system was weak.” (Provincial department of health official)

Early implementation of the reform agenda included the transfer of more than 600 million Pakistani Rupees (approximately US\$ 3 million at the time) to PHC management committees for facility improvements in 550 BHUs by mid-2022, and the recruitment of more than 120 medical officers under contract. A considerable increase in public health investments was observed, with the overall health budget increasing by almost 40% between the 2019/2020 and 2022/2023 financial years (23). Respondents attributed this increase to the alignment of health and finance leadership roles and to heightened political support for health spending following COVID-19.

“[It is] true that, after COVID, [the] importance of investing in health has increased even further because people saw its effects directly.” (Provincial political adviser)

Figure 2 Pre-COVID-19 priorities, drivers of primary health care reform, and reform agenda components



Participants further noted that the reform momentum was strengthened by the increased political influence of health reform and by positive experiences that demonstrated the feasibility and effectiveness of interventions during the emergency response. One respondent said:

“(the Minister of Health) would not have had the leadership time to focus on these issues, if it were not for the pandemic.”
(International organisation adviser)

Future of primary health care reforms

Interview participants were generally optimistic about the sustainability of reforms, particularly those related to financial devolution, human resources and medicines. However, political participants expressed concern about the continuity of reforms if senior leadership changed.

In January 2023, the provincial government was dissolved due to broader political developments, resulting in changes in senior health leadership under a caretaker administration (32). Interviews conducted in early 2023 highlighted concerns that leadership turnover and fiscal pressures could undermine the 2020 reform efforts. Participants identified protective factors, including the continued presence of technical leaders involved in reform design and the difficulty of reversing reforms that were already contractually or financially committed. At the same time, several participants with a technical background expressed concern that emphasis on visible facility-based investments, reinforced during

the COVID-19 period, had reduced attention to preventive and long-term primary health care functions. One participant described how electoral incentives shaped political priorities:

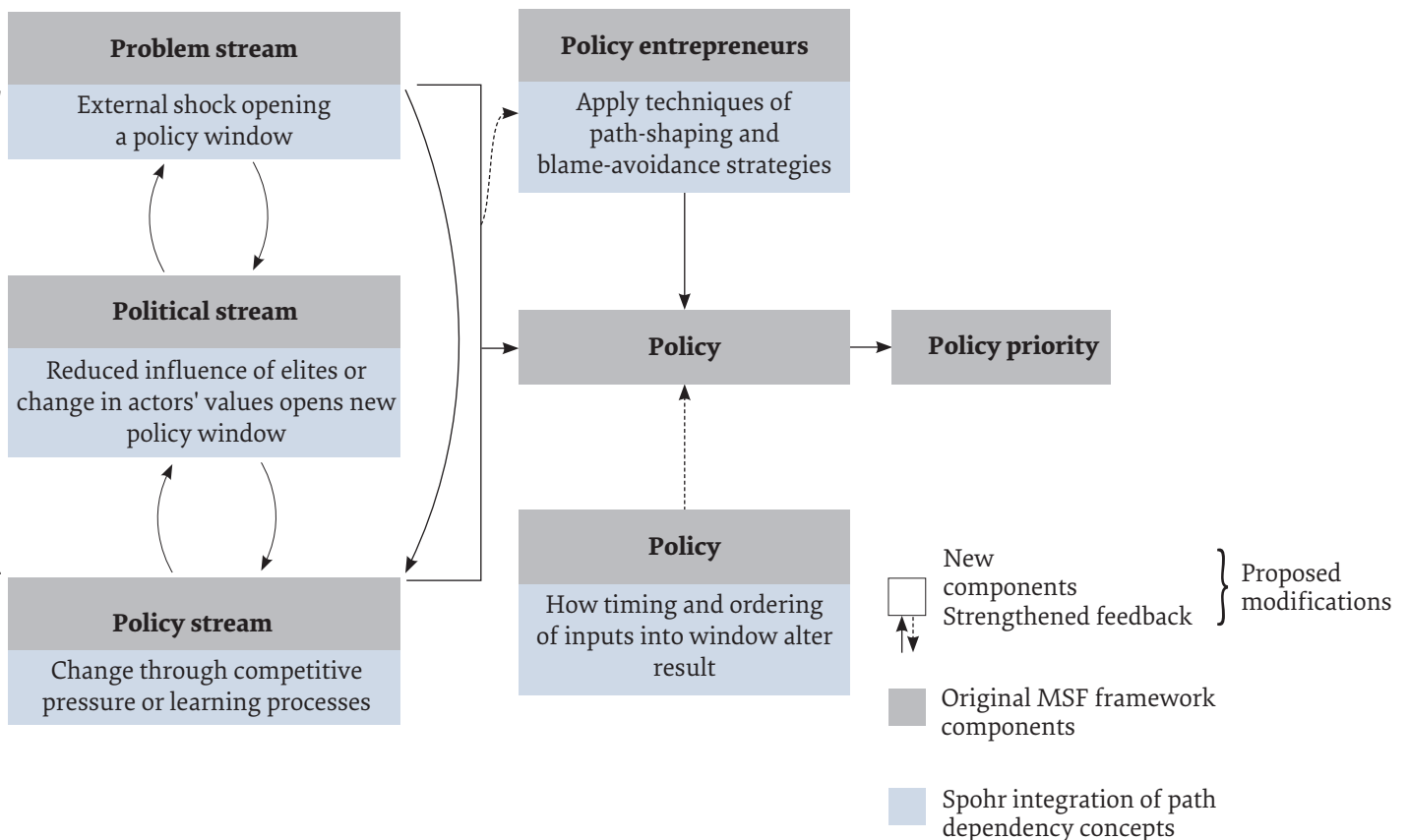
“Political leadership follows public demand. When they go in their constituency, people complain about the lack of doctors and medicines. No one asks about vaccination, antenatal care, nutritional services, surveillance of epidemic diseases, or vaccination for preventable diseases.”
(Provincial department of health official)

Refinements to the modified multiple streams framework integrating policy feedback theory

Accounts of the participants suggested that COVID-19 influenced all 3 MSF streams (Figures 2 and 3). Shared recognition of gaps in the health system shaped the problem stream, while the perceived success of the COVID-19 response strengthened political authority and resource mobilisation within the health sector. The policy stream was affected by the reform experience in Punjab Province and by the leadership interest in pursuing a legacy reform.

The mechanics driving the reform effort in Khyber Pakhtunkhwa during the COVID-19 pandemic aligned closely with the modified MSF based on the framework by Spohr. However, the analysis suggests several refinements that could increase the framework’s utility in describing the effects of COVID-19 and similar events

Figure 3 Proposed refinements to modified MSF integrating PFT for the Khyber Pakhtunkhwa case example



on health policy processes, as illustrated in a revised version of the framework (Figure 3).

The first refinement relates to the role of feedback loops between newly adopted policy agendas and components of the modified framework integrating PFT. This reflects the influence of previous policy decisions and the existing policy environment on the emergence of subsequent reform agendas (14). In Khyber Pakhtunkhwa, the successful adoption of new policies and allocation of resources to these policies created a positive feedback loop that supported later reform components (33).

The second refinement relates to the need to place greater emphasis on interactions between different components of the modified MSF. In Khyber Pakhtunkhwa, the 3 streams were influenced by a small policy community of fewer than 12 individuals. The MSF does not fully capture the interdependence of these components, as noted in previous analyses (14).

Third, greater attention should be given to the timing and sequencing of key factors within the MSF. In Khyber Pakhtunkhwa, a reform example from the neighbouring Punjab Province was presented at a time when a reform agenda was being explored. Had the timing differed, the resulting reform agenda may have taken a different path.

Discussion

This case study describes a pre-COVID-19 PHC system that was largely reactive and shaped by external influences. During the pandemic, the system evolved towards a reform agenda led by local health system actors and informed by experiences from neighbouring provinces and lessons emerging from the pandemic response.

Some findings from this study may be transferrable to other LMIC PHC systems with comparable characteristics, including large populations, performance gaps and decentralised governance structures (1). The findings highlight the role of a small and cohesive policy community in advancing a shared reform agenda and demonstrate pandemic-related shifts in political influence among actors engaged in the reform. Taken together, the findings suggest that the COVID-19 pandemic opened a time-limited window of opportunity for reform that was recognised and acted upon by policymakers. This window emerged through a heightened awareness of health system performance gaps, the availability of solutions tested during the early emergency response, and increased political standing of key reform advocates.

The modified MSF framework proved useful in understanding the drivers of the reform process observed

in this case. Refinements that emphasise feedback cycles, strengthen interactions between streams and elevate the role of timing and sequencing may enhance the relevance of the framework for analysing health reforms in LMICs. We recommend the expanded use of this type of policy frameworks to support understanding of policy reform in health systems.

Despite the prominence of the reform agenda in provincial discourse on PHC, its long-term trajectory remains uncertain. The period following data collection was characterised by rapid political change and worsening fiscal pressures in Pakistan. Follow-up discussions with interview participants suggested that some reform components demonstrated continuity, while others experienced delays or setbacks in implementation, including additional budget allocations for medicines and contracting of human resources. Further research could expand on the paths these reforms followed after their initial implementation and the factors influencing their sustainability.

This study has several limitations. The sample comprised a small number of relatively senior key informants, many of whom were known to the lead author through previous engagement in the health policy context in Pakistan. This may have introduced social desirability or other response biases, and may have influenced the analysis through author positionality. The politically dynamic context in which the study was conducted, together with the time lag against which participants recalled events, may have contributed to recall bias and may limit the broader applicability of the findings.

Conclusion

The COVID-19 pandemic played a critical role in advancing a new PHC reform agenda in Khyber Pakhtunkhwa, Pakistan. This case study offers insights for national and global policymakers on recognising and acting upon policy windows to support broader systems reforms, using the interventions and policy processes mobilised during the pandemic to help advance longer-term goals related to PHC and universal health coverage. The proposed refinements to the modified MSF framework integrating PFT may enhance its usefulness for evaluating the effects of COVID-19 and other events focusing on policy processes in similar settings.

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