

COVID-19: Monitoring and Assessment of Pandemic Governance

March 2021



TRUST FOR DEMOCRATIC EDUCATION
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ABOUT THIS REPORT

This monitoring and assessment report aims to summarise citizens' oversight of the COVID-19 response carried out till the month of February, 2021 and the official data of the pandemic as of March 15, 2021. Key informant interviews (KIIs), observation checklists, and media monitoring at national, provincial, and district levels were used as data collection tools, and the collected data is substantiated with the help of secondary sources and media monitoring. KIIs were carried out at the district level with key government officials, including Deputy Commissioners, District Disaster Management Authority representatives, District Health Officers, Executive District Officers, heads of doctors and paramedic associations, those of local civil society organizations, journalists, beneficiaries of health institutions, and direct observation of health facilities. Press releases, statements and opinion pieces were monitored at both national and district level. Considering the vaccination drive a part of the COVID-19 response, 30 representatives of district administration, 33 doctors and 33 paramedics were asked about their points of views on vaccination.

The current report is based on primary data collected from 35 project districts between February 1, 2021 to February 26, 2021. The findings are based on interviews of 29 district health/administration officials, 34 representatives of doctors' associations, 35 representatives of paramedics' associations, 141 health institution beneficiaries, 34 CSO representatives, 41 journalists, and observation of 82 healthcare facilities. To better reflect on the impact of the trends observed in February, the numbers for cases, mortality and positivity ratio ending March 15, 2021 are accounted for as are some key developments before the finalization of this report.

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List of Acronyms

AVC	Adult Vaccine Centres
BISP	Benazir Income Support Program
COVID-19	Coronavirus Disease 2019
COVAX	COVID-19 Vaccines Global Access
CSO	Civil Society Organization
DC	Deputy Commissioner
DDMA	District Disaster Management Authority
DMA	District Management Authority
DRAP	Drug Regulatory Authority of Pakistan
EDO	Executive District Officer
FAFEN	Free and Fair Election Network
GAVI	Global Alliance for Vaccine Immunization
ICT	Islamabad Capital Territory
ICU	Intensive Care Unit
KP	Khyber Pakhtunkhwa
NADRA	National Database and Registration Authority
NCC	National Coordination Committee
NCOC	National Command and Operation Centre
NGO	Non-Governmental Organization
NHS	National Health Services
NIH	National Institute of Health
NIMS	National Immunization Management System
NSC	National Security Committee
NVACC	National Vaccination and Administration Control Cell
PDM	Pakistan Democratic Movement
PDMA	Provincial Disaster Management Authority
PEMRA	Pakistan Electronic Media Regulatory Authority
PMA	Pakistan Medical Association
PPE	Personal Protective Equipment
SAPMH	Special Assistant to the Prime Minister on Health
SOP	Standard Operating Procedure
TDEA	Trust for Democratic Education and Accountability
TIP	Transparency International Pakistan
VIP	Very Important Person
WHO	World Health Organization

Analysis of data – from February 1 to March 15 – for this report underlined the urgency of exercising sustained effort and vigilance in the governance of COVID-19 response as Pakistan transitioned into the third wave of COVID-19. Whereas the overall mortality rate decreased over this period, as did the monthly infection rate for February, the spike in the last week of the previous month and acceleration of new infections in the first two weeks of March reflected the start of the new wave.

- Number of active COVID-19 cases surged as third wave of the pandemic grips Pakistan. The trend from around the end of the month was one of increasing infections as well as positivity rate, which grew from 3.6 percent in the first week of February to 5.8 percent in the second week of March.
- The third wave follows the lack of compliance with SOPs observed in February. Even at public and health establishments, compliance with some of the key SOPs by staff and visitors at public offices and health facilities registered decline or remained low in February. Social distancing, for instance, was observed at 70 percent of the public offices and 66 percent of the health facilities.
- Relaxed trends were also observed in other key indicators as well. Monthly tests in February declined overall to 0.98 million and were the second lowest since the onset of the second wave. Reflecting a reactive mode, the number of tests increased from 31,000 per week in the beginning of February to above 40,000 around mid-March.
- Administering only 0.16 COVID-19 vaccine doses per 100 people in the total population, Pakistan vaccination drive remained slower than expected, lagging behind such regional countries as India, Nepal, Bangladesh, and Sri Lanka.
- One to three COVID-19 vaccination centres were established in 15 of the 35 districts. No centres were, however, reported in two districts. Combined with the increasing momentum of the third wave, mortality rates among the frontline warriors and their need for vaccination, and lower numbers of vaccine available, this lack of infrastructure can negatively affect both efficiency and effectiveness of the ongoing response.
- The legislative oversight of the government's COVID-19 response showed signs of improvement but remained inadequate. During February, meetings of standing committees of Senate and the National Assembly were held and individual legislators raised questions seeking information on vaccines and the vaccination plan.

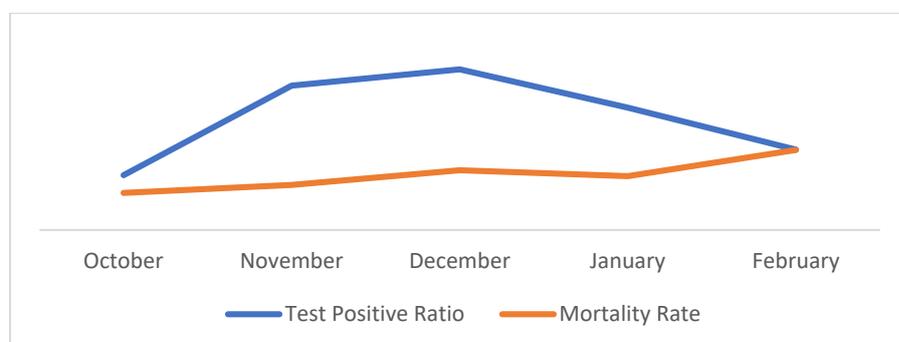
Managing the third wave of COVID-19, Pakistan's pandemic response will require a more proactive approach for ensuring not just a faster vaccination drive but more importantly, compliance with SOPs among the general public. Announcements of restrictions have to be coupled with a public education and sensitization effort that involves community leaders and representatives of key sectors, including among others, representatives of traders, private school and *madrassahs*. Furthermore, the response's relief component needs to be well thought out and cognizant of the needs of sections of society that, for a variety of reasons, may not fulfil the application requirements. In particular, women who are self-employed or work in the informal sector and the estimated 12.7 million adult women who do not have NIC demands a more thoughtful consideration in the design and implementation of relief packages.

This section analyses stakeholders' survey findings and direct observation of enumerators deployed in 35 project districts.¹ The project team collected data for this report from February 1, 2021, to February 26, 2021. Discussion in the current section is based on interviews of 29 district health/administration officials, 34 representatives of doctors' associations, 35 representatives of paramedics' associations, 141 health institution beneficiaries, 34 CSO representatives, 41 journalists, and observation of 82 healthcare facilities carried out in February 2021.² Findings from previous months are also compared with the monitoring data of the current month to add timeline perspective to the report.

I. FROM SECOND TO THE THIRD WAVE

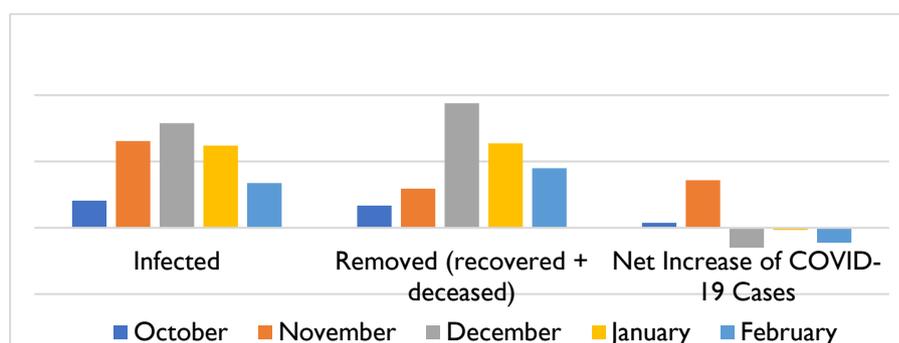
With total 1,150 fatalities, the overall mortality rate in February increased to 3.4 percent. The positivity trend, on the other hand, decreased generally over the month, but the surge in the number of new infections during the last week reversed the declining trend of the preceding two weeks, and portended an outbreak of new wave of infections and triggering of third wave.

Figure 1: Monthly Deaths due to COVID-19



As per Figure 2, the number of overall new infections in February dropped to 33,717, as compared to 62,066 in January, with the net decline of 11,267 in active COVID-19 cases indicating a decreasing burden on health system due to COVID-19. The monthly numbers, however, hides the shift in trend towards the onset of a third wave.

Figure 2: Comparative Reading of COVID-19 Cases



Source: <http://COVID.gov.pk/>

As mentioned, the closing week of February witnessed a consistent increase in the number of new infections which rose above 9000 during the same week. The situation was compounded further in March with the increasing velocity of new infections as well as the overall positivity rate that jumped from 3.3 percent at the end of February

¹ For details of the selection criteria for districts, please refer to Annexure-I.

² For details of interviews and observations in the selected districts, please refer to Annexure-II.

Chronology of COVID-19 spread response

February 2020: Pakistan reports its first case of coronavirus.

March 13, 2020: A meeting of the National Security Committee (NSC) discusses the crisis after the World Health Organization (WHO) declares a pandemic and the government announces a countrywide lockdown.

August 7, 2020: The government begins to ease lockdown in phases starting with the construction industry; National Coordination Committee (NCC) on COVID-19 lifts restrictions on tourism, restaurants, and the transport sector.

September 15 & 26, 2020: Schools and marriage halls reopen.

October 2020: Significant increase in infections reported. Government issues new guidelines and SOPs, making face masks in public places mandatory.

November 2020: All offices of Senate closed for three days (starting from November 3); office hours reduced, minimum staff for offices, visitors' entry banned (from November 9).

December, 2020: All employees of the Senate asked to work from home. A senator passed away due to COVID-19.

January 2021: The decision-makers finalised the COVID-19 vaccine among the available options; Phase-wise distribution plan of vaccine was announced, and schools and educational institutions started opening.

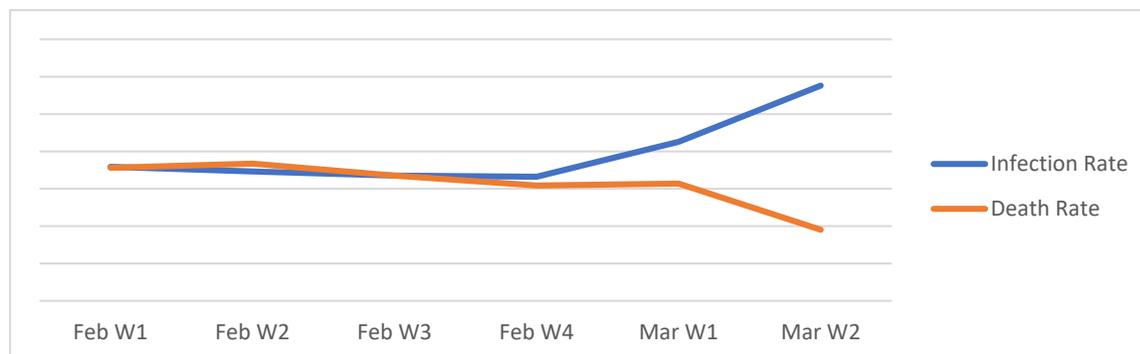
February 2021: Pakistan received first batch of China-made COVID-19 vaccine, approved emergency use of CanSino. However, there have been reports of vaccine shortage across the country where demand (measured by number of registered first-line health workers) exceeded supply.

February 24, 2021: Government announced relaxation in restrictions.

March, 2021: FAFEN warned of a third wave of COVID-19; government put on hold its plan to allow private import of Sputnik-V vaccine, following public criticism and dispute over price-cap

to 5.8 percent during the second week of March. As the primary data for February suggest (See chapter 5, Section I), the rapid decline in adherence to SOPs contributed to the onset of third wave as manifested in the rising infections which accelerated significantly since the fourth week of February.

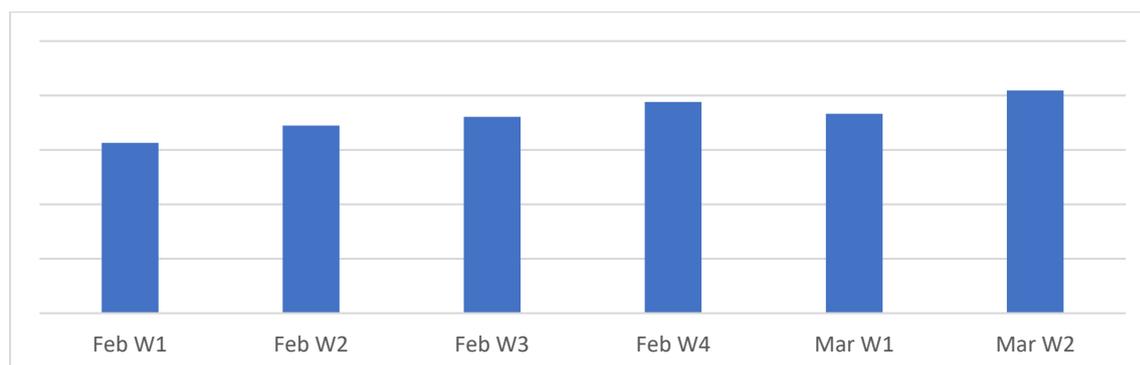
Figure 3: Infection and Death Rate from February to Mid-March



The mortality rate, on the other hand, which had increased to monthly average of 3.4 percent in February, registered a gradual decrease as weeks went by and plummeted further during the second week of March to 1.9 percent.

While the positive cases consistently increased through February and March, the number of tests did not. In fact, total number of tests conducted in February were the second lowest since onset of the second wave (see figure 23).

Figure 4: Average Tests per Week from February to Mid-March



Weekly testing rate increased gradually through successive weeks in February, gathering pace with the rise in infections at the end of the month, and rose above 40,000 in the second week of March from around 31,000 in the beginning of February.

1.1 Scale and Impact of the Pandemic at the District Level

The project interviewed Deputy Commissioners (DCs), Executive District Officers (EDOs) of the health departments, officials at the District Disaster Management Authorities (DDMAs), and District Management Authorities (DMAs) in 29 districts. Officials from three districts – Abbottabad, Faisalabad, and Sanghar – could not be interviewed, whereas the remaining three from Lahore, Quetta, and Tharparkar, refused. Lahore and Tharparkar officials did not give interviews even in the preceding four months – October, November, December, and January.

The interviewers were informed that as many as 18,607 COVID-19 patients were undergoing treatment in public healthcare facilities.

Both doctors and paramedics have also been infected or lost their lives in the line of duty. According to head-representative of doctors' associations in 17 districts, the total sum of doctors having been infected till date was 1909; whereas the number of deceased doctors so far was 18 for five reporting districts. Of the deceased doctors, five were women and thirteen men.

Likewise, among paramedics, respondents from 17 districts reported 943 accumulative cases, whereas the number of casualties (male only) stood at eight for two reporting districts. The relatively higher number of COVID-19-related casualties among paramedics requires special attention, not least because they are playing a

pivotal role in the healthcare of COVID-19 patients, and whose efforts will continue to be critical for the safe and effective administration of the COVID-19 vaccine.

2. CAPACITY TO RESPOND AT THE DISTRICT LEVEL

2.1 Infrastructure

DC/EDOs Health from 29 (83 percent) out of 35 districts agreed to share data on the pandemic's scale and the availability of necessary supplies in the districts. Reportedly, public sector hospitals in 29 districts had 780 ventilators, the number of private sector facilities providing COVID-19 treatment/care was 40, and the number of welfare/NGO/INGO facilities providing such care was 17.

Considering the huge discrepancies in the data provided by the districts' officials, National Command and Operation Centre (NCOC) data was consulted for information on testing, quarantine and isolation facilities in 35 districts. There were 125 testing labs – public, private and public-private – functional in 18 (51 percent) of these 35 districts,³ 26 quarantine facilities with a capacity of 12,549 beds in 16 (46 percent) of these districts,⁴ and 66 isolation facilities/wards with bed capacity of 1,598 in 29 (83 percent) districts.⁵ Substantiating the information from NCOC resources with the data collected for this report shows that a total 2,117 doctors and paramedics are performing their duties at the surveyed facilities.

It bears mentioning here that based on the survey data huge disparities exist among districts with regards to provision and availability of resources and necessary supplies. For instance, there was less than one patient per bed at quarantine/isolation centres in nine (31 percent) out of 29 districts – Bannu, Jacobabad, Karachi West, Lodhran, Mardan, Mianwali, Multan, Shikarpur, and Torghar; but, in three districts, namely, Karachi Central, Khairpur, and Loralai, these figures were 85, 58, and 67, respectively.

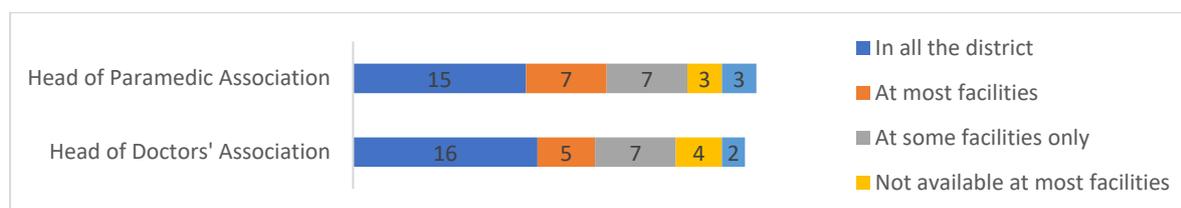
There is a similar trend concerning data on patients per ventilator and patients per doctor/paramedic. In Karachi East and Muzaffargarh, there are 784 and 701 patients per ventilator, respectively, whereas, for Mianwali and Multan, the figure is four for each. Likewise, for patients per doctor/paramedic, there is an equal number of doctors for patients in Khanewal, Mardan and Shikarpur, but there are as many as 400 and 340 patients per doctor/paramedic in Loralai and Karachi East, respectively.

2.1.1 Personal Protection Equipment (PPE)

When asked about the availability of Personal Protection Equipment (PPE) at district facilities, 16 (47 percent) doctors' representatives said PPE was available at all facilities of their districts, five (15 percent) said at most facilities, seven (21 percent) said at some facilities, and four (12 percent) said it was not available at most facilities, while responses of two (six percent) were missing.

On the other hand, 15 (43 percent) paramedics reported PPE availability at all facilities, seven (20 percent) stated PPE was available at most facilities, seven (20 percent) said at some facilities, three (nine percent) were of the view it was not available at most facilities, while responses for the remaining three (9 percent) were reported missing.

Figure 5: Availability of PPEs



Additional data on facilities and services related to treating, testing, quarantining and isolating COVID-19 patients was obtained through monitoring of district health institutions by observers, who inspected 79 of the total 82 facilities – public and private – in 34 districts. Of these facilities, 49 (62 percent) had isolation wards, 31 (39 percent) had quarantine facilities, 53 (67 percent) had testing facilities, and 47 (59 percent) had treatment

³<https://ncoc.gov.pk/facilities/16%20Feb%202021%20Current%20Laboratory%20Testing%20Capacity%20for%20COVID%20Web.pdf>

⁴<https://ncoc.gov.pk/facilities/List%20of%20Province-wise%20COVID-19%20Quarantine%20Facilities%20Pakistan.pdf>

⁵<https://ncoc.gov.pk/facilities/List%20of%20Province-wise%20COVID-19%20Hospital%20Isolation%20Wards%20Pakistan.pdf>

facilities. The total number of doctors assigned to 69 of these facilities (no data was shared by the remaining 10 facilities) was 675, of which 475 (70 percent) and 200 (30 percent) were male and female, respectively.

2.2 Technical Skills and Expertise

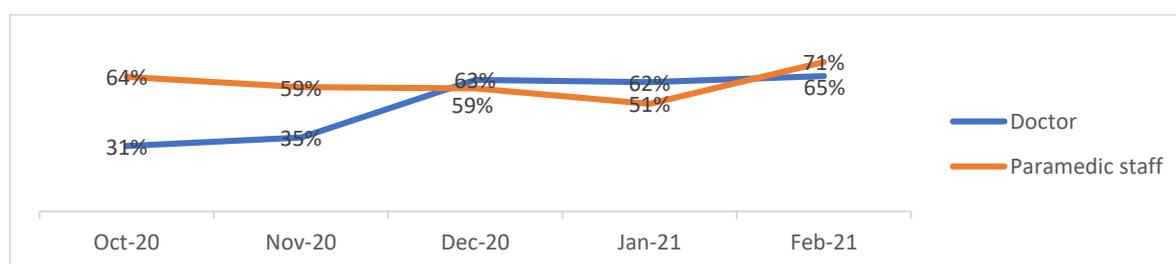
2.2.1 Healthcare Providers

To have an appraisal of the district level capacity of the health workers' preparedness to deal with the pandemic, 16 doctors' representatives were interviewed in October, 34 in November, 35 in December, 2020, 34 in January, and the same number, in February of the current year. On the other hand, the number of paramedics' representatives interviewed for the same months were 14, 32, 34, 35, and 35, respectively.

During the initial month of the project observation, 31 percent doctors found themselves adequately equipped in dealing with the pandemic, with the figure increasing to 63 percent in December, experiencing limited change in January, and ending up at 65 percent in February.

On the other hand, 64 percent paramedics said they had adequate training in October, following which the percentage of them decreased in the intervening months, until reaching 51 percent in January, after which it saw a sharp increase and peaked at 71 percent in February.

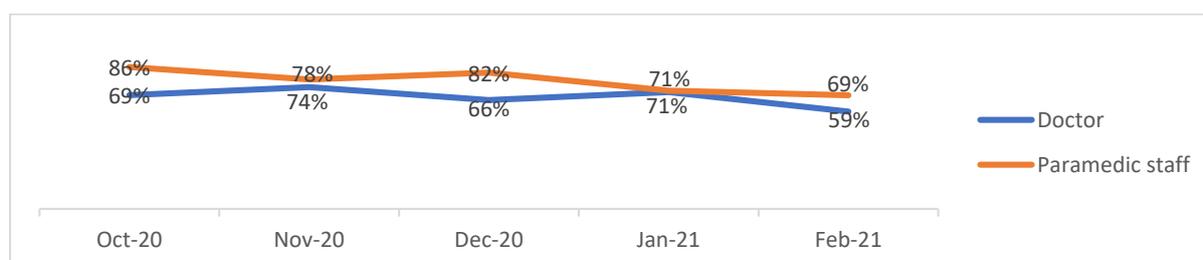
Figure 6: Comparative Reading of Technical Readiness of Doctors and Paramedics



With respect to training for increasing their capacity in dealing with the pandemic, 69 percent doctors expressed their need for further training in October, after which an uptick of five percentage points was seen in November, which dipped to 66 percent in December and rose again to 71 percent in January. In February, however, it plummeted to 59 percent, revealing that lesser number of doctors felt the need for additional training.

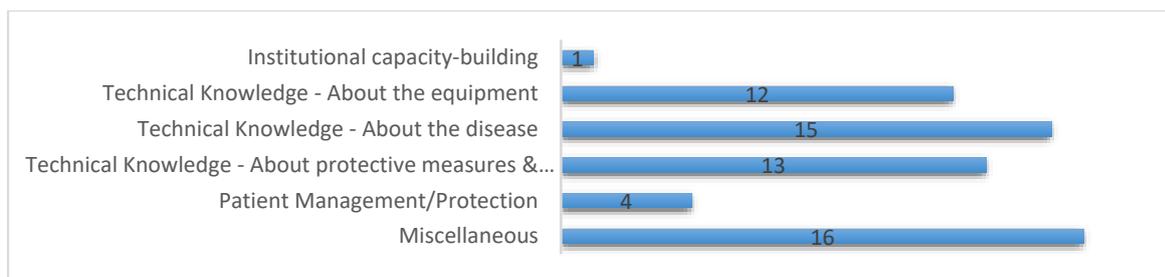
The trend for paramedics' need for training, on the other hand, began with 86 percent in October, and with the exception of December, kept plummeting until it reached its lowest point in February, where only 69 percent staff expressed the need for further capacity-building for better handling of the COVID-19 pandemic.

Figure 7: Comparative Reading of Training Need for Doctors and Paramedics



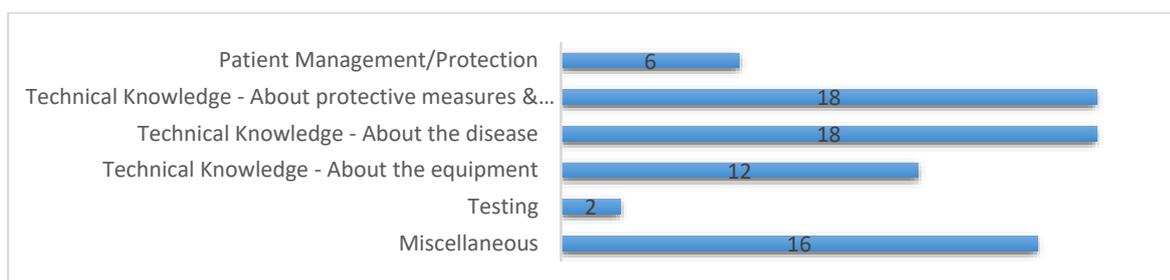
When doctors were asked in February about the areas in which they needed orientations, a mix of 61 responses was received, of which the following three critical areas were most frequently mentioned: 15 (25 percent) underlined the need for knowledge about the disease, 13 (21 percent) emphasized the imperative of increasing awareness regarding the protective measures, with 12 (20 percent) calling for technical knowledge about the equipment (PPEs, ventilator, Intensive Care Unit).

Figure 8: Training Requirements for Doctors



On the other hand, and what is interesting to note, is that paramedics also identified the same areas as their priority in training, with 18 (25 percent), 18 (25 percent), and 12 (17 percent), respectively the frequencies of such areas as knowledge about the disease, awareness regarding the protective measures and technical knowledge about equipment use.

Figure 9: Training Requirements for Paramedics



As of February, while the majority of doctors and paramedics are adequately trained, there is a significant number of them who still lack skills and requisite training in dealing with the pandemic.

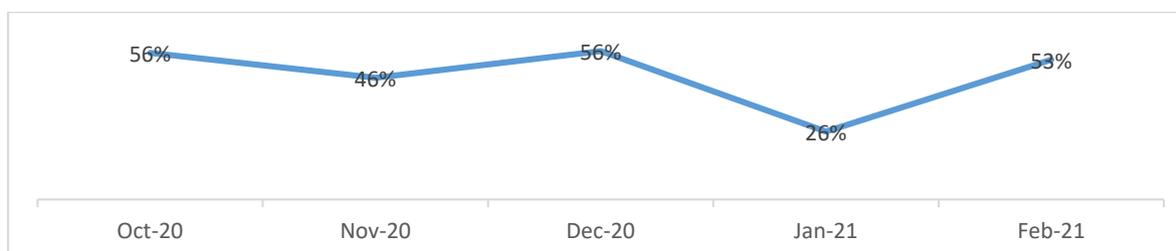
That a significant number of doctors (59 percent) and paramedics (69 percent) called for further training sessions reveals that not enough efforts have been made by the authorities to meet the challenge of the pandemic. What is alarming, however, is that among these many complained about basic knowledge about the disease and protective measures! The persistent lack of progress in this critical area (lack of awareness) should be a matter of serious concern for policymakers, as with ill/miss-informed and ill-equipped healthcare workers, the country will continue to face serious difficulties in sailing through the pandemic.

2.2.2 CSOs and Media

CSO representatives were interviewed each month to gain their views on difficulties they faced during their relief work: 18 in October, 39 in November, 32 in December, 35 in January, and 34 in February.

The resulting response trend tended to vary through the five months—October 2020 to February 2021. As the figure given below shows, beginning from 56 percent, the percentage of CSO representatives reporting difficulties goes up and down in November and December, decreasing once again in January to 26 percent, followed by a final two-fold increase in February to 53 percent. Overall, the percentage of CSOs' difficulties at the end of the period remains close to that at the start of the observation.

Figure 10: Comparative Reading of Problems Faced by CSOs

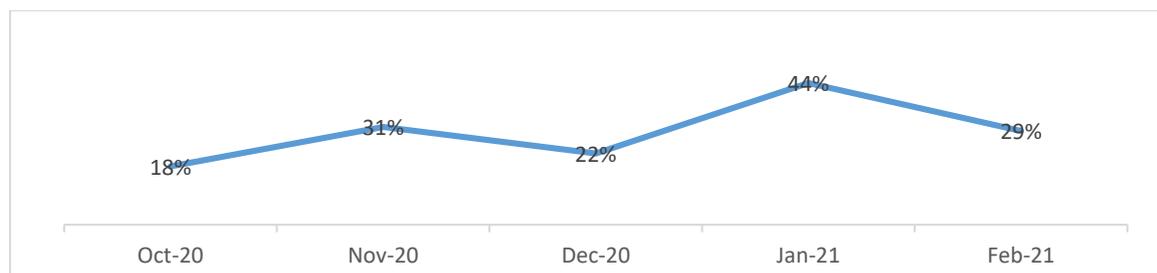


Varying number of journalists were interviewed each month successively from October, 2020 to February, 2021 (33, 59, 45, 43, and 41 journalists, respectively over the five months) to assess their reporting capacity.

Beginning with 18 percent journalists in October who claimed training adequacy for reporting on the pandemic, the trend goes recurrent pattern of decline and regrowth over the subsequent months. More journalists, i.e. 31 percent, reported being equipped in November, but the percentage went down by 9 points in December,

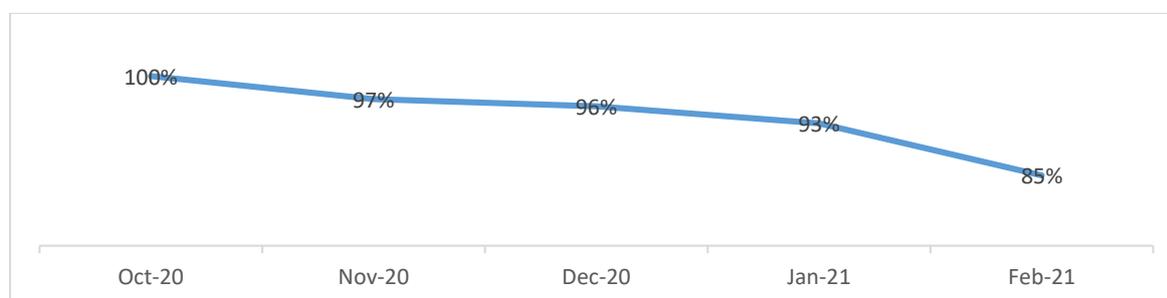
reaching its peak at 44 percent in January, and nosediving again the following month, wherein only 29 percent said they were equipped to report COVID-19 related stories.

Figure 11: Comparative Reading of Training Adequacy of Journalists



There is a continual decline in percentages of journalists calling for training and orientations to increase their pandemic-related reporting skills. Initially, 100 percent said they needed training, with the pattern over subsequent months constantly decreasing, reaching 85 percent in February. It is important to note that TDEA-FAFEN conducted workshops for journalists of these 35 districts in January, 2021 and may have contributed to the trend.

Figure 12: Comparative Reading of Training Need for Journalists



For local journalists, the most frequently mentioned areas in which they needed training to enhance their pandemic/health governance reporting skills, were awareness/knowledge regarding the virus and the associated SOPs (30 or 28 percent), general and COVID-specific data gathering & reporting techniques (25 or 24 percent), and use of modern technology (20 or 16%).

Figure 13: Training Requirement for Journalists



Although, over the months, a declining number of journalists have been expressing the need for training, the overall percentage of journalists calling for capacity-building to cover COVID-19 better is still high (e.g., 85 percent, February). In the absence of well-informed and trained journalists, it will be difficult to communicate the risks of COVID-19 and increase public awareness regarding the importance of compliance with SOPs in fighting the pandemic. Of particular significance is the need of equipping journalists with the use of modern technology and social networks, given that people are increasingly switching to social media for news and information. With improved capacity and awareness, journalists will be better placed in helping build public trust in government response, alleviating their fears and concerns as well as encountering the fake news and propaganda on digital networks regarding the current vaccination phase and the pandemic itself.

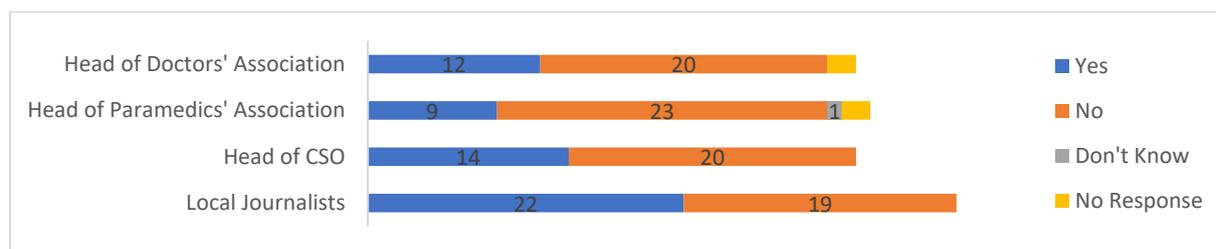
2.3 Coordination Mechanisms and Platforms

As part of its COVID-19 response, government formed different coordination and oversight platforms for synergizing the response efforts of the involved stakeholders. For this report, interviews were conducted with all relevant stakeholders to judge the efficacy of these coordination mechanisms.

In February, 27 (84 percent) DC-EDO Health representatives said they had an active DDMA in their districts. Moreover, in 28 (88 percent) districts, the respondents stated coordination bodies were established with provincial health ministries, while in 27 (84 percent) districts coordination with the Provincial Disaster Management Authority (PDMA) was also reported. Inclusive review and decision-making mechanisms/platforms other than DDMA were also reportedly set up in 25 (78 percent) districts. Finally, 26 (81 percent) reported coordination with public sector healthcare institutions established/represented in DDMA; 22 (69 percent) informed of coordination/cooperation mechanisms with CSOs established/given membership/allowed participation/contribution in DDMA; and 27 (84 percent) stated that an awareness and information dissemination mechanisms/communication strategy was adopted and implemented.

When other stakeholders were asked about the level of their representation in the coordination platform/committees, only 12 (35 percent) representatives of doctors' association, nine (26 percent) paramedic representatives, 14 (41 percent) CSO representatives, and 22 (54 percent) local journalists reported representation of their association/community in the COVID-19 response coordination platforms.

Figure 14: Stakeholders Representation at Coordination Level



From the data it can be concluded that coordination efforts were not fully satisfactory. Inclusion and engagement of these stakeholders in the district coordination committees can bring fruitful results for the response managers as all these groups have direct interaction with public and can serve as useful change agents when it comes to public attitude towards current issues such as complying with SOPs, and future efforts such as administration of vaccine about which only next to nothing is being communicated to the public.

CSO representatives were also inquired about the effectiveness of the coordination platforms in helping coordinate the COVID-19 response, to which four (12 percent) said they were most effective, nine (26 percent) stated mostly effective, 13 (38 percent) reported they were average, four (12 percent) said mostly ineffective, while three (nine percent) said completely ineffective.

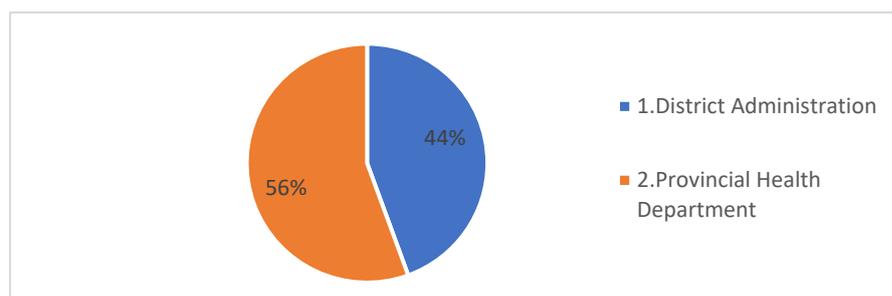
Comparison of district officials' claims with those of other stakeholders indicate that there is a further need for involving and representing doctors, paramedics, journalists and CSOs in coordination platforms and committees at district level to evolve a concerted and unified response to the pandemic.

3. VACCINATION

One of the highlights of February was the increased acceleration of the COVID-19 vaccination drive. Additional questions were asked from 35 district authorities about the status and situation of vaccination. 24 of these districts had information about the demanded numbers of vaccines, i.e, 209,172 units, while 27 had information about the actual number of vaccines received, i.e., 139,908 units. This highlights the difference of 69,264 vials between demand and supply on the basis of available data.

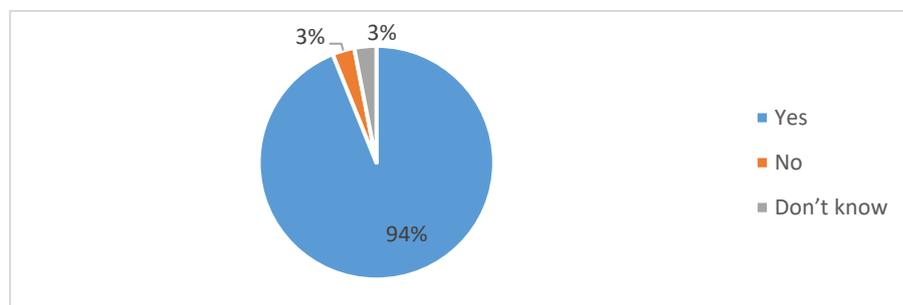
In 12 (44 percent) districts, district administration was responsible for administration of vaccine while in 15 (56 percent) districts, provincial government retained the mandate.

Figure 15: Responsibility of Vaccination



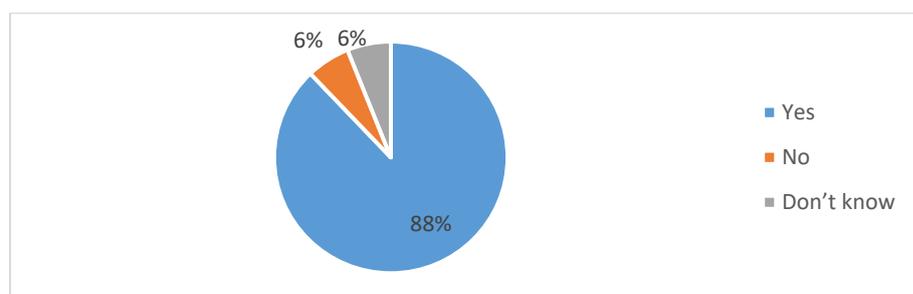
A total of 51,711 doctors were registered for receiving the vaccine in 20 districts, while 36,915 paramedics were registered in 21 districts. Where the trend in allocation of vaccines may vary across doctors and paramedics, it can be safely deduced that vaccinating the frontline health staff shall serve to increase their confidence to perform their duty. Thirty-one (94 percent) doctors reported that having vaccinated shall help them in caring for COVID-19 patients.

Figure 16: Contribution of Vaccination in Performance of Duty-Doctors



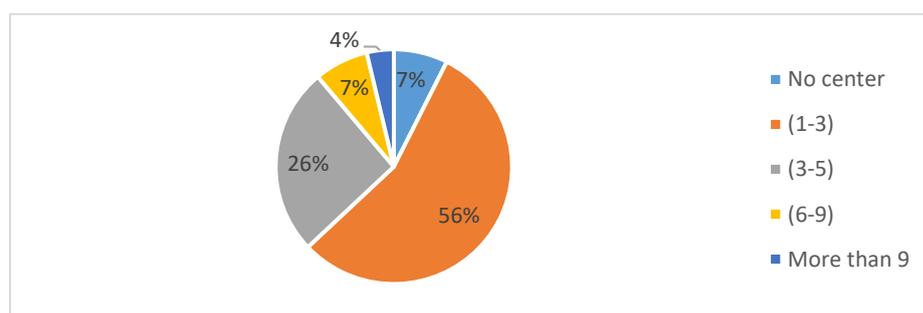
Paramedics were relatively less confident about the effectiveness and role of vaccine in helping them perform their job. Twenty-nine (88 percent) paramedics stated that they feel that the vaccine shall help them performing their jobs in a better way. While two (six percent) denied the statement, and another two (six percent) said they did not know.

Figure 17: Contribution of Vaccination in Performance of Duty- Nurses



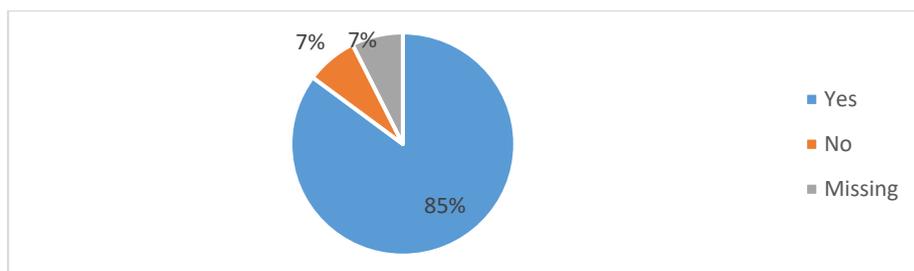
To administer the vaccines, 15 (56 percent) districts had 1-3 vaccination centres established. In seven (26 percent) districts, 3-5 centres were established, 6-9 centres were established in two districts (seven percent) with another two (seven percent) districts having no vaccination centres established at the onset of the third wave.

Figure 18: Number of Vaccination Centres Established in Surveyed Districts



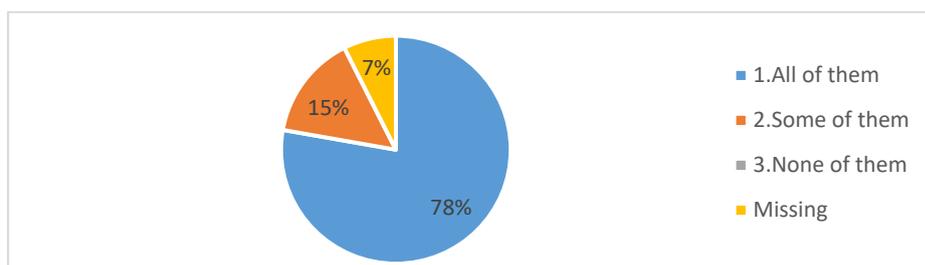
Asked about special arrangements regarding storage of vaccines, 23 (85 percent) districts reported that special arrangements were made to ensure safe storage and administration of COVID-19 vaccine. No such arrangements were reported by two (seven percent) districts, while responses from another two were missing.

Figure 19: Opinions about Special Arrangements for COVID-19 Vaccine



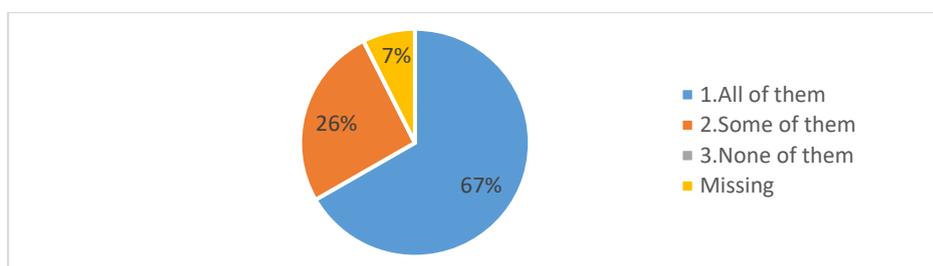
Considering capacity challenges of doctors regarding care of COVID-19 patients, the doctors were asked about the readiness for administering a vaccine that is still a work-in-progress. In 21 (78 percent) districts, all the doctors were trained to administer the vaccine, while in four (15 percent) there were only some.

Figure 20: Training for Administration of Vaccine- Doctors



Among the paramedics, respondents from 18 (67 percent) districts shared that all the paramedics were trained, with seven (26 percent) stated that only some of their colleagues in their districts were trained to administer the vaccine.

Figure 21: Training for Administration of Vaccine- Paramedics



4. TESTING REGULATIONS

Pakistan's testing rate has been very low since the beginning of the pandemic, with its per capita testing rate among the lowest in the region.⁶

Figure 22: Testing per 1 Million Population⁷



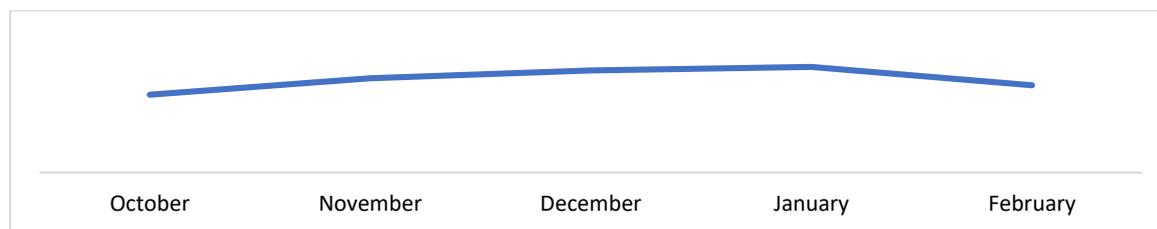
The total number of tests conducted decreased from 1,191,674 in January to 984,382 in February, with average daily testing rate standing at 35,157 for the latter month. Furthermore, there were 162 functioning testing labs

⁶<https://www.dawn.com/news/1598082/lethal-second-wave>

⁷<https://www.worldometers.info/coronavirus/> [Accessed: Feb 15, 2021, 08:22 GMT]

in the country, the average daily testing capacity for which, as calculated from NCOC daily situation reports, was 60,110.⁸ The utilization remained at meagre 58 percent of the total average daily capacity.

Figure 23: Comparative Reading of Total Monthly Tests Conducted



The overall decline in the total number of tests conducted per month can be accounted for by the decrease in the new infections and the total number of active cases as well as by the roll-out of vaccination drive since the first week of February. As outlined in the section I.I, however, the weekly tests increased throughout February and peaked around the mid of March, driven by the rising infections that gave impetus to a third wave of the pandemic.

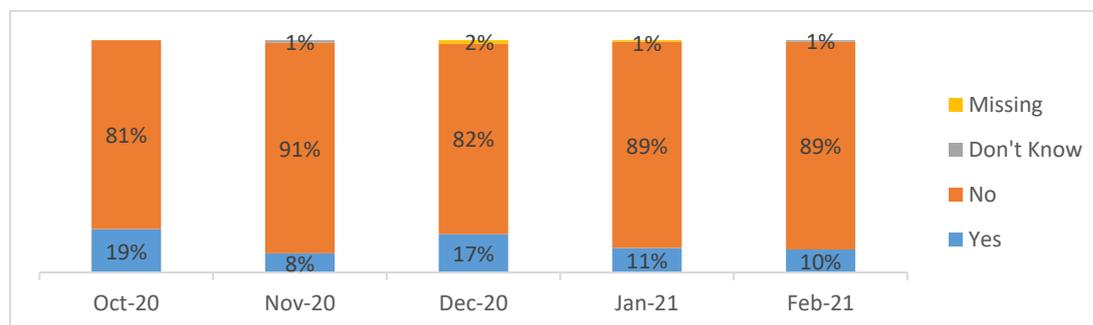
To evaluate whether patients had access to COVID-19 testing or whether they could afford testing costs, both quantitative and qualitative questions were posed to the patients or their attendants. This primary data was triangulated with secondary data to produce an analysis of testing regulation, cost and access.

4.1 Testing Access

To assess the level of access to testing enjoyed by patients 16 patient attendees were interviewed in October, 96 in November, 133 in December, 2020, 142 in January, and 141 in February of the current year.

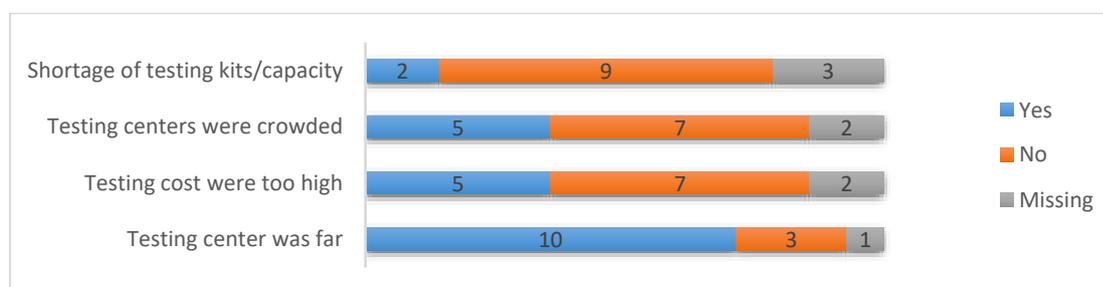
During the initial month of the project observation, 19 percent reported having difficulties during COVID-19 testing, followed by eight percent in November, 17 percent in December, 11 percent in January, and 10 percent in February.

Figure 24: Comparative Reading of Access to COVID-19 Testing



On the nature of these hurdles, of these 14 attendees ten (71 percent) said testing centre was far, five (36) percent thought testing costs were too high, another five (36 percent) stated that testing centres were crowded, while two (14 percent) said that there was shortage of testing capacity/kits in the district.

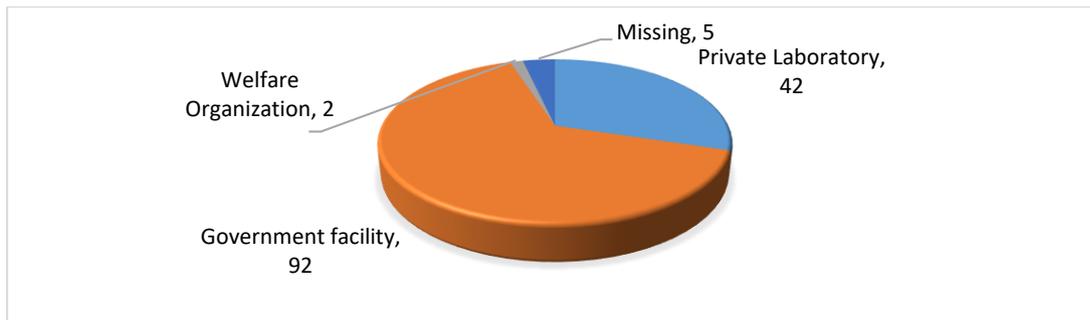
Figure 25: Types of Difficulties Faced During COVID-19 Test



When attendees were asked what facility visited for conducting their test, 92 (65 percent) said government facility, while 42 (30 percent) mentioned percent laboratory, while two said welfare organization.

⁸ <https://ncoc.gov.pk/sitrep.php>

Figure 26: Facilities at which COVID-19 Test was Conducted



The concentration of high number of patients in government facilities is due to the free or subsidized testing services provided by these facilities.

4.2 Testing Cost

In response to a question on the testing cost, 85 (57 percent) said it was free of cost, four (one percent) stated they were charged Rs. 500 to 2000, 13 (eight percent) said Rs. 2000 to 5000, 29 (30 percent) replied it cost them more than Rs. 5000, while ten (four percent) did not provide the figure.

Figure 27: Costs of First Covid-19 Test



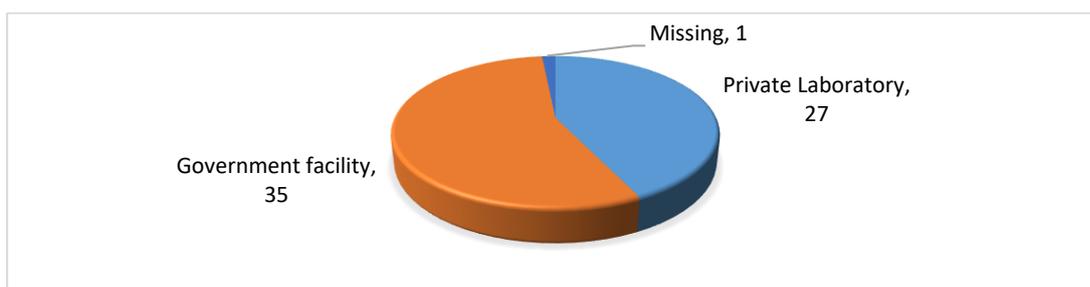
When 141 respondents were asked if they conducted a second COVID-19 test, 63 (45 percent) replied in affirmative, whereas 69 (49 percent) said no.

Figure 28: Second COVID-19 Test



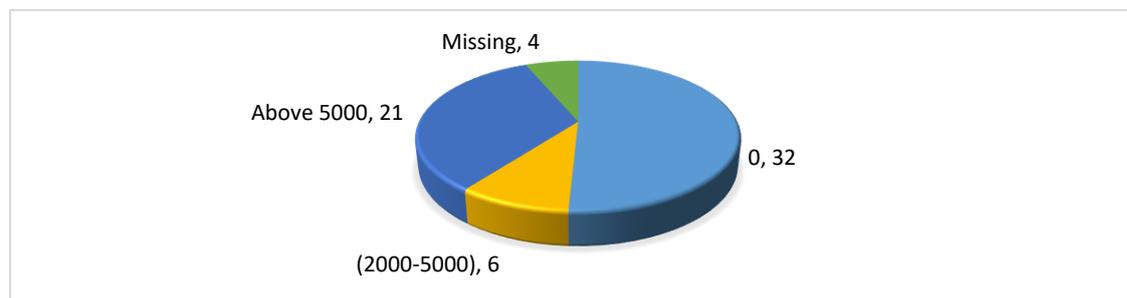
As during the first test, the two most commonly utilized facilities for the second test were government and private facilities, at which respectively 35 (56 percent) and 27 (43 percent) respondents conducted their test.

Figure 29: Facilities at which Second Test was Conducted



Majority, i.e. 32 (51 percent), of the respondents conducting second test in February were not charged any fee, 21 (33 percent) were charged more than Rs. 5,000, while six (10 percent) were charged between Rs. 2,000 and 5,000.

Figure 30: Consolidated Reading of Cost of Second COVID-19 Test



Analysis of testing data shows that these variations in the testing cost reflect the differences in amounts charged by public facilities and private laboratories. It was noted, based on the data for February, that private testing facilities on average charged patients more than Rs. 5,500 per test, but mostly they were charged below Rs. 7,000, and, in a few cases, even as high as between Rs. 8,000 to 9,000 per test. This is in stark contrast to the situation in government hospitals which, as per the respondents' data, have been providing subsidized or free testing services.

Since private laboratories are providing 50 percent of overall testing capacity,⁹ patients have been reporting very high costs as one of the problems faced by them during COVID-19 testing. As verified by other observers, a reliable COVID-19 testing in Pakistan costs patients more than Rs. 6,000,¹⁰ which is unaffordable for people from weak socio-economic background. This brings to light loopholes in the regulation of private testing facilities which are charging patients arbitrary costs.

It bears mentioning here that in countries such as India state authorities have imposed varying price caps on COVID-19 tests conducted by private facilities. Following the central government's move in December, 2020, to slash COVID-19 testing prices charged by private facilities, a number of other states followed suit and reduced maximum testing costs to less than INR 1,000 (PKR 2,160) for both RT-PCR and Rapid Anti-Gen Tests. For example, the Odisha and Uttar Pradesh governments capped the prices of RT-PCR test at INR 400 and 600 (PKR 864 and 1,296), respectively.¹¹

Given that early, efficient and affordable cheaper and rapid testing is one of the crucial strategies in containing the pandemic, the government needs to further take further steps – such as introducing regulations – to reduce the cost of testing while also ensuring availability of tests that yield quick results. Forging effective public-private partnerships – as Sindh did¹² – can be considered as one of the options to ensure greater, efficient and equitable access to testing and other services.

5. RELIEF PROGRAMS: ACCESS AND EFFICACY

During the initial phase of the pandemic the federal government had unveiled Rs.1.2 trillion relief package to mitigate the socio-economic impacts of COVID-19. This included Rs. 150 billion cash transfers to poor families through Ehsaas/BISP program, Rs. 200 billion assistance for workers laid-off in the formal industrial sector, Rs. 50 billion for medical staff, along with supplementary grant of Rs. 100 billion for the Residual-Emergency Relief Fund.¹³

Additional provincial relief packages of varying sizes were announced by Punjab (Rs. 10 billion),¹⁴ I I Sindh (Rs. 34 billion),¹⁵ 12 Khyber Pakhtunkhwa – KP (Rs. 32 billion),¹⁶ and Balochistan (Rs. 750 million),¹⁷ with all but Sindh

⁹ <https://www.dawn.com/news/1597881>

¹⁰ <https://www.thenews.com.pk/print/770226->

¹¹ For state-wise breakdown, see <https://www.timesnownews.com/india/article/covid-19-how-much-does-rt-pcr-test-cost-find-state-wise-price-here/686056>

¹² <https://www.dawn.com/news/1597881>

¹³ <https://www.thenews.com.pk/print/637287-ecc-approves-rs-1-2tr-relief-package>

¹⁴ <https://www.dawn.com/news/1544624/punjab-unveils-rs-10bn-relief-package-for-daily-wage-earners>

¹⁵ <https://www.dawn.com/news/1567822>

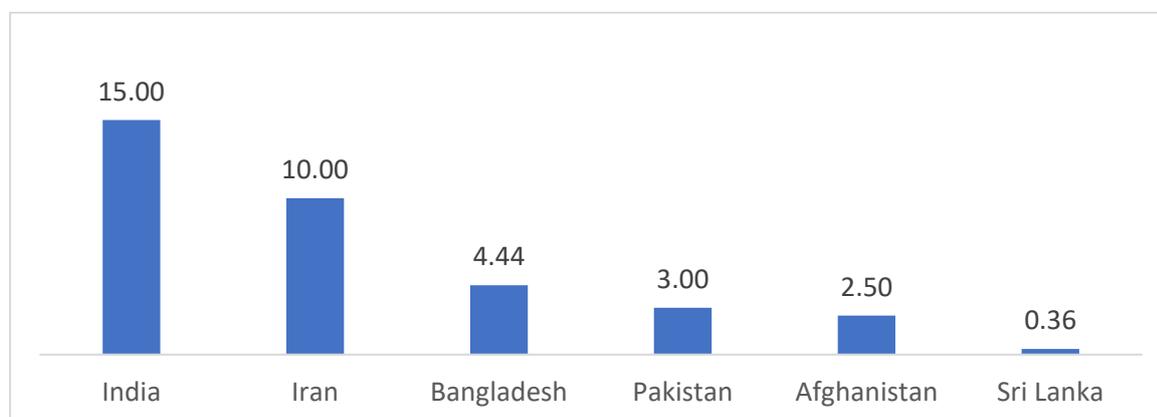
¹⁶ <https://www.dawn.com/news/1544619/kp-chief-minister-announces-rs32bn-package>

¹⁷ <https://tribune.com.pk/story/2191097/1-balochistan-govt-approves-relief-package-daily-wagers>

transferring varying chunks of the earmarked funds to federal government for provision of cash assistance through Ehsaas/BISP/Kafalat program.

To provide financial relief and award compensation to frontline healthcare providers, different Shuhada Packages were also set aside by federal and provincial governments. So while KP government decided to award Rs. 7 million amongst other incentives to each deceased healthcare provider,¹⁸ the federal government announced monetary compensation of Rs. 3-10 million alongside other benefits and privileges included in the Shuhada Package.¹⁹

Figure 31: Fiscal Stimulus Packages for Regional Countries as Percentage of GDP²⁰



Caution needs to be exercised in comparing fiscal stimulus packages across countries, as relief packages of some countries – e.g. India – comprise mostly of loans/guarantees and other liquidity measures,²¹ with relatively less composition of cash-transfers or other direct relief measures for health care workers.

Pakistan’s stimulus package, considered from the standpoint of expenditure on direct social assistance, has been touted as the largest in South Asia (in terms of extending direct relief to vulnerable people and healthcare workers).²²

Other regional countries such as India and Bangladesh have announced multiple relief packages at different stages of the COVID-19,²³ something which has not been seen in Pakistan, given that that here only one major stimulus package was set aside, and even that, as will be shown later, does not remain fully utilized.

For measuring access and efficacy of these programs, the government officials were asked if their respective districts were covered in Ehsaas/BISP COVID-19 relief program.

To that end, a varying number districts were monitored each month since the project began last year: 19 in October, 32 in November, 32 in December, 29 in January, and the same number, in February of the ongoing year.

Of the 29 district officials interviewed in February, 22 (76 percent) answered in affirmative when asked if their respective districts were covered under Ehsaas/BISP relief programs.

Comparative analysis of the percentage of district officials claiming beneficiaries were identified for Ehsaas/BISP, was done across months monitored.²⁴ With 57 percent in the initial month, it increases to 46 percent in December, falls by eight points in January. Lastly, in February, 41 percent district officials said that they were identifying new beneficiaries.

¹⁸<https://www.dawn.com/news/1572511/govt-to-award-shuhada-package-to-fallen-health-workers>

¹⁹<https://www.thenews.com.pk/print/672124-7-point-package-for-frontline-health-workers-announced>

²⁰ For Afghanistan, Sri Lanka and Iran, see <https://www.imf.org/en/Topics/imf-and-covid19/Policy-Responses-to-COVID-19>; for Bangladesh, <https://www.thedailystar.net/opinion/macro-mirror/news/how-effective-have-stimulus-packages-been-2018197>; for India, <https://indianexpress.com/article/explained/atmanirbhar-bharat-fiscal-stimulus-sitharaman-budget-7049911/>; for Pakistan, <https://thewire.in/political-economy/covid-19-in-south-asia-india-lags-behind-pak-on-stimulus-lanka-on-overall-performance>

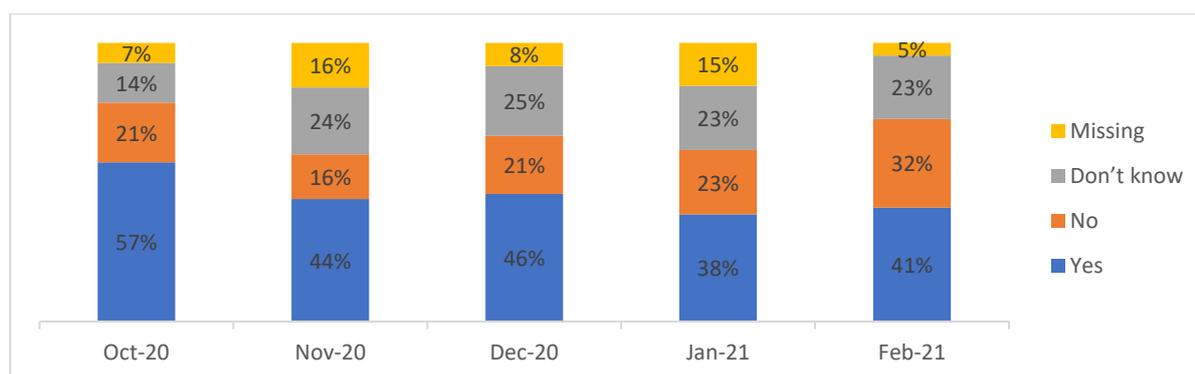
²¹<https://www.unescap.org/resources/policy-responses-covid-19-combating-covid-19-asia-and-pacific-measures-lessons-and-way>

²²<https://thewire.in/political-economy/covid-19-in-south-asia-india-lags-behind-pak-on-stimulus-lanka-on-overall-performance>; see also, http://ipcig.org/publication/30008?language_content_entity=en

²³<https://indianexpress.com/article/explained/atmanirbhar-bharat-fiscal-stimulus-sitharaman-budget-7049911/>

²⁴ Percentage calculated for those who answered in affirmative that districts were covered under Ehsaas/BISP relief programs: 14 in October, 25 in November, 24 in December, 26 in January, and 22 in February.

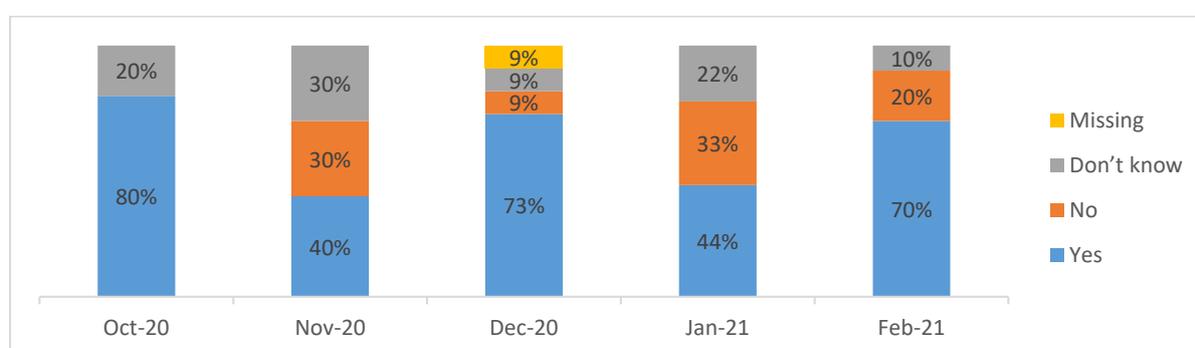
Figure 32: Comparative Reading of Beneficiaries Identification for Ehsaas/BISP Relief programs



Furthermore, of these officials ten (34 percent) also affirmed that provincial relief programs were implemented in their respective districts.

Comparative analysis across months shows sharp ups and downs in the percentage of district officials claiming beneficiaries' identification for provincial relief programs.²⁵ With 80 percent in the initial month, it decreased twice in November and January, and finally went up to 70 percent in February, 2021.

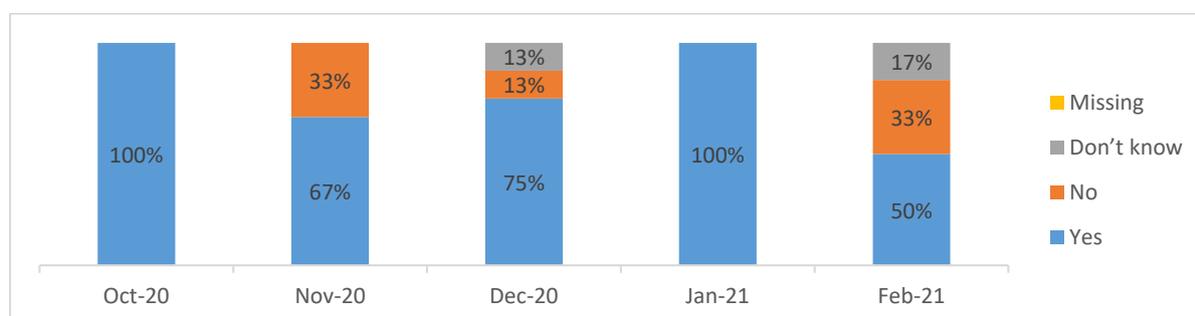
Figure 33: Comparative Reading of Beneficiaries' Identification for Provincial Relief Programs



Only six (21 percent) officials said yes when asked if any district relief programs were being implemented. A significant number of officials, 10 (35 percent), did not give any response or claimed they did not know have knowledge about the district-specific programs.

Comparative analysis was done for the beneficiaries' identification process for those responses which affirmed that there did exist district-specific relief programs.²⁶ The resulting trend is given in the figure below, which shows that all district officials said yes in October. The percentage then decreased to 67 in November, went up by eight points the next month, and in January, 2021 again all officials said yes. On the other hand, for February, only 50 percent said that district-specific relief programs were implemented in their districts.

Figure 34: Comparative Reading of Beneficiaries Identification for District-specific Relief programs



²⁵ Percentage calculated for those who answered in affirmative that provincial relief programs were implemented: 5 in October, 10 in November, 11 in December, 9 in January, and 10 in February.

²⁶ The numbers who said so were 4 in October, 3 in November, 8 in December, 4 in January, and 6 in February.

5.1 Relief for Patients

Health Institution Beneficiary Feedback was gathered from 141 respondents in 28 districts. Only eight (six percent) said they applied for the relief programs, while a whopping 128 (91 percent) said they did not.

Furthermore, only one (13 percent) of these eight respondents got the desired relief package, four (50 percent) of them were denied it, while the status of three (38 percent) was pending.

Health institution beneficiaries were also asked if any welfare/nongovernmental organization provided aid/assistance at any stage during the treatment of their patient, to which 116 (82 percent) replied in negative, while nine (six percent) informed such aid was provided.

When respondents who got relief was further asked to elaborate on the type of assistance provided by these organizations, they gave a mix of responses, mentioning food/ration, subsidized testing, financial aid, PPE/medicine, and free treatment.

5.2 Relief for Healthcare Providers

As both doctors and paramedics were also infected by the virus during duty, these stakeholders were asked to state if there had been any assistance/relief package from the government.

Only four (22 percent) of the 18 doctors who gave responses reported availability of relief packages for the doctors. On the other hand, of the 27 paramedics five (29 percent) claimed receiving assistance from the government.

To what extent have these programs achieved their intended results will need further assessment and evaluation. As of November, 2020, only 12 percent households against the estimated 50 percent affected reported access to these relief programs.²⁷ The status of all components for the Rs. 1.2 trillion package could not be traced due to the limited data available on completion (or lack thereof) and on the progress achieved in each of these components. Recent estimates, however, suggest that Rs. 575 billion of the Rs. 1.2 trillion remain unutilized.²⁸

As mentioned, cash transfers under Ehsaas Program was one of the components of the government's relief package. According to the official data, as of Feb 19, 2020, 179 billion had already been disbursed (this includes cash transfer funds allocated by provinces) to 14.8 million beneficiaries.²⁹ This tallies with the claims of district officials regarding the coverage of their respective districts under Ehsaas programs.

As for relief packages for the workers laid off, DRI's COVID-10 Policy Brief Series for December, 2020,³⁰ reported that only 17 billion against the original allocation of 200 billion had been disbursed; the reason for low disbursement are difficulties and hurdles involved in getting socio-economic data on workers in the informal sectors in urban areas.³¹

There is a need of further transparency and availability of data/information to fully assess these programs. More data and surveys need to be collected on those still out of the relief coverage to have an understanding of the size of population in persistent need for assistance and the requisite budget size for them.

Going by the primary data used in this report, it is needs to be emphasized that more efforts will be needed to extend and implement these relief packages (with the onset of third wave, this could not be emphasized more). As the government officials' responses show, all districts were not covered under federal and/or provincial relief programs. Moreover, not all officials reported identifying new beneficiaries in the districts that were covered under relief programs. This could reflect the fact that government is not disbursing as much funds as were being done in the initial phase of the pandemic.

Special attention need to be paid to the status of separate relief packages for the healthcare staff: as the responses of doctors and paramedics how (73 and 71 percent doctors and paramedics respectively reported non-availability of relief packages) very few received assistance from federal, provincial or district-specific programs. Further data and probing will be needed to identify the reasons for the lack of assistance for healthcare workers. One likely reason is the lack of implementation of Shuhada Packages; for example, in KP Provincial Doctors' Association was voicing concerns over the government's failure in implementation of relief programs for doctors.³²

²⁷ ibid

²⁸<https://www.dawn.com/news/1610608/the-great-covid-dole>; also, <https://tribune.com.pk/story/2280277/66-of-covid-19-relief-package-remains-unutilised>

²⁹ https://www.pass.gov.pk/ecs/uct_all.html

³⁰ https://democracy-reporting.org/wp-content/uploads/2021/01/DRI-brief_Eco-Stimulus-Package_small.pdf

³¹ <https://www.dawn.com/news/1588146/protecting-against-the-second-wave>

³²<https://www.dawn.com/news/1598809/shuhada-package-sought-for-medics-dying-of-covid>

Not much different has been the fate of patient beneficiaries, among whom eight (six percent) applied to relief program over the past five months, and only one of these were extended relief. The same observation was made vis-à-vis welfare programs, for which 116 (82 percent) said they did not get assistance from them.

6. OBSERVATION OF PUBLIC ATTITUDE AND ADHERENCE TO COVID-19 SAFETY GUIDELINES

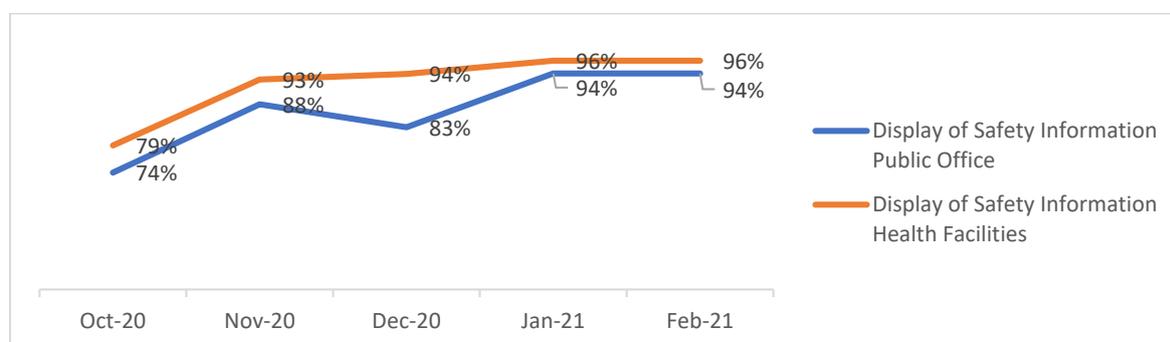
Observation of public offices and health facilities helps to substantiate the findings of survey data.

To substantiate the monitoring observations, 19 public offices were observed in October, 32 in November, 35 in December, 2020, 32 in January and a similar number in February of the current year. On the other hand, 24 health facilities were observed in October, 67 in November, 79 in December, 2020; while 82 health facilities were observed in January 2021, and a similar number, i.e., 82 in February, 2021.

6.1 Display of Safety Information

Display of safety information at health facilities followed an upward trend for the months of October and November, 2020, and became steady onwards. At the start of the observation period, a total of 79 percent observed health facilities were displaying safety information. The percentage rose up to 93 percent in November, 2020 and remained almost uniform from that point onwards. In February 2021, 96 percent of observed health facilities were displaying safety information.

Figure 35: Longitudinal Analysis of Display of Information



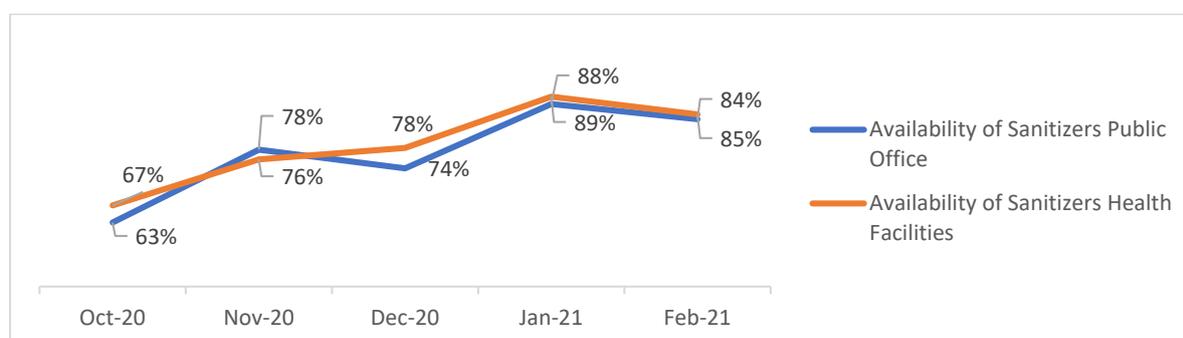
On the other hand, at the offices of EDO/DC/DDMA, the safety information was displayed at 74 percent offices initially and reached a maximum of 94 percent in February, 2021. While, the period from November to December saw a five-point decline (from 88 percent to 83 percent), compliance with this SOP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

6.2 Availability of Sanitizers

Use and availability of hand sanitizers at all public places is the second SOP observed by the TDEA-FAFEN observers at the public offices and health facilities, which both followed more or less same trend over a period of time.

In October 2020, sixty-seven percent the health facilities provided hand sanitizers. The number gradually rose up to its highest 88 percent in January 2021 and dropped down to 84 percent in February 2021. This decline in the provision of hand sanitizers can be due to the lack of budgets allocations with the apparent decline in number of COVID-19 cases, or due to lack of diligence in the management of the health facilities.

Figure 36: Longitudinal Analysis of Availability of Sanitizers

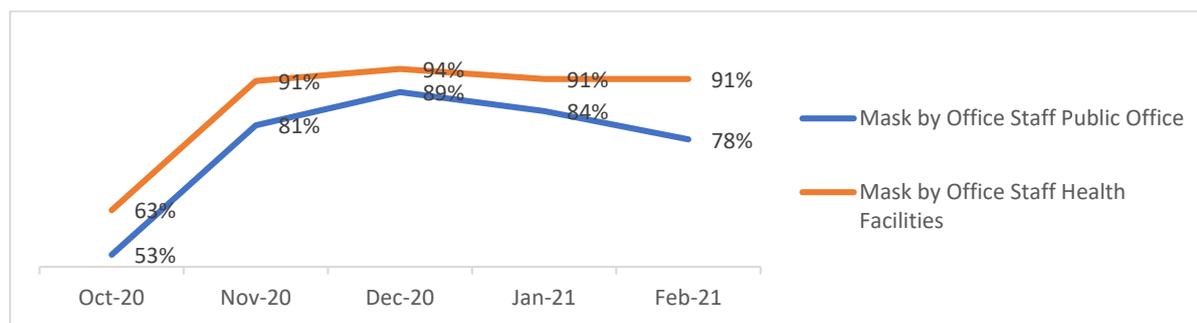


In October, hand sanitizers were available at 63 percent public offices. This number rose up to 89 percent in January 2021, but dropped by an equal four points in February, 2021, reaching 85 percent. This number is still higher than the availability of hand sanitizers at the start of the observation period. However, it is imperative not to equate the availability of hand sanitizers with their usage and it shall be useful to look at the other SOPs before reaching to a conclusion about the implementation of SOPs at public offices and health facilities.

6.3 Mask by Staff

Wearing masks is one of the key, critical SOPs to curtail the spread of deadly COVID-19 virus. At health facilities, in October 2020, only 63 percent of the staff was wearing masks. The number, however, underwent a sharp increase to 91 percent in November 2020, reached its highest with 94 percent of the staff wearing masks at the public health facilities in December 2020, and dropped to 91 percent from that point till the February 2021.

Figure 37: Longitudinal Analysis of Masks by Office Staff

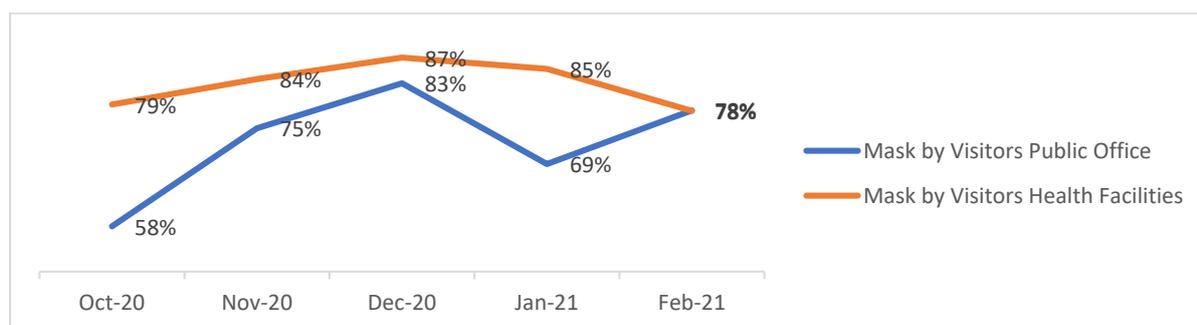


On the other hand, although the graph plotted for the number of staff wearing masks at the public offices overall followed the same trend, the corresponding percentages of them complying with this SOP remained lower than that of staff at health facilities. Only 53 percent of the staff at the public offices wore masks to in October 2020. This number reached its highest of 89 percent in December, from where it started following downward trend and 78 percent of the public offices' staff was reported wearing face masks in February 2021.

6.4 Mask by Visitors

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

Figure 38: Longitudinal Analysis of Masks by Visitors

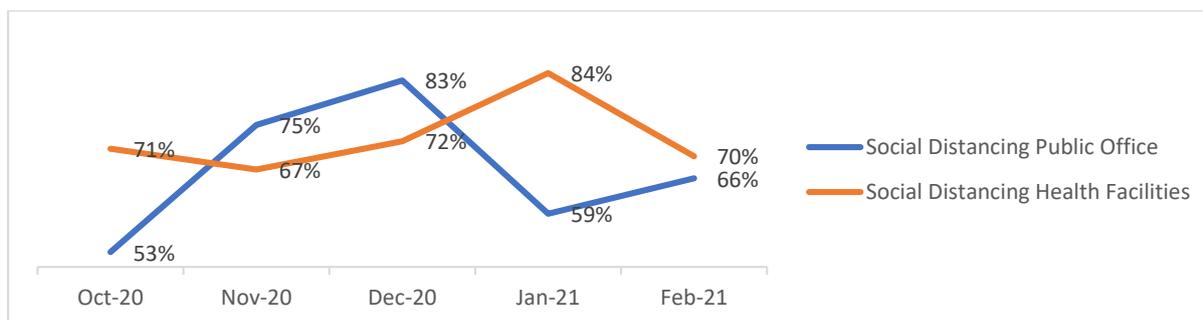


Overall the visitors at public offices were more cautious than those at health facilities. With 79 percent of public office visitors wearing face masks in October, their number kept increasing and they were observed to be exercising the highest level of caution in December (87 percent). However, in February,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

6.5 Social Distancing

Social distancing compliance was observed at 71 percent public offices in October 2020. It followed a decline in November to 67 percent, but increased to 72 and 84 percent respectively in December 2020 and January 2021. In February, there was a sharp decline in social distancing at public offices with only 70 percent such facilities complying with this SOP. This is lower than the initial observation of 71 percent in October, indicating that public's attitude towards this SOP is negligent.

Figure 39: Longitudinal Analysis of Social Distancing

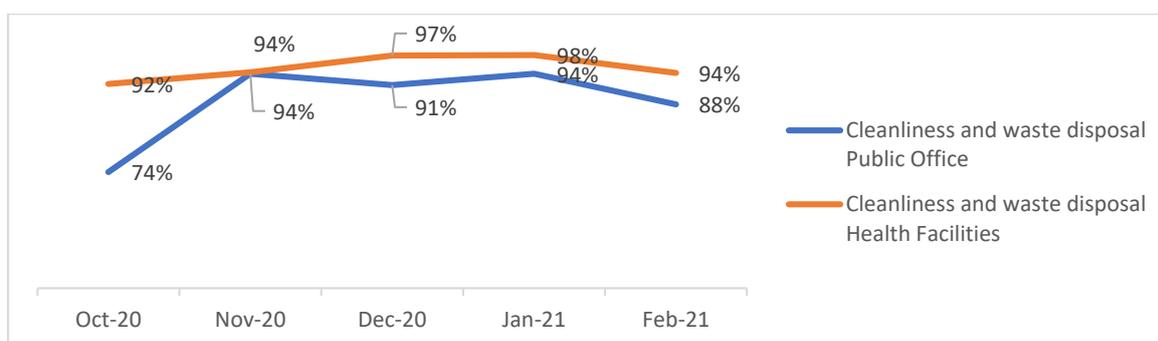


Considering COVID-19 a health emergency, and given the recent spike in new infections, a 66 percent of health facilities reported compliance with social distancing is still a cause for concern, notwithstanding the uptick of 13 percentage points from the last month.

6.6 Cleanliness and waste disposal

Cleanliness and waste disposal at health facilities were observed to be positive since October 2020 when 92 percent offices were following this SOP. The trend went only upward from this point onwards with 98 percent of health facilities complying with this SOP in January 2021. The following month, however, SOP compliance declined to 94 percent.

Figure 40: Longitudinal Analysis of Cleanliness and Waste Disposal



On the other hand, initially 74 percent public offices were following SOPs regarding cleanliness and waste disposal. Following an uptick of 20 points in November 2020, 94 percent offices were observed compliant with this SOP; the same percentage was also witnessed in January, 2021. However, only 88 percent of health facilities followed this SOP in February, 2021.

Vaccination campaign gained momentum throughout the country, starting with frontline healthcare workers and then progressing to those aged 60 and above. Media carried reports of various vaccines that were being authorized by official channels, with four receiving approvals. Furthermore, lockdown restrictions were eased during the last week of February. However, these steps were quickly followed by a rise in infection cases, escalating towards a third wave of COVID-19. Despite these developments, parliamentary oversight continued to be minimal.

Four vaccines have been registered and approved for use in Pakistan:

1. Sinopharm (China)
2. Oxford-AstraZeneca (UK)
3. Sputnik-V (Russia)
4. Cansino Bio (China)

1.1 NATIONAL LEVEL

National media continued to give high importance to COVID-19 statistics and reported number of new patients and deaths on a daily basis. Overall figure of deaths in country crossed the 12,000 mark on February 8. However, this month, news about ongoing vaccination campaign in various parts of the country found more coverage in media than any other issue related to the pandemic.

1.1.1 Vaccination drive

The government-run vaccination drive began in the country in February. On February 1, the first batch of half a million doses of the Chinese Sinopharm vaccine fetched through a special Pakistan Air Force aircraft had been received by Foreign Minister Shah Mehmood Qureshi in the presence of the Chinese Ambassador in Pakistan, Mr Nong Rong, at Nur Khan Air Base in Rawalpindi. Prime Minister Imran Khan inaugurated the vaccination campaign for healthcare workers in Islamabad on February 2 and the drive formally began the next day.

The response from healthcare workers to the vaccination drive, however, was not overly enthusiastic. Joint Executive Director of Islamabad's largest hospital, Pakistan Institute of Medical Sciences (PIMS), Dr Minhaj-us-Siraj, stated that due to the general air of reluctance, especially by nurses, the administration had to issue a circular, warning employees of disciplinary action if they did not get vaccinated.

The Pakistan Medical Association (PMA) blamed the government for the poor response to the vaccine, alleging that those at the helm of affairs had not handled the issue seriously and had not run an effective awareness campaign. The organization also raised concerns about the non-provision of data regarding healthcare workers who had already been vaccinated. Furthermore, it expressed its reservations on the absence of an enforced price cap on private companies that were importing the vaccine independently and could consequently charge hefty prices.

On February 22, the National Accountability Bureau (NAB) office in Lahore initiated a probe into a complaint that a known private laboratory was procuring COVID-19 vaccine from Russia and intending to sell it with an exorbitant profit in the local market. Despite the government's permission to private companies to import COVID-19 vaccines without the imposition of price caps, NAB took action based on Sections 33 C and 27 of the NAB Ordinance which states, "excessive profiteering or loss of public money should be checked."

Also on February 22, Special Assistant to the Prime Minister (SAPM) on Health, Dr Faisal Sultan, received the first dose of the Sinopharm vaccine at PIMS. Dr Sultan said that he received the shot not as a special assistant but in the capacity of a licensed medical practitioner, and urged other healthcare workers to also come forward and get vaccinated, dispelling the myth that senior doctors were avoiding getting vaccinated and that the vaccines had serious side effects. He said the AstraZeneca vaccine would start arriving in the first week of March, and by June there would be 17 million doses. Moreover, he stated that the country had adequate stocks of vaccines and the frontline health workers who were already registered in the system and were below the age of 60 could receive the dose by visiting the nearest vaccination centre, no appointment necessary.

On March 24, Ministry of National Health Services (NHS) was reported to have penned a response to Transparency International Pakistan's (TIP) letter, in which the latter appealed the government to review and annul its decision of allowing private import of vaccine. While pointing out that Pakistan had become one of the first countries to make such decision, TIP had earlier drawn attention to the fact that maximum price-cap imposed by the government on Sputnik-V vaccine was 160 percent higher than the international price. It was also mentioned in the letter that globally inoculation was considered a public good and that allowing private firms to import it would increase likelihood of corruption and pricing concerns. However, in its response, the government held that its decision was a "deliberate policy tool" to include sections of society which were out

of government's inoculation drive. Due to dispute over the price-cap, imported batch of 50,000 Sputnik-V vaccine could not be rolled out.

1.1.2 Myth-busting

The national media also highlighted the confusion about whether people over 60 should get vaccinated. The confusion arose following a statement issued by SAPM on health Dr Faisal Sultan in which he had said that Sinopharm should not be administered to people over 60. However, the very next day, he clarified that he did not mean that the vaccine was hazardous for senior citizens, only that it had not been tested on people over 60, and hence it was decided to administer it only to people who were up to 60 years of age. He added that other vaccines, including Oxford-AstraZeneca, had no such issue.

In addition to this, the national media also reported on the contradictions within the ranks of the government over the level of emergency. On one hand, on February 24, the National Command Operation Centre (NCOC) lifted almost all the restrictions, saying that the number of active cases had started dropping; and on the other hand, government ministers and health experts were issuing warnings about the possibility of a third wave.

For example, on February 25, Federal Minister for Education Shafqat Mahmood announced that the restrictions imposed on schools in some major cities — Karachi, Hyderabad, Lahore and Peshawar — to conduct only three-day classes in a week, had been removed. They were now allowed to hold regular classes. However, health experts termed it a hasty decision, saying that restrictions should only be lifted once 70 percent of the population had been inoculated and herd immunity kicked in. Warnings about a potential rise in infections came from multiple quarters, including the Secretary General of the PMA, Dr Qaisar Sajjad and the Federal Minister for Planning, Development, Special Initiatives, Asad Umar, and an official of the Ministry of National Health Services, Regulation and Coordination (NHSRC).

1.1.3 Infection rates

On February 14, the number of active cases in the country had reduced by half in two and a half months, from about 50,000 in December 2020 to 25,635. But then the tide started turning. On February 28, it was reported that after a gap of over one month, the capital city recorded over 150 COVID-19 cases, showing an increase in positivity ratio from 1.57 percent to 2.65 percent. Moreover, only 6,599 healthcare workers had been vaccinated in the federal capital to date.

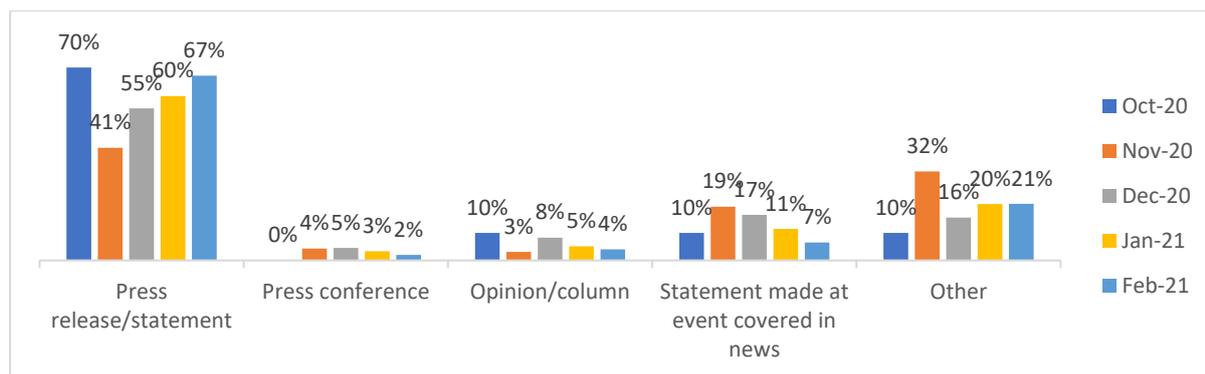
On February 27, the federal government claimed that Pakistan was among 92 countries where the UK strain of COVID-19 had been detected, and urged the people to follow health guidelines and get vaccinated to help achieve herd immunity. On the same day, NCOC data revealed that as many as 8,912,918 COVID-19 tests had been conducted to date since the first case was detected in the country on February 26, 2020, out of which 578,797 had contracted the virus.

1.2 DISTRICT LEVEL

This section presents a comparative analysis of COVID-19-related media pieces in the last five months to see how the focus on the issue and the frames have changed and evolved over time. These include 10 media pieces analysed in October 2020, 257 in November 2020, 399 in December 2020, 332 in January, and 200 in February 2021. These local-level media pieces are analysed on the basis of the nature of media, content, and stakeholders.

Press releases followed a U-shaped curve from October 2020 to February 2021. With 70 percent of the total media pieces being press releases in October 2020, these numbers went down to 41 percent in November 2020 and started increasing afterwards. In February 2021, 67 percent of the total media pieces analysed were press releases focusing on the issue of COVID-19.

Figure 41: Types of Media Pieces Analysed



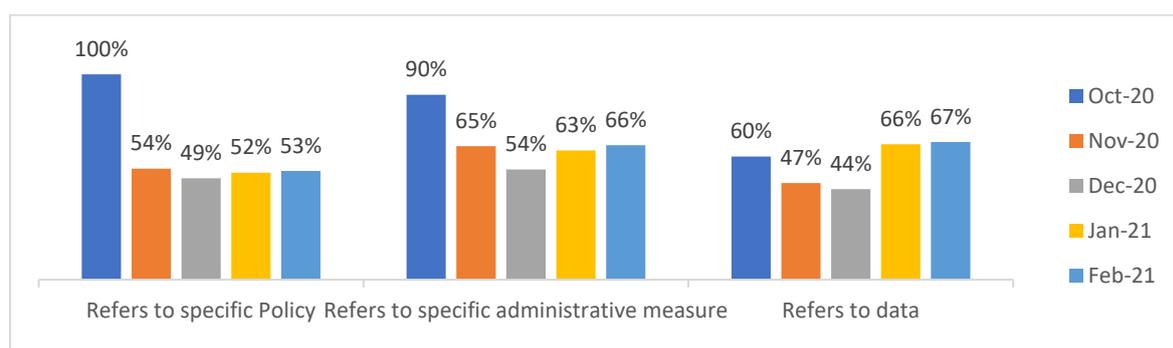
Reports of press conferences, on the other hand, followed a bell-curve. With no press conferences on the issue in the first month of media monitoring, there was a gradual increase with four percent of media monitored in November 2020 being press conferences. This number rose to its highest five percent in December 2020 and went downwards from there, reaching two percent in February 2021.

Journalists offered their opinions in the form of columns most frequently in October 2020, wherein ten percent of the total media monitored at the local level consisted of opinion columns. The second highest percentage for this type of media was observed in December 2020, with eight percent being the share opinion columns in the total set of media pieces monitored. However, this percentage declined to five percent in January 2021, and to four percent in February 2021.

Statements made at events covered in the news also followed a bell-curve over a period of five months. In October 2020, statements made at events constituted ten percent of the total media pieces analysed. This type of media was highest reported – 19 percent – in November 2020. The trend started to decline from December 2020 to 17 percent and decreased further by ten points in February 2021, when only seven percent of the all media pieces analysed comprised of statements made at events.

In terms of content, reference to policy dominated the media in October 2020, with all 100 percent of the media pieces mentioning policy matters related to COVID-19. However, as months went by, it reduced to 54 percent in November 2020 and to 49 percent in December 2020. From January 2021, the trend started showing a slight increase with 53 percent of the media pieces referring to policy, and undergoing a limited increase of one percent, it reached 54 percent in February 2021.

Figure 42: Longitudinal Analysis of Nature of Media



References to administrative measures have been following a U-shaped curve in the last five months. Starting with 90 percent of the media pieces referring to the administrative measures in October 2020, this changed to 54 percent in December 2020. In January 2021, 63 percent media pieces referred to administrative measures at the district level and in February 2021, it was 66 percent.

However, a deeper look into the local media shows that these media pieces are largely skewed towards discussion on COVID-19 vaccines, showing that the interest of local-level media has shifted from issues like SOP implementation and lockdown to the upcoming COVID-19 vaccination drive.

The use of data and evidence-based reporting has followed an overall promising trend. Beginning from October, 2020, 60 percent of media pieces referred to data, but the number declined to 44 percent in December 2020. Finally, it increased to 66 percent in January and 67 percent in February, 2021. This was a positive goal which the project may have contributed to through its trainings of district-level journalists on the incorporation of evidence-based data in their reportage to make it more accurate and authoritative.

Analysis in terms of the tone of media shows that the balance between appreciative and critical discussion has been shifting over the past five months. An appreciative tone dominated local media in October 2020 with 60 percent of local media pieces framing their discussion by way of commendation. This percentage hit its lowest in November with only 30 percent of the media. However, as the restrictions of lockdown eased, local-level media started adopting an appreciative tone more frequently, with 47 percent of the media pieces in January 2021, and 55 percent in February 2021 employing complimentary tone in their discussion.

Using the lens of stakeholders focused on in the local media, it was evident that though the general public uncontestedly remained the most important stakeholder group discussed in local media pieces, its proportion varied from 80 percent in October 2020, to a rise to 82 percent in December 2020, and to its lowest in February 2021, i.e., 72 percent. Doctors and paramedics were not covered in any local-level media in October 2020, but they were discussed in 15 percent of local media pieces in November 2020. This percentage dropped to nine percent in December 2020 and started rising gradually to 14 percent in January 2021 and 23 percent in February 2021. Women and transgender persons were discussed in ten percent of local media pieces in October 2020. This number dropped to four percent in November 2020, rose up to five percent in December 2020 and six percent in January 2021. However, media monitoring in February 2021 shows that four percent of media pieces addressed women and transgender community members as their stakeholders.

Table 1 Longitudinal Analysis of Stakeholder Group Focused

Stakeholder Group	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
General Public	80%	73%	82%	76%	72%
Doctors and Medical professionals	0%	15%	9%	14%	23%
Teachers	0%	6%	6%	7%	6%
Labourers	0%	4%	3%	5%	5%
Minorities	0%	3%	2%	3%	1%
Sects	0%	4%	3%	3%	0%
Ethnic communities	0%	7%	4%	3%	0%
Women/transgender persons	10%	4%	5%	6%	4%

2. COVID-19 RESPONSE: LEGISLATIVE OVERSIGHT

There continued to be very little parliamentary oversight of pandemic-related activities in the reporting month. The National Assembly (NA) held eight sittings and the Senate met for three days but the members did not debate on the issue of the pandemic. Instead, the proceedings were dominated by other political issues, particularly the upcoming Senate elections in March. The parliament did not provide any input regarding the government's measures to deal with the pandemic and procuring the vaccines. However, some of the members asked written questions during the NA session which were adequately responded to by the concerned minister.

On February 4, the issue of the procurement of the vaccines came under the scrutiny of National Assembly's Public Accounts Committee (PAC) in its meeting, but no major decisions were taken. Auditor General Javed Jahangir briefed the PAC members on audit reports for the first phase of COVID-19 spending up to June 30, 2020.

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

On February 22, during Question Hour in the National Assembly (NA), five Members of National Assembly (MNA) asked various questions regarding the COVID-19 situation and the government's vaccination policy:

1. To a query by MNA James Iqbal, the Minister for NHSRC replied that the coronavirus vaccine was not being manufactured in the country.
2. To queries by MNA Abdul Qadir Patel, the Minister for NHSRC provided a detailed response regarding the agreement with China to conduct phase-III clinical trials on humans in Pakistan, jointly by the National Institute of Health (NHS) and CanSinoBio, after successful clinical trials (on animals) and clinical phase-I and II trials (on humans) in China. These trials were successfully conducted in five accredited research centres, Shifa International Hospital (Islamabad), Indus Hospital (Karachi), Aga Khan University Hospital (Karachi), Shaukat Khanum Memorial Cancer Hospital and Research Centre and University of Health Sciences (Lahore), with positive results. China will initially provide half a million doses of the vaccine on a priority basis followed by bulk supply. Other companies have also been contacted for vaccine availability including Sinopharm, CanSinoBio, AstraZeneca, Sputnik, J&J and Pfizer. From the COVAX facility grant, the government has applied for vaccines for 45 million of the population free of cost. Negotiations with the companies are under process for quantity and price.
3. To a similar query by MNA Naz Baloch, the NA was provided the details of a clinical phase-III trial of a coronavirus vaccine.
4. To a query by MNA Muhammad Riaz, the Minister for NHSRC gave an outline of the nationwide trends in COVID-19 infection since July 2020. According to him, a decrease in the number of cases and deaths had recently been observed, with a steady decrease in cases and a fluctuating decline in deaths as of February 16.

3. GOVERNMENT STRATEGY AND IMPLEMENTATION

3.1 NATIONAL COMMAND AND OPERATION CENTRE (NCOC)

During the reporting month, the NCOC oversaw the administration of the vaccination campaign. On February 10, it took an overview of the various operational and administrative issues needing prompt action with regard to the vaccination of healthcare workers. Violations in its well-defined procedure were noted and the agency asked the provinces to ensure compliance with the agreed guidelines.

By February 17, only 52,768 healthcare workers had been vaccinated across the country in two weeks, so the NCOC asked all frontline healthcare workers to register themselves for vaccination in their respective areas and centres. On February 20, it announced that general healthcare workers could register themselves on www.covid.gov.pk/vaccine, and generated awareness and mobilization through the release of a video showing vaccinated healthcare workers encouraging others to get vaccinated also.

The NCOC also announced the launch of vaccination for people aged 60 and above, and requested them to register for the same. The SAPM on Health, Dr Faisal Sultan, tweeting about the arrival of the Oxford-AstraZeneca vaccine in early March, requested senior citizens to register for the vaccine. According to NCOC data, Pakistan will receive 5.6 million doses by the end of March, with 2.8 million doses of Gavi/Covax expected in the first week and another 2.8 million doses by the second week. In all, 17.1 million doses will reach Pakistan by the end of June.

On February 24, the NCOC relaxed a number of restrictions. It:

1. Lifted the time limit on commercial activities and removed the condition of 50 percent attendance at workplaces, with immediate effect. Granted permission to hold indoor wedding ceremonies, and opened cinemas and shrines with effect from March 15. However, the decision to allow indoor dining was dependent on the outcome of the review meeting to be held on March 10;
2. Allowed the Election Commission of Pakistan to hold local government and cantonment board elections by the end of May or early June; and
3. Increased the number of spectators attending Pakistan Super League pool cricket matches from 20 percent to 50 percent and permitted full attendance during play-offs with stringent SOPs.

However, the decisions were subject to review in case the infection rate rose again.

3.2 PUBLIC OUTREACH, PANDEMIC AWARENESS AND MEASURES COMMUNICATION

On February 1, Punjab Minister for Health, Dr Yasmin Rashid, declared that frontline workers were the first priority for vaccination, and it would not be administered to the 'VIPs' or any departmental secretary. Police and

journalists would also be administered the vaccine. She made it clear that the vaccine could not be forcibly injected.

On February 6, the Drug Regulatory Authority of Pakistan (DRAP) issued an Emergency Use Authorization (EUA) to Russian COVID-19 vaccine Sputnik V. This meant that both the government and the private sector could procure three vaccines, i.e., British vaccine Oxford AstraZeneca, Chinese vaccine Sinopharm and Russian Sputnik V.

On February 8, the Sindh government announced that it would buy 20 million doses of the COVID-19 vaccine from China. Health Minister, Dr Azra Fazal Pechuho, held a meeting with the Chinese Consul General, Li Bijian, and shared matters related to the purchase of the COVID-19 vaccine, training of healthcare providers, and transfer of health technology.

Also on February 8, DRAP held a training session in collaboration with the World Health Organization on monitoring the possible adverse effects following immunization. This was in keeping with the announcement by the Ministry of NHSRC regarding the establishment of a comprehensive system to monitor the post-immunization impact of the vaccines. DRAP also gave the go-ahead to another Chinese company to hold a clinical trial of its vaccine – ‘ZF2001’ – in Pakistan, through which 9,000 volunteers will be vaccinated through the University of Health Sciences (UHS) and Aga Khan University (AKU). So far, four vaccines – Sinopharm (China), Oxford-AstraZeneca (UK), Sputnik-V (Russia), and Cansino Bio (China) – have been registered, the last of which was authorized by DRAP for emergency use on February 12. Such measures, as per an official of the Ministry of NHSRC, will enable the arrangement of vaccines to cater to the large population and create herd immunity.

Private vaccine options were also announced to be in the pipeline. On February 14, an official of Chughtai Lab stated that they would soon receive Russia’s Sputnik V COVID-19 vaccine for commercial sale, making Pakistan one of the first countries to market shots privately. Chughtai Lab aims to import the other vaccines as well, but Sputnik V was the first to become available. While import costs/prices were not specified, the lab official stated that the price would “appear inflated” compared to what has been reported for Sputnik V globally, given the smaller volume it was planning to sell relative to global procurement. Sputnik V’s developers have said that the two-dose vaccine would be sold at \$10 per dose.

As the Sindh government vaccinated more than 30,000 healthcare providers against COVID-19 across the province, the authorities on February 20 revised the estimated number of total professionals associated with the health and medical fraternity. Earlier, the total strength of healthcare personnel in the province was estimated at 175,000, out of whom the department had identified 54,000 as the frontline force. The fresh estimates included those individuals who were not directly engaged with treating coronavirus patients or working at virus-related centres, but were associated with the health profession in different capacities. Thus, the government planned to inoculate more than 300,000 people. The federal government had allotted 84,000 doses of the Sinopharm vaccine – part of the half a million doses gifted by China – to the Sindh government.

In addition to China, the United Kingdom has also pledged its support for the country’s vaccination campaign. According to a statement issued by the British High Commission, the UK, through the COVID-19 Vaccines Global Access Facility (COVAX)³³, will help supply vaccines for 45 million Pakistanis in 2021.

In the last week of February, the health department started the vaccination of its staff members in different districts of Khyber Pakhtunkhwa. A vaccination campaign in Chitral was inaugurated at a function held at the district headquarters hospital.

4. POLITICS AND POLITICIZATION

There was a considerable decline in the trend of using the COVID-19 issue for political purposes and very few political statements on the issue found space in the national media. Federal Minister for Planning, Development and Special Initiatives, Asad Umar, while addressing a PTI workers’ convention near Shikarpur on February 1, alleged that the Sindh government (PPP) was playing politics with the vaccine issue. He said that PPP leaders were claiming that their government was buying vaccines from its own resources when in fact it was receiving the doses from the federal government.

On the other hand, Sindh government spokesperson, Barrister Murtaza Wahab, accused the PTI of politicizing the purchase of the vaccine in Sindh. He stated that the Chief Minister of Sindh had sought the approval of the Prime Minister to procure the vaccine at the provincial level to expedite the vaccination process. However, he

³³ COVAX is an international initiative to support the discovery, manufacture and fair distribution of COVID-19 vaccines for one billion people by the end of 2021.

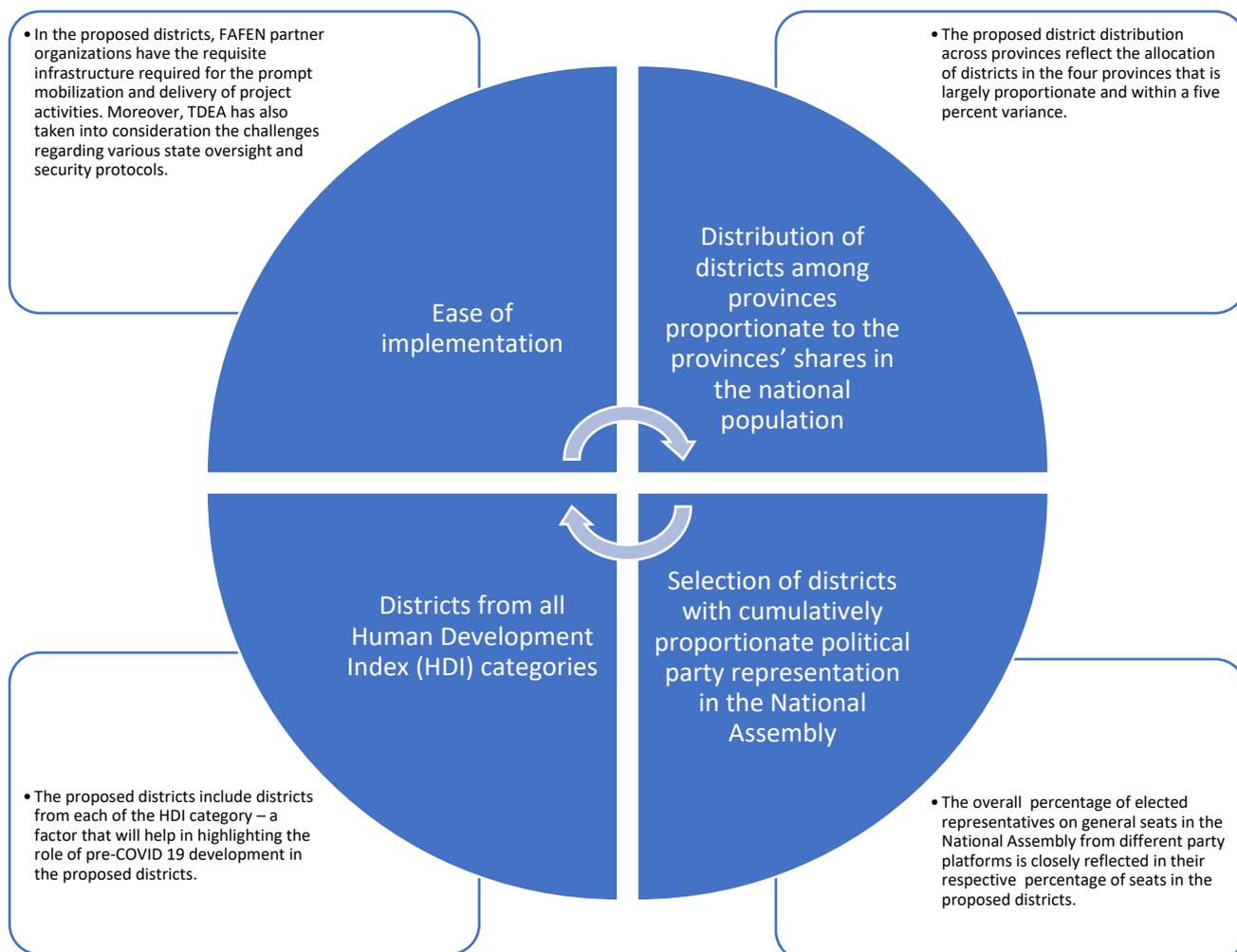
claimed that the federal government had shown reluctance, arguing that the province would not be able to handle it. According to Mr Wahab, the federal government had announced that it had set aside \$150 million for the procurement of the vaccine but had not yet imported a single dose; and all the recent consignments were donated by the respective countries.

Asad Umar, through a Tweet on February 7, alleged that the vaccine was being administered to VIPs in Sindh. He claimed that in the capital city of Islamabad, the vaccine had not even been given to Prime Minister Imran Khan, the federal ministers or their families. Mr Umar said that complaints had been received that people other than healthcare workers were receiving the vaccine shots in Karachi. As a result, representatives of the Sindh government were instructed during the NCOC meeting to vaccinate healthcare workers only. According to media reports, NCOC National Coordinator, Lt Gen Hamooduz Zaman Khan, has been directed to investigate the matter further.

On March 20, Faisal Sultan confirmed that PM Imran Khan had tested positive for COVID-19 and was self-isolating at home. The development came a couple of days after the premier had received his first vaccine dose. A few days later, on March 25, a picture of PM Khan chairing a meeting of his media team was uploaded on social media. The move was followed by widespread criticism from the opposition as well as social media who criticized PM for flouting quarantine SOPs. Later, some PTI officials rejected the criticism and defended the move, stating that the attendees were strictly adhering to SOPs during the meeting.

ANNEXURE I: DISTRICT SELECTION CRITERIA

Trust for Democratic Education and Accountability (TDEA) adopted four-fold criteria to select the 35 project districts – 15 in Punjab, 10 in Sindh, six in Khyber Pakhtunkhwa (KP), three in Balochistan and one in Islamabad Capital Territory (ICT). The selected districts represent the political and demographic diversities in the country.



ANNEXURE II: STAKEHOLDER INTERVIEWS/OBSERVATIONS OF FACILITIES AT DISTRICT LEVEL

Sr. No.	District	Interview with DC -- EDO Health -- Head of DDMA	Interview with Head-Representative of Doctors Association	Interview with Head-Representative of Paramedic Staff Association	Health Institution Monitoring Form	Health Institution Beneficiary Feedback	Interview with Head of CSO -- Welfare organization	Interview with Local Journalist	Political Leaders' Media Statement Monitoring	Overall
1	Abbottabad	0	1	1	1	3	1	1	15	23
2	Bahawalpur	1	1	1	1	2	1	1	8	16
3	Bannu	1	1	1	1	8	1	1	29	43
4	Chakwal	1	1	1	4	8	1	1	4	21
5	Faisalabad	0	1	1	3	8	1	1	1	16
6	Hafizabad	1	1	1	4	0	1	1	0	9
7	Hyderabad	1	1	1	3	6	1	1	0	14
8	Islamabad	1	1	1	3	8	1	1	12	28
9	Jacobabad	1	1	1	1	0	1	1	3	9
10	Karachi Central	1	1	1	4	8	1	1	25	42
11	Karachi East	1	1	1	1	1	1	1	0	7
12	Karachi West	1	1	1	4	9	1	1	33	51
13	Khairpur	1	1	1	2	2	1	1	1	10
14	Khanewal	1	1	1	2	4	1	1	2	13
15	Lahore	Refused	1	1	4	6	1	1	1	15
16	Lasbela	1	1	1	1	1	1	1	5	12
17	Lodhran	1	1	1	4	8	1	4	1	21
18	Loralai	1	1	1	1	0	1	1	0	6
19	Mandi Bahauddin	1	1	1	1	0	1	1	0	6
20	Mardan	1	1	1	3	4	1	0	3	14
21	Mianwali	1	0	1	3	0	1	1	0	7
22	Multan	1	1	1	3	8	1	1	10	26

23	Muzaffargarh	1	1	1	1	2	1	4	1	12
24	Narowal	1	1	1	3	9	1	1	5	22
25	Peshawar	1	1	1	4	8	1	0	4	20
26	Quetta	Refused	1	1	2	2	1	1	14	22
27	Rahim Yar Khan	1	1	1	4	8	1	1	12	29
28	Sanghar	0	1	1	2	0	1	1	0	6
29	Shikarpur	1	1	1	1	0	0	0	0	4
30	Sialkot	1	1	1	4	3	1	1	2	14
31	Sukkur	1	1	1	3	3	1	1	2	13
32	Swat	1	1	1	1	1	1	1	2	9
33	Tank	1	1	1	1	2	1	4	5	16
34	Tharparkar	Refused	1	1	0	5	1	1	0	9
35	Tor Ghar	1	1	1	2	4	1	1	0	11
Overall		32	34	35	82	141	34	41	200	596

Three health facilities refused to give interview.