Punjab Health and Population Survey (PHPS) 2024–25

December 2025

Baseline Survey Report

HEALTH & POPULATION DEPARTMENT

BUREAU OF STATISTICS

POPULATION COUNCIL
Ideas. Evidence. Impact.

POPULATION CENTER PAKISTAN
From Evidence to Action

Punjab Health and Population Survey (PHPS) 2024–25

December 2025

Baseline Survey Report

HEALTH & POPULATION DEPARTMENT

BUREAU OF STATISTICS

POPULATION COUNCIL
Ideas. Evidence. Impact.

POPULATION CENTER PAKISTAN
From Evidence to Action

Punjab Health and Population Survey (PHPS) 2024–25: Baseline Survey Report

Published: December 2025

Suggested Citation:

Bureau of Statistics, Punjab. 2025. *Punjab Health and Population Survey (PHPS) 2024–25: Baseline Survey Report.* Punjab: Bureau of Statistics, Planning and Development Board, Government of the Punjab.

About the Bureau of Statistics Punjab

The Bureau of Statistics (BoS), Punjab, is the provincial hub for statistical data and operates as an attached department of the Planning and Development Department, Government of Punjab. Established in 1957, it has evolved to serve as the central agency for collecting, processing, and disseminating statistical information through surveys, censuses, and institutional sources. Its functions, standardized by the National Statistical Council, include coordinating statistical activities across the province, liaising with the federal statistical system, and producing provincial indicators to support evidence-based planning and policy. Headquartered in Lahore, the BoS maintains divisional and district field offices to ensure comprehensive data coverage across Punjab.

About the Population Council

The Population Council confronts critical health and development issues—from stopping the spread of HIV to improving reproductive health and ensuring that young people lead full and productive lives. Through biomedical, social science, and public health research in 50 countries, we work with our partners to deliver solutions that lead to more effective policies, programs, and technologies that improve lives around the world. Established in 1952 and headquartered in New York, the Council is a non-governmental, nonprofit organization governed by an international board of trustees.

About the Population Center Pakistan

The Population Center Pakistan was established in 2018 to undertake and support initiatives in social sector development. Issues of special interest include population impacts on poverty and inequality in the context of access to maternal and child health, family planning, nutrition, sanitation, and safe drinking water services, especially among poor and marginalized populations.

Table of Contents

List of Tables

List of Figures

Foreword

Health and population welfare are central priorities for the Government of Punjab, as they are essential for improving human development and achieving sustainable growth. In line with our commitment to the Sustainable Development Goals (SDGs), the Government continues to strengthen the health system, ensure universal health coverage, and promote evidence-based planning for equitable service delivery across all districts.

The Punjab Health and Population Survey (PHPS) 2024–25, conducted under the National Health Support Program (NHSP), provides a comprehensive baseline on health, family planning, maternal and child health, communicable and non-communicable diseases, and health service coverage across Punjab. The fieldwork of this extensive survey was successfully executed by the Punjab Bureau of Statistics, Planning and Development Board, Government of the Punjab, which managed household interviews, supervision, and data collection with the support of the Population Center Pakistan (PCP), Population Council, and other national and international partners.

The PHPS 2024–25 holds particular significance as it was designed to generate district-level estimates on key health and population indicators. It highlights progress made in expanding service delivery as well as persistent challenges such as regional disparities in antenatal care, institutional deliveries, immunization coverage, and the adoption of modern family planning methods. The findings will not only serve as a critical input for provincial and district administrations to identify gaps and set priorities but will also provide development partners, academia, and civil society with reliable data to design and evaluate interventions.

The Government of Punjab places great importance on using such high-quality evidence for informed decision-making. By providing a solid baseline, this survey will enable us to track progress over time, evaluate the impact of health and population programs, and ensure accountability in the use of public resources. It will also help in aligning provincial policies with global commitments under the SDGs, while ensuring that the benefits of development reach the most underserved and vulnerable populations.

I am confident that this survey report will serve as an important reference for planning and decision-making, guiding us toward more inclusive and effective health and population policies. It reflects the Government of Punjab's unwavering commitment to ensuring better health and wellbeing for all citizens, and to advancing our shared goal of sustainable development.

(Dr. Naeem Rauf)
Chairman
Planning & Development Board
Government of Punjab

Acknowledgements

The Punjab Health and Population Survey (PHPS) 2024-25 has provided important evidence of the key indicators for the National Health Support Program (NHSP) and the Punjab Family Planning Program (PFPP).

The important provincial survey was successfully conducted as a result of dedicated efforts by the Health & Population Department, the Planning and Development Board and by the Bureau of Statistics, Punjab, with technical support from the Population Council (PC) and Population Centre Pakistan (PCP). The World Bank has played a pivotal role in ensuring effective coordination within the broader NHSP partnership.

I commend the Bureau of Statistics (BoS) Punjab team for completing the district-level survey. I extend my sincere thanks to all the field teams, including interviewers, supervisors, district monitors, and quality control supervisors.

I am grateful to the Gates Foundation for the financial support provided to the Population Council and the Population Centre Pakistan to provide quality assurance based on international standards.

In the end, we must all acknowledge the survey respondents from all the districts of Punjab who generously consented to and spared time for being interviewed. Their combined responses will contribute to enhancing public health services and outcomes in Punjab.

(Nadia Saquib)
Secretary
Health & Population Department
Government of the Punjab

The Punjab Health and Population Survey (PHPS) 2024–25 under the National Health Support Program (NHSP) has been accomplished through the joint efforts of the Health Department, Planning and Development Department, and Population Welfare Department, with dedicated technical support from the Population Council (PC) and Population Center Pakistan (PCP). The World Bank provided valuable facilitation and coordination within the broader NHSP framework, while the Pakistan Bureau of Statistics (PBS) shared the survey sample and the Bureau of Statistics Punjab (BoSP) successfully carried out the field operations across all 36 districts of Punjab.

I want to express my sincere gratitude to the Chairman, Planning and Development Board, for his leadership and guidance. I am also thankful to the Secretary, Planning and Development Board, for his continued support, and to the Chief Economist for his technical direction, which ensured that the survey was completed in line with the province's planning and policy objectives.

The Bureau of Statistics Punjab was responsible for household interviews, supervision, and data management. These tasks were conducted with diligence and supported by modern data collection tools and strong monitoring systems to ensure accuracy and reliability.

I especially acknowledge the valuable contributions of Ms. Saira Abid, Deputy Director, along with Assistant Directors Mr. Muhammad Farooq, Mr. Muhammad Ameen, Ms. Aqsa Shoukat, Mr. Isaac Shahzad, Mr. Aftab Ahmad, and Ms. Humera Qasim. Their dedication and hard work were central to the success of this survey.

On behalf of the Bureau of Statistics Punjab, I extend my appreciation to all institutions, partners, and colleagues whose cooperation made this survey possible. The PHPS 2024–25 will serve as a valuable source of evidence for shaping health and population policies and will strengthen data-based decision-making for the development of Punjab.

(Muhammad Ali Ammer)
Director General
Bureau of Statistics
Government of Punjab

Acronyms and Abbreviations

AAPGR	Average Annual Population Growth Rate
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BISP	Benazir Income Support Programme
BoS	Bureau of Statistics
BoSP	Bureau of Statistics, Punjab
CAPI	Computer-Assisted Personal Interviewing
CD	Communicable Disease
CMW	Community Midwife
CNIC	Computerized National Identity Card
CPR	Contraceptive Prevalence Rate
CSPro	Census and Survey Processing System (Software)
DLI	Disbursement-Linked Indicator
EPI	Expanded Programme on Immunization
FIC	Full Immunization Coverage
FWW	Family Welfare Worker
HH	Household
HPS	Health and Population Survey
IUD	Intrauterine Device
KMC	Kangaroo Mother Care
LHV	Lady Health Visitor
LHW	Lady Health Worker
mCPR	Modern Contraceptive Prevalence Rate
MoNHSR&C	Ministry of National Health Services, Regulations, and Coordination
MRV	Multiple Response Variable
NADRA	National Database and Registration Authority
NCD	Non-Communicable Disease
NHSP	National Health Support Program
ORS	Oral Rehydration Salts (Or Solution)
PBS	Pakistan Bureau of Statistics

PC	Population Council
PCP	Population Center Pakistan
PDO	Project Development Objective
PHC	Primary Healthcare
PHPS	Punjab Health and Population Survey
PFPP	Punjab Family Planning Program
PPFP	Postpartum Family Planning
PNC	Postnatal Care
PSU	Primary Sampling Unit
PWD	Population Welfare Department
RMNCH	Reproductive, Maternal, Newborn and Child Health
SBA	Skilled Birth Attendant
SPSS	Statistical Package for Social Sciences
SSU	Secondary Sampling Unit
TB	Tuberculosis
TFR	Total Fertility Rate
UHC	Universal Health Coverage
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

1

Introduction

National Health Support Program

The National Health Support Program (NHSP) is a nationwide initiative designed to support the Federal Ministry of National Health Services Regulations, and Coordination (MoNHSR&C), as well as the provinces of Punjab, Khyber Pakhtunkhwa, and Sindh. Although the Government of Pakistan's broader health program covers both primary and secondary care services, the NHSP focuses specifically on primary healthcare (PHC) within these three provinces. The essential package of PHC services emphasizes interventions and services related to reproductive, maternal, newborn, and child health and nutrition, as well as infectious and non-communicable diseases, health education, and communication.

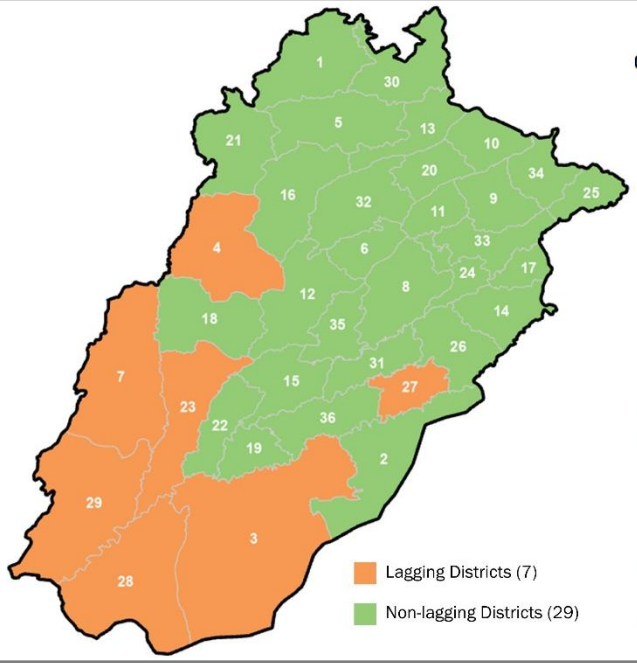
The NHSP aims to strengthen PHC reforms by addressing systemic weaknesses and barriers that hinder the effective delivery of these essential services. In the Pakistani context, this includes services provided at rural health centers, basic health units, and within communities. While provincial governments are primarily responsible for implementing the NHSP, the World Bank's support strengthens the MoNHSR&C's capacity for coordination, research, and reporting to advance progress toward universal health coverage (UHC).

A core element of the NHSP is a commitment to promoting both geographical and gender equity. Reducing disparities in access to quality health services is a fundamental principle of UHC, and the goal is to ensure that disadvantaged populations—such as marginalized ethnic groups, women, different age groups, and households facing geographic or financial barriers—benefit equally from essential health services. To embed this principle, equity is integrated directly into the program's disbursement-linked indicators (DLIs).

For each province, the NHSP employs an innovative approach to identifying underserved areas by analyzing district-level service coverage and access indicators, such as the UHC Service Coverage Index or the proportion of "zero-dose children"—those who have not received a single dose of the diphtheria, pertussis, and tetanus-containing vaccine. Districts are ranked based on these metrics, with those falling behind designated as "lagging districts" (Figure 1.1). In the case of Punjab Province, the bottom seven districts are characterized as lagging based on their UHC Service Coverage Index value reported in the MNHSRC Monitoring Report 2021.

Financing under the NHSP is based on performance measured against DLIs through household surveys, health facility assessments, and routine monitoring by provincial health departments. The program requires that at least 20% of the results for each relevant DLI be achieved in lagging districts. The NHSP is structured around a results framework (Table 1.1) that outlines progress through a Project Development Objective (PDO), four PDO-level result indicators, three result areas, and 11 DLIs.

Figure 1.1: Punjab's lagging and non-lagging districts



Code	District	Code	District
1	Attock	19	Lodhran
2	Bahawalnagar	20	Mandi Bahauddin
3	Bahawalpur	21	Mianwali
4	Bhakkar	22	Multan
5	Chakwal	23	Muzaffargarh
6	Chiniot	24	Nankana Sahib
7	Dera Ghazi Khan	25	Narowal
8	Faisalabad	26	Okara
9	Gujranwala	27	Pakpattan
10	Gujrat	28	Rahim Yar Khan
11	Hafizabad	29	Rajanpur
12	Jhang	30	Rawalpindi
13	Jhelum	31	Sahiwal
14	Kasur	32	Sargodha
15	Khanewal	33	Sheikhupura
16	Khushab	34	Sialkot
17	Lahore	35	Toba Tek Singh
18	Leiah	36	Vehari

Punjab Family Planning Program

The Punjab Family Planning Program (PFPP) is a World Bank-funded program that supports the Government of Punjab's efforts to improve family planning (FP) Indicators in the province. While the NHSP focuses on the delivery of essential health services, the PFPP is geared exclusively toward addressing key challenges and barriers to increasing service delivery, enhancing demand, and—most importantly—prioritizing FP as a development agenda for Punjab. The program addresses both supply- and demand-side barriers to the adoption and continuation of use of contraceptive methods.

The core element of this program is advocating FP through the promotion of girls' education, social equity, and the delivery of high-quality FP services by adopting rights-based approaches. This includes addressing regional variations in modern contraceptive use across Punjab, poor-quality training, and inadequate service delivery.

The Project Development Objective (PDO) is to increase the utilization of effective and high-quality FP services in Punjab. The issue of unreliable and inconsistent supplies of FP commodities will be addressed through warehouse expansion, strengthening the management information system (MIS), and provision of adequate program funding. The insufficient community-level coverage of FP services in areas without Lady Health Workers (LHWs) or family welfare workers will also be addressed, and the provision of a method-mix will be ensured so that clients receive their method of choice with full information during counselling.

The program will also extend FP services by introducing postpartum FP at secondary and tertiary levels. Services will be expanded through outreach programs and by leveraging the potential of the private sector, particularly the social marketing sector.

Table 1.1: Structured results framework for NHSP and PFPP

National Health Support Program (NHSP)	Punjab Family Planning Program (PFPP)
Project Development Objective (PDO): Strengthening equitable delivery and quality of essential health services at the PHC level in support of UHC **PDO-level indicators** 1. UHC Service Coverage Index (adjusted to cover the essential health package at the PHC level) (%) 2. Use of modern contraceptives among married women of reproductive age (%) 3. Non-salary PHC budget (%) 4. Effective antenatal care (ANC) coverage (%) **Result areas** 1. Improving the coverage and quality of essential health services 2. Enhancing governance and accountability 3. Improving health financing/public financial management **Disbursement-linked Indicators (DLIs)** 1. PHC facilities meeting essential health service delivery norms, including those in lagging districts and addressing climate risks. 2. PHC providers delivering essential quality health services, including those in lagging districts. 3. Timely and appropriate referrals between the PHC level and higher levels of care, including those in lagging districts. 4. TB case notification rate 5. Average provincial coverage of Penta-1 and coverage of fully immunized children in zero-dose districts 6. Health information systems strengthened through greater integration and the use of dashboards, including those in lagging districts. 7. PHC facilities reporting reductions in stock-outs of select family planning and nutrition commodities and essential drugs/medicines, including those in lagging districts. 8. Improved budgeting and budget flow practices 9. Domestic resource mobilization for PHC 10. Punjab DGHS strengthened to monitor and manage performance of PHC providers and facilities for integrated service delivery. 11. Increased community engagement in LHW-uncovered areas in Punjab, including in lagging areas	**Project Development Objective (PDO):** Increase utilization of effective quality family planning services in Punjab **PDO-level indicators** 1. P&SHD facilities & PWD facilities have availability of the required mix of contraceptives (%) 2. Improved mCPR, disaggregated by wealth quintiles, education, and rural–urban (%) 3. Family planning users have been counselled appropriately (%) **Result areas** 1. Improved availability of family planning services and commodities 2. Increased demand for family planning commodities 3. Advocacy and leadership **Disbursement-linked Indicators (DLIs)** 1. Family planning commodities procurement and management strengthened and integrated within the province's management information system. 2. Improvement in the use of modern contraceptives and quality of care 3. Increased use of social marketing and private sector 4. Improved demand for family planning services 5. Improved advocacy and leadership

Punjab Health and Population Survey

The Punjab Health and Population Survey (PHPS) 2024–25 was initiated as part of the NHSP to collect data for assessing healthcare coverage and levels, providing a foundation for design changes, and ultimately measuring impact through an end-line survey at the project's conclusion. This report additionally fulfills the data needs of the Punjab Family Planning Program (PFPP). For this reason, two chapters are dedicated to the topic of family planning. The report presents baseline results to meet the needs for robust data in Punjab.

The PHPS is a population-based household survey designed to generate reliable data on key health, demographic, and population indicators across districts using representative samples. It collects information from households and individuals—particularly women of reproductive age and children under five—on various topics, focusing primarily on the NHSP and PFPP indicator frameworks as well as other priorities identified by provincial stakeholders. The PHPS aims to measure changes in these key indicators, alongside variables capturing women's empowerment, equity, and background characteristics influencing health-seeking behavior.

Organization of the Report

CHAPTER 1 introduces the household survey, detailing its background, objectives, provincial profile, and roles and responsibilities of collaborating institutions. It also covers sample design, sampling, tools, training, and data quality measures.

CHAPTER 2 describes household characteristics such as ownership, floor materials, cooking fuel, main sources of income, school attendance by sex for children aged 5–9 years, household vulnerability to disasters and hardship in the past 24 months, coverage by social protection programs, and access to improved water, sanitation, and hygiene.

CHAPTER 3 focuses on ever-married women's characteristics, including media exposure, access to and use of mobile phones, and women's empowerment, with components of decision-making, earnings, unconditional cash transfers, insurance, and mobility.

CHAPTER 4 discusses maternal healthcare indicators, including antenatal care, delivery, and post-natal care, focusing on the number of visits, sources of services sought, content of visits, quality of care, costs, and postpartum FP.

CHAPTER 5 examines fertility and fertility preferences, covering pregnancy and pregnancy outcomes, fertility rates, desired number of children, desired additional children, and ideal family size.

CHAPTER 6 analyzes the use of contraceptive methods (modern or traditional) by type and sector (public or private), contraceptive prevalence rates, main reasons for method choice, satisfaction with method use, quality of visits, associated costs, and reasons for non-use, and unmet need for FP and modern methods.

CHAPTER 7 extends analysis on postpartum counselling and timing of FP method adoption, quality of general FP counselling, the role of primary and secondary healthcare departments, and FP use among BISP beneficiaries.

CHAPTER 8 emphasizes infant and child health, focusing on breastfeeding practices for newborns, prevalence of diarrhea, and acute respiratory infections.

CHAPTER 9 discusses child immunization through various vaccinations, considering factors such as age group, gender, mother's education, Urban/ rural residence, healthcare provider, verification of immunization cards, and child nutrition.

CHAPTER 10 addresses the self-reported prevalence and treatment of communicable and non-communicable diseases, including tuberculosis, malaria, hypertension, and diabetes, by gender and treatment location.

CHAPTER 11 reviews treatment sought by household members for general ailments, particularly whether the last facility visited was public or private. It also presents travel time to facilities, mode of transportation, and costs (when applicable) by service type.

CHAPTER 12 presents the Service Coverage Index, comprising three components: 1) reproductive, maternal, newborn, and child health; 2) infectious diseases; and 3) non-communicable diseases—disaggregated by rural and urban areas and lagging vs. non-lagging districts.

CHAPTER 13 briefly outlines the Way Forward, translating survey findings into evidence-based policy priorities and targeted reforms to accelerate progress toward universal health coverage in Punjab.

Roles and Responsibilities

Supported by the Gates Foundation, the Population Council (PC) provided technical support on the Health and Population Survey. The Population Center Pakistan (PCP) guided survey implementation. Both organizations were responsible for survey questionnaires, sample design, the survey manual, master trainer training, and ensuring data quality, analysis of the findings comprising the contents of this report.

The Government of Punjab financed the survey through the Department of Health. The Bureau of Statistics Punjab (BoSP) managed administration and data collection, including field implementation, data collection using tablets, hiring enumerators, organizing training, and supervising enumerators and fieldwork.

The PHPS was guided by a provincial technical advisory group including representatives from the Planning and Development Department, Department of Health, Population Welfare Department (PWD), BoSP, Global Financing Facility, World Bank, PC, and PCP.

PHPS-specific Project Development Objective (PDO) and Disbursement-linked Indicators (DLIs) Under NHSP and PFPP

The PHPS, a population-based household survey, is designed to cover all PDOs and DLIs that can be collected and crafted through household data. The structured results frameworks of both programs (NHSP and PFPP) enable the province to receive performance-based disbursements upon verification

of progress. While the overall frameworks have been outlined above, the PHPS was specifically designed to analyze results through cross-cutting themes of gender and equity, along with high-priority indicators identified in the framework (Table 1.1).

The PHPS focused on access (coverage), quality of services for UHC, modern contraceptive prevalence rates (mCPRs), ANC, and immunization, with equity and gender as cross-cutting considerations. Additional topics suggested by provincial stakeholders were also included. The details of relevant PDOs and DLIs measured through the PHPS are presented below.

National Health Support Program Indicators

PDO-1: Abbreviated UHC Service Coverage Index of essential health services

This composite index assesses whether individuals and communities are receiving essential health services, particularly at the PHC level. It encompasses services for reproductive, maternal, newborn, and child health, as well as for communicable and non-communicable diseases.

PDO-2: Use of modern contraceptives

This indicator measures the percentage of currently married women aged 15–49 using modern family planning methods. It reflects both the availability of services and the demand for fertility regulation, which is crucial for tracking unmet need for modern contraception with significant implications for maternal and child health.

PDO-4: Effective ANC coverage

This indicator evaluates not just the number of ANC visits but also the quality and content of care received by women during pregnancy, considering whether essential ANC components—such as screenings, counselling, and vaccinations—were provided, ensuring that care is timely and effective.

DLI-5: Child immunization coverage

This DLI includes two sub-indicators critical for measuring child health outcomes and the performance of the Expanded Programme on Immunization (EPI).

- #### DLI-5a: Penta-1 coverage

  This measures the percentage of children aged 12–23 months who received the first dose of the pentavalent vaccine.

- #### DLI-5b: Fully immunized child coverage

  This tracks the percentage of children aged 12–23 months who have received all recommended routine immunizations.

Punjab Family Planning Program Indicators

PDO-2: Use of modern contraceptives

This indicator applies to currently married women of reproductive age (15–49 years), disaggregated by wealth quintiles, education, district type, and rural/urban areas.[1]

PDO-3: Appropriate counselling on family planning

Among current users, by rural/urban area and district type, this indicator measures awareness of possible side effects, actions to take if experiencing side effects, and where to seek help.

DLI-2.1: Post-pregnancy family planning counselling

This indicator measures counselling provided to currently married women aged 15–49 who had a pregnancy outcome (live birth or pregnancy loss) in the three years before the survey, by rural/urban area and district type.

DLI-2.2: Post-pregnancy adoption of family planning

This tracks the percentage of currently married women who delivered in the last three years and started using any modern method within one year after delivery, disaggregated by rural/urban area and district type.

DLI-3: Increased use of family planning through the private sector

This focuses on expanding access to contraceptives and reproductive health services by engaging private healthcare providers, pharmacies, and clinics. It aims to reach diverse populations, improve service quality, and ensure wider availability of FP options.

These indicators serve as benchmarks for performance-based disbursements from the provincial government and development partners. Their inclusion in the PHPS ensures that Punjab has the necessary data to demonstrate compliance, identify performance gaps, and redirect interventions as needed.

[1] The NHSP and PFPP's PDO-2 is mCPR. However, the PFPP additionally requires disaggregation by wealth and education of the respondents.

Aims and Objectives of PHPS

The PHPS's primary aim is to provide baseline and end-line data for the NHSP and to serve as benchmark data for the Punjab Family Planning Program. Data collection for this round of the PHPS was conducted in 2024–25, following delays, but provides essential benchmarks for tracking key indicators tied to the NHSP's health-related goals. Additionally, it assesses the implementation and impact of programmatic interventions to inform planning, resource allocation, and policymaking in Punjab's health and population sectors.

The PHPS was conducted from November 2024 to February 2025. This round of the survey was designed as a baseline. An end-line survey, expected in 2026 or 2027, will be a panel survey conducted in the same clusters as the baseline.

The specific objectives of PHPS were to:

- Provide high-quality data that meets international standards for evaluating baseline and end-line indicators, implementation status, and the impact of the NHSP.
- Fully integrate provincial priority themes identified through stakeholder consultations into the survey content, including issues related to gender, equity, and geographical disparities, such as districts with zero-dose children.

Consultations were held with Punjab's Department of Health, the Population Welfare Department (PWD), and the Department of Planning and Development to address PHPS's second objective. The PHPS gathered information on the provincial priorities identified during these consultations,[2] which included the following topics:

- Delivery planning during ANC visits
- Post-pregnancy FP counselling and adoption
- Nutrition awareness
- The use of tobacco and other addictive non-tobacco substances (a list was provided)

Methodology

To achieve the survey objectives, the design facilitates the comparison of baseline and end-line indicators across various population groups over time. These groups include female vs. male children, male illness vs. female illness, urban vs. rural residence, zero-dose/lagging districts vs. non-lagging districts, as well as other gender and equity variables. The end-line survey will be conducted in the same clusters as the baseline, allowing for statistically robust measurement of change attributable to NHSP.

[2] After incorporating provincial information needs into the first draft of the questionnaire, it was shared with the province for review. This gave provincial departments an additional opportunity to submit their information needs for PHPS.

Eligible respondents for interviews included:

- Knowledgeable and responsible adults, preferably household heads, for household-level information.
- Ever-married women of reproductive age (15–49 years) for information on fertility, reproductive health, and maternal and child health indicators. Data were collected from all ever-married women of reproductive age and about all children aged 0–59 months.

Sample Design

The survey sample was drawn from the sampling frame developed by the Pakistan Bureau of Statistics (PBS) based on the Seventh Population and Housing Census 2023. In urban areas, each city or town is divided into small, compact areas called enumeration blocks (EBs). Each block consists of an average of 200–250 houses, with clearly defined boundaries recorded in prescribed forms and corresponding maps, along with physical features within the blocks. Rural areas are also divided into EBs, which may consist of entire villages or parts of villages. These EBs are referred to as primary sampling units (PSUs). Stratification for both urban and rural areas within each administrative district is treated as an independent stratum.

The sample size and its allocation considered the variability of key variables, population distribution, and field resources. Various exercises were conducted to determine the appropriate sample size for the survey, focusing on prevalence indicators such as pre- and postnatal care, modern contraceptive prevalence rate (mCPR), and immunization coverage for children aged 12–23 months. These indicators were analyzed with margins of error of 12% and 15% at a 95% confidence interval.

The survey characterized seven districts as “lagging districts” based on their UHC service index scores. Given the lower values of key performance indicators (PDOs) in these districts, a larger sample size was essential to reliably measure an expected five-percentage-point change in the mCPR and other PDOs. In contrast, non-lagging districts required a sample size sufficient to detect a ten-percentage-point change.

Based on these calculations, a total sample of 24,540 households covering 1,330 PSUs, with 20 households per PSU, was deemed sufficient to produce reliable estimates, using the mCPR as the key indicator, with a 15% relative margin of error at a 95% confidence level.

A two-stage stratified sampling design was adopted for the survey. In the first stage, EBs in rural and urban areas were selected; in the second stage, households within the selected EBs were chosen. The detailed allocation plan for the sample size across the 36 districts of Punjab is provided in Table 1.2.

Table 1.2: List of lagging and non-lagging districts in Punjab

Lagging districts	Non-lagging districts	
1. Rahim Yar Khan	1. Attock	16. Multan
2. Bhakkar	2. Bahawalnagar	17. Nankana Sahib
3. Dera Ghazi Khan	3. Gujranwala	18. Okara
4. Muzaffargarh	4. Gujrat	19. Sahiwal
5. Pakpattan	5. Hafizabad	20. Sargodha
6. Rajanpur	6. Jhelum	21. Sheikhupura
7. Bahawalpur	7. Mandi Bahauddin	22. Toba Tek Singh
	8. Rawalpindi	23. Vehari
	9. Chiniot	24. Chakwal
	10. Jhang	25. Faisalabad
	11. Kasur	26. Lahore
	12. Khanewal	27. Layyah
	13. Khushab	28. Narowal
	14. Lodhran	29. Sialkot
	15. Mianwali	

The selection of PSUs/EBs in the chosen districts, for both rural and urban domains, was taken as PSUs. The sampled PSUs from each stratum were selected using the probability proportional to size (PPS) method, where the total number of households within a PSU serving as the measure of size.

Households were considered secondary sampling units for the survey. The field staff of the Bureau of Statistics conducted a complete household listing in each sampled PSU. From this list, 20 households were then selected within each sampled PSU using the systematic random sampling technique with a random start.

Table 1.3 provides details of the actual sample from PBS, including the number of interviews conducted and the response rate. A total of 26,600 households were sampled, of which 24,540 were successfully interviewed, resulting in a response rate of 92.3%. In addition, 19,536 ever-married women were interviewed, yielding a response rate of 88%. The response rates for urban vs. rural areas and for lagging vs. non-lagging districts were generally similar and high.

Table 1.3: Number of sampled PSUs and households, by stratum and district

		Sampled PSUs			Sampled households*		
No.	Districts	Rural	Urban	Total	Rural	Urban	Total
1	Attock	24	11	35	480	220	700
2	Bahawalnagar	55	21	76	1,100	420	1,520
3	Gujranwala	17	23	40	340	460	800
4	Gujrat	20	13	33	400	260	660
5	Hafizabad	22	11	33	440	220	660
6	Jhelum	20	12	32	400	240	640
7	Mandi Bahauddin	28	10	38	560	200	760
8	Rahim Yar Khan	54	19	73	1,080	380	1,460
9	Rawalpindi	11	19	30	220	380	600
10	Bhakkar	55	11	66	1,100	220	1,320
11	Chiniot	20	13	33	400	260	660
12	Dera Ghazi Khan	42	13	55	840	260	1,100
13	Jhang	21	13	34	420	260	680
14	Kasur	19	11	30	380	220	600
15	Khanewal	19	11	30	380	220	600
16	Khushab	21	11	32	420	220	640
17	Lodhran	22	9	31	440	180	620
18	Mianwali	24	11	35	480	220	700
19	Multan	15	15	30	300	300	600
20	Muzaffargarh	47	13	60	940	260	1,200
21	Nankana Sahib	21	9	30	420	180	600
22	Okara	19	11	30	380	220	600
23	Pakpattan	19	11	30	380	220	600
24	Rajanpur	24	13	37	480	260	740
25	Sahiwal	19	11	30	380	220	600
26	Sargodha	22	12	34	440	240	680
27	Sheikhupura	20	13	33	400	260	660
28	Toba Tek Singh	17	13	30	340	260	600
29	Vehari	22	8	30	440	160	600
30	Bahawalpur	18	12	30	360	240	600
31	Chakwal	24	9	33	480	180	660
32	Faisalabad	15	15	30	300	300	600
33	Lahore	0	30	30	0	600	600
34	Layyah	19	11	30	380	220	600
35	Narowal	26	9	35	520	180	700
36	Sialkot	19	13	32	380	260	640
	Total	**860**	**470**	**1,330**	**17,200**	**9,400**	**26,600**

*20 households per PSU.

Table 1.4: Sample size, number of interviews conducted, and response rate.

PSUs & interview type	Sampled/total	Interviewed	Response rate (%)
PSUs			
Overall	1,330	1,330	100.0
Rural	860	860	100.0
Urban	470	470	100.0
Lagging districts			
Overall	351	351	100.0
Rural	259	259	100.0
Urban	92	92	100.0
Non-lagging districts			
Overall	979	979	100.0
Rural	601	601	100.0
Urban	378	378	100.0
Households			
Overall	26,600	24,540	92.3
Rural	17,200	15,952	92.7
Urban	9,400	8,588	91.4
Lagging districts			
Overall	7,020	6,585	93.8
Rural	5,180	4,882	94.2
Urban	1,840	1,703	92.6
Non-lagging districts			
Overall	19,580	17,955	91.7
Rural	12,020	11,070	92.1
Urban	7,560	6,885	91.1
Ever-married women			
Overall	22,209	19,536	88.0
Rural	14,567	12,864	88.3
Urban	7,642	6,672	87.3
Lagging districts			
Overall	5,890	5,415	91.9
Rural	4,383	4,058	92.6
Urban	1,507	1,357	90.0
Non-lagging districts			
Overall	16,319	14,121	86.5
Rural	10,184	8,806	86.5
Urban	6,135	5,315	86.6

Survey questionnaires

The survey utilized two questionnaires: a household questionnaire and a detailed questionnaire for eligible ever-married women of reproductive age (15–49 years).

- The household-level questionnaire gathered information on communicable and non-communicable diseases (for all members aged five and above), household socioeconomic characteristics, child immunization, and the availability and use of health facilities.
- The eligible women's questionnaire focused on all ever-married women of reproductive age (15–49 years) in the sampled households. Its main sections covered eligible women's reproductive background (pregnancy history, fertility preferences, contraception, maternal healthcare, and quality of care) as well as child treatment, nutrition, and women's empowerment.

The design of these questionnaires drew on major international instruments, including the Demographic and Health Survey, Multiple Indicator Cluster Survey, and PC-tested questionnaires. The Pakistan Demographic and Health Survey 2017–2018[3] served as the primary reference for both the household and individual women surveys, which were supplemented with questions from other validated tools. Drafts were reviewed by professionals with multidisciplinary expertise, including contributors from the World Bank, Global Financing Facility, Gates Foundation, and Global Alliance for Vaccines and Immunization. The questionnaires were pre-tested three times in the field and underwent multiple rounds of revision before finalization. The final questionnaires (shown in Annex C) were approved by the provincial technical committee of PHPS.

Data management and technology use

A comprehensive, technology-driven system was implemented to enhance data management and ensure high-quality data collection for the PHPS 2024–25. Central to this system was the development and deployment of a bilingual computer-assisted personal interviewing (CAPI) application using the Census and Survey Processing (CSPro) platform. This software was designed to accommodate the survey's complex structure and integrated robust quality assurance protocols. The CAPI application supported both English and Urdu, ensuring usability in the field.

A secure server environment was established to allow for real-time data transmission, with offline functionality to ensure uninterrupted data collection in areas with limited or no internet connectivity. Additionally, integrating listing data with the CAPI system streamlined household identification and assignment, reducing errors and improving operational efficiency.

A customized PHPS dashboard was developed for the Bureau of Statistics Punjab (BoSP). This dashboard enabled real-time monitoring of fieldwork progress, tracking of completed interviews, and oversight of data quality indicators. These innovations—introduced for the first time to the provincial bureaus of statistics—significantly improved data accuracy and timeliness, supervision, and adherence to the survey methodology. Further technical details are provided in Annex A.

[3] National Institute of Population Studies (NIPS) [Pakistan] and ICF. (2019). Pakistan demographic and health survey 2017–18. NIPS and ICF. https://dhsprogram.com/pubs/pdf/FR354/FR354.pdf.

Field staff training

The survey's primary data collection phase began on 17 November 2024 with the hiring of survey staff and concluded in the first week of February 2025 with the production of a clean dataset.

Interviewer selection criteria included a minimum of 14 years of education, proficiency in the local language of their deployment area, and 1–2 years of experience in household surveys. Many enumerators held master's degrees, while others had bachelor's degrees. Supervisors and quality assurance team members had 16 years of education, fluency in a regional language, and over five years of survey experience. Field and data managers were required to have previous experience with panel and/or multi-topic household surveys, along with four to five years of supervisory experience.

The BoSP engaged 120 female interviewers and 24 male field workers through advertisements and walk-in interviews. Male field workers did not conduct interviews; instead, they provided logistical support, located survey areas, and ensured the safety and privacy of respondents and interviewers. Additionally, 24 male supervisors were deployed to monitor and oversee fieldwork. In total, 24 teams conducted fieldwork across 36 districts.

The PC and PCP teams organized and conducted two training sessions in Islamabad for master trainers from the Bureau of Statistics. The first session took place from 2–5 January 2024, and the second from 27 May–1 June 2024. Four master trainers from the BoSP participated in the first training session; during the second training, the same officials were joined by two additional officials, one resource person from the Department of Health, and two from the PWD.

BoSP conducted step-down training for field enumerators in three batches. The first batch began in the first week of September 2024, and the last was completed by the end of October 2024.

Fieldwork officially commenced in Multan division on 17 November 2024 and continued until the first week of February 2025, following a phased rollout across divisions. PC and PCP teams participated as technical observers in the first batch of enumerator training and facilitated CAPI sessions in the remaining sessions. All enumerators were trained prior to the pre-test and data collection. The PC and PCP teams also coordinated with the Department of Health and PWD in Punjab to arrange resource persons who delivered sessions on complex questionnaires sections, including pregnancy history and contraception.

Monitoring for quality

The PCP implemented strict quality assurance measures during data collection. An experienced ten-member quality assurance team, well-versed in the questionnaires, was deployed to supervise fieldwork, support staff, and address interviewers' queries. They worked alongside BoSP teams and maintained continuous communication with the PCP and PC project teams in Islamabad, allowing field teams to share updates and discuss challenges. A dedicated PHPS WhatsApp group was also created to share survey queries, challenges and solutions.

The customized PHPS dashboard (Annex A) was developed to give BoSP access to real-time data—enabling preliminary checks, tracking of survey progress, monitoring of field activities, and ensuring data quality.

No serious challenges were reported during data collection. Data integrity and quality were enhanced through CAPI, which included built-in quality checks for consistency and completeness. Rigorous training and close supervision ensured that fieldwork challenges were addressed promptly. Response rates showed no bias by area, district, household, or women respondents.

Ethical considerations

The PC and PCP obtained ethical clearance from the Institutional Ethical Review Committee of the Health Services Academy, Islamabad in November 2023 to ensure compliance with established ethical standards and to safeguard participants' rights and wellbeing.

The survey's ethical framework included comprehensive informed consent procedures designed to uphold participant autonomy and protect their rights. Participants were fully briefed on the survey's purpose, procedures, and the use of their data. They were encouraged to ask questions and assured that participation was entirely voluntary. Participants retained the right to skip any questions they did not wish to answer and to withdraw from the interview at any time without negative consequences.

Before providing consent, participants were informed about the expected duration of the interview and any potential risks involved. Anonymity and confidentiality measures were implemented to protect participant privacy. Overall, the study prioritized ethical standards, ensuring participant welfare and data integrity.

Data analysis

The data analysis plan was developed in parallel with the questionnaire and consisted of two parts:

1. **Headline indicators:** This component provided baseline values and allowed the rapid release of survey results soon after completing the baseline survey. The goal was to disseminate key findings quickly and enable provincial stakeholders and NHSP program managers to use the results in determining baseline values for indicators. This part included five headline indicators at the provincial level, disaggregated by urban–rural area and lagging vs. non-lagging districts, as well as overall district-level indicators. The immediate results were presented in a Key Findings Report[4], which explained each indicator.
2. **Detailed analysis:** This component focused on in-depth analysis of each indicator by individual and household characteristics, with results further disaggregated by socioeconomic variables, particularly age, gender, and wealth quintile. The analysis highlighted equity in coverage, access to facilities, and the cost of receiving health services. These findings formed the basis of this comprehensive baseline report, supplemented with extensive tabulations to identify performance gaps and areas for improvement.

After completing fieldwork, the final CSPro-based dataset was downloaded from the central server and converted into SPSS and Stata formats for further processing. A comprehensive series of internal and external consistency checks was conducted prior to analysis to ensure data accuracy, completeness,

[4] Bureau of Statistics, Punjab. 2025. Punjab Health and Population Survey (PHPS) 2024–25: Key Findings Report. Punjab: Bureau of Statistics, Planning and Development Board, Government of the Punjab.

and reliability. Analysis syntax was written in both SPSS and Stata for transparency and accuracy, with multiple team members cross reviewing one another's syntax to verify computations and logic before generating results.

Following this rigorous validation process, data analysis was conducted to produce results for the topline indicators. These results were shared with the Government of Punjab on 30 May 2025, at which time it was recommended that they be presented to the Chairman of the Planning and Development Board for approval. Subsequently, the results were presented to the Chairman on 24 July 2025, during which the survey findings were formally approved.

After approval, the data analysis process was further expanded to produce this comprehensive baseline survey report. Almost every section of the questionnaire was explored during this phase, with detailed analysis across most sections to provide deeper insights to support evidence-based decision-making.

2

Characteristics of Households and Household Members

Key Findings

Housing characteristics

- 53.3% of rural households and 50.9% of urban households were owner-occupied.
- 66% of rural households had finished floors, compared to 95.2% of urban households.
- 13% of rural households had no exterior walls or had walls made of dirt, compared to 1.2% of urban households.
- Wood was the primary cooking fuel for 44.4% of rural households, while 67.1% of urban households used natural gas.

Main sources of household income and international remittances

- Daily wages were the primary source of income for 39.4% of rural households, compared to 26% of urban households.
- Agriculture, livestock, and poultry were the main income sources for 22.1% of rural households, while private service was the primary source for 17.9% of urban households.
- Remittances from abroad were the main income source for 5% of rural households and 5.5% of urban households.

Experience of disasters and/or other shocks and the need for loans

- Economic shocks were the primary hardship for 22.3% of rural households in the past 24 months, compared to 17.7% of urban households.
- 28.8% of rural households and 28.3% of urban households reported taking loans to cope with economic constraints and maintaining a stable level of consumption following a sudden decline in income.

Social protection support

- 22% of rural households and 11% of urban households had at least one member who benefited from the Benazir Income Support Programme (BISP).

- 5.5% of rural households and 5.8% of urban households had a Sehat Sahulat card.
- Nutritional support for pregnant and lactating women was minimal, with only 1% of women in rural areas and 0.4% in urban areas benefiting from such programs.
- Private insurance plans were not reported.

Water, sanitation, and hygiene

- 98.9% of urban households and 98.6% of rural households had improved water sources.
- 90.7% of urban households and 77.7% of rural households had improved sanitation.
- 84.5% of urban households and 77.1% of rural households had a handwashing facility with soap.

School attendance of children aged 5–9 and 10–14 years

- 22.8% of girls aged 5–9 in rural areas were out of school, compared to 21.6% of boys.
- Among children aged 10–14 in rural areas, 28.3% of girls were out of school, compared to 27.5% of boys.

The Context: A profile of Punjab

It is important first to set the context by providing a profile of the province. Punjab, the heartland of Pakistan, is a province of striking contrasts—ranging from the snow-fed rivers in the north to fertile green plains in the south. According to the 2023 Population and Housing Census, it is the most populous province of Pakistan, with an estimated population of 127.69 million.[5] Punjab is economically vibrant, characterized by rich agricultural plains, diverse cultural heritage, and significant urbanization. Stretching from the Potohar Plateau in the north to the Cholistan Desert in the south, the province offers diverse landscapes—from semi-arid zones to fertile river basins nourished by the Indus and its tributaries.

As the heartland of the subcontinent, Punjab is also one of the most ethnically diverse provinces. While the majority identifies as Punjabi, the province is home to ethnic groups such as Saraikis, Potoharis, and Hazaras. Located in northeastern Pakistan along the border with India, Punjab serves as the country's economic and agricultural hub. It has experienced significant internal migration, particularly from rural to urban areas, fueling rapid urbanization and reshaping socioeconomic dynamics. Additionally, Punjab is a major contributor to Pakistan's labor force abroad.

In recent years, the province has undergone significant governance reforms aimed at improving service delivery, strengthening local governance, and expanding infrastructure. However, ensuring equitable access to quality health, education, and basic amenities, particularly in lagging districts,

[5] Table 1, Pakistan Bureau of Statistics. (2023). *Population and housing census 2023*. Government of Pakistan. https://www.pbs.gov.pk/sites/default/files/population/2023/tables/table_1_punjab_province.pdf.

remains a critical focus for provincial policymakers. Bridging these disparities is essential to fostering inclusive development and enhancing the wellbeing of all citizens across Punjab.

To effectively interpret population and health data, it is important to consider people's context and living conditions. The Punjab Health and Population Survey (PHPS) household questionnaire collected data on indicators related to households and their members. The first half of this chapter presents the province's profile using various data sources. The second half draws on PHPS findings to highlight characteristics critical for understanding the population and health conditions of people in both urban and rural Punjab.

Demographic Overview

Table 2.1 presents key demographic and social indicators for Punjab, offering insights into the province's population dynamics and human development challenges. Recent estimates show that Punjab accounts for 52.9% of Pakistan's total population, with a high density of 621.8 persons per square kilometer. The average annual population growth rate was 2.13% between 1998 and 2017, rising to 2.53% between 2017 and 2023.

Notably, Punjab remains predominantly rural, with 59.3% of its population living in rural areas. Households average 6.4 members, among the highest in the country. Literacy rates[6] reveal a significant gender gap: 72.0% of males aged 10 and above are literate, compared to 60.2% of females in the same age group, highlighting disparities in educational access and attainment for women.

Table 2.1: Punjab's key sociodemographic indicators

Indicator	
Population (million)	127.7
Population density (persons per sq. km)	621.8
Avg. annual population growth rate (2017–2023) (%)	2.5
Population share of Pakistan (%)	52.9
Rural population (%)	59.3
Average household (HH) size	6.4
Male literacy (aged 10+) (%)	72.0
Female literacy (aged 10+) (%)	60.2

Source: Pakistan Population and Housing Census, 2023.

Data from the Pakistan Labour Force Survey 2020–21[7] show significant gender disparities in Punjab's workforce (Table 2.2). The employment-to-population ratio is 75.9% for men compared to only 27.3%

[6] Table 12, Ibid.

[7] Pakistan Bureau of Statistics. (2022). *Labour force survey 2020–21: Annual report*. Government of Pakistan. https://www.pbs.gov.pk/sites/default/files/labour_force/publications/lfs2020_21/LFS_2020-21_Report.pdf.

for women. Additionally, men are more represented in informal employment (53.2%), while women predominantly work in agriculture (67.5%).

Table 2.2: Punjab's labor force indicators for the age group of 15+ years

Labor force indicators	Male	Female
Employment-to-population ratio (%)	75.9	27.3
Employment by sector		
Total	100.0	100.0
Formal	18.9	11.6
Informal	53.2	20.9
Agriculture	27.9	67.5
Employment by sector		
Total	100.0	100.0
Agriculture	27.9	67.5
Industry	30.1	14.4
Services	41.9	18.1

Source: Pakistan Labour Force Survey, 2020–2021.

Punjab's migration profile indicates low levels of movement, with 92.5% of residents originally from the province. Total migration comprises only 7.5% of the population,[8] confirming limited mobility within Punjab. The data reveal relatively low levels of in-migration from other provinces and suggests that population pressures and service delivery challenges stem primarily from natural growth rather than migration.

Punjab's health indicators also point to persistent challenges in improving maternal and child health outcomes. According to the Pakistan Demographic and Health Survey 2017–2018,[9] the province's neonatal mortality rate stands at 51 deaths per 1,000 live births, the infant mortality rate is 73, and the under-five mortality rate is 85. These figures indicate that a significant proportion of child deaths occur within the first year of life. Furthermore, the maternal mortality ratio, as reported in the Pakistan Maternal Mortality Survey 2019,[10] is 157 maternal deaths per 100,000 live births, highlighting the persistent risks associated with pregnancy and childbirth.

These statistics underscore the urgent need to strengthen maternal, neonatal, and child health services, particularly in rural and underserved areas, to reduce preventable deaths and improve overall health outcomes in the province.

[8] Pakistan Bureau of Statistics. (2023). *Population and housing census 2023.* Government of Pakistan. https://www.pbs.gov.pk/sites/default/files/population/2023/tables/table_18_national.pdf.

[9] National Institute of Population Studies (NIPS) [Pakistan] and ICF. (2019). *Pakistan demographic and health survey 2017–18.* NIPS and ICF. https://dhsprogram.com/pubs/pdf/FR354/FR354.pdf.

[10] National Institute of Population Studies (NIPS) [Pakistan] and ICF. (2020). *2019 Pakistan maternal mortality survey summary report*. NIPS and ICF. https://dhsprogram.com/pubs/pdf/SR267/SR267.pdf.

Households' Socioeconomic Characteristics

Of the 24,540 households surveyed in Punjab (Table 2.3), 52.3% were owner-occupied, with ownership higher in rural areas (53.3%) compared to urban areas (50.9%). The materials used for floors and exterior walls varied significantly between rural and urban settings. In rural areas, 34% of dwellings had natural floors made of earth or sand, compared to just 4.8% in urban areas.

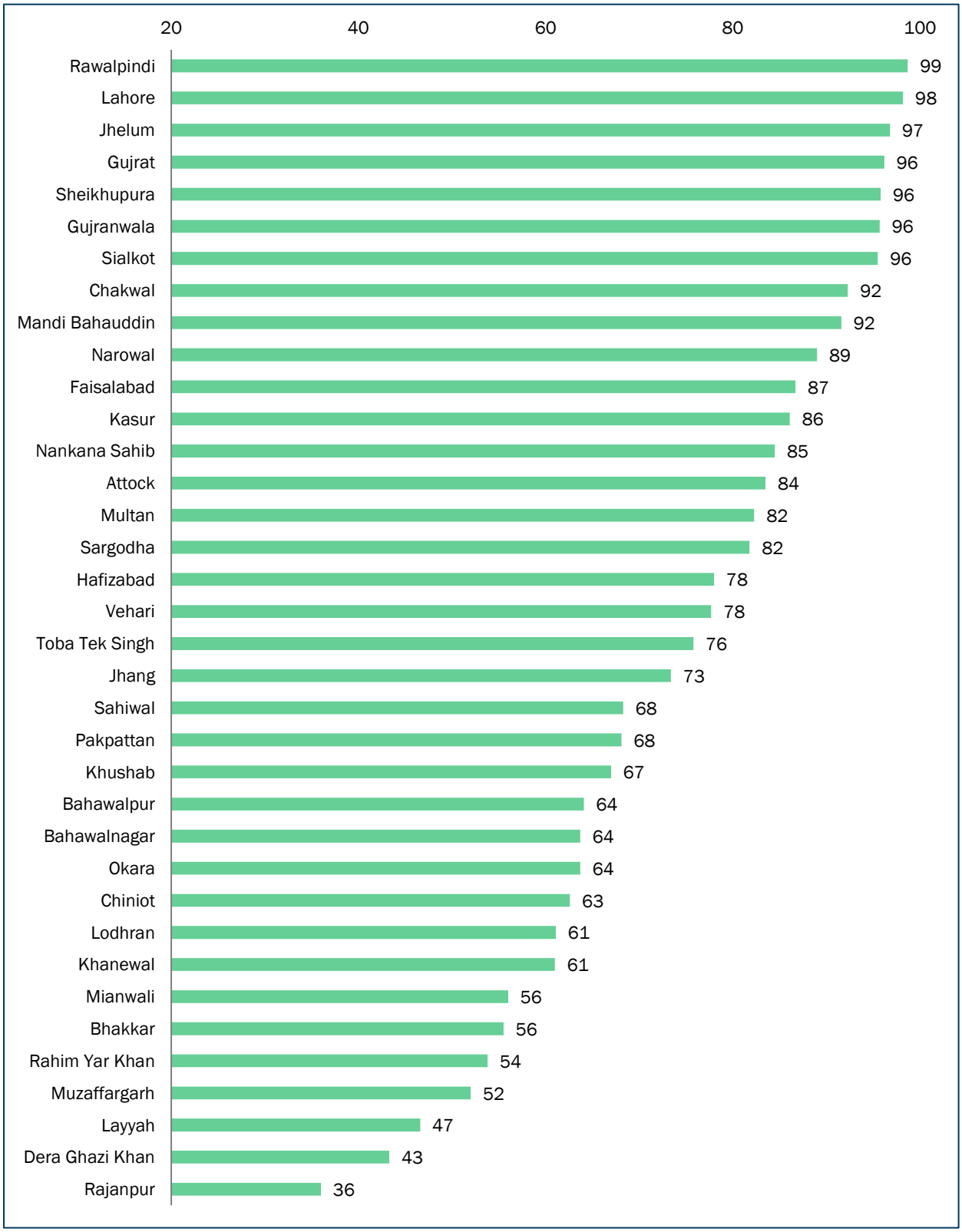
By contrast, 95.2% of urban dwellings had finished floors—constructed from materials such as parquet or polished wood, ceramic tiles, cement, chips/concrete, bricks, or marble—with cement and marble being the most common. In rural areas, 66% of dwellings had finished floors, primarily of cement or marble.

The percentage of dwellings with finished floors varied widely by district, ranging from 36% in Rajanpur to 99% in Rawalpindi (Figure 2.1). In three districts—Rajanpur, Dera Ghazi Khan, and Layyah—fewer than half of all dwellings had finished floors. In contrast, nine districts (Mandi Bahauddin, Chakwal, Sialkot, Gujranwala, Sheikhupura, Gujrat, Jhelum, Lahore, and Rawalpindi) reported rates above 90%. Four districts—Muzaffargarh, Rahim Yar Khan, Bhakkar, and Mianwali—fell in the middle range, with 50% to 60% of dwelling having finished floors.

Table 2.3: Percentage of households by housing characteristics

	Total	Rural	Urban
Dwelling's ownership status			
Rented	10.1	2.8	20.2
Rent-free	35.5	41.1	27.8
Mortgaged	0.1	0.0	0.3
Owned	52.3	53.3	50.9
Other	2.0	2.9	0.8
Total	100.0	100.0	100.0
Floor's primary material			
Natural floor	21.8	34.0	4.8
Rudimentary floor	0.0	0.0	0.0
Finished floor	78.2	66.0	95.2
Total	100.0	100.0	100.0
Exterior walls' primary material			
Natural walls	8.1	13.0	1.2
Rudimentary walls	1.2	1.4	0.9
Finished walls	90.6	85.5	97.8
Other	0.1	0.1	0.2
Total	100.0	100.0	100.0
Cooking fuel			
Electricity	0.2	0.3	0.2
Liquefied petroleum gas	10.9	7.8	15.2
Natural gas	37.8	16.7	67.1
Wood	31.0	44.4	12.6
Straw, shrubs, grass	8.9	13.7	2.2
Animal dung	10.1	15.7	2.3
Other	1.1	1.5	0.5
Total	100.0	100.0	100.0
No. of HHs (unweighted)	**24,540**	**15,952**	**8,588**

Figure 2.1: Percentage of dwellings with finished floors, by district



There is a clear urban–rural contrast in the primary materials used for exterior walls of dwellings. Nearly 13% of rural households had natural walls, compared to just 1.2% of urban households. Conversely, 97.8% of urban dwellings featured finished walls, while the proportion for rural dwellings was 85.5%.

The urban–rural contrast was also evident in the types of cooking fuels used (Table 2.3). In rural areas, wood was the most common fuel (44.4%), followed by natural gas (16.7%) and animal dung (15.7%). In contrast, urban households relied more on natural gas (67.1%). Liquefied petroleum gas was used twice as often in urban households (15.2%) compared to rural households (7.8%).

Main source of household income and remittances

Daily wages were the primary source of income overall (33.8%), and for rural households (39.4%) in particular (Table 2.4). The proportion was lower in urban households, where 26% of households depended on daily wages. A significant percentage of people in rural Punjab worked in agriculture, livestock, or poultry (22.1%), while in urban areas, private service (contract work) was the second most common source of income (17.9%). Overall, businesses without employees (12.9%) and private contract services (12.6%) were the third most common sources of income.

Punjab also has a significant share of households supported by migration, with family members working abroad in other provinces, or in Islamabad. In total, about 15.5% of households in Punjab received remittances either from abroad or from within Pakistan (13.7% of urban and 16.7% of rural households). About 5.2% of all households in Punjab relied on remittances as their main income source—5% in rural areas and 5.5% in urban areas.

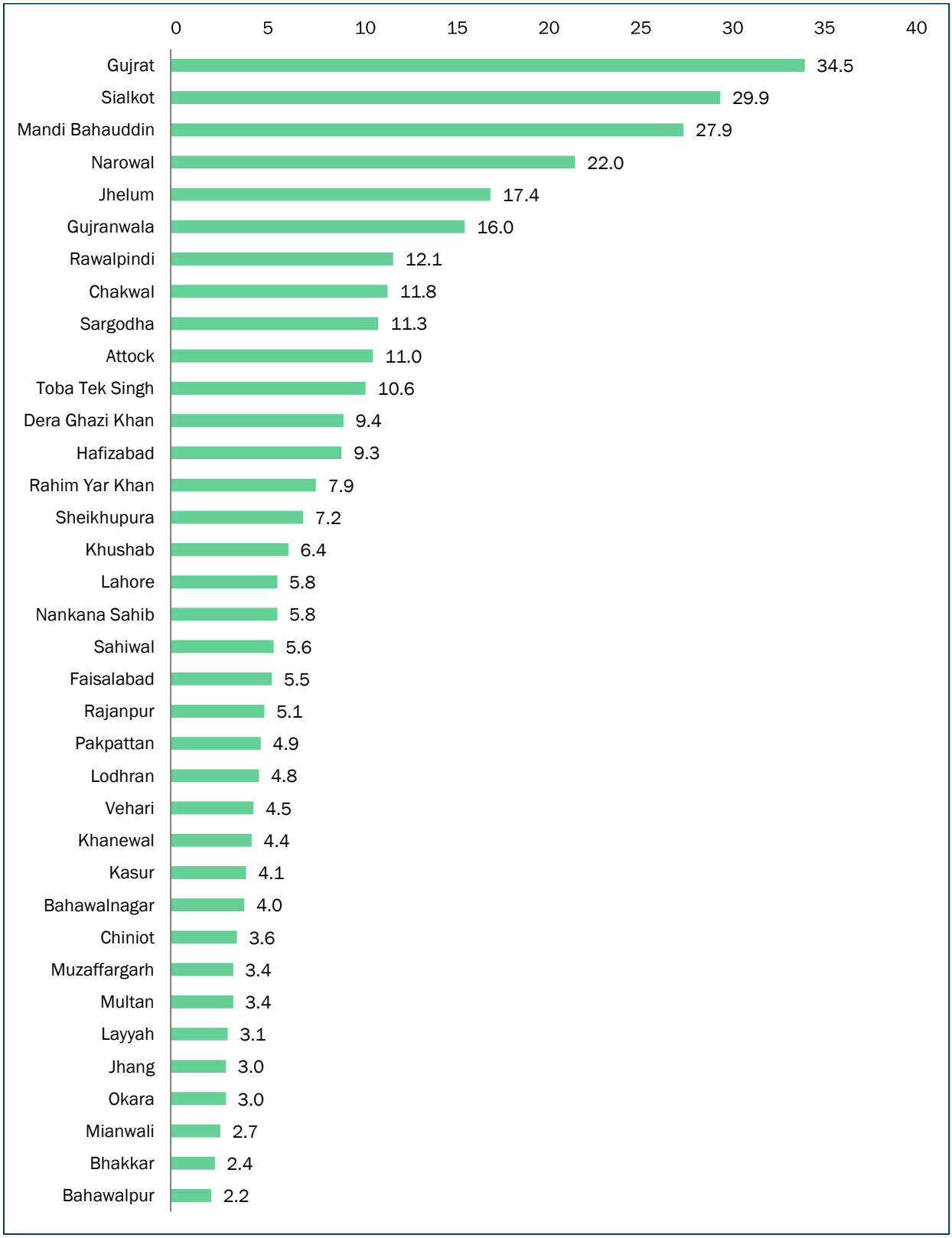
Overall, 8.7% of households in Punjab received remittances from abroad, with no difference between urban and rural households. Remittances by district (Figure 2.2) showed the highest reliance on international remittances in four districts: Narowal (22.0%), Mandi Bahauddin (27.9%), Sialkot (29.9%), and Gujrat (34.5%). Gujrat was the only district where over 30% of households received remittances from abroad. The proportion of households receiving remittances in the remaining districts ranged from below 5.0% to 17.4%.

By comparison, remittances from individuals working elsewhere in Pakistan were slightly lower, at 6.8% overall—8.1% for rural households and 5.0% for urban households.

Table 2.4: Percentage of households by main income source and receipt of remittances

	Total	Rural	Urban
Main income source			
Agriculture, livestock, poultry	14.2	22.1	3.4
Govt. service (permanent)	6.0	4.5	8.0
Govt. service (contract)	0.6	0.5	0.7
Private. service (permanent)	5.3	3.0	8.5
Private service (contract)	12.6	8.7	17.9
Business (with employees)	4.3	2.2	7.3
Business (without employees)	12.9	9.8	17.2
Daily wages	33.8	39.4	26.0
Remittances	5.2	5.0	5.5
Pension	3.2	2.8	3.6
Raising birds	0.0	0.1	0.0
Rent	0.3	0.1	0.5
Other	1.8	2.0	1.5
Total	100.0	100.0	100.0
Have you received remittances from outside Pakistan during the last year?			
Yes	8.7	8.7	8.7
No	91.4	91.4	91.3
Total	100.0	100.0	100.0
Have you received remittances from within Pakistan during the last year?			
Yes	6.8	8.1	5.0
No	93.2	91.9	95.0
Total	100.0	100.0	100.0
No. of HHs (unweighted)	**24,540**	**15,952**	**8,588**

Figure 2.2: Percentage of households receiving remittances from abroad in the last year, by district.



Vulnerability to disasters and hardship

The household questionnaire included the question: "During the past 24 months, has your household faced any natural disasters, agricultural adversities, health problems, economic shocks, serious challenges due to law-and-order situations, or any displacement?" Multiple responses were allowed.

Overall, 69.7% of respondents indicated that they had faced none of these issues (Table 2.5). More households in rural areas (34%) experienced some form of disaster or hardship compared to urban areas (25.1%). Economic shocks were the most reported hardship in both rural (22.3%) and urban (17.7%) households. Health issues were also noted, affecting 9.3% of rural households and 7.6% of urban households.

Borrowing was more common in rural households, with 27.9% of households taking out loans in the past 24 months, compared to 22.4% of urban households. The predominant reason for taking loan was to "maintain stable spending," reported by 28.8% of rural households and 28.3% of urban households. The second most common reason was purchasing food, mentioned by 15.9% of rural respondents and 11.8% of urban respondents. Starting a business was also a notable reason, with 19.2% of urban households and 15.1% of rural households citing this as a reason.

Nearly half of all households in Punjab and rural areas reported taking loans to maintain stable spending, buy food, manage health shocks, or cope with family illnesses. The incidence of borrowing was significantly higher in urban areas than in rural areas, though the reasons were largely similar.

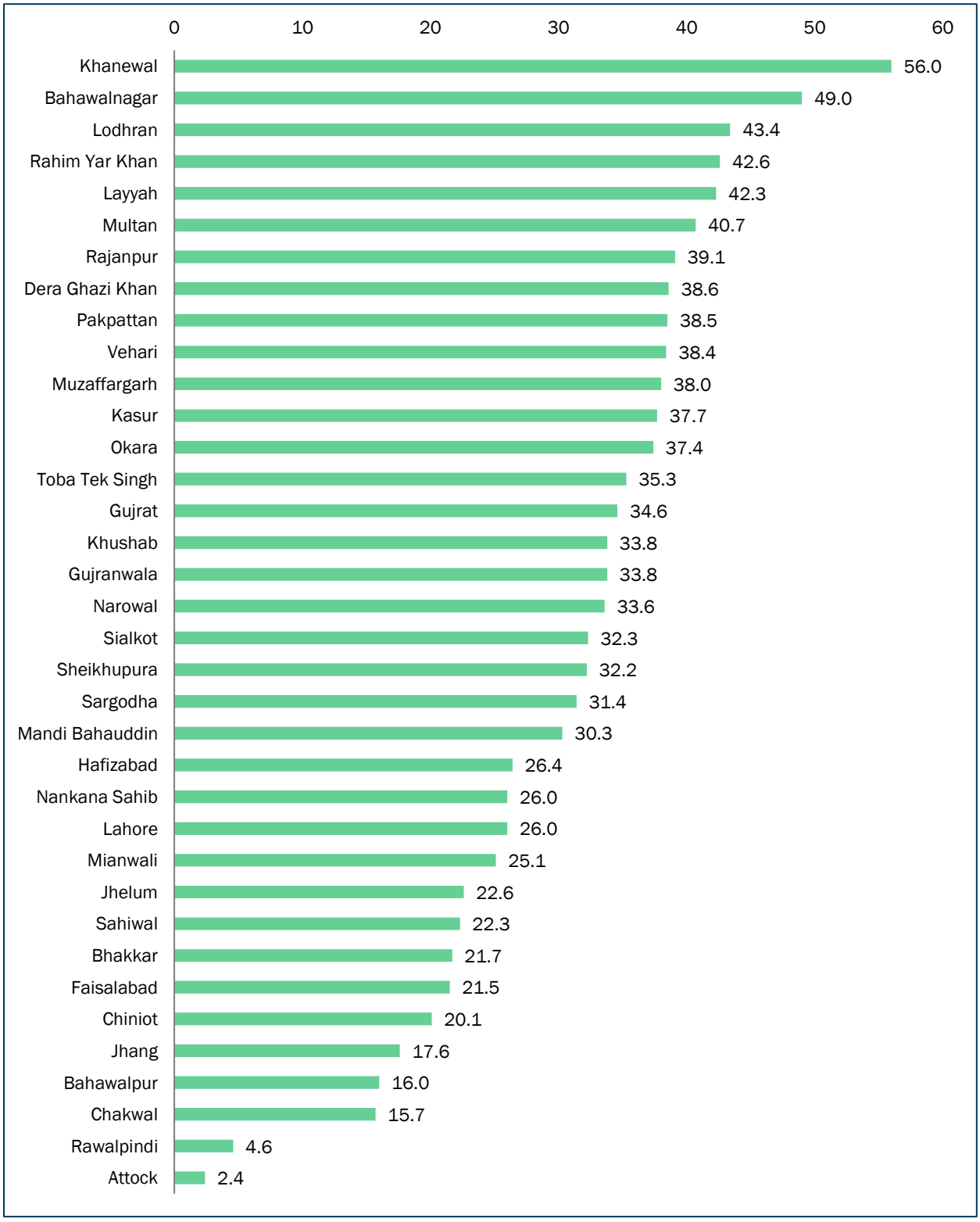
The percentage of households experiencing disasters or hardships varied significantly across districts in Punjab (Figure 2.3). In districts such as Attock (2.4%) and Rawalpindi (4.6%), fewer than 5.0% of households reported facing any disaster or hardship. In Chakwal (15.7%), Bahawalpur (16.0%), and Jhang (17.6%), fewer than 20% of households were affected.

In contrast, more than 40% of households in several Southern Punjab districts—Multan (40.7%), Layyah (42.3%), Rahim Yar Khan (42.6%), Lodhran (43.4%), Bahawalnagar (49.0%), and Khanewal (56%)—reported experiencing disasters or hardships. Southern Punjab is considered more vulnerable to natural disasters and socioeconomic challenges compared to central and northern Punjab.

Table 2.5: Percentage of households experiencing disasters/hardship and requiring a loan during the last 24 months

	Total	Rural	Urban
Have you experienced disasters/hardship in the last 24 months? (multiple responses allowed)			
None	69.7	66.0	74.9
Rain/floods	3.2	4.9	1.0
Agricultural shocks	2.9	4.6	0.5
Economic shocks	20.4	22.3	17.7
Law and order	0.6	0.6	0.5
Displacement	0.9	1.0	0.8
Accident/injury	2.3	2.3	2.3
Health issues	8.6	9.3	7.6
COVID-19	0.2	0.2	0.3
Earthquakes	0.0	0.0	0.0
Droughts	0.1	0.1	0.0
Death of working member	1.2	1.2	1.2
Other	0.7	0.8	0.4
Total	100.0	100.0	100.0
Have you taken a loan in the last 24 months?			
Yes	25.6	27.9	22.4
No	74.4	72.1	77.6
Total	100.0	100.0	100.0
What was the reason for your loan? (multiple responses allowed)			
Other health shocks, e.g., accidents	12.4	12.4	11.8
Floods or earthquakes	0.7	0.7	0.2
Purchasing food	15.9	15.9	11.8
Maintaining stable spending	28.8	28.8	28.3
Education costs	3.6	3.6	4.2
Purchasing an asset	5.7	5.7	4.5
Starting a business	15.1	15.1	19.2
Paying for a wedding	13.6	13.6	14.1
Paying for a funeral	3.8	3.8	3.1
Paying off past debt	8.3	8.3	7.3
Family member illness	12.4	12.4	13.1
Other (specify)	10.2	10.2	10.7
Total	100.0	100.0	100.0
N (unweighted)	6,422	4,489	1,933
No. of HHs (unweighted)	**24,540**	**15,952**	**8,588**

Figure 2.3: Percentage of households experiencing disasters/hardship in the last 24 months, by district



Social protection program: Coverage and health insurance

The Government of Punjab and the federal government have both established social protection programs to support poor and underprivileged families. Launched in 2008, Benazir Income Support Program (BISP) is a federal unconditional cash transfer initiative designed to provide additional cash to the poorest households.

In Punjab, 17.4% of households included a BISP beneficiary (Table 2.6). Coverage was twice as high in rural areas (22%) as in urban areas (11%). Other conditional cash transfer programs—such as Agosh in Punjab for pregnant or lactating women—reached only a very small minority of respondents (0.4%–1.0%), including programs related to nutrition and immunization.

The coverage of the Sehat Sahulat Program, which provides free or subsidized healthcare services to underprivileged families, was also low: 5.6% overall, with 5.5% in rural households and 5.8% in urban households.

Despite the large share of households experiencing disasters and health emergencies, the reach of social protection programs remains limited. Health insurance coverage—whether through employers or private means—is very low in both urban and rural areas. Only a small fraction of households reported coverage through employer-sponsored plans (5.6% in urban and 3.1% in rural households). Consequently, most people must cover their health expenses out of pocket and are frequently compelled to take out loans to cope with natural disasters and health crises.

Table 2.6: Percentage of households with members receiving social protection support

	Total	Rural	Urban
Are there any woman BISP beneficiaries in your Household?			
Yes	17.4	22.0	11.0
No	82.6	78.0	89.1
Total	100.0	100.0	100.0
Is anyone benefiting from the Sehat Sahulat card?			
Yes	5.6	5.5	5.8
No	94.4	94.5	94.2
Total	100.0	100.0	100.0
Are pregnant or lactating women benefitting from nutritional programs?			
Yes	0.7	1.0	0.4
No	61.7	63.2	59.6
Don't know	1.8	1.8	1.9
Not applicable	35.8	34.1	38.1
Total	100.0	100.0	100.0
Is anyone benefiting from nutritional programs for immunization?			
Yes	0.4	0.5	0.3
No	64.3	65.7	62.4
Don't know	2.1	2.0	2.2
Not applicable	33.2	31.8	35.1
Total	100.0	100.0	100.0
Is anyone insured through an employer's insurance plan?			
Yes	4.1	3.1	5.6
No	64.8	65.4	63.8
Don't know	1.4	1.5	1.3
Not applicable	29.7	30.0	29.3
Total	100.0	100.0	100.0
Is anyone insured by privately purchased insurance?			
Yes	2.4	1.8	3.1
No	85.9	86.2	85.5
Don't know	1.4	1.7	1.1
Not applicable	10.3	10.3	10.3
Total	100.0	100.0	100.0
No. of HHs (unweighted)	**24,540**	**15,952**	**8,588**

Water, sanitation, and hygiene

Water safety, type of sanitation facilities, and hygiene practices are significant determinants of morbidity. The PHPS 2024–25 household questionnaire included a series of questions regarding households' water, sanitation, and hygiene (WASH) conditions. Relevant definitions include the following:

- **Improved drinking water sources:** Sources with the potential to provide safe water, including piped water, boreholes or tube wells, protected dug wells, protected springs, rainwater, and packaged or delivered water.
- **Improved sanitation facilities:** Wet sanitation technologies, such as flush and pour-flush toilets connected to sewers, septic tanks, or pit latrines, and dry sanitation technologies, including dry pit latrines with slabs and composting toilets.
- **Hygiene:** Assessed based on the self-reported availability of a handwashing facility with soap and water on the premises, indicating that water is accessible when needed. Handwashing facilities may include both fixed (tap) and mobile (bucket) options designed to contain, transport, or regulate the flow of water for handwashing within the dwelling, yard, or plot. Soap includes bar soap, liquid soap, or detergent (powder, liquid, or paste).

Improved water

Overall, only 15.1% of households had a water source located within their dwellings, while 38.8% had a source in their own yard or plot (Table 2.7). There was a 7.7 percentage point difference in the proportion of urban households with a water source in their dwelling (19.6%) compared to rural households (11.9%). About one in seven households relied on water sources located outside their dwelling or yards/plots.

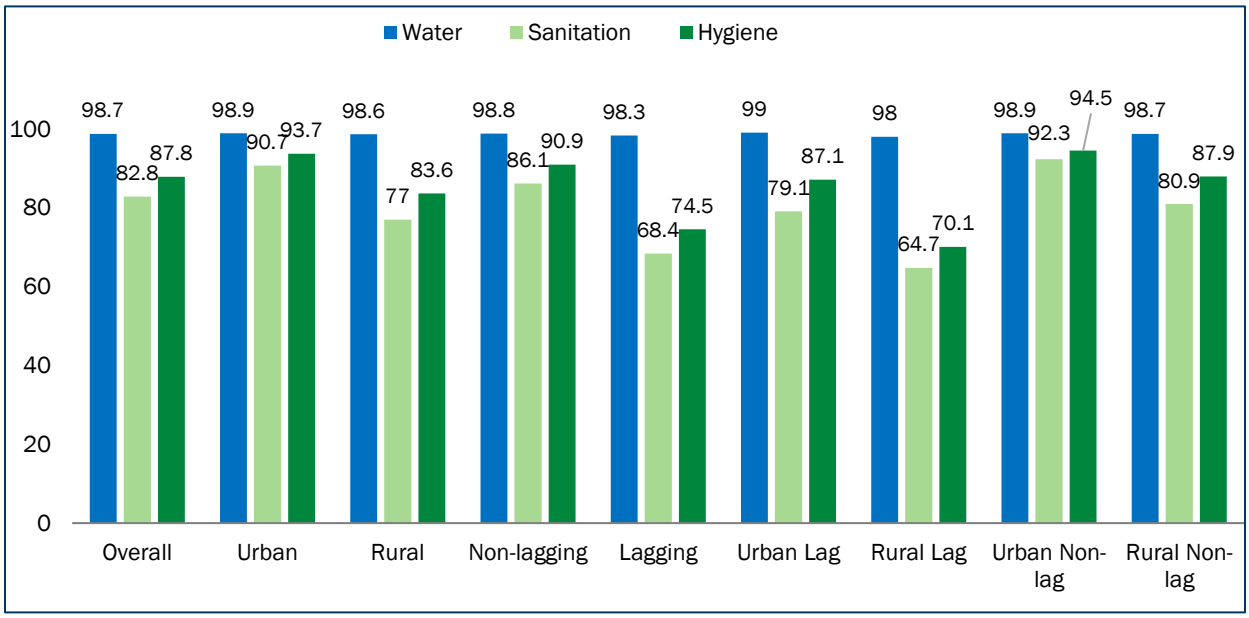
Water shortages during the month before the survey were reported more often in urban areas (12.6%) than in rural areas (11.7%). The most common reason was the unavailability of a household member to collect water, cited by 5.9% of urban and 4.7% of rural households.

Power failures and the unavailability of water at the source were cited less frequently. Treating water to make it safe was uncommon, with only 3.8% of households engaging in this practice (2% in rural areas and 6.2% in urban areas).

Overall, 82.8% of households had access to improved sanitation facilities, with higher coverage in urban areas (90.7%) than in rural areas (77.0%) (Figure 2.4). The disparity was more pronounced in lagging districts, where only 68.4% of households had access, compared to 86.1% in non-lagging districts. Within lagging districts, rural households had the lowest sanitation coverage at 64.7%, underscoring a critical gap requiring targeted interventions.

Most districts had over 95% coverage of improved water services (Figure 2.5), with exceptions in Khushab (92%), Rawalpindi (94%), and Dera Ghazi Khan (94%).

Figure 2.4: Percentage of households with improved WASH* services availability



*Availability of handwashing facility (fixed or mobile container) designed to contain, transport, or regulate the flow of water to facilitate handwashing with soap—bar soap, liquid soap, detergent (powder, liquid, paste)—within the dwelling.

Table 2.7: Percentage of households by water source location, availability, and treatment

	Total	Rural	Urban
Location of water source			
In own dwelling	15.1	11.9	19.6
In own yard/plot	38.8	50.7	22.2
Elsewhere	46.1	37.4	58.2
Total	100.0	100.0	100.0
Shortage of drinking water last month			
No shortage	87.9	88.3	87.4
Water unavailable from source	2.4	2.3	2.6
Water too expensive	0.1	0.1	0.1
Source inaccessible	0.8	1.0	0.6
No person in HH available to fetch water	5.2	4.7	5.9
Power failure	3.0	3.1	2.8
Other	0.6	0.6	0.6
Total	100.0	100.0	100.0
Are you treating water to make it safe?			
Yes	3.8	2.0	6.2
No	96.2	98.1	93.8
Total	100.0	100.0	100.0
No. of HHs (unweighted)	**24,540**	**15,952**	**8,588**

Improved sanitation

About a quarter of households (22.1% overall, 26.3% in rural areas, and 16.2% in urban areas) reported sharing toilet facilities with other households (Table 2.8). A greater percentage of urban dwellings (58.4%) had toilet facilities for men within the dwelling compared to rural areas (23.5%), with a similar trend observed for women. Notably, 6.9% of women lacked toilet facilities within their own dwellings, yards, or plots—an issue more prevalent in rural households (11.1%) than in urban ones (1%).

Improved sanitation facilities were accessible to 82.8% of households overall, with higher coverage in urban households (90.7%) than in rural households (77.0%). The gap was wider in lagging districts, where only 68.4% of households had access to improved sanitation services compared to 86.1% in non-lagging districts. Within lagging districts, rural households had the lowest coverage at 64.7%, underscoring a critical gap that requires targeted interventions (Figure 2.4).

Most districts reported high availability of improved sanitation services; however, some fell well below average. Among lagging districts, availability was lowest in Dera Ghazi Khan (30%), Rajanpur (45%), and Muzaffargarh (64%), indicating severe gaps in sanitation infrastructure. In non-lagging districts, Chiniot (62%) and Sahiwal (67%) also showed notably low coverage, emphasizing the need for targeted improvements. These findings highlight regional disparities in sanitation services, with districts in southern and parts of central Punjab districts lagging behind (Figure 2.6).

Table 2.8: Percentage of households sharing toilet facilities and location of toilets for men and women

	Total	Rural	Urban
Are you sharing toilet facilities with other Households?			
Yes	22.1	26.3	16.2
No	77.9	73.7	83.8
Total	100.0	100.0	100.0
Location of men's toilet facility			
Own dwelling	38.2	23.5	58.4
Own yard/plot	55.0	65.4	40.6
Elsewhere	6.9	11.1	1.1
Total	100.0	100.0	100.0
Location of women's toilet facility			
Own dwelling	38.3	23.6	58.5
Own yard/plot	54.9	65.3	40.4
Elsewhere	6.9	11.1	1.0
Total	100.0	100.0	100.0
No. of HHs (unweighted)	**24,540**	**15,952**	**8,588**

Hygiene

Among the three indicators, hygiene—defined as the availability of a handwashing facility with soap inside the dwelling—was the least prevalent, with an overall rate of 87.8%. This included 83.6% in rural areas and 93.7% in urban areas (Figure 2.4). In lagging districts, only 74.5% of households reported having a handwashing facility, compared to 90.9% in non-lagging districts. The lowest availability was in rural households of lagging districts (70.1%), while the highest was in urban non-lagging districts (94.5%).

The availability of water for washing and bathing was relatively high, reported by 93.3% of households overall (91.7% in rural areas and 95.4% in urban areas) (Table 2.9). The availability of soap also exceeded 90% in both rural and urban areas; however, 8.6% of rural households lacked soap and relied solely on water for handwashing.

At the district level, Dera Ghazi Khan recorded the lowest availability of handwashing facilities (62%), followed by Bhakkar (69%) and Mianwali and Rajanpur (74% each). In contrast, Gujranwala reported the highest availability at 99%. Several other non-lagging districts—including Sheikhupura (97%), Sargodha (96%), Lahore (96%), and Sialkot (96%)—also reported over 95% availability (Figure 2.7).

Table 2.9: Percentage of households by water availability for washing/bathing and type of soap used to wash hands

	Total	Rural	Urban
Is water available when needed for washing and bathing?			
Yes	93.3	91.7	95.4
No	6.7	8.3	4.6
Total	100.0	100.0	100.0
Type of soap used for handwashing*			
Soap	93.3	90.2	97.6
Liquid soap	0.5	0.3	0.8
Detergent (powder, liquid, paste)	0.2	0.3	0.1
Ash, mud, sand	0.3	0.6	0.0
Water only	5.6	8.6	1.5
Other	0.1	0.1	0.0
Total	100.0	100.0	100.0
No. of HHs (unweighted)	**24,540**	**15,952**	**8,588**

* A multiple-response variable with four options was used. However, for 85% of households, no secondary responses were recorded beyond their initial answer. This tabulation was based on the first response only.

Figure 2.5: Percentage of households with improved water service availability by district

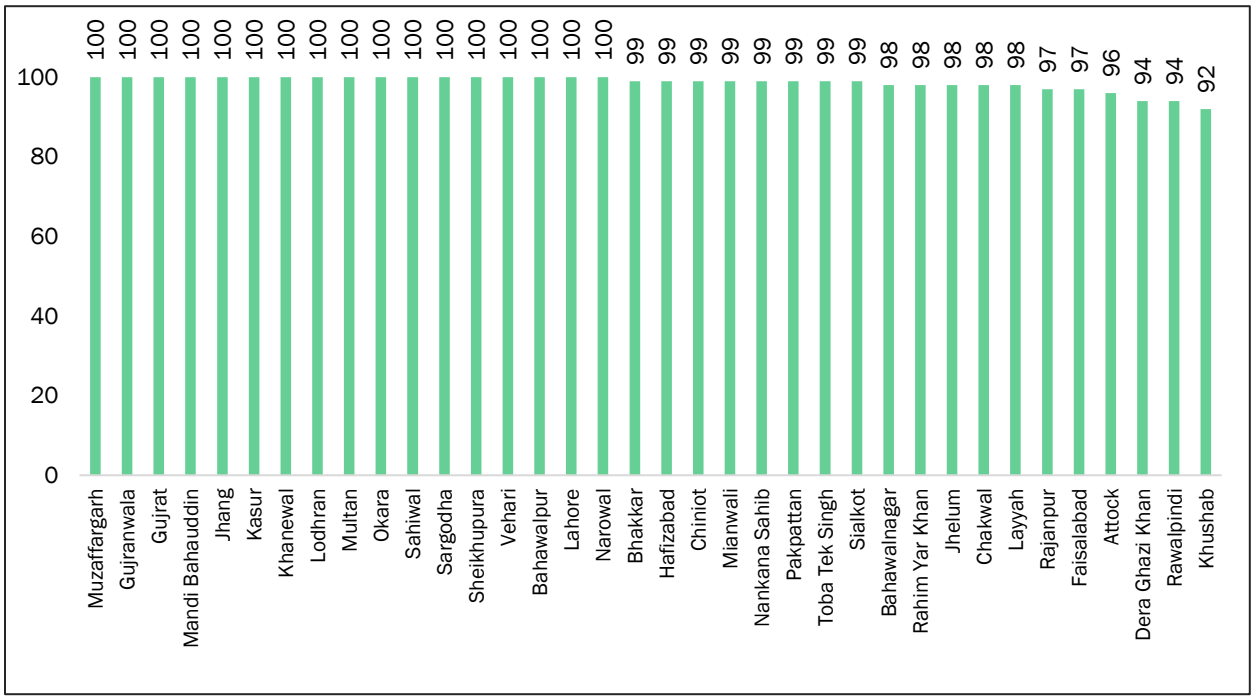


Figure 2.6: Percentage of households with improved sanitation service availability by district

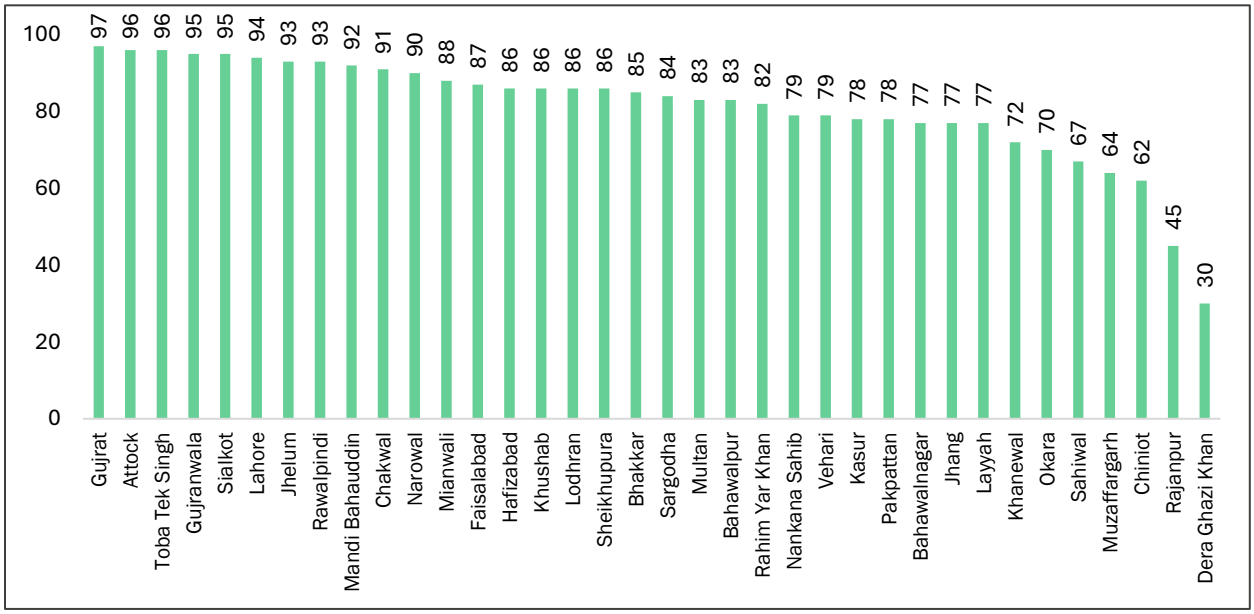
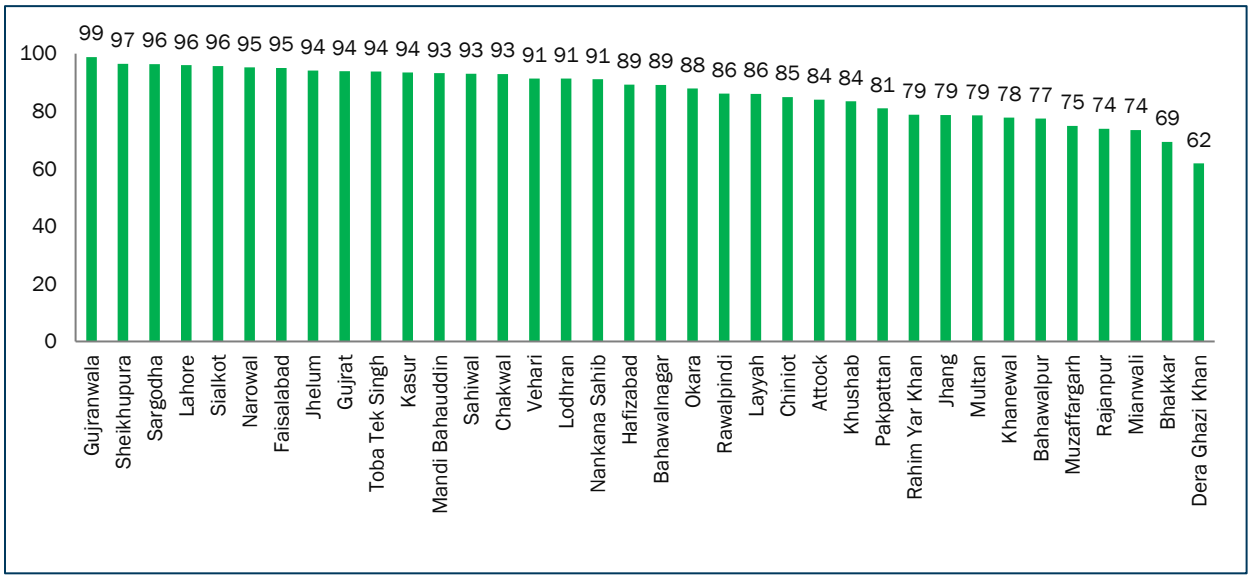


Figure 2.7: Percentage of households with on-premises washing facilities with soap for handwashing by district



Background Characteristics of Household Members

A total of 143,951 permanent members were living in the households surveyed in PHPS 2024–25, resulting in an average household size of 5.8 members. Of these, 95,683 members resided in rural areas, with an average family size of 5.9, compared to 48,268 members in urban households, which averaged 5.6 members. The population was almost evenly split by gender, with 50.3% male and 49.7% female (Table 2.10).

Most of the population (59.8%) belonged to the economically active age group of 15–64 years, while 4.8% were 65 years or older. The dependency ratio—the percentage of individuals under 15 years and over 65 years—was high at 40.3%. Reflecting higher fertility rates, rural areas had a greater percentage of children under five (12%) and a higher dependency ratio (42.0%). In contrast, the proportion of children under five in urban areas was 10.9%, with a lower dependency ratio at 37.7%. The median age of household members also reflected this rural–urban difference: rural males had a median age of 21 years compared to 22 years in urban areas, while rural females had a median age of 21 years compared to 23 years in urban areas.

Coverage of computerized national identity cards (CNICs) and B forms (for children) was high, though not universal. CNICs are issued by the National Database and Registration Authority (NADRA) and are required for most formal transactions. Overall, 90.1% of males and 87.9% of females were registered with NADRA and possessed a CNIC. In rural areas, the proportions were 88.4% for males and 85.6% for females, compared to 92.6% for males and 91.2% for females in urban areas.

Table 2.10: Percentage distribution of permanent household members, by background characteristics

	Total	Rural	Urban
Sex			
Male	50.3	50.3	50.3
Female	49.7	49.7	49.7
Total	100.0	100.0	100.0
Current age (years)			
under 5	11.6	12.0	10.9
5–14	23.9	24.8	22.6
15–64	59.8	58.0	62.3
65+	4.8	5.2	4.2
Total	100.0	100.0	100.0
Average HH size	5.8	5.9	5.6
Average no. of people by age group			
Under 5	0.7	0.7	0.6
5–14	1.4	1.5	1.3
15–64	3.5	3.4	3.5
65+	0.2	0.3	0.2
Median age (in years)			
Males	21.0	21.0	22.0
Females	22.0	21.0	23.0
Have CNIC or form B?			
Males			
Yes	90.1	88.4	92.6
No	9.8	11.4	7.4
Don't know	0.1	0.2	0.1
Total	100.0	100.0	100.0
N (unweighted)	**72,295**	**48,138**	**24,157**
Females			
Yes	87.9	85.6	91.2
No	12.0	14.3	8.7
Don't know	0.1	0.1	0.1
Total	100.0	100.0	100.0
N (unweighted)	**71,656**	**47,545**	**24,111**
No. of HH members	**143,951**	**95,683**	**48,268**

School attendance among 5–9-year-old and 10–14-year-old boys and girls

Article 25-A of the Constitution of Pakistan mandates the state to provide free and compulsory quality education to children aged 5–16 years. Despite this requirement, a staggering 19.7% of boys and 20.4% of girls aged 5–9 in rural areas have never attended school (Table 2.11). In urban areas, the gender difference was modest, with 12.4% of boys and 12.3% of girls never attended. Among children aged 5–9 currently in school, gender disparities were minimal: 78.4% of boys and 77.2% of girls were enrolled in rural areas, compared to 85.8% of boys and 85.7% of girls in urban areas.

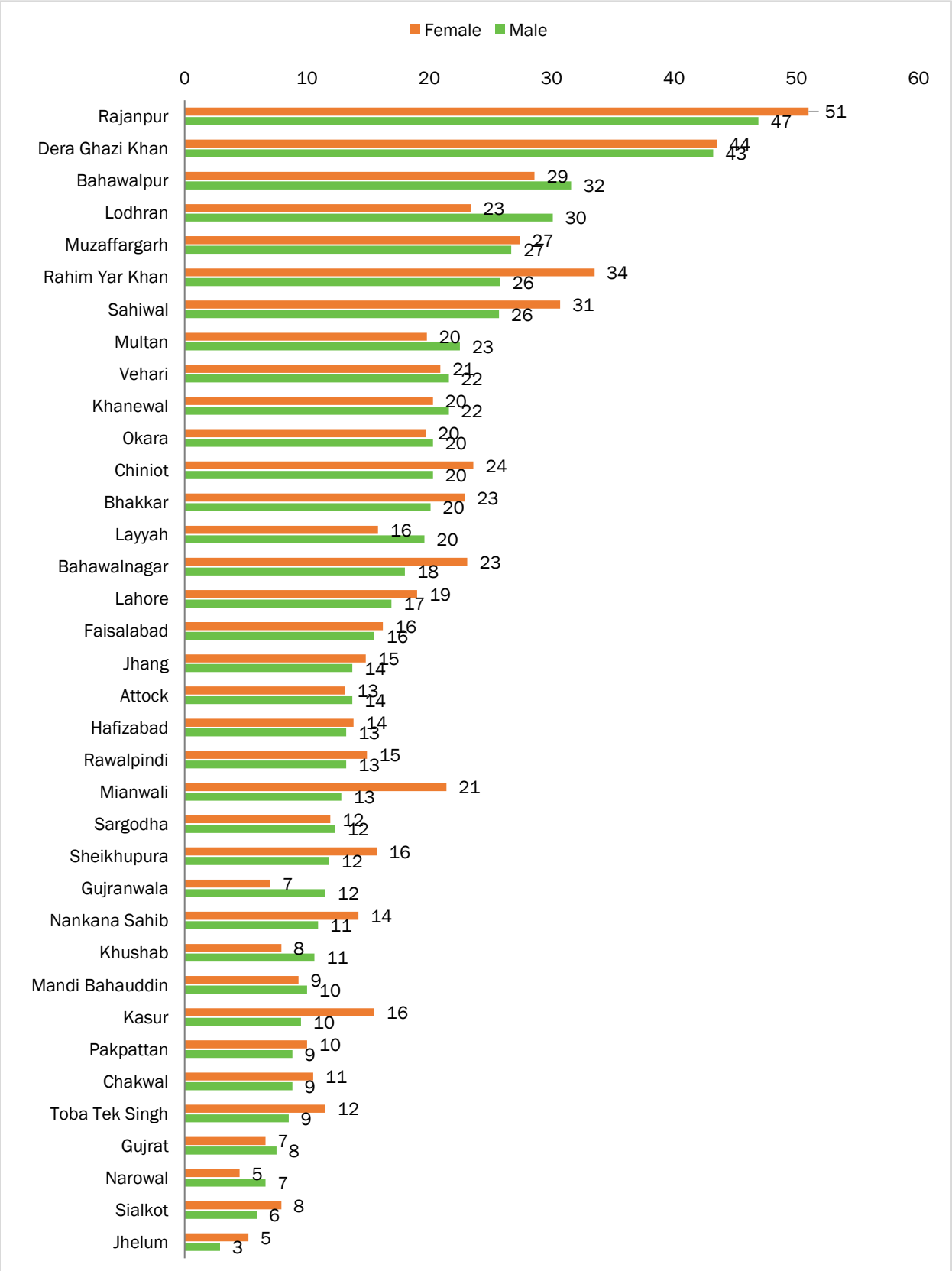
For the 10–14 age group, which also falls under the constitutional mandate for free and compulsory education, disparities remain. In rural areas, 12.7% of girls had never attended school, which was 1.6 percentage points higher than boys (11.1%). In urban areas. The difference was narrower, with 4.6% of boys and 4.9% of girls not attending school. School attendance among 10–14-year-olds was 72.5% for boys and 71.7% of girls in rural areas, compared to 83.6% for boys and 84.7% for girls in urban areas. Overall, Table 2.11 highlights persistent inequities in schooling by gender and between urban and rural areas.

At the district level, gender disparities are particularly stark. In 21 of Punjab's 36 districts, more girls than boys aged 5–9 years were out of school (Figure 2.8). The largest gaps were observed in Rajanpur (51% of girls vs. 47% of boys), Rahim Yar Khan (34% vs. 26%), and Sahiwal (31% vs. 26%). A few districts—such as Narowal, Khushab, and Gujranwala—showed the reverse trend, with boys more likely than girls to be out of school. These patterns underscore the persistence of gender inequities in school participation across many districts in Punjab.

Table 2.11: Percentage of children aged 5–9 and 10–14 years, by status of school attendance and sex

School attendance	Age 5–9				Age 10–14			
	Boys		Girls		Boys		Girls	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Education status								
Currently attending	78.4	85.8	77.2	85.7	72.5	83.6	71.7	84.7
Attended in past	1.9	1.8	2.4	2.0	16.4	11.8	15.6	10.4
Never attended	19.7	12.4	20.4	12.3	11.1	4.6	12.7	4.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Out of school	*21.6*	*14.2*	*22.8*	*14.3*	*27.5*	*16.4*	*28.3*	*15.3*
No. of children (unweighted)	**6,454**	**2,956**	**6,123**	**2,710**	**5,890**	**2,695**	**5,536**	**2,620**

Figure 2.8: Percentage of out-of-school children aged 5–9 years, by district and sex



3

Background Characteristics of Ever-married Women, Empowerment, and Their Exposure to Mass Media

Key Findings

Education, employment, and marriage

- Over one-third of ever-married women in Punjab had no education (35.3%). The percentage was much higher in rural areas (44.9%) than in urban areas (21.4%). The gap was particularly high between lagging districts (59.7%) and non-lagging districts (29.6%).
- The proportion of women with primary or higher education was as low as 20% in Rajanpur and 25% in Dera Ghazi Khan, compared to 91% in Sialkot and 87% in Gujrat.
- Only 14.9% of women reported working for income in the 30 days prior to the survey.
- In rural areas, 14.6% of women were beneficiaries of the unconditional stipend from the Benazir Income Support Programme (BISP), compared to 7.4% in urban areas.
- A significant 15.1% of women married before age 18, and 34.2% married before age 20. This limits their opportunities for education and work while increasing their risks associated with early childbearing.
- Consanguineous marriages remained prevalent at 43.9% overall, including 49.4% in rural areas, and 36.2% in urban areas.
- While 12.6% of women had not yet started childbearing, 21.5% already had five or more children. Fertility was the highest in Muzaffargarh and Dera Ghazi Khan (mean parity 3.7), Rajanpur (3.4), and Kasur and Bahawalpur (3.3).

Media exposure and technology access

- Very few women reported reading newspapers or listening to the radio. Only 1.4% of ever-married women read newspapers and 0.4% listened to the radio at least once a week. Watching TV was

more common, with 36% watching at least once a week (42.4% in urban areas vs. 31.5% in rural areas).

- Internet access was reported by 37.9% of women overall, primarily via mobile devices (28.3%), followed by fixed Wi-Fi (7.6%) or both combined (2.0%). Urban women had significantly greater access (54%) than rural women (26.6%).
- Mobile phone ownership and reachability varied sharply by residence. Overall, 28.4% of women owned a mobile phone, with ownership being higher in urban areas (57.8%) than in rural areas (34.4%).

Women's empowerment

- More women in urban areas reported being able to visit places independently compared to those in rural areas. For example, 29.4% of urban women could visit a hospital or doctor in the community alone, compared to 27.4% in rural areas.
- Decisions about household purchases, daily expenses, medical treatment, and the use of household or individual earnings were most often made by the husband or jointly by both partners.

In total, 19,534 ever-married women were interviewed across Punjab. Their socioeconomic and demographic profiles, along with their exposure to mass media, internet access, and mobile phone ownership, provide valuable insights into the context shaping population and health outcomes. This chapter also examines women's autonomy and empowerment in activities outside the home and their role in household decision-making.

Socioeconomic and Demographic Background Characteristics

Nearly all ever-married women aged 15–49 years (95.2%) were currently married at the time of the survey, while 2.3% were widowed, 1.6% were divorced, and 0.9% were separated (Table 3.1). Differences in marital status by residence (urban/rural) or district type (lagging/non-lagging districts) were negligible.

Overall, more than one-third of ever-married women (35.3%) had received no formal education. As expected, a higher percentage of women in rural areas had received no education compared to those in urban areas (44.9% vs. 21.8%), and in lagging districts compared to non-lagging districts (59.7% vs. 29.6%). The proportion of women with secondary or higher education was higher in urban areas (46.9%) than in rural areas (22.4%), and in non-lagging (36.8%) than lagging districts (14.2%).

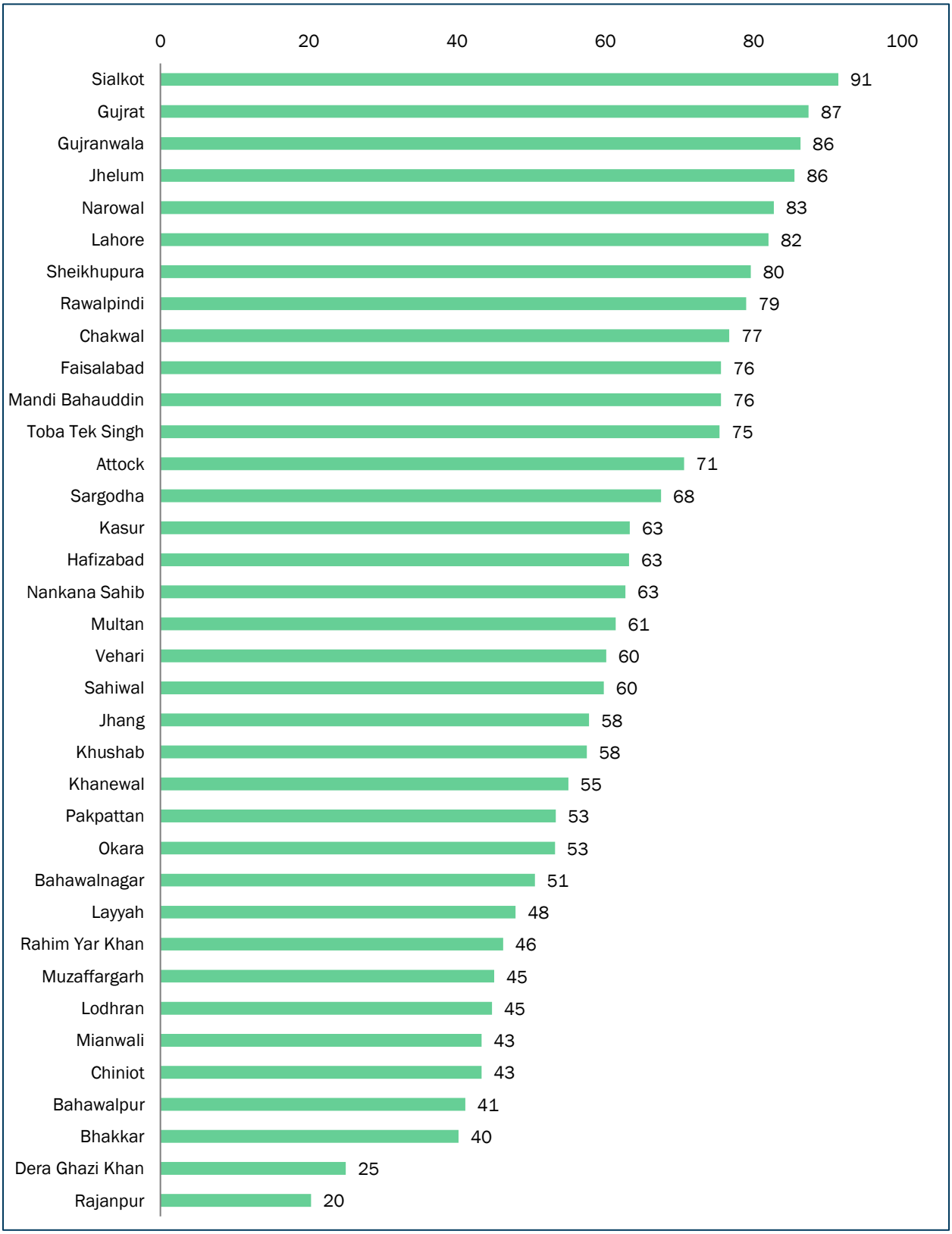
The percentage of women with primary or higher education varied widely across districts—from less than 30% in Dera Ghazi Khan and Rajanpur to over 90% in Sialkot (Figure 3.1). In contrast, significantly higher proportions were observed in central and northern Punjab, including Lahore (82%), Narowal (82.7%), Jhelum (85.5%), Gujranwala (86.3%), Gujrat (87.4%), and Sialkot (91.4%). These patterns reveal stark inequalities in women's educational attainment across the province.

Table 3.1: Percentage distribution of ever-married women, by background characteristics

Background characteristics	Total	Rural	Urban	Lagging districts	Non-lagging districts
Current marital status					
Currently married	95.2	95.1	95.3	96.3	94.9
Widowed	2.3	2.4	2.2	2.2	2.4
Divorced	1.6	1.6	1.7	1.0	1.8
Separated	0.9	0.9	0.9	0.5	1.0
Total	100.0	100.0	100.0	100.0	100.0
Education					
No education	35.3	44.9	21.8	59.7	29.6
Primary and middle	32.2	32.7	31.3	26.1	33.6
Secondary and higher	32.5	22.4	46.9	14.2	36.8
Total	100.0	100.0	100.0	100.0	100.0
Currently working*					
Yes	14.9	15.8	13.6	16.6	14.4
No	85.2	84.3	86.4	83.4	85.6
Total	100.0	100.0	100.0	100.0	100.0
BISP beneficiary					
Yes	11.60	14.60	7.40	21.10	9.40
No	88.40	85.40	92.60	78.90	90.60
Missing	0.02	0.01	0.02	0.00	0.02
Total	100.00	100.00	100.00	100.00	100.00
Age at first marriage (years)					
< 18	15.1	16.9	12.5	23.3	13.2
18–20	34.2	36.0	31.7	39.2	33.0
21–24	28.5	25.8	32.4	20.8	30.3
25 or older	21.4	20.2	23.0	13.5	23.2
Don't know/missing	0.9	1.2	0.4	3.2	0.3
Total	100.0	100.0	100.0	100.0	100.0
Marriage was consanguineous					
No	39.8	34.0	48.0	24.1	43.5
Yes, with first cousin	43.9	49.4	36.2	56.8	40.9
Yes, with other relative	11.4	11.7	11.1	15.5	10.5
Missing	4.8	4.9	4.7	3.7	5.1
Total	100.0	100.0	100.0	100.0	100.0
Current age (years)					
15–24	14.1	16.1	11.3	18.8	13.0
25–34	37.7	37.7	37.6	37.7	37.6
35–49	48.2	46.2	51.1	43.4	49.4
Total	100.0	100.0	100.0	100.0	100.0
No. of children ever born					
0	12.6	13.2	11.8	12.4	12.6
1–2	30.0	28.9	31.6	26.3	30.9
3–4	36.0	34.3	38.3	33.9	36.4
5 or more	21.5	23.6	18.4	27.3	20.1
Total	100.0	100.0	100.0	100.0	100.0
No. of women (unweighted)	**19,536**	**12,864**	**6,672**	**5,415**	**14,121**

*Based on the question: "Aside from your own housework, have you done any work for income in the last 30 days?"

Figure 3.1: Percentage of ever-married women with primary or higher education, by district



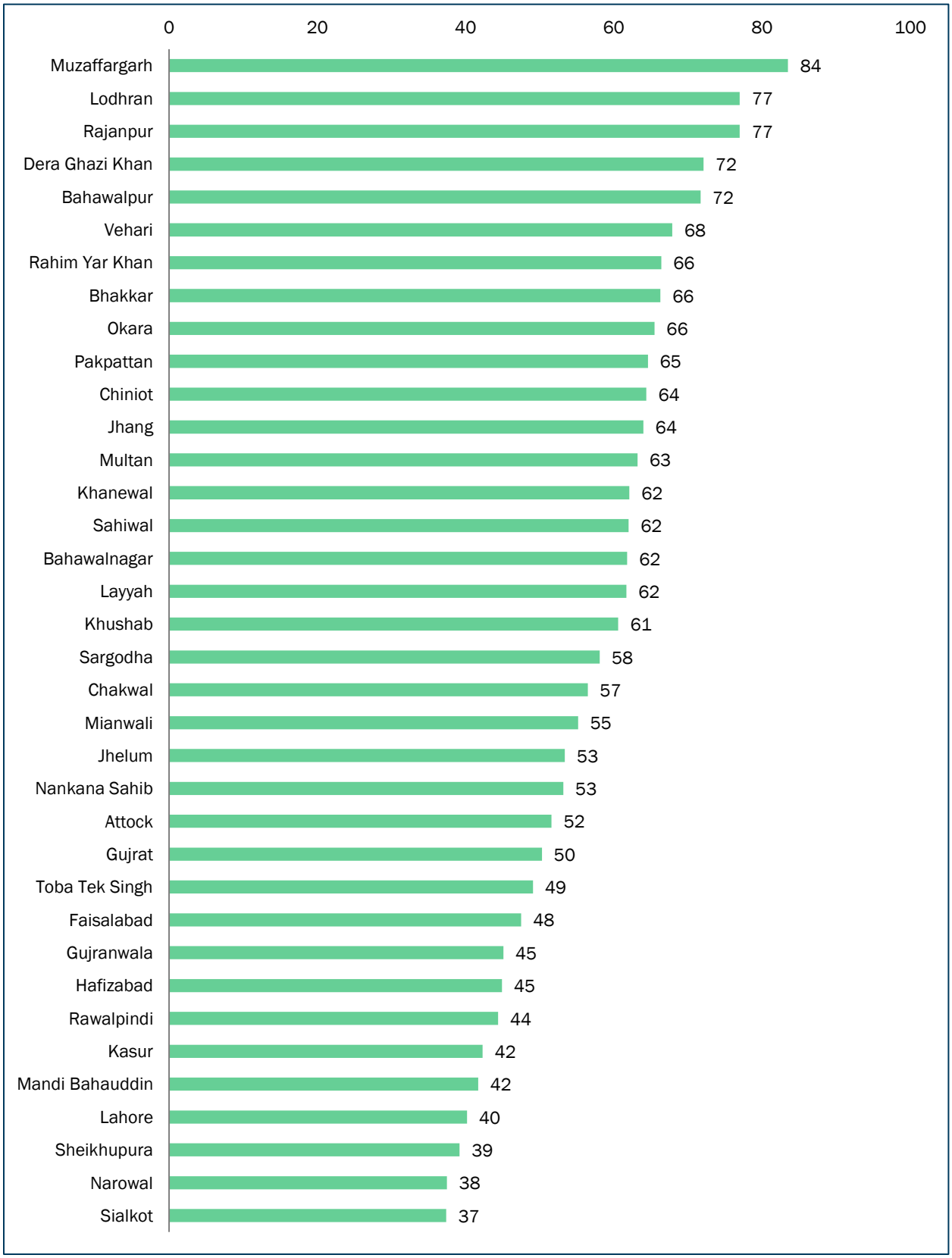
Overall, 14.9% of women reported working for income in the 30 days prior to the survey. A slightly higher percentage of women in rural areas (15.8%) worked for income compared to those in urban areas (13.6%). Employment was also somewhat more common in non-lagging districts (16.6%) than in lagging districts (14.4%). The high percentage of evermarried women who did not work for income has detrimental implications for women's empowerment, decision-making, and other measures of wellbeing.

Overall, 11.6% of women reported being BISP beneficiaries, with a higher percentage in rural areas (14.6%) compared to urban areas (7.4%), and in lagging districts (21.1%) compared to non-lagging districts (9.4%).

The Child Marriage Restraint (Amendment) Bill of 2018 established a minimum legal age of 18 years for females, although it has yet to be passed nationwide. Despite this, about one in seven ever-married women reported marrying before age 18. Child marriage was more common in rural areas (16.9%) compared to urban areas (12.5%). The difference between lagging and non-lagging districts was significant, with rates of 23.3% and 13.2%, respectively. Additionally, nearly one-third of women married between the ages of 18 and 20. Altogether, about half of women in Punjab married before age 20, limiting their opportunities for education and employment while increasing the serious health risks associated with early childbearing.

The prevalence of consanguineous marriages was high, with 43.9% of women in Punjab married to their first cousins. There was a 13 percentage point difference in the prevalence of first cousin marriages between rural (49.4%) and urban areas (36.2%). Similarly, 56.8% of women in lagging districts were married to their first cousins, compared to 40.9% in non-lagging districts. Although consanguineous marriages were reported in all districts, the extent varied (Figure 3.2). In Sialkot, Narowal, Sheikhupura, and Lahore, fewer than 40% of marriages were consanguineous. Conversely, in Bahawalpur, Dera Ghazi Khan, Rajanpur, Lodhran, and Muzaffargarh, over 70% of marriages were consanguineous.

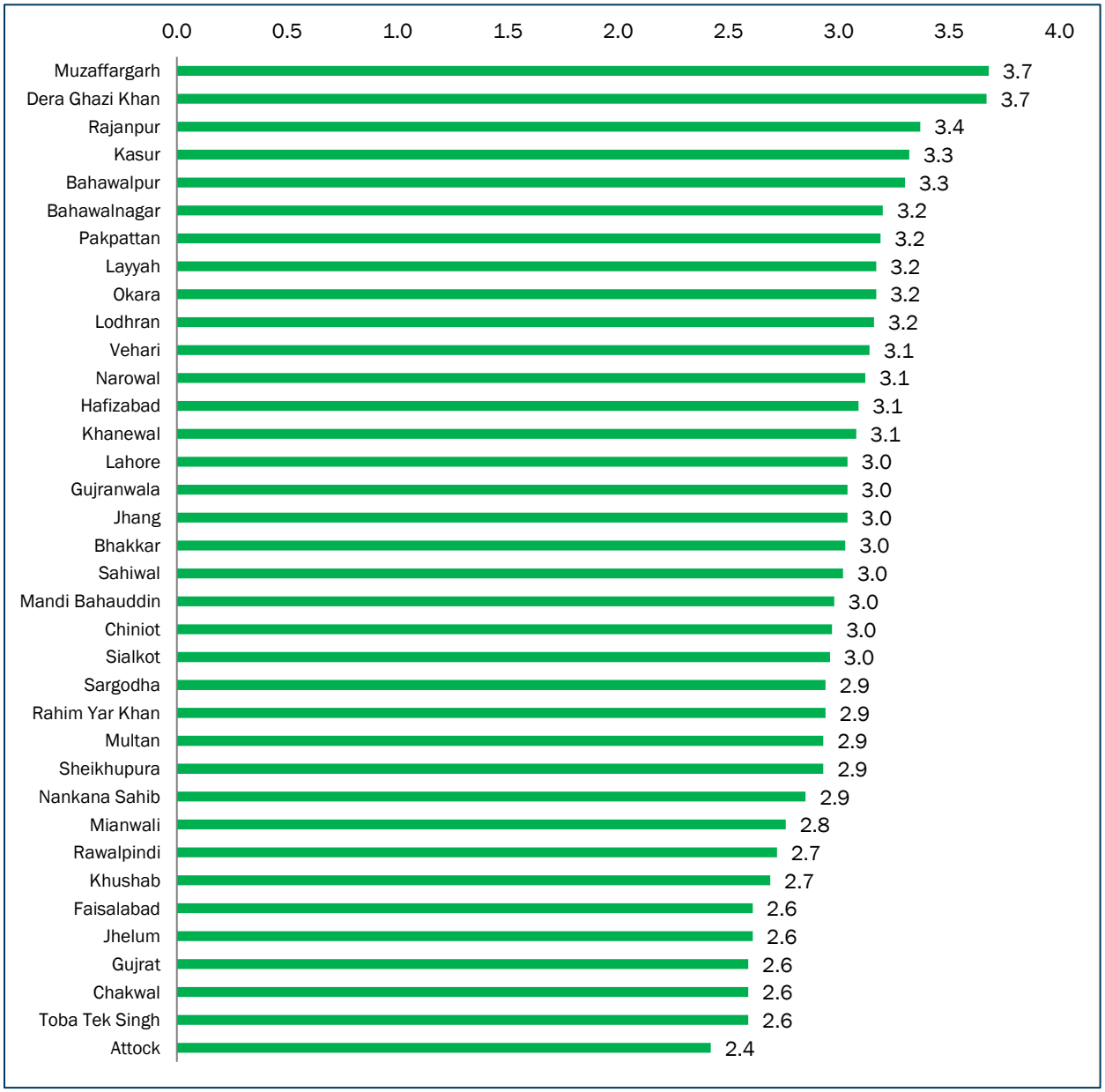
Figure 3.2: Percentage of ever-married women with consanguineous marriages, by district



Regarding the average number of children ever born, approximately 12.6% of women were childless at the time of the survey, with little variation across urban and rural areas or between lagging and non-lagging districts. The proportion of women in the high parity group, defined as having five or more children, was 21.5% for Punjab overall, 23.6% for rural areas, and 18.4% for urban areas. A significant difference was observed between lagging and non-lagging districts, with 27.3% of women in lagging districts and 20.1% in non-lagging districts reporting five or more children.

Unlike other characteristics—such as education levels and consanguineous marriage—the variation in mean parity across districts was relatively narrow. The lowest mean number of children was observed in Attock (2.4), while the highest was reported in Muzaffargarh and Dera Ghazi Khan (3.7). In Toba Tek Singh, Chakwal, Gujrat, Jhelum, and Faisalabad, the mean parity was 2.6 children.

Figure 3.3: Mean number of children ever born, by district



Exposure to Mass Media

Women's exposure to mass media can strengthen their agency by providing access to information needed for informed decision-making.

In Punjab, only 4.3% of women reported reading newspapers at least once a week, with lower readership in rural areas (3.1%) than in urban areas (5.9%) (Table 3.2). Listening to the radio was also infrequent; just 2.1% of women in Punjab tuned in at least once a week (1.9% in rural areas compared to 2.4% in urban areas). Watching television was more common: 36.0% of women watched at least once a week, while 20.4% watched less than once a week. In rural areas, 31.5% watched weekly and 16.5% less than weekly, compared to 42.4% and 26.0% in urban areas.

Table 3.2: Percentage of ever-married women, by exposure to mass media, internet access, and mobile phone ownership

	Total	Rural	Urban
Reading newspapers			
At least once a week	1.4	1.0	1.9
Less than once a week	2.9	2.1	4.0
Not at all	65.5	58.1	76.1
Unable to read	30.3	38.9	18.0
Total	100.0	100.0	100.0
Listening to the radio			
At least once a week	0.4	0.4	0.5
Less than once a week	1.7	1.5	1.9
Not at all	97.9	98.1	97.6
Total	100.0	100.0	100.0
Watching TV			
At least once a week	36.0	31.5	42.4
Less than once a week	20.4	16.5	26.0
Not at all	43.6	52.0	31.7
Total	100.0	100.0	100.0
Having internet access			
No	62.2	73.4	46.2
Yes, fixed (WiFi)	7.6	4.2	12.3
Yes, on mobile	28.3	21.2	38.5
Both	2.0	1.2	3.0
Total	100.0	100.0	100.0
Owning a mobile phone			
Yes	44.0	34.4	57.8
No	56.0	65.7	42.2
Total	100.0	100.0	100.0
Reachable via mobile phone*			
Yes	73.2	75.8	71.0
No	26.8	24.2	29.0
Total	100.0	100.0	100.0
No. of ever-married women (unweighted)	**19,536**	**12,864**	**6,672**

* Applies only to those who own a mobile phone.

In Punjab, 62.2% of ever-married women had no access to the internet. Access was higher in urban areas (53.8%) than in rural areas (26.6%). Mobile phones were the primary means of connectivity, with 28.3% of women overall, 21.2% in rural areas, and 38.5% in urban areas using them for internet access. Less than half (44.0%) of ever-married women owned a mobile phone, with ownership being higher in urban areas (57.8%) compared to rural areas (34.4%). Among women who owned a mobile phone, about three-quarters indicated that they could be reached via mobile phone. Mobile phone ownership and the ability to be contacted not only suggests a degree of autonomy but also provides women with an important channel for information.

Empowerment

Empowerment is a dynamic and context-specific process, making it difficult to establish a universally applicable standard definition. Key domains of empowerment include: (1) decision-making; (2) freedom of movement; (3) control over resources; (4) partner power balance; and (5) gender role attitudes. Jejeebhoy and Sathar (2025) found that at least one of these domains was positively associated with contraceptive use.[11]

The PHPS included a series of questions to assess the degree of women's empowerment in the province. Fewer than one in three women reported owning a mobile phone, while approximately three in four who owned a mobile phone and said they could be directly reached. When asked, "Do you have an account (other than BISP) in a bank or other financial institution that you yourself use?" only 3.7% of ever-married women responded affirmatively.

We further examined the freedom of movement among ever-married women. In Punjab, as elsewhere in Pakistan, it is uncommon for women to visit places independently—whether for hospital appointments, shopping, or visiting friends or relatives. Instead, the norm is visiting with accompaniment or with permission from their husband. Women in urban areas generally reported slightly greater freedom of movement than those in rural areas, but the difference was modest.

The overall percentage of women who could visit a hospital or doctor on their own, whether within or outside the community, was below 30%, even in urban areas (Table 3.3). The ability to visit independently was somewhat greater in urban areas, though not significantly so. For example, 28.2% of women overall, 27.4% in rural areas, and 29.4% in urban areas reported that they could visit a hospital or doctor in the community alone. A high proportion of 40.1% overall, 40.3% in rural areas, and 39.8% in urban areas indicated that they could do so only with someone else. The ability to visit a hospital or doctor outside the community independently was mentioned less frequently.

Notably, more women in urban areas (29.5%) could visit a shop within the community compared to women in rural areas (27.2%). A similar pattern emerged for visiting shops outside the community-21.4% for urban and 18.7% for rural women.

[11] Jejeebhoy, S. J., & Sathar, Z. (2025, May 5). Women's empowerment and contraception in low- and middle-income countries. *N-IUSSP*. https://www.niussp.org/gender-issues/womens-empowerment-and-contraception-in-low-and-middle-income-countries/.

Overall, 29.9% of women reported visiting friends or relatives within the community on their own, 30.0% in rural areas and 29.9% in urban areas. These figures were approximately ten percentage points lower for visits to friends or relatives outside the community. Together, these findings highlight that while access to mobile technology and internet is gradually expanding opportunities for women, significant barriers remain in mobility, financial independence, and decision-making power.

Table 3.3: Percentage distribution of ever-married women, by ability to visit places outside the home

	Total	Rural	Urban
Ability to visit hospital/doctor within community			
On own	28.2	27.4	29.4
With husband's permission	29.1	29.6	28.4
With someone only	40.1	40.3	39.8
Cannot go at all/do not go	2.6	2.7	2.4
Total	100.0	100.0	100.0
Ability to visit hospital/doctor outside community			
On own	19.9	19.0	21.1
With husband's permission	29.3	30.2	28.0
With someone only	48.5	48.3	48.8
Cannot go at all/do not go	2.3	2.5	2.0
Total	100.0	100.0	100.0
Ability to go to a shop within community			
On own	28.1	27.2	29.5
With husband's permission	27.9	28.3	27.3
With someone only	38.5	38.1	39.1
Cannot go at all/do not go	5.5	6.4	4.2
Total	100.0	100.0	100.0
Ability to go to a shop outside community			
On own	19.8	18.7	21.4
With husband's permission	27.7	28.5	26.6
With someone only	48.2	48.0	48.4
Cannot go at all/do not go	4.3	4.7	3.7
Total	100.0	100.0	100.0
Ability to visit friends/relatives within community			
On own	29.9	30.0	29.9
With husband's permission	28.3	28.5	27.9
With someone only	39.1	38.7	39.7
Cannot go at all/do not go	2.7	2.8	2.5
Total	100.0	100.0	100.0
Ability to visit friends/relatives outside community			
On own	20.7	20.0	21.6
With someone only	28.9	29.8	27.7
With chaperone	48.0	47.6	48.6
Cannot go at all/do not go	2.4	2.5	2.2
Total	100.0	100.0	100.0
No. of ever-married women (unweighted)	**19,534**	**12,863**	**6,671**

Participation in decision-making

PHPS inquired about who typically makes decisions regarding household and individual matters. The response categories included: (1) self (the respondent); (2) jointly with husband; (3) husband; and (4) someone else (mostly parents-in-law). Self-reported decision-making by respondents was low, ranging from two percent to four percent. For seven critical matters, the percentages of women reporting "self" were as follows:

1. Major household purchases: 6.9%
2. Daily household purchases: 9.0%
3. Getting medical treatment for the respondent: 8.9%
4. Getting medical treatment for son: 8.2%
5. Getting medical treatment for daughter: 7.9%
6. Using household earnings: 8.1%
7. Using the respondent's own earnings: 10.4%

Notably, even for decisions regarding their own earnings, only 3.1% reported making those decisions independently, while husbands reportedly made decisions in 40.8% of cases. Given the low percentages indicating "self" as the usual decision-makers, we combined the categories of "self" and "jointly with husband" (Table 3.4).

Table 3.4: Percentage of ever-married women, by participation in decision-making

	Total	Rural	Urban
Who usually makes decisions about major household purchases?			
Self or jointly with husband	56.9	53.5	61.7
Husband	23.6	25.4	21.2
Someone else	19.5	21.2	17.1
Total	100.0	100.0	100.0
Who usually makes decisions about daily household purchases?			
Self or jointly with husband	60.4	57.3	64.8
Husband	20.4	21.9	18.2
Someone else	19.2	20.9	16.9
Total	100.0	100.0	100.0
Who usually makes decisions about getting medical treatment for the respondent?			
Self or jointly with husband	68.0	65.5	71.7
Husband	19.6	21.0	17.6
Someone else	12.4	13.6	10.7
Total	100.0	100.0	100.0
Who usually makes decisions about getting medical treatment for the son?			
Self or jointly with husband	71.1	68.17	75.3
Husband	19.9	21.69	17.4
Someone else	9.0	10.13	7.3
Total	100.0	100.00	100.0
Who usually makes decisions about getting medical treatment for the daughter?			
Self or jointly with husband	71.1	68.7	74.5
Husband	19.9	21.3	17.9
Someone else	9.0	10.0	7.5
Total	100.0	100.0	100.0
Who usually makes decisions about using household earnings?			
Self or jointly with husband	72.0	69.1	76.2
Husband	20.3	22.3	17.4
Someone else	7.7	8.6	6.5
Total	100.0	100.0	100.0
Who usually makes decisions about using your own earnings?			
Self or jointly with husband	67.4	64.1	72.0
Husband	20.3	22.4	17.2
Someone else	12.3	13.5	10.7
Total	100.0	100.0	100.0
No. of ever-married women* (unweighted)	**19,460**	**12,813**	**6,647**

*Those currently not married or who did not respond were excluded from the analysis.

Women reported making decisions about major household purchases either independently or jointly with their husbands in 56.9% of cases overall, with 53.5% in rural areas compared to 61.7% in urban areas. This indicates that joint decision-making is more prevalent in urban settings. The second major category, "husband," accounted for 23.6% overall, with a higher proportion in rural areas (25.4%) compared to urban areas (21.2%).

For daily purchase decisions, joint decision-making was reported by 60.4% of women overall, with 57.3% in rural areas and 64.8% in urban areas—further demonstrating greater autonomy or shared decision-making among urban women.

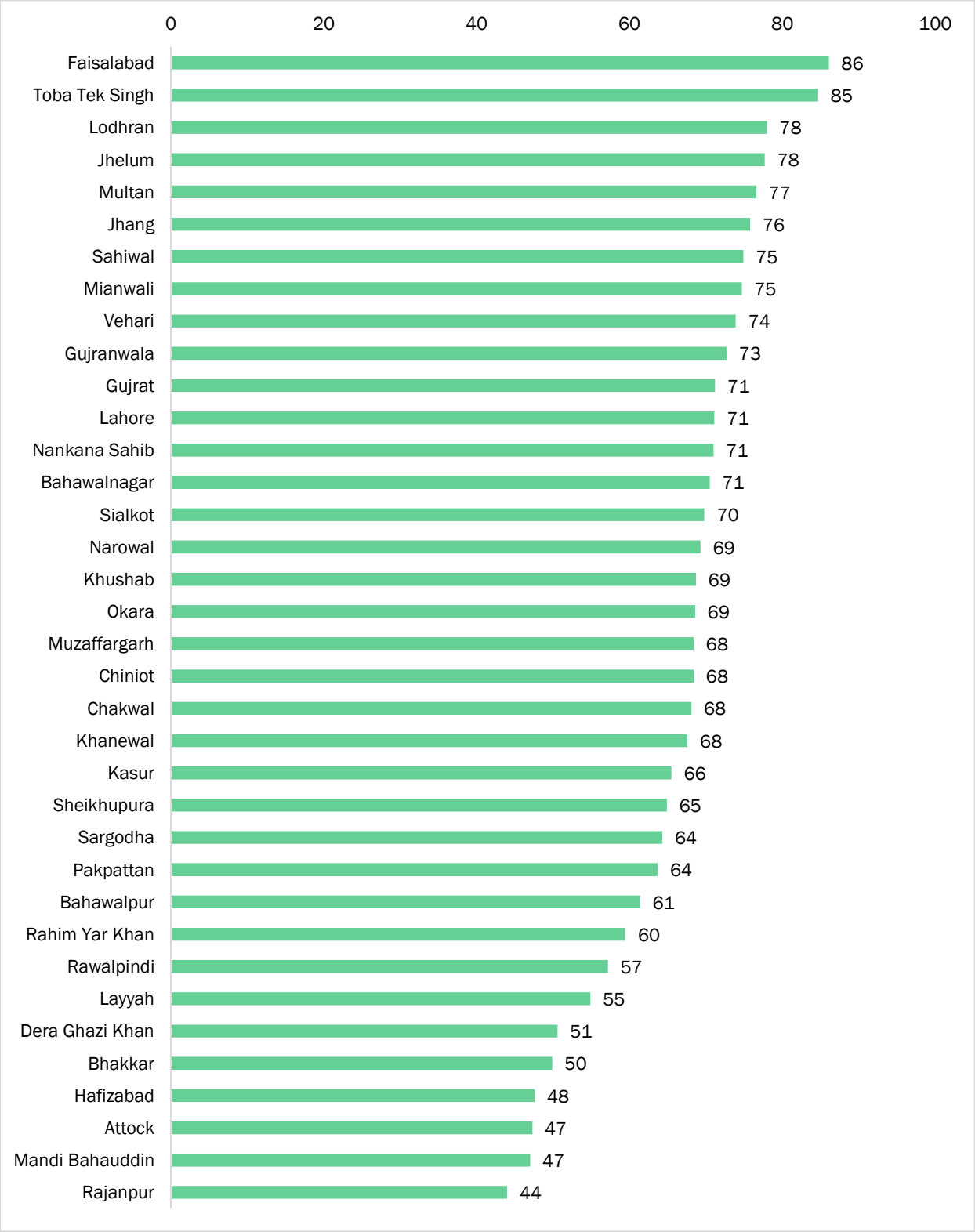
Decisions regarding medical treatment for respondents were made by the woman herself or jointly with her husband in 68.0% of cases overall—65.5% in rural areas and 71.7% in urban areas—while husbands were sole decision-makers in 19.6% of cases. A similar pattern was observed for decisions about medical treatment for children.

Decisions about the use of household earnings were made by women themselves or jointly with their husbands in 72.0% of cases overall, with 69.1% in rural areas and 76.2% in urban areas. In contrast, 20.3% reported that the husband made the decision alone. Regarding the use of the respondents' own earnings, 67.4% reported making the decision themselves or jointly, with 64.1% in rural areas and 72.0% in urban settings. Meanwhile, 20.3% indicated it was the husband's decision, and 12.3% reported that someone else decided.

The proportion of women making decisions about their medical treatment independently or jointly with their husbands varied significantly, ranging from less than 50% in Rajanpur to over 80% in Faisalabad and Toba Tek Singh (Figure 3.4).

Overall, few women typically made decisions independently on any matter, including the use of their own earnings. Across all decision domains, women in urban areas reported higher involvement in decision-making compared to those in rural areas, with urban women more frequently participating in joint decisions. Husbands alone made most decisions, including those related to medical treatment for respondents. Self-reported data indicate low levels of women's participation in decision-making and limited freedom of movement. Cultural norms may lead women to attribute decisions to their husbands even when they participate in joint decision-making.

Figure 3.4: Percentage of women who report making decisions about their medical treatment themselves or jointly with their husbands, by district



4

Maternal Health: Antenatal Care, Delivery Care, and Postnatal Care

Key Findings

Antenatal care

- 90% of women who had their last pregnancy within three years prior to the survey attended at least one antenatal care (ANC) consultation.
- Only 46.2% of all women—39.1% in rural areas and 57.4% in urban areas—had four or more ANC visits during their last pregnancy.
- Coverage of "effective" ANC was low, at 18.3% overall, and below 20% for most subgroups.
- Blood pressure measurement during ANC visits was widespread (86.0% overall, 83.3% in rural areas, and 90.4% in urban areas). Over half of the women had their weight measured (54.0%), while breast examinations were notably low at just 18.4%.
- Two doses of tetanus toxoid were received by 80.5% of women overall, 79.5% in rural areas, and 82.0% in urban areas.
- Except for the poorest women, ANC services were more commonly received from private facilities.
- When ANC was provided, doctors were the providers in 77.8% of cases.

Delivery care

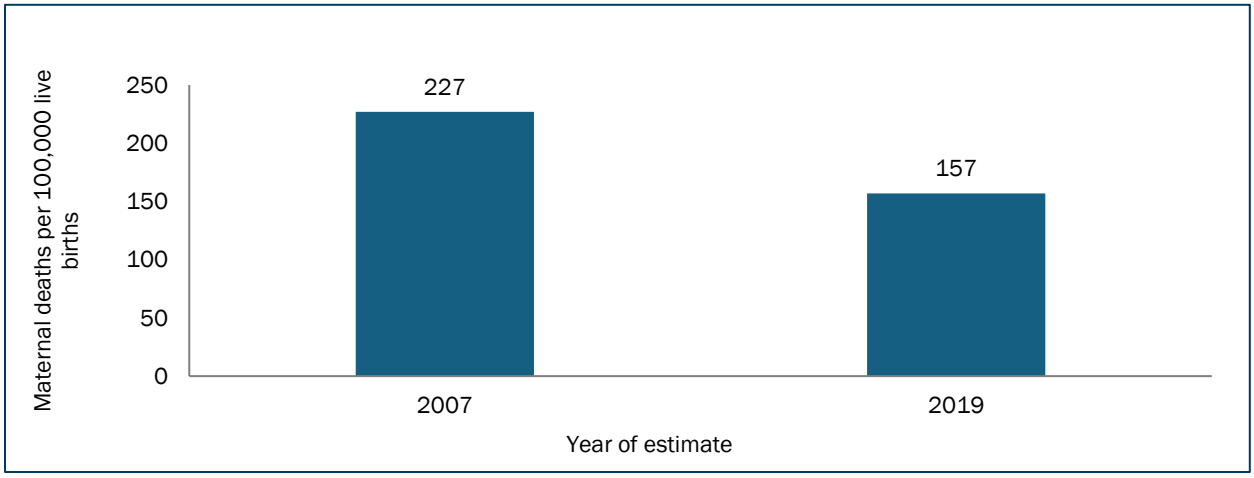
- Overall, 88.6% of deliveries in the three years preceding the survey were attended by skilled health professionals.
- Three-fourths of deliveries with a skilled birth attendant (SBA) were assisted by a doctor.
- Cesarean sections accounted for 43.4% of deliveries.
- 17.2% of babies experienced immediate skin-to-skin contact—Kangaroo mother care (KMC)—after birth.

Postnatal care

- Almost 60% of all women who had a live birth in the three years preceding the survey received at least one postnatal care (PNC) checkup.
- Women in the lowest wealth quintile exhibited the lowest PNC coverage at 29.2%, followed by women in lagging districts (36.5%) and women with no education (32.7%).

Pakistan has made steady progress in reducing the national maternal mortality ratio (MMR) from 419 per 100,000 live births in 2000 to 155 in 2023 (Figure 4.1).[12] However, an estimated 11,000 women died during pregnancy or within 42 days of pregnancy termination in 2023.[13] The 2019 Pakistan Maternal Mortality Survey estimated the MMR for Punjab at 157 deaths per 100,000 live births, compared to 227 according to the PDHS 2006-07.[14]

Figure 4.1: MMRs per 100,000 live births, 2007 & 2019, Punjab



Source: Pakistan DHS 2006-07 & Pakistan Maternal Mortality Survey 2019

Most maternal deaths are preventable. The World Health Organization (WHO) recommends access to reproductive health services, skilled birth attendance, and a continuum of quality care throughout all stages of pregnancy, childbirth, and the postpartum period. Punjab has implemented a provincial policy and guidelines focused on integrated reproductive, maternal, newborn, child, and adolescent health and nutrition, alongside the Punjab Health Policy 2019–2028.

[12] World Health Organization. 2025. Trends in maternal mortality estimates 2000 to 2023: Estimates by WHO, UNICEF, UNFPA, World Bank Group, and UNDESA/Population Division. https://iris.who.int/bitstream/handle/10665/381012/9789240108462-eng.pdf?sequence=1.

[13] In the International Classification of Diseases-11, maternal death is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from unintentional or incidental causes."

[14] National Institute of Population Studies (Pakistan) and ICF. (2020). *2019 Pakistan maternal mortality survey summary report.* https://dhsprogram.com/pubs/pdf/SR267/SR267.pdf.

This chapter discusses three critical services for pregnant women: ANC, delivery care, and PNC. Together, these essential services play a key role in ensuring the survival and wellbeing of pregnant women and their newborns.

Antenatal Care

Comprehensive ANC, which includes the early detection and management of complications such as pre-eclampsia, is essential for ensuring a safe journey from the onset of pregnancy to its conclusion. In the PHPS, women who completed a pregnancy in the three years prior to the survey or were currently pregnant at the time of the survey were asked about the number of ANC visits, type of care provider, location of care, and components of ANC received during their most recent pregnancy.

Number of antenatal care visits

There are encouraging signs regarding ANC utilization in Punjab. Ninety percent of women who had their last pregnancy within three years prior to the survey, as well as those who were currently pregnant, reported at least one ANC visit.

Nearly half the women (46.2%) had four or more ANC visits during their most recent pregnancy, indicating progress toward WHO's updated recommendation of a minimum of eight contacts. Coverage of four or more visits was notably higher among women with secondary or higher education (65.6%) and those in the highest wealth quintile (68.5%) (Table 4.1). Additionally, urban women (57.4%), women living in non-lagging districts (53.3%), and women aged 25–34 years (49.1%) reported relatively higher levels of ANC coverage of four or more visits compared to their counterparts. In contrast, coverage remained particularly low among women with no education (26.4%), those in lagging districts (19.9%), and women in the lowest wealth quintile (21.5%) (Figure 4.2).

Despite these positive trends, significant disparities persist. Overall, a substantial 10% of women in Punjab had no ANC visit during their most recent pregnancy, with the situation being much worse among women from the lowest wealth quintile, where 24.4% had no ANC visits during their last pregnancy. Coverage of four or more ANC visits remains particularly low in rural areas (39.1%), lagging districts (19.9%), and among older women aged 35–49 years (41.4%), women with no education (26.4%), and those in the poorest wealth quintile (21.5%).

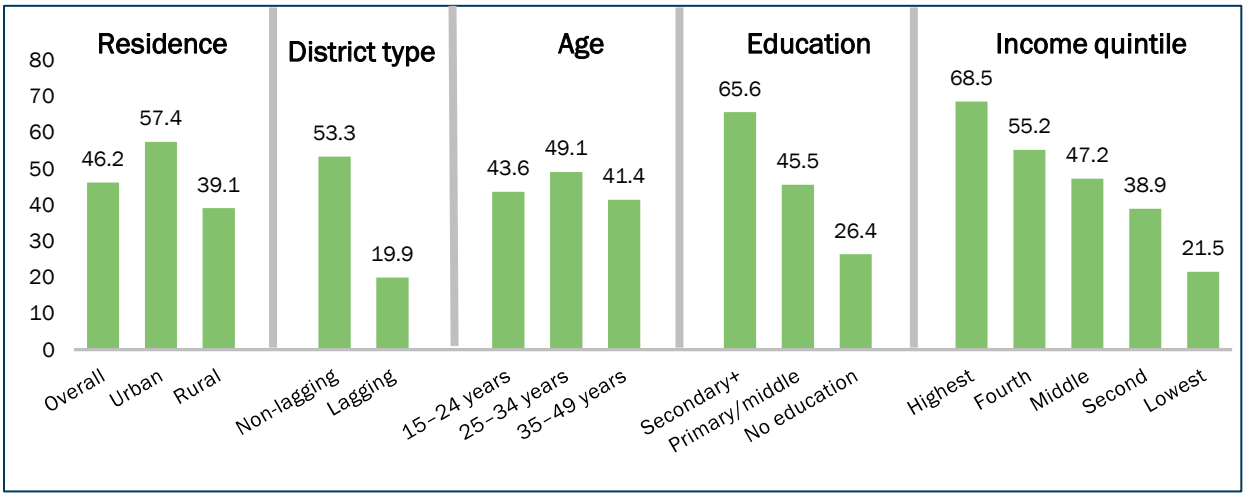
Stark district-level differences in ANC coverage highlight deep inequities across Punjab (Figure 4.3). In Sialkot, nearly three in four pregnant women (75.6%) received four or more ANC visits—the highest in the province. In contrast, districts like Dera Ghazi Khan (15.3%), Rajanpur (14.3%), and Rahim Yar Khan (11.9%) lagged far behind. Alarmingly, in Muzaffargarh, coverage was as low as 19.6%, and in Bahawalpur, only 23% of women met the minimum threshold of four ANC visits. Out of 36 districts, seven had coverage below 30%, underscoring persistent barriers to maternal healthcare access in southern and underserved regions of Punjab.

Table 4.1: Percentage distribution of women by number of antenatal care (ANC) visits during their last pregnancy and background characteristics

Background characteristics	No. of ANC visits					
	0 visits	1–3 visits	4 or more visits	Don't know	Total	No. of women (unweighted)
Residence						
Overall	10.0	43.4	46.2	0.4	100	7,693
Rural	11.6	48.8	39.1	0.5	100	5,270
Urban	7.4	34.9	57.4	0.3	100	2,423
District type						
Lagging	20.3	59.4	19.9	0.4	100	2,321
Non-lagging	7.2	39.1	53.3	0.4	100	5,372
Age (years)						
15–24	11.2	45.0	43.6	0.3	100	1,860
25–34	8.4	42.1	49.1	0.5	100	4,181
35–49	12.9	45.3	41.4	0.5	100	1,652
Education						
No education	18.9	54.2	26.4	0.6	100	2,916
Primary/middle	7.1	47.1	45.5	0.3	100	2,412
Secondary or higher	4.3	29.8	65.6	0.4	100	2,365
Wealth quintiles						
Lowest	24.4	53.1	21.5	1.0	100	1,845
Second	9.1	51.6	38.9	0.4	100	1,530
Middle	7.9	44.7	47.2	0.2	100	1,526
Fourth	6.3	38.4	55.2	0.1	100	1,471
Highest	1.9	29.2	68.5	0.5	100	1,317

Note: The percentages in this table were calculated for women who had a pregnancy in the three years preceding the survey.

Figure 4.2: Percentage of women who had four or more ANC visits during their last pregnancy, by background characteristics



Note: The percentages in this figure were calculated for women who had a pregnancy in the three years preceding the survey.

Timing of first antenatal care visit

The WHO recommends that the first ANC visit occur during the first trimester (up to 12 weeks) of pregnancy. In Punjab, 51.3% of the 6,781 women who were pregnant at the time of the survey or had been pregnant in the three years prior had their first ANC visit at two months of pregnancy or earlier (Table 4.2). This percentage increased to 52.9% when excluding the 1.2% of women who did not remember the timing of their visit. Alarmingly, 9.8% of women had their first ANC visit during the six-to-nine-month period of pregnancy, which rose to 9.9% when excluding those who could not recall the timing. Urban–rural differences in the timing of the first ANC visit were significant: 59.3% of urban women initiated ANC visit within the first two months, compared to 46.2% of rural women.

Table 4.2: Percentage distribution of women by timing of first ANC visit during their last pregnancy

Month of pregnancy when ANC was received for the first time	Total	Rural	Urban
≤ 2 months	51.3	46.2	59.3
3–5 months	37.7	40.7	33.1
6–9 months	9.8	11.8	6.7
Don't remember	1.2	1.3	1.0
Total	100.0	100.0	100.0
No. of women (unweighted)	**6,781**	**4,575**	**2,206**

Note: The percentages in this table were calculated for women who had a pregnancy in the three years preceding the survey.

Effective antenatal care coverage

While the number and timing of ANC visits are important, the components of care received indicate the quality of that care. "Effective ANC" is defined as coverage that includes: (1) at least four ANC visits; (2) iron and folic acid supplementation; (3) at least two tetanus injections; (4) blood pressure measurement; and (5) urine sample collection.

Overall, effective ANC coverage was below 20% for most groups (Table 4.3). Exceptions included urban areas (25.1%), women with secondary or higher education (28.4%), and women in the highest wealth quintile (31.6%). Effective ANC coverage in urban areas was nearly twice as high as in rural areas, more than three times higher for women with secondary or higher education compared to those with no education, and five times higher for women in the highest wealth quintile compared to those in the lowest.

Low effective ANC coverage was observed across all districts in Punjab, though levels varied substantially (Figure 4.3). In eight districts—Dera Ghazi Khan (0.4%), Muzaffargarh (1.5%), Khanewal (3.3%), Rahim Yar Khan (4.2%), Lodhran (5.5%), Layyah (6.8%), Rajanpur (7.0%), and Bahawalnagar (9.2%)—less than 10% of women received effective ANC, highlighting severe gaps in service delivery. In contrast, higher coverage was seen in districts such as Chakwal (37.4%), Rawalpindi (37.0%), Faisalabad (35.8%), Gujrat and Toba Tek Singh (34.0% each), and Gujranwala (30.8%). While no district reached 40%, this variation reflects a clear urban–rural and regional divide in access to quality maternal health services.

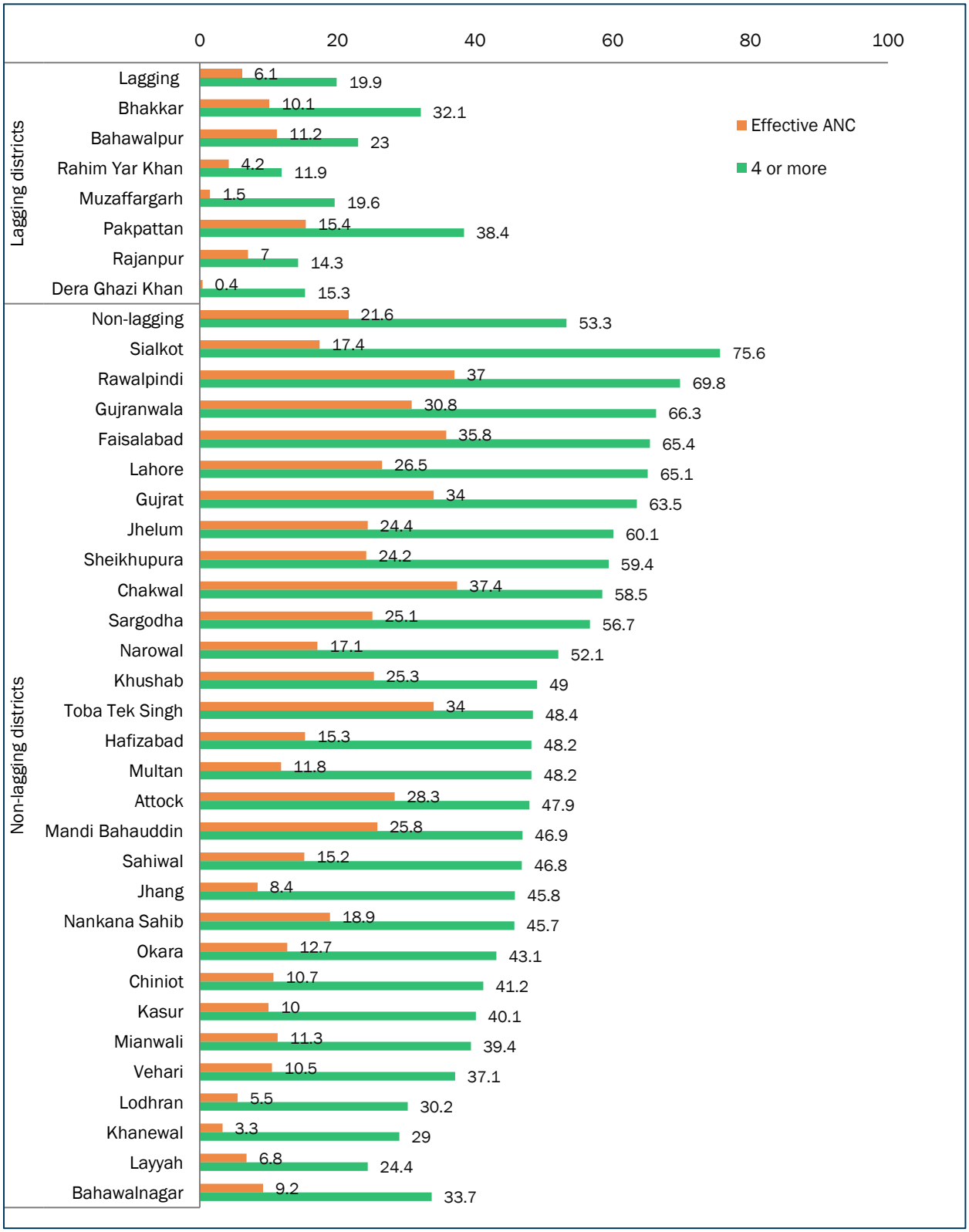
Table 4.3: Percentage of women who received effective ANC during their last completed or current pregnancy, by background characteristics

	Effective ANC coverage*	No. of women
Residence		
Overall	18.3	7,693
Rural	14.0	5,270
Urban	25.1	2,423
District type		
Lagging	6.1	2,321
Non-lagging	21.6	5,372
Age (years)		
15–24	14.6	1,860
25–34	20.8	4,181
35–49	15.8	1,652
Education		
No education	8.3	2,916
Primary/middle	17.5	2,412
Secondary or higher	28.4	2,365
Wealth quintiles		
Lowest	6.4	1,845
Second	13.3	1,530
Middle	17.0	1,526
Fourth	23.2	1,471
Highest	31.6	1,317

Note: The percentages in this table were calculated for women who had a pregnancy in the three years preceding the survey.

*(1) At least four ANC visits; (2) receipt of iron supplements; (3) two tetanus injections; (4) blood pressure and urine samples.

Figure 4.3: Percentage of women who had four or more ANC visits and "effective ANC" during their last completed or current pregnancy, by district



Note: The percentages in this figure were calculated for women who had a pregnancy in the three years preceding the survey.

Quality of antenatal care

Most women (86.0%) reported that their blood pressure was measured during their last ANC visit in their most recent pregnancy (Table 4.4). Blood and urine samples were taken in 70.9% and 59.4% of cases, respectively. An ultrasound was performed in 84.5% of cases, a genital examination in 75.1% of cases, and fetal heart sounds were reportedly checked in 71.5%. However, a significantly lower proportion of women (54.0%) reported that their weight was measured, 39.8% underwent a pelvic examination, and only 18.4% received a breast examination. For each component, more urban women received care than their counterparts. The differences were more marked for blood sample taken (65.1% in rural compared to 80.3% in urban areas) and weight measured (45.9% in rural vs. 66.9% in urban areas).

Table 4.4: Percentage of women who received a specific type of service during the last ANC visit of their last completed or current pregnancy, by place of residence

	Total	Rural	Urban
During visit to provider			
Blood pressure	86.0	83.3	90.4
Blood sample	70.9	65.1	80.3
Urine sample	59.4	54.2	67.7
Weight measured	54.0	45.9	66.9
Breast exam	18.4	14.5	24.6
Pelvic exam	39.8	35.7	46.4
Fetal heart sound	71.5	67.7	77.6
Ultrasound/anomaly scan	84.5	81.9	88.6
Condition of genitals checked	75.1	71.9	80.2
No. of women (unweighted)	**7,693**	**5,270**	**2,423**

Note: The percentages in this table were calculated for women who had a pregnancy in the three years preceding the survey.

Tetanus toxoid injection

The WHO recommends that pregnant women receive at least two doses of tetanus toxoid during pregnancy to protect both the mother and the neonate from tetanus. The first dose should be administered during the initial contact in pregnancy, with the second dose given at least four weeks later and at least two weeks before the due date. Three additional doses are provided after delivery to complete the vaccination schedule. Among women receiving at least one tetanus injection (80.5% received two doses, 10.4% received one dose, and only 7.5% received three or more doses (Table 4.5). Slightly more urban women (82%) received two doses of tetanus toxoid compared to rural women (79.5%).

Table 4.5: Percentage of women with a pregnancy, by number of tetanus injections received during the last or current pregnancy

	Total	Rural	Urban
Percentage receiving at least one tetanus injection			
Percentage of women	68.5	68.2	69.0
Among those who received tetanus injection during last or current pregnancy, number of injections received			
Once	10.4	10.1	10.7
Twice	80.5	79.5	82.0
Three or more times	7.5	8.3	6.3
Don't know	1.7	2.1	1.0
Total	100.0	100.0	100.0
No. of women (unweighted)	**4,692**	**3,159**	**1,533**
No. of women (unweighted)	**6,781**	**4,575**	**2,206**

Note: The percentages in this table were calculated for women who had a pregnancy in the three years preceding the survey.

Antenatal care service providers

Table 4.6 shows the location of the last ANC consultation during the previous and current pregnancy (if the women is pregnant for the first time). Among all women who had a pregnancy in the three years preceding the survey, 30.0% received ANC care from a public sector provider, while 58.9% received it from a private provider. Excluding women who did not have any ANC visit, these proportions increased to 33.3% for public care and 65.3% for private care. In all subgroups—except for women in the lowest and second-lowest wealth quintiles—more women accessed ANC from private facilities than from public ones.

The use of private facilities varies substantially by household wealth. Among women in the highest quintile, 75.9% used private facilities compared to 21.0% who used public facilities, a difference of 54.9 percentage points. This indicates that while the private sector is the preferred option, poorer women are often constrained to public sector services due to financial limitations. Similarly, 67.8% of women with secondary or higher education received ANC from a private facility, compared to 26.8% who accessed public sector care.

Table 4.6: Percentage of women with a pregnancy in the last three years, by type of ANC service provider during the most recent pregnancy and background characteristics

	No visit	Public	Private	Community health worker*	Other	Total	No. of women (unweighted)
Residence							
Overall	10.0	30.0	58.9	0.2	0.9	100	7,693
Rural	11.6	30.5	56.6	0.1	1.1	100	5,270
Urban	7.4	29.1	62.5	0.2	0.7	100	2,423
District type							
Lagging	20.3	32.2	46.1	0.3	1.1	100	2,321
Non-lagging	7.2	29.4	62.4	0.1	0.9	100	5,372
Age (years)							
15–24	11.2	28.7	59.0	0.1	1.1	100	1,860
25–34	8.4	30.0	60.6	0.2	0.9	100	4,181
35–49	12.9	31.5	54.4	0.3	1.0	100	1,652
Education							
No education	18.9	32.0	48.2	0.2	0.7	100	2,916
Primary/middle	7.1	31.5	60.3	0.1	1.2	100	2,412
Secondary/higher	4.3	26.8	67.8	0.2	0.9	100	2,365
Wealth quintiles							
Lowest	24.4	33.0	41.5	0.4	0.7	100	1,845
Second	9.1	36.1	53.4	0.2	1.2	100	1,530
Middle	7.9	31.2	60.0	0.2	0.7	100	1,526
Fourth	6.3	28.6	64.3	0.0	0.8	100	1,471
Highest	1.9	21.0	75.9	0.1	1.3	100	1,317

Note: The percentages in this table were calculated for women who had a pregnancy in the three years preceding the survey.

*Nutrition assistants, vaccinators, Suraj workers, Pehli Kiren workers, Marvi workers, *hakims*/homeopaths, and pharmacists/chemists.

Type of healthcare provider for antenatal care

About 87% of women received ANC from a skilled provider (Table 4.7), with higher coverage in urban areas (90.7%) compared to rural areas (84.1%). Most women received ANC services from doctors—77.8% overall, 84.7% in urban areas, and 73.4% in rural areas—while mid-level healthcare providers accounted for 8.9% of ANC services. Notably, there was almost a complete absence of traditional birth attendants (TBAs)/*dais* as ANC providers, indicating a clear shift away from reliance on unskilled care during pregnancy.

Table 4.7: Percentage of women with a completed pregnancy who received ANC from a skilled provider at last ANC visit, by type of provider

		Skilled		Unskilled					
	% receiving ANC from skilled providers	Doctors	CMWs, LHVs, FWWs, nurses, Suraj workers	LHWs	TBAs/ Dais	Other	No ANC visit reported	Total	No. of women (unweighted)
Total	86.7	77.8	8.9	2.9	0.1	0.4	10.0	100	7,693
Rural	84.1	73.4	10.7	3.6	0.2	0.5	11.6	100	5,270
Urban	90.7	84.7	6.0	1.7	0.0	0.2	7.4	100	2,423

[a] Skilled providers include doctors, community midwives (CMWs), lady health visitors (LHVs), family welfare workers (FWWs), nurses, and Suraj workers.
[b] Unskilled providers refer to lady health workers (LHWs) and TBAs/*dais*.
[c] Other providers are family welfare counselors, family welfare assistants, Pehli Kiren workers, Marvi workers, and dispensers/compounders.

Type of advice received during antenatal checkups

Table 4.8 indicates that women in Punjab do not get the full benefit of ANC check-ups in terms of essential advice and information on critical aspects of pregnancy care. Among women who completed a pregnancy in the three years preceding the survey, 68.3% reported receiving information and advice on nutrition and healthy eating, while 53.7% received guidance on the use of iron tablets or syrup. Additionally, 53.5% reported advice on anemia, and 61.9% on tetanus toxoid injections. Information on danger signs during pregnancy and appropriate responses was reported by only 36.2% and 34.2% of women, respectively. Furthermore, 33.9% received advice on breastfeeding, and 29.7% on birth preparedness and delivery planning.

Advice on birth spacing and postpartum family planning (PPFP) was notably lacking; only 20.1% reported receiving advice on the importance of birth spacing, 15.3% on importance of contraceptive use, and 12.9% on PPFP. Moreover, only 15.5% of women reported receiving information and advice on childhood anemia. Across nearly all topics, women in urban areas received more information than those in rural areas, highlighting persistent inequities in the provision of advice and information during ANC.

Table 4.8: Percentage of women who reported on advice on specific topics received during any ANC check-ups during their last pregnancy, by rural/urban residence

	Total	Rural	Urban
Healthcare providers offered advice on:			
Nutrition and healthy eating	68.3	65.4	73.0
Anemia among mothers	53.5	51.4	56.9
Tetanus toxoid shots	61.9	59.0	66.7
Use of iron tablets/syrup	53.7	48.9	61.3
Danger signs during pregnancy	36.2	32.9	41.5
What to do if danger signs are seen	34.2	30.2	40.6
Birth preparedness/delivery plan (money, transport, attendant, place of delivery)	29.7	28.0	32.5
Importance of birth spacing	20.1	17.3	24.7
Importance of contraceptive use	15.3	13.0	19.1
Postpartum family planning (PPFP)	12.9	10.9	16.0
Counselling for husbands regarding family planning	9.8	9.1	11.0
Child's anemia	15.5	14.2	17.4
Breastfeeding	33.9	30.7	38.9
No. of women (unweighted)	**7,693**	**5,270**	**2,423**

Note: The proportions in this table were calculated for women who had a pregnancy in the three years preceding the survey.

Health problems experienced during last pregnancy

A small proportion of women (6.8%) who were either currently pregnant or had completed a pregnancy within three years before the survey reported experiencing health problems during the pregnancy. The main health issues included: a diagnosis of anemia (32.5%); weakness (31.5%); high blood pressure (28.9%); severe lower abdominal pain (27.1%); severe or prolonged vomiting; and severe headaches (18.4%) (Table 4.9).

Urban–rural differences were evident in the types of health problems reported. More rural women experienced weakness, severe or prolonged vomiting, blurred vision, facial swelling, severe lower abdominal pain, spotting, heavy vaginal bleeding, seizures or convulsions, and unconsciousness. In contrast, more urban women reported shortness of breath, facial swelling, severe lower abdominal pain, and diagnoses of anemia and high blood pressure compared to their rural counterparts.

Among women who experienced a health problem, 25.5% sought initial treatment from a public facility, 64% from a private facility, 8.9% did not seek any treatment, and 1.7% sought help from other sources.

Table 4.9: Percentage of women experiencing serious health problems during their last pregnancy, by type of problem and place of residence

	Total	Rural	Urban
Percent experiencing serious health problems during current or last pregnancy			
	6.8	6.7	7.0
Health problems faced during current or last pregnancy among those who reported problems			
Severe/prolonged vomiting	23.5	21.5	26.7
Shortness of breath	11.3	10.7	12.1
Severe headache	18.4	18.6	18.0
Blurred vision	5.8	5.6	6.2
Facial swelling	10.1	8.6	12.5
Severe lower abdominal pain	27.1	24.5	31.2
Spotting	7.5	7.4	7.6
Heavy vaginal bleeding	15.8	13.6	19.1
High fever with or without rigors	7.5	8.0	6.8
High blood pressure	28.9	27.2	31.5
Fits/convulsions	0.5	0.2	1.1
Unconsciousness	1.8	2.2	1.3
Weakness	31.5	33.7	28.1
Anemia	32.5	33.7	30.6
Others	9.4	8.4	10.9
Total	100.0	100.0	100.0
First source of treatment for any serious health problems among those who experienced problems			
Nowhere	8.9	11.1	5.5
Public facility	25.5	23.6	28.5
Private facility	64.0	63.7	64.4
Community health workers*	1.1	0.9	1.3
Others	0.6	0.8	0.3
Total	100.0	100.0	100.0
No. of women (unweighted)	**7,693**	**5,270**	**2,423**

Note: The percentages in this table were calculated for women who had a pregnancy in the three years preceding the survey.

*Nutrition assistants, vaccinators, Suraj workers, Pehli Kiren workers, Marvi workers, *hakims*/homeopaths, and pharmacists/chemists.

Delivery Care

Comprehensive delivery care includes prenatal care, labor and delivery, and postpartum care, encompassing newborn care and the management of complications during pregnancy, labor, and the postpartum period. Information on key aspects of delivery care was collected and is summarized below.

Institutional deliveries

The WHO recommends that women deliver with a skilled birth attendant (SBA) at a health facility, as facility-based deliveries reduce the risk of complications and infections that could endanger the mother, baby, or both. National and Punjab maternal, newborn, and child health programs emphasize the importance of facility-based deliveries and promote them through community health workers, such as lady health workers (LHWs). Traditionally, women in Pakistan, particularly in rural areas of Punjab, delivered at home. However, due to these concerted efforts and the expansion of services, home deliveries have declined, with only 14% of births now occurring at home (Table 4.10).

Table 4.10: Percentage of deliveries, by place of last delivery and background characteristics

	At home	Public facility	Private facility	Other*	Total	N (unweighted)
Residence						
Overall	14.0	32.8	51.7	1.5	100	6,755
Rural	16.6	34.0	47.7	1.7	100	4,649
Urban	9.7	30.9	58.3	1.1	100	2,106
District type						
Lagging	26.9	35.4	35.9	1.8	100	2,068
Non-lagging	10.5	32.1	56.1	1.4	100	4,687
Age (years)						
15–24	14.0	32.1	52.2	1.7	100	1,542
25–34	12.3	32.6	53.5	1.6	100	3,748
35–49	18.4	34.1	46.5	1.1	100	1,465
Education						
No education	25.4	33.4	40.3	0.9	100	2,594
Primary/middle	12.1	33.9	52.4	1.5	100	2,108
Secondary or higher	4.7	31.2	62.1	2.0	100	2,053
Wealth quintiles						
Lowest	32.1	34.4	32.6	1.0	100	1,651
Second	16.0	38.0	44.3	1.7	100	1,351
Middle	11.8	33.8	53.1	1.4	100	1,337
Fourth	6.8	32.0	60.2	1.1	100	1,274
Highest	2.8	25.9	69.1	2.2	100	1,138

Note: The percentages in this table were calculated for women who had a delivery in the three years preceding the survey.
*Nutrition assistants, vaccinators, Suraj workers, Pehli Kiren workers, Marvi workers, *hakims*/homeopaths, and pharmacists/chemists.

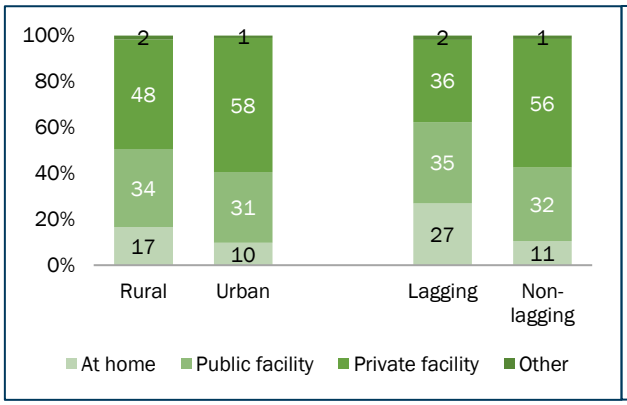
Institutional deliveries are widely prevalent in Punjab, with 86% of births occurring in a health facility, marking a significant shift from the traditional practice of home deliveries. Home deliveries are more common in rural areas than in urban areas (16.6% vs. 9.7%) and are more than twice as frequent in

lagging districts compared to non-lagging districts (26.9% vs. 10.5%). Women aged 35–49 years are more likely to deliver at home than younger women aged 15–24 years (18.4% vs. 14.0%). Additionally, a higher percentage of women with no education deliver at home (25.4%) compared to those with primary/middle or secondary/higher education (12.1% and 4.7%, respectively).

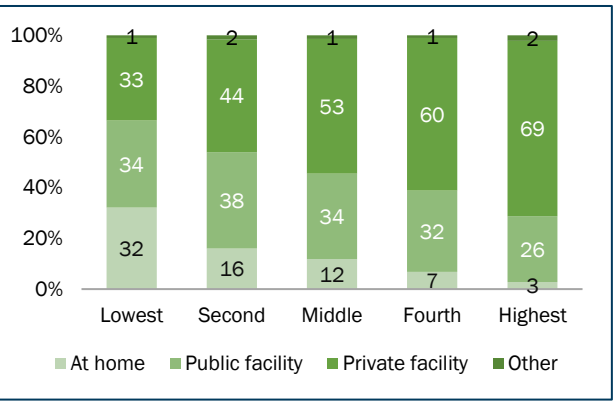
The greatest disparity is observed by wealth: 32.1% of women in the lowest wealth quintile deliver at home, compared to only 2.8% in the highest quintile. Notably, across all subgroups—except women with secondary or higher education and those in the highest wealth quintile—more women delivered their last birth in public facilities. Figure 4.4 illustrates the differences in the location of the last delivery by background characteristics.

Figure 4.4: Percentage of deliveries, by place of residence and district type, and wealth quintile

(a) Place of residence and district



(b) Women's wealth quintile



Note: The proportions in these figures were calculated for women who had a delivery in the three years preceding the survey.

Skilled birth attendants

Skilled birth attendance during childbirth by qualified providers (e.g., doctors, nurses, and midwives) is essential for the timely management and treatment of complications. Recognizing its critical role in saving mothers' lives, Sustainable Development Goal (SDG) 3.1 aims to reduce the global maternal mortality ratio to fewer than 70 deaths per 100,000 live births by 2030. The proportion of births attended by skilled birth attendants (SBAs) is a key indicator for monitoring progress toward this goal.

In Punjab, an impressive 88.6% of deliveries in the three years preceding the survey were attended by SBAs (Table 4.11). SBA-assisted deliveries were 6.8 percentage points higher in urban areas than in rural areas and 13 percentage points higher in non-lagging districts compared to lagging districts. A slightly higher percentage of young women (aged 15–24 years) (88.5%) received assistance from skilled attendants during delivery compared to those aged 35–49 years (87.1%).

Differences by education and wealth quintile were more pronounced. Among women with no formal education, 79.8% received assistance from SBAs, compared to 95.9% of women with secondary or higher education. Similarly, 75.6% of women in the lowest wealth quintile received assistance, compared to 97.1% in the highest quintile.

Deliveries at health facilities, whether public or private, were closely associated with SBA attendance. Figure 4.5 illustrates the percentage of deliveries those occurring in health facilities and attended by SBAs , disaggregated by background characteristics.

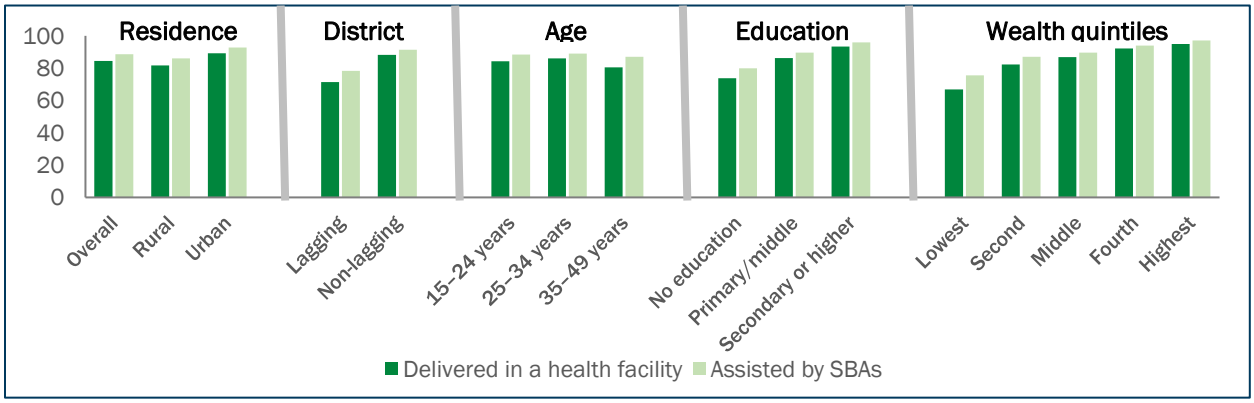
SBA-assisted deliveries varied widely by district, ranging from 59.4% in Dera Ghazi Khan to 98.5% in Jhelum (Figure 4.6). In Dera Ghazi Khan and Rajanpur, fewer than 70% of deliveries were SBA-assisted. In contrast, 20 districts—including Jhelum, Mianwali, Mandi Bahauddin, Gujrat, Sheikhupura, Hafizabad, Lahore, Khushab, Attock, Lodhran, Rawalpindi, Chiniot, Nankana Sahib, Jhang, Sargodha, Chakwal, Faisalabad, Sialkot, Sahiwal, and Gujranwala—reported SBA attendance exceeding 90%. In the remaining districts, coverage ranged from 68.4% in Rajanpur to 90.1% in Kasur.

Table 4.11: Percentage of most recent deliveries that were assisted by SBAs and delivered in a health facility, by background characteristics

	Delivered in a health facility	Assisted by SBAs	No. of women (unweighted)
Residence			
Overall	84.5	88.6	6,755
Rural	81.6	86.0	4,649
Urban	89.2	92.8	2,106
District type			
Lagging	71.3	78.4	2,068
Non-lagging	88.2	91.4	4,687
Age (years)			
15–24	84.3	88.5	1,542
25–34	86.1	89.1	3,748
35–49	80.5	87.1	1,465
Education			
No education	73.7	79.8	2,594
Primary and middle	86.3	89.7	2,108
Secondary or higher	93.3	95.9	2,053
Wealth quintiles			
Lowest	66.9	75.6	1,651
Second	82.3	87.1	1,351
Middle	86.8	89.6	1,337
Fourth	92.1	93.9	1,274
Highest	95.0	97.1	1,138

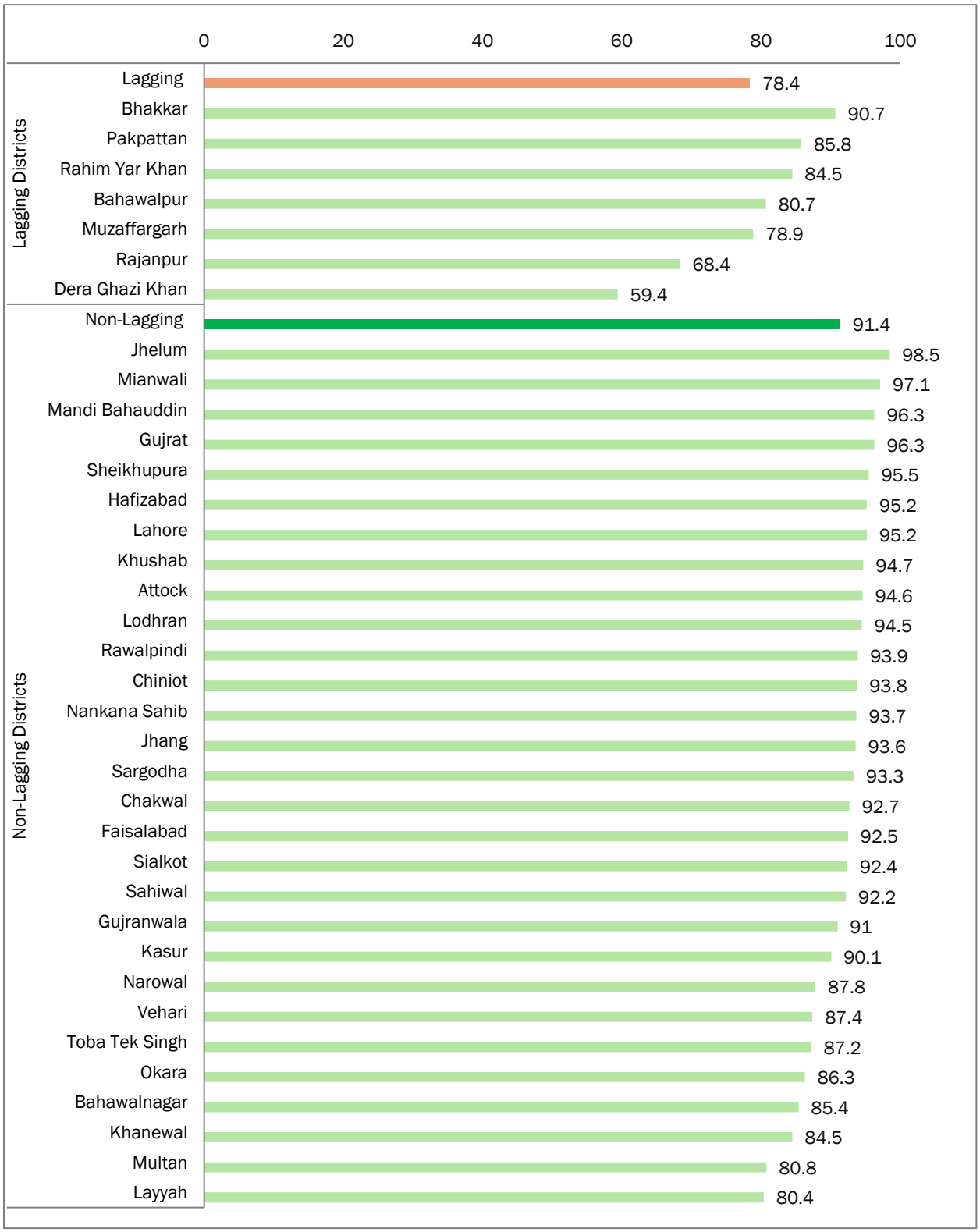
Note: The percentages in this table were calculated for women who had a delivery in the three years preceding the survey.

Figure 4.5: Percentage of most recent deliveries that were assisted by SBAs and delivered at a health facility, by background characteristics



Note: The percentages in this figure were calculated for women who had a delivery in the three years preceding the survey.

Figure 4.6: Percentage of most recent deliveries that were assisted by SBAs, by district



Note: The percentages in this figure were calculated for women who had a delivery in the three years preceding the survey.

Type of birth attendance

Three-fourths of deliveries were assisted by doctors (Table 4.12), followed by mid-level healthcare providers, including CMWs, LHVs, family welfare workers (FWWs), nurses, and Suraj workers.

In 4.8% of cases overall, deliveries were assisted by a female friend, relative, or neighbor; this percentage rose to 5.8% in rural areas and declined to 3.1% in urban areas. Deliveries by doctors were 13.4 percentage points more common in urban areas than in rural areas. In rural areas, a higher proportion of women received assistance from mid-level healthcare professionals (15.6%) than from a female relative, friend, or neighbor (5.8%).

Table 4.12: Percentage of most recent deliveries (by type of birth attendant)

		Skilled		Unskilled					
	% delivered by skilled provider	Doctors	CMWs, LHVs, FWWs, nurses, Suraj workers	LHWs	TBAs/ *Dais*	Female relatives, friends, neighbors	Other	Total	No. of women (unweighted)
Total	88.6	75.4	13.1	2.8	3.8	4.8	0.0	100	6,755
Rural	86.0	70.3	15.6	3.4	4.8	5.8	0.1	100	4,649
Urban	92.8	83.7	9.1	1.9	2.2	3.1	0.0	100	2,106

Note: The percentages in this table were calculated for women who had a delivery in the three years preceding the survey.
[a] Skilled providers include doctors, CMWs, LHVs, FWWs, nurses, and Suraj workers.
[b] Unskilled providers refer to LHWs and TBAs/*dais*.
[c] Other providers are family welfare counselors, family welfare assistants, Pehli Kiren workers, Marvi workers, and others.

Type of delivery by place of delivery

According to WHO, the ideal Cesarean section rate is considered to be 10–15% by the international healthcare community. Table 4.13 shows that nearly 43.3% of deliveries in Punjab were Cesarean sections, with a significantly higher prevalence in urban areas (48.5%) compared to rural areas (40.2%). This urban–rural difference likely reflects better availability of surgical obstetric services and greater health-seeking behavior in urban settings.

When analyzed by facility type, the Cesarean section rate was twice as high in private facilities (62.5%) compared to public facilities (31.2%). This disparity may be attributed to differences in clinical practices, financial incentives, and patient preferences in private settings. The high Cesarean section rates underscore the need for stricter monitoring and regulation, particularly in urban areas, to ensure that the procedure is performed based on medical necessity rather than provider convenience or other non-clinical reasons.

Table 4.13: Percentage of most recent deliveries, by normal/Cesarean and place of delivery

	Normal delivery/assisted vaginal delivery	Cesarean section	Total	N (unweighted)
Residence				
Overall	56.6	43.4	100	6,755
Rural	59.8	40.2	100	4,649
Urban	51.5	48.5	100	2,106
Place of delivery				
At home	100.0	0.0	100	1,054
Public facility	68.8	31.2	100	2,285
Private facility	37.5	62.5	100	3,301
Others	47.3	52.7	100	115

Note: The percentages in this table were calculated for women who had a delivery in the three years preceding the survey.

Maternal health complications during last delivery

The proportion of women who experienced serious health problems during their most recent delivery was 3.9%, with at least one serious health complication reported. The prevalence was slightly higher in urban areas (4.2%) compared to rural areas (3.8%) (Table 4.14).

Among women reporting complications, the most frequently cited issues were low hemoglobin levels (47.5%), high blood pressure (42.6%), and excessive bleeding after birth (39.2%). These were followed by excessive bleeding before birth (34.3%) and high fever (33.1%). A notable proportion of women also reported prolonged labor (24.2%), breech presentation (23.3%), convulsions (22.7%), and retained placenta (15.7%).

In rural areas, among women who reported health problems, 46.8% experienced high blood pressure, 36.7% had high fever, 37.6% faced excessive bleeding before birth, and 42.6% had low hemoglobin levels. In urban areas, the most common health issues reported were low hemoglobin levels (54.7%), excessive bleeding after birth (52.6%), and high blood pressure (36.5%).

When asked about their first source of treatment for serious health problems, more than half of the affected women (53.3%) sought care from private facilities, while 26.9% approached public providers. A significant portion (17.5%) did not seek care at all, indicating potential barriers related to access, awareness, or affordability. Urban women relied more on private facilities (63.7%) than rural women (46.2%), while rural women were more likely to use public care (32.0% vs. 19.4%).

Most respondents who reported experiencing serious complications during their last delivery cited high-grade fever as one of the symptoms. Its prevalence was nine percentage points higher among rural women than urban women. The incidence of postpartum fever is a significant public health concern, as it often indicates underlying maternal infections, that, if not managed promptly, can lead to severe morbidity or even mortality.

Postpartum high-grade fever can result from various underlying conditions, most of which are infectious. Puerperal sepsis—a bacterial infection of the genital tract that occurs after delivery—is a leading cause, often arising from poor hygiene during labor and delivery or retained placental fragments.

Although the overall reported incidence of complications may seem low, the notably high frequency of high-grade postpartum fever in Punjab underscores serious gaps in post-partum care, including infection prevention and control, adherence to clean delivery practices, and the provision of adequate postnatal follow-up care.

Table 4.14: Percentage of women with deliveries reporting serious health problems during their last delivery, by rural/urban residence

	Total	Rural	Urban
Percentage of women who faced serious health problems			
	3.9	3.8	4.2
Type of health problems faced (multiple response variable)			
Excessive bleeding before birth	34.3	37.6	29.5
Excessive bleeding after birth	39.2	30.1	52.6
Convulsions	22.7	24.7	19.9
Retained placenta	15.7	20.3	8.8
High fever	33.1	36.7	27.7
High blood pressure	42.6	46.8	36.5
Prolonged labor	24.2	23.3	25.6
Breech	23.3	24.5	21.6
Low hemoglobin count	47.5	42.6	54.7
No. of women reporting health problem(s)	267	161	106
First source of treatment for any serious health problems			
Nowhere	17.5	20.1	13.5
Public	26.9	32.0	19.4
Private	53.3	46.2	63.7
Other	2.4	1.7	3.4
Total	100.0	100.0	100.0
No. of women (unweighted)	**6,755**	**4,649**	**2,106**

Note: The percentages in this table were calculated for women who had a delivery in the three years preceding the survey.

Postnatal Care

Postnatal care (PNC), also referred to as postpartum care, is a critical phase for both mother and newborn. Continuation of high-quality care during this period is essential for ensuring their wellbeing, monitoring progress and preventing or treating complications such as severe bleeding and infections.

The WHO's 2022 recommendations on maternal and newborn care for a positive postnatal experience advise that the first postnatal checkup occur within 24 hours of birth, followed by three additional checkups on day 3 (48–72 hours), between 7 and 14 days, and at six weeks. These postnatal visits are designed to assess various physical and emotional symptoms, including vaginal bleeding and micro nutritional needs, while also monitoring the baby's growth.

In alignment with WHO recommendations, nearly 56% of women who had a live birth in the three years preceding the survey received a PNC checkup (Table 4.15). However, almost 44% did not receive this care. Among women who delivered at a healthcare facility, 36.3% did not receive a PNC checkup, compared to 91.8% of those who delivered at home.

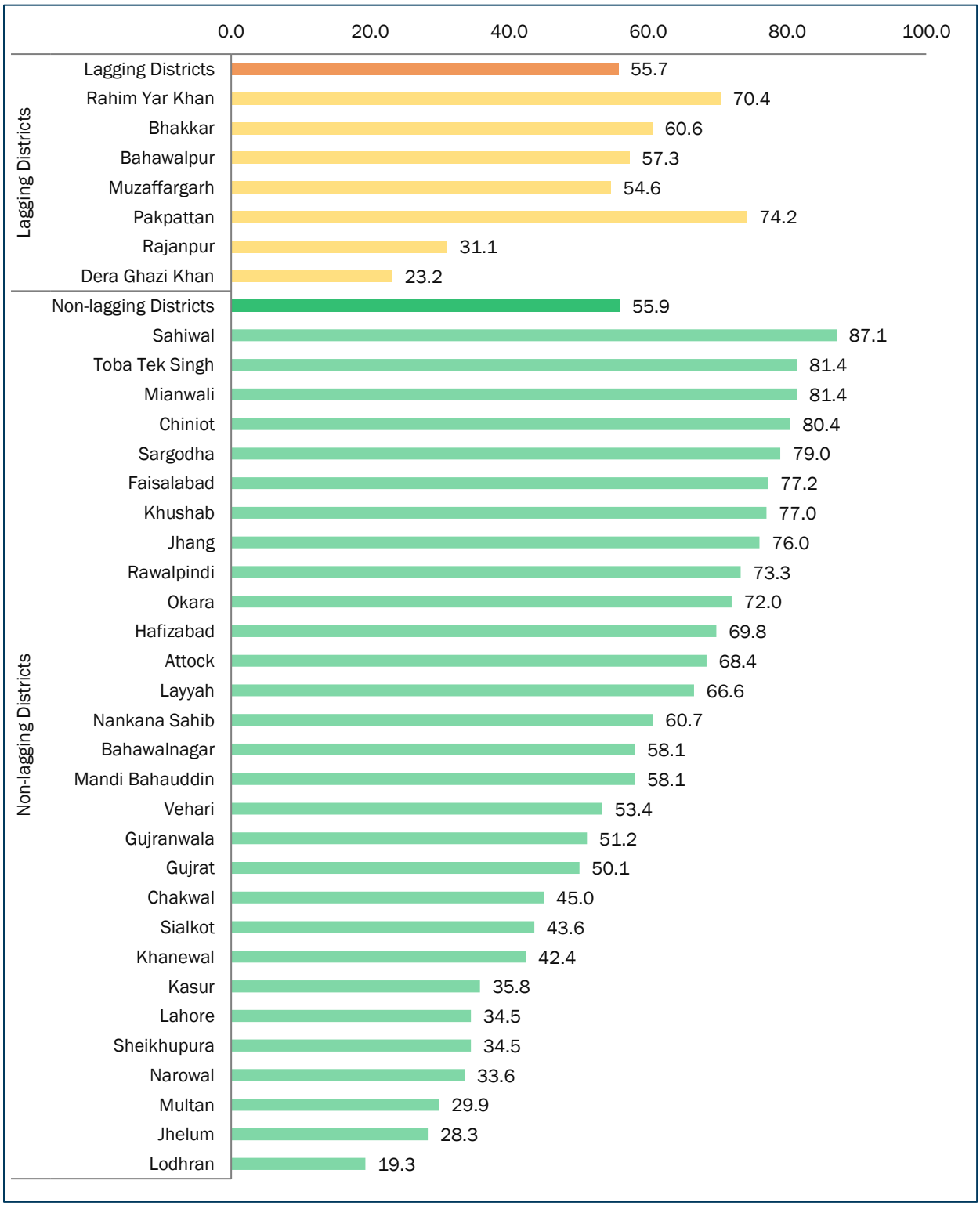
The proportion of women receiving PNC varied significantly by district (Figure 4.7). In Lodhran (19.3%), Jhelum (28.3%), and Multan (29.9%), fewer than 30% of women with a live birth received a postnatal checkup. In contrast, coverage was over 80% in Sahiwal (87.1%), Toba Tek Singh (81.4%), and Mianwali (81.4%).

Table 4.15: Percentage of women who received postnatal care by place of last delivery among those who had a live birth in three years before the survey.

	PNC received		PNC not received		Total	
Place of delivery	%	N (unweighted)	%	N (unweighted)	%	N (unweighted)
Overall	55.9	3,874	44.1	2,881	100.0	6,755
Health facility	63.7	3,803	36.3	1,898	100.0	5,701
At home	8.2	71	91.8	983	100.0	1,054

Note: The percentages in this table were calculated for women who had a live birth in the three years preceding the survey.

Figure 4.7: Percentage of women who had a live birth and received postnatal care following their last birth, by district



Note: The percentages in this figure were calculated for women who had a live birth in the three years preceding the survey.

Timing of first postnatal checkup

Overall, 31.7% of women who delivered within three years before the survey had their first postnatal checkup within 24 hours (Figure 4.8). However, the timing of the first checkup varied by background characteristics (Table 4.16). The largest difference was observed between women in the middle and highest wealth quintiles—34.8% vs. 27.7% respectively, a gap of 7.1 percentage points. While 30.1% of women in urban areas had their first postnatal checkup within 24 hours, the proportion for rural women was slightly higher at 32.7%.

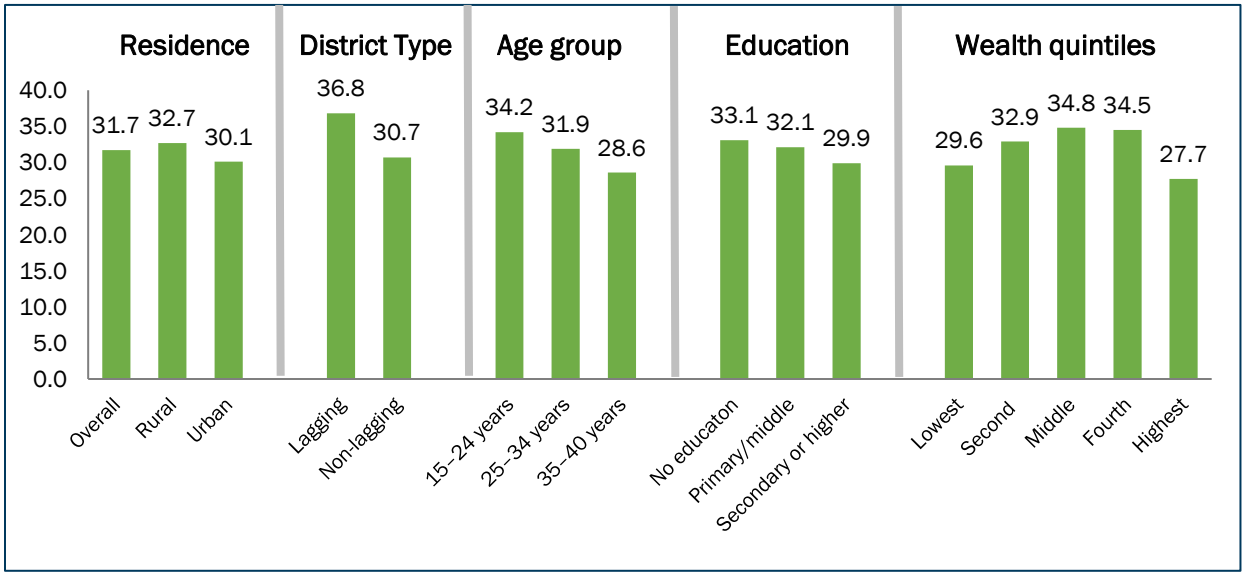
Women with no education were slightly less likely to have their first postnatal checkup within 24 hours compared to those with secondary or higher education. Notably, almost 8% of women overall received PNC care after two days. These later visits are critical because certain maternal complications—such as infections, anemia, hypertension, or postpartum depression—may not be evident immediately after birth and often emerge several weeks later.

Analysis by wealth quintile revealed significant disparities. Among women in the lowest wealth quintile, only 2.9% received within three to six days while 3.6% received after six days. In comparison, among women in the highest wealth quintile, the proportions were slightly higher at 5.9% and 13.0% for the same period.

Four groups of women had particularly high proportions without any postnatal checkup: women in the lowest wealth quintile (55.1%), women living in lagging districts (44.3%), women aged 15-24 years (42.6%), and those with no education (48.5%).

Among all women who received at least one postnatal checkup, doctors were the most frequently cited providers, accounting for 75.5% overall, 71.5% in rural areas, and 82.5% for urban areas (Table 4.17). Nurses were the next most frequently cited providers, representing 11.1% of all women, 12.8% in rural areas, and 8.2% in urban areas.

Figure 4.8: Percentage of women with a live birth who had their first postnatal checkup within 24 hours after last birth, by background characteristics



Note: The percentages in this figure were calculated for women who had a live birth in the three years preceding the survey.

Table 4.16: Percentage of women who had a live birth, by timing of first postnatal checkup and background characteristics

	Less than 4 hours	4–23 hours	24–48 hours	3–6 days	7–40 days	Don't know/ remember	No PNC	Overall	No. of women (unweighted)	% of women with postnatal check on the first day after delivery
Overall	28.2	3.5	7.2	4.8	7.8	4.4	44.1	100.0	6,755	31.7
Residence										
Rural	29.1	3.6	7.3	4.2	7.1	4.0	44.6	100.0	4,649	32.7
Urban	26.7	3.4	7.0	5.7	8.9	5.2	43.2	100.0	2,106	30.1
District type										
Lagging	33.4	3.4	8.9	2.8	4.6	2.5	44.3	100.0	1,858	36.8
Non-lagging	27.1	3.5	6.8	5.2	8.4	4.8	44.1	100.0	4,897	30.7
Age (years)										
15–24	30.6	3.6	6.9	5.6	6.5	4.3	42.6	100.0	1,542	34.2
25–34	28.5	3.4	7.5	4.7	8.4	4.2	43.3	100.0	3,748	31.9
35–49	24.8	3.8	6.6	4.1	7.7	5.2	47.8	100.0	1,465	28.6
Education										
No education	29.6	3.5	6.4	3.6	4.3	4.1	48.5	100.0	2,594	33.1
Primary/middle	28.9	3.2	5.9	4.2	7.6	3.6	46.6	100.0	2,108	32.1
Secondary or above	26.1	3.8	9.1	6.4	11.4	5.6	37.6	100.0	2,053	29.9
Wealth quintiles										
Lowest	27.4	2.1	4.7	2.9	3.6	4.1	55.1	100.0	1,769	29.6
Second	30.0	2.9	6.1	4.0	5.6	5.0	46.4	100.0	1,335	32.9
Middle	30.7	4.1	7.7	5.8	6.7	5.6	39.5	100.0	962	34.8
Fourth	30.4	4.1	7.5	5.5	9.6	3.4	39.6	100.0	1,434	34.5
Highest	23.2	4.5	10.0	5.9	13.0	4.6	38.8	100.0	1,255	27.7

Note: The percentages in this table were calculated for women who had a live birth in the three years preceding the survey.

Table 4.17: Percentage of women who received at least one postnatal checkup* after their last live birth, by type of healthcare provider and place of residence

	Total		Residence	
	%	N (unweighted)	Rural (%)	Urban (%)
Provider of postnatal checkup				
Doctors with an MBBS	75.7	3,397	71.5	82.5
LHWs	1.4	64	1.7	0.9
CMWs	3.2	193	4.1	1.7
Suraj workers	0.3	11	0.4	0.1
Nurses	11.1	534	12.8	8.2
Others[a]	8.4	395	9.5	6.6
Overall	100.0	4,594	100.0	100.0

Note: The percentages in this table were calculated for women who had a live birth in the three years preceding the survey.
*Includes women who delivered at a facility or at home.
[a] Other providers are FWWs, Pehli Kiren workers, Marvi workers, LHVs, untrained TBAs/*dais*, and dispensers.

Health problems encountered 40 days postpartum

Among women who delivered in the three years preceding the survey, 3.1% reported experiencing serious health problems within 40 days after childbirth. The most common issues were weakness (65.6%), severe headache (51.7%), and high fever (47.6%) (Table 4.18). Urban–rural differences were modest, except for weakness, which was reported by 74.2% of urban women compared to 60.4% of rural women among those who reported at least one health problem. Among those who experienced health problems, 70.3% sought treatment from a private facility, with a slightly higher rate in rural areas (71.4%) than in urban areas (68.2%).

Table 4.18: Percentage of women who had a live birth and reported serious health problems within 40 days of delivery, by type of health problem and place of residence

	Total	Rural	Urban
Percentage of women who experienced serious health problems within 40 days of delivery	3.1	3.2	2.9
Type of health problems faced (multiple response variable)			
Weakness	65.6	60.4	74.2
Anemia	51.0	46.1	59.1
Severe headache	51.7	51.8	51.6
High fever	47.6	47.8	47.3
Excessive bleeding	35.9	34.8	37.7
Blurred vision	34.3	33.2	36.1
Continued bleeding	27.7	27.3	28.5
Abdominal pain with high fever	24.0	24.5	23.1
Smelly discharge/dysuria	22.1	22.7	21.1
Convulsions	16.5	13.9	20.9
Postpartum depression	7.2	5.7	9.8
Lumps in breast	9.3	11.7	5.3
Others	9.2	9.1	9.2
First source of seeking treatment for complications			
Public	29.0	28.6	29.8
Private	70.3	71.4	68.2
Others	0.7	0.0	2.0
Total	100.0	100.0	100.0
No. of women (unweighted)	186	120	66

Note: The percentages in this table were calculated for women who had a live birth in the three years preceding the survey.

Quality of neonatal care following last live birth

In this section, we examine key aspects of early neonatal care, including Kangaroo mother care (KMC), cord-cutting practices, and the application of substances to the umbilical cord. Table 4.19 presents findings for women who had a live birth in the three years preceding the survey, disaggregated by place of residence.

Kangaroo mother care (KMC) practices

The WHO recommends KMC as routine care for newborns, particularly those weighing 2,000 grams or less at birth. KMC, which involves skin-to-skin contact between mother and baby along with exclusive breastfeeding or breast milk feeding, provides numerous benefits for both infant and mother, including temperature regulation, improved breathing, reduced stress, and enhanced bonding.

Only about one in four women (26.6%) reported that their baby was placed on their chest immediately after birth, with slightly higher prevalence in urban areas (29.0%) compared to rural areas (25.0%). Actual skin-to-skin contact between mother and newborn was reported by just 17.2% of women overall, with a difference of 2.4 percentage points between urban (18.7%) and rural (16.3%) settings. Most respondents (86.5%) indicated that the baby was not wrapped before being placed on the mother's chest, which aligns with KMC recommendations. However, 12.9% reported wrapping the baby, which is not advised.

Cord-cutting practices

Safe and hygienic cord-cutting practices are essential for preventing neonatal infections, a leading cause of newborn mortality.

New blades were the most reported instruments used to cut the cord (26.0%), followed by scissors (19.2%). However, more than half of respondents (54.0%) were unsure about which instrument was used, with uncertainty higher in urban areas (56.3%) than in rural areas (52.5%).

Fewer than half of women (45.9%) reported that a sterilized instrument was used. About one-fourth (25.6%) said that the instrument was not sterilized, and 28.5% were unsure—highlighting major gaps in awareness and provider communication.

Substances applied to the umbilical cord

Applying substances to the umbilical cord stump is a common practice in Pakistan. However, it poses risks when harmful or unsterile substances are used.

More than two-thirds (70.6%) of women reported that something was applied to the cord after cutting. Urban women (71.0%) were slightly more likely to report this compared to rural women (70.3%).

Commonly reported substances included: Chlorhexidine (15.5%), the WHO-recommended antiseptic, with nearly equal usage in urban (15.7%) and rural (15.4%) areas; mustard oil (24.3%), a traditional but potentially harmful practice, was more common in rural areas (28.8%) than urban areas (17.1%); other antiseptics, such as spirit and gentian violet (47.0%); and ash (0.9%), a high-risk practice. Notably, no respondents reported using animal dung.

Table 4.19: Percentage of women with a live birth, by quality of neonatal care received

	Total	Rural	Urban
KMC			
Was the baby put on the chest immediately after birth?			
Yes	26.6	25.0	29.0
No	62.5	63.7	60.6
Don't know	10.9	11.3	10.4
Total	100.0	100.0	100.0
Did skin-to-skin contact take place between mother and baby?			
Yes	17.2	16.3	18.7
No	81.9	83.0	80.1
Don't know	0.9	0.7	1.2
Total	100.0	100.0	100.0
Was the baby wrapped up before being placed on bare skin on the mother's chest?			
Yes	12.9	12.49	13.5
No	86.5	86.87	86.0
Don't know	0.6	0.6	0.5
Total	100.0	100.0	100.0
Cord-cutting practices			
Instrument used to cut cord			
New blade	26.0	28.9	21.4
Blade used for other purposes	0.5	0.6	0.5
Scissors	19.2	17.7	21.5
Others	0.3	0.3	0.3
Don't know	54.0	52.5	56.3
Total	100.0	100.0	100.0
Was the instrument sterilized?			
Yes	45.9	41.3	54.0
No	25.6	29.6	18.6
Don't know	28.5	29.1	27.5
Total	100.0	100.0	100.0
Was anything applied to the cord after cutting?			
Yes	70.6	70.3	71.0
No	8.5	9.4	7.0
Don't know	20.9	20.3	22.0
Total	100.0	100.0	100.0
What was applied to the cord?			
Chlorhexidine (tube)	15.5	15.4	15.7
Other antiseptics (spirit, gentian violet)	47.0	41.1	56.5
Mustard oil	24.3	28.8	17.1
Ash	0.9	1.4	0.2
Animal dung	0.0	0.0	0.0
Others	10.2	10.8	9.2
Don't know	2.1	2.5	1.3
Total	100.0	100.0	100.0
No. of women with a live birth (unweighted)	**6,755**	**4,649**	**2,106**

Note: The percentage in this table were calculated for women who had a live birth in the three years preceding the survey.

Recommendations

The findings of the PHPS 2024–25 revealed both encouraging progress and persistent gaps in maternal and newborn healthcare in Punjab. A notable positive shift is the declining role of TBAs, indicating a movement toward skilled maternal healthcare. Additionally, more women are accessing ANC and delivery services from qualified professionals.

Despite this positive trend, significant challenges remain in ensuring the quality, continuity, and equity of care. Disparities based on geography, education, and socioeconomic status continue to hinder universal access to essential maternal, newborn, and child health services.

To systematically address these persistent gaps and move toward equitable maternal health outcome, several key recommendations must be implemented:

1. **Strengthen the continuum of care:** Maternal health programs must adopt a lifecycle approach that ensures seamless care from pregnancy detection, especially at the community level, through delivery and postnatal follow-up. Promoting early registration and encouraging the first ANC visit within 12 weeks of gestation through community mobilization and engagement of community health workers is essential. Community health workers can also be instrumental in birth planning by deciding on facility for delivery and transportation arrangements.
2. **Increase effective ANC coverage:** Beyond the number of visits, the quality and content of ANC services must improve. Standardizing protocols and ensuring core services, including fetal health monitoring, is critical.
3. **Improve the quality of delivery and newborn care:** Institutional delivery protocols should be revisited to ensure the universal application of evidence-based interventions, such as KMC (skin-to-skin contact) and delayed cord clamping. Reinforcing staff training, supportive supervision, and accountability mechanisms is necessary.
4. **Expand and strengthen PNC:** Greater emphasis should be placed on ensuring not just the first, but also the fourth and fifth PNC visits, particularly for high-risk women. Outreach to the poorest and those in remote or underserved areas is crucial. Mobile health units and digital reminders serve as effective tools to support continuity of care. Mechanisms must be developed for PNC checkups of women who deliver at home.
5. **Address harmful traditional practices:** Behavioral change communication strategies, including community-based social and behavior change campaigns, must discourage home-based deliveries and harmful practices, such as applying ash or mustard oil to the cord, early bathing of the newborn, and delayed initiation of breastfeeding.
6. **Tackle inequities through targeted interventions:** Disparities in service uptake based on wealth, education, and geography require focused interventions in lagging districts. These should include capacity building for providers, improving facility readiness, and implementing targeted social protection schemes to reduce financial barriers.

5

Fertility and Fertility Preferences

Key Findings

Fertility rates

- Fertility rates in Punjab remain high at 3.2 children per woman, though this reflects a slight decline in fertility since 2018–19.
- Fertility differentials by residence are notable: rural women had 3.5 children on average compared to 2.8 children per woman in urban areas.
- Fertility differentials by income are also stark: the poorest women had an average of 4.1 children, while the wealthiest had 2.8 children.
- Many women began childbearing early, with one fifth having a child during adolescence.

Pregnancy and pregnancy outcomes

- Most pregnancies in Punjab resulted in live births, with only 2.1% ending in stillbirths.
- A small proportion of pregnancies ended in spontaneous abortions (8.0% overall, 7.7% in rural areas, and 8.4% in urban areas), with an additional 1.0% (0.6% in rural and 1.5% in urban) ending in induced abortion overall.

Wantedness of pregnancies and births

- Most women in Punjab (73.0% overall, 73.8% in urban areas, 72.4% in rural areas) reported that their last pregnancy was wanted and planned.
- A small proportion of women (3.2%) reported that their last pregnancy was either mistimed or unwanted.

Ideal family size and Desire for additional children

- The median ideal family size in Punjab was four children.
- The mean family size in Punjab was 3.5 overall, 3.6 in rural areas, and 3.4 in urban areas.
- The desire for additional children was negatively associated with parity: 88.0% of women with one living child wanted more, compared to only 5.3% of women with six or more children.

Information on fertility and preferences helps assess policies and programs aimed at supporting couples in achieving their fertility goals. It also highlights the prevalence of mistimed and unwanted pregnancies that need to be prevented, as well as the demand for children.

The PHPS gathered data on pregnancies, fertility, and desired fertility from both ever-married and currently married women.

This chapter discusses pregnancy outcomes, the total fertility rate (TFR) per woman, the adolescent fertility rate (AFR), birth planning, and the desired number of children.

Pregnancy and Pregnancy Outcomes

Data on all pregnancies were collected from ever-married women. A total of 66,495 pregnancies were reported in the PHPS, including 44,746 in rural areas and 21,749 in urban areas (Table 5.1). Most pregnancies resulted in live births (89.0% overall, 89.4% in rural areas, 88.5% in urban areas). Stillbirths accounted for 2.1% overall (2.3% in rural areas and 1.7% in urban areas). Miscarriages (spontaneous abortions) accounted for 8.0% overall (7.7% rural, 8.4% urban).

As with other demographic surveys, abortions are often underreported or misclassified as spontaneous abortions (miscarriages) due to social stigma. In this survey, only 1.0% of all pregnancies were reported by women to have ended in induced abortion.

Table 5.1: Percentage distribution of all pregnancies of ever-married women aged 15–49 years, by pregnancy outcome and place of residence

	Total	Rural	Urban
Pregnancy outcome			
Live births	89.0	89.4	88.5
Stillbirths	2.1	2.3	1.7
Induced abortions	1.0	0.6	1.5
Miscarriages	8.0	7.7	8.4
No. of pregnancies (unweighted)	**66,495**	**44,746**	**21,749**

Total Fertility Rate and Adolescent Fertility Rate

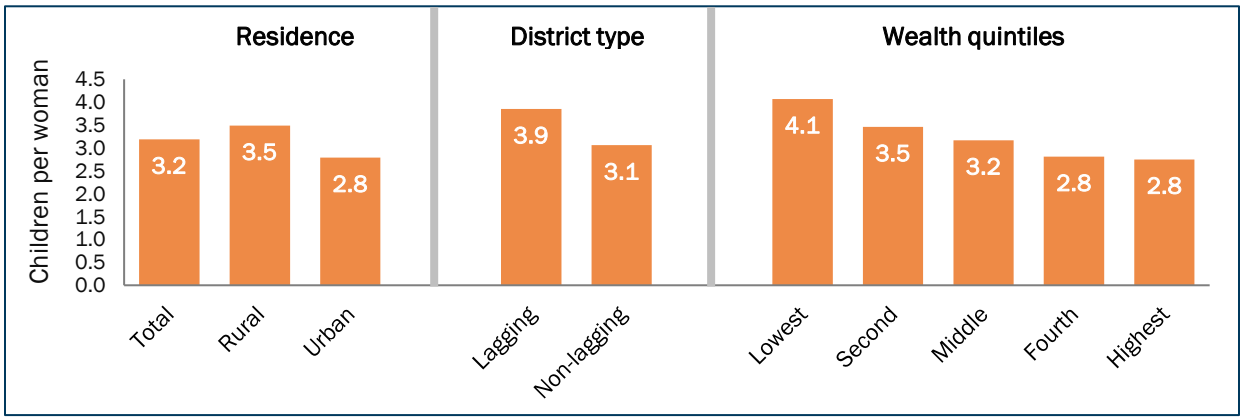
The TFR represents the average number of children a woman would have during her lifetime if she experienced the age-specific fertility rates observed at the time of the survey. In Punjab, the TFR is 3.2 children (Table 5.2). Women in rural areas were expected to have 3.5 children, compared to 2.8 in urban areas. Fertility was also higher in lagging districts (3.9 children) than in non-lagging (3.1 children) (Figure 5.1). By wealth quintile, women in the lowest group had the highest fertility (4.1 children), while those in the highest wealth quintile had the lowest (2.8 children).

The AFR—defined as the number of births per 1,000 adolescents aged 15–19—ranged from 37 in urban areas to 77 in the lowest wealth quintile. Early initiation of childbearing during adolescence is common across all subgroups in Punjab. This practice poses significant health risks for both mothers and infants and restricts girls' educational attainment and future employment opportunities.

Table 5.2: Total fertility rate per woman aged 15–49 years and adolescent fertility rate, by background characteristics

	TFR (children per woman)	AFR (children per 1,000 women aged 15–19 years)
Residence		
Overall	3.2	52
Rural	3.5	63
Urban	2.8	37
District type		
Lagging	3.9	76
Non-lagging	3.1	48
Wealth quintiles		
Lowest	4.1	77
Second	3.5	56
Middle	3.2	52
Fourth	2.8	54
Highest	2.8	34

Figure 5.1: Total fertility rate per woman, by background characteristics



Mistimed or Unwanted Last Pregnancy

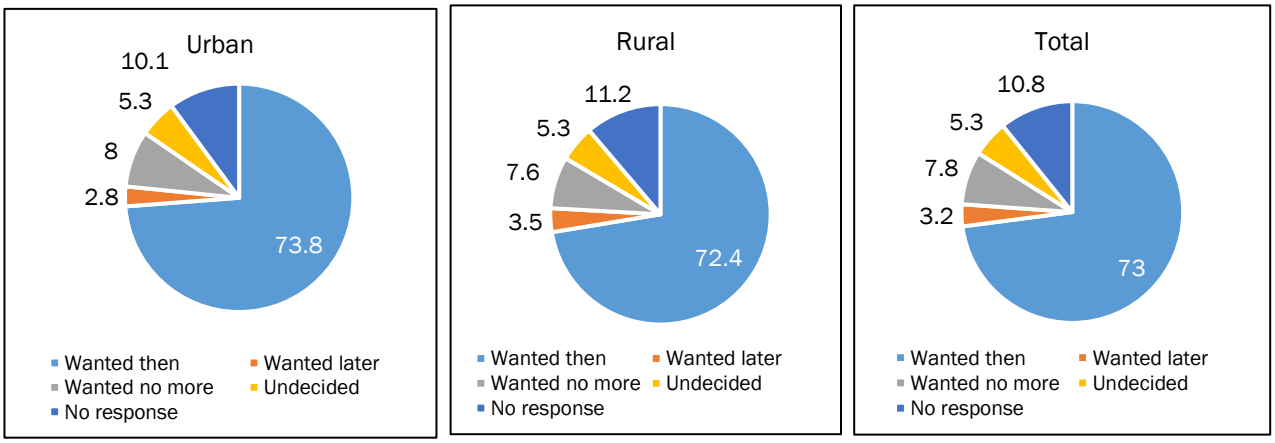
The survey asked women, "During your last pregnancy, did you want to become pregnant at that time, wish to wait until later, or not want any more children at all?" Among the 7,230 women who had experienced at least one pregnancy (including those pregnant at the time of the interview), 73% overall (72.4% in rural areas and 73.8% in urban areas) reported their pregnancy was planned and wanted (Table 5.3). Mistimed pregnancies—those that were "wanted later"—accounted for 3.2% overall (3.5% rural, 2.8% urban). Unwanted pregnancies were reported more frequently, at 7.8% overall (7.6% rural, 8.0% urban) (Figure 5.2).

More than 15% of women either did not respond or were undecided. Excluding these non-responses, the data showed that 3.8% of pregnancies were mistimed (4.2% rural, 3.3% urban), while 9.3% of last pregnancies were unwanted (9.1% rural areas, 9.5% urban). Overall, this means that approximately 87% of last pregnancies were planned and appropriately timed among women who provided a response.

Table 5.3: Percentage distribution of last pregnancy among ever-married women aged 15–49 years, by planning status of birth and place of residence

	Total	Rural	Urban
Wanted then	73.0	72.4	73.8
Wanted later	3.2	3.5	2.8
Wanted no more	7.8	7.6	8.0
Undecided/ don't know	5.3	5.3	5.3
Missing (no response)	10.8	11.2	10.1
Total	100.0	100.0	100.0
No. of ever-married women (unweighted)	7,230	4,977	2,253

Figure 5.2: Percentage distribution of women's (aged 15–49) latest births, by planning status of last pregnancy



Fertility Preferences

Two indicators measured fertility preferences: (1) ideal number of children and (2) desire for additional children.

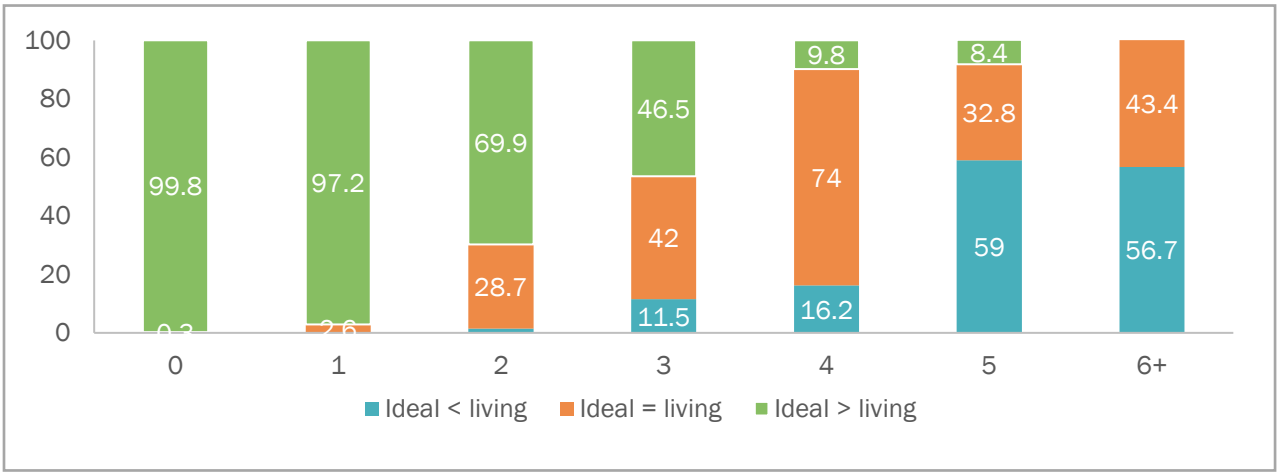
Ideal number of children

All currently married women respondents were asked, "If you could choose the exact number of children to have in your lifetime, how many would that be, and how many would be sons and how many daughters?" The ideal family size reported by 46.4% of currently married women was four children, while 7.7% preferred six or more (Table 5.4). When comparing the ideal number of children to the number of living children, 97.1% of women with one child and 69.8% of those with two children indicated that their ideal number was greater than their current number of living children. Among women with three living children, 46.5% reported that their ideal family size was larger than their current number of living children (Figure 5.3).

Table 5.4: Percentage distribution of currently married women, by ideal family size according to number of living children

	No. of living children							
	0	1	2	3	4	5	6+	Total
Ideal no. of children								
0	0.3	0.3	0.7	1.0	1.8	1.5	2.5	1.1
1	0.8	2.6	0.8	1.0	0.7	0.3	0.3	0.9
2	30.3	23.5	28.7	9.5	5.9	5.6	2.8	15.3
3	16.3	27.4	23.8	42.0	7.8	8.1	4.4	20.0
4	43.4	40.0	41.3	40.8	74.0	43.5	32.3	46.4
5	4.6	4.0	2.9	3.8	6.7	32.8	14.4	8.6
6+	4.4	2.3	1.9	1.9	3.1	8.4	43.4	7.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of currently married women (unweighted)	**2,371**	**2,369**	**3,034**	**3,396**	**3,237**	**1,951**	**2,241**	**18,599**

Figure 5.3: Percentage of women whose ideal number of children was less than, equal to, or greater than their living children, by number of living children



Two-thirds of women with four living children considered that to be their ideal number. Interestingly, 32.8% of those with five living children and 43.4% of those with six living children reported the same number as their ideal.

Desire for additional children

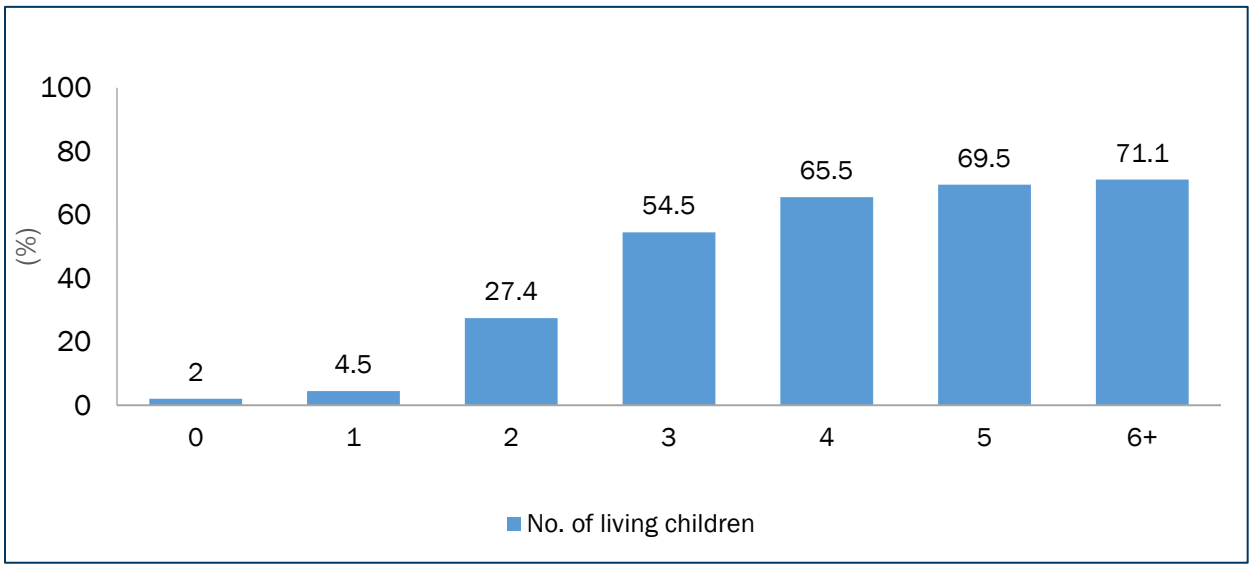
When asked about their desire for additional children, 41.3% of respondents expressed a wish for additional children, while 42.4% did not (Table 5.5). The desire for more children was strongly linked to achieved parity. Nearly 90% of women with fewer than two living children wanted more (89.9% with no children, 88.0% with one child). In contrast, less than one-third of women with three living children desired more (28.9%). Among women with four living children, only 12.3% wanted additional children, further dropping to 6.4% among those with five living children and 5.3% for those with six or more.

Figure 5.4 illustrates the positive association between the percentage of women desiring no more children and their number of living children. Specifically, two in three women with four or more living children do not want additional children.

Table 5.5: Percentage of currently married women by desire for more children, by number of living children

	No. of living children							
	0	1	2	3	4	5	6+	Total
Desire for more children								
Want more	89.9	88.0	60.2	28.9	12.3	6.4	5.3	41.3
Don't want more	2.0	4.5	27.4	54.5	65.5	69.5	71.1	42.4
Cannot get pregnant	5.7	4.2	5.5	10.3	18.5	20.3	20.4	11.8
Don't know/unsure	2.5	3.3	6.9	6.3	3.8	3.8	3.2	4.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of currently married women (unweighted)	2,365	2,366	3,031	3,396	3,236	1,950	2,240	18,584
No. of desired sons								
None	0.4	0.0	0.0	0.8	3.3	3.5	2.8	0.5
1–2	32.6	45.1	66.7	70.8	70.1	71.2	54.1	52.2
3–4	58.0	50.9	30.8	21.9	12.1	4.6	7.9	40.7
5+	9.0	4.0	2.5	6.5	14.5	20.7	35.3	6.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of currently married women (unweighted)	2,115	2,071	1,875	1,032	451	154	124	7,822
No. of desired daughters								
None	0.7	5.9	13.9	19.7	17.3	11.3	6.8	8.9
1–2	87.9	87.4	82.2	71.2	73.0	73.3	71.5	83.0
3–4	10.4	6.2	3.6	8.8	9.3	10.7	10.1	7.3
5+	0.9	0.5	0.3	0.2	0.5	4.7	11.5	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of currently married women (unweighted)	**2,115**	**2,071**	**1,875**	**1,032**	**451**	**154**	**124**	**7,822**

Figure 5.4: Percentage of currently married women wanting no more children, by number of living children



Both demand and achieved fertility in Punjab remain high – desired fertility is about four children on average and the total fertility rate is 3.2 births per woman. However, one-in-ten pregnancies was reported to have occurred too soon or was unplanned. Addressing prevention of unwanted and mistimed pregnancies need to be a priority for interventions and policies. At the same time, generating demand for fewer children should be a focus for IEC and behavioral change interventions in Punjab.

6

Contraceptive Use and Unmet Need for Family Planning

Key Findings

Contraceptive prevalence rate (CPR) and modern contraceptive prevalence rate (mCPR)

- Contraceptive prevalence in Punjab was relatively low, with 38.2% of currently married women using a contraceptive method. Of these, 29.5% used modern methods, and 8.8% used traditional methods.
- Contraceptive use was higher in urban areas (43.4%) than in rural areas (34.5%), and higher in non-lagging (40%) districts compared to lagging districts (30.8%).
- Women in the highest wealth quintile were more likely to use both modern and traditional methods compared to those in the lowest quintile.
- Educated women were more likely to use traditional methods than those with no education.

Type of contraceptive method currently used: Method mix

- The method mix in Punjab was dominated by three methods: withdrawal, male condoms, and injectables.
- Male condoms were the most widely used method in urban areas, with reported use at 32.4%, while female sterilization was the most common method in rural areas at 33.1%.
- Highly educated couples and those in higher wealth quintiles were more likely to use withdrawal than those with less education or in lower wealth quintiles.

Main reasons for choice of contraceptive method and satisfaction with the method used

- “Easy availability” was the leading reason (29.4%), followed by “convenient to use” (18.0%) for choosing methods such as withdrawal, male condoms, and injectables.
- Most users were satisfied with their choice of method and intended to continue its use.

Demand for family planning and unmet need

- Total demand for family planning in Punjab was high, at 59.5%.
- The proportion of demand satisfied by any method (modern or traditional) was 38.2%, with modern methods accounting for 49.6% of the satisfied demand.
- Unmet need for family planning—the gap between contraceptive demand and actual use—was substantial at 21.3% overall.
- The unmet need for spacing was 5.4%, while the unmet need for limiting childbearing was 15.9%.

Evidence is well-established regarding the numerous medical and non-medical benefits of family planning, particularly its critical role in improving women's health by reducing unintended and high-risk pregnancies. This reduction decreases the number of women exposed to the risk of maternal death or morbidity. Family planning also improves newborn and child health by allowing women to practice healthy timing and spacing of pregnancies, enabling them to focus on their own health as well as the care of their newborns, infants, and children.

In addition to these maternal and child health benefits, family planning can enhance women's socioeconomic status by allowing girls and young women to continue their education, achieve higher qualifications, and participate in employment that increases their earning potential and contributes to household income.

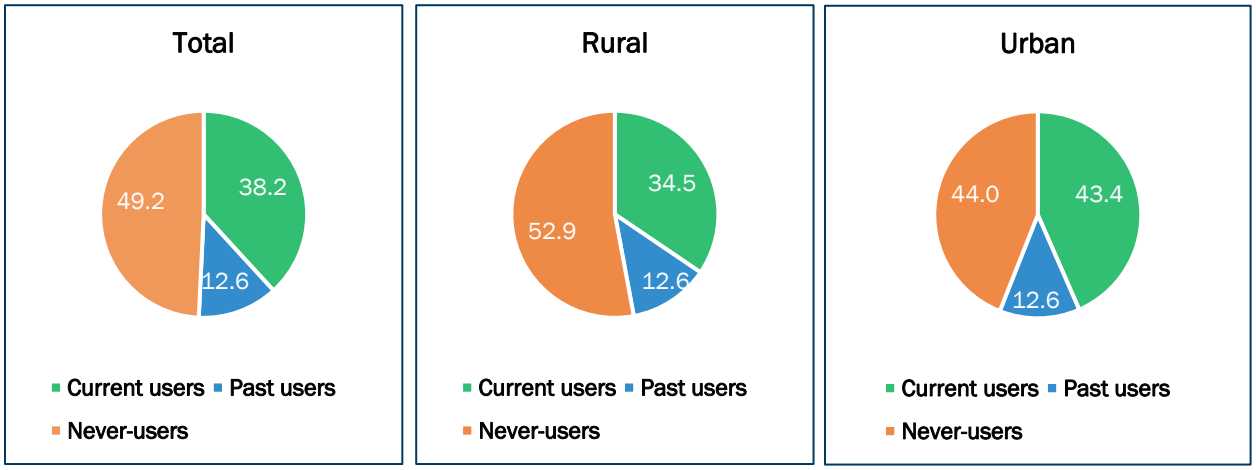
Family planning methods are used to delay, limit, or space childbearing. Traditional methods include periodic abstinence (the rhythm method) and withdrawal, while modern methods encompass male and female sterilization, injectables, Sayana Press, intrauterine devices (IUDs), contraceptive pills, implants, male and female condoms, the standard days method, lactational amenorrhea method, and emergency contraception.

The contraceptive prevalence rate (CPR) is measured as the percentage of currently married women using a contraceptive method, while the percentage using modern methods is referred to as the modern contraceptive prevalence rate (mCPR). The PHPS collected detailed information from women regarding their use of and perspectives on family planning methods. This chapter describes the levels and differentials in the use of family planning in Punjab.

Contraceptive Use Status of Currently Married Women

Just over half of currently married women in Punjab (50.8%) had used any method of contraception, at some point in time (Figure 6.1). In urban areas, the percentage of women who had ever used a contraceptive method was higher, at 56%. Overall, 12.6% of currently married women had used a contraceptive method in the past but were not using any method at the time of the survey. This percentage remained the same across both rural and urban areas, with 12.6% of women in each category reporting past contraceptive use but not currently using.

Figure 6.1: Percentage distribution of currently married women, by contraceptive use status and place of residence



The composition of users—categorized as never, past, or current—varied by background characteristics (Figure 6.2). Current users were 8.9 percentage points higher in urban areas compared to rural areas (43.4% vs. 34.5%). Additionally, current usage was 28.3 percentage points higher among women aged 35–49 years than among those aged 15–24 years (45.2% vs. 16.9%).

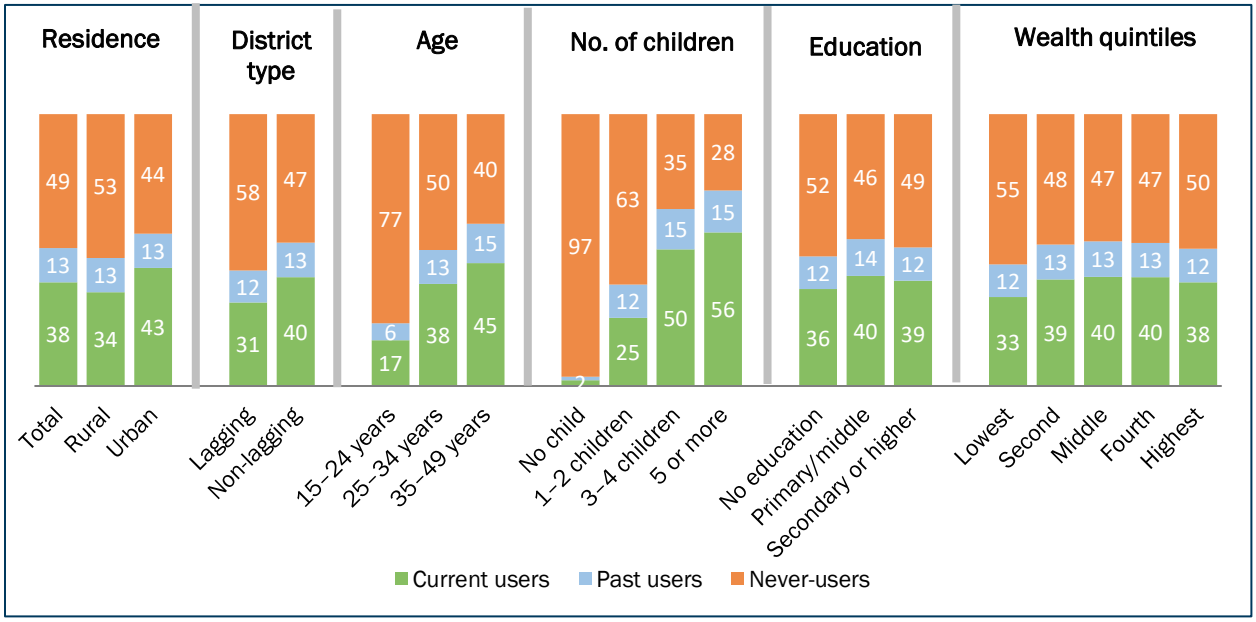
Current use was also 54.3 percentage points higher among women with five or more children than among those with no children (56.5% vs. 2.2%), and 31.5 percentage points higher when compared to women with one to two children (56.5% vs. 25.0%).

There is a difference in current use between women in the lowest and highest wealth quintiles (32.7% vs. 38.2%). A noticeable difference in current use was observed among women in lagging districts (30.8%) versus those in non-lagging districts (40%), resulting in a gap of 9.2 percentage points.

A smaller difference was noted between women with no education (35.7%) and those with secondary or higher education (38.7%), with a gap of 3 percentage points.

Groups with a high level of current use also had a greater number of past users. The significantly higher current usage among women aged 35–49 years and those with five or more children suggests that contraception is likely being used more for limiting rather than spacing childbearing. This pattern indicates a response to high fertility rather than a proactive approach to regulating family size.

Figure 6.2: Percentage distribution of currently married women, by contraceptive use status and background characteristics



Contraceptive Prevalence

Overall, 38.2% of currently married women in Punjab were using a contraceptive method: 29.5% relied on a modern method, while 8.8% relied on a traditional method (Table 6.1). As expected, contraceptive use was higher in urban areas (43.4%) than in rural areas (34.5%). The prevalence of modern methods was also greater in urban areas (32.5%) compared to rural areas (27.3%). Surprisingly, the use of traditional methods was significantly higher in urban areas (10.9%), despite easier access to modern methods compared to rural areas, where traditional method prevalence was 7.2%

The overall prevalence of any contraceptive method was lower in lagging districts (30.8%) compared to non-lagging districts (40%), reflecting a difference of 9.2 percentage points. Similarly, modern method use was higher in non-lagging districts (30.6%) than in lagging districts (24.7%). Traditional method use was also higher in non-lagging districts (9.4%) than in lagging districts (6%).

A positive association between current contraceptive use and age was observed: contraceptive use was 16.9% among women aged 15–24 years rising to 37.6% among those aged 25–34, and further to 45.2% among women aged 35–49 years. Both modern and traditional method usage increased with age.

Female education was strongly positively associated with contraceptive use: 35.7% of women with no education used a method, compared to 40.5% of those with primary or middle education, and 38.7% of women with secondary or higher education. Modern method use was 28.7% among those with no education and 29.2% among those with secondary or higher education. Traditional method use was 6.9% for women with no education, 10% for those with primary/middle education, and 9.5% for women with secondary or higher education.

Differences by wealth quintile were more pronounced. Among women in the lowest wealth quintile, 32.7% used a contraceptive method (26.1% modern and 6.6% traditional), compared to 40.1% (31.3% modern and 8.8% traditional) in the fourth wealth quintile.

Table 6.1: Percentage of currently married women aged 15–49 using any method of family planning (CPR), a modern method (mCPR), or a traditional method, by background characteristics

	Any method	Modern method[a]	Traditional method[b]	No. of women (unweighted)
Overall	38.2	29.5	8.8	18,600
Residence				
Rural	34.5	27.3	7.2	12,259
Urban	43.4	32.5	10.9	6,341
District type				
Lagging	30.8	24.7	6.0	5,209
Non-lagging	40.0	30.6	9.4	13,391
Age (years)				
15–24	16.9	11.9	5.0	2,814
25–34	37.6	28.5	9.0	7,099
35–49	45.2	35.5	9.7	8,687
Education				
No education	35.7	28.7	6.9	7,499
Primary/middle	40.5	30.5	10.0	5,826
Secondary or higher	38.7	29.2	9.5	5,275
Wealth quintiles				
Lowest	32.7	26.1	6.6	4,009
Second	39.2	29.6	9.7	3,752
Middle	40.1	30.1	9.9	3,794
Fourth	40.1	31.3	8.8	3,654
Highest	38.2	29.5	8.6	3,382

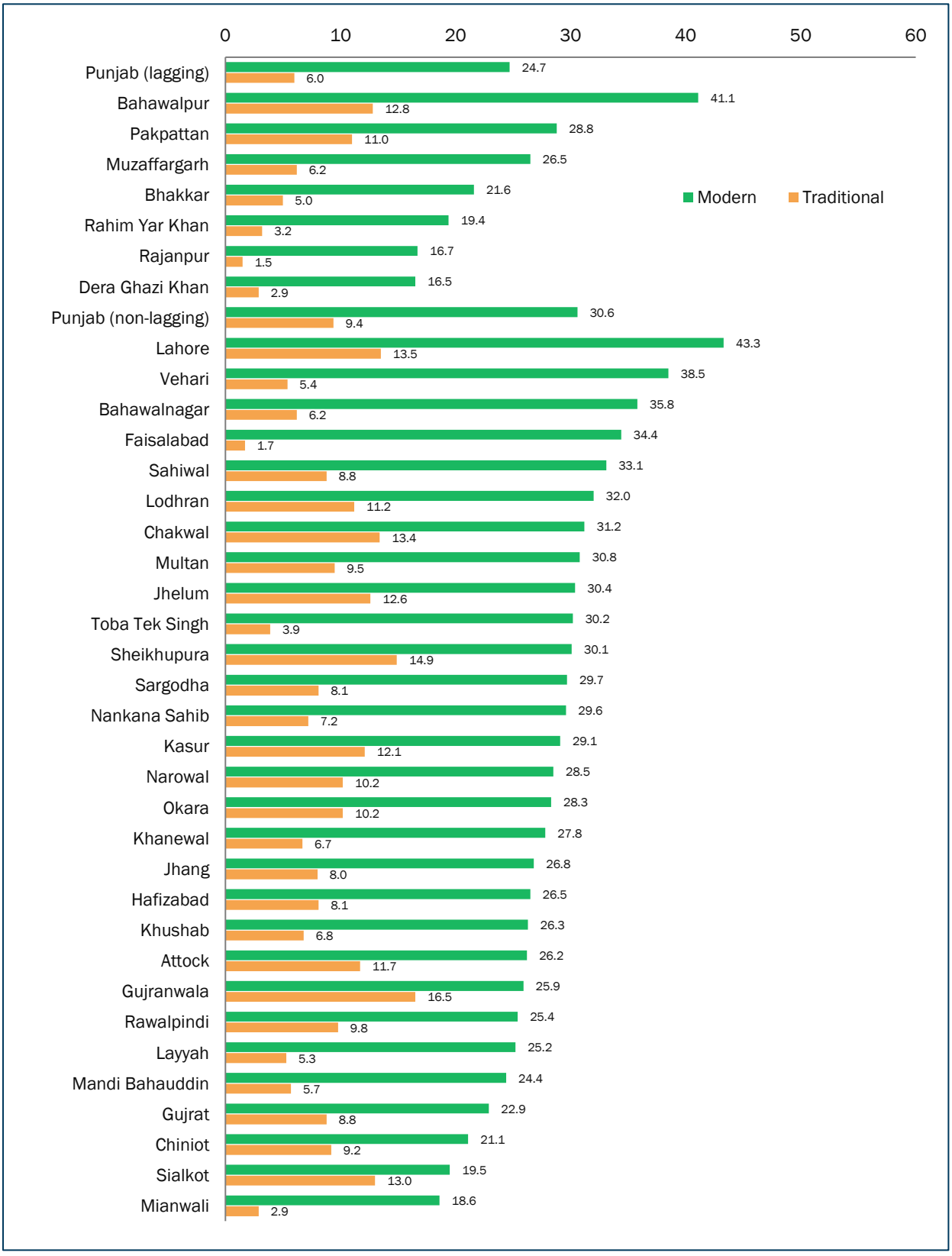
[a] Male and female sterilization, injectables, Sayana Press, IUDs, contraceptive pills, implants, male and female condoms, the standard days method, lactational amenorrhea method, and emergency contraception.

[b] Periodic abstinence (rhythm method), withdrawal, and folk methods.

The mCPR consistently surpassed traditional methods across all districts in Punjab. The levels of use of modern methods varied by district. In lagging districts, Bahawalpur (41.1%) had the highest mCPR, while Rajanpur (16.7%) and Dera Ghazi Khan (16.5%) had the lowest. Traditional method use was relatively high in Bahawalpur (12.8%) but minimal in Rajanpur (1.5%).

In non-lagging districts, Lahore (43.3%), Vehari (38.5%), and Faisalabad (34.4%) reported high modern method use. Traditional method use was notably high in Gujranwala (16.5%), Sheikhupura (14.9%), and Chakwal (13.4%), whereas Faisalabad (1.7%) had very low prevalence of traditional methods.

Figure 6.3: Percentage of currently married women using a modern or traditional contraceptive method, by district



Method Mix: Contraceptive Method Choice

A wide range of contraceptive methods is essential for meeting the diverse needs and preferences of women and couples. A method mix that includes permanent methods (male and female sterilization), long-acting reversible methods (IUDs and implants), and short-acting methods (oral contraceptives, injectables, condoms, and emergency contraceptive pills) is crucial for providing method choice and facilitating greater uptake of contraception. This mix also allows users to switch methods when necessary, rather than abandoning contraception altogether.

Despite a long history of family planning initiatives in Pakistan, overall contraceptive prevalence remains low, with limited diversity in the method mix. Female sterilization (30.4%) is the most used method, particularly among rural (33.1%) and less educated women (39.2%). Male condoms (27.5%) and withdrawal (22.4%) also comprise a significant share of contraceptive use, especially in urban areas. However, withdrawal is known for its high failure rate, and condoms, if not used consistently and correctly, can lead to unintended pregnancies. The current reliance on permanent methods like sterilization and short-term, user-dependent methods like condoms and withdrawal indicates a need to strengthen access to long-acting reversible contraceptives and broaden method choices through improved counselling and service delivery mechanisms.

The contraceptive method mix in Punjab is also quite limited. Table 6.2 shows the percentage of current users by method type and background characteristics. Female sterilization was the most used method (30.4%) among contraceptive users in Punjab, both in urban (27.4%) and rural areas (33.1%), as well as in lagging (29.8%) and non-lagging districts (30.5%). Among women aged 35–49, about two fifths (39.6%) had opted for female sterilization. Notably, users with no education (39.2%) were more likely to use female sterilization than those with higher education (20.4%).

Male condoms were the second most widely used contraceptive choice, employed by 27.5% of users in the province. Use is higher in urban areas (32.4%) compared to rural areas (23.2%), greater in non-lagging districts (28.9%) than in lagging districts (20.3%), and increases with education and wealth, reaching 39.8% among women with secondary or higher education and 36.7% in the highest wealth quintile.

Withdrawal *(coitus interruptus)* was the third most common method overall (22.4%), with slightly higher prevalence in urban areas (24.9%) compared to rural areas (20.3%). Among district types, withdrawal use was 18.9% in lagging districts and 23.1% in non-lagging districts. Younger women aged 15–24 years (28.7%) and those aged 25–34 years (23.6%) relied more on withdrawal compared to older women. Withdrawal use was positively associated with education and wealth, though it remained lower than condom use.

Other spacing methods, including IUDs (6.3%), injectables (4.6%), and oral pills (3.4%) were used by a small segment of women.

Table 6.2: Percentage distribution of currently married women using a contraceptive method, by type of contraceptive method and background characteristics

	Female sterilization	Male sterilization	IUDs	Injectables	Sayana Press	Implants	Oral pills	Male condoms	Female condoms	ECPs	Standard days method	Lactational amenorrhea method	Rhythm method	Withdrawal	Others	Total
Overall	30.4	0.2	6.3	4.6	0.1	0.7	3.4	27.5	0.5	0.2	0.3	3.0	0.2	22.4	0.3	100
Residence																
Rural	33.1	0.2	7.2	6.0	0.1	0.9	3.9	23.2	0.2	0.2	0.2	3.9	0.3	20.3	0.4	100
Urban	27.4	0.1	5.2	3.1	0.0	0.6	2.9	32.4	0.8	0.2	0.3	1.9	0.1	24.9	0.1	100
District type																
Lagging	29.8	0.6	7.5	9.3	0.1	1.1	6.1	20.3	0.0	0.5	0.7	4.4	0.3	18.9	0.4	100
Non-lagging	30.5	0.1	6.0	3.8	0.1	0.7	2.9	28.9	0.6	0.1	0.2	2.7	0.2	23.1	0.3	100
Age (years)																
15–24	5.5	0.0	6.8	7.1	0.1	0.7	2.8	35.5	0.0	0.0	1.2	10.8	0.0	28.7	0.7	100
25–34	20.9	0.2	6.3	4.9	0.1	0.8	4.6	32.2	0.8	0.3	0.1	4.8	0.3	23.6	0.2	100
35–49	39.6	0.2	6.2	4.2	0.0	0.7	2.7	23.5	0.3	0.1	0.3	0.9	0.2	20.9	0.3	100
Education																
No education	39.2	0.3	8.4	6.1	0.1	0.8	3.7	17.8	0.2	0.3	0.4	3.3	0.1	18.9	0.5	100
Primary/middle	31.6	0.2	5.9	5.0	0.1	0.8	3.3	24.9	0.1	0.2	0.2	3.0	0.2	24.3	0.3	100
Secondary or higher	20.4	0.0	4.5	2.9	0.1	0.5	3.3	39.8	1.2	0.0	0.2	2.7	0.4	24.1	0.0	100
Wealth quintiles																
Lowest	31.4	0.4	8.5	9.1	0.2	0.7	4.9	17.0	0.0	0.5	0.6	6.5	0.1	19.2	0.8	100
Second	33.2	0.2	6.7	4.3	0.1	0.9	3.8	22.3	1.0	0.2	0.1	2.7	0.1	24.2	0.3	100
Middle	31.3	0.2	6.1	5.0	0.0	0.7	2.3	25.8	1.0	0.0	0.5	2.3	0.1	24.3	0.4	100
Fourth	31.3	0.1	4.9	3.2	0.0	1.0	3.0	32.0	0.3	0.1	0.2	1.9	0.2	21.7	0.0	100
Highest	25.2	0.0	5.8	2.9	0.1	0.3	3.5	36.7	0.1	0.1	0.0	2.6	0.5	22.0	0.1	100

Contraceptive Method Preference

The rationale behind choosing a particular contraceptive method was explored. Focusing on the three most used methods: injectables, male condoms, and withdrawal. Table 6.3 shows the primary reasons cited by users.

For injectables, the leading reason was "easily available" (29.4%), followed by "convenient to use" (18%) and "provider advised" (15.9%). Additionally, "advice from a friend or relative" was cited by 9.5% of injectable users overall, with 10.7% among rural women. In urban areas, the long protection period of injectables was mentioned by 9.8% of users as a significant reason. Interestingly, perceived fewer side effects (9.1%) was not a major factor in the choice of injectables.

Among male condom users, the top three reasons were "easily available" (40.2%), "no or fewer side effects" (16.0%), and "convenient to use" (14.3%). "Low cost" was also noted by 7.6% of users as a reason for selecting the condom.

Withdrawal users reported their main reasons as "no or few side effects" (29.3%), "suitability for the woman or couple" (22.2%), "convenient to use" (20.5%), and "easily available" (19.8%). Notably, among urban users, "no or few side effects" was the second most frequently cited reason, reported by 27.0%.

Table 6.3: Percentage distribution of currently married women using injectables, male condoms, or withdrawal, by reasons for choice of method

Reasons (multiple responses)	Injectables			Male condoms			Withdrawal		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
Easily available	29.4	33.5	20.5	40.2	43.9	37.2	19.8	19.3	20.3
Low cost	3.4	3.3	3.6	7.6	7.5	7.7	0.7	1.5	0.1
Convenient to use	18.0	15.1	24.5	14.3	14.7	14.1	20.5	20.7	20.3
Suitable for respondent/ husband	5.3	3.5	9.2	13.3	13.3	13.4	22.2	21.0	23.4
No/fewer side effects	7.8	7.7	8.1	16.0	11.9	19.4	29.3	31.7	27.0
Can be used for long period	9.1	8.8	9.8	0.6	0.4	0.8	1.1	0.9	1.2
No other method available	0.4	0.6	0.0	0.5	0.8	0.3	2.8	2.3	3.3
Method always available	1.1	0.4	2.7	0.6	0.6	0.7	1.0	0.5	1.5
Provider advised	15.9	16.5	14.5	3.0	2.9	3.1	0.3	0.4	0.2
Female friend/relative advised	9.5	10.7	6.7	2.1	2.3	1.9	1.5	0.8	2.1
Others	0.1	0.0	0.4	1.7	1.8	1.6	19.8	19.3	20.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of users	**350**	**259**	**91**	**1,699**	**922**	**777**	**1,436**	**812**	**624**

Satisfaction With and Intention to Continue Using the Method

Over 90% of current users of injectables, male condoms, and withdrawal reported satisfaction with their chosen method and expressed an intention to continue using it. Satisfaction was slightly lower among injectable users (93.3%) compared to male condom users (97.9%) and withdrawal users (97.5%). Urban–rural differences in satisfaction and intention to continue using each method were negligible. High levels of satisfaction and intention to continue were also observed among users of both modern and traditional methods (Table 6.5).

Satisfaction and intention to continue using traditional methods were slightly higher than for modern methods. This high level of reported satisfaction with the chosen method is notable and reassuring for continued protection against unintended pregnancy. However, these results are based solely on current users and do not account for individuals who may have discontinued these methods in the past due to dissatisfaction or method failure.

Table 6.4: Percentage distribution of currently married women using injectables, condoms, or withdrawal; reporting satisfaction with their use; and intending to continue with their method, by type of method

	Injectables			Male condoms			Withdrawal		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
Satisfied with method?									
Yes	93.3	93.8	92.2	97.9	97.0	98.6	97.5	96.6	98.3
No	6.7	6.2	7.8	2.1	3.0	1.4	2.5	3.4	1.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Intend to continue using method?									
Yes	90.1	90.2	89.9	96.5	95.9	97.0	96.0	96.1	96.0
No	9.9	9.8	10.1	3.5	4.1	3.0	4.0	3.9	4.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N (unweighted)	**350**	**259**	**91**	**1,699**	**922**	**777**	**1,436**	**812**	**624**

Table 6.5: Percentage distribution of currently married women using traditional or modern contraceptive methods; reporting satisfaction with their use; and intending to continue with their method

	Total	Traditional	Modern
Satisfied with method?			
Yes	97.6	97.4	97.6
No	2.4	2.6	2.4
Total	100.0	100.0	100.0
Intend to continue using method?			
Yes	96.0	95.7	96.1
No	4.0	4.3	4.0
Total	100.0	100.0	100.0
No. of women (unweighted)	**6,504**	**1,474**	**5,030**

Side Effects

A relatively small proportion of women, 7.7%, reported experiencing any side effects while using a contraceptive method (Table 6.6). The most reported method-related side effects included heavy bleeding (30.6%), irregular bleeding (13.5%), and weight gain (11.8%) (Table 6.7). Differences in the type or severity of side effects between methods obtained from public or private sources were modest.

Table 6.6: Percentage of currently married women using a modern contraceptive method and reporting method-related side effects, by source of method

	Total	Public	Private
Experienced side effects?			
Yes	7.7	8.9	6.8
No	92.3	91.1	93.2
No. of women (unweighted)	**3,515**	**1,488**	**2,027**

Table 6.7: Percentage of currently married women who experienced method-related side effects, by type of side effect and source of contraceptive method

Type of side effects (Multiple responses)	Total	Public	Private
Heavy bleeding	30.6	31.9	29.5
Irregular bleeding	13.5	15.9	11.3
Weight gain	11.8	9.1	14.3
Weakness	9.8	9.9	9.8
Spotting	1.0	0.8	1.3
Infection	3.5	1.9	5.0
Nausea/dizziness	2.2	2.6	1.8
Headache	2.9	5.3	0.6
Backache	2.4	0.8	4.0
Allergy	0.4	0.5	0.3
Irritation	0.8	1.3	0.4
White discharge	1.1	1.1	1.2
Pain in low abdomen	2.2	1.5	2.8
Body swelled	2.5	2.0	3.1
Menopause	8.1	10.7	5.7
Freckles on the face	2.8	1.4	4.1
Others	4.2	3.4	4.9
Total	**100.0**	**100.0**	**100.0**
No. of women (unweighted)	**298**	**145**	**153**

Among the three short-term spacing methods (pills, condoms, and injectables), side effects from condom use were the lowest (2.3% overall, 1.2% in rural areas, and 3.2% in urban areas). Side effects from injectables were 15.1% overall, 14.3% in rural areas, and 17% in urban areas (Table 6.8). For oral pill users, 14.5% overall reported side effects, including 17.3% in rural areas. In urban areas, the percentage of oral pill users reporting side effects was significantly lower at 10.3%.

Table 6.8: Percentage of current users of injectables, male condoms, or oral pills reporting method-related side effects, by type of method

Experienced side effects?	Injectables			Male condoms			Oral pills		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
Yes	15.1	14.25	17.0	2.3	1.2	3.2	14.5	17.3	10.3
No	84.9	85.75	83.0	97.7	98.8	96.8	85.5	82.7	89.7
Total	**100.0**	**100.00**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of women*	**312**	**230**	**82**	**809**	**454**	**355**	**202**	**136**	**66**

* unweighted

Source of Current Contraceptive Method

The sources of current methods varied by specific methods (Table 6.9). Sterilization services were primarily obtained from private health facilities (55.3%) compared to 41.4% from public facilities. Similarly, Sayana Press was mainly sourced from private facilities (56.7%) than public facilities (32.4%). In contrast, IUDs (60.4%), injectables (64.6%), and implants (76.7%) were predominantly obtained from public health facilities. Private facilities accounted for 37.2% of IUDs, 23.6% of injectables, and 23.4% of implants. Pharmacies were the leading suppliers of condoms (38.6%), emergency contraceptive pills (ECPs) (53.8%), and oral pills (26.9%).

Table 6.9: Percentage of currently married women using a method, by source of current contraceptive method

	Public	Private	Pharmacy	Others[a]	Don't know	Missing	Total	No. of women (unweighted)
Sterilization	41.4	55.3	0.0	0.4	2.5	0.4	100.0	2,015
IUDs	60.4	37.2	0.0	1.1	1.1	0.2	100.0	412
Injectables	64.6	23.6	6.2	3.2	1.8	0.6	100.0	350
Sayana Press	32.4	56.7	10.9	0.0	0.0	0.0	100.0	7
Implants	76.7	23.4	0.0	0.0	0.0	0.0	100.0	61
Oral pills	44.9	18.7	26.9	1.9	6.6	1.1	100.0	239
Condoms	11.7	3.5	38.6	4.6	23.8	17.9	100.0	1,709
ECPs	17.5	9.4	53.8	0.0	19.4	0.0	100.0	10
Total	**33.7**	**30.0**	**16.4**	**2.3**	**10.6**	**7.0**	**100.0**	**4,803**

[a]Vaccinators, Suraj workers, Pehli Kiren workers, hakims/homeopaths, husbands, and others.

Quality of Care

The quality of care reported by users of modern methods during their last visit to a family planning facility varied by facility type and urban–rural location (Table 6.10).

Overall, 55.3% of users rated staff attitude and behavior as cooperative or friendly. This positive rating was slightly lower in rural public facilities (72.4%) than in urban public facilities (74.3%). In contrast, rural private facilities had a higher percentage of users reporting cooperative or friendly staff (62.0%) compared to urban private facilities (50.2%).

The availability of a doctor was nearly universal across all facility types, though slightly lower in rural areas: 98.8% in rural public versus 99.4% in urban public facilities, and 97.4% in rural private versus 98.3% in urban private facilities.

No waiting time was reported by 30.5% of visitors to rural public facilities, compared to 35.9% of visitors to urban public facilities. The figures for private facilities were higher: 37.1% for rural and 44.7% for urban areas. Waiting for more than an hour was uncommon, particularly in urban private facilities, where it was reported by only 3.1% of respondents.

Table 6.10: Percentage of currently married women using modern contraceptive methods reporting on the quality of care received during their last visit to a family planning facility, by type of facility and area

	Total	Public		Private	
		Rural	Urban	Rural	Urban
Staff attitude and behavior					
Cooperative/friendly	55.3	72.4	74.3	62.0	50.2
Polite attitude	17.0	23.4	21.9	17.9	15.8
Non-cooperative/unfriendly/hostile	0.9	1.6	1.5	0.6	0.9
Missing	26.8	2.7	2.4	19.5	33.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Availability of doctor/worker					
Yes	97.9	98.8	99.4	97.4	98.3
No	2.1	1.2	0.6	2.6	1.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Wait time (minutes)					
No wait time	36.4	30.5	35.9	37.1	44.7
1–30	50.0	54.1	53.4	47.9	44.5
31–60	4.1	5.9	3.6	3.9	3.3
60+	5.2	6.8	5.8	6.0	3.1
Don't remember	4.4	2.7	1.3	5.2	4.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of women (unweighted)	**3,515**	**1,003**	**485**	**1,246**	**781**

Information received during the first family planning consultation is crucial for helping clients make informed choices about methods and ensure continued use. Table 6.11 presents the distribution of clients by the information they received on key topics. Contrary to common belief, public facilities provided a greater range of information than private ones.

Clients at public facilities were more likely to receive information on all topics than those at private facilities. For instance, 80.5% of public facility clients were informed about their preferred method, compared to only 60.6% of private facility clients. Additionally, crucial information on what to do in the event of side effects was provided to 57.3% of public facility clients, compared to just 42.6% at private facilities.

Table 6.11: Percentage of currently married women using a modern contraceptive method who reported receiving information about that method from a service provider during their first visit, by place of facility

Received information about	Total	Public	Private
Method of client's preference	68.8	80.5	60.6
How method works	65.6	78.7	56.3
How to use method	63.0	75.1	54.5
Contraindications	57.1	67.5	49.7
Effectiveness and duration of effectiveness	59.5	72.7	50.2
Advantages compared to other methods	57.4	68.7	49.4
Disadvantages compared to other methods	51.8	60.3	45.8
Possible side effects	47.9	55.6	42.5
What to do if side effects are experienced	48.7	57.3	42.6
Where to go in case of side effects	49.1	57.9	43.0
Possibility of switching	43.2	50.5	38.1
Other methods that could be used	42.9	49.5	38.3
No. of women (unweighted)	3,515	1,488	2,027

Note: Cases of "don't know or missing" for source of method were excluded from the analysis.

Receiving the contraceptive method of choice is a key indicator of quality care and respect for clients' rights and preferences. Approximately 97.8% of clients reported receiving their preferred method (Table 6.12). There was a small difference in percentages between clients in public (98%) and private facilities (97.7%).

Table 6.12: Percentage of currently married women using a modern contraceptive method and reporting receipt of their method of choice

	Total	Public	Private
Received method of choice?			
Yes	97.8	98.0	97.7
No	2.2	2.0	2.3
No. of women (unweighted)	3,515	1,488	2,027

Past Users of Contraceptive Methods

A notable 12.6% of currently married women had used a contraceptive method in the past but had discontinued use, with minimal differences between urban and rural areas. Understanding the experiences of past users is crucial for identifying which methods were discontinued and the reasons behind discontinuation. Nearly 67% of past users stopped using their method within the first year. While 29.3% cited the desire to have another child as the reason for discontinuation, 26.7% of past users reported no specific reason (Table 6.13).

The contraceptive methods most likely to be discontinued, included, male condoms (29.8%), withdrawal (16.1%), IUD (12.5%), injectables (16.3%) and oral pills (8.4%) (Table 6.14). Past use of male condoms (35.7%) was higher in urban areas compared to rural areas (25.7%) and withdrawal (16.8%) was higher in rural areas compared to urban areas (15.1%).

Table 6.13: Percentage of currently married women who were past users stating reasons for discontinuing last used method

	Total	Rural	Urban
Reason for discontinuation (%)			
Wanted another child	29.3	27.1	32.1
Experienced side effects	7.7	8.2	7.2
Method failure	2.1	1.6	2.7
Source of method was too far	0.3	0.4	0.1
Due to travel/travel cost	0.0	0.0	0.0
Faced health issues other than side effects	4.7	5.1	4.3
Method was not available	0.4	0.3	0.5
Cost was not affordable	0.4	0.6	0.2
Method was inconvenient to use	0.2	0.3	0.2
Rest from the method	2.7	3.1	2.2
Missed the dose	0.1	0.2	0.1
Provider advised to stop use	0.9	0.7	1.3
Infrequent sex/husband away	3.1	3.4	2.8
Husband's advice	5.9	6.0	5.9
In-laws oppose	0.2	0.1	0.4
Menopause	2.9	2.9	3.0
Others	12.3	12.2	12.5
Don't know	26.7	28.2	24.7
Total	**100.0**	**100.0**	**100.0**
No. of women (unweighted)	**5,331**	**3,400**	**1,931**

Table 6.14: Percentage of currently married women who were past users reporting the method last used and duration of use

	Total	Rural	Urban
Percent distribution of Method last used			
IUDs	12.5	11.1	14.4
Injectables	16.3	17.9	14.1
Implants	1.3	1.6	0.8
Sayana Press	0.0	0.0	0.0
Oral pills	8.4	10.0	6.2
Male condoms	29.8	25.7	35.7
Female condoms	0.5	0.4	0.6
ECPs	0.3	0.3	0.4
Standard days method	0.4	0.3	0.7
Lactational amenorrhea	3.3	3.4	3.1
Rhythm method	0.9	1.3	0.2
Withdrawal	16.1	16.8	15.1
Others	10.3	11.4	8.7
Total	100	100	100
Percentage stating duration of use (months)			
0–12	59.3	62.8	54.3
13–24	12.8	12.4	13.5
25+	27.9	24.8	32.2
Total	**100.0**	**100.0**	**100.0**
No. of women (unweighted)	**2,149**	**1,415**	**734**

Among users of traditional methods, the primary reason for not using modern contraceptives was the concern about side effects, reported by 24.7% overall (24.1% in rural areas and 25.3% in urban areas) (Table 6.15).

Fatalistic beliefs ("up to God") were cited by 9.7% of traditional method users, with slightly higher prevalence in urban areas (11.2%) than in rural areas (8.1%).

Infrequent sexual activity was another common reason, reported by 13.1% of traditional method users (15.7% in rural areas and 10.6% in urban areas).

Additionally, 16.8% of users indicated their husbands' opposition to modern contraceptive methods, with opposition notably higher in urban areas (20.5%) compared to rural areas (13%).

Table 6.15: Percentage of currently married women using a traditional contraceptive method and reasons for not using modern methods

	Total	Rural	Urban
Reason (multiple responses)			
No sexual activity	1.3	1.6	1.1
Infrequent sexual activity	13.1	15.7	10.6
Menopausal	0.7	1.0	0.4
Cannot get pregnant	0.2	0.2	0.2
Not menstruated since last birth	0.5	0.4	0.6
Breastfeeding	1.4	1.6	1.1
Up to God (fatalistic)	9.7	8.1	11.2
Respondent opposed	2.0	2.8	1.2
Husband opposed	16.8	13.0	20.5
In-laws opposed	1.0	0.8	1.1
Religious prohibition	2.4	3.2	1.6
Unaware of modern methods	2.8	3.2	2.3
Unaware of modern method sources	1.2	1.2	1.2
Inconvenient to use	2.2	2.8	1.6
Changes in menstrual bleeding	1.0	1.5	0.5
Methods could cause infertility	0.7	1.1	0.4
Modern methods interfere with body's normal processes	5.7	4.8	6.5
Lack of access/too far	0.2	0.3	0.1
Too expensive	1.7	2.0	1.5
Not a preferred method	0.5	0.1	0.9
Methods unavailable	0.3	0.3	0.3
Side effects	24.7	24.1	25.3
Want (more) children	8.2	8.0	8.4
Hysterectomy	0.3	0.5	0.1
Others	1.6	1.7	1.4
Total	**100.0**	**100.0**	**100.0**
No. of women (unweighted)	**1,474**	**842**	**842**

Among women who had never used contraception, the main reasons for not using any method were the desire for more children (39.2%) and fatalistic beliefs, such as leaving it "up to God" (22.8%) (Table 6.16).

Additionally, 9.3% cited infrequent sexual activity, while smaller percentages mentioned inability to become pregnant (2.6%), opposition from husbands (2.8%), health issues (2.4%), and fear of side effects (2%).

Table 6.16: Percentage of currently married women who had never used any family planning method by reported reason for non-use

Reasons for never using any family planning method*	Total	Rural	Urban
Not having sex	4.1	4.2	4.0
Infrequent sex	9.3	9.8	8.2
Menopausal	1.3	1.3	1.3
Can't get pregnant	2.6	2.5	2.7
Not menstruated since last birth	0.7	0.8	0.5
Breastfeeding	1.2	1.3	1.2
Up to God/fatalistic	22.8	23.1	22.2
Respondent opposed	0.3	0.5	0.1
Husband opposed	2.8	2.8	2.8
Others opposed	0.5	0.5	0.4
Religious prohibition	1.6	1.5	1.7
Knows no method	0.8	0.8	0.8
Knows no source	0.3	0.2	0.3
Inconvenient to use	0.0	0.1	0.0
Changes in menstrual bleeding	0.7	0.6	1.1
Methods could cause infertility	0.2	0.1	0.3
Interferes with body's normal processes	0.5	0.6	0.4
Health issues	2.4	2.1	2.9
Fear of side effects	2.0	1.8	2.2
Source of method was too far	0.1	0.1	0.0
Due to travel/travel cost	0.0	0.1	0.0
Costs too much	0.0	0.0	0.0
Preferred method not available	0.0	0.0	0.0
No method available	0.2	0.3	0.2
Respondent/husband infertile	1.0	1.0	1.0
Wanted (more) children	39.2	38.8	39.9
Hysterectomy	2.0	1.7	2.5
Others	3.5	3.7	3.2
Total	**100.0**	**100.0**	**100.0**
No. of women (unweighted)	**9,947**	**6,868**	**3,079**

*Multiple response variable.

Access and Affordability of Family Planning Services

Access to family planning services was measured by the one-way travel time to facilities. A significant majority (61.8%) of family planning clients reported reaching a facility within 30 minutes. Notably, a higher proportion of urban clients reached a private facility within 30 minutes (75%) compared to rural areas (55.5%). For public facilities, 63.7% of urban users reached one within 30 minutes, while 56.1% of rural users could do so (Table 6.17).

Only 11.1% of all respondents reported a one-way travel time of over one hour: 13.7% for rural public facilities and 5.2% for urban private facilities. Thus, travel time did not appear to be a significant constraint for most women in Punjab.

Table 6.17: Percentage distribution of currently married women using a modern contraceptive method and travel time (one-way) to access the method's source

		Public		Private	
	Total	Rural	Urban	Rural	Urban
One-way time to reach facility (minutes)					
1–30	61.8	56.1	63.7	55.5	75.0
31–60	22.6	27.1	20.6	27.5	14.8
60+	11.1	13.7	13.0	14.0	5.2
Don't know	4.6	3.1	2.7	3.0	5.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of women (unweighted)	**3,095**	**986**	**474**	**1,061**	**574**

In contrast, the cost of accessing services was a significant barrier to both the uptake and continuation of contraceptive use. Expenses varied by method, transportation costs, and whether services were obtained from public or private facilities. While public family planning services are free, clients often incurred costs for transportation, fees, medicines, and tests.

Overall, 53.6% of current users of modern methods reported costs associated with family planning services (Table 6.18). A higher percentage of women with secondary or higher education (57%) faced these costs compared to those with no education (51.9%). Similarly, more women in the highest wealth quintile (61.2%) incurred costs compared to those in the poorest quintile (52.1%).

Current users were asked about costs associated with their chosen method. Since mean cost estimates were influenced by extreme values, we present both mean and median values, with emphasis on medians for comparison.

The median cost of the current method was PKR 2,500—higher in rural areas (PKR 2,700) than in urban areas (PKR 2,000), and in non-lagging districts (PKR 2,500) than in lagging districts (PKR 2,000).

By age, women aged 35–49 spent PKR 5,000—ten times as much as women aged 15–24 years (PKR 500)—likely reflecting greater preference for long-term methods. It is important to note that the most

widely used modern methods in Punjab—female sterilization, male condoms, injectables, and oral pills—are less expensive than implants or IUDs.

Table 6.18: Percentage of current users of family planning incurring costs for service and average cost incurred

	Percentage incurring cost		Amount spent (PKR)[a]			
	%	N	Median	Mean	Std. dev.	N (unweighted)
Total	53.6	3,664	2,500	16,236	43,426	1,982
Residence						
Rural	53.4	2,312	2,700	16,999	48,884	1,244
Urban	53.9	1,352	2,000	15,326	35,822	738
District type						
Lagging	47.3	773	2,000	13,937	46,710	397
Non-lagging	54.7	2,891	2,500	16,591	42,886	1,585
Current age (in years)						
15–24	43.5	189	500	11,833	36,945	80
25–34	53.6	1,249	1,200	12,820	33,076	665
35–49	54.4	2,226	5,000	18,491	48,618	1,237
Education						
No education	51.9	1,462	5,000	16,580	45,920	767
Primary/middle	52.4	1,224	3,500	18,523	51,739	673
Secondary and above	57.0	975	1,000	13,655	29,499	541
Wealth quintile						
Lowest	52.1	699	3,000	15,044	27,270	373
Second	47.1	789	4,000	18,319	60,100	386
Middle	51.9	787	3,000	13,471	19,986	418
Fourth	55.4	742	2,000	14,860	38,115	426
Highest	61.2	646	1,500	19,308	55,580	379

Note: Current modern method costs include transport, fees, medicine/method, lab/tests, operations, and beds.

[a]Current users of modern methods who incurred any costs.

Intention to Use in the Future

Married women who had previously used a contraceptive method but were not currently using one, as well as those who had never used any method, were asked about their intentions to use a method in the future. Among past users, 26.3% women overall, 27.1% in rural areas, and 25.1% in urban areas indicated they were "very definitely" or "most likely" to use a method in the future (Table 6.19). In contrast, intention to use a method among never-users was considerably lower, with only 10.6% overall, 9.7% in rural areas, and 12.4% in urban areas expressing they would "very definitely" or "most likely" use a method in the future.

Table 6.19: Percentage of currently married women who intend to use contraception in the future but are currently not using any method, by residence.

	Total	Rural	Urban
Intention to use family planning in future			
Past users			
Very definitely	18.7	19.0	18.2
Most likely	7.6	8.1	6.9
Not sure/maybe	28.9	27.7	30.7
No	28.4	29.2	27.2
Can't get pregnant	16.4	16.0	17.1
Total	100.0	100.0	100.0
N (unweighted)	**2,149**	**1,415**	**734**
Never-users			
Very definitely	6.3	6.1	6.8
Most likely	4.3	3.6	5.6
Not sure/maybe	37.5	37.5	37.3
No	43.1	44.5	40.6
Cannot get pregnant	8.8	8.3	9.8
Total	100.0	100.0	100.0
N (unweighted)	**9,947**	**6,868**	**3,079**

The three most preferred methods for future use among those intending to adopt a method were the same as the most popular methods among current users: male condoms (25.7%), female sterilization (17.7%), and withdrawal (10.5%) (Table 6.20). Female sterilization was more preferred in rural areas (20.4%) compared to urban areas (13.7%), while male condoms were more preferred in urban areas (30.3%) compared to rural areas (22.6%). Preference for withdrawal was also slightly higher in urban areas (11.3%) than in rural areas (9.9%).

Table 6.20: Percentage of currently married women who intend to use in the future among those who are currently not using a method by future method preferred, and by residence.

	Total	Rural	Urban
Preferred method to use in future			
Female sterilization	17.7	20.4	13.7
Male sterilization	0.4	0.3	0.7
IUDs	4.5	4.8	4.2
Injectables	4.8	4.9	4.7
Sayana Press	1.2	1.2	1.2
Implants	0.0	0.0	0.1
Oral pills	3.0	3.5	2.2
Male condoms	25.7	22.6	30.3
Female condoms	0.1	0.0	0.3
ECPs	0.3	0.4	0.2
Standard days method	0.1	0.2	0.0
Lactational amenorrhea	0.5	0.8	0.2
Rhythm method	0.2	0.3	0.1
Withdrawal	10.5	9.9	11.3
Others (specify)	1.2	1.2	1.0
Don't know	29.7	29.6	29.8
Total	**100.0**	**100.0**	**100.0**
No. of women (unweighted)	**2,270**	**1,506**	**764**

Unmet Need for Family Planning

Unmet need for family planning refers to the gap between the desire to delay or limit childbearing and the lack of contraceptive use to prevent pregnancy. It serves as an indicator for Sustainable Development Goal (SDG) 3.7, which aims to ensure universal access to sexual and reproductive healthcare services. Specifically, SDG indicator 3.7.1 measures the "proportion of women of reproductive age (15–49 years) whose need for family planning is satisfied with modern methods."[15] This indicator reflects a country's or province's progress in ensuring that women have access to essential family planning and reproductive health services, a core SDG objective.

Generally, low contraceptive use correlates with high unmet need for family planning. Addressing unmet need for family planning is a public health and human rights imperative that warrants high priority for interventions and investment.

[15] United Nations. (n.d.). *SDG indicator 3.7.1 on contraceptive use.* Retrieved June 25, 2025, from https://www.un.org/development/desa/pd/data/sdg-indicator-371-contraceptive-use.

In Punjab, 21.3% of currently married women aged 15–49 had an unmet need for family planning—5.4% for spacing and 15.9% for limiting (Table 6.21). The overall unmet need was higher in rural areas (22.4%) than in urban areas (19.7%), among women aged 35–49 years (25.3%) compared to those aged 15–24 years (14.8%), among women with no education (23.7%) versus those with secondary or higher education (20.5%), and among women in the lowest wealth quintile (25.7%) compared to those in the highest wealth quintile (20.7%). Overall, the unmet need for limiting was greater than for spacing in all subgroups, except for women aged 15–24 years.

Table 6.21 and Figure 6.4 show varied patterns of unmet need for spacing and limiting across subgroups. Unmet need for spacing was lower in urban areas (4.7%) than in rural areas (5.9%), while unmet need for limiting differed by 1.5 percentage points (15.0% vs. 16.5%).

Both lagging and non-lagging districts showed higher unmet need for limiting than for spacing. In lagging districts, unmet need for spacing was 6.9% compared to 19.2% for limiting births. In non-lagging districts, unmet need for spacing was 5.0% compared to 15.2% for limiting.

The unmet need for spacing decreased from 11.7% among women aged 15–24 to 2.4% among those aged 35–49, while unmet need for limiting rose sharply from 3.1% to 22.9%.

Differences in unmet need for spacing by education were modest, ranging from 4.8% among women with no education to 6.4% among those with secondary or higher education. However, unmet need for limiting was higher among women with no education (18.9%) compared to those with secondary or higher education (14.1%).

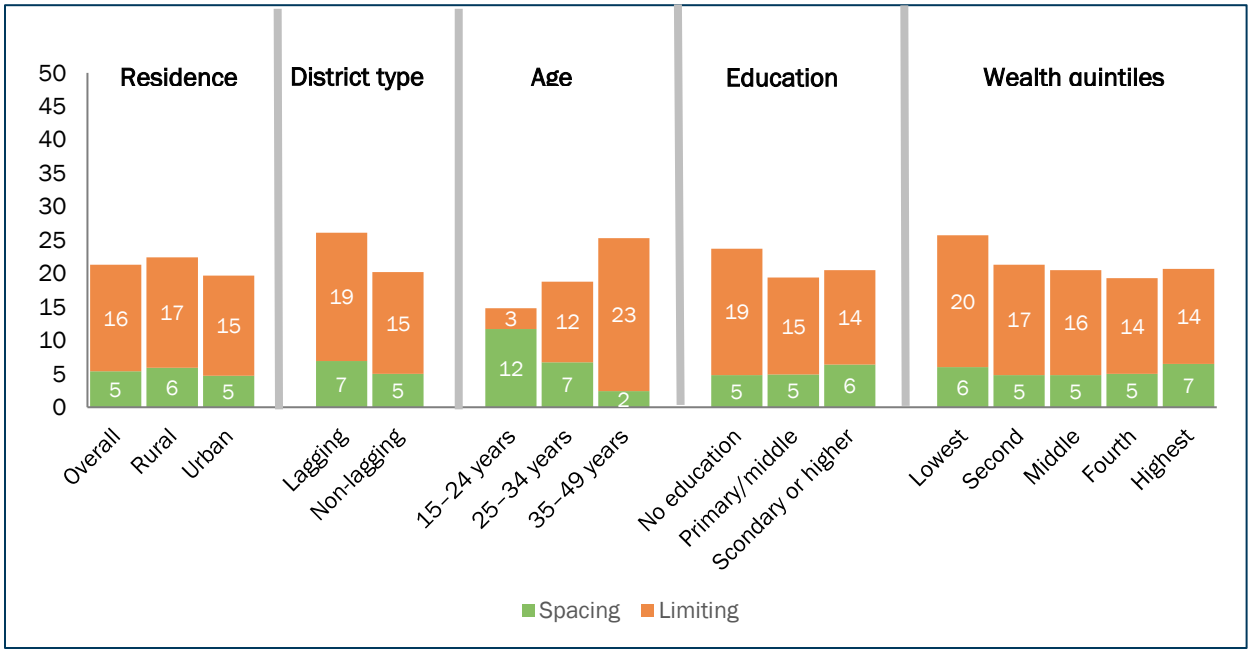
Variations in unmet need for both spacing and limiting births across wealth quintiles were also moderate, ranging from 19.7% in the poorest to 14.2% in the highest wealth quintile.

Total unmet need overall—as well as the unmet need for spacing and limiting—varied significantly by district (Figure 6.5). In lagging districts, the highest total unmet need was in Dera Ghazi Khan (37%), followed by Rahim Yar Khan (32%) and Bhakkar (31%). Most non-lagging districts had lower levels of total unmet need, with the exceptions of Layyah (36%) and Sialkot (34%). In all districts, lagging or non-lagging, unmet need for limiting was substantially more prevalent than unmet need for spacing.

Table 6.21: Percentage of currently married women with unmet need for family planning for spacing and limiting childbearing, by background characteristics

	Unmet need for family planning			
	Total unmet need	Unmet need for spacing	Unmet need for limiting	N (unweighted)
Overall	21.3	5.4	15.9	18,601
Residence				
Rural	22.4	5.9	16.5	12,259
Urban	19.7	4.7	15.0	6,342
District type				
Lagging	26.1	6.9	19.2	5,209
Non-lagging	20.2	5.0	15.2	13,392
Current age (years)				
15–24	14.8	11.7	3.1	2,814
25–34	18.8	6.7	12.1	7,100
35–49	25.3	2.4	22.9	8,687
Education				
No education	23.7	4.8	18.9	7,499
Primary/middle	19.4	4.9	14.5	5,827
Secondary and above	20.5	6.4	14.1	5,256
Wealth quintile				
Lowest	25.7	6.0	19.7	4,009
Second	21.3	4.8	16.5	3,753
Middle	20.5	4.8	15.7	3,794
Fourth	19.3	5.0	14.3	3,654
Highest	20.7	6.5	14.2	3,382

Figure 6.4: Percentage of currently married women with unmet need for family planning for spacing or limiting childbearing



The total demand for family planning, defined as the percentage using a contraceptive method plus the percentage with an unmet need, was estimated at a high level of 59.5% for Punjab overall (Table 6.22). Of this, 64.2% of demand was satisfied. Demand was highest among women aged 35–49 years (70.5%) and lowest among the youngest women aged 15–24 years (31.7%).

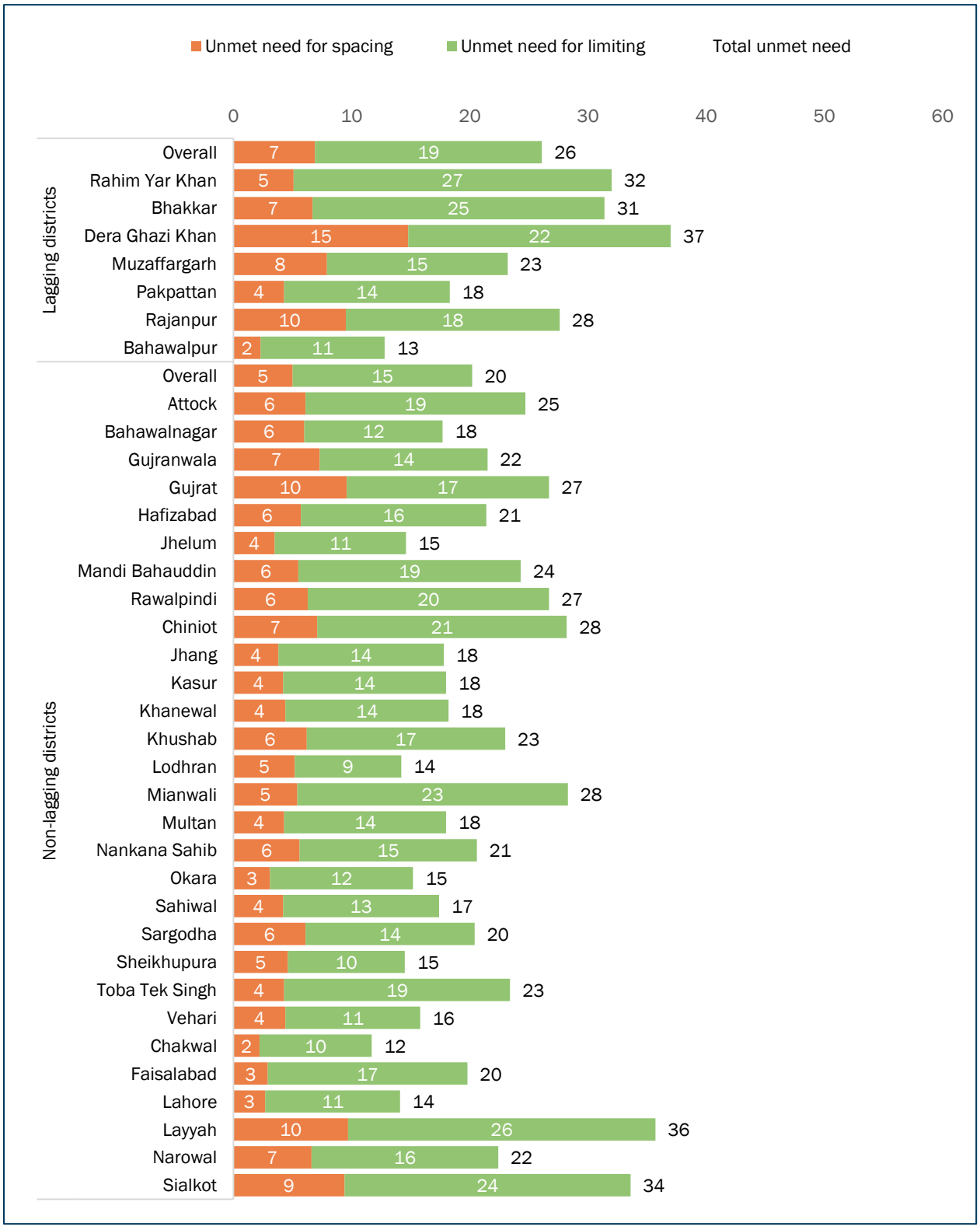
For other subgroups, total demand was around 60.0%. The percentage of demand satisfied by modern methods was 50.1% among women in the highest wealth quintile and 49.3% among women with secondary or higher education.

These findings indicate that the potential to meet family planning demand through modern methods is substantial and attainable if efforts are made to improve access and quality of services.

Table 6.22: Percentage of currently married women with total demand for family planning, unmet need for family planning, and the percentage of demand satisfied by a modern method

	Unmet need for family planning	Met need for family planning (currently using)	Total demand for family planning	Percentage of demand satisfied	Percentage of demand satisfied by modern methods	N (unweighted)
Residence						
Overall	21.3	38.2	59.5	64.20	49.58	18,600
Rural	22.4	34.5	56.9	60.63	47.98	12,259
Urban	19.7	43.4	63.1	68.78	51.51	6,341
District type						
Lagging	26.1	30.8	56.9	54.13	43.41	5,209
Non-lagging	20.2	40.0	60.2	66.45	50.83	13,391
Current age (years)						
15–24	14.8	16.9	31.7	53.31	37.54	2,814
25–34	18.8	37.6	56.4	66.67	50.53	7,099
35–49	25.3	45.2	70.5	64.11	50.35	8,687
Education						
No education	23.7	35.7	59.4	60.10	48.32	7,499
Primary/middle	19.4	40.5	59.9	67.61	50.92	5,826
Secondary and above	20.5	38.7	59.2	65.37	49.32	5,275
Wealth quintile						
Lowest	25.7	32.7	58.4	55.99	44.69	4,009
Second	21.3	39.2	60.5	64.79	48.93	3,752
Middle	20.5	40.1	60.6	66.17	49.67	3,794
Fourth	19.3	40.1	59.4	67.51	52.69	3,654
Highest	20.7	38.2	58.9	64.86	50.08	3,382

Figure 6.5: Percentage of currently married women with unmet need for family planning for spacing or limiting, by district



7

Integrating Family Planning into Maternal Health Care

Key Findings

Limited access to family planning information and services

- The gap in family planning (FP) information and services in Punjab is widespread and substantial.
- Nearly 80% of non-users do not know where to obtain FP services.

Service delivery patterns

- Most women (60%) who use modern contraception obtain their services from the private sector.
- Across both private and public sector sources, a higher percentage of women who current contraceptive users report obtaining a method from primary-level hospitals or lower-level facilities.
- Tertiary hospitals are rarely cited as a source of contraceptive methods.

Limited family planning counselling

- Counselling for FP is limited: only 28% of current modern contraceptive users received "appropriate counselling."
- Among women who received antenatal care (ANC) and delivery care at a facility in the last three years, only 35% percent received FP counselling during ANC, and just 11% were counselled during delivery care.
- Postpartum FP counselling levels were 19.1%, and postpartum contraceptive adoption was at 5.3%.

Socioeconomic disparities in contraceptive use

- Women who were beneficiaries of the BISP program reported a higher modern contraceptive use rate (40.4%) compared to non-beneficiaries (28.0%).

The World Bank–supported Punjab Family Planning Program comprises several initiatives aimed at promoting the use of FP in Punjab. Key strategies include integrating FP into mainstream health services, conducting behavioral-change communications campaigns, expanding the role of the private sector, providing travel vouchers and service subsidies through social protection programs, and strengthening the link between FP and maternal health through postpartum FP services. The program also seeks to dispel myths and fears of side effects regarding FP and adopt a rights-based approach to service delivery by improving FP counselling and quality of care. Indicators related to these aspects are included in this chapter.

A notable development in Punjab occurred in December 2024, when the Chief Minister announced merger of the Primary Health Care and Population Welfare Departments. The newly formed Health and Population department is now responsible for delivering a broad range of public health services, including FP. This merger is expected to facilitate the integration of FP services within maternal, newborn, and child health programs—for example, by providing FP counselling during ANC and at the time of labor and delivery.

Community outreach under this new structure involves collaboration with local health workers, particularly Lady Health Workers (LHWs), who go door-to-door to raise awareness about general health, family planning and refer women to higher level care. The department also distributes and provides contraceptive methods through its network of public health facilities, including dispensaries, rural health centers (RHCs), and hospitals.

In this chapter, we provide essential information on FP components, with a particular focus on post-pregnancy FP. The data presented here are directly relevant to the aims and objectives of the Punjab Family Planning Program. Some of the key indicators collected through the Punjab Health and Family Survey (PHFS) household survey 2024–25 include:

- Percentage of currently married women using a modern contraceptive method (PDO-2)
- Percentage of currently married women of reproductive age (15–49 years) who have received appropriate FP counselling (PDO-3)
- Percentage of currently married women aged 15–49 who received postpartum FP counselling during their last delivery in the past three years (DLI-2.1)
- Percentage of currently married women aged 15-49 who adopted postpartum FP following their last delivery in the past three years (DLI-2.2)
- Percentage of currently married women aged 15-49 who adopted FP from the private sector in the past three years (DLI-3)

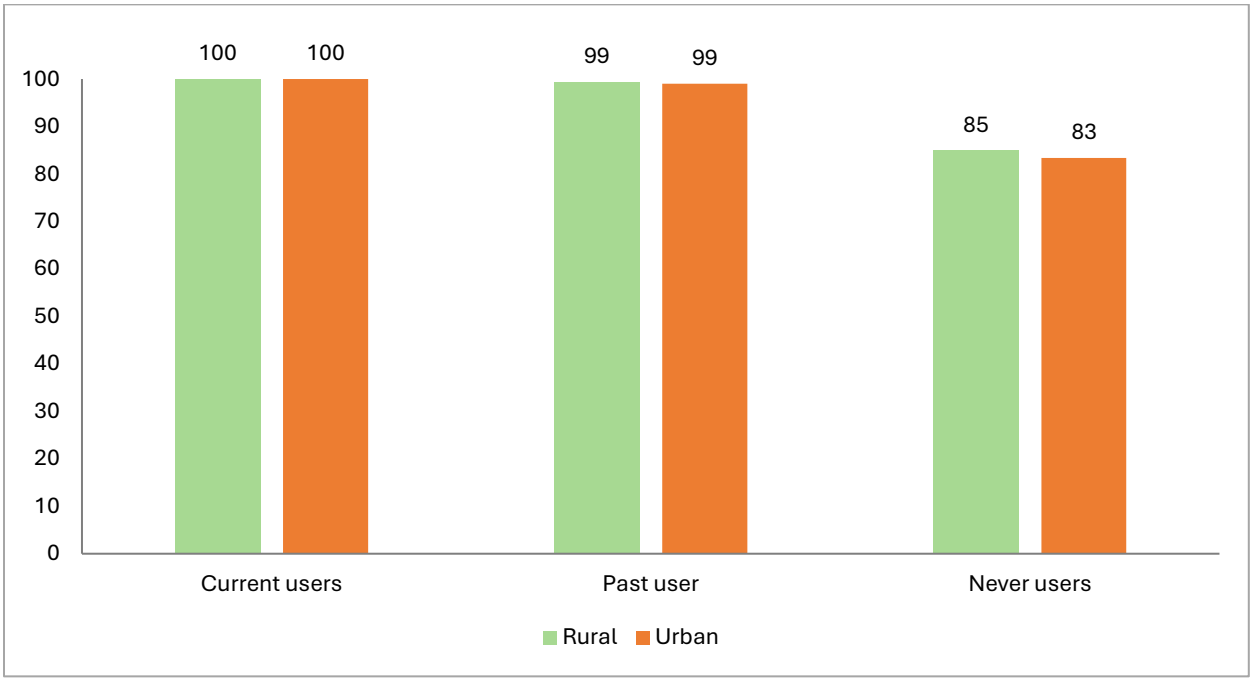
While PDO-2 was covered in Chapter 6, this chapter focuses on PDO 3 and DLIs 2.1, 2.2 and 3, which are related to counselling and postpartum FP services. These data were specifically collected through the Punjab Health and Population Survey 2024–25 and analyzed for this report.

Knowledge of Modern Contraceptive Methods and Their Sources

The use of modern contraception in Punjab was 29.5%, with high unmet need at 21.3%. The overall aim of the Punjab FP Program is to increase the use of modern contraception. To understand the potential for expansion, it is important to assess the levels of knowledge of modern contraception, particularly among women who have never used any modern or traditional method.

A substantial 49.2% of women in Punjab have never used a modern contraceptive method. As shown in Figure 7.1, knowledge of modern methods is high among current and past users, but significantly lower among never-users (85% in urban and 83% in rural areas). These women represent a critical target group for focused communication and outreach efforts to increase awareness of available FP services.

Figure 7.1: Percentage of currently married women who know a modern contraceptive method, by use status and rural–urban residence



.

Knowledge of Sources for Modern Contraceptive Methods

While knowledge of modern methods is relatively high among never-users, knowledge of where to obtain these methods is considerably lower. Table 7.1 shows that only 19.3% of women who never used a modern method know a source where they can obtain one. This knowledge is highest among never users with secondary or higher education (27.3%) and lowest among women aged 15–24 years (13.4%). Urban never-users are slightly more likely to know of a source than their rural counterparts (21.5% vs. 18.1%, respectively).

Table 7.1: Percentage of women who have never used a modern contraceptive method, by knowledge of a modern method and where to obtain it, disaggregated by age, education and rural–urban residence

		Knowledge of a modern contraceptive method (%)	Knowledge of where to obtain a method	Number of Cases
Overall		84.3	19.3	9,947
Current age (years)	15–24	78.8	13.4	2,229
	25–34	85.4	20.8	3,892
	35–49	86.4	21.3	3,826
Education	No education	82.8	14.3	4,239
	Primary & Middle	85.7	16.9	2,915
	Secondary or above	84.8	27.3	2,787
Residence	Rural	84.9	18.1	6,872
	Urban	83.4	21.5	3,080

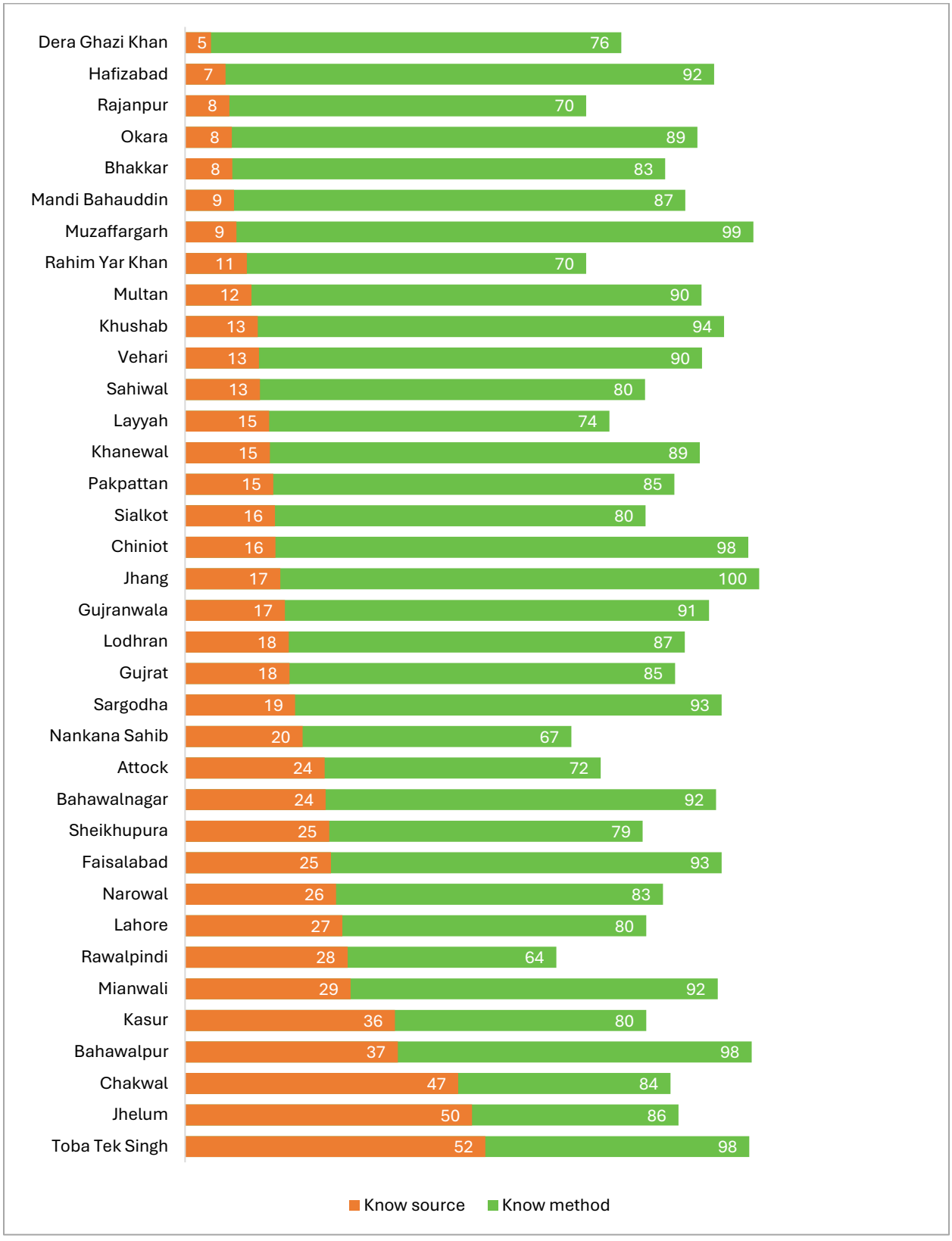
By district, the percentage of never-users who know a source for modern FP method ranged from 7.0% in Hafizabad to 52.1% in Toba Tek Singh (Figure 7.2).

District-level interventions should be twofold:

1. Prioritize intensified information campaigns in the seven districts where fewer than 10% of women know a source: Bhakkar, Dera Gazi Khan, Muzaffargarh, Rajanpur, Hafizabad, Mandi Bahauddin, and Okara.

2. In the five districts where over 30% know a source—Bahawalpur, Jhelum, Kasur, Toba Tek Singh, and Chakwal—focus on addressing barriers to actual method use, thereby narrowing the “know-do” gap in family planning.

Figure 7.2: Percentage of women who know of a modern contraceptive method and where to obtain it, among never-users of modern contraception, by district



Sources of Supply Among Current Users

The source for the current or most recent modern contraceptive method among current users, disaggregated by public and private facilities, is presented in Table 7.2. Among current users of modern methods, 40.4% obtained their method from a government source, which includes community-level services, primary health care facilities, first-level hospitals, and tertiary care facilities. Within the public sector, the role of community outreach, primary health care, and tertiary facilities is minimal.

Table 7.2 also underscores the dominant role of the private sector in the provision of FP services for both current and past users. Nearly 60% of users rely on private sector channels for FP services and supplies. Within the private sector, pharmacies and first-level hospitals are the most common sources. Community outreach programs, dispenser clinics, LHV/Nurse clinics, and Hakim/ homeopath providers play a much smaller role in service provision.

Table 7.2: Percent distribution of current users of modern contraceptive methods by source of current or most recent method

Type and level of current/last method source	Percent
Public	**40.4**
Community level	6.2
Primary health care level	8.9
First level hospital	18.3
Tertiary level/care	7.0
Private	**59.5**
Community level	0.1
Pharmacy/chemist	19.8
Dispenser clinic	1.6
LHV/Nurse clinic	2.2
Primary health care level	9.7
First level hospital	22.4
Hakim/Homeopath	0.1
Others	3.6
%	100.0
N	**4,011***

*Nearly 1,000 women reported that they did not know the source, as their husbands brought the method. Most of these couples use condoms or oral pills.

Note: The percentage of currently married women aged 15–49 who adopted family planning from the private sector in the past three years is Disbursement-Linked Indicator (DLI-3) of the Punjab Family Planning Program.

Counselling for Family Planning Services

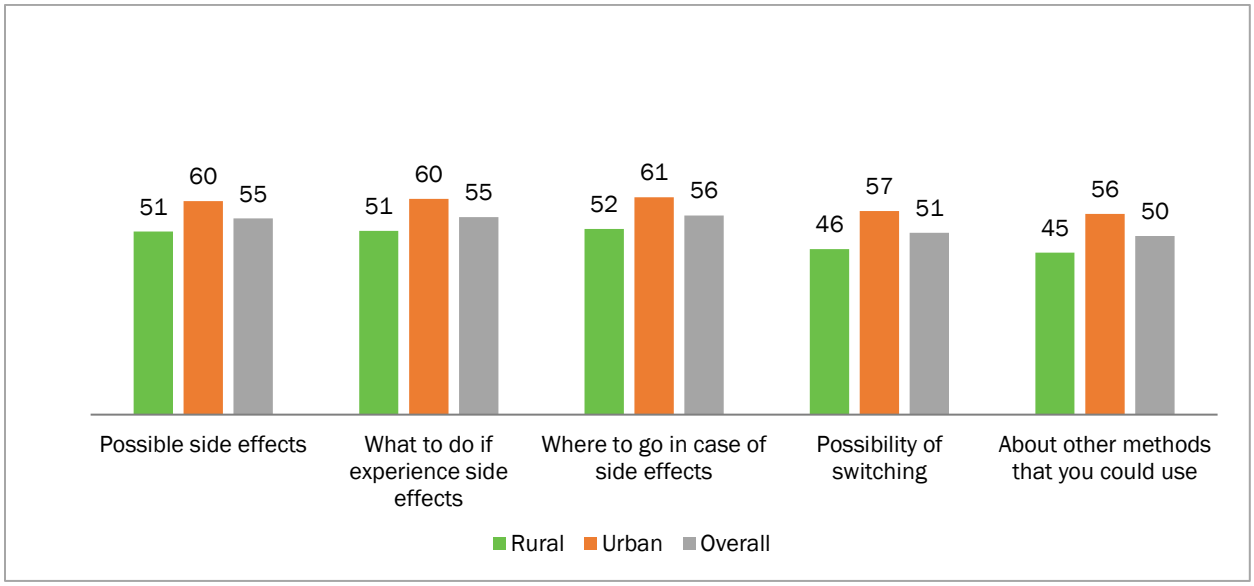
As agreed by member states during the International Conference on Population and Development (ICPD) in 1994, information and counselling on FP should be provided to all women to enable informed choices. While contraceptive use and method choice are individual decisions, the provision of information and counselling falls within the remit of FP and health service programs.

The definition of "appropriate counselling" includes comprehensive information on five aspects of contraceptive use:

1. Possible side effects
2. What to do if experiencing side effects
3. Where to go in case of side effects
4. Possibility of switching methods
5. Information about other methods, which is critical to rights-based family planning

Figure 7.3 shows the levels of counselling received by current contraceptive users for each of these five elements, disaggregated by area of residence. Overall, the proportion of women reporting counselling on these aspects—central to contraceptive adoption—ranges between 50% and 56%. Counselling across all five areas is consistently higher in urban areas and lower in rural areas, underscoring a great need to strengthen comprehensive counselling even among women who have adopted a method. The need is likely to be even greater for potential users who intend to adopt a method in the future.

Figure 7.3: Percentage of current users of modern methods reporting receipt of each element of appropriate family planning counselling, by area of residence



Overall, only 28% of current users of modern methods in Punjab reported receiving "appropriate counselling" (Table 7.3), meaning they were informed about all five components.

Younger users aged 15–24 were less likely to receive appropriate counselling (22.7%) compared with older women aged 35–49 years (30.7%).

Current users of modern methods in rural areas were less likely to receive appropriate counselling (26.4%) than those in urban areas (30.0%).

Interestingly, women with no education were slightly more likely to be counselled (29.3%) than those with secondary or higher education (27.5%).

Table 7.3: Percentage of current users of modern contraceptives who reported receiving the full range of "appropriate" family planning counselling, by age, education, wealth and urban–rural residence*

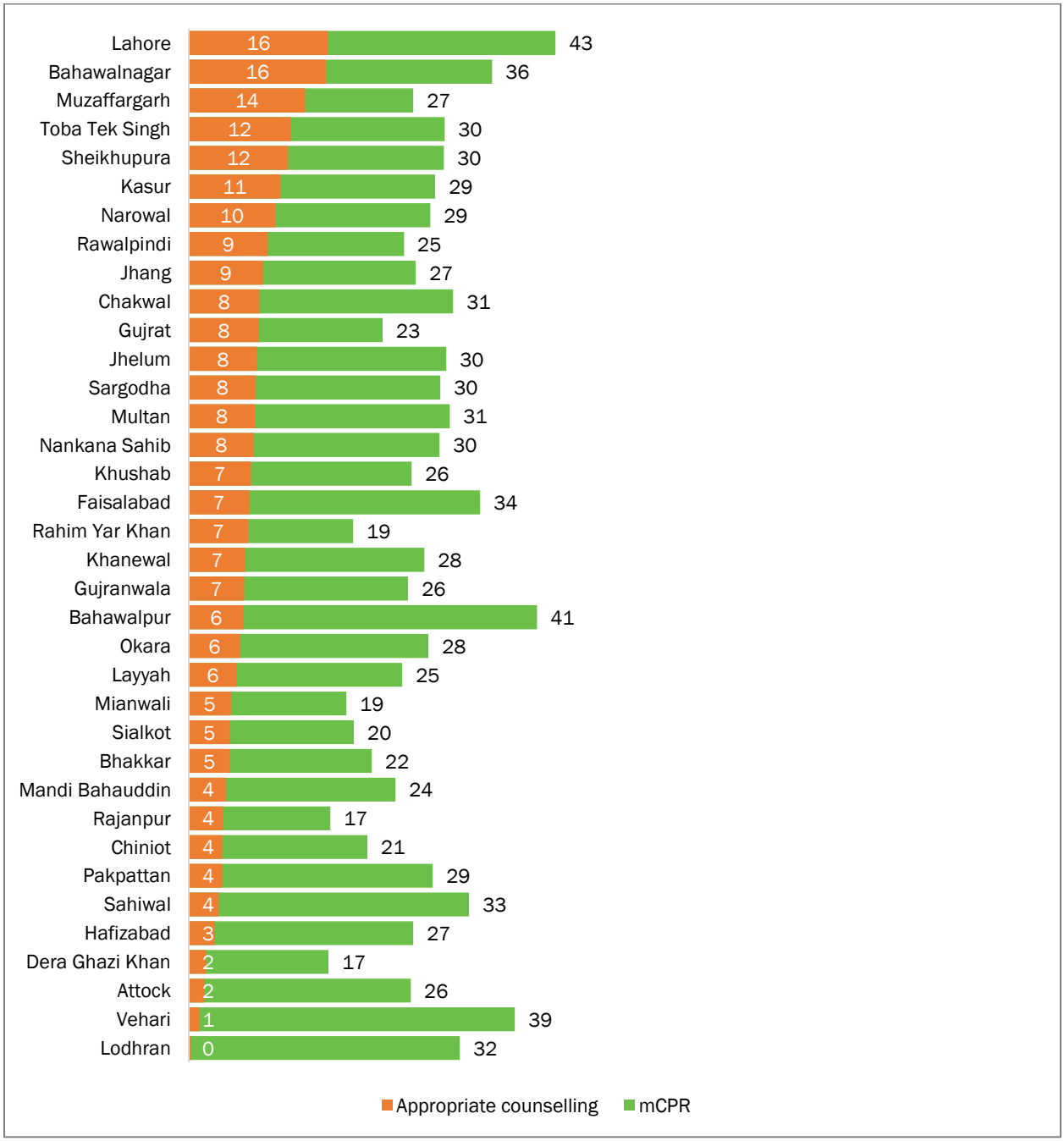
		Percentage counselled	
		%	N
Overall		**28.0**	**5,030**
Current age in completed years	15–24	22.7	302
	25–34	24.8	1,821
	35–49	30.7	2,907
Education	No education	29.3	1,956
	Primary & Middle	27.2	1,670
	Secondary and above	27.5	1,401
Wealth quintiles	Lowest	28.6	966
	Second	29.9	1,058
	Middle	27.7	1,051
	Fourth	28.7	1,027
	Highest	25.6	924
Residence	Rural	26.4	3,134
	Urban	30.0	1,896

*"Appropriate counselling" indicates having been counselled on: (1) possible side effects, (2) what to do if side effects occur, (3) where to go in case of side effects, (4) the possibility of switching methods, and (5) other methods that could be used.

Note: The percentage of currently married women of reproductive age (15–49 years) who have been appropriately counselled on family planning is a Program Development Objective indicator (PDO-3) of the Punjab Family Planning Program.

Figure 7.4 shows the proportion of current contraceptive users who received appropriate counselling across districts in Punjab. The variation is considerable: Lahore had the highest reported level of appropriate counselling, while Lodhran had the lowest, at just 0.9%.

Figure 7.4: Percentage of current users of modern contraceptive methods and proportion reporting appropriate family planning counselling, by district



Note: "Appropriate counselling" indicates having been counselled on: (1) possible side effects, (2) what to do if side effects occur, (3) where to go in case of side effects, (4) the possibility of switching methods, and (5) other methods that could be used.

Integrating Family Planning Counselling within Pregnancy and Delivery Care

Information and counselling on FP should be a priority at every point of contact within the health system. Counselling must be an integral part of the continuum of pregnancy care. The World Health Organization (WHO) recommends FP counselling be included during ANC, delivery, and postnatal care. ANC and delivery care visits provide important opportunities for FP counselling with lasting impact on future contraceptive use.

Table 7.4 shows the level of counselling received by women during ANC visits and whether they received advice on the importance of birth spacing and on adopting a family planning method. A significant opportunity is being missed, as counselling on the use of family planning methods during pregnancy-related care is particularly low. The overall proportion of women receiving advice on family planning methods is: 37.9% during ANC visit, 11.4% after delivery, and 19.1% at the time of a PNC visit. Counselling levels are slightly higher in urban areas.

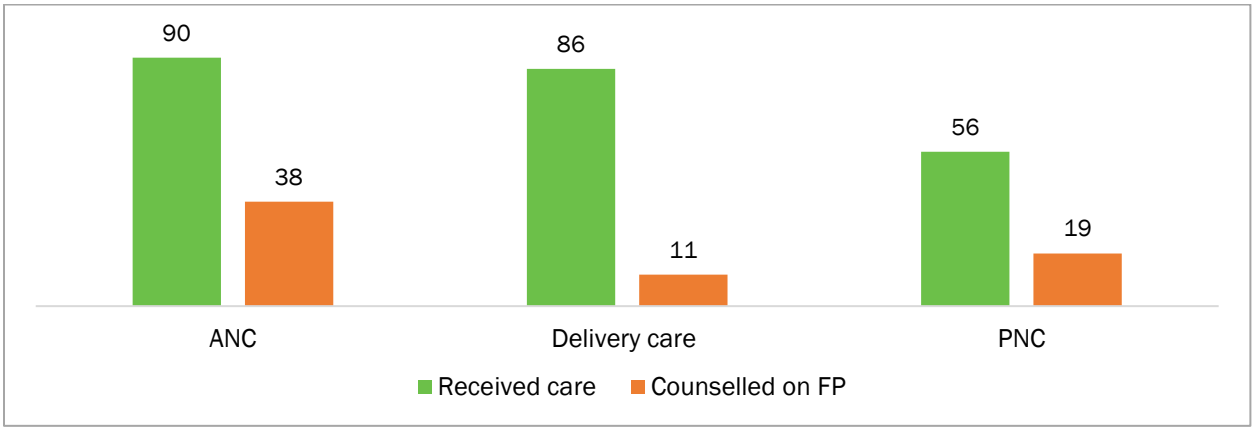
Table 7.4: Percentage of women who received family planning counselling during institutional care for antenatal care, delivery, and postnatal care among those who had a pregnancy in the last three years, by residence

		Residence		
		Rural	Urban	Overall
Antenatal care	Received ANC services	88.4	92.6	90.0
	Counselled on FP	34.9	42.7	37.9
N		4,873	2,219	7,092
Delivery care	Received institutional delivery services	83.4	90.3	86.0
	Counselled on FP	9.6	14.3	11.4
N		4,908	2,224	7,132
Postnatal care	Received PNC within 0-40 days of delivery	55.4	56.8	55.9
	Counselled on FP	16.5	23.3	19.1
N		4,908	2,224	7,132

Figure 7.5 shows the percentage of women who received institutional care during antenatal, delivery, and postnatal visits, and those who received FP counselling. There is a missed opportunity for integrating FP counselling into routine maternal health services.

Despite the high rate of institutional care among women in the past three years, FP counselling levels remain low. The lowest counselling rate was reported during delivery care (11%), which is a critical time to introduce FP. Improving FP counselling coverage across the range of maternal care could substantially improve the uptake of FP services, particularly at the time of PNC.

Figure 7.5: Percentage of women who received family planning counselling during antenatal care, delivery, and postnatal care among those who had a pregnancy in the last three years



Another huge opportunity of integrated services is to advise women visiting a facility for post-pregnancy care about the benefits of delaying the next pregnancy. The percentage of women who reported receiving post-pregnancy family planning counselling after a delivery or after pregnancy loss in the three years prior to the survey was low overall at 19.1% (Table 7.5).

This rate was: lower for younger women aged 15-24 years (13.7%) than for older women 35-49 years (21.5%); higher for women with secondary or higher education (23.0%) compared to those with no education (16.9%); higher for women in the richest quintile (23.6%) compared to those in the poorest quintile (15.7%); and higher for urban women (23.3%) compared to rural women (16.5%).

Table 7.5: Percentage of currently married women aged 15-49 who received post-pregnancy family planning counselling, among those who had a pregnancy during the three years before the survey, by age, education, wealth, and residence

		%	N
Overall		19.1	7,132
Current age in completed years	15–24	13.7	1,649
	25–34	20.3	3,938
	35–49	21.5	1,545
Education	No education	16.9	2,699
	Primary & Middle	16.9	2,243
	Secondary and above	23.0	2,181
Wealth quintiles	Lowest	15.7	1,708
	Second	17.6	1,420
	Middle	18.0	1,420
	Fourth	20.6	1,363
	Highest	23.6	1,217
Residence	Rural	16.5	4,908
	Urban	23.3	2,224

Note: Post-pregnancy counselling includes following a live birth or pregnancy loss/induced abortion. This indicator is a Disbursement-Linked Indicator (DLI-2.1) of the Punjab Family Planning Program.

Postpartum Contraceptive Uptake

Among all women who delivered in the last three years, 5.3% began using a modern method within one year after delivery (Table 7.6). Postpartum uptake was higher among older women aged 25–34 years (6.4%) and 35–49 years (5.8%) compared with younger women aged 15–24 years. Women in urban areas were more likely to adopt postpartum modern contraception within one year (7.2%) than rural women (4.2%).

Differences by education and wealth present a mixed picture:

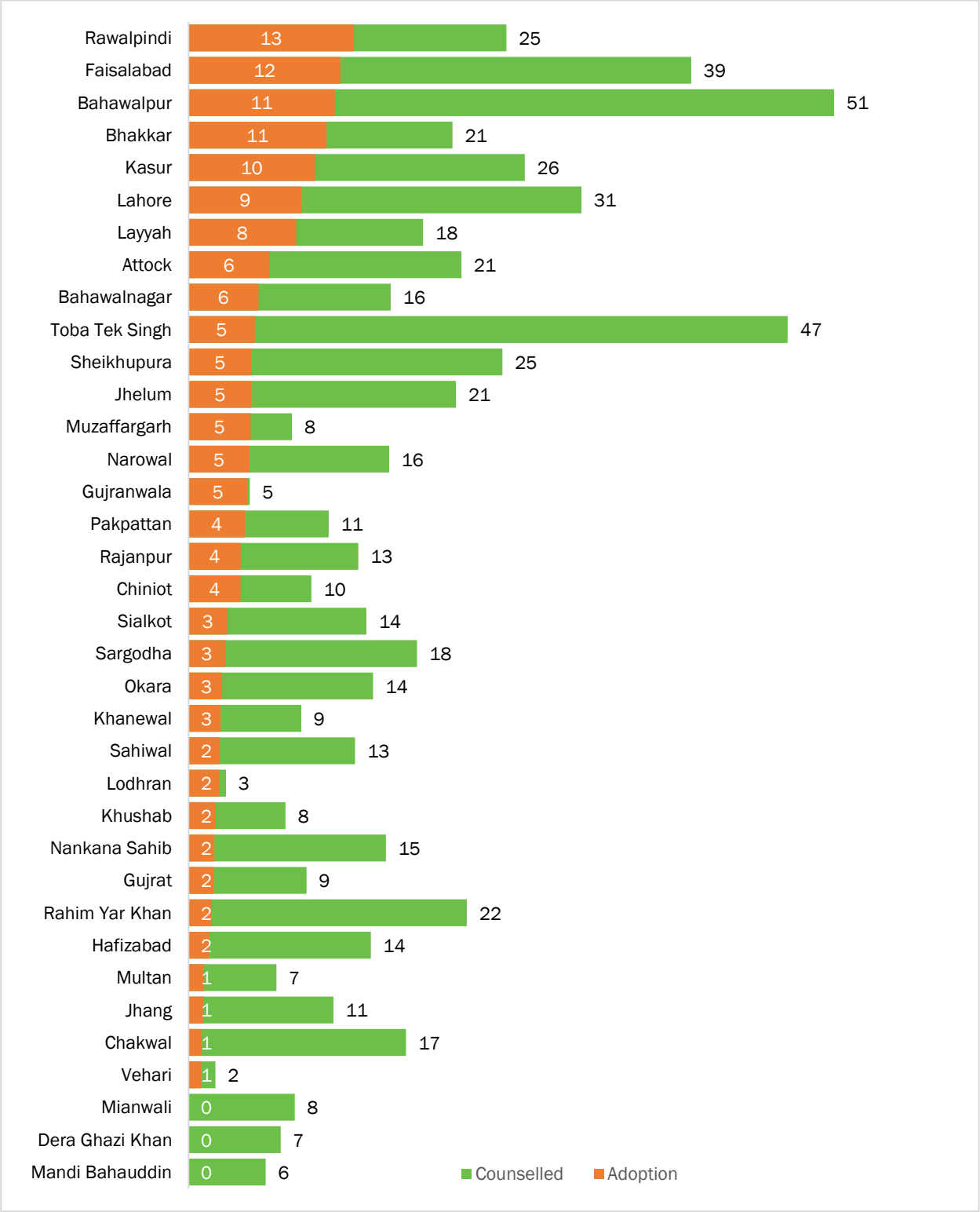
- 6.0% of women with no education started using a modern method within one year postpartum, compared with 4% of women with primary or middle education and 5.8% with secondary or higher education.
- Uptake was unexpectedly higher among lower-income women: 5.4% of women in the lowest two income quintiles began using a modern method postpartum, compared with 4.9% in the richest quintile.
- Women in the fourth wealth quintile reported the highest postpartum contraceptive use at 6.3%.

Table 7.6: Percentage of currently married women who had a delivery in the last three years who started using a modern method within one year after delivery, by rural–urban residence

		Post-partum uptake of modern methods within 1 year	
		%	N
Overall		5.3	7,132
Current age in completed years	15–24	2.2	1,649
	25–34	6.4	3,938
	35–49	5.8	1,545
Education	No education	6.0	2,699
	Primary & Middle	4.0	2,243
	Secondary and above	5.8	2,181
Wealth quintiles	Lowest	5.4	1,708
	Second	5.4	1,420
	Middle	4.6	1,420
	Fourth	6.3	1,363
	Highest	4.9	1,217
Residence	Rural	4.2	4,908
	Urban	7.2	2,224

Note: Post-partum FP is defined as when women adopt FP within 48 hours, 40 days, or within the first year of delivery. This indicator is a Disbursement-Linked Indicator (DLI-2.2) of the Punjab Family Planning Program.

Figure 7.6: Percentage of currently married women who received postpartum counselling and adopted a method within one year after delivery, among those who had a delivery in the last three years, by district



Integrating Family Planning into Social Protection Programs

Integrating FP counselling with social protection programs is often a successful strategy to address unmet need for FP and latent demand for FP information and services. The Benazir Income Support Program (BISP), launched in 2008, provides unconditional cash transfers to the poorest households in Pakistan to reduce poverty and enhance economic stability. BISP beneficiaries are identified through the National Social Registry, and all recipients are women.

Table 7.7 shows that overall use of modern contraceptive methods was substantially higher among BISP beneficiaries than among non- beneficiaries (40.4% vs 28.0%, respectively). This pattern holds across age groups, education levels, and urban–rural residence.

Vouchers and other subsidized reproductive health services provided to BISP beneficiaries offer exceptionally effective opportunities to expand access to reproductive health and FP information and services, potentially contributing to greater coverage and uptake of FP in Punjab.

Table 7.7: Percentage of currently married women using a modern method, by BISP beneficiary status

		BISP beneficiary		Others (non-BISP)	
		%	N	%	N
Overall		40.4	2,583	28.0	16,015
Current age in completed years	15–24	15.2	62	11.8	2,752
	25–34	39.4	696	27.6	6,401
	35–49	41.5	1,825	34.2	6,862
Education	No education	39.8	1,774	25.6	5,730
	Primary & Middle	41.6	659	29.3	5,172
	Secondary and above	40.5	153	29.0	5,102
Residence	Rural	40.8	1,939	24.9	10,328
	Urban	39.2	647	32.0	5,695

Conclusion

This chapter provides information on extended family planning services in Punjab, especially in relation to the World Bank-supported Punjab Family Planning Program. It will help program managers of both the NHSP and the PFPP to meet their program development objectives by pointing out some critical gaps in FP information and services in Punjab. The findings highlight several key areas for improvement and opportunities to enhance FP uptake across different population groups and to make it a priority within reproductive health services.

Gaps in information and counseling

Knowledge of sources: Nearly eighty percent of women who had never used modern methods did not know of any source for obtaining one. Knowledge about the source to obtain a FP method should be universal, and a separate mass information campaign is needed exclusively to address this gap. Furthermore, targeted information campaigns for never-users, especially in districts highlighted in this chapter, could also help reduce the "knowledge-attitude-practice" gap among those who know about FP but do not know where to get the methods.

Quality of counselling. The survey asked all current users about FP counselling, which is perhaps the most critical component for adopting FP. The overall provision of “appropriate counselling” is far below expectation. Notably, counselling on potential side effects, alternatives, and the possibility of switching methods remains low. Only 28% of women who were current users of modern contraceptives reported adequate counselling. Strengthening counselling services, especially in rural areas and among younger women, is essential to ensure informed choices and improve the continuation of use of modern methods.

Missed opportunities for integration

Postpartum FP. Family planning counselling particularly at the time of ANC, turns out to be a missed opportunity for women who may want to space the next pregnancy. Similarly, even during delivery care, less than one in five women received FP counselling post-delivery. The postpartum FP adoption rate is extremely low at 5.3%. Strengthening the referral system during the postpartum period is critical to addressing unmet family planning needs and increasing adoption. Notably, this gap is most pronounced among younger women and those living in rural areas.

Social protection programs. The integration of FP programs within social protection programs, such as the Benazir Income Support Program (BISP), appears to be an effective strategy in expanding family planning coverage. BISP beneficiaries reported significantly higher use of modern contraceptive methods (40% mCPR) compared to non-beneficiaries (28% mCPR), highlighting the potential for social protection programs to increase FP uptake.

8

Infant and Child Health

Key Findings

Breastfeeding practices

- Breastfeeding was nearly universal, with 92.2% of women in Punjab breastfeeding their babies—91.9% in rural areas and 92.6% in urban areas.
- 17.3% of babies were put to the breast within two hours of delivery.
- 59.3% of newborns received colostrum.
- Nearly half of babies were breastfed for a duration of four to six months.
- Three-in-four babies (77%) were given liquids other than breast milk during the first three days.

Diarrhea prevalence and treatment

- 12.7% of male children and 11.4% of female children under age five had diarrhea in the last two weeks.
- Treatment for diarrhea was sought for 10.2% of male children and 9.4% of female children under age five.
- Private facilities were the source of treatment for 80% of diarrhea cases.
- Anti-diarrhea medications or antibiotic pills were the primary treatment for diarrhea.

Acute respiratory infection prevalence and treatment

- The prevalence of acute respiratory infection (ARI) among children in the last two weeks was 6.5%.
- 5.4% of children in Punjab received treatment for ARI in the last two weeks.
- Private facilities were the primary source of treatment in 70.4% of cases.
- The prevalence of ARI in non-lagging districts was 5.4%, compared to 7.8% in lagging districts.

Nutrition

- Only 3.3% of children under age 5 received iron supplements on the day before the survey.
- The use of supplements was associated strongly with mothers' education, household wealth, and place of residence.

The United Nations Sustainable Development Goals (SDGs), particularly Goal 3, aim to ensure healthy lives and promote the wellbeing of people of all ages. Several targets and indicators within this goal specifically address infant and child health, including reducing under-five mortality, decreasing neonatal mortality, and increasing access to skilled health personnel during childbirth. This chapter focuses on four major determinants of infant and child health: breastfeeding, diarrhea, ARIs, and nutrition.

Breastfeeding

The World Health Organization (WHO) and United Nations Children's Fund (UNICEF) recommend the initiation of breastfeeding within the first hour after birth and exclusive breastfeeding for the first six months of life. Breastfeeding is common in Punjab, with 92.2% of mothers reporting that they breastfed their child (91.9% in rural areas and 92.6% in urban areas). Among those who breastfed, only 4.7% initiated immediately, with 5.0% in rural areas and 4.3% in urban areas. The majority (71.8%) initiated breastfeeding five or more hours after delivery. Breastfeeding for four to six months was practiced by 46.6% of women in Punjab, with 46.1% in rural areas and 47.5% in urban areas (Table 8.2).

Colostrum, the first milk produced by mothers—a highly nutritious substance essential for newborns—was given by nearly 60% of women who gave birth in the three years preceding the survey. The proportion of newborns who were given the colostrum was 59.3% overall, 58.7% in rural areas, and 60.2% in urban areas (Table 8.1).

Table 8.1: Percentage of women by breastfeeding patterns for their last-born child

	Total	Rural	Urban
No. of women (unweighted)	**6,755**	**4,649**	**2,106**
Percentage who breastfed	92.2	91.9	92.6
Was baby given colostrum?			
Yes	59.3	58.7	60.2
No	40.7	41.3	39.8
Total	100.0	100.0	100.0
Time the child was put to breast after birth (based on women who breastfed their babies)			
Immediately	4.7	5.0	4.3
1–2 hours	12.6	12.7	12.6
3–4 hours	10.5	9.4	12.3
5+ hours	71.8	72.7	70.4
Don't know	0.4	0.3	0.4
Total	100.0	100.0	100.0
No. of women who breastfed (unweighted)	**6,224**	**4,291**	**1,933**

Nearly universal breastfeeding in Punjab is a positive finding, further supported by the significant proportion of mothers who provided colostrum. Additionally, one in two women practiced breastfeeding for the globally recommended duration. However, the introduction of liquids other than breast milk during the first four to six months after birth remains a harmful practice that undermines the benefits of exclusive breastfeeding.

Table 8.2: Percentage of women with a live birth in the three years preceding the survey, by duration of breastfeeding and age when weaning was initiated

	Total	Rural	Urban
Duration of breastfeeding (months)			
< 1	24.2	23.6	25.2
1–3	17.2	18.7	14.9
4–6	46.6	46.1	47.5
7+	11.9	11.6	12.5
Total	100.0	100.0	100.0
No. of women (unweighted)	**6,226**	**4,291**	**1,935**
Age at start of weaning (months)			
1–3	4.7	5.1	4.0
4–6	61.7	59.9	64.3
7+	21.8	23.2	19.6
Not applicable	11.9	11.8	12.1
Total	100.0	100.0	100.0
No. of women (unweighted)	**4,834**	**3,250**	**1,584**

Breastfeeding for only one to three months—shorter than the six months recommended by WHO and UNICEF—was practiced by 17.2% overall, 18.7% in rural areas, and 14.9% in urban areas. Approximately 11.9% of mothers breastfed their last child for seven or more months. Weaning was initiated at four to six months for 61.7% overall, 64.3% in urban areas, and 59.9% in rural areas, aligning with global recommendations.

More than three-quarters of women provided fluids in addition to breast milk during the first three days after delivery (Table 8.3). The most given liquid was milk other than breast milk, reported by 49.3% overall, 54.6% in rural areas, and 40.9% in urban areas. Honey was the second most common, given by 37.4% of women overall, with slightly higher use in urban areas (40.8%) compared to rural areas (35.2%). Ghutti, a mild laxative for infants that is not medically recommended but is believed to relieve constipation and protect against diarrhea, was given by 30.1% of women overall—31.8% in rural areas and 27.5% in urban areas. The use of infant formula was also notable, reported by 29% of women overall, with higher usage in urban areas (37.7%) compared to rural areas (23.6%). The use of other liquids, such as gripe water, tea or herbal preparations, and plain water, was reported at much lower rates.

Table 8.3: Percentage of women with a live birth in the three years preceding the survey, by liquid types given to baby besides breast milk during the first three days

	Total	Rural	Urban
No. of women (unweighted)	**6,755**	**4,649**	**2,106**
Percentage given liquid(s) other than breast milk	77.0	76.2	78.2
Types of drinks given during the first three days after delivery (multiple response variable)			
Tea/traditional herbal preparations	5.4	5.5	5.3
Ghutti	30.1	31.8	27.5
Milk—other than breast milk	49.3	54.6	40.9
Plain water	4.8	5.5	3.6
Honey	37.4	35.2	40.8
Gripe water	5.5	4.3	7.5
Infant formula	29.0	23.6	37.7
Sugar/glucose water	1.3	1.2	1.4
Others [a]	6.0	5.8	6.2
Total	100.0	100.0	100.0
No. of women (unweighted)	**5,078**	**3,457**	**1,621**

[F] fruit juice, prescribed medicine, sugar-salt-water solution, and others. Percentages by type of drink were based on women who reported giving drink(s) besides breast milk during the first three days after delivery.

Diarrheal Incidence, Symptoms, and Treatment-Seeking Among Children Under Five

Diarrhea is a leading cause of death and malnutrition in children under five. In the two weeks preceding the survey, 12.1% of children had diarrhea, with prevalence slightly higher among males (12.7%) than females (11.4%) (Table 8.4).

Among **children with diarrhea**, only 81% sought treatment, with a negligible difference by sex (80.3% for males and 82.5% for females).

The most reported symptom was loose stools (89.8%), followed by lethargy (25.9%), vomiting (22.4%), dehydration (15.1%), and refusal to eat (9.3%). A small proportion (2.4%) reported other symptoms, such as blood or mucus in stools.

In terms of treatment sources for diarrhea, 19.0% sought care from public facilities, while 80.5% relied on private providers.

Table 8.4: Percentage of children aged 0–59 months who had diarrhea in the two weeks preceding the survey, symptoms, and source of treatment, by sex of child

	Total	Male child	Female child
Children who had diarrhea in the last two weeks			
Incidence (%)	12.1	12.7	11.4
Treatment sought (%)	9.8	10.2	9.4
N (unweighted)	9,700	4,964	4,736
Symptoms of diarrhea of those who had diarrhea (multiple response variable)			
Three loose stools	89.8	88.3	91.6
Vomiting	22.4	25.2	19.1
Child refusing food	9.3	8.9	9.8
Lethargy	25.9	24.9	27.1
Dehydration	15.1	16.3	13.8
Others[a]	2.4	3.2	1.6
N (unweighted)	1,139	598	541
Source of treatment among those who sought treatment (multiple response variable)			
Public	19.0	19.4	18.7
Private	80.5	79.8	81.2
Others	1.6	1.8	1.4
Total	100.0	100.0	100.0
No. of women (unweighted)	**909**	**475**	**434**

[a]Blood/mucus in stools, and others.

The differences in the incidence of diarrhea and the treatments sought are shown in Table 8.5 and illustrated in Figures 8.1 and 8.2. Both incidence and treatment rates were highest during the first year of life (29.6% and 23.9%, respectively) and declined with age (Figure 8.1).

Although treatment rates were consistently lower than incidence rates, the two followed a similar pattern. The incidence of diarrhea was slightly higher in urban areas (13.0%) compared to rural areas (11.5%) (Figure 8.2). Differences in incidence and treatment rates between lagging and non-lagging districts were minimal. No significant variation was observed in diarrhea prevalence between children of young mothers aged 15–24 years (12.6%) and those of mothers aged 25–34 years (12.2%).

Diarrhea was associated with children belonging to poorer households and those whose mothers had less than secondary education.

Children of mothers in the lowest wealth quintile exhibited the highest incidence (15%) and treatment rates (10.7%) of diarrhea compared to children of mothers in the highest wealth quintile (8.4% and 7.2%, respectively).

Table 8.5: Percentage of youngest children aged 0–59 months who had diarrhea in the two weeks preceding the survey and percentage receiving treatment, by background characteristics

		Incidence	Treatment	N (unweighted)
Overall		12.1	9.8	9,700
Sex	Male child	12.7	10.2	4,964
	Female child	11.4	9.4	4,736
Child's age in months	0–6	12.6	10.0	2,271
	7–12	17.0	13.9	1,574
	13–18	15.4	12.3	1,291
	19–24	14.7	12.2	903
	25–36	11.0	9.0	1,538
	37–48	5.9	4.3	1,105
	49–59	5.8	5.0	1,018
Residence	Rural	11.5	9.2	12,875
	Urban	13.0	10.8	6,676
District type	Lagging	12.7	10.0	5,112
	Non-lagging	12.0	9.7	14,439
Mother's age (years)	15–24	12.6	9.9	2,905
	25–34	12.2	9.5	7,332
	35–49	11.6	10.3	9,302
Mother's education	No education	13.0	9.9	7,920
	Primary and middle	14.1	11.5	6,137
	Secondary or higher	9.2	8.0	5,473
Wealth quintiles	Lowest	15.0	10.7	4,253
	Second	13.8	10.9	3,971
	Middle	13.0	11.1	3,984
	Fourth	10.3	9.0	3,812
	Highest	8.4	7.2	3,522

The gap between the incidence of illness and the proportion of children who received treatment reflects the health-seeking behavior of households. Table 8.5 shows that 10.7% of children in the lowest wealth quintile received treatment, compared to only 7.2% of children in the wealthiest households. The second largest disparity in treatment rates was associated with education level of mothers: 9.9% of children whose mothers had no education, received treatment, while children's mothers who had secondary or higher education received treatment (8.0%).

Table 8.6: Percentage of children aged 0–59 months who had diarrhea in the two weeks preceding the survey, by type of treatment sought and source of care

	Overall	Public	Private
Treatment given to child (multiple response variable)			
Antibiotic pills/syrup	27.8	28.3	28.5
Antimotility (anti-diarrhea) pills/syrup	35.7	43.3	34.6
Other (pill or syrup)	8.3	9.0	7.7
Unknown pills/syrup	21.1	14.5	22.6
Antibiotic (injection)	6.9	1.4	8.1
Unknown injection	4.5	3.0	5.0
Intravenous injection	1.0	0.0	1.2
Drip	4.7	9.6	3.6
Others*	12.1	12.6	12.3
Total	100.0	100.0	100.0
N (unweighted)	**909**	**180**	**724**

*Non-antibiotic injections, home remedies, and others.

The incidence of diarrhea in the two weeks preceding the survey did not vary substantially across districts but was highest in Lodhran (24%), Bahawalpur (20%), and Bahawalnagar and Pakpattan (19% each), and lowest (5%) among children in Sialkot, Mianwali, Mandi Bahauddin, and Gujrat (Figure 8.3).

The findings indicate that the private sector remains the primary source of treatment. Reliance on community-based health workers for diarrhea treatment was notably low. A positive finding was the consistency in treatment-seeking behavior for both male and female children. Analysis by maternal age suggests that younger mothers, possibly due to limited experience, reported a higher incidence of diarrhea among their children (Table 8.4).

Figure 8.1: Percentage of children aged 0–59 months who had diarrhea in the two weeks preceding the survey and the percentage who received treatment, by child's age in months

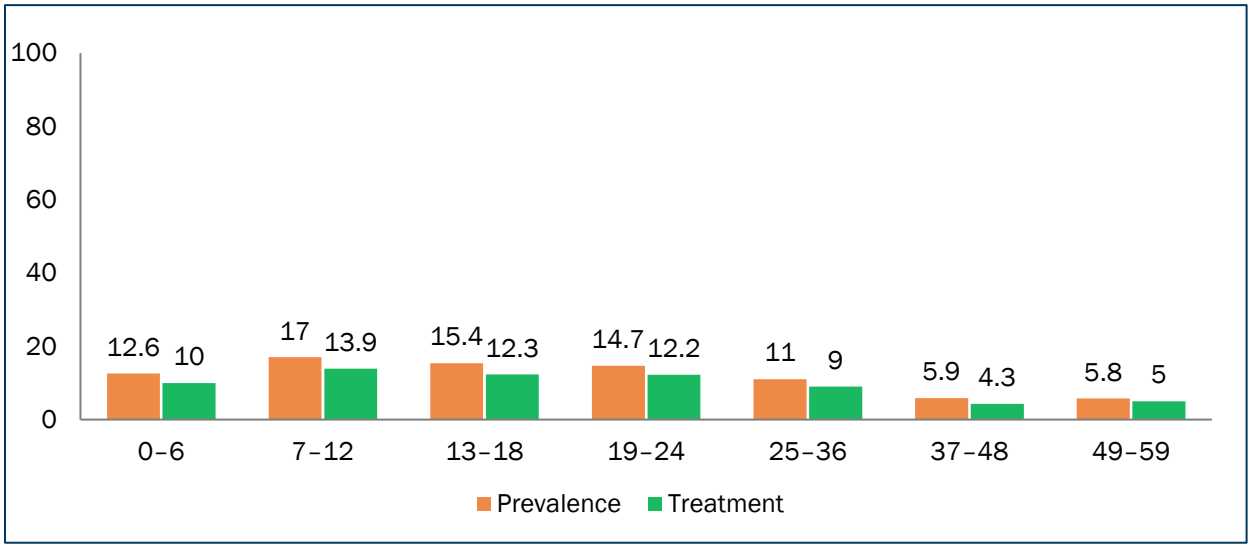


Figure 8.2: Percentage of children aged 0–59 months who had diarrhea in the two weeks preceding the survey and the percentage who received treatment, by background characteristics

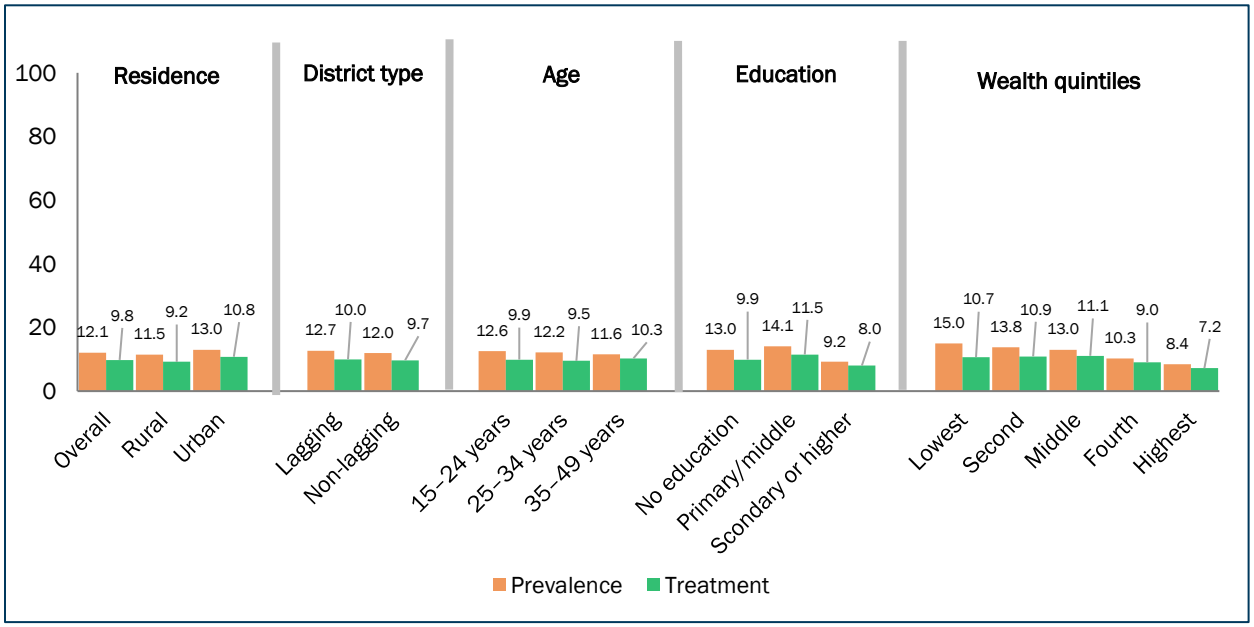
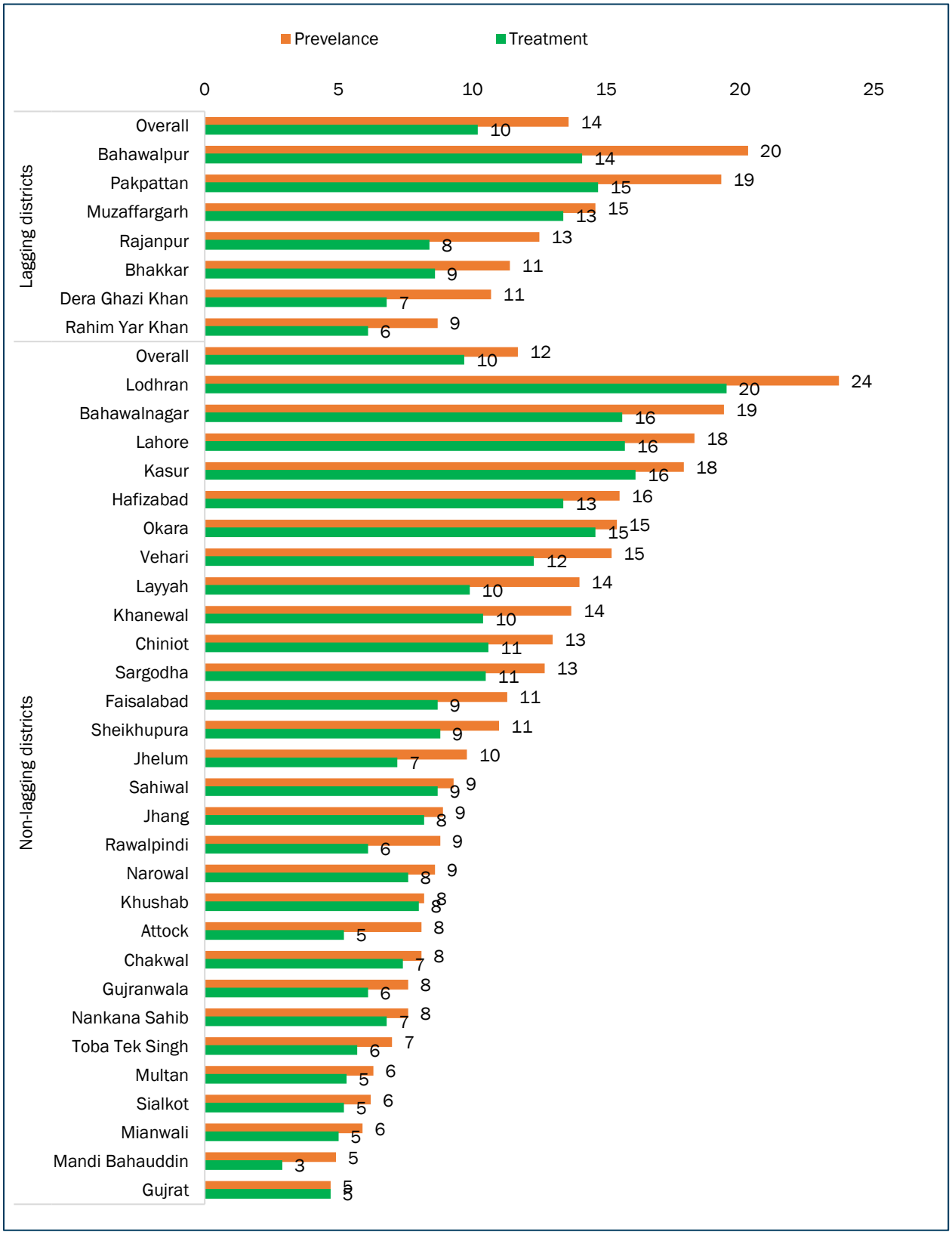


Figure 8.3: Percentage of youngest children aged 0–59 months who had diarrhea in the two weeks preceding the survey and the percentage who received treatment, by district



Home-based practices for managing diarrhea in children

Different feeding practices were reported during episodes of diarrhea among children under age five who had diarrhea in the two weeks preceding the survey. Among breastfed children, 47.4% of mothers maintained their usual liquid intake, while 30.2% slightly reduced it. Only 13.9% of female children received significantly less liquid than usual, compared to 13.4% of male children. Among children who were not breastfed, a higher proportion of males (22.2%) received less liquid than usual compared to females (18.4%) (Table 8.7).

Table 8.7: Percentage of youngest children aged 0–59 months who had diarrhea in the two weeks preceding the survey, by home management practices and sex of child

	Overall	Male	Female
Among breastfed children: Amount of liquid given compared to usual amount during diarrhea			
Much less	13.6	13.4	13.9
Somewhat less	30.2	29.4	31.2
About the same	47.4	45.6	50.1
More	4.9	5.8	3.6
Nothing to drink	3.9	5.8	1.2
Total	100.0	100.0	100.0
N (unweighted)	511	268	243
Among non-breastfeeding children: Amount of liquid given compared to usual amount during diarrhea			
Much less	20.4	22.2	18.4
Somewhat less	32.3	35.6	28.8
About the same	41.3	36.8	46.1
More	4.7	3.9	5.5
Nothing to drink	1.4	1.5	1.2
Total	100.0	100.0	100.0
N (unweighted)	312	159	153
Among all children: Amount of liquid given compared to usual amount during diarrhea			
Much less	13.7	12.7	14.9
Somewhat less	28.8	31.3	25.9
About the same	38.3	36.8	40.0
More	3.4	3.4	3.6
Stopped food	6.7	7.5	5.7
Never initiated food	9.1	8.2	10.0
Total	100.0	100.0	100.0
N (unweighted)	1,139	598	541
Treatment administered during diarrhea			
Fluid form of oral rehydration solution (ORS) (packet)	24.9	25.5	24.2
ORS liquid	10.3	9.9	10.7
Homemade fluid	5.7	5.4	6.1
Zinc syrup/tablets	55.5	54.1	57.2
Others	8.1	8.7	7.5
Don't know	15.3	13.8	17.1
Total	100.0	100.0	100.0
N (unweighted)	**1,139**	**598**	**541**

Overall, 38.3% of children maintained their usual liquid intake during diarrhea, while 13.7% consumed much less and 28.8% consumed somewhat less. By sex, 36.8% of male children and 40% of female children maintained their usual liquid intake. A concerning finding was that food was completely stopped in 7.5% of male cases and 5.7% of female cases.

Regarding oral rehydration, 24.9% of children received ORS in packet form, and 10.3% received ORS liquid. Homemade fluids were provided to 5.7% of children. Overall, 55.5% received zinc tablets or syrup, with slightly higher usage among females (57.2%) compared to males (54.1%). Additionally, 15.3% of children received no clear treatment, with caregivers responding, "don't know."

These findings highlight opportunities to improve diarrheal care through better home-based diarrhea management, particularly ensuring adequate fluids and food intake.

Acute Respiratory Infections (ARIs)

Respondents were asked about their youngest child under five years regarding ARI symptoms, specifically: "Has the child had fast, short, or rapid breaths, or difficulty breathing at any time in the last two weeks?" For children exhibiting ARI symptoms, a follow-up question was posed: "Did you seek any advice or treatment for ARI?"

Overall, 6.5% of children under five had ARI symptoms in the two weeks prior to the survey (6.6% for males and 6.4% for females). The treatment-seeking rate was 5.4% (Table 8.8), with most care accessed mainly through private facilities (70.4%).

The incidence of ARI peaked among children aged 7–12 months (Figures 8.4 and Figure 8.5, Table 8.9), with lower rates observed in older children. Unlike diarrhea, ARI rates were lower among children aged 37–48 and 49–59-months. ARI incidence was slightly higher in lagging districts (6.8%) compared to non-lagging districts (6.4%).

Similarly, younger mothers (15–24 years) reported a higher incidence of ARI among their children (8.6%) than older mothers aged 35–49 years (5.3%). By wealth quintile, children of women in the second and fourth quintiles exhibited higher ARI rates than those in the lowest and highest quintiles.

High temperature was the leading symptom of ARI, affecting 68.6% of male children and 63.2% of female children who had the illness. Sore throat, runny nose, and rapid breathing were also frequently reported symptoms.

Figure 8.5 and Table 8.9 show that the incidence and treatment rates of ARI among male and female children are broadly similar, as are the patterns observed in rural and urban areas.

Table 8.8: Percentage of youngest children aged 0–59 months who had ARI in the two weeks preceding the survey, symptoms, and source of treatment, by sex of child

	Total	Male child	Female child
Children who had ARI			
Incidence	6.5	6.6	6.4
Treatment sought	5.4	5.4	5.4
Symptoms of ARI (multiple response variable)			
High temperature	66.0	68.6	63.2
Sore throat	39.7	42.3	36.9
Runny nose	38.3	38.9	37.6
Throat irritation	16.5	17.3	15.7
Indrawing ribs	6.5	8.9	4.0
Rapid breathing	26.0	27.5	24.5
Child's refusal to eat	9.4	9.9	8.9
Cough	47.9	50.9	44.6
Others	0.7	1.2	0.2
Don't know	6.3	4.1	8.6
Total	100.0	100.0	100.0
N (unweighted)	**615**	**337**	**278**
Source of treatment (among those treated)			
Public	16.7	19.1	14.2
Private	70.4	68.1	72.9
Workers	9.9	8.2	11.6
Others	3.0	4.6	1.3
Total	100.0	100.0	100.0
N (unweighted)	**515**	**283**	**232**
No. of children (unweighted)	**9,661**	**4,948**	**4,713**

Table 8.9: Percentage of youngest children aged 0–59 months who had ARI in the two weeks preceding the survey and percentage receiving treatment, by background characteristics

		Incidence	Taking medicine	N (unweighted)
	Overall	6.5	5.4	9,661
Sex of child	Male	6.6	5.4	4,948
	Female	6.4	5.4	4,713
Child age (months)	0–6	6.9	5.5	2,273
	7–12	8.8	7.9	1,567
	13–18	7.1	6.1	1,283
	19–24	6.0	5.4	903
	25–36	6.0	5.1	1,546
	37–48	4.9	3.3	1,134
	49–59	4.3	3.3	955
Residence	Rural	6.9	5.8	6,577
	Urban	5.8	4.9	3,084
District type	Lagging	6.8	5.9	2,931
	Non-lagging	6.4	5.3	6,730
Mother's age (years)	15–24	8.6	7.1	1,712
	25–34	6.4	5.3	5,197
	35–49	5.3	4.5	2,752
Mother's education	No education	5.8	4.8	3,732
	Primary and middle	7.4	5.9	3,059
	Secondary or higher	6.4	5.5	2,870
Wealth quintile	Lowest	6.3	5.0	2,315
	Second	7.1	5.6	1,965
	Middle	6.2	5.6	1,929
	Fourth	7.3	6.0	1,812
	Highest	5.6	4.7	1,640

There was considerable difference in ARI incidence by district. Lodhran had the highest ARI incidence at 24%, while Mandi Bahauddin and Gujrat had the lowest at 5% (Figure 8.6). In Gujrat and Mianwali, both the incidence of ARI and treatment rates were identical at five percent. Lagging districts had slightly higher incidence of ARI.

Figure 8.4: Percentage of children aged 0–59 months who had ARI in the two weeks before the survey and the percentage receiving treatment, by age of child in months

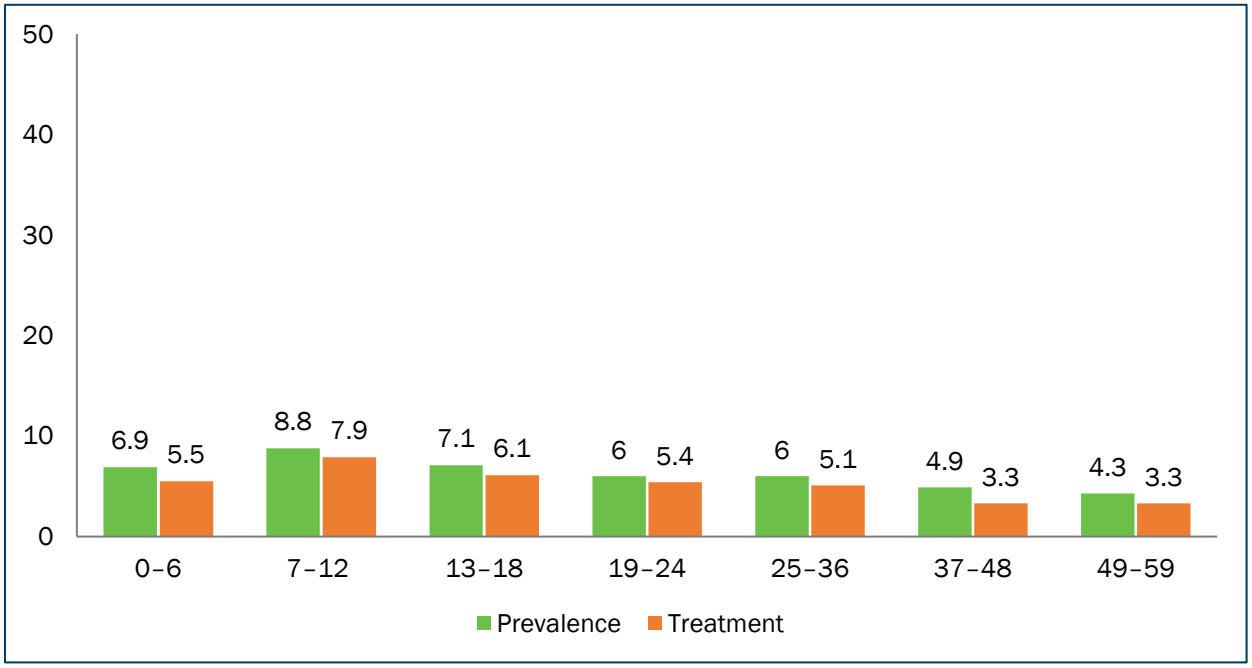


Figure 8.5: Percentage of children aged 0–59 months who had ARI in the two weeks preceding the survey and the percentage receiving treatment, by background characteristics

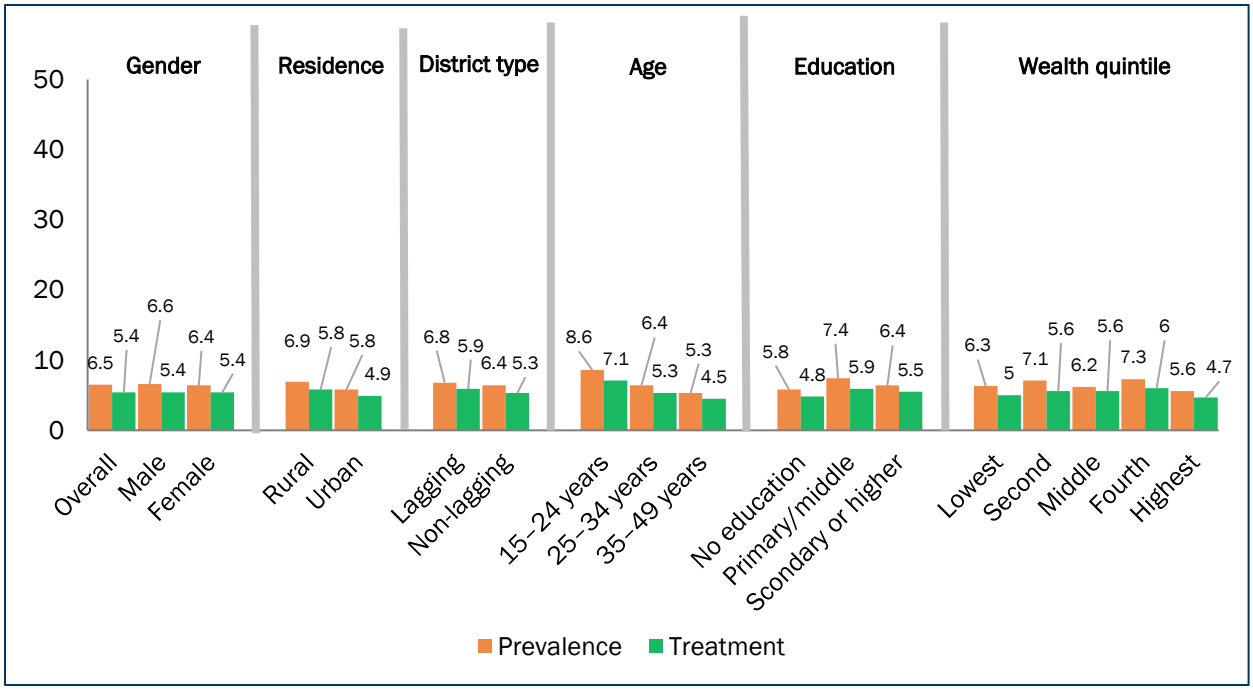
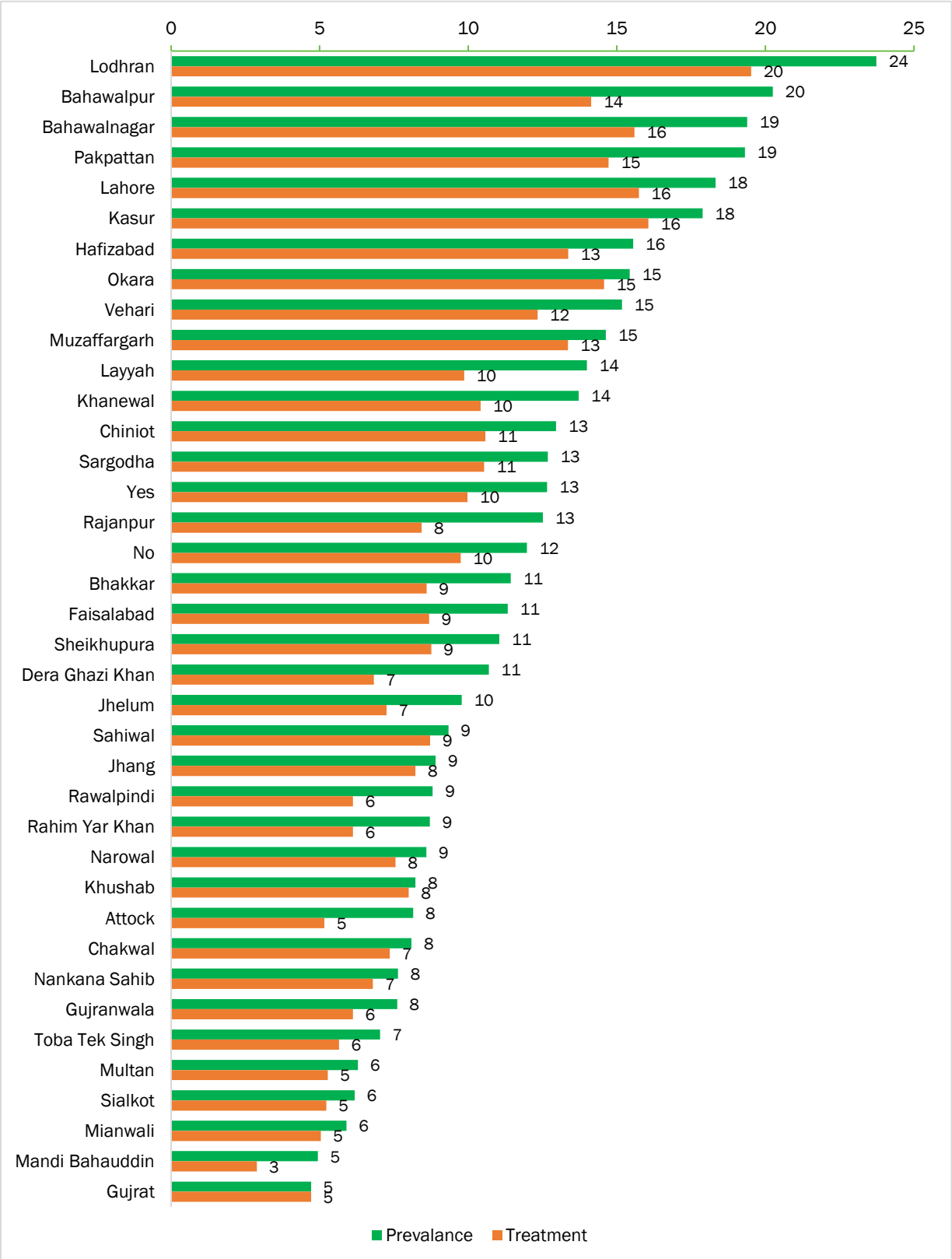


Figure 8.6: Percentage of children aged 0–59 months who had ARI in the two weeks preceding the survey and percentage receiving treatment, by district



For 91.0% of children with ARI (92.0% of males and 90.2% of females), advice or treatment was sought within one to three days of symptom onset (Table 8.10). Delays of more than five days were rare, reported in only 5.2% of cases, while 3.8% of caregivers were unsure about when care was first sought.

Table 8.10: Treatment-seeking behavior and type of medication administered for ARI among the youngest children aged 0–59 months, by sex

	Total	Male child	Female child
No. of days after illness when first advice/treatment for ARI sought			
1–3	91.1	92.0	90.2
4–5	2.1	1.7	2.4
6+	3.1	2.2	4.0
Don't know	3.8	4.1	3.4
Total	100.0	100.0	100.0
Child given any medicine for illness at any time during ARI			
Yes	90.0	89.9	90.2
No	10.0	10.1	9.8
Total	100.0	100.0	100.0
Treatment given to child (among those taking medicine for ARI) (multiple response variable)			
Amoxicillin	26.6	29.1	23.9
Cotrimoxazole	4.1	5.4	2.8
Other antibiotic pills/syrups	43.4	37.3	49.8
Other antibiotic injections/IVs	14.3	14.1	14.6
Paracetamol/Panadol/acetaminophen	48.8	47.8	49.8
Aspirin	2.1	2.6	1.7
Ibuprofen	24.6	26.8	22.2
Other	7.1	7.2	7.1
Don't know	11.3	12.2	10.3
Total	100.0	100.0	100.0
N (unweighted)	**474**	**264**	**210**

Among specific treatments, the most administered medications were paracetamol/ Panadol/ acetaminophen (48.8%), other antibiotic pills/ syrups (43.4%), amoxicillin (26.6%), and ibuprofen (24.6%). Female children were slightly more likely to receive paracetamol/Panadol/acetaminophen (49.8% vs. 47.8%) and other antibiotic pills/syrups (49.8% vs. 37.3%).

Child Nutrition

Micronutrient supplementation among children under five

Child malnutrition remains a serious public health concern in Pakistan, with high rates of stunting, wasting, and underweight among children under five.

Micronutrient deficiencies—particularly of vitamin A, zinc, and iron—significantly compromise children's growth, immunity, cognitive development, and overall survival.

Ever-married respondents were asked about the supplements given to children under five. Overall, consumption of key micronutrients was strikingly low: only 3.3% of children received iron supplements, 0.8% received vitamin A, and 0.8% received multi-micronutrient powder in the 24 hours prior to the survey (Table 8.11). Iron supplement provision was higher than that of vitamin A or multi-micronutrient powder.

Given the universally low intake of iron supplements, the observed differences across subgroups are minimal. Children in urban areas had higher consumption of iron supplements (3.8%) compared to those in rural areas (2.8%). Urban children also had slightly higher intake of vitamin A (1.0%) and multi-micronutrient powder (0.9%) than rural children (0.7% for both). Children in lagging and non-lagging districts had modest intake of vitamin A (0.7% vs. 0.8%), while lagging districts had lower multi-micronutrient powder consumption than non-lagging districts (0.9% vs. 0.3%). However, iron intake was slightly higher in lagging than non-lagging districts (3.5% vs. 3.1%).

Differences were also observed by mother's age, with the highest iron supplement intake among children of mothers aged 25–34 (3.6%) and the highest multi-micronutrient powder intake among children of mothers aged 35–49 (1.1%). These patterns indicate minor disparities in supplement access and utilization across different population subgroups, but the main point is the very low overall coverage.

Children of mothers with secondary or higher education had slightly higher consumption of iron supplements (3.9%) compared to those with no education (2.4%). Vitamin A intake and multi-micronutrient powder consumption were modest across all education groups and negligible differences by gender of child.

Micronutrient intake varied significantly by age. Children aged 9–11 months had the highest intake of iron supplements (4.2%). Consumption of multi-micronutrient powder peaked at 9–11 months (1.8%) and declined sharply among older children, especially those aged 48–59 months, where all three supplement types were minimally consumed.

Table 8.11: Percentage of children aged 0–59 months who consumed iron supplements, vitamin A supplements, and multi-micronutrient powder in the 24 hours preceding the survey, by background characteristics

		Consumed iron supplements	Consumed vitamin A supplements	Consumed multi-micronutrient powder	No. of children (unweighted)
Overall		3.3	0.8	0.8	6,579
Sex of the child	Male child	3.4	0.8	1.0	3,341
	Female child	3.1	0.9	0.6	3,238
Age of child (0–36 months)	6–8	2.7	0.7	0.8	599
	9–11	4.2	0.7	1.8	798
	12–17	3.2	1.3	0.6	1,292
	18–23	3.4	0.5	0.7	793
	24–35	3.5	0.7	0.2	1,021
	36–47	4.0	0.5	0.3	243
	48–59	0.9	1.3	0.3	268
Residence	Rural	2.8	0.7	0.7	4,649
	Urban	3.8	1.0	0.9	2,106
District type	Lagging	3.5	0.7	0.3	1,858
	Non-lagging	3.1	0.8	0.9	4,897
Mother's age (years)	15–24	3.2	0.5	0.9	1,542
	25–34	3.6	0.9	0.6	3,748
	35–49	2.1	0.7	1.1	1,465
Mother's education	No education	2.4	0.6	0.5	2,594
	Primary and Middle	3.2	0.7	1.0	2,108
	Secondary and above	3.9	1.1	0.9	2,053
Wealth quintiles	Lowest	2.8	1.2	0.6	1,769
	Second	2.8	0.4	1.0	1,335
	Middle	2.4	0.2	0.7	962
	Fourth	4.1	1.2	0.5	1,434
	Highest	3.5	0.8	1.1	1,255

Conclusions and Recommendations

The PHPS 2024–25 provides valuable insights into child morbidity patterns, treatment-seeking behavior, feeding practices, and nutrition. While several encouraging trends were evident, the findings also highlighted persistent challenges that require policy attention and programmatic action.

Key conclusions

- **Care-seeking behavior:** Private sector health facilities remained the primary source for treating common childhood illnesses. However, the increasing reliance on private providers, particularly for ARI, raised concerns about the quality and accessibility of public health care. Notably, there was minimal gender discrimination and equal access to care for both boys and girls.
- **Home-based management:** Suboptimal home care practices were observed in management of diarrhea. A significant proportion of caregivers reduced or stopped fluid intake during episodes of diarrhea, contrary to WHO guidelines. This underscores the need for improved caregiver education on effective home management of childhood illnesses.
- **Micronutrient supplementation:** The uptake of iron and Vitamin A and multi-micronutrient powders supplements remained very low across all population groups despite their known benefits in preventing malnutrition and boosting immunity. The poorest households, those in lagging districts, and children of less-educated mothers were the least likely to receive supplements.
- **Infant feeding practices:** Breastfeeding was nearly universal (a positive finding), supported by high rates of colostrum feeding and exclusive breastfeeding for the first four to six months among half of all mothers. However, the premature introduction of other liquids during the exclusive breastfeeding period (four to six months) continues to be a harmful and widespread practice that compromises child nutrition and immunity.

Recommendations

1. **Improve public sector services:** Invest in enhancing the quality, responsiveness, and accessibility of public health services, especially for childhood illnesses, to reduce unnecessary out-of-pocket expenses associated with private care.
2. **Strengthen community health education:** Expand community awareness programs through LHVs, focusing on proper home care during episodes of diarrhea and ARI, the importance of continued feeding and hydration, and timely care-seeking and recognition of danger signs.
3. **Enhance micronutrient supplementation coverage:** Introduce or strengthen the routine community- and facility-based distribution of essential supplements, such as iron, vitamin A, and zinc, particularly in underperforming districts and among disadvantaged groups. Prioritize integration into maternal and child health contacts, e.g., Expanded Programme on Immunization visits and growth monitoring sessions.
4. **Promote exclusive breastfeeding:** Intensify advocacy for exclusive breastfeeding for the first six months, addressing misconceptions and harmful cultural practices that encourage the early introduction of other liquids. Health care providers should counsel mothers during antenatal and postnatal visits and media campaigns should reinforce the need for exclusive breastfeeding.
5. **Address socioeconomic and educational disparities:** Target interventions toward younger mothers, those without formal education, and lower-income households, which consistently show poorer outcomes in child health and nutrition. Consider tailored communication strategies and establish mother support groups.

9

Child Immunization

Key Findings

Coverage of the Pentavalent-1 (Penta-1) vaccine dose

- Vaccination coverage of Penta-1 was high in Punjab, with 94.6% of children aged 12–23 months receiving the vaccine. Coverage was similar in urban (94.5%) and rural areas (94.6%).
- Lagging districts had slightly lower coverage (91.1%) compared to non-lagging districts (95.4%).
- Households in the lowest wealth quintile had significantly lower coverage (88%) than those in the highest wealth quintile (96.3%).
- Children of mothers with secondary or higher education had much higher coverage (97%) than children of women with no formal education (92.4%).

Full immunization coverage

- Full immunization coverage (FIC) for all eight doses of the Expanded Programme on Immunization (EPI) vaccines was 88.6% (88.4% for boys and 88.8% for girls) among children aged 12–23 months.
- FIC for children aged 12–23 months was 88.5% in urban areas and 88.7% in rural areas.
- Children in non-lagging districts were more likely to receive all eight vaccine doses compared to those in lagging districts (90.0% vs. 83.3%).
- Maternal education and household wealth were positively correlated with full immunization, while children of uneducated mothers and those from the lowest wealth quintile lagged.

Source of immunization

- Government health facilities were the primary source of immunization, accounting for 83.2%. of coverage.

Type of vaccine by week since birth

- Most children received the Bacillus Calmette-Guérin (BCG), polio, and hepatitis B vaccinations at birth.
- Significant gaps were observed between lagging and non-lagging districts for some vaccine doses, particularly the polio vaccine at birth (90.9% in lagging districts vs. 95.3% in non-lagging districts).

Children with no vaccine coverage (zero dose)

- A relatively small proportion of children (3.5%) were unvaccinated, including 3.0% of boys and 4.1% of girls.
- Among children of mothers with no education, 5.3% were unvaccinated compared to just 0.4% of children whose mothers had secondary or higher education.
- The three main reasons for non-vaccination were perceived distance to immunization sites, fear of vaccine reactions, and family issues, including maternal illness.

According to WHO, children are considered "fully immunized" if they receive: one dose of the BCG vaccine, three doses of the diphtheria, pertussis, and tetanus (DPT) vaccine, three doses of the polio vaccine (excluding the dose given at birth), and one dose of the measles vaccine. All children should receive these vaccines during their first year of life.

Detailed questions on immunization were included in the household questionnaire, covering all children aged 0–48 months. Immunization data were based on 7,681 children aged 12–35 months, including 3,825 in the 12–23-month age group and 3,856 in the 24–35-month age group (Table 9.1).

Among children aged 12–23 months, 95.2% had a vaccination card, compared to 93.8% of those aged 24–35 months. Interviewers checked for vaccination cards during the survey and recorded immunization status for each dose after physically observing the card. Vaccination cards were available and checked for 50.3% of boys and 49.7% of girls.

Results for children aged 12–23 months and 24–35 months were based on data gathered from both vaccination card records and respondents' recall when the cards were unavailable.

Table 9.1: Percentage of children aged 12–35 months, by age group, sex, and vaccination card status

	12–23 months	24–35 months
Vaccination card found and observed		
Sex		
Boy	50.3	50.3
Girl	49.7	49.7
Total	100.0	100.0
Vaccination card status		
Ever had a vaccination card	95.2	93.8
Never had a vaccination card	4.7	6.2
Total	100.0	100.0
Reasons for card unavailability		
Don't think it's important	0.4	1.1
Never visited a facility	1.0	1.3
Card was unavailable	0.0	0.1
The vaccinator/facility did not provide a card	0.2	0.4
Not aware of such cards	0.4	0.3
Others (specify)	2.7	3.0
Card available at time of interview?		
Yes (observed by interviewer)	70.5	60.6
No (card not available)	29.5	39.4
Total	100.0	100.0
No. of children (unweighted)	**3,825**	**3,856**

Coverage of Penta-1 and Full Immunization

The Pentavalent-1 (Penta-1) vaccine protects infants against five serious diseases: diphtheria, tetanus, pertussis (whooping cough), hepatitis B, and *Haemophilus influenzae* type b (Hib). Among children aged 12–23 months, Penta-1 coverage was high at 94.6%, based on both caregiver recall and vaccination card information verified by interviewers (Table 9.2). Overall coverage was nearly identical for boys (94.5%) and girls (94.6%) (Figure 9.1) and similar across rural (94.6%) and urban areas (94.5%). However, lagging districts had slightly but significantly lower coverage (91.1%), compared to non-lagging districts (95.4%).

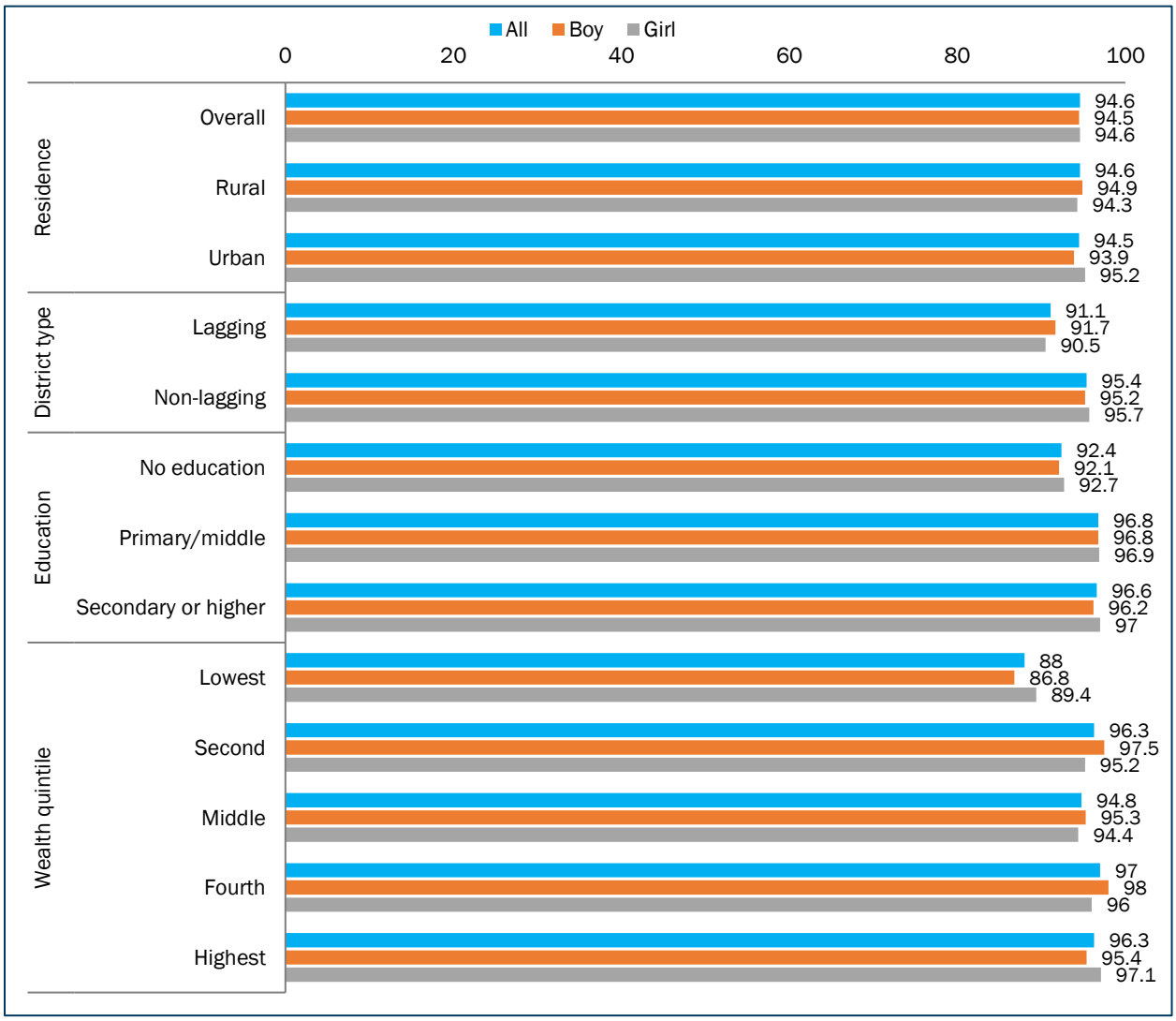
A strong relationship existed between mothers' education and children's immunization coverage. Penta-1 coverage for children whose mothers had a secondary education or higher was 96.6%, compared to 92.4% for those with no education. No significant difference in Penta-1 coverage was found based on the child's sex. The widest gap in coverage was observed by household wealth. Penta-1 coverage increased with wealth quintile, ranging from 88.0% for children in the lowest quintile to 96.3% for children from the highest wealth quintile.

Table 9.2: Percentage of children aged 12–23 months who received the Penta-1 (at any time before the survey) and percentage who were fully immunized, by background characteristics

	Penta-1			All eight EPI doses[a]			N (unweighted)
	Boy	Girl	Overall	Boy	Girl	Overall	
Recall only	22.7	25.4	24.0	16.6	19.6	18.1	1,110
Card only	71.8	69.2	70.5	71.8	69.2	70.5	2,695
Card plus recall	94.5	94.6	94.6	88.4	88.8	88.6	3,825
Residence							
Rural	94.9	94.3	94.6	89.4	88.0	88.7	2,619
Urban	93.9	95.2	94.5	86.9	90.1	88.5	1,206
District type							
Lagging	91.7	90.5	91.1	84.3	82.2	83.3	1,080
Non-lagging	95.2	95.7	95.4	89.5	90.5	90.0	2,745
Mother's education							
None	92.1	92.7	92.4	87.0	87.7	87.4	1,187
Primary/middle	96.8	96.9	96.8	92.8	91.8	92.2	1,047
Secondary+	96.2	97.0	96.6	90.7	92.2	91.4	940
Wealth index							
Lowest	86.8	89.4	88.0	80.4	82.9	81.5	878
Second	97.5	95.2	96.3	88.7	90.4	89.6	755
Middle	95.3	94.4	94.8	89.2	89.0	89.1	733
Fourth	98.0	96.0	97.0	92.2	90.3	91.2	748
Highest	95.4	97.1	96.3	91.8	90.6	91.2	711

[a]Eight doses = one dose of BCG, three doses of DPT, three doses of the polio vaccine (excluding vaccine given at birth), and one dose of the measles vaccine. This is considered as FIC.

Figure 9.1: Percentage of children aged 12–23 months who received Penta-1 at any time before the survey, by background characteristics

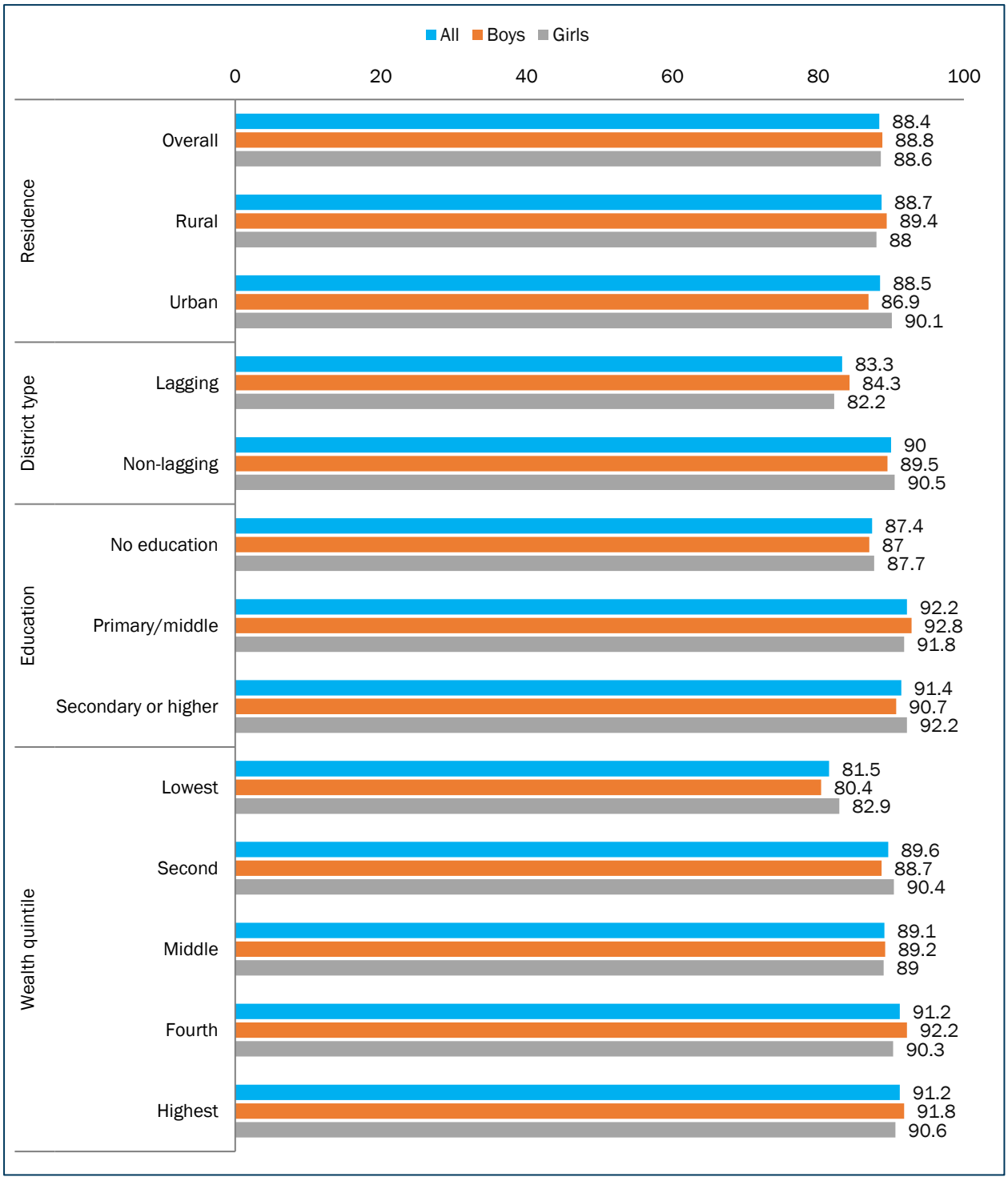


Overall, coverage of all eight doses of EPI vaccines among children aged 12–23 months was 88.6%—88.4% for boys and 88.8% for girls (Figure 9.2). Gender differences in coverage were negligible, except in urban areas where slight variation was observed.

Inequities in vaccine coverage were evident by location, district of residence, maternal education, and wealth quintile. Coverage was nearly identical in rural (88.7%) and urban areas (88.5%). However, children in lagging districts had lower coverage (83.3%) compared to those in non-lagging districts (90.0%).

Mother's education played a significant role in full immunization coverage (FIC): 87.4% of children of mothers with no formal education were fully immunized, compared to 91.4% of children of mothers with secondary or higher education. A similar disparity was seen by household wealth, with only 81.5% of the poorest children (lowest wealth quintile) receiving all eight doses, compared to 91.2% of the wealthiest (highest wealth quintile).

Figure 9.2: Percentage of children aged 12–23 months who received all eight* EPI vaccine doses, by background characteristics



*Eight doses of EPI vaccines include one dose of BCG, three doses of DPT, three doses of the polio vaccine (excluding vaccine given at birth), and one dose of the measles vaccine.

Pakpattan was the only lagging district to exceed 97.1% coverage of Penta-1 among children aged 12–23 months (Figure 9.3). Pental-1 coverage exceeded 95% in most non-lagging districts, with Gujrat, Hafizabad, Mandi Bahauddin, Jhang, and Nankana Sahib achieving full coverage at 100%.

Other districts, such as Sheikhupura (99.3%), Mianwali (99.2%), Narowal (99.1%), Jhelum (99%), and Toba Tek Singh (98.7%), also reported high coverage rates. Unexpectedly, lower coverage was observed in some non-lagging districts, including Lodhran (91.5%), Layyah (91.4%), Bahawalnagar (90.8%), and Lahore (89.2%).

FIC for children aged 12–23 months (Figure 9.4) mirrored the Penta-1 pattern. Among lagging districts, Muzaffargarh reported the highest FIC at 93.4%, followed by Pakpattan (89.9%), Rajanpur (88.6%), Rahim Yar Khan (85.2%), Bhakkar (81.5%), Bahawalpur (78.8%), and Dera Ghazi Khan, which had the lowest with 60.8%.

In non-lagging districts, overall FIC was 90%. Several districts demonstrated strong performance, including Jhang (98.8%), Mandi Bahauddin (98%), Jhelum (97.9%), and Nankana Sahib (96.4%). Other districts with coverage rates above 90% included Faisalabad (96.2%), Narowal (96.1%), Toba Tek Singh (95.6%), Khanewal (95.4%), Gujrat (95.3%), and Khushab (94.7%). The low FIC levels were recorded in Bahawalnagar (78.1%), Vehari (79.1%), Rawalpindi (82.2%), Sialkot (83.6%), and Lahore (84.3%).

Figure 9.3: Percentage of children aged 12–23 months who received Penta-1, by district

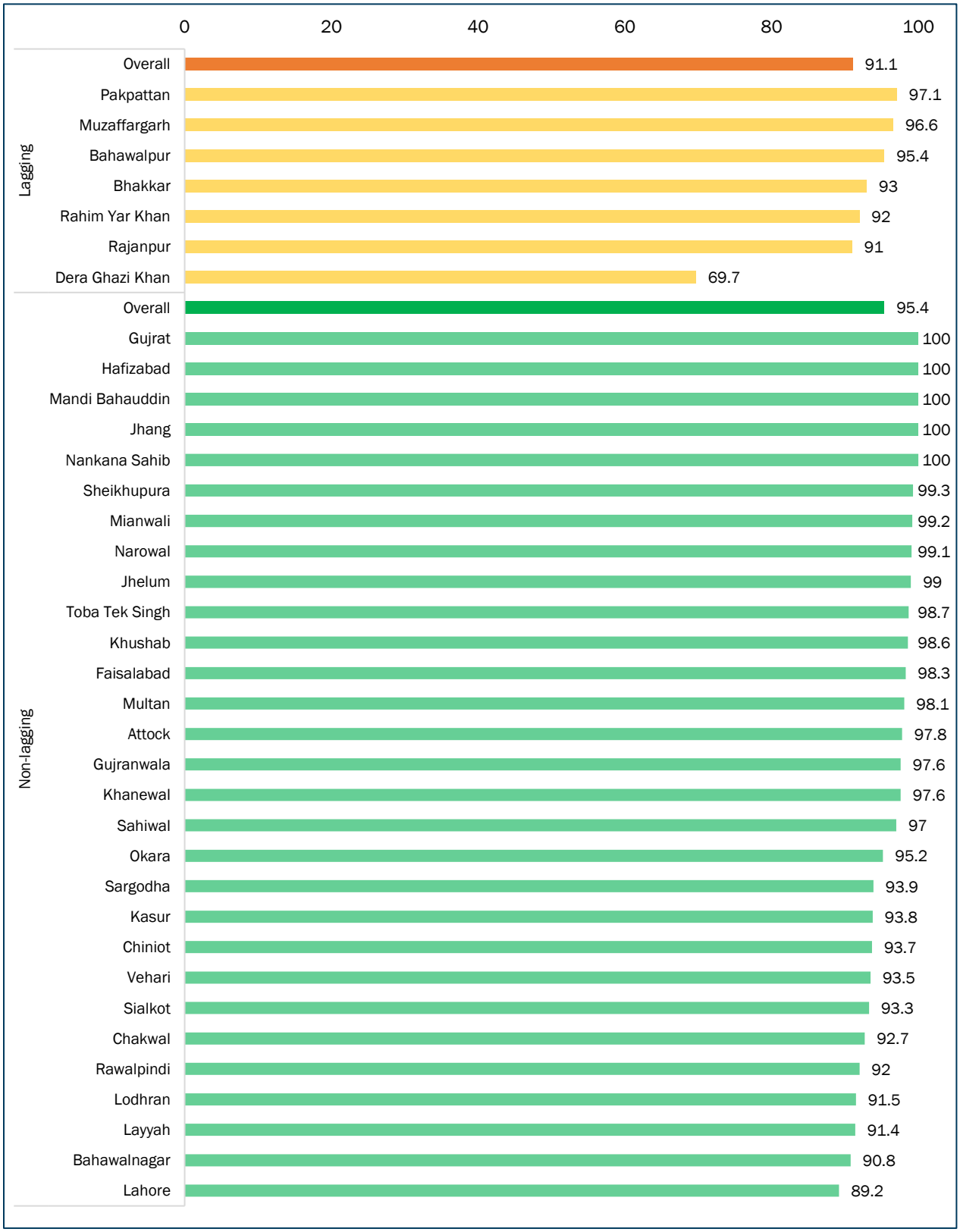
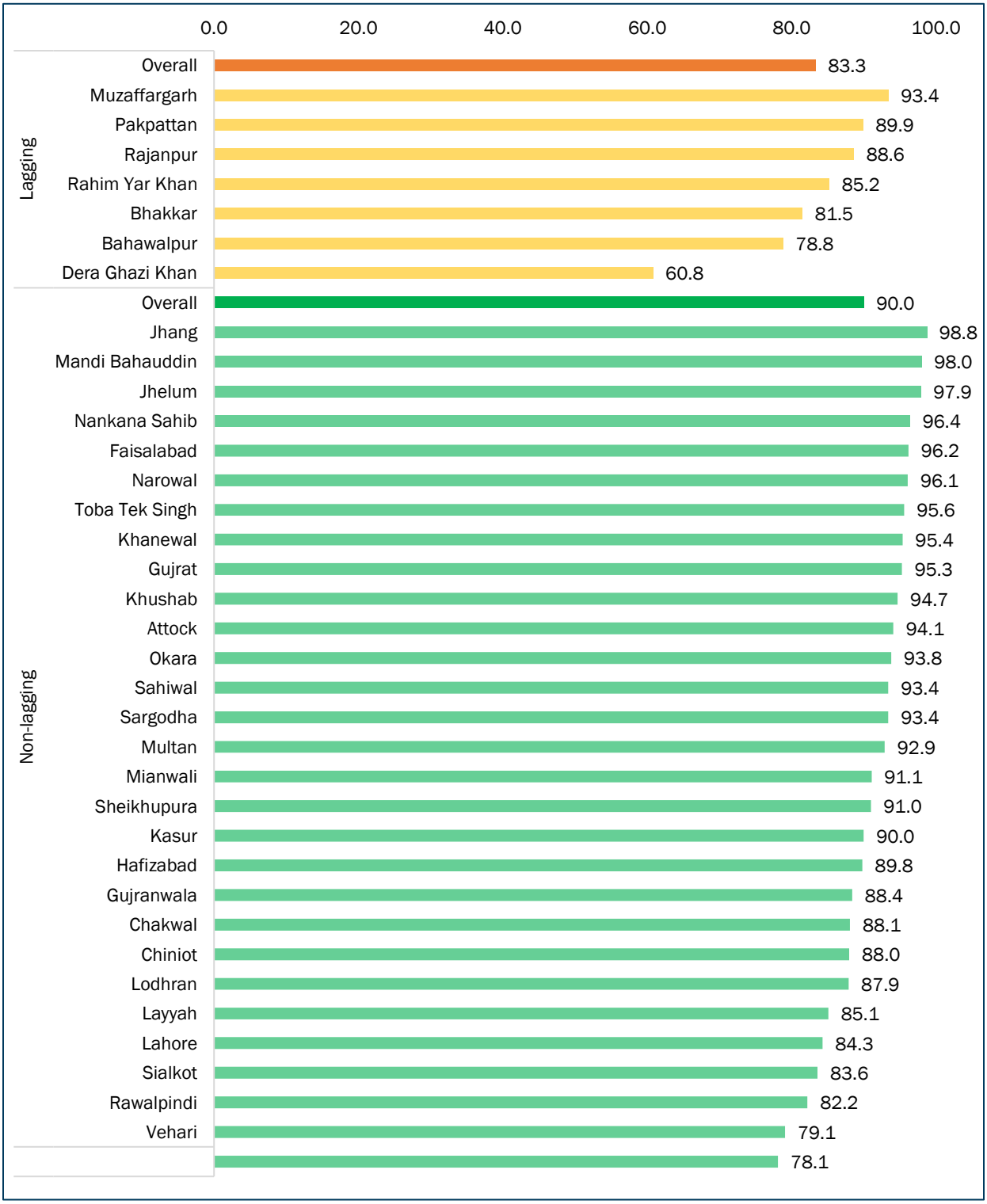


Figure 9.4: Percentage of children aged 12–23 months who received all eight* doses of EPI vaccines, by district



*Eight doses of EPI vaccines include one dose of BCG, three doses of DPT, three doses of the polio vaccine (excluding vaccine given at birth), and one dose of the measles vaccine.

Source of Vaccines for Children Aged 12–23 Months

Government health facilities were the primary source of vaccines for children aged 12–23 months, accounting for 47.2% (Table 9.3 and Figure 9.5). These facilities were reported as the primary source more frequently in urban areas (55.3%) than in rural areas (42.1%), and in non-lagging (52.3%) compared to lagging districts (47.2%).

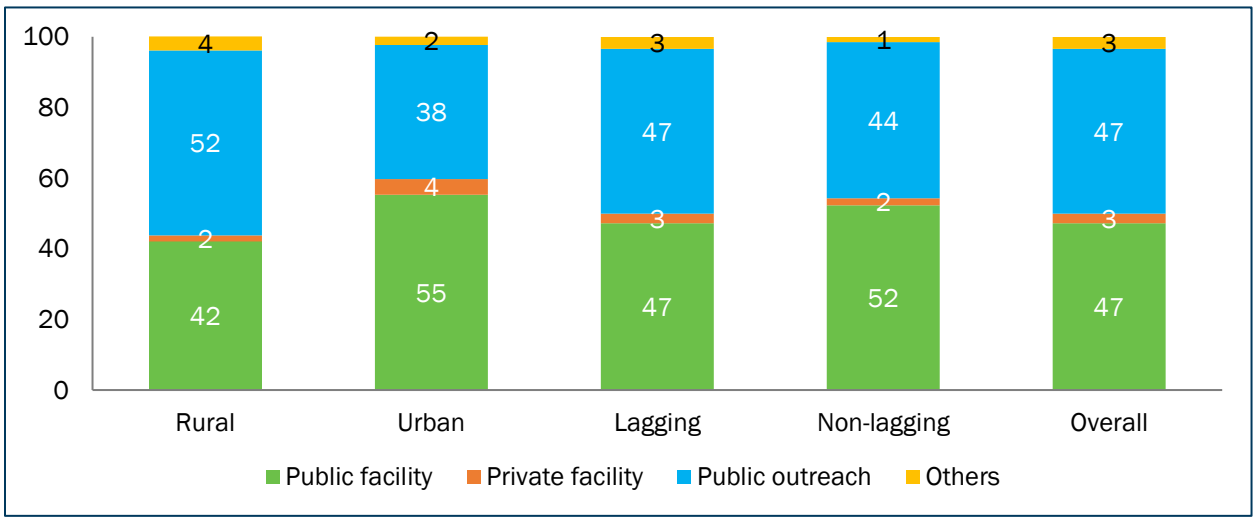
Government outreach immunization programs were the second most reported source, especially in rural areas (52.3%) and lagging districts (46.7%).

Private health facilities accounted for only 2.7% of immunizations overall, with higher use in urban areas (4.4%) than in rural areas (1.7%), and slightly greater reliance in lagging districts (2.7%) compared to non-lagging districts (2.0%).

Table 9.3: Percentage distribution of vaccination sources among children aged 12–23 months

	Residence		District type		Overall
	Rural	Urban	Lagging	Non-lagging	
Place vaccines administrated					
Government health facility	42.1	55.3	47.2	52.3	47.2
Private health facility	1.7	4.4	2.7	2.0	2.7
Government outreach	52.3	38.0	46.7	44.2	46.7
Others	4.0	2.3	3.3	1.4	3.3
Total	100.0	100.0	100.0	100.0	100.0
No. of children (unweighted)	**2,521**	**1,184**	**3,705**	**1,000**	**3,705**

Figure 9.5: Percentage distribution of immunization coverage for vaccinated children aged 12–23 months, by source of vaccine



Vaccinations by Schedule

The vaccination schedule followed under EPI guidelines is shown in Table 9.4. Newborns are scheduled to receive the BCG, polio, and hepatitis B vaccines at birth. In Punjab, 96.5% of newborns received BCG, 94.4% received polio, and 91.1% received hepatitis B at birth (Table 9.4). Coverage for all three vaccinations showed significant variation, with lower rates in rural areas compared to urban areas. The coverage gap for specific vaccine doses was substantial between lagging and non-lagging districts, particularly for polio at birth (90.9% in lagging districts vs. 95.3% in non-lagging districts).

Table 9.4: Percentage distribution of children aged 12–23 months, by type and dose of vaccine given and timing in weeks since birth)

	Residence		District type		
	Rural	Urban	Lagging	Non-lagging	Overall
First round (at birth)					
BCG	95.9	97.3	92.6	97.4	96.5
Oral polio vaccine (OPV) zero (at birth)	93.3	96.1	90.9	95.3	94.4
Hepatitis B	90.9	91.5	89.7	91.5	91.1
Second round (6 weeks)					
OPV1	95.4	97.3	91.6	97.3	96.1
Pneumococcal 1st dose	94.5	95.0	91.2	95.5	94.7
Rotavirus 1st dose	94.5	95.4	91.4	95.7	94.8
Penta-1 dose	94.6	94.5	91.1	95.4	94.6
Third round (10 weeks)					
OPV2	94.5	96.0	90.0	96.4	95.1
Pneumococcal 2nd dose	93.8	94.7	90.9	95.0	94.1
Rotavirus 2nd dose	91.6	92.3	87.7	92.9	91.8
Penta-2	93.5	93.4	90.0	94.4	93.5
Fourth round (14 weeks)					
OPV3	90.3	89.2	85.6	91.0	89.9
Pneumococcal 3rd dose	89.2	89.0	83.0	90.7	89.1
Inactivated polio vaccine (IPV) 1	93.9	94.9	91.4	95.1	94.3
Penta-3 dose	90.4	90.4	85.4	91.7	90.4
Fifth round (36 weeks)					
Measles 1 dose (at 9 months)	93.0	93.8	89.2	94.3	93.3
Typhoid conjugate vaccine	91.1	92.2	88.6	92.3	91.6
IPV2	92.2	93.6	89.7	93.5	92.8
Sixth round (60 weeks)					
Measles 2nd dose (at 15 months)	87.1	83.8	83.5	86.5	85.9
Received all eight classic EPI doses	88.7	88.5	83.3	90.0	88.6
N (unweighted)	**2,619**	**1,206**	**1,080**	**2,745**	**3,825**

The gap in vaccination coverage between lagging and non-lagging districts widened with each subsequent dose after birth. For instance, coverage for the first dose of Rotavirus at six weeks after birth was 91.4% in lagging districts, compared to 95.7% in non-lagging districts. For the second dose of polio at ten weeks, coverage was 90.0% in lagging districts versus 96.4% in non-lagging districts. By the third dose of polio at 14 weeks, coverage declined further, with 85.6% in lagging districts compared to 91.0% in non-lagging districts.

By the 60th week after birth, the FIC rate for the eight core EPI doses was 88.6% overall, with similar rates in rural (88.7%) and urban areas (88.5%), but a pronounced gap between lagging (83.3%) and non-lagging (90.0%) districts.

These findings underscore the need to increase immunization coverage across all areas while prioritizing efforts to close the persistent gap between rural and urban populations, as well as between lagging and non-lagging districts.

Children with No Vaccines: 'Zero-dose' Coverage

Overall, 3.0% of the 3,825 children aged 12–23 months had received no vaccines and were classified as "zero-dose" children (Table 9.5).

By sex, 2.6% of boys and 3.5% of girls were unvaccinated. Zero-dose prevalence was slightly higher in rural areas (3.5%) compared to urban areas (2.2%). It was more common in lagging districts (7.2% overall, 6.6% boys, and 7.9% girls) than in non-lagging districts (2.0% overall, 1.6% boys, and 2.3% girls).

Disparities in zero-dose children based on mothers' education and wealth quintile were notable. Among children of women with no education, 5.3% of children were unvaccinated (5.1% boys and 5.5% girls), compared to just 0.4% of children whose mothers had secondary or higher education (0.6% boys and 0.3% girls). Similarly, 8.4% of children in the lowest wealth quintile were unvaccinated (7.9% boys and 9.0% girls), versus only 1.1% from the highest wealth quintile (0.6% boys and 1.5% girls).

Across most sub-groups, zero-dose prevalence was broadly similar between boys and girls.

Table 9.5: Percentage of children aged 12–23 months who did not receive any vaccinations (zero dose), by background characteristics

	Boys	Girls	Overall
Overall	2.6	3.5	3.0
Residence			
Rural	3.0	4.1	3.5
Urban	1.9	2.5	2.2
District type			
Lagging	6.6	7.9	7.2
Non-lagging	1.6	2.3	2.0
Mother's education			
No education	5.1	5.5	5.3
Primary and middle	1.4	2.2	1.8
Secondary and above	0.6	0.3	0.4
Mother's wealth quintile			
Lowest	7.9	9.0	8.4
Second	1.2	2.4	1.8
Middle	2.1	2.6	2.4
Fourth	1.0	2.6	1.8
Highest	0.6	1.5	1.1
No. of children (unweighted)	**1,937**	**1,888**	**3,825**

Reasons for non-vaccination

Respondents cited several reasons for households and parents not vaccinating their children aged 12–23 months. The three main reasons were: (a) "immunization site too far" (20.4%); (b) "fear of reactions" (16.5%); and (c)" don't know" (25.2%) (Table 9.6). The perception that immunization locations were too far was significantly more common in rural (25.9%) compared to urban areas (7.2%) and—paradoxically—in non-lagging (34.2%) compared to lagging districts (5.6%).

Lack of confidence in immunization was cited by a smaller proportion overall (3.4%) but was more frequent in urban (6.3%) than in rural areas (2.3%), and in non-lagging (6.1%) compared to lagging districts (1.0%). Fear of vaccine reactions was a reason reported more frequently in urban (19.7%) than in rural areas (15.1%) and in lagging (17.5%) compared to non-lagging districts (15.4%).

Interventions must be tailored to address both behavioral and logistical concerns. Behavioral concerns—such as fear of reactions and lack of confidence—require focused behavior change communication, including appropriate information and counselling. Conversely, logistical barriers—such as not knowing the location or schedule of immunization, vaccine unavailability, absence of vaccinators, or visiting on non-vaccination days—fall within the health system's responsibility and can be addressed through strengthened supervision and monitoring.

Table 9.6: Percentage distribution of unvaccinated (zero-dose) children aged 12–23 months, by reasons for not vaccinating

Reason for not vaccinating child (multiple response variable)	Residence		District type		Overall
	Rural	Urban	Lagging	Non-lagging	
Place of immunization too far	25.9	7.2	34.2	5.6	20.4
Time of immunization not convenient	1.5		2.1		1.1
Mother too busy	2.6	1.8	3.6	1.1	2.4
Family problems, including mother being ill	10.0	1.5	4.9	10.3	7.5
Child ill, not brought for vaccination	5.4	22.7	2.5	19.1	10.5
Child ill, brought but not vaccinated	4.6	7.8	3.6	7.6	5.5
Long wait times	2.9		4.0		2.1
Rumors about vaccination	1.4	6.2	0.7	5.1	2.8
No faith in immunization	2.3	6.3	1.0	6.1	3.4
Fear of reaction	15.1	19.7	17.5	15.4	16.5
Place of immunization unknown	0.5		0.7		0.4
Time of immunization unknown	2.6		3.5		1.8
Brought child, vaccine unavailable	1.1	1.3	2.3		1.2
Brought child, vaccinator unavailable	0.7		1.0		0.5
Brought child, facility closed					
Brought child, but not a vaccination day	2.6		3.6		1.8
Others	10.0	8.3	7.3	11.8	9.5
Don't know	24.9	25.7	21.3	29.3	25.2
Total	100.0	100.0	100.0	100.0	100.0
No. of children (unweighted)	**108**	**28**	**92**	**44**	**136**

10

Communicable and Non-communicable Diseases

Key Findings

Reported prevalence and treatment of diseases

- The reported prevalence of ever suffered communicable diseases was 2.68% with no major differences by sex or residence.
- The overall reported prevalence of non-communicable diseases among individuals aged five and older was 15.7%. Females had a higher prevalence of each major type of disease compared to males.
- Prevalence of non-communicable diseases was higher in urban areas (16.1%) than in rural areas (15.5%) and in non-lagging districts (16.2%) compared to lagging districts (13.8%), except for heart disease.
- High/low blood pressure was the most reported condition among both sexes, followed by diabetes.
- Treatment rates exceeded 90% for non-communicable, heart, and respiratory diseases.

Tuberculosis

- The reported prevalence of tuberculosis (TB) was 0.37% among household members aged five or older (0.44% in rural and 0.26% in urban areas) during last two years.
- Treatment rates were high for both females and males.
- About three-fourths (74.4%) of TB patients sought treatment from public health facilities.

Household use of tobacco, drugs, and substances

- Approximately one-third of households had at least one member aged 15 or older who smoked daily or occasionally.
- A small minority reported the use of substances other than tobacco, mainly alcohol.

Malaria

- The reported prevalence of malaria during last two years was 0.02% overall, with no difference between rural and urban areas (0.02% each).

- About 19.1% of households (21.8% in rural and 15.4% in urban areas) reported having a mosquito net for malaria prevention.
- Among those infected with malaria, 74.4% sought treatment from private health facilities.

Hypertension

- Hypertension was more prevalent among women (5.0%) than men (1.8%) during last two years.
- Prevalence of hypertension increased with age, reaching 10.3% among those aged 45–59 and 12.8% among those 60 or older.
- A large proportion (97.0%) of individuals with hypertension sought treatment from either public or private facilities.

Diabetes

- The overall reported prevalence of diabetes during last two years was 3.3%, with a higher prevalence in urban areas (4.0%) compared to rural areas (2.7%).
- As with hypertension, prevalence of diabetes increased with age, reaching 13.5% for those aged 60 or older.
- More than half (56.4%) of diabetic patients sought treatment from private facilities.

The National Health Support Program (NHSP) aims to reduce the prevalence and increase the treatment rate of both communicable (infectious) and non-communicable diseases. The PHPS 2024–25 household questionnaire gathered baseline information on the reported prevalence of these diseases for all household members aged five years or older.

The household roster included a question: "Have any persons aged five years or older ever suffered from a communicable or non-communicable/long-term/chronic/acute disease?" Respondents who answered positively were then asked about the specific illnesses of each household member, categorized as respiratory, neurological, heart, non-communicable, and communicable diseases. They were further asked whether the household member was receiving treatment for the illness.

Results on the reported prevalence of specific communicable and non-communicable diseases, as well as their treatment rates, are presented in the following sections. Only nine household members across Punjab were reported to have HIV/AIDS; therefore, no meaningful analysis of prevalence or treatment-seeking for HIV/AIDS was undertaken.

Reported Prevalence and Treatment of Diseases

A total of 127,194 household members aged five years or older were the reference group for most questions regarding communicable and non-communicable diseases. The overall reported prevalence of various diseases is presented in Table 10.1. Note that the percentage taking medications are based on all persons aged five years or older (and not just among those who have reported the disease).

The prevalence of communicable diseases was high for rural female at 3.1% with minimal differences by place of residence and sex. The prevalence of non-communicable diseases was highest among females in urban areas (19.8%) and 18.4% in rural areas, compared to 12.6% for males in rural areas and 12.4% in urban areas. Among the five major disease types, respiratory diseases had the lowest prevalence.

Table 10.1: Percentage of household members aged five years or older who ever had a disease and were taking medication (by major groups of illnesses and by sex and place of residence)

Major groups of illness		Reported prevalence				Taking medication			
		Male		Female		Male		Female	
		Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Communicable		**2.7**	**2.4**	**3.1**	**2.4**	**2.3**	**2.1**	**2.6**	**2.1**
Non-Communicable	Respiratory	1.3	0.7	1.3	0.8	1.2	0.7	1.3	0.8
	Neurological	1.7	1.0	1.7	1.4	1.5	0.9	1.5	1.3
	Heart	3.3	4.1	5.8	7.2	3.0	3.7	5.2	6.8
	Other non-communicable	6.4	6.6	9.7	10.3	5.6	6.0	8.4	9.1
	Total	**12.6**	**12.4**	**18.4**	**19.8**	**11.2**	**11.3**	**16.3**	**17.9**

The reported prevalence of major disease types was higher among females than among males (Table 10.1). The prevalence of disease was higher in rural areas than in urban areas, except for heart disease, which was more common in urban areas. Heart disease affected 4.1% of males and 7.2% of females in urban areas, compared to 3.3% of males and 5.8 % of females in rural areas. Notably, other non-communicable diseases were significantly more prevalent in females (9.9%) than in males (6.5%).

Figure 10.1: Percentage of household members aged five years or older who ever had a disease, by major group of illnesses and sex

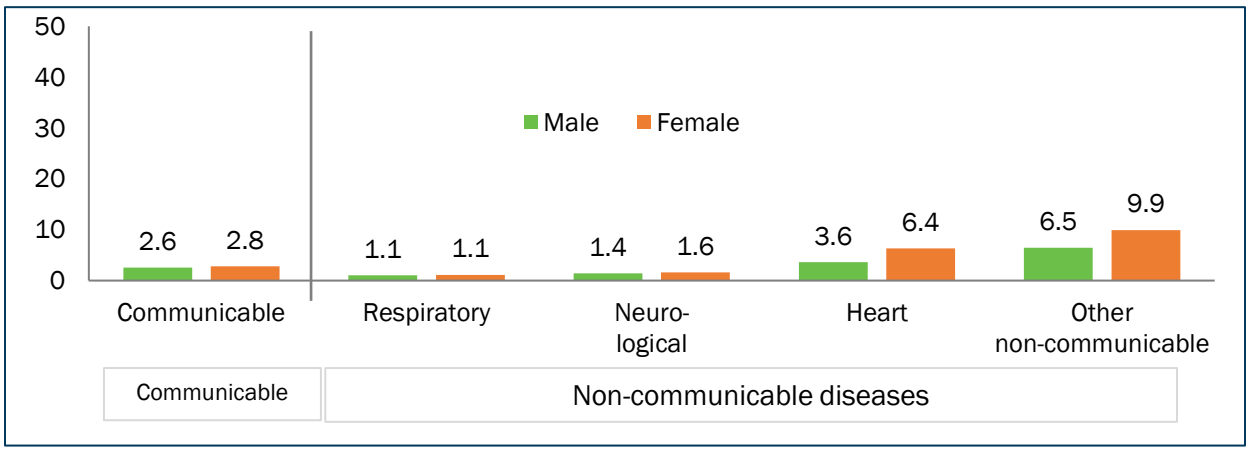


Table 10.2: Percentage of household members aged five years or older who ever had a disease and percentage taking medication, by type of disease and sex

	Reported prevalence			Taking medication		
	Overall	Male	Female	Overall	Male	Female
Communicable diseases	**2.68**	**2.57**	**2.80**	**2.33**	**2.24**	**2.42**
Malaria	0.02	0.01	0.03	0.02	0.01	0.02
Pneumonia	0.05	0.06	0.04	0.05	0.06	0.04
Typhoid	0.27	0.24	0.30	0.25	0.21	0.29
HIV/AIDS	0.01	0.01	0.00	0.01	0.01	0.00
Hepatitis B or C	1.21	1.10	1.32	1.03	0.96	1.10
COVID-19	0.01	0.02	0.01	0.01	0.02	0.01
Febrile condition	0.20	0.21	0.18	0.19	0.21	0.17
Thalassemia	0.01	0.01	0.01	0.01	0.01	0.01
TB	0.37	0.40	0.34	0.32	0.34	0.30
Others	0.54	0.51	0.57	0.45	0.42	0.48
Non-communicable diseases	**15.72**	**12.51**	**18.96**	**14.86**	**11.74**	**18.01**
Respiratory diseases	**1.06**	**1.05**	**1.08**	**1.03**	**1.00**	**1.06**
Asthma	0.81	0.80	0.82	0.78	0.76	0.80
Any respiratory disease	0.25	0.24	0.27	0.25	0.24	0.26
Neurological diseases	**1.49**	**1.40**	**1.59**	**1.33**	**1.27**	**1.40**
Epilepsy	0.17	0.23	0.11	0.16	0.22	0.10
Nerve disorder	0.42	0.32	0.52	0.38	0.29	0.47
Mental health	0.33	0.30	0.35	0.27	0.24	0.30
Stroke/paralysis	0.41	0.41	0.42	0.38	0.39	0.36
Other neurological diseases	0.16	0.14	0.19	0.15	0.13	0.16
Heart diseases	**4.97**	**3.59**	**6.36**	**4.79**	**3.45**	**6.14**
High/low blood pressure	3.40	1.82	5.00	3.28	1.75	4.82
Other heart-related diseases	1.57	1.78	1.36	1.51	1.70	1.32
Other non-communicable diseases	**8.19**	**6.47**	**9.94**	**7.70**	**6.02**	**9.41**
Stomach/gastrointestinal illness	1.12	0.76	1.49	1.08	0.72	1.44
Diabetes	3.26	2.81	3.73	3.19	2.72	3.67
Kidney	0.65	0.60	0.69	0.60	0.55	0.65
Liver illness	0.26	0.17	0.35	0.24	0.15	0.32
Arthritis/gout/swollen joints	1.21	0.74	1.69	1.13	0.66	1.61
Blood disease	0.05	0.05	0.05	0.05	0.05	0.05
Anemia	0.17	0.11	0.23	0.15	0.10	0.19
Skin condition	0.31	0.29	0.33	0.29	0.27	0.30
Cancer	0.12	0.08	0.16	0.11	0.07	0.15
Goiter	0.15	0.06	0.25	0.14	0.06	0.23
Congenital diseases	0.22	0.22	0.21	0.14	0.15	0.13
Others non-communicable	0.67	0.58	0.76	0.59	0.52	0.66
No. of household members ≥ 5 years	**127,194**	**63,867**	**63,327**	**127,194**	**63,867**	**63,327**

Table 10.2 shows that the burden of illness among household members aged five years and above is dominated by non-communicable diseases (NCDs), with a markedly higher prevalence among females. Overall, 12.66% of males and 19.05% of females reported an NCD, compared with 2.57% of males and 2.80% of females reporting a communicable disease.

Among communicable diseases, hepatitis B or C and tuberculosis account for the largest share of reported illness for both sexes, while other infections such as malaria, pneumonia and COVID-19 are reported at very low levels.

For NCDs, females consistently report higher prevalence than males, particularly for heart diseases (6.36% vs. 3.59%), and for diabetes (3.73% vs. 2.81%). Other conditions with notable female disadvantage include arthritis/gout, goiter, anemia, and gastrointestinal illness.

Across all disease categories, the proportion taking medication is only slightly lower than the reported prevalence, indicating generally high treatment uptake among those who report having a disease, for both males and females.

Figure 10.2: Percentage of household members aged five years or older who had reported the disease they ever suffered, who were taking medication for it, by major group of illnesses and sex

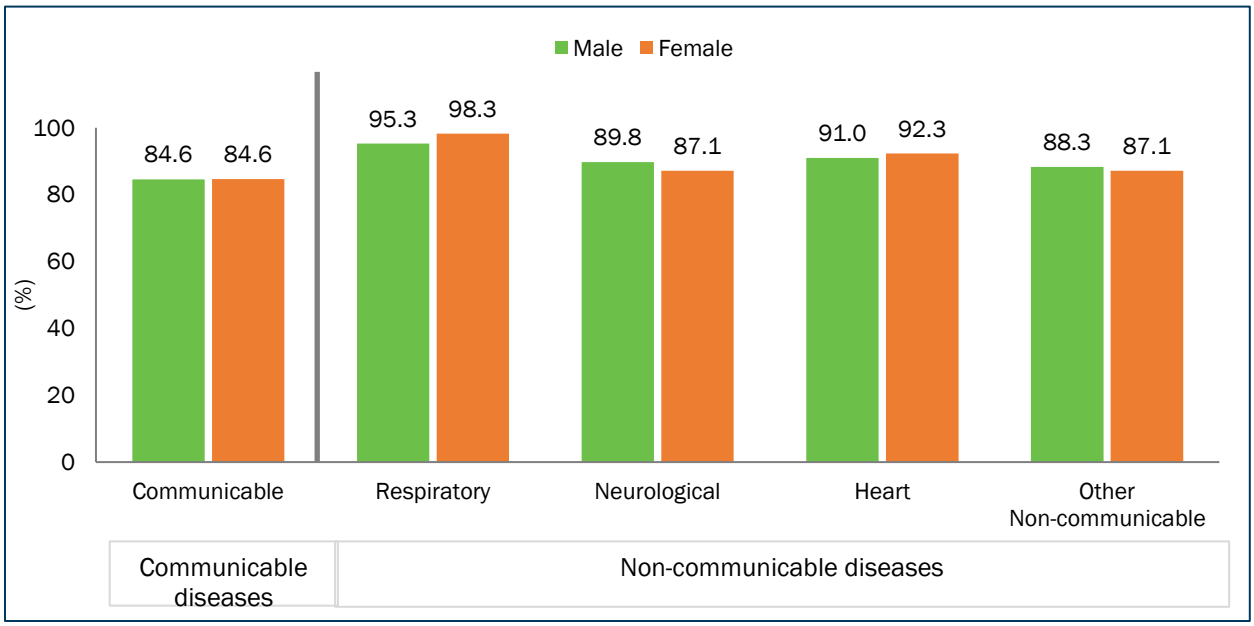


Figure 10.2 shows that medication uptake is generally high for both males and females, particularly for non-communicable diseases (NCDs). A higher share of individuals with NCDs report taking medication compared with those suffering from communicable diseases, reflecting the chronic nature of many NCDs and the need for continuous treatment.

Treatment rates closely follow reported prevalence patterns. Overall, treatment rates for those with communicable diseases and other communicable diseases" was lower among those who reported such ailments. Treatment rates for most non communicable diseases primarily heart and respiratory diseases exceeded 90%.

Generally, there were no major differences in prevalence and treatment between males and females, except in a few cases: treatment rates for respiratory diseases were higher among females (98.1%) than males (95.3%); for neurological diseases, rates were slightly lower among females (87.1%) than males (89.8%).

Communicable Diseases

Tuberculosis

The household questionnaire included the question: “Has any member of your household suffered from TB in the last two years (from July 1, 2022, to date)?” Those who answered positively were then asked: “How many members of your household have suffered from TB during the last two years (from July 1, 2022, to date)?” For those who reported TB, an additional question inquired whether the person was taking any medication for the illness.

The percentage of reported TB cases among individuals aged five or older was 0.33% for Punjab overall— 0.39% in rural areas and 0.25% in urban areas (Table 10.3). The reported prevalence was slightly lower in non-lagging districts (0.33%) than in lagging districts (0.36%). Prevalence was notably higher among older individuals, particularly those aged 45–59 years (0.65%) and 60 years or older (0.89%), compared to those under 45.

There was little difference between males (0.34%) and females (0.32%). However, prevalence was significantly higher among individuals with no education (0.51%) compared to those with secondary or higher education (0.17%). Similarly, prevalence was higher in the poorest quintile (0.47%) than in the richest quintile (0.16%).

Table 10.3: Percentage of household members aged five years or older with TB and percentage seeking treatment, by background characteristics

	Reported prevalence	Treatment	N (unweighted)
Overall	0.33	0.32	127,194
Residence			
Rural	0.39	0.38	84,133
Urban	0.25	0.24	43,061
District type			
Lagging	0.36	0.35	34,884
Non-lagging	0.33	0.32	92,310
Age (years)			
5–14	0.08	0.08	34,984
15–29	0.29	0.29	38,215
30–44	0.28	0.28	25,623
45–59	0.65	0.61	17,147
60+	0.89	0.89	11,225
Sex			
Male	0.34	0.33	63,867
Female	0.32	0.32	63,327
Education			
No education	0.51	0.50	43,383
Primary/middle	0.30	0.29	53,949
Secondary or higher	0.17	0.17	29,862
Wealth quintiles			
Lowest	0.47	0.45	29,395
Second	0.40	0.39	26,283
Middle	0.36	0.36	25,352
Fourth	0.29	0.29	23,735
Highest	0.16	0.14	22,429

Among the 462 household members with TB, 18.5% were smokers and 72.9% were non-smokers (Table 10.4). The proportion of smokers was much higher among men (32.3%) than among women (4.1%).

Table 10.4: Percentage of household members aged five years or older with TB, by smoking behavior

	Total	Male	Female
Whether cigarette smoker?			
No	72.9	54.5	92.1
Yes	18.5	32.3	4.1
Don't know/missing/unsure	8.6	13.2	3.8
Total	100.0	100.0	100.0
No. of people with TB (unweighted)	**462**	**247**	**215**

About two-thirds of TB patients (66%) sought treatment from public health facilities, with a slightly higher proportion of men (66.4%) than women (65.5%) seeking treatment (Table 10.5).

Table 10.5: Percentage of household members aged five years or older with TB, by treatment-seeking and place of treatment

	Total	Male	Female
Whether treatment sought			
Yes	97.9	97.1	98.6
No	2.1	2.9	1.4
Total	100.0	100.0	100.0
Source of treatment			
Public	66.0	66.4	65.5
Private	33.9	33.3	34.5
Other	0.2	0.3	0.0
Total	100.0	100.0	100.0
No. of people with TB (unweighted)	**462**	**247**	**215**

Household use of tobacco, drugs, and substances

Exposure to secondhand smoke, or passive smoking, increases the risk of developing TB, particularly among children. In Punjab, 35.2% of households had at least one member aged 15 or older who used tobacco daily or occasionally (Table 10.6). The rate was notably higher in rural areas (40.4%) than in urban areas (28%). Tobacco use among females was minimal. At least one male member used tobacco in 33.1% of households: 37.5% in rural and 26.9% in urban areas.

Cigarettes were the most used form of tobacco, reported by 69% of all tobacco users: 65.5% in rural and 76.1% in urban areas. *Hukkah* was the second most common type, with 24.8% of tobacco users, with prevalence higher in rural areas (31.6%) than in urban areas (11.1%). *Naswar,* a moist, powdered form of smokeless tobacco, ranked third, consumed by 20% of all users, with similar patterns in rural (20.2%) and urban areas (19.5%).

Table 10.6: Percentage of household members aged 15 years and older, by tobacco use

	Total	Rural	Urban
Tobacco used daily or occasionally by any household member			
Yes	35.2	40.4	28.0
No	64.7	59.5	72.0
Don't know	0.1	0.1	0.0
Total	100.0	100.0	100.0
No. of household members using any type of tobacco			
Male (aged 15 or older)			
No male member	66.9	62.5	73.1
1 male member	29.8	33.6	24.5
2 male members	2.9	3.4	2.2
3 or more male members	0.4	0.6	0.3
Total	100.0	100.0	100.0
Female (aged 15 or older)			
No female member	94.9	92.8	97.9
1 female member	4.8	6.8	2.1
2 female members	0.3	0.4	0.1
3 or more female members	0.0	0.0	0.0
Total	100.0	100.0	100.0
Type of tobacco used (multiple response variable)			
Cigarette	69.0	65.5	76.1
Hukkah	24.8	31.6	11.1
Chewing tobacco	0.4	0.3	0.5
Snuff by mouth	0.4	0.5	0.3
Snuff by nose	0.3	0.2	0.3
Paan with tobacco	2.7	0.8	6.5
Berri	3.5	4.3	1.8
Gutka	0.1	0.1	0.1
Naswar	20.0	20.2	19.5
Mawa tobacco	0.0	0.0	0.0
Naas and *man pori*	0.0	0.0	0.1
Pipes full of tobacco	0.0	0.0	0.0
Cigars, cheroots, or cigarillos	0.1	0.1	0.1
Others	0.1	0.1	0.2
Total	100.0	100.0	100.0
No. of users (unweighted)	**9,052**	**6,561**	**2,491**
No. of household members ≥ 15 years (unweighted)	**24,540**	**15,952**	**8,588**

Reported use of drugs other than tobacco was negligible. However, underreporting cannot be ruled out due to illegal and the stigmatized nature of such behaviors. Overall, only 1.0% of household

members aged 15 and older reported using drugs or substances other than tobacco (Table 10.7). Prevalence was slightly higher in urban (1.3%) than in rural households (0.8%).

Among the small proportion (1.0%) who reported drug use, alcohol (26.9%) was the most used substance, with similar usage in rural (27.5%) and urban (26.4%) households. This was followed by heroin (19.1%), ice (16.7%), *sheesha* (15.2%), and marijuana/cannabis (11.9%). Hashish (7.6%) and cocaine (4.6%) were reported by fewer users, with urban areas showing a higher prevalence of *sheesha,* ice, and cocaine use compared to rural areas. Additionally, a significant proportion of respondents (34.4%) mentioned using other unspecified substances, more commonly reported in rural areas (41.7%) than in urban areas (27.9%).

Table 10.7: Percentage of household members aged 15 years and older, by drug/substance use

	Total	Rural	Urban
Use of any other drug besides smoking			
Yes	1.0	0.8	1.3
No	98.9	99.0	98.6
Don't know	0.1	0.2	0.1
Total	100.0	100.0	100.0
No. of household members ≥ 15 years (unweighted)	**24,540**	**15,952**	**8,588**
Type of drugs used other than tobacco (multiple response variable)			
Alcohol	26.9	27.5	26.4
Marijuana/cannabis	11.9	10.5	13.1
Hashish	7.6	7.7	7.5
Heroin	19.1	22.2	16.3
Cocaine	4.6	0.9	8.0
Sheesha	15.2	5.6	23.9
Ice	16.7	10.9	22.0
Total	100.0	100.0	100.0
N (unweighted)	**188**	**104**	**84**

Malaria

With 177 million people at risk, malaria is endemic in Pakistan, according to the World Health Organization (WHO). The overall reported prevalence of malaria among household members aged five years or older was 0.02%, with 0.02% in both rural and urban areas (Table 10.8). Lagging districts had a significantly higher reported prevalence (0.054%) compared to non-lagging districts (0.013%).

Prevalence increased up to ages 30–44 years (0.047%) before declining, reaching its lowest among those aged 45–59 years (0.005%) and those aged 60 years or older (0.015%). Reported prevalence was higher among females (0.027%) than males (0.015%).

Educational attainment showed an inverse relationship with malaria prevalence: individuals with no education (0.027%) or primary/middle education (0.021%) reported higher rates compared to those

with secondary or higher education (0.012%). By wealth quintile, prevalence was highest among households in the lowest quintile (0.043%), followed by the middle quintile (0.025%), and the highest quintile (0.020%).

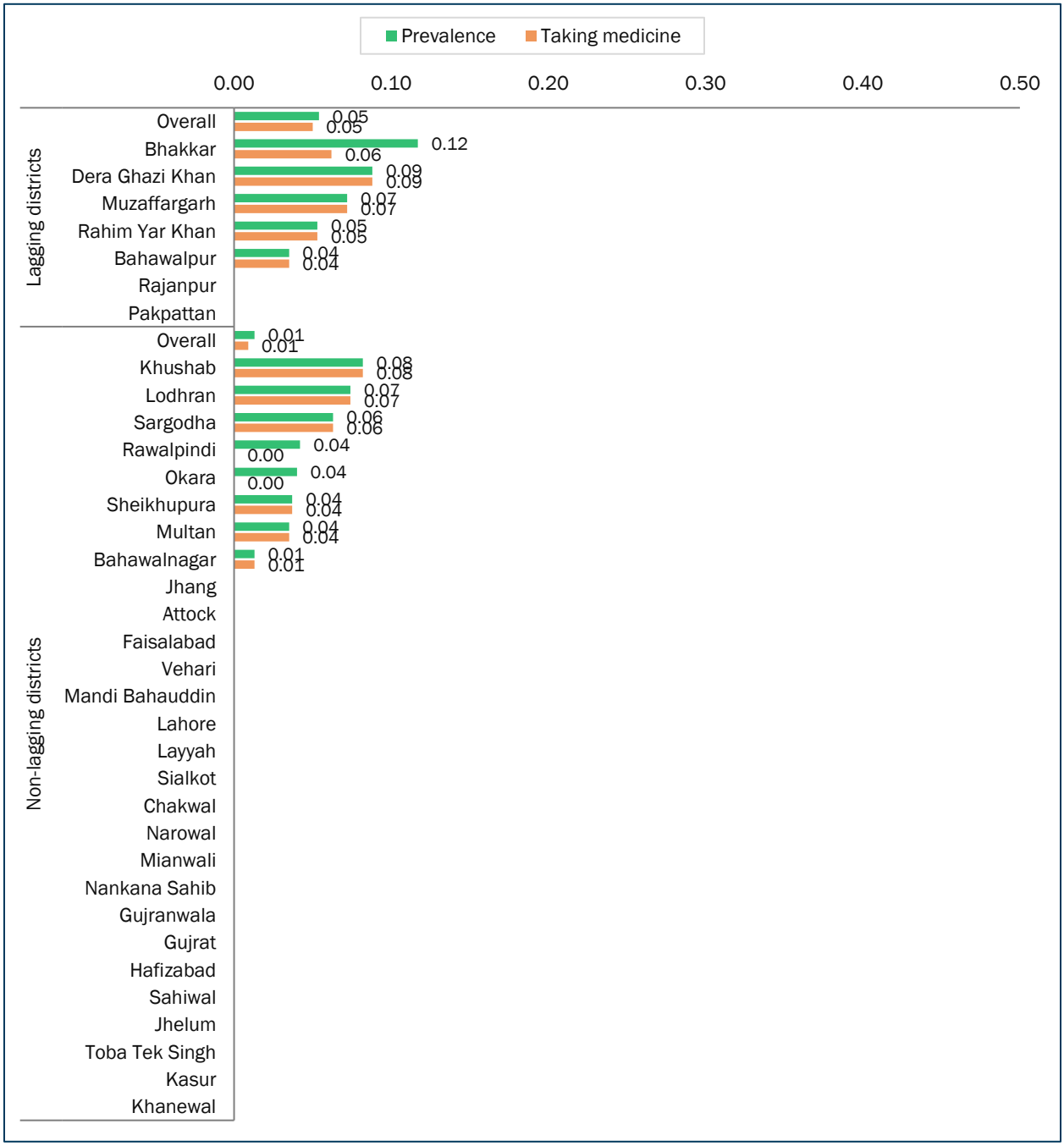
Table 10.8: Percentage of household members aged five years or older who had malaria (reported prevalence) and percentage seeking treatment, by background characteristics

	Reported prevalence	Treatment	N (unweighted)
Overall	0.021	0.017	127,194
Residence			
Rural	0.024	0.019	84,133
Urban	0.017	0.014	43,061
District type			
Lagging	0.054	0.050	34,884
Non-lagging	0.013	0.009	92,310
Age (years)			
5–14	0.013	0.013	34,984
15–29	0.018	0.017	38,215
30–44	0.047	0.031	25,623
45–59	0.005	0.003	17,147
60+	0.015	0.015	11,225
Sex			
Male	0.015	0.012	63,867
Female	0.027	0.022	63,327
Education			
No education	0.027	0.026	43,383
Primary/middle	0.021	0.015	53,949
Secondary or higher	0.012	0.008	29,862
Wealth quintiles			
Lowest	0.043	0.039	29,395
Second	0.016	0.016	26,283
Middle	0.025	0.015	25,352
Fourth	0.002	0.002	23,735
Highest	0.020	0.013	22,429

Importantly, 23 out of 36 districts in Punjab, including major urban centers such as Lahore, Faisalabad, and Gujranwala, reported no malaria cases (Figure 10.3). Among lagging districts, Bhakkar had the highest reported prevalence at 0.12, followed by Dera Ghazi Khan (0.09) and Muzaffargarh (0.07). Other lagging districts, including Rahim Yar Khan (0.05) and Bahawalpur (0.04), reported cases, while Rajanpur and Pakpattan reported none.

In non-lagging districts, Khushab (0.08), Lodhran (0.07), and Sargodha (0.06) reported malaria cases. Additional non-lagging districts such as Rawalpindi (0.04), Okara (0.04), Sheikhupura (0.04), Multan (0.04), and Bahawalnagar (0.01) also recorded cases.

Figure 10.3: Percentage of household members aged five years or older who had malaria and were under treatment, by district



Note: Districts with reporting zero incidence are left blank.

Among the population aged five years and older who reported having malaria, 80.6% sought treatment. Treatment-seeking was slightly higher in urban areas (83.8%) than in rural areas (79.1%) (Table 10.9).

Public health facilities were used by 22.3% of malaria patients overall: 20.5% in rural areas and 25.7% in urban areas. Private facilities were the main source of treatment for 74.4% of patients, with similar usage in rural (74.4%) and urban areas (74.3%). Reliance on community health workers was minimal (2.3%), and slightly higher in rural areas (3.5%) compared to none in urban settings.

Table 10.9: Percentage of household members aged five years or older who had malaria and sought treatment

	Total	Rural	Urban
Treatment sought among those who reported malaria			
Yes	80.6	79.1	83.8
No	19.4	20.9	16.2
Total	100.0	100.0	100.0
N (unweighted)	39	30	9
Source of treatment			
Public	22.3	20.5	25.7
Private	74.4	74.4	74.3
Workers	2.3	3.5	0.0
Missing	1.1	1.6	0.0
Total	100.0	100.0	100.0
N (unweighted)	**32**	**24**	**8**

A major preventive measure against malaria is the use of mosquito nets. However, only 19.1% of households in Punjab reported having nets for sleeping, with availability slightly higher in rural (21.8%) compared to urban areas (15.4%) (Table 10.10). The low availability of nets likely did not meet household needs, particularly in rural areas with larger family sizes and higher malaria prevalence. Overall, 6% of households had two nets and 3.5% had three. In rural areas, 6.9% of households had two nets and 3.9% had three, while in urban areas, 4.9% had two nets and 2.9% had three nets. (Table 10.10). Only 1.3% of households had malaria treatment medication at home, and about 5.5% of nets were already treated with mosquito repellent.

In addition to nets, households used various methods to keep mosquitoes away. The most common were coils (38%), mats (24.8%), sprays (17.9%), and electric spray repellents (12.3%). Rural households predominantly used coils (36.1%) and mats (26.8%), while urban households relied more on coils (39.9%) and sprays (23.7%). The use of smoke as a mosquito repellent was significantly higher in rural areas (14.7%) compared to urban areas (1.9%). Multiple methods were often used simultaneously to combat mosquitoes.

Table 10.10: Percentage of households with availability and use of mosquito nets, by place of residence

	Total	Rural	Urban
Availability of mosquito nets (that can be used while sleeping)			
Yes	19.1	21.8	15.4
No	80.9	78.2	84.6
Total	100.0	100.0	100.0
No. of mosquito nets available in household			
No net	80.9	78.2	84.6
1 net	5.9	6.8	4.6
2 nets	6.0	6.9	4.9
3 nets	3.5	3.9	2.9
4 nets	1.6	1.9	1.3
5 or more nets	2.1	2.4	1.8
Total	100.0	100.0	100.0
Do you have medicine to treat malaria at home?			
Yes	1.3	1.0	1.6
No	97.9	97.9	97.9
Don't know	0.9	1.1	0.5
Total	100.0	100.0	100.0
Whether net is already sprayed with mosquito repellent			
Yes	5.5	5.8	5.0
No	87.7	86.6	89.7
Don't know	6.8	7.6	5.4
Total	100.0	100.0	100.0
Ways used to keep mosquitoes away other than nets (multiple response variable)			
Coil	38.0	36.1	39.9
Mat	24.8	26.8	22.8
Spray	17.9	12.1	23.7
Electric spray repellent	12.3	8.4	16.1
Insect repellent	7.7	7.9	7.5
Electric racket	2.7	2.0	3.3
Through smoke	8.3	14.7	1.9
Kri Kri mosquito killer	0.4	0.4	0.5
Others (specify)	7.7	10.1	5.4
Total	100.0	100.0	100.0
N (unweighted)	**12,233**	**6,986**	**5,247**
No. of households (unweighted)	**24,540**	**15,952**	**8,588**

All family members used mosquito nets in 35.6% of households, with similar usage rates in rural (35.5%) and urban areas (35.9%) (Table 10.11). In 25.9% of households, only children used mosquito nets: 26.5% in rural and 24.9% in urban areas. Nets were used exclusively by male family members in 9.8% of households and exclusively by female members in 4.4% of households.

Table 10.11: Percentage of households with mosquito nets, by household member

	Total	Rural	Urban
Household member(s) using nets (multiple response variable)			
All family members	35.6	35.5	35.9
Only male family members	9.8	10.0	9.5
Only female family members	4.4	4.8	3.6
Only adult male and female family members	6.4	6.4	6.5
Only children	25.9	26.5	24.9
Male family member and children	2.7	2.6	2.9
Female family member and children	8.6	8.3	9.1
Nobody uses nets	6.5	5.9	7.7
Total	100.0	100.0	100.0
No. of household member(s) using nets (unweighted)	**4,764**	**3,381**	**1,383**
No. of households (unweighted)	**24,540**	**15,952**	**8,588**

Non-communicable Diseases

Hypertension (high blood pressure)

Hypertension is defined as blood vessel pressure that is too high (140/90 mmHg or higher). If left untreated, it can lead to serious consequences, including heart attack, stroke, heart failure, kidney disease, vision loss, and even death.

A relatively small proportion of the population aged five years or older in Punjab—3.4% overall, 3% in rural and 4% in urban areas—had hypertension (Table 10.12 and Figure 10.4). Prevalence was lower in lagging districts (2.7%) compared to non-lagging districts (3.6%).

Hypertension prevalence increased with age, reaching 10.3% among those aged 45–59 years and 12.8% among those aged 60 or older. It was more common among women (5%) than men (1.8%).

Additionally, hypertension was more prevalent among individuals with no education (4.9%) compared to those with primary, middle, secondary, or higher education. By wealth quintile, hypertension was more common among the wealthiest households (4.3%) than the poorest (2.4%).

Table 10.12: Percentage of household members aged five years or older with hypertension and percentage seeking treatment, by background characteristics

	Reported prevalence	Treatment	N (unweighted)
Overall	3.4	3.3	127,194
Residence			
Rural	3.0	2.9	84,133
Urban	4.0	3.9	43,061
District type			
Lagging	2.7	2.7	34,884
Non-lagging	3.6	3.4	92,310
Age (years)			
5–14	0.0	0.0	34,984
15–29	0.4	0.4	38,215
30–44	3.7	3.5	25,623
45–59	10.3	10.0	17,147
60+	12.8	12.7	11,225
Sex			
Male	1.8	1.8	63,867
Female	5.0	4.8	63,327
Education			
No education	4.9	4.8	43,383
Primary/middle	2.5	2.4	53,949
Secondary or higher	3.0	3.0	29,862
Wealth quintiles			
Lowest	2.4	2.3	29,395
Second	3.4	3.2	26,283
Middle	3.2	3.1	25,352
Fourth	3.7	3.5	23,735
Highest	4.3	4.2	22,429

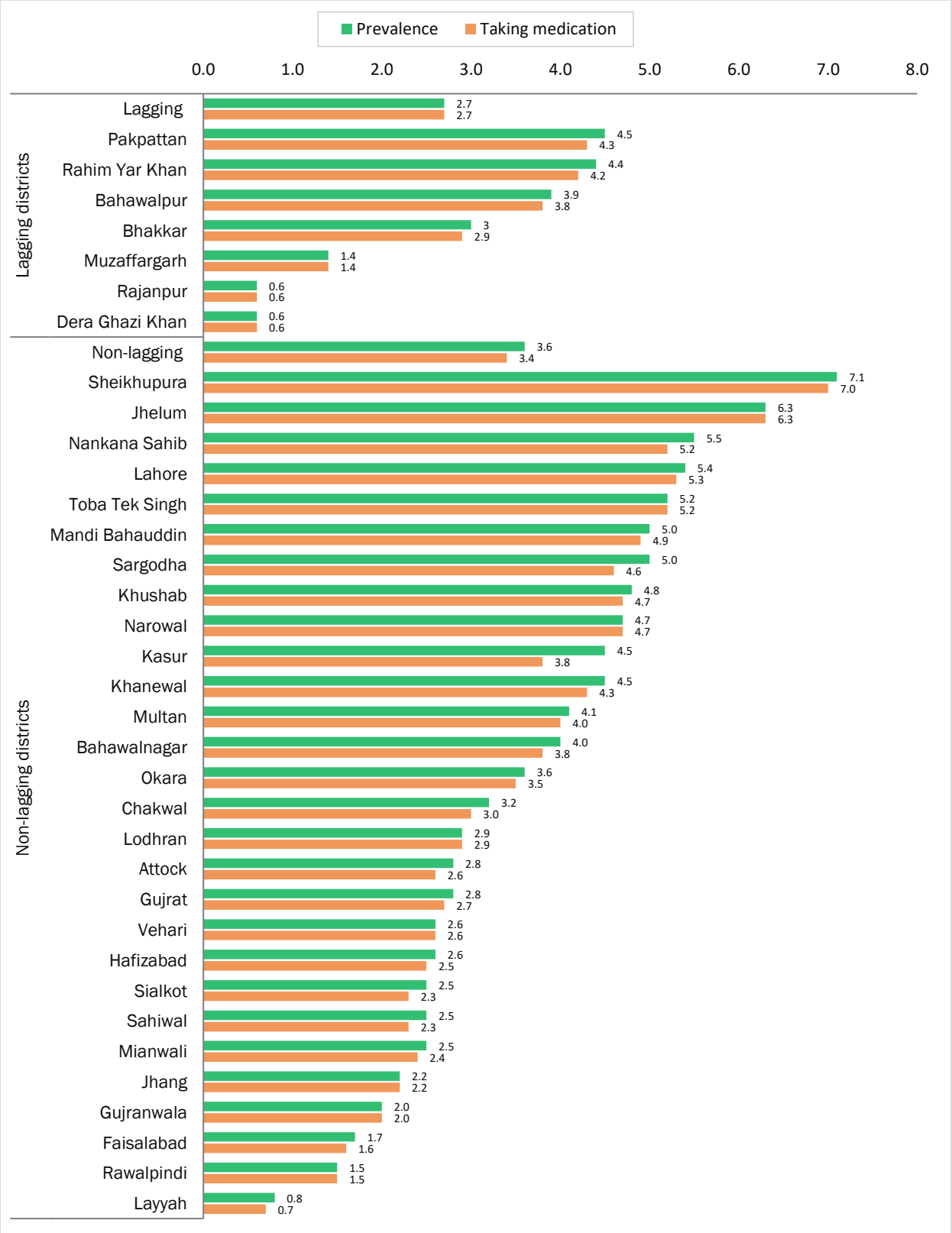
Treatment rates were high (96.6%), with similar levels reported in rural (96%) and urban areas (97.2%) (Table 10.13). Most household members with hypertension sought treatment from private facilities (59.5%), followed by public facilities (23.1%). Use of private facilities was slightly higher in rural areas (62.3%) than in urban areas (56.7%).

Figure 10.4 shows the variation in reported prevalence and treatment of hypertension across districts. The prevalence of hypertension ranged from below 1% in Rajanpur, Dera Ghazi Khan, and Layyah to over 5% in Toba Tek Singh, Jhelum, and Sheikhupura.

Table 10.13: Percentage of household members aged five years or older with hypertension who sought treatment, by rural/urban

	Total	Rural	Urban
Treatment sought?			
Yes	96.6	96.0	97.2
No	3.4	4.0	2.8
Total	**100.0**	**100.0**	**100.0**
Source of treatment			
Public facility	23.1	21.1	25.3
Private facility	59.5	62.3	56.7
Workers	14.8	13.2	16.4
Others	1.5	2.1	0.9
Missing	1.1	1.4	0.7
Total	**100.0**	**100.0**	**100.0**
N (unweighted)	**4,163**	**2,448**	**1,715**

Figure 10.4: Percentage of household members aged five years or older who had hypertension and who were under treatment, by district



Diabetes

Diabetes was prevalent among 3.3% of household members aged five years or older (Table 10.14, Figure 10.5). Prevalence was higher in urban areas (4.1%) than in rural areas (2.7%), and higher in non-lagging districts (3.6%) compared to lagging districts (1.9%). Like hypertension, diabetes prevalence increased with age, reaching 11.2% among individuals aged 45–59 years and peaking at 13.5% among those aged 60 or older.

Diabetes was more common among females (3.7%) than males (2.8%) and among individuals with no education (4.2%) compared to those with secondary or higher education (3.6%). By wealth quintile, prevalence was lowest among the poorest wealth quintile (1.5%) and highest among the richest (5.1%).

Table 10.14: Percentage of household members aged five years or older with diabetes and percentage seeking treatment, by background characteristics

	Reported prevalence	Treatment	N (unweighted)
Overall	3.3	3.2	127,194
Residence			
Rural	2.7	2.6	84,133
Urban	4.1	4.0	43,061
District type			
Lagging	1.9	1.8	34,884
Non-lagging	3.6	3.5	92,310
Age (years)			
5–14	0.0	0.0	34,984
15–29	0.2	0.1	38,215
30–44	2.6	2.4	25,623
45–59	11.2	11.0	17,147
60+	13.5	13.3	11,225
Sex			
Male	2.8	2.7	63,867
Female	3.7	3.7	63,327
Education			
No education	4.2	4.1	43,383
Primary/middle	2.4	2.3	53,949
Secondary or higher	3.6	3.6	29,862
Wealth quintiles			
Lowest	1.5	1.4	29,395
Second	2.6	2.6	26,283
Middle	3.0	3.0	25,352
Fourth	4.0	3.9	23,735
Highest	5.1	4.9	22,429

Among those who reported having diabetes, 97.7% sought treatment overall, including 97.1% in rural areas and 98.4% in urban areas (Table 10.15).

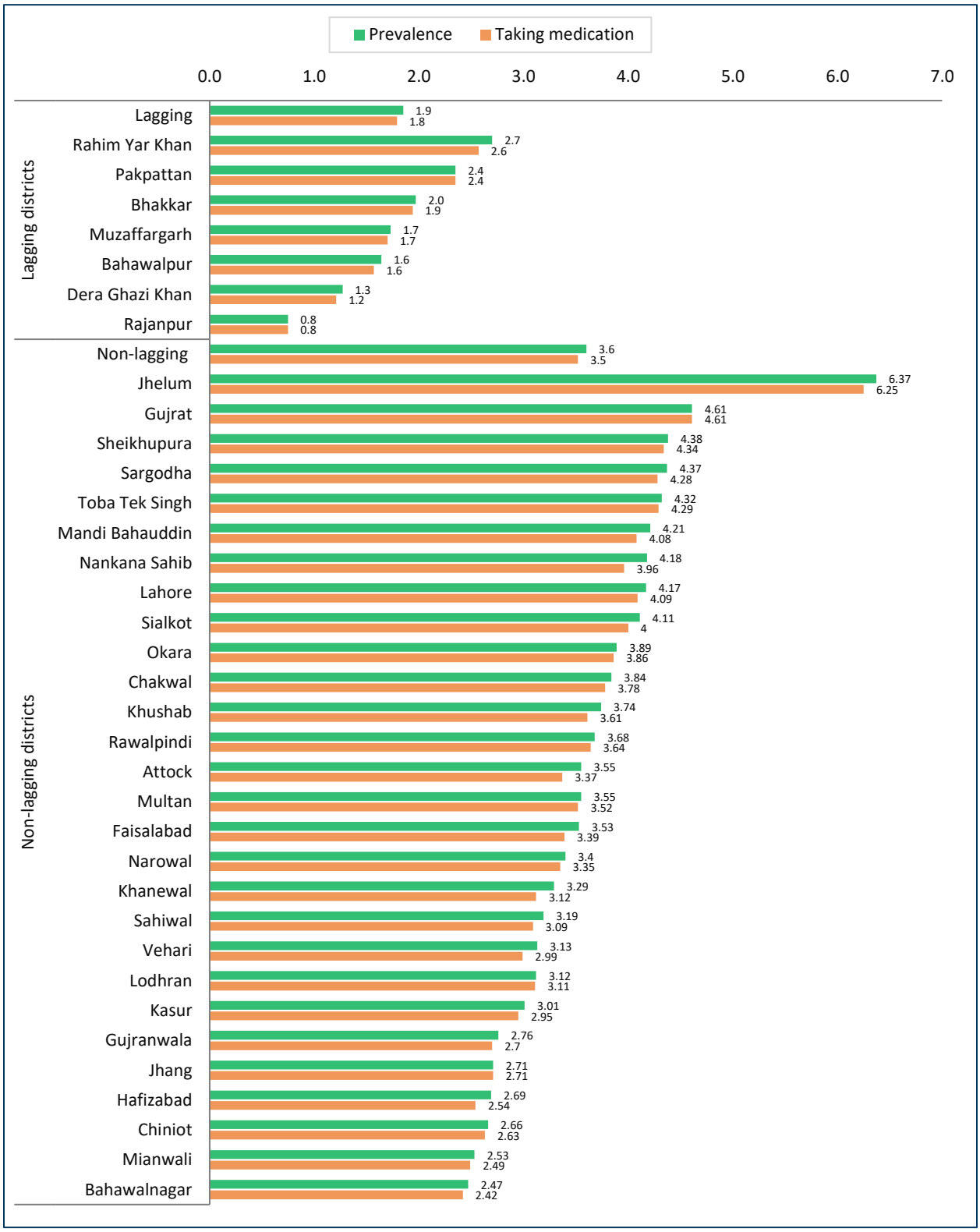
Private facilities were used by 56.4% of patients, while 28.2% utilized public health facilities. In rural areas, 58.6% opted for private facilities compared to 27.1% for public ones. In urban areas, 54.3% used private facilities, and 29.3% sought treatment from public health facilities.

Table 10.15: Percentage of household members aged five years or older who reported diabetes and who sought treatment

	Total	Rural	Urban
Treatment sought			
Yes	97.7	97.1	98.4
No	2.3	2.9	1.6
Total	**100.0**	**100.0**	**100.0**
Source of treatment			
Public facility	28.2	27.1	29.3
Private facility	56.4	58.6	54.3
Health workers	12.3	11.2	13.4
Others	2.5	2.5	2.5
Missing	0.6	0.6	0.6
Total	**100.0**	**100.0**	**100.0**
N (unweighted)	**3,888**	**2,146**	**1,742**

The prevalence of diabetes was reported as the lowest in the lagging district of Rajanpur (0.8%) and the highest in the non-lagging district of Jhelum (6.4%) (Figure 10.5). The reported prevalence rate of diabetes in lagging districts was about half that of the rate for non-lagging districts. In general, more affluent districts reported higher prevalence of diabetes.

Figure 10.5: Percentage of household members aged five years or older who reported diabetes and those who were taking medication, by district



11

Access to General Healthcare

Key Findings

Type of health facility frequently visited

- More household members visited private health facilities (57.3%) than public health facilities (33.8%) during their last health visit.
- Notably, 7.9% of household members did not visit any health care facility at all.
- In the poorest households, around 40% of members utilized public facilities, with no significant difference compared to private facilities. In contrast, among the wealthiest households, 67.9% used private facilities compared to just 24.6% using public facilities.
- The use of private facilities was more common in non-lagging districts than in lagging districts—59.8% vs. 46.7%.

Travel time to health facility

- On average, it took 20 minutes to reach a public health facility compared to 15 minutes for a private facility.
- Travel time in rural areas was about five minutes longer than in urban areas.
- Average travel time was five minutes shorter in non-lagging than lagging districts.

Costs of visit for healthcare

- The median cost incurred during the last healthcare visit was PKR 200 per visit and about the same for a public or private facility.
- Overall costs were lower in urban areas than in rural areas, and lower in lagging districts than in non-lagging districts.
- Transport and lab/test costs were higher for public facilities.

Mode of transport

- About 32.2% of visits to private facilities and 25.1% to public facilities were on foot; a slightly higher proportion of urban residents (33.0%) walked to a facility compared to rural residents (25.9%).
- Motorcycles were the most common mode of transport, used by 47.4% of household members overall, particularly in rural areas (51.7%) compared to urban areas (41.5%).

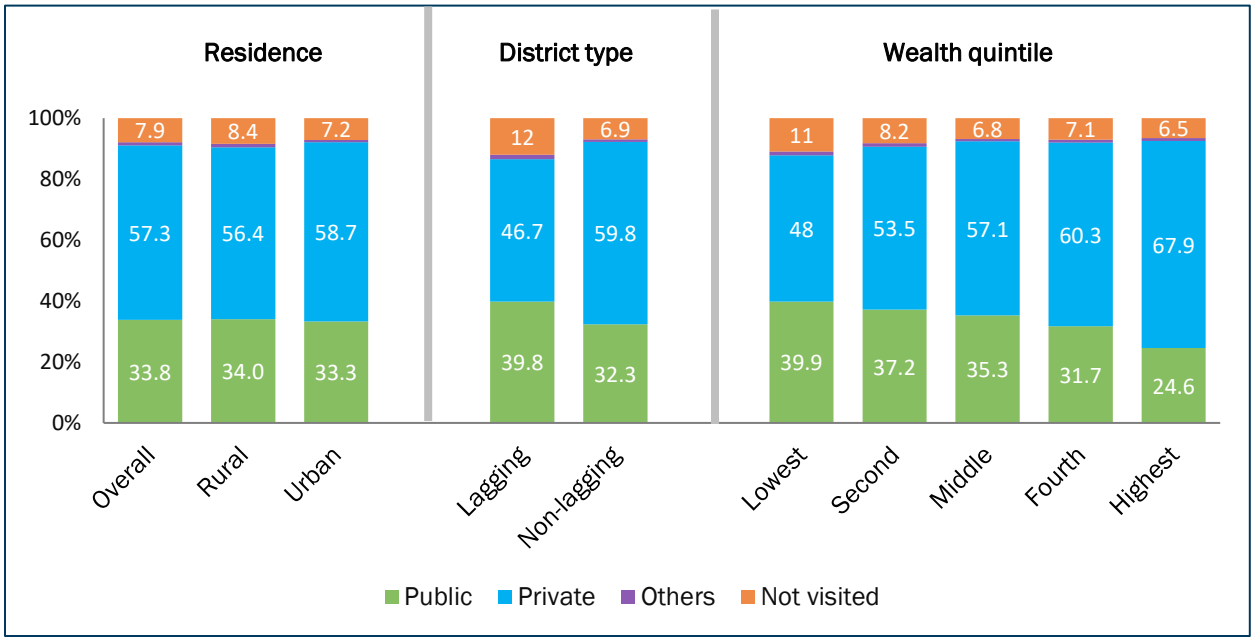
The household questionnaire collected information about household members' contact with the health system, including access, affordability, and facility preferences within the public and private sectors. Note that data for the chapters on maternal health, family planning, and infant and child health relied on information provided by women, but information on access to healthcare were provided by any responsible household member. While there is a caveat regarding proxy reporting for other members, the information remains valuable for assessing contact with Punjab's health system.

The first set of information pertains to where household members who had a health issue most recently sought care. Table 11.1 and Figure 11.1 show that most household members visited private facilities (57.3%) during their last visit, while 33.8% visited a public facility. Of great concern, 7.9% of household members did not visit any healthcare facility for general health issues.

Table 11.1: Percentage of household members visiting a facility most frequently during the last year (by type of facility and background characteristics)

	Type of facility					
	Public	Private	Others	Not Visited	Total	N
Overall	33.8	57.3	1.0	7.9	100.0	24,540
Residence						
Rural	34.0	56.4	1.2	8.4	100.0	15,952
Urban	33.3	58.7	0.7	7.2	100.0	8,588
District Type						
Lagging	39.8	46.7	1.5	12.0	100.0	6,585
Non-lagging	32.2	59.8	0.9	6.9	100.0	17,955
Wealth Index						
Lowest	39.9	48.0	1.2	11.0	100.0	5,967
Second	37.2	53.5	1.2	8.2	100.0	5,181
Middle	35.3	57.1	0.8	6.8	100.0	4,832
Fourth	31.7	60.3	0.9	7.1	100.0	4,433
Highest	24.6	67.9	1.0	6.5	100.0	4,127

Figure 11.1: Percentage of facilities most frequently visited during the last year, by type of facility



There were slight differences between rural and urban areas in this pattern. Rural households reported 34.0% use of public facilities and 56.4% use of private facilities, compared to 33.3% and 58.7%, respectively, in urban areas. Differences in access to health care by household wealth quintile were more pronounced: among the poorest households, 39.9% used public facilities, 48% used private facilities, and 11% did not use any facility. In contrast, among the wealthiest households in the highest income quintile, 24.6% used public facilities, 67.9% used private facilities, and only 6.5% did not seek care from the health system.

Differences between lagging and non-lagging districts were also notable. Lagging districts reported higher use of public facilities (39.8%) and lower use of private facilities (46.7%) compared to non-lagging districts (32.2% and 59.8%, respectively).

When public and private facilities were further categorized by level of facility, respondents in rural areas frequently visited primary healthcare facilities (16.7%), followed by first-level hospitals (14.7%) and tertiary-level/care facilities (2.2%) (Table 11.2).

In urban areas, first-level public hospitals were the most frequently used (19.4%), followed by primary healthcare facilities (7.6%) and tertiary-care facilities (6.2%). In the private sector, primary healthcare-level facilities were the most common in urban areas (18.9%) while dispenser clinics were most used in rural areas (21.3%). First-level public hospitals were the main facilities visited in lagging 21.5%) and non-lagging districts (15.5%). for general healthcare. Private primary healthcare level was the main option for 13.6% in lagging and 16.7% in non-lagging districts.

Table 11.2: Percent distribution of type of most frequently visited facility, by member of household in the last year

Essential Health Services Package coding	Residence		District type		Overall
	Rural	Urban	Lagging	Non-lagging	
Public	**34.0**	**33.3**	**39.8**	**32.2**	**33.8**
Community level	0.4	0.1	0.1	0.3	0.3
Primary healthcare level	16.7	7.6	15.8	12.2	12.9
First-level hospital	14.7	19.4	21.5	15.5	16.7
Tertiary level/care	2.2	6.2	2.4	4.2	3.9
Private	**56.4**	**58.7**	**46.7**	**59.8**	**57.3**
Community level	0.1	0.0	0.1	0.0	0.0
Pharmacy/chemist	5.8	10.5	5.2	8.4	7.8
Dispenser clinic	21.3	12.3	17.3	17.6	17.5
LHV*/nurse clinic	0.4	0.1	0.1	0.3	0.3
Primary healthcare level	14.1	18.9	13.6	16.7	16.1
First-level hospital	12.2	15.3	9.2	14.5	13.5
Hakim/homeopath	2.5	1.6	1.2	2.3	2.1
Others	**1.2**	**0.7**	**1.5**	**0.9**	**1.0**
Not visited	**8.4**	**7.2**	**12.0**	**6.9**	**7.9**
Total	100.0	100.0	100.0	100.0	100.0
No. of household members	**15,952**	**8,588**	**6,585**	**17,955**	**24,540**

Public sector - Community level: Mobile service unit, lady health worker,* community midwife.

Public sector - Primary healthcare level: Reproductive health center, basic health unit, maternal and child health center/family health center, government/civil dispensary.

Public sector - First-level hospital: District headquarters, *tehsil* headquarters, type-D health facility, reproductive health services center - type A, family welfare center, family welfare worker, family welfare counselor, family welfare assistant. Public sector - Tertiary level/care: Teaching hospital.

Private sector - Community level: Vaccinator, NGO worker, etc.

Private sector - Primary healthcare level: Private male/female MBBS doctor clinic, Greenstar Social Marketing clinic, NGO clinic.

Private sector - First-level hospital: Private hospital with inpatient facility.

Access is primarily defined by how long it takes to reach health facilities. Table 11.3 shows distribution of travel time to the most frequently visited health facility by background characteristics. Less than half of rural inhabitants (42.9%) visited a facility within 15 minutes, compared to 64.1% of urban inhabitants. Additionally, 9.7% of rural residents traveled more than an hour to reach a health facility, compared to 3.5% of urban residents.

Table 11.3: Percentage of household members by time (minutes) to reach their most frequently visited health facility, by background characteristics

Household characteristics	One-way time to reach (in minutes)				Total		Median (in Min)
	0–15	16–30	31–60	60+	%	n	
Residence							
Rural	42.9	29.8	17.6	9.7	100.0	14,132	20.0
Urban	64.1	27.0	5.4	3.5	100.0	7,725	15.0
District type							
Lagging	39.1	34.7	15.6	10.7	100.0	5,524	20.0
Non-lagging	54.7	27.3	11.7	6.3	100.0	16,333	15.0
Facility type							
Public	37.0	36.7	17.3	9.1	100.0	8,195	20.0
Private	60.8	24.0	9.5	5.6	100.0	13,442	15.0
Others	42.6	20.4	14.7	22.3	100.0	220	25.0
Wealth index							
Lowest	43.5	32.5	14.5	9.5	100.0	5,093	20.0
Second	51.4	29.2	13.1	6.3	100.0	4,615	15.0
Middle	53.7	28.2	11.4	6.7	100.0	4,358	15.0
Fourth	55.2	26.2	11.7	6.9	100.0	4,029	15.0
Highest	55.1	27.3	11.5	6.0	100.0	3,762	15.0

Nearly 43.5% belonging to the lowest wealth index are able to reach a health facility within 15 minutes of traveling, as compared to 55.1% of the highest wealth quintile. The median time by background characteristics was 5 minutes longer in rural areas compared to urban areas, in lagging compared non-lagging districts and to a public facility compared to a private facility.

Table 11.4 gives another view of time to reach a facility by level of public and private facilities accessed frequently. The findings show that 82.0% of private pharmacy level facilities and 77.3% of dispenser level clinics are within 15 minutes of one-way travel time from the household. This supports the preference for private sector health services, as private pharmacies are generally located nearer and reliance on directly taking medicines from pharmacies is prevalent.

The primary healthcare level facilities, where an MBBS physician is available, have an equal median travel time for reaching a public or private facility (15 minutes). The reported median time varies for first-level hospitals. Nearly 37% of households can reach a private first-level hospital, while another 10% say that the time is more than one hour. The median travel time to a private first-level hospital is five minutes shorter than first-level hospitals in public sector (25 minutes vs. 30 minutes). The public sector tertiary-level/care hospitals are relatively and understandably farthest. While the median time is 30 minutes, nearly 25% report more than one hour to tertiary level care.

Table 11.4: Percentage of household members by time taken (in minutes) to reach their most frequently visited health facility, by type of facility

Essential Health Services Package coding	One-way time to reach (in minutes)				Total		Median (in Min)
	0–15	16–30	31–60	61–hi	%	n	
Public	**37.0**	**36.7**	**17.3**	**9.1**	**100.0**	**8,195**	**20.0**
Community level	86.6	12.3	0.6	0.5	100.0	51	5.0
Primary healthcare level	50.9	35.1	11.1	2.9	100.0	3,021	15.0
First-level hospital	28.8	39.4	21.5	10.3	100.0	4,548	30.0
Tertiary level/care	22.6	32.2	20.6	24.6	100.0	575	30.0
Private	**60.8**	**24.0**	**9.5**	**5.6**	**100.0**	**13,442**	**15.0**
Community level	88.9	6.3	4.8	0.0	100.0	8	10.0
Pharmacy/chemist	82.9	13.5	2.9	0.6	100.0	1,726	10.0
Dispenser clinic	77.3	18.8	3.2	0.7	100.0	4,311	10.0
LHV/nurse clinic	70.7	24.9	4.4	0.0	100.0	61	12.0
Primary healthcare level	52.3	28.6	12.3	6.8	100.0	3,632	15.0
First-level hospital	36.5	31.5	18.4	13.5	100.0	3,096	25.0
Hakim/homeopath	61.8	23.1	8.8	6.3	100.0	608	15.0

We also collected unique information on costs incurred for general health ailments by household members over the past year. A notable finding was that household members incurred the same median cost of PKR 200 for healthcare—using either government or private facilities (Table 11.5).

The average cost for rural residents was higher (PKR 250) than for urban residents (PKR 200). The median cost in lagging districts was also higher (PKR 300) compared to non-lagging districts (PKR 200). The availability of free care was moderate: 46.6% overall, 47.6% in public, and 45.9% in private facilities.

Table 11.5: Percentage of household members who last visited a healthcare facility, by costs incurred and background characteristics

	Total cost (PKR)						Total		Total cost
	Free	500 or less	501–1,500	1,501–2,500	2,501–3,500	3,501 or more	%	n	Median total cost
Residence									
Rural	46.0	14.8	13.2	7.0	3.9	15.0	100.0	12,832	250
Urban	47.3	15.3	14.4	7.0	3.5	12.5	100.0	7,063	200
Overall	46.6	15.0	13.7	7.0	3.7	14.0	100.0	19,895	200
District type									
Lagging	45.7	12.5	14.2	7.5	4.0	16.2	100.0	4,693	300
Non-lagging	46.8	15.5	13.6	6.9	3.7	13.5	100.0	15,202	200
Last facility type									
Public	47.6	13.4	13.5	7.2	3.9	14.4	100.0	8,930	200
Private	45.9	16.2	14.0	6.8	3.6	13.4	100.0	10,423	200

The distribution of costs for various items did not differ significantly between public or private facilities. The average cost for any category—total, transport, or lab/test—was PKR 200 in both sectors, with no reported costs for transport and lab/tests (Table 11.6). Medicine and beds also showed no difference: the same average cost was PKR 250 for both sectors, while beds incurred no cost. Overall, visiting a private facility does not appear to be significantly more expensive than visiting a public facility.

Table 11.6: Percentage of household members who incurred costs, by services paid for and type of facility last visited

	Percentage who paid at:		Overall	Median amount (PKR) paid at:		Overall
Type of cost	Public	Private		Public	Private	
Any cost	52.4	54.1	53.4	200	200	200
Transport	48.9	39.1	43.3	0	0	0
Fee	27.3	33.5	30.8	0	0	0
Medicine	56.4	59.0	57.9	250	250	250
Lab/test	10.8	9.1	9.9	0	0	0
Operation	0.8	0.9	0.8	0	0	0
Bed	0.7	0.7	0.7	0	0	0
Other	8.0	4.2	5.8	0	0	0
N (unweighted)	10,734	12,557	23,291	10,734	12,557	23,291

Another dimension of healthcare accessibility is the mode of transport used to reach facilities (Table 11.7). Motorcycles were the most common mode, used by 47.4% of all household members: 47.6% for public and 47.3% for private facilities. Motorcycle use was more prevalent in rural (51.7%) than in urban areas (41.5%), and significantly higher in lagging (63.7%) compared to non-lagging districts (43.8%).

Overall, 28.9% accessed facilities on foot: 32.2% for private and 25.1% for public facilities. Walking was more common in urban areas (33.0%) than rural areas (25.9%), and in non-lagging (31.6%) compared to lagging districts (16.4%).

Rickshaws/Chingchi were used by 11.7% of respondents—13.3% for public and 10.5% for private facilities—with higher use in urban (14.8%) than in rural areas (9.4%), and in non-lagging (12.5%) than lagging districts (8.2%).

Buses/vans were used by 6.0% of those visiting a health facility—7.8% for public facilities and 4.4% for private facilities—with higher usage in rural (8.0%) than urban areas (3.2%), and slightly higher in lagging (7.3%) compared to non-lagging districts (5.7%).

Cars were used by 5.1% overall, slightly more in urban (6.6%) than rural areas (3.9%), and more in non-lagging (5.5%) than lagging districts (3.3%). Car use did not differ substantially between public (5.2%) or private facilities (4.8%).

The median total cost of using either facility was around PKR 200, with little difference between sectors. While fewer patients reported paying fees and operation costs were lower in public facilities, medicine and bed costs were slightly higher compared to private facilities. Overall, based on both total and itemized costs, public facilities in Punjab did not appear to be a substantially cheaper option compared to private facilities.

Table 11.7: Percent distribution of household members, by type of transport used last time

	Last facility type		Residence		District type		
	Public	Private	Rural	Urban	Lagging	Non-lagging	Overall
On foot	25.1	32.2	25.9	33.0	16.4	31.6	28.9
Motorcycle	47.6	47.3	51.7	41.5	63.7	43.8	47.4
Rickshaw/chingchi	13.3	10.5	9.4	14.8	8.2	12.5	11.7
Bus/van	7.8	4.4	8.0	3.2	7.3	5.7	6.0
Car	5.2	4.8	3.9	6.6	3.3	5.5	5.1
Other (specify)	0.7	0.6	0.7	0.5	0.7	0.6	0.6
Don't know	0.3	0.2	0.3	0.3	0.5	0.3	0.3
Overall %	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N (unweighted)	**9,964**	**11,720**	**14,436**	**7,887**	**5,684**	**16,639**	**22,323**

12

Service Coverage Index (SCI)

Key Findings

Overall performance (Service Coverage Index)

- The Service Coverage Index (SCI) for the province was 64.2 points, indicating low access to essential health services.
- The SCI was calculated using the geometric mean of scores across three dimensions:
    1. Reproductive, maternal, newborn, and child health (RMNCH)
    2. Infectious diseases (IDs)
    3. Noncommunicable diseases (NCDs)

Dimension 1: Reproductive, maternal, newborn, and child health (RMNCH)

- The RMNCH score was 64.1 points.
- There is significant difference between urban (68.4 points) and rural (61.0 points) residence.
- Lagging districts had a significantly lower RMNCH score (50.2 points), indicating major gaps in family planning, antenatal care, immunization, and child treatment services.

Dimension 2: Infectious diseases score

- The infectious diseases score was the lowest-performing dimension at 50.1 points.
- Rural areas scored higher (53.8 points) than urban areas (46.1 points).
- Non-lagging districts scored higher (52.3 points) than lagging districts (39.3 points), highlighting the need for focused efforts in lagging districts.

Dimension 3: Noncommunicable diseases score

- The overall noncommunicable diseases score was highest at 82.4 points among the three dimensions of SCI.
- The score was higher in urban areas at 85.3 points, compared to 80.0 points in rural areas.

The first output indicator of the National Health Support Program's (NHSP) project development objectives is the SCI, a composite measure of access to essential health services. Project Development Objective 1, the NHSP SCI, was constructed from independent indicators pooled under the following three dimensions to develop a viable index of health sector performance. The NHSP household and ever-married women questionnaires collected data on several tracer indicators of health-seeking behavior, enabling the construction of the NHSP SCI.[16]

Scores were calculated for each dimension, and the SCI was estimated by taking the geometric mean of the dimension's score. Higher values, expressed as points ranging from 0 to 100, indicate better performance. The dimensions and their independent indicators are as follows:

Dimension 1: Reproductive, maternal, newborn, and child health (core)

1. **Family planning:** Percentage of need satisfied with modern methods.
2. **Pregnancy and delivery care:** Percentage of women who received antenatal care four or more times during pregnancy.
3. **Child immunization:** Percentage of infants receiving three doses of diphtheria, pertussis, and tetanus (DPT)-containing vaccine.
4. **Child treatment:** Percentage of children under five years taken to a health facility/provider.

Dimension 2: Infectious diseases score

5. **Tuberculosis:** Percentage of cases detected and treated.
6. **Malaria:** Percentage of the population sleeping under an insecticide-treated net.
7. **Water and sanitation:** Percentage of households using improved water and sanitation facilities.[17]

Dimension 3: Noncommunicable diseases score

8. **Hypertension:** Percentage taking medication for hypertension.
9. **Diabetes:** Percentage taking medication for diabetes.
10. **Tobacco:** Percentage not smoking tobacco.

---

[16] The Universal Health Coverage SCI is ideally based on 14 independent health sector surveys, as outlined in the methodology of Sustainable Development Goal (SDG) indicator 3.8.1. Since the PHPS is a household-based survey, the indicators for hospital beds per capita, health workforce, and health security were unavailable. While the NHSP SCI follows the computation methodology of SDG 3.8.1, it is limited to the indicators available in the PHPS.

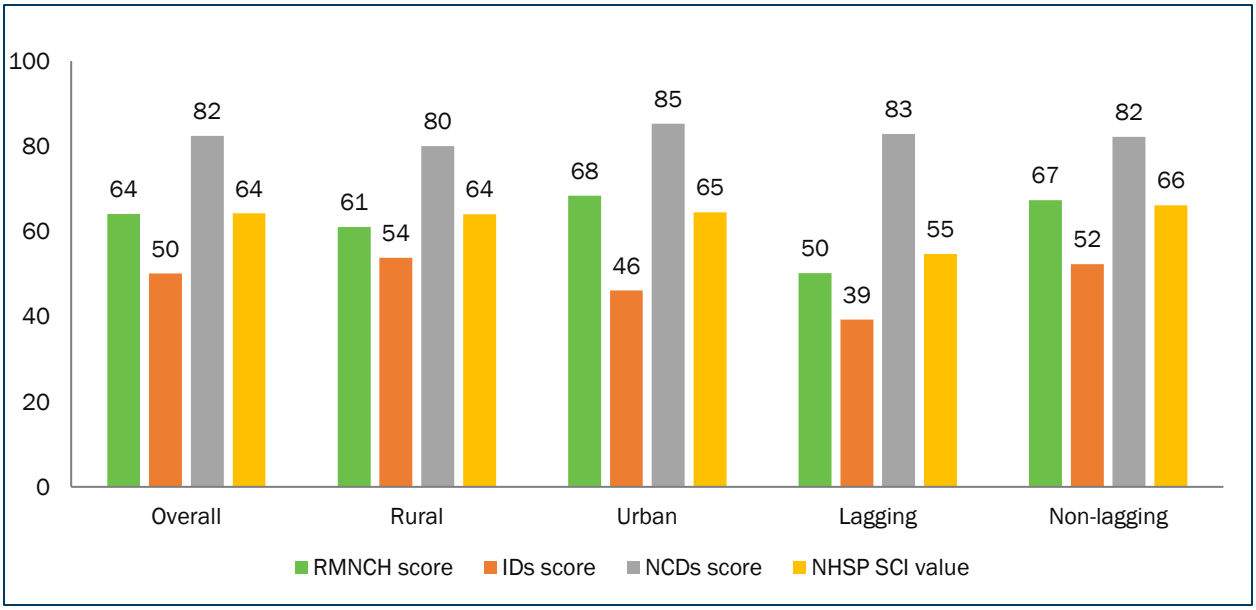
[17] Improved sanitation facilities include wet sanitation technologies, such as flush and pour-flush toilets connected to sewers, septic tanks, or pit latrines, and dry sanitation technologies, such as dry pit latrines with slabs and composting toilets.

Baseline data on each dimension score and the overall SCI are presented in Table 12.1 and Figure 12.1. The overall SCI for the province of Punjab was 46.1 points. The IDs score was the lowest at 50.1 points, underscoring the need for targeted strategies and interventions to control IDs. The RMNCH score was moderate at 64.1 points, highlighting the importance of continued improvements in modern contraceptive use and maternal, newborn, and child health services. Performance on addressing NCDs was stronger relative to the other dimensions.

Table 12.1: Dimension scores and service coverage index

	RMNCH score	ID score	NCD score	NHSP SCI value
Overall	64.1	50.1	82.4	64.2
Residence				
Rural	61.0	53.8	80.0	64.0
Urban	68.4	46.1	85.3	64.5
District type				
Lagging	50.2	39.3	82.9	54.7
Non-lagging	67.3	52.3	82.2	66.1

Figure 12.1: Dimension scores, by rural/urban and lagging/non-lagging



Rural-urban differentials were minimal (Table 12.1 and Figure 12.1). However, the RMNCH score was seven percentage points lower in rural areas (61.0 points). This indicates that rural areas face greater challenges in family planning, maternal, newborn, and child health than urban areas (68.4 points).

The IDs score showed that the baseline performance of the health sector was better among rural residents (53.8 points) than urban residents (46.1 points), highlighting higher risks or challenges in managing IDs in urban areas.

However, NCDs were addressed more effectively in urban areas (85.3 points) compared to rural areas (80.0 points).

The lagging districts had the lowest overall SCI value (54.7 points). These districts faced challenges in infectious diseases score (39.3 points), contributing to lower performance in Punjab, followed by the RMNCH (50.2 points). The score for IDs was better in non-lagging districts (52.3 points) compared to lagging districts (39.3 points).

The overall SCI and its individual scores suggest that targeted interventions in lagging and rural areas are necessary to improve healthcare access, quality, and outcomes for maternal, newborn, and child health, as well as to address IDs more effectively. IDs require significantly more concentrated attention than they have received so far.

13

Way Forward

The immediate objectives of PHPS 2024-25 were to collect baseline data for NHSP and World Bank Punjab Family Planning Program PDOs and DLIs. However, the ultimate objective was for such data to be utilized for evidence-informed policies, programs and interventions. Various chapters indicate implications for actions based on the findings of PHPS.

Significant improvements have taken place in Punjab, especially in maternal health care and child immunization. Yet major gaps in coverage, equity and empowerment continue to persist and need to be addressed.

While 90% of women with a live birth in three years prior to the survey report at least one ANC visit, only 46% report WHO-recommended 4 or more visits. About 50% of women marry before the age of 20 years which jeopardizes their higher education and work participation. One-in-five girls and boys in the age group 5-9 years are out-of-school. Other issues such as the non-availability of a provider, lack of vaccines, service hours not known, among others, were identified by respondents for not being able to immunize their child. Similarly, not knowing the place to procure a contraceptive method was indicated by women who knew a method and were not using it-indicating the need for more information dissemination. Specific interventions for behavior change and health reforms are indicated in different chapters.

The findings suggest that Punjab will have to continue to make progress across all areas and subgroups of population-but certain groups need to be especially targeted. These groups include women and children in rural areas, lagging districts and in the poorest households. Women with no education, in younger ages and poorest need to be prioritized within these targeted groups for improving health outcomes and addressing inequities.

For improving women's health and for reducing maternal mortality we recommend that strengthening the quality of maternity care and increasing contraceptive use is paramount. Globally, it has been shown that 61·2% of the maternal mortality decline between 2000 and 2023 was attributed to improvements in maternity care (through skilled-birth attendant, facility delivery) and 38·8% to fertility reduction through contraceptive use[18] For Pakistan, 72.9% of reduction in maternal mortality was attributed to improvements in maternity care and 27.1% to fertility reduction due to increased contraceptive use. This shows that despite its well-known health and socio-economic benefits, raising

[18] Ahmad, Saifuddin, Moazzam Ali, Iqbal Shah, Amy Tsui. 2025. Effect of maternity care improvement, fertility decline, and contraceptive use on global maternal mortality reduction between 2000-2023: results from a decomposition analysis. *Lancet Global Health*.

contraceptive use in Pakistan overall and in Punjab continues to pose a formidable challenge requiring intensified efforts and commitments. The recent integration of Health and Population Department and the offering of combined services is a promising opportunity for improving the record on family planning services and their use in Punjab.

All districts regardless of whether they are lagging or non-lagging require continued improvements in access to quality health services. However, it is important to prioritize districts that are substantially behind others on health indicators and access. We identify these districts in Table 13.1 for priority attention by district health officials, provincial authorities, donors and other stakeholders. Some districts, for example, Rajanpur and Dera Gazi Khan, are disadvantaged on multiple indicators requiring a comprehensive and integrated program and interventions.

Table 13.1: Districts with weak health indicators

Indicator	District (%)
Low Proportions who go for 4 or more ANC visits	Dera Ghazi Khan (15.3%), Rajanpur (14.3%), Muzaffargarh (19.6%)
Low Effective ANC*	Dera Ghazi Khan (0.4%), Rajanpur (7.0%), Muzaffargarh (1.5%)
Fewer Deliveries assisted by skilled birth attendants	Dera Ghazi Khan (59.4%), Rajanpur (68.4%)
Low receipt of post-natal care checks up	Dera Ghazi Khan (23.2%), Lodhran (19.3%), Rajanpur (31.1%)
Low prevalence of modern contraceptive use (mCPR)	Dera Ghazi Khan (16.5%), Rajanpur (16.7%). Mianwali (18.6%), Rahim Yar Khan (19.4%)
High fertility (average number of children ever born)	Muzaffargarh (3.7), Dera Ghazi Khan (3.7)
High unmet need for family planning	Dera Ghazi Khan (37%), Layyah (36%). Sialkot (34%)
No postpartum family planning counselling	Mandi Bahauddin, Dera Ghazi Khan, Mianwali
Low Penta-1 Immunization	Dera Ghazi Khan (69.7%)
Low full immunization coverage (FIC)	Dera Ghazi Khan (60.8%)
High vulnerability to disasters or hardship	Khanewal (56.0%), Bahawalnagar (49.0%)
Low availability of improved sanitation service	Rajanpur (45%), Dera Ghazi Khan (30.0%)
High percentage of out-of-school boys (5-9 years) High percentage of out-of-school girls (5-9 years)	Rajanpur (47%), Dera Ghazi Khan (43%) Rajanpur (51%), Dera Ghazi Khan (44%)

*"Effective ANC" is defined as coverage that includes: (1) at least four ANC visits; (2) iron and folic acid supplementation; (3) at least two tetanus injections; (4) blood pressure measurement; and (5) urine sample collection.

Annex A: Data Management and Use of Technology

Computer-assisted personal interview (CAPI) Development

The survey questionnaires were translated into Urdu after finalization. A CAPI application was developed using CSPro, a globally recognized software for managing complex survey data, based on both the English and Urdu versions. The HPS survey design required a multi-record structure, including a household roster and modules for household-level data and eligible women's data. CSPro was chosen for its capability to handle hierarchical file structures, complex skip logic, and indexing across multiple levels of respondents.

Selecting appropriate hardware, including considerations for internet connectivity, storage, memory, and screen size, was essential to ensure the smooth functioning of the CAPI application in the field. In situations where the CAPI system was unavailable, a desktop data entry application in CSPro was developed to maintain continuity using paper-based forms. A detailed CAPI manual was also developed and provided to field teams.

The CAPI application was deployed on Android-based tablets, which were configured to run the full bilingual version of the questionnaires. However, in practice, enumerators primarily used the Urdu version to facilitate communication and comprehension among respondents.

Beyond data capture, the CAPI system served as a key data quality assurance tool, helping to reduce entry errors and ensure real-time consistency. The system featured a wide range of validation and quality control mechanisms, such as:

- Range checks; skip-and-fill rules
- Inter- and intra-record consistency checks with a table lookup function
- Support for long strings for verbatim responses of "others"
- Screen design to minimize scrolling strain and match the questionnaire layout.
- Error alerts (beeps) with user and system messages
- Separate entry, edit, verification, and double-entry mode (for paper-based questionnaires)
- Operator statistics, including user, keystroke, and error logs.
- Report/log generation identifying interviewers and data entry operators.

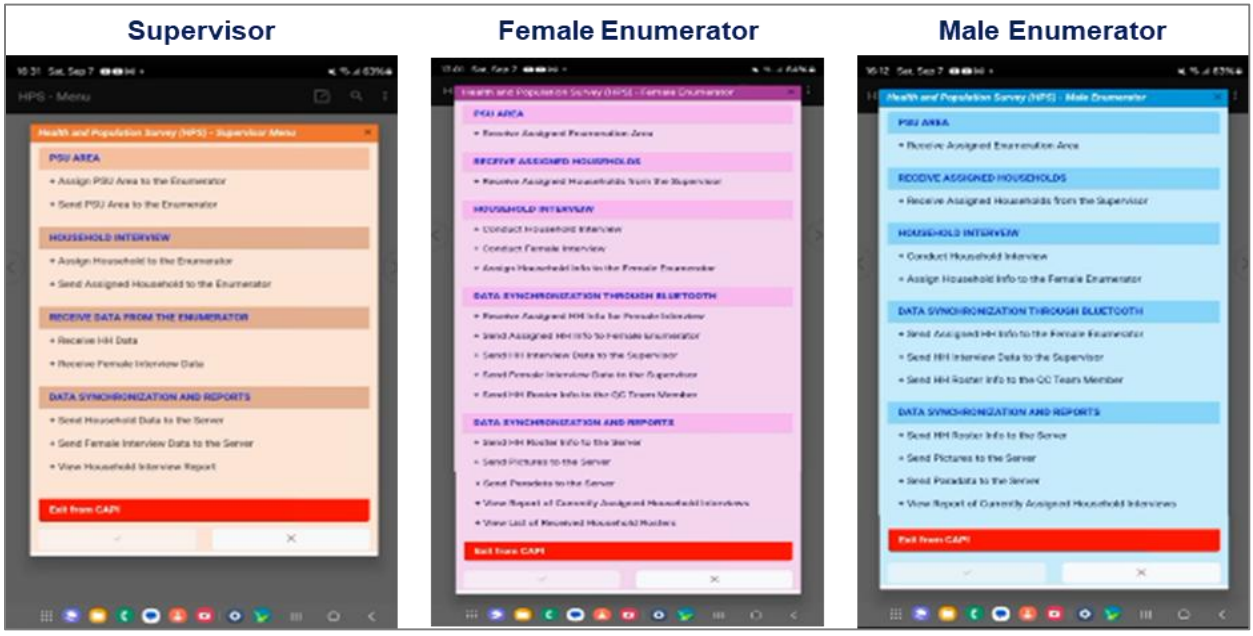
- Capability to import data into various database formats, particularly SPSS and Stata, with proper labeling and metadata.
- CSPro's para data files and survey management information

These features enabled the real-time identification of errors and inconsistencies during data collection, significantly enhancing overall data quality. The final output of the data management process was a clean dataset, accompanied by a database schema, codebook, and post-coded open-ended responses, all ready for analysis and reporting.

Server Setup and CAPI Deployment

To facilitate real-time data transmission and monitoring, a CSWeb server was deployed as the central platform for receiving and managing incoming data from the field. This secure server enabled data collected via the CAPI application to be transmitted directly from field teams to a centralized database in real time. While the CAPI system supported real-time data submission, it was also designed to function effectively in low or non-connectivity environments. In such cases, the application stored completed interviews locally on the device and synchronized with the CSWeb server once internet connectivity was restored. This functionality ensured uninterrupted data collection and seamless integration with the central server.

Figure A-1: Main CAPI screens for team supervisors and female and male enumerators



Listing Data Processing and Integration

Listing data was received from the BoSP during the preparatory phase. This data included the complete list of households within each selected PSU. The listing information was processed centrally to ensure accuracy, completeness, and consistency. Subsequently, using a systematic random sampling technique, 20 households per PSU were selected as the final sample for the main survey. Once the selection process was complete, the processed listing data was integrated into the CAPI

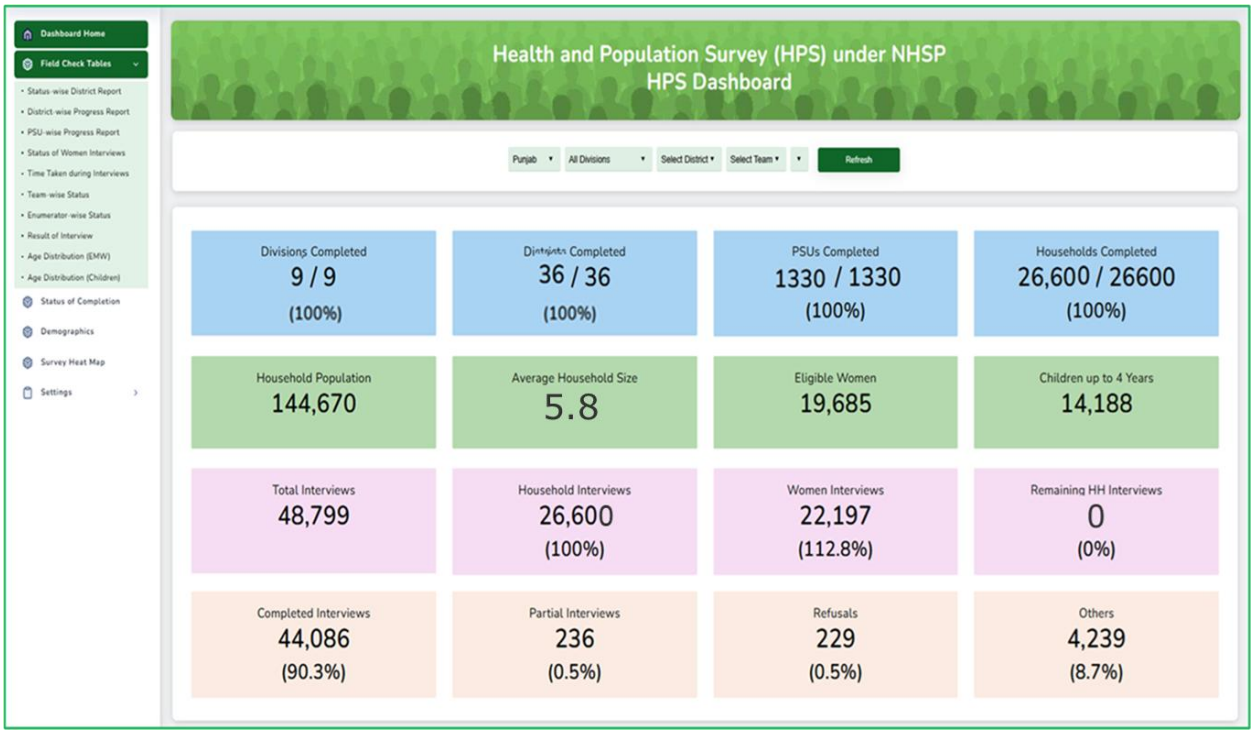
application, allowing team supervisors and enumerators to access preloaded household information in the field. This integration streamlined household identification, reduced field errors, and ensured adherence to the sampling design.

HPS Dashboard Development

A customized HPS dashboard was developed and deployed on the same server as the CSWeb platform to support real-time data monitoring and quality control (Figure B). The dashboard served as a central monitoring tool and was actively used by team supervisors, BoSP, PCP, and PC. It provided live updates on survey progress by capturing and visualizing incoming data from the field in real time.

In addition to tracking progress, the dashboard was instrumental in maintaining data quality standards throughout the fieldwork. It allowed supervisors and technical teams from the BoS to generate detailed reports by district, team, enumerator, and PSU. These reports showed key metrics, including the number of completed household interviews, eligible women interviewed, and children under five years covered in each PSU and household. The dashboard also captured the time taken by enumerators to complete each interview, helping to identify unusually short or long durations that could indicate quality issues or inconsistencies. This level of real-time visibility enabled timely interventions, supported field supervision, and ensured adherence to the survey protocol.

Figure A-2: Homepage of the HPS dashboard showing survey stats based on real-time data.



Annex B: Sampling Error Tables

Table B-1: Average Household Size (Mean member per household)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Mean Members	5.79	0.026	5.74	5.84	2.523	24,540
Residence						
Rural	5.92	0.033	5.86	5.99	2.195	15,952
Urban	5.61	0.041	5.53	5.69	3.091	8,588
District type						
Lagging	5.92	0.064	5.79	6.04	2.533	6,585
Non-lagging	5.76	0.029	5.71	5.82	2.549	17,955

Table B-2: Antenatal Care (ANC): Any Visit (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	90.00	0.494	89.03	90.97	2.090	7,693
Residence						
Rural	88.41	0.644	87.14	89.67	1.915	5,270
Urban	92.56	0.749	91.09	94.03	2.411	2,423
District type						
Lagging	79.71	1.290	77.18	82.24	1.685	2,321
Non- lagging	92.79	0.488	91.83	93.74	2.155	5,372

Table B-3: Effective Antenatal Care (eANC)* (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	18.28	0.769	16.77	19.79	3.047	7,693
Residence						
Rural	14.04	0.787	12.50	15.58	2.433	5,270
Urban	25.06	1.506	22.10	28.01	3.580	2,423
District type						
Lagging	6.12	0.671	4.80	7.43	1.286	2,321
Non-lagging	21.57	0.927	19.75	23.38	3.077	5,372

* At least four ANC visits, receipt of iron supplementation and at least two tetanus injections, and blood pressure and urine samples taken

Table B-4: Contraceptive Prevalence Rate: Any Method (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	38.21	0.687	36.86	39.56	3.718	18,600
Residence						
Rural	34.52	0.720	33.10	35.93	2.502	12,259
Urban	43.44	1.209	41.07	45.81	4.579	6,341
District type						
Lagging	30.77	1.288	28.24	33.30	2.798	5,209
Non-lagging	39.99	0.778	38.46	41.51	3.791	13,391

Table B-5: Contraceptive Prevalence of Modern Methods (mCPR) (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	29.45	0.593	28.29	30.62	3.155	18,600
Residence						
Rural	27.27	0.656	25.99	28.56	2.371	12,259
Urban	32.54	1.050	30.48	34.60	3.868	6,341
District type						
Lagging	24.75	1.060	22.67	26.83	2.169	5,209
Non-lagging	30.58	0.682	29.24	31.91	3.292	13,391

Table B-6: Acute Respiratory Infection (ARI) Prevalence (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	6.51	0.332	5.86	7.16	1.751	9,652
Residence						
Rural	6.93	0.406	6.13	7.72	1.503	6,572
Urban	5.86	0.553	4.77	6.94	2.093	3,080
District type						
Lagging	6.85	0.560	5.75	7.95	1.011	2,929
Non-lagging	6.42	0.393	5.65	7.19	1.959	6,723

Table B-7: Acute Respiratory Infection (A) Treatment (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	5.41	0.301	4.82	6.00	1.707	9,652
Residence						
Rural	5.76	0.373	5.03	6.50	1.509	6,572
Urban	4.86	0.491	3.90	5.83	1.973	3,080
District type						
Lagging	5.88	0.515	4.87	6.90	0.988	2,929
Non lagging	5.28	0.355	4.59	5.98	1.914	6,723

Table B-8: Pentavalent 1st Dose Vaccination, age 12–23 months (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	94.56	0.586	93.41	95.71	2.556	3,825
Residence						
Rural	94.57	0.603	93.39	95.76	1.672	2,619
Urban	94.54	1.182	92.22	96.86	3.969	1,206
District Type						
Lagging	91.13	1.226	88.73	93.54	1.442	1,080
Non-Lagging	95.43	0.669	94.12	96.75	3.137	2,745

Table B-9: Full Immunization Coverage, age 12–23 months—Received All 8 classic EPI doses (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	88.61	0.767	87.11	90.12	2.229	3,825
Residence						
Rural	88.69	0.850	87.02	90.36	1.700	2,619
Urban	88.49	1.459	85.63	91.35	3.063	1,206
District Type						
Lagging	83.27	1.493	80.34	86.19	1.241	1,080
Non-Lagging	89.97	0.881	88.24	91.70	2.626	2,745

Table B-10: Improved Water Source (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	98.69	0.166	98.37	99.02	5.277	24,552
Residence						
Rural	98.55	0.236	98.09	99.02	5.562	15,961
Urban	98.89	0.226	98.44	99.33	4.761	8,591
District type						
Lagging	98.29	0.450	97.40	99.17	5.594	6,589
Non lagging	98.79	0.177	98.44	99.13	5.188	17,963

Table B-11: Improved Sanitation (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	82.76	0.610	81.56	83.95	6.398	24,552
Residence						
Rural	77.00	0.825	75.38	78.62	5.483	15,961
Urban	90.73	0.698	89.36	92.10	5.970	8,591
District type						
Lagging	68.39	1.569	65.31	71.47	5.309	6,589
Non lagging	86.12	0.612	84.92	87.32	6.248	17,963

Annex C: Survey Questionnaires

Processing ID [To be filled by interviewer]

				Yes---1 No---2													
A01 Province code		**A02** District code		**A03** Is this lagging district		**A04** PSU ID number				**A05** HH number from PSU list			**A06** HH serial number				

[Province name]

Health and Population Survey ([P]HPS)

2024

HPS Household (HH) Questionnaire

Eligible Respondent: HH Head or person identified by the initial respondent.

Section A: Informed consent and household identification

Household Identification

Q.No.	Questions and Filters	Responses and Codes
A07	Timeline of interview	Baseline..... **(Go to A09)** ..... 1 Endline..... 2
A07a	PSU code [Enter the PSU code from the list]	__|__|__|__
A07b	Block code [The block code in the list will be entered automatically in the key]	__|__|__|__
A08	Panel status of PSU (To be filled in endline)	Panel PSU ..... 1 Baseline PSU only ..... 2 Endline PSU only 3
A09	Name of province/region	Punjab..... 1 Sindh..... 2 Khyber Pakhtunkhwa (KP)..... 3 Balochistan..... 4 Azad Jammu & Kashmir (AJK) ..... 5 Gilgit Baltistan (GB)..... 6 Islamabad Capital Territory (ICT) 7
A10	Name and code of district	a) Name: _____ b) Code: ..... __|__|__
A11	Is this a lagging/ zero dose district? **[Interviewer: Please don't ask]**	Yes .....1 No.....2
A12	Name of tehsil	Name: _____
A13	Name of union council	Name: _____
A14	Name and code of community [Enter PSU code]	
A15	Is this area Katchi Abadi? [Interviewer: Observe don't ask]	Yes .....1 No.....2

Q.No.	Questions and Filters	Responses and Codes
A16	Complete postal address of household (Interviewer: ask from the respondent) a) House #, _____ b) Street #, _____ c) Mohallah, _____ d) Dhoke/ Village/ City _____	
A17	Household number (from the PSU list)	__|__|__
A18	Household serial number	__|__
A19a	Write the name of the Head of Household as per HH Listing	Name _____
A19b	What is the name of the head of your household?	
A19c	Is the name the same in A19a and A19b?	Yes..... **(Go to A19e)** .....1 No 2
A19d	Why is there a difference between the name of the head of household given during HH Listing, and the name you have given now?	We don't know [name].....01 [Name] was never part of the household.....02 [Name] have changed residence.....03 [Name] have separated the household .....04 [Name] have recently passed away .....05 [Name] passed away a long time ago .....06 Others **[Specify]** 96
A19e	[Write down the ID of the Head of Household from the Roster]	

Q.No.	Questions and Filters	Responses and Codes
A20	Day / Month / Year of interview	__|__: __|__:|2024 dd mm yyyy
A21	Time of starting interview [24-hour format]	__|__:__|__ Hours: Minutes
A22	Interview mode	FTF PAPI..... 1 FTF CAPI..... 2 Telephonic 3
A23	What is the primary language used in the interview with the respondent?	Urdu ..... 01 Punjabi..... 02 Sindhi..... 03 Pashto..... 04 Balochi..... 05 Saraiki..... 06 Hindko..... 07 Pothowari..... 08 Brahvi..... 09 Persian..... 10 Shina..... 11 Kohistani..... 12 Kashmiri ..... 13 Balti..... 14 Kalasha..... 18 Khowar..... 19 Wakhi..... 20 Others **[Specify]** 96

INFORMED CONSENT FORM

[Interviewer must read the informed consent statement as a part of compliance to research ethics principles before starting interview.]

Greet as per the custom.

My name is _____. I belong to **[Provincial/ Regional] Bureau of Statistics**. We are conducting this survey to seek views from citizens regarding public health services. This is a three-year study, which aims to gauge your perception of health. This study is being carried out in all provinces and regions of Pakistan. I would request you to kindly spare some time and express your experiences and opinions about the health services you and/or other members of your household have utilized. Please allow me to explain it further. The study will gather information about **availability, accessibility, affordability, and acceptability** of health services in your area. In addition to this, we shall ask some questions about your family members and have a separate conversation with ever-married women about their health and childbearing.

Study Procedures

You have been selected as a potential participant, since your community was selected coincidently as a study site, and your household was selected, also coincidently, from a list of households in this community. We plan to include approximately 25,000 households in the study from [province/region], including ever-married women of age 15 to 49 years. Usually, it takes 35-40 minutes to go through this questionnaire. Please do not hesitate to ask any questions at any point before, during or after the interview. I will respond to each question you may have to the best of my ability. I am going to ask you questions about the health of your family and other household members. We will be asking questions about children's immunization and your satisfaction with the health services provided.

Risk and Benefit

The structured interviews for household level information will be conducted privately. A place/ corner in your home or some other place where the conversation cannot be overheard, will be identified and that is where the interview will take place to minimize the risk of others hearing what the respondents will have to say. All procedures and precautions will be taken to ensure confidentiality of the information provided by the respondent and none of it will be disclosed to anyone. Secondly, respondents will have the right not to respond to any question that makes them uncomfortable, or they are unwilling to respond. Furthermore, risks of any breach of confidentiality will be minimized through adherence to confidentiality and informed consent procedures, and through training of the data collectors regarding these issues. Interviews will be arranged at a time that suits the respondents, ensuring auditory privacy, minimal social risks, inconvenience, and income loss. Cultural and gender-related sensitivities will be respected throughout the process. For this purpose, male enumerators will be hired to conduct interviews with male heads of the household. The time for the interview will be arranged as per the participants' convenience. No immediate tangible benefit is likely to accrue to the respondents through participation and this survey. However, the potential benefits of the study itself will be described to the participants so that they are fully aware that the data gathered will be used in designing future programs to improve family planning services in Pakistan.

Confidentiality

Data collected during the interviews will be kept strictly confidential. Contact information of respondents will be kept separate from the data set, which will have unique identifiers. The linking information will be kept safely and separate from the baseline and endline questionnaire responses. A strict data management procedure will be in place to minimize any breach of confidentiality. The data will be used for research and program evaluation purposes only and will be based on numerical identifiers. No individual data will be published in any reports etc., even the names of the clusters will not be made public to protect the identity of the respondents. All information provided during the interviews and discussions will be kept confidential. Data collected as part of this project will be stored at a secure location in the Population Council office in Islamabad, Pakistan and kept under lock and key. Only authorized research staff will have access to filing cabinets or any research files or documents. When results are disseminated through reports or presentations at meetings, data that can potentially identify participants will not be presented. The local research manager will train research assistants and other study personnel on the importance of protecting participants' confidence.

A24	Would you like to ask any questions before starting the interview?	Yes..... 1 No..... **(Go to A26)**..... 2
A25	If yes, what are the questions? **[Interviewer:** Respond to question(s) to the best of your ability]	
A26	May I start the interview now?	Yes..... 1 No..... 2
A27	**Name and code of interviewer.** [I have read the informed consent to the respondent, and he/ she has expressed his/ her consent for the interview.]	Name _____ Code ..... __|__|__
If "A26=2" then "Go to H01".		

Section B: Household roster

Demographic Information of Permanent Family Members

Now I will ask you some basic questions about all permanent household members who live together and cook and eat from the same cooking pot.

Included in HH roster.

- All permanent household members cook and eat together.
- Servant/ Maid/ Helper who live permanently in household, same dwelling.
- Temporary living away children 0-48 months.
- Guest children aged 0-48 months.

B00: Total number of members included in HH roster __|__

BPSU	BHH	B01	B02	B03	B04	B05	B06	B07	B08	B09	B10	B11	B12	B13
Enter the PSU code. [will be auto entered in CAPI]	Enter the house number from the list of houses [will be auto entered in CAPI]	Line number	Name of household member. **(Start with the head of the household)**	What is [NAME]'s relationship to the head of the household? [Check name of the HH head from A19] **[Write codes of B03 from the next page]**	What is [name]'s gender? 1. Male 2. Female 3. Transgender	How old was [name] on his/her last birthday? (If less than one year old, enter 000)	Does [name] have CNIC or Form-B number issued by NADRA. 1. Yes 2. No 7. Don't know	What is [name]'s current marital status? 1. Never married 2. Only Nikah 3. Married 4. Separated 5. Divorced 6. Widowed	Have [name] ever attended school? 1. Currently attending 2. Attended in past 3. Never attended **(If never attended school, go to B12)**	What is the highest formal class [name] has passed. (Ask for all HH members ≥ 3 years of age)	Line number of father [name] 93. Deceased 94. Live elsewhere	Line number of mother [name] 93. Deceased 94. Live elsewhere	Is [NAME] a permanent member of household or temporary? 1. Permanent 2. Temporary	Is this person the respondent/ eligible for HH, EMW or child 0-48 months? 1. For HH Questionnaire 2. EMW selected for interview 3. 0-48 month child for immunization 4. For both interviews (HH, EMW) 8. Not applicable
		1.												
		2.												
		3.												
		4.												
		5.												
		6.												
		7.												
		8.												
		9.												
		10.												
		11.												
		12.												

Codes for B03

Head 01	Grandson 08	Sister 15	Nephew 22
Wife 02	Granddaughter 09	Brother-in-law 16	Niece 23
Husband 03	Father 10	Sister-in-law 17	Servant/ Maid/ Helper 24
Son 04	Mother 11	Uncle 18	Guest child 0-48 months 25
Daughter 05	Father-in-law 12	Aunt 19	Others **[Specify]** 96
Son-in-law 06	Mother-in-law 13	Grandfather 20	
Daughter-in-law 07	Brother 14	Grandmother 21	

Codes for B09

Less than Class 1 00	Class 7 07	Degree in Engineering 17
Class 1 01	Class 8 08	Degree in Medicine 18
Class 2 02	Class 9 09	Degree in Agriculture 19
Class 3 03	Class 10 10	Degree in Law 20
Class 4 04	FA/ FSc/ ICOM 12	MPhil / PhD 21
Class 5 05	BA/ BBA/ BSc/ BCOM/ BED 14	Polytechnic Diploma 22
Class 6 06	MA/ MBA/ MSc/ MED 16	Others **[Specify]** 96

Section C: Communicable and non- communicable diseases roster (All ≥ 5 years members)

Now I will ask you some questions about household members aged 5 years or above (including Servant/ Maid/ Helper) who have ever suffered from communicable or non-communicable / long term / chronic / acute disease.

Ask for.

- All ≥ 5 years permanent household members who live together and cook and eat from the same cooking pot.
- ≥ 5 years servant/ Maid/ Helper who live permanently in household.

C00: You have just told me the names of all the members of your household (including Servant/ Maid/ Helper). Have any person/ persons aged 5 years or above ever suffered from communicable or non-communicable / long term / chronic / acute disease?

Yes.....1
No..... **(Go to D01)**.....2

CPSU	CHH	CB01	CB02	C01	C02	C03	C04	C05	C06	C07	C08	C09	C10	C11
Enter the PSU code [will be entered automatically in the CAPI]	Enter the house number from the list of houses [will be auto entered in the CAPI]	Enter the respondent's line number [will be auto entered in CAPI]	Enter the name of the respondent [will be auto entered in CAPI]	Case number	Name of the HH member who suffered from a long-term/ chronic/ acute illness?	Line from number from HH roster	What is/ was the illness? **[see codes on next page]**	Is [name] currently suffering from the same illness? 1. Yes 2. No	How long ago did [name] suffer from this illness? [Write duration in months. If less than one month, write "00"]	Is/ was [name] taking any medicines for this illness? 1. Yes 2. No	Did/do [name] use any health facility or services for the treatment? 1. Yes 2. No **(If yes, go to C10)**	Why did [name] not use a health facility or services for treatment? **(Multiple responses are allowed)** **(Go to next line / section D after asking C09)** **[see codes on next page]**	Which health facility did/ do [name] visit last for treatment? **[see codes on next page]**	How many months ago did [name] last visit the health facility for treatment? **(If less than 1 month write "00")**
				1			a.							
							b.							
							c.							
				2			a.							
							b.							
							c.							
				3			a.							
							b.							
							c.							

Codes for C04.

Respiratory diseases

Tuberculosis 01
Asthma 02
Any respiratory disease **[Specify]** 03

Neurological diseases

Epilepsy 04
Nerve disorder 05
Mental health 06
Stroke/ Paralysis 07
Other neurological diseases **[Specify]** 08

Heart diseases

High/ Low blood pressure 09
Other heart related 10
Other heart diseases **[Specify]** 11

Non-communicable diseases

Stomach/ Gastrointestinal illness 12
Diabetes 13
Kidney 14
Liver illness 15
Arthritis/ Gout/ Swelling of joints 16
Blood disease 17
Anemia 18
Skin condition 19
Cancer 20
Goiter 21
Congenital diseases 22
Others non-communicable **[Specify]** 23

Communicable diseases

Malaria 24
Pneumonia 25
Typhoid 26
HIV/ AIDS 27
Hepatitis B or C 28
COVID 29
Febrile condition 30
Thalassemia 31
Others communicable **[Specify]** 96

Codes for C09.

No opinion 01
Not aware of service/ facility 02
Access/ distance/ travel 03
Affordability/ Cost of service 04
Infrastructure not available 05
The timing of services is not appropriate 06
Non-availability of medical staff 07
Attitude of staff is not good 08
Staff professional quality is not good 09
Opening/closing time not suitable 10
Suitable for female only 11
Suitable for male only 12
Unavailability of Services 13
Irresponsive to poor 14
No serious illness not treated 15
Long waiting time 16
Medicines not available 17
No waiting area 18
Others **[Specify]** 96

Codes for C10.

Public

Teaching hospital 01
DHQ 02
THQ 03
Type-D health facility 04
RHC 05
BHU 06
MCH Center/ FH Center 07
TB Center/ Hospital 08
Government/ Civil Dispensary 09
Family Welfare Centre (FWC) 10
Family Welfare Worker (FWW) 11
Family Welfare Counselor (FWC) 12
Family Welfare Assistant (FWA) 13
Lady Health Worker (LHW) 14
Community Midwife (CMW) 15
Private hospital with inpatient facility 16
Private Male MBBS Doctor Clinic 17
Private Female MBBS Doctor Clinic 18
Nurse Clinic 19
LHV Clinic 20
Dispenser Clinic 21
GSM Clinic 22
NGO Clinic 23
TB Clinic 24
Nutrition Assistant 25
Vaccinator 26
Suraj Worker 27
Pehli Kiren Worker 28
Marvi Worker 29
Hakim/ Homeopath 30
Pharmacy/ Chemist 31
Others **[Specify]** 96

Section D: Household socio-economic characteristics

Now I would like to ask some questions about the socio-economic features, such as water, sanitation, internet access of your household.

Q.No.	Questions and Filters	Responses and Codes
DPSU	Re-enter the PSU code from the list	__|__|__|__
DHH	Re-enter the house number from the list	__|__|__|__
DB01	Re-enter the respondent's line number from the roster	__|__
DB02	Re-enter the respondent's name from the roster	
D01	What language is most commonly spoken in your household?	Urdu.....01 Punjabi.....02 Sindhi.....03 Pashto.....04 Balochi.....05 Saraiki.....06 Hindko.....07 Pothowari.....08 Brahvi.....09 Persian.....10 Shina.....11 Kohistani.....12 Kashmiri.....13 Balti.....14 Burushaski.....15 Domaaki.....16 English.....17 Kalasha.....18 Khowar.....19 Wakhi.....20 Others **[Specify]**.....96

HH WATER, SANITATION AND HYGIENE

I will now ask you some questions about the water availability, sanitation, and hygiene facilities in your household.

Q.No.	Questions and Filters	Responses and Codes
D02	What is the main source of drinking water for members of your household?	**Piped water** Piped into dwelling..... 01 Piped to yard/ plot..... 02 Piped to neighbor..... 03 Public tap/ standpipe..... 04 **Bore water** Bore/ Tube well..... 05 Hand pump..... 06 Electric/ Solar pump..... 07 **Dug well** Protected well..... 08 Unprotected well..... 09 **Water from spring** Protected spring..... 10 Unprotected spring..... 11 Rainwater..... 12 Tanker truck..... 13 Cart/ Rickshaw with small tank..... 14 Surface water (river/ dam/ lake/ pond/ stream/ canal/ irrigation channel)..... 15 Bottled water..... 16 Others **[Specify]**..... 96
D03	Where is that water source located?	In own dwelling.....**(Go to D05)**..... 1 In own yard/plot.....**(Go to D05)**... 2 Elsewhere..... 3
D04	How long in total does it take in minutes to go there on foot, get water, and come back?	Minutes .....__|__|__ Don't have to bring, supplied at home..... 995 Don't know..... 997
D05	In the past month, has there been any time when your household did not have sufficient quantities of drinking water when needed?	Yes, at least once..... 1 No, always sufficient....**(Go to D07)**..... 2 Don't know.....**(Go to D07)**..... 7
D06	What was the main reason you did not have sufficient quantities of drinking water when needed?	Water was not available from source..... 01 Water was too expensive..... 02 Source was not accessible..... 03 HH person not available to get water..... 04 Power supply failure..... 05 Others **[Specify]**..... 96

Q.No.	Questions and Filters	Responses and Codes
D07	Do you treat this water in any way to make it safer to drink?	Yes....1 No....(Go to D10)....2
D08	What do you usually do to make drinking water safer to drink? **(Multiple responses are allowed)**	Boil....01 Add bleach/chlorine....02 Use alum....03 Strain through a cloth....04 Use water filter (ceramic/Sand/composite)....05 Solar disinfection....06 Let it stand and settle....07 Others **[Specify]**....96
D09	How is drinking water stored?	Don't store....01 In pitchers....02 In buckets....03 In jars....04 In bottles....05 In drums....06 In tank....07 Others **[Specify]**....96
SANITATION		
D10	What kind of toilet facility do members of your household usually use?	**Flush or pour flush toilet** Flush connected to sewer line....01 Flush to septic tank....02 Flush to pit latrine....03 Flush connected to open drain [unsafely]....04 Flush, don't know where....05 **Pit latrine** Ventilated improved pit latrine....06 Pit latrine with slab....07 Pit latrine without slab/ open pit....08 Composting toilet....09 Bucket toilet....10 Hanging toilet/ hanging latrine....11 No facility/ bush/ field....12 Others **[Specify]**....96
D11	Do you share this toilet facility with other households?	Yes....1 No....2
D12	Where is this toilet facility located for men?	In own dwelling....1 Own yard/ plot....2 Elsewhere....3
D13	Where is this toilet facility located for women?	In own dwelling....1 Own yard/ plot....2 Elsewhere....3
HYGIENE		
D14	Where do the members of your household most often wash their hands? **[Interviewer: If possible observe, otherwise ask]**	**Sink/ Tap** In dwelling....01 In yard/ plot....02 Mobile object reported (bucket/ jug/ kettle)....03 No handwashing place in dwelling/ yard/ plot....04 Others **[Specify]**....96
D15	What type of soap do most people in your household use to wash their hands? **(Multiple responses are allowed)** **[Interviewer: If possible to observe, otherwise ask]**	Bar soap....01 Liquid soap....02 Detergent (Powder / Liquid / Paste)....03 Ash/ Mud / Sand....04 Nothing water only....05 Others **[Specify]**....96
D16	Is water available when needed for washing and bathing?	Yes....1 No....2
HOUSING CHARACTERISTICS		
D17	How many rooms in this household are used for sleeping?	Number of rooms....__|__
D18	Is this house rented, rent-free, mortgaged, or owned by a member of the household?	Rented....1 Rent free....2 Mortgaged....3 Owned....4 Others **[Specify]**....6

Q.No.	Questions and Filters	Responses and Codes
D19	What is the main material of the floor of the dwelling? **Interviewer:** If the interview is being conducted on the premises of the house, then observe, otherwise ask.	**Natural floor** Earth/ sand ..... 01 Dung ..... 02 **Rudimentary floor** Wood planks ..... 03 Palm/ bamboo ..... 04 **Finished floor** Parquet or polished wood ..... 05 Vinyl or asphalt strips ..... 06 Ceramic tiles ..... 07 Cement ..... 08 Carpet ..... 09 Chips/ Concrete ..... 10 Bricks floor ..... 11 Matt ..... 12 Marble ..... 13 Others **[Specify]** 96
D20	What is the main material of the roof of the dwelling? **[Interviewer:** If the interview is being conducted on the premises of the house, then observe, otherwise ask.]	**Natural roofing** No roof ..... 01 Thatch/ Palm leaf ..... 02 **Rudimentary roofing** sticks and twigs roof ..... 03 Palm/ Bamboo ..... 04 Wood planks ..... 05 Cardboard ..... 06 **Finishing roofing** Metal / Tin / T-Iron / Girders ..... 07 Wood / Wooden beams ..... 08 Calamine/ Cement fiber ..... 10 Ceramic tiles ..... 11 Cement/ R.C.C ..... 12 Roofing shingles ..... 13 Others **[Specify]** 96

Q.No.	Questions and Filters	Responses and Codes
D21	What is the main material of the exterior walls of the dwelling? **[Interviewer:** If the interview is being conducted on the premises of the house, then observe, otherwise ask.]	**Natural walls** No walls ..... 01 Wood/ Palm/ Trunks ..... 02 Dirt ..... 03 **Rudimentary walls** Bamboo with mud ..... 04 Stone/ Bricks with mud ..... 05 Uncovered adobe ..... 06 Plywood ..... 07 Cardboard ..... 08 Reused wood ..... 09 **Finished walls** Cement ..... 10 Stone with lime/ Cement ..... 11 Bricks ..... 12 Cement blocks ..... 13 Covered adobe ..... 14 Wood planks/ Shingles ..... 15 Others **[Specify]** 96
D22	What type of fuel does your household mainly use for cooking?	Electricity ..... 01 LPG ..... 02 Natural gas ..... 03 Biogas ..... 04 Kerosene ..... 05 Coal, lignite ..... 06 Charcoal ..... 07 Wood ..... 08 Straw/shrubs/ Grass ..... 09 Agricultural crop ..... 10 Animal dung ..... 11 No food cooked in household ..... 12 Others **[Specify]** 96
D23	Does your household use iodized salt?	Yes ..... 1 No ..... 2 Don't know 7
D24	Does any male or female member of this household own any agricultural land?	Yes ..... 1 No ..... **(Go to D26)** ..... 2 Don't know ..... **(Go to D26)** 7

Q.No.	Questions and Filters	Responses and Codes
D25	How many total acres or kanals or marlas of agricultural land do all members of this household own? **[20 Marlas = 01 Kanal]** **[08 Kanals = 01 Acre]**	a) Marlas ..... __|__ b) Kanals ..... __|__ c) Acres..... __|__ 95 or more acres .....95 Don't know 97
D26	Does this household own any livestock, herds, other farm animals, or poultry or none of these?	Yes.....1 No..... **(Go to D28)** 2
D27	How many [animal] does this household own? **If none, record '00'.** **If 95 or more, record '95'.** **If unknown, record '97'.**	a) Cows/ Ox..... __|__ b) Buffalo..... __|__ c) Camels ..... __|__ d) Horses/ Donkeys/ Mules ..... __|__ e) Goats/ Sheep..... __|__ f) Chickens/ Poultry ..... __|__
D28	What is the **main** source of income for your house?	Agriculture/ Livestock/ Poultry..... 01 Government service (permanent) .... 02 Government service (contract) ..... 03 Private service (permanent)..... 04 Private service (contract)..... 05 Business (with employees)..... 06 Business (without employees) ..... 07 Daily wager..... 08 Remittances..... 09 Pension ..... 10 Raising birds ..... 11 Rent..... 12 Others **[Specify]** 96
D29	Has any member of your household working abroad sent any remittances to your household from outside Pakistan during the last one year?	Yes..... 1 No..... 2
D30	Has any member of your household working within Pakistan sent any remittances to your household during the last one year?	Yes..... 1 No..... 2

Q.No.	Questions and Filters	Responses and Codes			
D31	Does your household have [name]:			Yes	No
		a)	Electricity	1	2
		b)	Radio	1	2
		c)	Television	1	2
		d)	Telephone line	1	2
		e)	Computer/ Laptop	1	2
		f)	Refrigerator/ Fridge	1	2
		g)	Gas heater	1	2
		h)	Cooking range/ Stove	1	2
		i)	Electric iron	1	2
		j)	Bed	1	2
		k)	Sofa	1	2
		l)	Cupboard	1	2
		m)	Wall clock	1	2
		n)	Washing machine	1	2
		o)	Air cooler/ Fan	1	2
		p)	Microwave oven	1	2
		q)	Air conditioner	1	2
D32	Does any member of this household own [name]:			Yes	No
		a)	Watch	1	2
		b)	Mobile phone	1	2
		c)	Bicycle	1	2
		d)	Motorcycle/ Scooter	1	2
		e)	Animal-drawn cart	1	2
		f)	Car	1	2
		g)	Truck/ Bus/ Van	1	2
		h)	Tractor trolley	1	2
		i)	Rickshaw/ Chingchi (QingQi)	1	2
		j)	Boat	1	2

INTERNET ACCESS

I will now ask you some questions about the availability and use of internet in your household.

D33	Does your household have an internet facility?	Yes ..... 1 No ..... **(Go to D35)** 2
D34	**[If yes]** what type of internet facility does your household have?	Fixed ..... 1 Mobile ..... 2 Both 3

NATURAL DISASTER, AGRICULTURAL, ECONOMIC SHOCK

Now I will ask you some questions regarding natural disasters, agricultural, and economic shock your household may have faced in the past 24 months.

D35	During the past 24 months, has your household faced any natural disaster, agricultural, health issues, economic shock or faced any serious challenges due to law-and-order situation or any displacement? **(Multiple responses are allowed)**	None ..... 01 Rains/ Floods ..... 02 Agricultural shocks ..... 03 HH economic shocks ..... 04 Law and order ..... 05 Displacement ..... 06 Accident/ Injury ..... 07 Health issues ..... 08 COVID ..... 09 Earthquake ..... 10 Drought ..... 11 Death of working member ..... 12 Others **[Specify]** 96
D36	Did you, or any member of your household, have to take any loan during the past 24 months?	Yes ..... 1 No ..... **(Go to D38)** 2
D37	**[If yes]** What was/were the reason(s) to take the loan(s) during the past 24 months? **(Multiple responses are allowed)**	Other health shock e.g., accident ..... 01 Flood or earthquake ..... 02 Buy food ..... 03 Consumption smoothing ..... 04 Education costs ..... 05 To buy an asset ..... 06 To start business ..... 07 To pay for wedding ..... 08 To pay for funeral ..... 09 Pay-off past debt ..... 10 Illness of family member ..... 11 Others **[Specify]** 96

HOUSEHOLD RECEIVED ANY TRANSFER FROM PUBLIC/ PRIVATE (SOCIAL PROTECTION, HEALTH CARD)

Now I will ask you some questions regarding social protection and transfers from public and private institutions.

D38	Does any member of this household have a commercial bank account other than BISP account?	Yes ..... 1 No 2
D39	What other means does your household use to transfer money besides a bank account? **[Multiple responses are allowed]**	None ..... 01 Jazz cash ..... 02 Easy paisa ..... 03 U-paisa ..... 04 Omni ..... 05 Others **[Specify]** 96
D40	Is there any woman in your household who is a BISP beneficiary?	Yes ..... 1 No ..... **(Go to D45)** 2
D41	How many women of your household are receiving BISP cash transfers from kafalat program?؟	None ..... 00 Number of women ..... __|__
D42	How many women and children are beneficiaries of BISP *Nashonuma* program?	None ..... 00 a) Number of women ..... __|__ b) Number of children ..... __|__
D43	How many girls and boys are receiving educational support from BISP *Waseela-e-taleem program?*	None ..... 00 a) Girls ..... __|__ b) Boys ..... __|__
D44	How many girls and boys in your household are receiving scholarships for university level education from the undergraduate program of BISP?	None ..... 00 a) Girls ..... __|__ b) Boys ..... __|__
D45	Is any member of your household benefiting from the sehat sehulat card?	Yes ..... 1 No 2
D46	Are pregnant and lactating women of your household benefiting from nutrition program (human capital program)?	Yes ..... 1 No ..... 2 Don't know ..... 7 Not applicable 8
D47	Is any member of your household benefiting from nutrition program for Immunization (human capital program)?	Yes ..... 1 No ..... 2 Don't know ..... 7 Not applicable 8

D48	Is any member of your household benefiting from economic inclusion [loan, TVET]?	Yes.....1 No.....2 Don't know.....7 Not applicable.....8
D49	Is any member of your household benefiting from an Insurance Plan through employer's organization?	Yes.....1 No.....2 Don't know.....7 Not applicable.....8
D50	Is any member of your household benefiting from privately purchased insurance?	Yes.....1 No.....2 Don't know.....7 Not applicable.....8

USE OF MOSQUITO NETS

Now I will ask you some questions regarding the use of mosquito repellents in your household.

D51	Does your household have any mosquito nets that can be used while sleeping?	Yes.....1 No..... **(Go to D57)**.....2
D52	How many mosquito nets does your household have?	Number of nets..... __|__
D53	Who uses mosquito nets?	All family members.....1 Only male family members.....2 Only female family members ....3 Only adult male and female family members .....4 Only children.....5 Male family member and children.....6 Female family member and children.....7 No one uses.....8
D54	Did you get a mosquito net that was already sprayed with mosquito repellent?	Yes..... **(Go to D57)**.....1 No.....2 Don't know.....7
D55	Since you got the mosquito net, was it ever soaked or dipped in a liquid to kill or repel mosquitoes?	Yes.....1 No..... **(Go to D57)**.....2 Don't know..... **(Go to D57)**....7
D56	How many months ago was the net last soaked or dipped for?	Months ago, ...__|__

D57	Does your household do anything (else) to keep mosquitoes away other than net(s)?	Yes.....1 No..... **(Go to D59)** 2
D58	What else do you do to keep mosquitoes away? **(Multiple responses are allowed)**	Coil .....01 Mat .....02 Spray .....03 Electric spray repellent.....04 Insect repellent.....05 Electric racket.....06 Through smoke.....07 Kiri Kiri mosquitoes killer .....08 Others **[Specify]** 96
D59	Do you have any medicines for treating malaria in your house now?	Yes.....1 No.....2 Don't know.....7

USE OF TOBACCO AND OTHER DRUGS

Now I will ask you some questions regarding the use of tobacco and other drugs by the male and female members aged 15 and above of your household.

D60	Does any male or female member in your household, age 15 or older, use any type of tobacco daily or occasionally?	Yes.....1 No..... **(Go to D64)**....2 Don't know...**(Go to D64)**7
D61	How many male and female household members aged 15 years of above are currently using any type of tobacco?	a) Male .....__|__ b) Female .....__|__

D62	Name and line number of those who are using tobacco.	1) Name	2) Line number
		a)	
		b)	
		c)	
		d)	
		e)	
		f)	

D63	What types of tobacco do they use? **(Multiple responses are allowed)**	Cigarette ..... 01 Hukkah ..... 02 Chewing tobacco ..... 03 Inhaling through the mouth ..... 04 Sniff by nose..... 05 Paan with tobacco..... 06

		Berri .....07 Gutka .....08 Naswar.....09 Mawa tobacco .....10 Naas and man pori .....11 Pipes full of tobacco.....12 Cigars, cheroots, or cigarillos.....13 Others **[Specify]** 96
D64	Does anyone in the household use any other drugs besides smoking?	Yes .....1 No.....**(Go to E01)**.....2 Don't know.....**(Go to E01)**.....7
D65	What types of drugs other than tobacco do they use? **(Multiple responses are allowed)**	Alcohol .....01 Marijuana/ Cannabis .....02 Hashish.....03 Heroin .....04 Cocaine.....05 Sheesha.....06 Ice .....07 Others **[Specify]** 96

Section E: Communicable diseases (All patients)

Now, I would like to enquire about communicable diseases, such as tuberculosis, that any member of your household may have suffered from.

Q.No.	Questions and Filters	Responses and Codes
EPSU	Enter PSU code [will be auto entered in CAPI]	__|__|__|__
EHH	Enter HH number from list [will be auto entered in CAPI]	__|__|__|__
EB01	Enter respondent's line number [will be auto entered in CAPI]	__|__
EB02	Enter respondent's name [will be auto entered in CAPI]	
E01	Has any member of your household suffered from TB during the last 2 years (From 01 July 2022 till date)?	Yes.....1 No....**(Go to F01)** 2
E02	How many members of your household have suffered from TB	Number of HH members ..... __|__
	during the last 2 years (From 01 July 2022 till date)?	
[Ask questions below for all who suffered from TB during last 2 year]		
E03	Case number of TB patient.	Case number.....__|__
E04	Name of TB patient from HH roster	
E05	Line number of TB patient from HH roster	Line number.....__|__
E06	On average, how many cigarettes does [name] smoke in a day?	Doesn't smoke cigarettes..... 00 Number of cigarettes.....__|__ Don't know 97
E07	Has a healthcare provider [doctor, nurse, or lady health visitor/lady health worker] ever told [name] that they have/had tuberculosis or TB?	Yes..... 1 No..... **(Go to F01)**..... 2
E08	Did [name] get treatment for tuberculosis or TB?	Yes..... 1 No..... **(Go to F01)**..... 2
E09	From which health facility or service provider did [name] get treatment for tuberculosis or TB the last time?	**Public facilities** Teaching hospital..... 01 DHQ ..... 02 THQ..... 03 Type-D health facility ..... 04 RHC..... 05 BHU ..... 06 MCH Center/ FH Center..... 07 TB Center/ Hospital ..... 08 Government/ Civil Dispensary..... 09 Family Welfare Centre (FWC)..... 10 Family Welfare Worker (FWW)..... 11 Family Welfare Counselor (FWC)..... 12 Family Welfare Assistant (FWA)..... 13 Lady Health Worker (LHW) ..... 14 Community Midwife (CMW) ..... 15 **Private facilities** Private hospital with inpatient facility ..... 16 Private Male MBBS Doctor Clinic .... 17 Private Female MBBS Doctor Clinic 18 Nurse Clinic..... 19 LHV Clinic ..... 20 Dispenser Clinic ..... 21 GSM Clinic..... 22 NGO Clinic ..... 23 TB Clinic..... 24

Q.No.	Questions and Filters	Responses and Codes
		Workers Nutrition Assistant .....25 Vaccinator .....26 Suraj Worker .....27 Pehli Kiren Worker .....28 Marvi Worker .....29 Hakim/ Homeopath .....30 Pharmacy/ Chemist .....31 Others **[Specify]** 96

Section F: Child immunization

Now I would like to ask you about the vaccination details of all the children in your household, aged 0-48 months. This includes both the biological child and children living elsewhere temporarily. If a child aged 0-48 months is a guest in the household, he/ she will also be included.

F01: Total number of 0-48 months children in the household including living elsewhere and guest children__|__

Q.No.	Questions and Filters	Responses and Codes
FPSU	Enter PSU code [will be auto entered in CAPI]	__|__|__|__
FHH	Enter HH number from list [will be auto entered in CAPI]	__|__|__|__
FB01	Enter respondent's line number [will be auto entered in CAPI]	__|__
FB02	Enter respondent's name [will be auto entered in CAPI]	
F02	Case number of 0-48 months child	Case number .....__|__
F03	What is the relationship of respondent [name] to the child?	Mother .....01 Father .....02 Grandmother .....03 Grandfather .....04 Aunt .....05 Uncle .....06 Sister .....07 Brother .....08 No relation .....09 Others **[Specify]** 96
F04	Name of child (aged 0-48 months) from HH roster (**B02**)	Full Name: _____

Q.No.	Questions and Filters	Responses and Codes
F05	Line number of child (aged 0-48 months) from HH roster (**B01**)	Line number..... __|__
F06	Name of child's mother from household roster (**B02**)	Full Name: _____ Not listed in HH roster ... 9995
F07	Line Number of child's mother from household roster (**B01**)	Line number..... __|__ Not listed in HH roster 95
F08	Sex of child	Male .....1 Female .....2 Transgender 3
F09	Date of birth of child	a) Day .....__|__ b) Month .....__|__ c) Year .....__|__|__|__
F10	Age of child in months	a) Age in days .....__|__ b) Age in months .....__|__
F10c	Is the child eligible? [Will be auto entered in CAPI]	Yes .....1 No 2
F11	Did you ever have a vaccination card from a government or private health provider where the child's vaccinations are written down? [For guest child, code 7 unless information is available to respondent]	Yes..... **(Go to F13)** ..1 No .....2 Don't know 7
F12	If not, why have you not received any vaccination card?	Don't think it's important .....01 Never visited a facility .....02 Card was not available with the health facility .....03 The vaccinator/ facility didn't provide the card .....04 Not aware of such cards .....05 Others **[Specify]** 96
After asking F12 "Go to F19"		
F13	If yes, may I see the card, please?	Yes..... **(Go to F15)** ..1 No 2
F14	If not seen, what is the reason for not showing the card?	Card not found at this time .....01 Card Misplaced .....02 Card is at vaccination center/ with vaccinator .....03 Others **[Specify]** 96
After asking F14 "Go to F19"		
F15	Check and copy date of birth recorded on card.	__|__: __|__:|202___ dd mm yyyy
F16	May I take the photo of the card?	Yes .....1 No 2

INSTRUCTIONS: Please record the date of immunization for *each antigen from card*
. If the date is recorded but not readable, record 44 in day column.

Q.No.	Questions and Filters	Responses and Codes

. If the date is not recorded but a tick (☐) mark is present, record 88 in day column.
. If neither date is recorded nor a tick (☐) mark is present, prompt the mother for each such antigen.
record 66 if she confirms the receipt of respective antigen.
record 97 if she doesn't confirm the receipt of respective antigen.
record 77 if she confirms non-receipt of respective antigen.
. Write 98 if not applicable.

GPSU	GHH	GB01	GB02	F02a	F05a	F7a	F18	Day		Month		Year			
Enter PSU code [will be auto entered in CAPI]	Enter HH number from list [will be auto entered in CAPI]	Enter respondent's line number [will be auto entered in CAPI]	Enter respondent's name [will be auto entered in CAPI]	Case number of 0-48 months child	Line number of child (aged 0-48 months) from HH roster (**B01**)	Line Number of child's mother from household roster (**B01**)	a) BCG (Vaccination for TB)								
							b) OPV-0 (Polio drops at birth)								
							c) Hepatitis-B Vaccine (at birth)								
							d) OPV-1 (Polio drops at 6 weeks)								
							e) Penta-1 (Pentavalent 1 at 6 weeks)								
							f) PCV-1 (Pneumococcal Conjugate at 6 weeks)								
							g) RV-1 (Rotavirus vaccine at 6 weeks)								
							h) OPV-2 (Polio drops at 10 weeks)								
							i) Penta-2 (Pentavalent 2 at 10 weeks)								
							j) PCV-2 (Pneumococcal Conjugate at 10 weeks)								
							k) RV-2 (Rotavirus vaccine 2) (at 10 weeks)								
							l) OPV-3 (Polio drops) (at 14 weeks)								
							m) Penta-3 (Pentavalent 3 at 14 weeks)								
							n) PCV-3 (Pneumococcal Conjugate at 14 weeks)								
							o) IPV1 (Inactivated polio vaccine 1 at 14 weeks)								
							p) Measles-Rubella-1 (at 9 months)								
							q) Typhoid TCV (at 9 months)								
							r) IPV2 (Inactivated polio vaccine 2 at 9 months)								
							s) Measles-Rubella-2 (at 15 months)								

Q.No.	Questions and Filters	Responses and Codes
Check F18, are all applicable vaccines (BCG to Measles-Rubella-2) recorded? If not, go back to F18 and fill all relevant cells. **After completing F18 go to F36.**		
G1PSU	Enter PSU code [will be auto entered in CAPI]	__|__|__|__
G1HH	Enter HH number from list [will be auto entered in CAPI]	__|__|__|__
G1B01	Enter respondent's line number [will be auto entered in CAPI]	__|__
G1B02	Enter respondent's name [will be auto entered in CAPI]	
F02b	Case number of 0-48 months child	Case number..... __|__
F05b	Line number of child (aged 0-48 months) from HH roster (**B01**)	Line number..... __|__
F07b	Line Number of child's mother from household roster (**B01**)	Line number..... __|__ Not listed in HH roster 95
F19	Has (**name**) ever received any vaccinations to prevent (him/her) from getting diseases, including vaccinations received in a campaign, immunization day or Child Health Day?	Yes..... 1 No..... **(Go to F38)**..... 2 Don't know... **(Go to F38)**..... 7 Not applicable...**(Go to F38)** 8
F20	Has (**name**) ever received a BCG vaccination against tuberculosis – that is, an injection in the arm or shoulder that usually causes a scar?	Yes..... 1 No ..... 2 Don't know ..... 7 Not applicable 8
F21	Has (**name**) ever received any vaccination drops in the mouth to protect (him/her) from polio? [Probe by indicating that the first drop is usually given at birth and later at the same time as injections to prevent other diseases]	Yes..... 1 No..... **(Go to F24)**..... 2 Don't know... **(Go to F24)**..... 7 Not applicable...**(Go to F24)** 8
F22	How many times was the polio vaccine received at Government/ Public health facility or from outreach facility? (including Polio drops at birth)	Number of times .....__|__ Don't know 97
F23	Were the first polio drops received in the first two weeks after birth?	Yes..... 1 No ..... 2 Don't know ..... 7 Not applicable 8
F24	Has (**name**) ever received Hepatitis B vaccination- that is, an injection in the arm or shoulder?	Yes..... 1 No ..... 2 Don't know ..... 7 Not applicable 8

Q.No.	Questions and Filters	Responses and Codes
	[Hepatitis B vaccine protects against a viral infection that causes inflammation and damage to the liver]	
F25	Has (**name**) ever received a Pentavalent vaccination – that is, an injection in the thigh to prevent (him/her) from getting tetanus, whooping cough, diphtheria, Hepatitis B disease, and Haemophilus influenza type B? [Probe by indicating that Pentavalent vaccination is sometimes given at the same time as the Polio drops.]	Yes.....1 No..... **(Go to F27)**.....2 Don't know..... **(Go to F27)**....7 Not applicable.....**(Go to F27)** ..8
F26	How many times was the Pentavalent vaccine received?	Number of times .....__|__ Don't know.....97
F27	Has (**name**) ever received a Pneumococcal Conjugate vaccination – that is, an injection to prevent (him/her) from getting pneumococcal disease, including ear infections and meningitis caused by pneumococcus? [Probe by indicating that Pneumococcal Conjugate vaccination is sometimes given at the same time as the Pentavalent vaccination.]	Yes.....1 No..... **(Go to F29)**.....2 Don't know..... **(Go to F29)**....7 Not applicable.....**(Go to F29)** ..8
F28	How many times was the pneumococcal vaccine received?	Number of times .....__|__ Don't know.....97
F29	Has (**name**) ever received drops for rotavirus vaccine (RV) vaccination- A vaccine given orally soon after 6 weeks birth to protect against rotavirus infections, which are the leading cause of severe diarrhoea among young children?	Yes.....1 No..... **(Go to F31)**.....2 Don't know..... **(Go to F31)**....7 Not applicable.....**(Go to F31)** ..8
F30	How many times were the Rota vaccine drops received?	Number of times .....__|__ Don't know.....97
F31	Has (**name**) ever received an inactivated polio vaccine (IPV) – that is, a shot in the thigh at the age of 14 weeks or older - to prevent (him/her) from getting polio?	Yes.....1 No..... **(Go to F33)**.....2 Don't know..... **(Go to F33)**....7 Not applicable.....**(Go to F33)** ..8
F32	How many times was the IPV injection vaccine received?	Number of times .....__|__ Don't know.....97
F33	Has (**name**) ever received a Measles Injection – that is, a shot in the arm at the age of 9 months or older - to prevent (him/her) from getting measles?	Yes.....1 No..... **(Go to F35)**.....2 Don't know..... **(Go to F35)**....7 Not applicable.....**(Go to F35)** ..8

Q.No.	Questions and Filters	Responses and Codes
F34	How many times was a Measles Injection vaccine received?	Number of times .....__|__ Don't know 97
F35	Has (**name**) ever received a Typhoid vaccination – that is, a shot in the upper part of the arm at the age of 9 months or older - to prevent (him/her) from getting Typhoid disease?	Yes ..... 1 No ..... 2 Don't know ..... 7 Not applicable 8
Check if F18 is blank and F19, F21, F23, F24, F25, F27, F29, F31, F33, F35 is equal to 2 or 7 then go to F38.		
F36	From where is (name) usually vaccinated? [If the child is vaccinated from multiple sources, mention the usual source with higher frequency of vaccine doses]	Government health facility ..... 1 Private health facility ..... 2 Government outreach service .. 3 Others **[Specify]** 6
F37	Can you please specify where this facility is located?	Within catchment area of 10 KMs ..... 01 Within city..... 02 Out of city ..... 03 Within district ..... 04 Out of district..... 05 Others **[Specify]** 96
After asking F37 go to F39.		
F38	Why (**name**) is not vaccinated? **[Multiple responses are allowed]**	Place of immunization too far .. 01 Time of immunization not convenient..... 02 Mother too busy ..... 03 Family problem including mother ill ..... 04 Child ill, not brought..... 05 Child ill, brought but not vaccinated..... 06 Long waiting time..... 07 Due to rumors about vaccination ..... 08 No faith in immunization ..... 09 Fear of side reaction..... 10 Place of immunization not known ..... 11 Time of immunization not known..... 12 Took child but no vaccine available ..... 13 Took child but no vaccinator .... 14 Took child but facility was closed 15

Q.No.	Questions and Filters	Responses and Codes
		Took child but not a vaccination day ..... 16 Others **[Specify]** ..... 96 Don't know 97
After asking F37 go to G01.		
F39	Has the child ever received polio drops during a national polio campaign?	Yes ..... 1 No ..... **(Go to F42)** ..... 2 Don't know ..... **(Go to F42)** 7
F40	How many times has the child received polio vaccine drops during national polio campaigns?	Number of times ..... __|__ Don't know 97
F41	Did the child receive polio drops during the last national polio campaign?	Yes ..... 1 No ..... 2 Don't know 7
F42	Observe BCG scar.	Scar present ..... 1 Scar absent ..... 2 Child not available ..... 3 Not observed 4

Section G: Availability and use of health facilities

Now I would like to ask some questions about the availability of health facilities near your community and the quality of care received during the last visit by any of your household members.

[Interviewer: Don't include the visit of women for family planning, antenatal care, delivery, or postnatal care]

Q.No.	Questions and Filters	Responses and Codes
AVAILABILITY OF HEALTH FACILITIES		
HPSU	Enter PSU code [will be auto entered in CAPI]	__|__|__|__
HHH	Enter HH number from list [will be auto entered in CAPI]	__|__|__|__
HB01	Enter respondent's line number [will be auto entered in CAPI]	__|__
HB02	Enter respondent's name [will be auto entered in CAPI]	
G00	What is the line number of the household member who visited health facility last time for getting healthcare?	Line number form HH roster ..... __|__
G01	Which health facilities are available in or near your community**?**	**Public facilities** Teaching Hospital 01
	[**Multiple responses are allowed**]	DHQ ..... 02 THQ ..... 03 Type-D Health Facility ..... 04 Reproductive health services center (RHSA) ..... 05 Mobile service unit (MSU) ..... 06 RHC ..... 07 BHU ..... 08 MCH Center/ FH Center ..... 09 Government/ Civil Dispensary .. 10 Family Welfare Centre (FWC) .... 11 Family Welfare Worker (FWW) .. 12 Family Welfare Counselor (FWC) ..... 13 Family Welfare Assistant (FWA) 14 Lady Health Worker (LHW) ..... 15 Community Midwife (CMW) ..... 16 **Private facilities** Private hospital with inpatient facility ..... 17 Private Male MBBS Doctor Clinic ..... 18 Private Female MBBS Doctor Clinic ..... 19 Nurse Clinic ..... 20 LHV Clinic ..... 21 Dispenser Clinic ..... 22 GSM Clinic ..... 23 NGO Clinic ..... 24 **Workers** Nutrition Assistant ..... 25 Vaccinator ..... 26 Suraj Worker ..... 27 Pehli Kiren Worker ..... 28 Marvi Worker ..... 29 Hakim/ Homeopath ..... 30 Pharmacy/ Chemist ..... 31 Others **[Specify]** 96
G02	Which three health facilities did your family use the most in the last one year? **[Other than community worker]** **if not visited write 98**	**Code from above (G01) – if not visited write 98** a) 1st ..... __|__ b) 2nd ..... __|__ c) 3rd ..... __|__
G03	How long does it usually take one way to reach this health facility?	**Time in minutes – if not visited write 98** a) 1st ..... __|__ b) 2nd ..... __|__ c) 3rd ..... __|__

Q.No.	Questions and Filters	Responses and Codes
G04	Which three health facilities are the closest to your home? **(Other than community worker)**	**Code from above (G01)** a) 1st ..... __|__ b) 2nd ..... __|__ c) 3rd ..... __|__
G05	What is the distance (KMs) to these three health facilities near your home?	**Distance (in KMs) - If less than 1 KM, write 00** a) 1st ..... _|_|_ b) 2nd ..... _|_|_ c) 3rd ..... _|_|_

USE OF HEALTH FACILITIES

I have only a few more questions to ask. I would like to ask about the **last** healthcare visit regarding general health by any member of your household to the health facility during the last **one year**. **[If not visited, go to Section H]**

G06	**Did the provider:**	**Yes**	**No**	**Don't know**
	a) Obtain consent before performing any procedure?	1	2	7
	b) Treat with courtesy and respect?	1	2	7
	c) Give clear and complete information about health care?	1	2	7
	d) Provided clear and complete information about treatment?	1	2	7
	e) Listen to concerns and take them seriously?	1	2	7
	f) Respect choices and preferences?	1	2	7
	g) Treat fairly and without discrimination?	1	2	7
	h) Provide privacy during all the procedures performed?	1	2	7
G07	**Did the patient:**	**Yes**	**No**	**Don't know**
	a) Feel involved/included in making decisions about his/ her care?	1	2	7
	b) Feel comfortable asking questions?	1	2	7
	c) Feel comfortable expressing his/ her concerns?	1	2	7
	d) Express his/ her preferences without judgment?	1	2	7
	e) Feel safe during his/ her care?	1	2	7

G08	What type of transport was used to reach the health facility during the last visit? (**Multiple responses are allowed**)	On foot ..... 01 Motorcycle ..... 02 Rickshaw/ Chingchi (Qingqi) ..... 03 Bus/ Van ..... 04 Tonga/ Cart ..... 05 Car ..... 06 Ambulance ..... 07 Boat ..... 08 Others **[Specify]** ..... 96 Don't know 97
G09	How long have to wait at the facility before receiving care during the last visit?	No waiting time ..... 01 5 – 10 minutes ..... 02 11 – 20 minutes ..... 03 21 – 30 minutes ..... 04 31 – 60 minutes ..... 05 More than 1 hour ..... 06 Don't know 97
G10	Was any medicine provided to the patient from the health facility durng the last visit?	Yes ..... 1 No ..... 2 Don't know 7
G11	What were the expenses that the household had to bear for getting services during the last visit? **(Interviewer: Probe for each one)** **If there is no expense write "0000000".** **If don't know expense write "9999997".** **If not applicable write "9999998".**	a) Expenses on travel ..... _|_|_|_|_|_|_ b) Expenses on fee ..... _|_|_|_|_|_|_ c) Expenses on medicine ... _|_|_|_|_|_|_ d) Expenses on lab tests .... _|_|_|_|_|_|_ e) Expenses on operation .. _|_|_|_|_|_|_ f) Bed charges ..... _|_|_|_|_|_|_ g) Other expenses ..... _|_|_|_|_|_|_ h) Total ..... _|_|_|_|_|_|_
G12	Was there a separate waiting area for male and female patients available in the health facility?	Yes ..... 1 No ..... 2 Don't know 7
G13	Was there a separate toilet facility for male and female patients available in the health facility?	No toilet facility ..... 1 Yes, separate ..... 2 Yes, combine ..... 3 Don't know 7

Section H: Permission for revisit/ call

Occasionally, it becomes necessary to clarify a point or reconcile information by going back to the respondent after the interview. Should this need arise:

Q.No.	Questions and Filters	Responses and Codes
IPSU	Enter PSU code [will be auto entered in CAPI]	__|__|__|__
IHH	Enter HH number from list [will be auto entered in CAPI]	__|__|__|__
IB01	Enter respondent's line number [will be auto entered in CAPI]	__|__
IB02	Enter respondent's name [will be auto entered in CAPI]	
H01	Could we revisit/ call you again?	Yes ..... 1 No..... **(Go to H03)** 2
H02	Please give me a phone number that we can use to reach you should the need arise?	
H03	Would you like to give us any suggestions or comments on the topics we have covered in this interview or have questions for us?	Yes ..... 1 No..... **(Go to H05)** 2
H04	If yes, what are the suggestions and questions?	a) Suggestions b) Questions
H05	Time to end the interview [24-hour format]	Hours ___|___ Minutes ___|___
H06	What was the result of the interview?	Interviewed **(End interview)** 01 Partially interviewed..... 02 No one at home..... 03 Entire household absent for extended period..... 04 Refused ..... 05 Dwelling vacant or address not a dwelling..... 06 Dwelling destroyed..... 07 Dwelling not found..... 08 Others **[Specify]** 96
H07	If partially interviewed or refused to be interviewed, then please provide the reasons.	

Thank You

Processing ID [To be filled by interviewer]

				Yes...1 No....2														
A01: Province code		**A02:** District code		**A03:** Is this lagging district		**A04:** PSU ID number				**A05:** HH number from PSU list			**A06:** HH serial number		**A07:** Woman serial number			

[Province name]

Health and Population Survey [[P]HPS] 2024

Ever-Married Woman's (Age 15-49 Years) Questionnaire

Section A: Household identification and informed consent

HOUSEHOLD IDENTIFICATION

Q.No.	Questions and Filters	Responses and Codes
A08	Timeline of interview	Baseline.....**(Go to A10)** ..... 1 Endline 2
A08a	PSU code [Enter the PSU code from the list]	__|__|__|__
A08b	Block code [The block code in the list will be entered automatically in the key]	__|__|__|__
A09	Panel status of PSU	Panel PSU ..... 1 Baseline PSU only..... 2 Endline PSU only 3
A10	Name of province/region	Punjab..... 1 Sindh..... 2 Khyber Pakhtunkhwa (KP) ..... 3 Balochistan..... 4 Azad Jammu & Kashmir (AJK)..... 5 Gilgit Baltistan (GB) ..... 6 Islamabad..... 7
A11	Name and code of district	a) Name: _____ b) Code:.....__|__|__
A12	Is this a lagging/ zero dose district? **[Interviewer: Please don't ask]**	Yes ..... 1 No..... 2
A13	Name of tehsil	Name: _____
A14	Name of union council	Name: _____
A15	Name and code of community [Enter code of PSU]	a) Name: _____ b) Code..... __|__|__|__
A16	Is this area Katchi Abadi? [Interviewer: Observe don't ask]	Yes ..... 1 No..... 2
A17	Complete postal address of household a) House #, _____ b) Street #, _____ c) Mohallah, _____ d) Dhoke/ Village/ City _____	
A18	Household number (from the PSU list)	__|__|__
A19	Household serial number (According to order of interview)	__|__
A20	Name of the head of household	Name _____
A21	Day / Month / Year of interview	__|__: __|__:|2024 dd mm yyyy
A22	Time of starting interview [24-hour format]	__|__:__|__ Hours: Minutes
A23	Interview mode	FTF PAPI ..... 1 FTF CAPI ..... 2 Telephonic..... 3
A24	What is the primary language used in the interview with respondent?	Urdu..... 01 Punjabi ..... 02 Sindhi ..... 03 Pashto ..... 04 Balochi ..... 05 Saraiki ..... 06 Hindko..... 07 Pothowari ..... 08 Brahvi ..... 09 Persian ..... 10 Shina ..... 11 Kohistani..... 12 Kashmiri..... 13 Balti ..... 14 Kalasha ..... 18 Khowar..... 19 Wakhi ..... 20 Others **[Specify]** 96

INFORMED CONSENT FORM

[interviewer: Before starting the interview, read the informed consent to the respondent.]

[Greet as per custom]

My name is _____. I belong to the [provincial/territorial] Bureau of Statistics. We are conducting this survey to find out people's opinion about public health services. This survey is being conducted in all provinces and regions of Pakistan. I would request you to please take some time and share your experiences and opinions about the health facilities you or your family have used.

[Study Procedures]

You have been selected as a respondent because your community was selected as the study site, and so your household was randomly selected from the list of households in that community. We will include approximately 60,000 participants like you in this survey from across the country. The questionnaire will take approximately 60 minutes to

complete. Please feel free to ask any questions at any time before, during or after the interview. I will try to answer each of your questions to the best of my ability. I will ask you about the health of your family and other household members. We will also ask questions about your satisfaction with health services and child immunization.

[Risk and Benefit]

Participating in this survey does not pose any risk to you. Your responses will be kept confidential and no one other than the survey team will have access to them. Please note that your participation is completely voluntary. You have no obligation other than the time you dedicate to answering our questions. You have the option to refuse to answer any questions or to stop the interview. Participating in this survey will not directly benefit you, but it will help you and your household better understand access to health services and help them plan and deliver health services. approach can be incorporated which will potentially benefit all citizens.

[Confidentiality]

As I mentioned earlier, your response will remain confidential. The information we collect will be presented in reports and research papers by pooling all responses together and without identifying the respondents. Your address will only be used by a specially designated individual for follow-up purposes or accessible to my supervisors only to monitor my work.

Q.No.	Questions and Filters	Responses and Codes
A25	Do you have any questions you would like to ask before we start?	Yes ..... 1 No..... **(Go to A27)** 2
A26	**If yes,** what are the questions? **Interviewer:** Respond to question(s) to the best of your ability.	
A27	May I start the interview now?؟	Yes ..... 1 No..... 2
A28	[I have read the informed consent to the respondent, and she has expressed her consent for the interview.] **Name and code of interviewer.**	Name _____ Code __|__|__
If "A27=2" then "Go to M01".		

Section B: Eligible woman's background

I would like to start this interview by asking you a few questions about your background.

Q.No.	Questions and Filters	Responses and Codes
BPSU	re-enter the PSU code from the list	__|__|__|__
BHH	Re-enter the house number from the list	__|__|__|__
B00	Line number of respondent.	Line number.....__|__
B01	Line number of respondent from household roster [B01].	Line number.....__|__
B02	What is your full name?	Name .....
B03	What is the month and year of your birth?	a) Month .....__|__ b) Year.....__|__|__|__ Don't know month .....97 Don't know year 9997
B04	How old were you on your last birthday?	Age in completed years.....__|__
B04a	Age of woman in years [as per date of interview and date of birth]	Age in years [self-entered in CAPI]
B04b	Remaining age of woman in months [as per date of interview and date of birth]	Age in months [self-entered in CAPI]
B04c	Is the woman illegible for interview? **[Will be entered automatically]**	Yes .....1 No.....2
B05	Are you currently married?	Yes.....**[Go to B07]**.....1 No.....2
B06	What is your current marital status now?	Widowed .....1 Divorced\ Khula .....2 Separated 3
B07	How old were you at the time of your [first] marriage?	Age in completed years.....__|__ Don't know.....97
B08	What is your mother tongue?	Urdu .....01 Punjabi .....02 Sindhi .....03 Pashto .....04 Balochi .....05 Saraiki 06

Q.No.	Questions and Filters	Responses and Codes
		Hindko ..... 07 Pothowari ..... 08 Brahvi ..... 09 Persian ..... 10 Shina ..... 11 Kohistani ..... 12 Kashmiri ..... 13 Balti ..... 14 Burushaski ..... 15 Domaaki ..... 16 English ..... 17 Kalasha ..... 18 Khowar ..... 19 Wakhi ..... 20 Others **[Specify]** 96
B09	Have you ever attended school?	Yes ..... 1 No ..... **[Go to B12]** 2
B10	What is the highest level of school you attended: primary, middle, secondary, or higher than secondary?	Primary ..... 1 Middle ..... 2 Secondary ..... 3 Above secondary 4
B11	What is the highest grade have you completed?	Less than Class 1 ..... 00 Class 1 ..... 01 Class 2 ..... 02 Class 3 ..... 03 Class 4 ..... 04 Class 5 ..... 05 Class 6 ..... 06 Class 7 ..... 07 Class 8 ..... 08 Class 9 ..... 09 Class 10 ..... 10 FA/ FSc/ ICOM ..... 12 BA/ BBA/ BSc/ BCOM/ BED ..... 14 MA/ MBA/ MSc/ MED ..... 16 Degree in Engineering ..... 17 Degree in Medicine ..... 18 Degree in Agriculture ..... 19 Degree in Law ..... 20 MPhil / PhD ..... 21 Polytechnic Diploma 22

Q.No.	Questions and Filters	Responses and Codes
		Others **[Specify]** 96
[Interviewer: check from "B05". If respondent is not currently married, then "Go to C00"]		
B12	How old was your husband on his last birthday?	Age in completed years ..... __|__ Don't know 97
B13	Did your husband ever attend school?	Yes ..... 1 No ..... **[Go to B16]** ..... 2 Don't know ..... **[Go to B16]** 7
B14	What is the highest level of school your husband attended: primary, middle, secondary, or higher than secondary?	Primary ..... 1 Middle ..... 2 Secondary ..... 3 Above secondary ..... 4 Don't know 7
B15	What is the highest grade your husband completed?	Less than Class 1 ..... 00 Class 1 ..... 01 Class 2 ..... 02 Class 3 ..... 03 Class 4 ..... 04 Class 5 ..... 05 Class 6 ..... 06 Class 7 ..... 07 Class 8 ..... 08 Class 9 ..... 09 Class 10 ..... 10 FA/ FSc/ ICOM ..... 12 BA/ BBA/ BSc/ BCOM/ BED ..... 14 MA/ MBA/ MSc/ MED ..... 16 Degree in Engineering ..... 17 Degree in Medicine ..... 18 Degree in Agriculture ..... 19 Degree in Law ..... 20 MPhil / PhD ..... 21 Polytechnic Diploma ..... 22 Others **[Specify]** ..... 96 Don't know 97
B16	What is the occupation of your husband? That is, what kind of work does he mainly do?	Agricultural work ..... 01 Raising poultry / livestock ..... 02 Producing ghee / cheese / butter ..... 03 Collecting fuel / wood-cutting ..... 04 Preparing food 05

Q.No.	Questions and Filters	Responses and Codes
	[**Interviewer:** If more than one, please ask which one occupation or activity he is most preoccupied with.] **[Circle one response only.]**	Sewing / embroidery / crocheting....06 Producing raw products/carpets/textile/ ropes....07 Offering services for others in HH/shop/hotel....08 Independent paid work....09 Buying/selling goods in market/street/home....10 Helping in construction work....11 Learning a skill....12 Government service....13 Private service....14 Abroad....15 Retired....16 Unemployed....17 Others **[Specify]**....96
B17	Is there a blood relationship between you and your husband?	Yes....1 No.... **[Go to C00]**....2
B18	If yes, what kind of blood relationship do you have with him?	First cousin on father's side....1 First cousin on mother's side....2 Second cousin....3 Others **[Specify]**....6

Section C: Reproduction

Now I would like to ask you about all the pregnancies you have had in your entire life. By this, I mean all the children you have given birth to, whether they were born alive or still born; whether they are alive now or not; whether they live with you or not, and all pregnancies that did not result in a live birth. I understand that it is not easy to talk about stillbirths or pregnancies that ended before full term, but it is very important that you tell us all about them so that the government can develop programs to improve women's and children's health.

Q.No.	Questions and Filters	Responses and Codes
CPSU	Re-enter the PSU code from the list	__|__|__|__
CHH	Re-enter the house number from the list	__|__|__|__
CB01	Re-enter the respondent's line number from the roster	__|__
CB02	Re-enter the respondent's name from the roster	

Q.No.	Questions and Filters	Responses and Codes
C00	**[Interviewer: Check in B05 and B06]** What is your current marital status?	Currently married....1 Widowed..... **[Go to C02]**....2 Divorced\ Khula... **[Go to C02]**....3 Separated..... **[Go to C02]**....4
C01	Is your husband living currently with you or lives elsewhere in Pakistan or currently living abroad?	Living with her....1 Lives elsewhere in Pakistan....2 Currently living abroad....3
C02	Are you currently pregnant?	Yes....1 No....2 Don't know....7
C03	Have you ever been pregnant before?	Yes....1 No.... **[Go to E03]**....2
C04	Have you ever had a live birth?	Yes....1 No.... **[Go to C10]**....2
C05	How many live births you have had during your life? **[Also include the baby who cried at birth or showed signs of life but did not survive]**	a) Total....__|__ b) How many sons?....__|__ c) How many daughters?....__|__
C06	Do you have any sons or daughters who are now living with you?	Yes....1 No.... **[Go to C08]**....2
C07	How many sons and daughters live with you?	a) Sons at home....__|__ b) Daughters at home....__|__
C08	Do you have any sons or daughters who are alive but do not live with you?	Yes....1 No.... **[Go to C10]**....2
C09	How many sons and daughters are living away from home?	a) Sons elsewhere....__|__ b) Daughters elsewhere....__|__
C10	Have you ever given birth to a boy or girl who was born alive but died later? **If not, probe:** Any baby who cried or showed signs of life but did not survive?	Yes....1 No.... **[Go to C12]**....2
C11	How many boys and girls that you have given birth to, have died?	a) Sons died....__|__ b) Daughters died....__|__
C12	Did any of your pregnancies result in spontaneous or induced abortion or in still birth?	Yes....1 No.... **[Go to D01]**....2
C13	How many of your pregnancies resulted in spontaneous or induced abortion or in still births?	a) Spontaneous abortions....__|__ b) Induced abortions....__|__ c) Still births....__|__

Section D: Pregnancy history

Now I would like to ask about all your pregnancies, whether they are live births, stillbirths, or pregnancies that ended in spontaneous or induced abortion. I will start from your **first** pregnancy.

DPSU	DHH	DB01	DB02	D01	D02	D03	D04	D05	D06	D07	D08	D09	D10
Enter the PSU code [will be auto entered in CAPI]	Enter the house number from the list of houses [will be auto entered in the CAPI]	Enter the respondent's line number [will be auto entered in CAPI]	Enter the name of the respondent [will be auto entered in CAPI]	Pregnancy number	How many months after marriage did you get pregnant? Or How many months after your last pregnancy ended, did you get pregnant (again)?	On what calendar month and year did this pregnancy end? **33=Currently pregnant** **97=Don't know month** **9997=Don't know year**	How long did this pregnancy last?	What was the outcome of this pregnancy? **If 1,2,3 go to next pregnancy [row]** **[If code is 5, skip to next section]**	Did [birth] result in single or twin? **[If outcome of birth is "Twin/Mult" ask D05-D10 for each newborn]**	What name was given to the baby?	What was the sex of the baby?	Is the baby still alive?	**[If alive]** What is the age of the baby? **[If died]** Age at death? [**Interviewers: Record days if less than 1 month. Months if less than one year.**
				a)1st pregnancy	__|__|__ Months after marriage	a) Month ..__|__ b) Year __|__|__|__	a) Weeks.__|__ b) Months__|__	Miscarriage 1 Abortion ..... 2 Still birth .... 3 Live birth ... 4 Currently pregnant.... 5	Single.....1 Twin/Mult...2		Son.....1 Daughter.....2 Transgender3	Yes.....1 No.....2	a) Days ..... __|__ b) Months . __|__ c) Years ..... __|__
				b)2nd pregnancy	__|__|__ Months after 1st pregnancy ended	a) Month ..__|__ b) Year __|__|__|__	a) Weeks.__|__ b) Months__|__	Miscarriage 1 Abortion ..... 2 Still birth .... 3 Live birth ... 4 Currently pregnant.... 5	Single.....1 Twin/Mult...2		Son.....1 Daughter.....2 Transgender3	Yes.....1 No.....2	a) Days ..... __|__ b) Months . __|__ c) Years ..... __|__
				c)3rd pregnancy	__|__|__ Months after 2nd pregnancy ended	a) Month __|__ b) Year __|__|__|__	a) Weeks.__|__ b) Months__|__	Miscarriage 1 Abortion ..... 2 Still birth .... 3 Live birth ... 4 Currently pregnant.... 5	Single.....1 Twin/Mult...2		Son.....1 Daughter.....2 Transgender3	Yes.....1 No.....2	a) Days ..... __|__ b) Months . __|__ c) Years ..... __|__
				d)4th pregnancy	__|__|__ Months after 3rd pregnancy ended	a) Month __|__ b) Year __|__|__|__	a) Weeks.__|__ b) Months__|__	Miscarriage 1 Abortion ..... 2 Still birth .... 3 Live birth ... 4 Currently pregnant.... 5	Single.....1 Twin/Mult...2		Son.....1 Daughter.....2 Transgender3	Yes.....1 No.....2	a) Days ..... __|__ b) Months . __|__ c) Years ..... __|__
				e)5th pregnancy	__|__|__ Months after 4th pregnancy ended	a) Month __|__ b) Year __|__|__|__	a) Weeks.__|__ b) Months__|__	Miscarriage 1 Abortion ..... 2 Still birth .... 3 Live birth ... 4 Currently pregnant.... 5	Single.....1 Twin/Mult...2		Son.....1 Daughter.....2 Transgender3	Yes.....1 No.....2	a) Days ..... __|__ b) Months . __|__ c) Years ..... __|__

Section E: Fertility preferences

Now I will ask you a few questions about your desire to have children.

Q.No.	Questions and Filters	Responses and Codes
EPSU	Enter the PSU code [will be auto entered in CAPI]	__|__|__|__
EHH	Enter the house number from the list of houses [will be auto entered in the CAPI]	__|__|__|__
EB01	Enter the respondent's line number [will be auto entered in CAPI]	__|__
EB02	Enter the name of the respondent [will be auto entered in CAPI]	
E00	**Interviewer: Check in B05 and B06** What is your current marital status?	Currently married .....1 Widowed .....2 Divorced/ Khula .....3 Separated 4
E01	The last/ this time you became pregnant, did you want to become pregnant then, did you want to wait until later, or did you not want to have any [more] children at all?	Then..... **[Go to E03]** .....1 Later .....2 Not at all..... **[Go to E03]**.....3 Undecided/ Don't know.... **[Go to E03]** 7
E02	How much longer would you like to have waited? **[Interviewer: Fill in a and b, if does not tell time, circle 97]**	a) Months ..... __|__ b) Years..... __|__ Don't know 97
	[If E00 = 2,3,4 (Not currently married) Go to E08]	
E03	In future would you like to have another child, or would you prefer not to have any (more) children? **If pregnant:** After the child you are expecting now, would you like to have another child, or would you prefer not to have any more children?	Want more.....1 Don't want more **[Go to E06]**.....2 Cannot get pregnant..... **[Go to E06]** .....3 Don't know/ Unsure..... **[Go to E06]**.....7

Q.No.	Questions and Filters	Responses and Codes
E04	How many more children do you want to have *in the future* i.e., how many sons and how many daughters? **If pregnant:** After the child you are expecting, how many more children do you want to have in the future i.e., how many sons and how many daughters?	a) Total..... __|__ b) How many sons?..... __|__ c) How many daughters? ..... __|__
E05	How long would you like to wait from now before the birth of a/ another child? **If Pregnant:** After the birth of the child you are expecting, how long would you like to wait until the birth of your next child?	a) Months..... __|__ b) Years..... __|__ As soon as possible.....94 God's will .....95 Undecided/ Don't know 97
E06	If you could choose exactly the number of children to have in your whole life, how many would that be and how many of them sons and how many daughters? **[Probe]**	a) Total..... __|__ b) How many sons?..... __|__ c) How many daughters? ..... __|__ Others **[Specify]**.....96
E07	Do you think your husband wants the same number of children that you want, or he wants more than what you want or fewer than what you want?	Same number.....1 More children .....2 Fewer children .....3 Don't know.....7
E08	When did your last menstrual period start?	a) Days ago, ... __|__ b) Months ago,..... __|__ c) Years ago, ... __|__ In menopause/ has had hysterectomy .....93 Before last birth.....94 Menstruation has not stopped yet.....95

Section F: Contraception

Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy.

FPSU	FHH	FB01	FB02	Q.No.	Questions and Filters			Responses and Codes				
Enter the PSU code [will be auto entered in CAPI]	Enter the house number from the list of houses [will be auto entered in the CAPI]	Enter the respondent's line number [will be auto entered in CAPI]	Enter the name of the respondent [will be auto entered in CAPI]	**List of contraceptive methods [read]**	**F01:** Do you know the [method]? **[if no, go to next row]**			**F02:** Have you *ever* used [method]? **[if F02=2 or C02=1 then go to next row]**		**F03:** Are you currently using [method]? **[Code 8 if not currently married]**		
					Spontaneous	Prompted	No	Yes	No	Yes	No	NA
				a) Female Sterilization	1	2	3	1	2	1	2	8
				b) Male Sterilization	1	2	3	1	2	1	2	8
				c) IUD	1	2	3	1	2	1	2	8
				d) Injectable	1	2	3	1	2	1	2	8
				e) Sayana press	1	2	3	1	2	1	2	8
				f) Implants	1	2	3	1	2	1	2	8
				g) Oral pills	1	2	3	1	2	1	2	8
				h) Male condom	1	2	3	1	2	1	2	8
				i) Female condom	1	2	3	1	2	1	2	8
				j) Emergency contraceptive pills [ECP]	1	2	3	1	2	1	2	8
				k) Standard Days Method	1	2	3	1	2	1	2	8
				l) Lactational amenorrhea method	1	2	3	1	2	1	2	8
				m) Rhythm method	1	2	3	1	2	1	2	8
				n) Withdrawal	1	2	3	1	2	1	2	8
				o) Others **[Specify]**	1	2	3	1	2	1	2	8

Q.No.	Questions and Filters	Responses and Codes
GPSU	Enter the PSU code [will be auto entered in CAPI]	__|__|__|__
GHH	Enter the house number from the list of houses [will be auto entered in the CAPI]	__|__|__|__
GB01	Enter the respondent's line number [will be auto entered in CAPI]	__|__
GB02	Enter the name of the respondent [will be auto entered in CAPI]	

F04	**Interviewer:** check F02:	At least one Yes [Ever user] 1 Not a single Yes [Never user] ..... **[Go to F56]** 2
F05	**Interviewer**: check F03:	At least one Yes [Current user] ..... 1 Not a single Yes [Past user] ... **[Go to F40]** 2
	Current Users	
F06	Since what month and year have you been using the current method without interruption? OR For how many months have you been using the current method without interruption?	**Calendar month and year** a) Month ..... __|__ b) Year..... __|__|__|__ Don't know month ..... 97 Don't know year..... 9997 **Duration in months** c) In months..... __|__|__ Don't know..... 997
F07	What were the reasons to choose the current method? **[Multiple responses are allowed]**	It is easily available ..... 01 Low cost..... 02 Convenient to use ..... 03 Suitable for respondent/ husband ..... 04 No/ fewer side effects..... 05 Can be used for long period..... 06 No other method available ..... 07 Method always available..... 08 Provider advised..... 09 Female friend/ relative advised..... 10 Others **[Specify]** 96
F08	**[Interviewer**: checkF03]	If yes in any m, n, or o: [Traditional method user]..... 1 Otherwise [Modern method user] ..... **[Go to F10]**..... 2
F09	What are the reasons that you are not using any modern contraceptive methods? **[Multiple responses are allowed]**	Not having sex..... 01 Infrequent sex ..... 02 Menopausal..... 03 Can't get pregnant..... 04 Not menstruated since last birth..... 05 Breastfeeding..... 06 Up to God/ Fatalistic ..... 07 Respondent opposed..... 08 Husband opposed ..... 09 In laws opposed ..... 10 Religious prohibition ..... 11 Knows no method ..... 12 Knows no source..... 13 Inconvenient to use..... 14 Changes in menstrual bleeding..... 15 Methods could cause infertility ..... 16 Interferes with body's normal processes..... 17
		Lack of access/ Too far ..... 18 Costs too much ..... 19 Preferred method not available ..... 20 No method available ..... 21 Due side effects..... 22 Want more children ..... 23 Hysterectomy ..... 24 Others **[Specify]** 96
F10	Where did you obtain the current method last time? If the source is a hospital, health center, or clinic, write the name and the place. _____ [Name and address of place]	**Public facility** Teaching Hospital..... 01 DHQ ..... 02 THQ ..... 03 Type-D Health Facility..... 04 RHC..... 05 BHU..... 06 MCH Center/ FH Center ..... 07 Government/ Civil Dispensary ..... 08 Family Welfare Centre [FWC]..... 09 Family Welfare Worker [FWW]..... 10 Family Welfare Counselor [FWC]..... 11 Family Welfare Assistant [FWA]..... 12 Lady Health Worker [LHW] ..... 13 Community Midwife [CMW]..... 14 **Private facility** Private hospital with inpatient facility ..... 15 Private Male MBBS Doctor Clinic..... 16 Private Female MBBS Doctor Clinic..... 17 Nurse Clinic ..... 18 LHV Clinic..... 19 Dispenser Clinic ..... 20 GSM Clinic..... 21 NGO Clinic ..... 22 **Workers** Nutrition Assistant ..... 23 Vaccinator..... 24 Suraj Worker..... 25 Pehli Kiren Worker ..... 26 Marvi Worker..... 27 Hakim/ Homeopath..... 28 Pharmacy/ Chemist..... 29 Others **[Specify]**..... 96 Not applicable..... 98
F11	Are you fully satisfied with the contraceptive method you are currently using?	Yes ..... 1 No 2
F12	Would you like to continue using your current method?	Yes ..... 1 No 2

HPSU	HHH	HB01	HB02	F13. Ask about each (worker).	1		2		3	
Enter the PSU code [will be auto entered in CAPI]	Enter the house number from the list of houses [will be auto entered in the CAPI]	Enter the respondent's line number [will be auto entered in CAPI]	Enter the name of the respondent [will be auto entered in CAPI]		Is there a [worker] in your area?		Has [worker] visited your home in the past 4 months?		Did the [worker] talk about family planning?	
					If "No", go to next line		If "No", go to next line			
					Yes	No	Yes	No	Yes	No
				a) Lady health worker (LHW)	1	2	1	2	1	2
				b) Community midwife (CMW)	1	2	1	2	1	2
				c) Suraj worker	1	2	1	2	1	2
				d) Pehli Kiren worker	1	2	1	2	1	2
				e) Marvi worker	1	2	1	2	1	2
				f) Others **[Specify]**	1	2	1	2	1	2

Q.No.	Questions and Filters	Responses and Codes
H1PSU	Enter the PSU code [will be auto entered in CAPI]	__|__|__|__
H1HH	Enter the house number from the list of houses [will be auto entered in the CAPI]	__|__|__|__
H1B01	Enter the respondent's line number [will be auto entered in CAPI]	__|__
H1B02	Enter the name of the respondent [will be auto entered in CAPI]	
	Questions F14 - F18 are only for PUNJAB	
F14	Do you know of any family planning voucher scheme introduced in your community?	Yes.....1 No..... **[Go to F19]**.....2
F15	Do you know what the procedure is to avail the voucher scheme for FP services?	Yes ..... 1 No 2
F16	Have you utilized this FP voucher?	Yes..... **[Go to F19]** ..... 1 No 2
F17	Why have you not utilized the FP voucher? **[Multiple responses are allowed]**	Infrequent sex/ No sex..... 01 Menopausal/ Too old ..... 02 No need because sterilization is done.... 03 Hysterectomy [surgical removal of uterus] ..... 04 No one visited home regarding voucher . 05 Want to become pregnant ..... 06 Don't want to use contraception..... 07 Doesn't know where to obtain a voucher ..... 08 Doesn't know if eligible for a voucher.. 09 Received voucher but don't know where/how to cash it..... 10 Provider refused to give me a voucher 11 Other **[Specify]** 96
	If "F17=11" then ask "F18" otherwise "Go to F19".	
F18	What reasons did the provider give you for not giving you a voucher? **[Multiple responses are allowed]**	No reason given..... 01 They were out of vouchers ..... 02 I am not eligible for financial reasons . 03 I do not have an ID card ..... 04 Was told I needed permission from my husband ..... 05 Was told I was too young/ had too few children ..... 06 Other **[Specify]** 96
	Check in "F08=1" if respondent is using a traditional method, then "Go to F40".	
	When you visited the health facility last time to get family planning services	
F19	How was the staff's attitude towards you?	Cooperative/Friendly..... 1 Polite attitude..... 2 Non-cooperative/Unfriendly..... 3 Hostile ..... 4 Her husband brought 5
F20	Was the doctor/worker available whenever you went to the facility?	Staff always available..... 1 Staff not available..... 2
F21	How long you have to wait at the facility before checkup?	No waiting time..... 01 5 – 10 minutes..... 02 11 – 20 minutes..... 03 21 – 30 minutes..... 04 31 – 60 minutes..... 05 More than 1 hour ..... 06 Don't remember 97

F22	What type of transport was used to reach the health facility? **Multiple responses are allowed][**	On foot ..... 01 Motorcycle ..... 02 Rickshaw/ Chingchi (QingQi) ..... 03 Bus/ Van ..... 04 Tonga/ Cart ..... 05 Car ..... 06 Ambulance ..... 07 Boat ..... 08 Others **[Specify]** ..... 96 Don't know 97
F23	How long does it take to go there? (ONE WAY)	Time (In minutes) ..... __|__|__ Don't know 997
F24	What were the expenses that you had to bear to get the current contraceptive method? (**Interviewer: Probe for each one)** **If no expense write "0000000".** **If don't know expense write "9999997".** **If not applicable write "9999998"**	a) Expenses on travel __|__|__|__|__|__|__ b) Expenses on fee __|__|__|__|__|__|__ c) Expenses on medicine __|__|__|__|__|__|__ d) Expenses on lab tests __|__|__|__|__|__|__ e) Expenses on operation __|__|__|__|__|__|__ f) Bed charges __|__|__|__|__|__|__ g) Other expenses __|__|__|__|__|__|__ h) Total ..... __|__|__|__|__|__|__
F25	Can you [usually] go there on your own or do you need to take someone along with you or cannot go at all?	Can go alone ..... 1 Need someone to accompany me ..... 2 Can't go at all 3
F26	Do you need permission to go there?	Yes ..... 1 No ..... (**Go to F28**) 2
F27	Whose permission do you require to go there?	Husband ..... 1 In-laws ..... 2 Both husband and in-laws ..... 3 Others **[Specify]** 6
F28	To access family planning service, do you visit the nearest facility?	Yes ..... (**Go to F30**) ..... 1 No 2

F29	Why do you not use your nearest facility? **[Multiple responses are allowed]**	Services are not good ..... 01 Facility remains close often ..... 02 Staff not available ..... 03 Female provider not available ..... 04 Expensive ..... 05 Shortage of FP methods ..... 06 Behavior of staff is not good ..... 07 No privacy ..... 08 Concerned about confidentiality ..... 09 Don't want neighborhood to know I am using FP ..... 10 Don't know which is the nearest health facility ..... 11 Doesn't want her family to know ..... 12 Others **[Specify]** 96
F30	Why did you choose this health facility for getting the contraceptive method you are currently using? **[Multiple responses are allowed]**	Close to home ..... 01 Unnoticeable location ..... 02 Know confidentiality will be respected ..... 03 Have the method that I want ..... 04 Providers have a good reputation ..... 05 Recommend by friend/ relative ..... 06 Method available for low cost / free ..... 07 Female provider available ..... 08 Others **[Specify]** 96
F31	Did you get the method you wanted?	Yes ..... (**Go to F33**) ..... 1 No 2
F32	If no, why not? **[Multiple responses are allowed]**	The method I needed was not available . 01 No specific method information ..... 02 The cost of the method was high ..... 03 The service provider suggested another method ..... 04 Female staff was not available ..... 05 Told that the method has more side effects ..... 06 She had no method in mind ..... 07 Others **[Specify]** 96
F33	Would you recommend your friend or relative to take family planning services from this health facility?	Yes ..... 1 No 2
F34	Can/ did you approach the topic of family planning with your husband easily or do/ did you have to wait for him to do so first?	Easily ..... 1 With difficulty ..... 2 Has to wait for husband to initiate discussion ..... 3 Can't talk at all 4

F35	Did the service provider provide you the [information] about the current contraceptive method the first time you visited him/ her for family planning? **Interviewer: Read one by one.**	Information	Yes	No	NA
		a) About the method, you prefer to use	1	2	8
		b) How the method works	1	2	8
		c) How to use method	1	2	8
		d) Contraindications	1	2	8
		e) Effectiveness/ Duration of effectiveness	1	2	8
		f) Advantages as compared to other methods	1	2	8
		g) Disadvantages as compared to other methods	1	2	8
		h) Possible side effects	1	2	8
		i) What to do if experience side effects	1	2	8
		j) Where to go in case of side effects	1	2	8
		k) Possibility of switching	1	2	8
		l) About other methods that you could use	1	2	8
		m) Others **[Specify]**	1	2	8

F36a	Have you experienced any side effects from using the current method?	Yes ..... 1 No 2
	Instructions for Interview: If 'no' in F36a **1. Check if F04=1 then go to F40.** **2. Check if F04=2 then go to G00.**	
F36	Did you experience or are you experiencing any side effects that you think are due to using the current method?	Yes ..... 1 No 2
	Instructions for Interview: If 'no' in F36a **1. Check if F04=1 then go to F40.** **2. Check if F04=2 then go to G00.**	

F37	What side effect[s] do/ did you face? **[Multiple responses are allowed]**	Heavy bleeding ..... 01 Irregular bleeding..... 02 Weight gain ..... 03 Weakness..... 04 Spotting..... 05 Infection..... 06 Nausea/ dizziness..... 07 Headache..... 08 Back ache ..... 09 Allergy..... 10 Irritation..... 11 White discharge..... 12 IUD expelled..... 13 Pain in low abdomen..... 14 Body swelled..... 15 Menopause..... 16 Freckles on the face..... 17 Others **[Specify]** 96
F38	Where did you go for the treatment of side effects? **[Multiple responses are allowed]**	Didn't seek treatment ..... 00 **Public facility** Teaching Hospital ..... 01 DHQ ..... 02 THQ..... 03 Type-D Health Facility ..... 04 RHC..... 05 BHU..... 06 MCH Center/ FH Center ..... 07 Government/ Civil Dispensary.... 08 Family Welfare Centre [FWC] ..... 09 Family Welfare Worker [FWW]..... 10 Family Welfare Counselor [FWC].. 11 Family Welfare Assistant [FWA] .. 12 Lady Health Worker [LHW] ..... 13 Community Midwife [CMW]..... 14 **Private facility** Private hospital with inpatient facility ..... 15 Private Male MBBS Doctor Clinic. 16 Private Female MBBS Doctor Clinic..... 17 Nurse Clinic..... 18 LHV Clinic ..... 19 Dispenser Clinic..... 20 GSM Clinic..... 21 NGO Clinic ..... 22 **Workers** Nutrition Assistant ..... 23 Vaccinator ..... 24 Suraj Worker 25

		Pehli Kiren Worker ..... 26 Marvi Worker.....27 Hakim/ Homeopath..... 28 Pharmacy/ Chemist..... 29 Others **[Specify]**..... 96
F39	Was the health problem resolved?	Yes ..... 1 No..... 2

Instructions for Interview: If 'no' in F36a
1. Check if F04=1 then go to F40.
2. Check if F04=2 then go to G00.

Past Users (F05=2)

F40	What was the most recent method you have used?	IUD ..... 03 Injectables ..... 04 Implants..... 05 Sayana Press..... 06 Oral Pills..... 07 Male Condom ..... 08 Female Condom ..... 09 EC Pills ..... 10 Standard Days Method ..... 11 Lactational Amenorrhea Method ..... 12 Rhythm Method..... 13 Withdrawal..... 14 Current method is being used continuously [Go to Section G] . 15 Others **[Specify]**..... 96
F41	In which month and year did you start using the [last] method?	**Calendar month and year** a) Month .....__|__ b) Year .....__|__|__|__ Don't know month.....97 Don't know year..... 9997 **Duration in months** c) In months.....__|__|__ Don't know..... 997
F42	In which month and year did you stop using the [last] method?	**Calendar month and year** a) Month .....__|__ b) Year .....__|__|__|__ Don't know month.....97 Don't know year..... 9997 **Duration in months** c) In months.....__|__|__ Don't know..... 997

F43	For how long you had used the [last] method before stopping to use?	Months..... __|__ Less than one month 00
F44	What were the reasons to choose the last method you used? **[Multiple responses are allowed]**	It is easily available .....01 Low cost.....02 Convenient to use.....03 Suitable for myself.....04 Suitable for husband.....05 Fewer side effects .....06 Can be used for long period.....07 No other method available.....08 Method always available.....09 Provider advised.....10 Female friend/ relative advised 11 Husband brought.....12 Others **[Specify]** 96
F45	Have you recommended this method to someone else?	Yes .....1 No 2
F46	Have you ever recommended someone not to use this method?	Yes .....1 No 2
F47	From where did you obtain the last method?	**Public facility** Teaching Hospital .....01 DHQ ..... 02 THQ..... 03 Type-D Health Facility ..... 04 RHC..... 05 BHU..... 06 MCH Center/ FH Center .....07 Government/ Civil Dispensary.... 08 Family Welfare Centre [FWC] ..... 09 Family Welfare Worker [FWW].....10 Family Welfare Counselor [FWC]..11 Family Welfare Assistant [FWA] .. 12 Lady Health Worker [LHW].....13 Community Midwife [CMW].....14 **Private facility** Private hospital with inpatient facility .....15 Private Male MBBS Doctor Clinic.16 Private Female MBBS Doctor Clinic.....17 Nurse Clinic.....18 LHV Clinic .....19 Dispenser Clinic..... 20 GSM Clinic.....21 NGO Clinic 22

		Workers Nutrition Assistant ..... 23 Vaccinator.....24 Suraj Worker..... 25 Pehli Kiren Worker ..... 26 Marvi Worker.....27 Hakim/ Homeopath..... 28 Pharmacy/ Chemist..... 29 Others **[Specify]**..... 96

F48 Did the service provider offer you any [information] about the last contraceptive method the first time you visited him/ her for family planning?

Interviewer: Read one by one.

Information	Yes	No	NA
a) About the method, you prefer to use	1	2	8
b) How the method works	1	2	8
c) How to use method	1	2	8
d) Contraindications	1	2	8
e) Effectiveness/ Duration of effectiveness	1	2	8
f) Advantages as compared to other methods	1	2	8
g) Disadvantages as compared to other methods	1	2	8
h) Possible side effects	1	2	8
i) What to do if experience side effects	1	2	8
j) Where to go in case of side effects	1	2	8
k) Possibility of switching	1	2	8
l) About other methods that you could use	1	2	8
m) Others **[Specify]**	1	2	8

F49	What were the reasons to stop using the [last] method? **[Multiple responses allowed]**	Wanted another child.....01 Experienced side effects.....02 Method failure.....03 Source of method was too far ..04 Due to travel/ travel cost.....05 Faced health issues other than side effects.....06 Method was not available .....07 Cost was not affordable.....08 Method was inconvenient to use.....09 Rest from the method.....10 Missed the dose.....11 Provider advised to stop use ....12 Infrequent sex/ husband away.13
		Husband's advice .....14 In-laws oppose.....15 Menopause.....16 Others **[Specify]** .....96 Don't know.....97
F50a	Did you face any side effects by using [last] method?	Yes .....1 No..... **[Go to F63]** 2
F50	The side affects you experienced were those due to the use of the [last] method?	Yes .....1 No..... **[Go to F63]** 2
F51	What side effect[s] did you face? **[Multiple responses are allowed]**	Heavy bleeding .....01 Irregular bleeding..... 02 Weight gain ..... 03 Weakness..... 04 Spotting ..... 05 Infection..... 06 Nausea/ dizziness .....07 Headache..... 08 Back ache ..... 09 Allergy .....10 Irritation .....11 White discharge ..... 12 IUD expelled .....13 Pain in low abdomen .....14 Body swelled .....15 Others **[Specify]** 96
F52	Did you consult anyone for the management of side effects?	Yes .....1 No.....**[Go to F63]** 2
F53	Whom did you consult? **[Multiple responses are allowed]**	**Public facility** Teaching Hospital ..... 01 DHQ..... 02 THQ..... 03 Type-D Health Facility ..... 04 RHC ..... 05 BHU ..... 06 MCH Center/ FH Center .....07 Government/ Civil Dispensary.... 08 Family Welfare Centre [FWC] ..... 09 Family Welfare Worker [FWW] .... 10 Family Welfare Counselor [FWC] 11 Family Welfare Assistant [FWA] .. 12 Lady Health Worker [LHW]..... 13 Community Midwife [CMW] ..... 14 **Private facility** Private hospital with inpatient facility ..... 15 Private Male MBBS Doctor Clinic 16

		Private Female MBBS Doctor Clinic ..... 17 Nurse Clinic ..... 18 LHV Clinic ..... 19 Dispenser Clinic ..... 20 GSM Clinic ..... 21 NGO Clinic ..... 22 **Workers** Nutrition Assistant ..... 23 Vaccinator ..... 24 Suraj Worker ..... 25 Pehli Kiren Worker ..... 26 Marvi Worker ..... 27 Hakim/ Homeopath ..... 28 Pharmacy/ Chemist ..... 29 Others **[Specify]** 96

F54	What did the service provider/ worker advise you to do? **[Interviewer: Read one by one]**	Information	Yes	No
		a) Advised to continue the use of method	1	2
		b) Advised to stop the use of method	1	2
		c) Gave medicine	1	2
		d) Switched to another method	1	2
		e) Advised rest from method	1	2
		f) Referred to higher level facility	1	2
		g) Others **[Specify]**	1	2

F55	Was the problem resolved?	Yes ..... 1 No 2

Interviewer: After asking F55 "Go to F63".

Never Users (F04=2)

F56	Did you ever want to do anything to delay or avoid getting pregnant?	Yes ..... 1 No ..... **[Go to F60]** 2
F57	Have you ever talked/ consulted anyone about using ways to delay or avoid getting pregnant?	Yes ..... 1 No ..... **[Go to F60]** 2
F58	Whom did you speak with first?	Husband ..... 01 Mother-in-law ..... 02 Sister-in-law ..... 03 Sister ..... 04 Mother 05

		Friend/ Neighbor/ Other relative ..... 06 UTBA/ DAI ..... 07 LHW/ CMW ..... 08 LHV/ Nurse ..... 09 FWW/ FWC/ FWA ..... 10 MBBS Doctor ..... 11 Suraj Worker ..... 12 Pehli Kiren Worker ..... 13 Marvi Worker ..... 14 Others **[Specify]** 96
F59	Whom did you speak with last?	Husband ..... 01 Mother-in-law ..... 02 Sister-in-law ..... 03 Sister ..... 04 Mother ..... 05 Friend/ Neighbor/ Other relative ..... 06 UTBA/ DAI ..... 07 LHW/ CMW ..... 08 LHV/ Nurse ..... 09 FWW/ FWC/ FWA ..... 10 MBBS Doctor ..... 11 Suraj Worker ..... 12 Pehli Kiren Worker ..... 13 Marvi Worker ..... 14 Others **[Specify]** 96
F60	What were the reasons for you and your husband to not use any form of contraception for delaying or avoiding pregnancy? **[Multiple responses are allowed]**	Not having sex ..... 01 Infrequent sex ..... 02 Menopausal ..... 03 Can't get pregnant ..... 04 Not menstruated since last birth ..... 05 Breastfeeding ..... 06 Up to God/ Fatalistic ..... 07 Respondent opposed ..... 08 Husband opposed ..... 09 Others opposed ..... 10 Religious prohibition ..... 11 Knows no method ..... 12 Knows no source ..... 13 Inconvenient to use ..... 14 Changes in menstrual bleeding 15 Methods could cause infertility. 16 Interferes with body's normal processes ..... 17 Health issues ..... 18 Fear of side effects ..... 19 Source of method was too far ... 20

		Due to travel/ travel cost.....21 Costs too much .....22 Preferred method not available 23 No method available.....24 Respondent/ Husband infertile 25 Wanted [more] children .....26 Hysterectomy.....27 Others **[Specify]**.....96
F61	Do you know a place where you can obtain a method to delay or avoid getting pregnant?	Yes ..... 1 No..... **[Go to F63]** 2
F62	What are the places that you know where you can obtain a method? **[Multiple responses are allowed]**	**Public facility** Teaching Hospital .....01 DHQ ..... 02 THQ..... 03 Type-D Health Facility..... 04 RHC..... 05 BHU..... 06 MCH Center/ FH Center .....07 Government/ Civil Dispensary .... 08 Family Welfare Centre [FWC] ..... 09 Family Welfare Worker [FWW]..... 10 Family Welfare Counselor [FWC]. 11 Family Welfare Assistant [FWA]... 12 Lady Health Worker [LHW] ..... 13 Community Midwife [CMW]..... 14 **Private facility** Private hospital with inpatient facility..... 15 Private Male MBBS Doctor Clinic.16 Private Female MBBS Doctor Clinic .....17 Nurse Clinic..... 18 LHV Clinic ..... 19 Dispenser Clinic ..... 20 GSM Clinic.....21 NGO Clinic ..... 22 **Workers** Nutrition Assistant ..... 23 Vaccinator.....24 Suraj Worker..... 25 Pehli Kiren Worker ..... 26 Marvi Worker.....27 Hakim/ Homeopath..... 28 Pharmacy/ Chemist..... 29 Others **[Specify]**..... 96

F63	Will you or your husband use any method in the future to delay or avoid getting pregnant?	Very definitely ..... 1 Most likely.....2 Not sure/ May be.....**[Go to G00]**3 No..... **[Go to G00]**..... 4 Can't get pregnant... **[Go to G00]**5
F64	Which method will you or your husband use in the future?	Female Sterilization.....01 Male Sterilization.....02 IUD .....03 Injectables .....04 Sayana Press .....05 Implants.....06 Oral Pills.....07 Male Condom .....08 Female Condom .....09 EC Pills .....10 Standard Days Method .....11 Lactational Amenorrhea Method .....12 Rhythm Method .....13 Withdrawal.....14 Others **[Specify]** .....96 Don't know.....97
F65	When do you think, you will start using a method?	a) Months.....__|__ b) Years..... __|__ Soon/ Now.....94 After the birth of this child.....95 Don't know.....97

Section G: Antenatal care [Last/ Current pregnancy in last 3 years]

Now I want to speak to you about your last full-term pregnancy that has taken place in the **last three years**.

Instructions for the interviewer:

- Ask about the last completed pregnancy of all women who are [currently pregnant] or not pregnant who had a completed pregnancy in the last 3 years.
- If the woman is currently pregnant for the first time, ask about the current pregnancy.
- If the woman has not had a full-term pregnancy in the last 3 years, ask about the current pregnancy.
- If the woman has had two pregnancies in the last 3 years, the last pregnancy was a miscarriage and the previous pregnancy was full term, ask about complete pregnancy.
- If the woman is not pregnant yet and has had a miscarriage in the last 3 years, ask about the pregnancy regardless of the number of months [of course it is 2 months or 3 months].
- If a woman is currently pregnant and has not completed a pregnancy in the previous 3 years, we will ask about the missed pregnancy in the previous 3 years.

Q.No.	Questions and Filters	Responses and Codes
IPSU	Enter the PSU code [will be auto entered in CAPI]	__|__|__|__
IHH	Enter the house number from the list of houses [will be auto entered in the CAPI]	__|__|__|__
IB01	Enter the respondent's line number [will be auto entered in CAPI]	__|__
IB02	Enter the name of the respondent [will be auto entered in CAPI]	
G00	Write the line number of respondent from HH roster?	Line number from HH roster.... __|__
G01	Write line number of pregnancy from **D01**.	Line number of pregnancy..... __|__
G02	**[Interviewer: Check C03]** Has the woman ever been pregnant?	Yes .....1 No..... **[Go to L01]**.....2
G03	How long ago did your last pregnancy start?	a) Months ago,..... __|__ b) Years ago, ... __|__ **[Skip to J01 if 37 or more months ago]**
G04	Did you see anyone for antenatal care during your [last/current] pregnancy?	Yes .....1 No..... **[Go to H01]**.....2
G05	Whom did you see? **[Multiple responses are allowed]**	MBBS Doctor ..... 01 Lady Health Worker [LHW]..... 02 Community Midwife [CMW]..... 03 Lady Health Visitor [LHV]..... 04 Family Welfare Worker [FWW] ..... 05 Family Welfare Counselor [FWC] .. 06 Family Welfare Assistant [FWA] .... 07 Nurse ..... 08 Suraj Worker..... 09 Pehli Kiren Worker ..... 10 Marvi Worker ..... 11 Dispenser/ Compounder ..... 12 Others **[Specify]**..... 96

Q.No.	Questions and Filters	Responses and Codes
G06	Where did you receive antenatal care for the [last/current] [pregnancy?	**Public facility** Teaching Hospital .....01 DHQ ..... 02 THQ..... 03 Type-D Health Facility ..... 04 RHC ..... 05 BHU ..... 06 MCH Center/ FH Center .....07 Government/ Civil Dispensary..... 08 Family Welfare Centre [FWC] ..... 09 Family Welfare Worker [FWW] .....10 Family Welfare Counselor [FWC] .....11 Family Welfare Assistant [FWA] ..... 12 Lady Health Worker [LHW]..... 13 Community Midwife [CMW].....14 **Private facility** Private hospital with inpatient facility ..... 15 Private Male MBBS Doctor Clinic.....16 Private Female MBBS Doctor Clinic .17 Nurse Clinic..... 18 LHV Clinic ..... 19 Dispenser Clinic..... 20 GSM Clinic.....21 NGO Clinic..... 22 **Workers** Nutrition Assistant ..... 23 Vaccinator .....24 Suraj Worker ..... 25 Pehli Kiren Worker..... 26 Marvi Worker.....27 Hakim/ Homeopath ..... 28 Pharmacy/ Chemist ..... 29 Others **[Specify]** 96
G07	How many weeks or months pregnant were you when you first received antenatal care for the [last/current] pregnancy?	a) Weeks .....__|__ b) Months.....__|__ Don't know.....97
G08	How many times did you receive antenatal care during the [last/current] pregnancy?	Number of times.....__|__ Don't know.....97

JPSU	JHH	JB01	JB02	G09. During your [visit] did the provider [Read]: [Interviewer: Probe for each one]	1	2	3	4	5	6
Enter the PSU code [will be auto entered in CAPI]	Enter the house number from the list of houses [will be auto entered in the CAPI]	Enter the respondent's line number [will be auto entered in CAPI]	Enter the name of the respondent [will be auto entered in CAPI]		Last visit	2nd last visit	3rd last visit	4th last visit	5th last visit	6th last visit
					1. Yes 2. No 7. DK 8. NA	1. Yes 2. No 7. DK 8. NA	1. Yes 2. No 7. DK 8. NA	1. Yes 2. No 7. DK 8. NA	1. Yes 2. No 7. DK 8. NA	1. Yes 2. No 7. DK 8. NA
				a) Measured blood pressure						
				b) Taken blood sample						
				c) Taken urine sample						
				d) Measured weight						
				e) Examined breast						
				f) Examined pelvic						
				g) Checked foetal heart sound						
				h) Performed ultrasound/ Anomaly scan						
				i) Checked genital condition						

Q.No.	Questions and Filters	Responses and Codes
J1PSU	Enter the PSU code [will be auto entered in CAPI]	__|__|__|__
J1HH	Enter the house number from the list of houses [will be auto entered in the CAPI]	__|__|__|__
J1B01	Enter the respondent's line number [will be auto entered in CAPI]	__|__
J1B02	Enter the name of the respondent [will be auto entered in CAPI]	

G10	During any of your antenatal check-ups of [last/current] pregnancy, did the healthcare provider offer you advice on [read]? **[Interviewer: Read one by one]**	Yes	No
	a) On your nutrition and healthy eating	1	2
	b) On your anaemia	1	2
	c) On TT shots	1	2
	d) On use of iron tablets/ syrup	1	2
	e) Danger signs during pregnancy	1	2
	f) What to do if see danger signs	1	2
	g) Birth preparedness/ delivery plan [money, transport, attendant, place of delivery]	1	2
	h) Importance of birth spacing	1	2
	i) Importance of contraceptive use	1	2
	j) On postpartum family planning	1	2
	k) Counselled husband regarding FP	1	2
	l) On child's anaemia	1	2
	m) On breastfeeding	1	2
	n) Others **[Specify]**	1	2

G11	Do you have a card or any other document where your own immunisations are listed? **Interviewer:** If yes, ask: May I see it please?	Yes, seen ..... 1 Yes, not seen ..... 2 Don't have 3
G12	When you were pregnant, did you receive any injection in the arm or shoulder to prevent the baby from getting tetanus, that is, convulsions after birth?	Yes ..... 1 No..... **[Go to G14]** 2
G13	During the [last/ current] pregnancy, how many times did you get a tetanus injection?	Number of times .....__|__ Don't know 97
G14	At any time <u>before your current/ last pregnancy</u>, did you receive any tetanus injections?	Yes ..... 1 No..... **[Go to G17]** 2
G15	<u>Before your current/ last pregnancy</u>, how many times did you receive a tetanus injection?	Number of times .....__|__ Don't know 97

G16	How many months or years ago did you receive the last tetanus injection? **[If less than one year, write in 'a' and if more than one year, write in 'b']**	a) Months, ago ..... __|__ b) Years ago,..... __|__ Don't know.....97
G17	During your current/ last pregnancy, were you given iron tablets or iron syrup?	Yes .....1 No..... **[Go to G21]**.....2
G18	During your current/ last pregnancy, did you buy any iron tablets or iron syrup?	Yes .....1 No..... **[Go to G21]**.....2
G19	In which month of pregnancy did you start taking iron tablets or syrup?	Month of pregnancy ..... __|__
G20	During the current/ last pregnancy, for how long did you take the tablets or syrup?	a) Number of days..... __|__ b) Number of months..... __|__
G21	During your current/ last pregnancy, did you take any medication for intestinal worms?	Yes .....1 No.....2
G22	During your current/last pregnancy, did you take Fansidar tablet or syrup to keep you from getting malaria?	Yes .....1 No..... **[Go to G24]**.....2
G23	How many times did you take Fansidar tablet or syrup during your current/ last pregnancy?	Number of times..... __|__ Don't know.....97
G24	Did you face any serious health problems during your current/ last pregnancy?	Yes .....1 No..... **[Go to G28]**.....2
G25	What serious health problems did you face during your current/ last pregnancy? **[Multiple responses allowed]**	Severe/ Prolonged vomiting ..01 Shortness of breath.....02 Severe headache.....03 Blurring of vision .....04 Swelling over face .....05 Severe lower abdominal pain .....06 Spotting .....07 Heavy vaginal bleeding .....08 High fever with or without rigors .....09 Diagnosed high blood pressure .....10 Fits or convulsions .....11 Unconsciousness.....12 Weakness.....13 Anemia.....14 Others **[Specify]** 96

G26	Where did you first go to seek treatment of any serious health problems that you faced during your current/ last pregnancy?	Nowhere ..... 00 **Public facility** Teaching hospital ..... 01 DHQ ..... 02 THQ ..... 03 Type-D Health Facility ..... 04 RHC ..... 05 BHU ..... 06 MCH Center/ FH Center ..... 07 Government/ Civil Dispensary ..... 08 Family Welfare Centre [FWC] ..... 09 Family Welfare Worker [FWW] ..... 10 Family Welfare Counselor [FWC] ..... 11 Family Welfare Assistant [FWA] ..... 12 Lady Health Worker [LHW] ..... 13 Community Midwife [CMW] ..... 14 **Private facility** Private hospital with inpatient facility ..... 15 Private Male MBBS Doctor Clinic ..... 16 Private Female MBBS Doctor Clinic ..... 17 Nurse Clinic ..... 18 LHV Clinic ..... 19 Dispenser Clinic ..... 20 GSM Clinic ..... 21 NGO Clinic ..... 22 **Workers** Nutrition Assistant ..... 23 Vaccinator ..... 24 Suraj Worker ..... 25 Pehli Kiren Worker ..... 26 Marvi Worker ..... 27 Hakim/ Homeopath ..... 28 Pharmacy/ Chemist ..... 29 Others **[Specify]** 96
G27	Would you recommend your friend or relative to take services from the last health facility you visited for antenatal care?	Yes ..... 1 No 2
G28	Is this the respondent's first pregnancy? **[Check from C02: if respondent is currently pregnant]**	Yes ..... **[Go to J01]** ..... 1 No 2

Section H: Delivery care
[Last Delivery/ Pregnancy loss in the last 3 years]

Now, I would like to ask you a few questions about the care you received for the last delivery in the last 3 years, irrespective of whether it resulted in a live birth or not.

Q.No.	Questions and Filters	Responses and Codes
KPSU	Enter the PSU code [will be auto entered in CAPI]	__|__|__|__
KHH	Enter the house number from the list of houses [will be auto entered in the CAPI]	__|__|__|__
KB02	Enter the name of the respondent [will be auto entered in CAPI]	
H00	Write the line number of respondent from HH roster?	Line number from HH roster ..... __|__
H01	Write line number of pregnancy from **D01**.	Line number of pregnancy ..... __|__
H02	What was the outcome of your last pregnancy?	Spontaneous abortion.. **[Go to H05]**.... 1 Induced abortion..... **[Go to H05]** ..... 2 Still birth ..... 3 Live birth 4
H03	Was baby delivered normally or by caesarean section, that is, did they cut your belly open to take the baby out?	Normal vaginal delivery **[Go to H05]**.... 1 Assisted vaginal delivery **[Go to H05]** ..... 2 Caesarean section 3
H04	When was the decision made to have the caesarean section?	Before labour pains started ..... 1 After labour pains started 2
H05	Who assisted with the delivery/ pregnancy loss?	Lady doctor ..... 01 LHW ..... 02 CMW ..... 03 LHV ..... 04 FWW ..... 05 FWC ..... 06 FWA ..... 07 Nurse ..... 08 Suraj worker ..... 09 Pehli Kiren worker ..... 10 Marvi worker ..... 11 Female relative/ friend/neighbour .... 12 Others **[Specify]** 96

Q.No.	Questions and Filters	Responses and Codes
H06	Where did the delivery/ pregnancy loss take place?	At home.....**[Go to H09]**.....00 **Public facility** Teaching Hospital .....01 DHQ .....02 THQ.....03 Type-D Health Facility .....04 RHC.....05 BHU.....06 MCH Center/ FH Center .....07 Government/ Civil Dispensary.....08 Family Welfare Centre [FWC] .....09 Family Welfare Worker [FWW].....10 Family Welfare Counselor [FWC].....11 Family Welfare Assistant [FWA] .....12 Lady Health Worker [LHW].....13 Community Midwife [CMW].....14 **Private facility** Private hospital with inpatient facility....15 Private Male MBBS Doctor Clinic.....16 Private Female MBBS Doctor Clinic.....17 Nurse Clinic.....18 LHV Clinic .....19 Dispenser Clinic.....20 GSM Clinic.....21 NGO Clinic .....22 **Workers** Nutrition Assistant .....23 Vaccinator .....24 Suraj Worker .....25 Pehli Kiren Worker.....26 Marvi Worker.....27 Hakim/ Homeopath .....28 Pharmacy/ Chemist.....29 Others **[Specify]** 96
H07	Were you given oxytocin/ syntocinon injection after birth to help the delivery of the placenta?	Yes .....1 No.....2 Don't know 7
H08	How long after the delivery/ pregnancy loss did you stay there?	a) Hours ..... __|__ b) Days..... __|__ Don't know..... 97
Interviewer: Check H02, if pregnancy result is not "LIVE BIRTH" [i.e. code 1,2, or 3] then "Go to H35" after asking H08.		
H09	Did you hear your baby cry immediately?	Yes..... **[Go to H11]**.....1 No.....2

Q.No.	Questions and Filters	Responses and Codes
H10	If not, what was done to help the baby breathe? **[Multiple responses are allowed]**	Dried the child .....01 Cleared airway suction mouth with bulb syringe .....02 Stimulated child rubbing back and soles of feet.....03 Clamp the cord .....04 Perform bag mask ventilation.....05 Gave oxygen.....06 Others **[Specify]** .....96 Don't know.....97
H11	Immediately after the birth, was your child put on your chest?	Yes..... 1 No..... **[Go to H14]** ..... 2 Don't know ..... **[Go to H14]**..... 7
H12	Was the child's bare skin touching your bare skin?	Yes..... 1 No..... **[Go to H14]** ..... 2 Don't know ..... **[Go to H14]**..... 7
H13	Before being placed on the bare skin of your chest, was the baby wrapped up?	Yes..... 1 No..... 2 Don't know..... 7
H14	Was the child dried or wiped soon after birth?	Yes..... 1 No..... 2 Don't know..... 7
H15	How long after the birth was child bathed for the first time?	Immediately/ Less than 1 hour.....00 a) Hours ..... __|__ b) Days ..... __|__ Not bathed.....95 Don't know.....97
H16	What instrument was used to cut the cord?	New blade ..... 1 Blade used for other purposes ..... 2 Scissors..... 3 Others **[Specify]** ..... 6 Don't know.....**[Go to H18]**..... 7
H17	Was the instrument used to cut the cord boiled or sterilised prior to use?	Yes..... 1 No..... 2 Don't know..... 7
H18	After the cord cutting, was anything applied to the cord?	Yes..... 1 No.....**[Go to H20]** ..... 2 Don't know.....**[Go to H20]**..... 7

Q.No.	Questions and Filters	Responses and Codes
H19	What was applied to the cord? **[Multiple responses are allowed]**	Chlorhexidine-Tube..... 01 Other antiseptic [spirit, gentian violet] ..... 02 Mustard oil..... 03 Ash ..... 04 Animal dung..... 05 Others **[Specify]** ..... 96 Don't know..... 97
H20	When the child was born, was [he/she] very large, larger than average, average, smaller than average, or very small?	Very large.....1 Larger than average.....2 Average.....3 Smaller than average.....4 Very small .....5 Don't know.....7
H21	Was the child weighed at birth?	Yes .....1 No.....**[Go to H23]**.....2 Don't know.....**[Go to H23]**.....7
H22	How much did the child weigh? If a card is available, record weight from card.	a) From card [grams]... __|__|__|__|__|__ b) From recall ..... __|__|__|__|__|__ Not told by provider..... 99995 Don't know..... 99997
H23	If your baby was small [<2500g] were you counselled about the special needs of your baby, breastfeeding, kangaroo mother care, and danger signs? **[Multiple responses are allowed]**	Not counselled..... 01 Counselled on breastfeeding..... 02 Counselled on kangaroo mother care 03 Counselled on danger signs..... 04 Others **[Specify]**..... 96
H24	Did you feed your child your first milk [colostrum]?	Yes .....1 No.....2
H25	Did you ever breastfeed the child?	Yes .....1 No.....**[Go to H29]**.....2
H26	How long after birth did you first put the child to the breast?	Immediately..... 00 a) Hours ..... __|__ b) Days..... __|__ Don't know..... 97
H27	How long have you breastfed the child exclusively?	Months..... __|__

Q.No.	Questions and Filters	Responses and Codes
H28	Are you currently breastfeeding the child?	Currently breastfeeding.....**[Go to H30]** ..... 1 Currently not breastfeeding 2
H29	Mainly why did you stop breastfeeding or have not breastfed the child? **[Multiple responses are allowed]**	No/insufficient milk..... 01 Child was not sucking..... 02 Poor health of mother ..... 03 Child was old enough to stop..... .04 Switched to another food ..... 05 Became pregnant..... 06 Child stopped..... 07 Mother working..... 08 Others **[Specify]** 96
H30	In the first three days after delivery, was the child given anything to drink other than breast milk?	Yes..... 1 No.....**[Go to H32]** 2
H31	In the first three days after delivery, what was the child given to drink? **[Multiple responses are allowed]**	Milk [other than breast milk]..... 01 Plain water ..... 02 Sugar or glucose water..... 03 Gripe water ..... 04 Sugar-salt-water solution..... 05 Fruit juice ..... 06 Infant formula ..... 07 Tea / Traditional herbal preparations ..... 08 Honey ..... 09 Prescribed medicine..... 10 Ghutti ..... 11 Others **[Specify]** 96
Interviewer: Check if "H25=2" and/ or "H28=2" then "Go to H33".		
H32	Are you breastfeeding your child exclusively?	Yes.....**[Go to H35]**..... 1 No..... 2
H33	What else are you giving the baby to drink? **[Multiple responses are allowed]**	Milk [other than breast milk]..... 01 Plain water ..... 02 Sugar or glucose water..... 03 Gripe water ..... 04 Sugar-salt-water solution..... 05 Fruit juice ..... 06 Infant formula ..... 07 Tea / Traditional herbal preparations 08 Honey ..... 09 Others **[Specify]** 96
H34	At what age did you start weaning foods?	Age in months..... __|__ Not applicable..... 98

Q.No.	Questions and Filters	Responses and Codes
H35	Before you left the health facility, did anyone counsel you on family planning?	Yes.....1 No..... **[Go to H37]**.....2 Don't know..... **[Go to H37]**.....7
H36	If yes, which family planning methods were you provided counselling for? **[Multiple responses are allowed]**	Female Sterilization.....01 Male Sterilization.....02 IUD.....03 Injectables.....04 Sayana Press.....05 Implants.....06 Oral Pills.....07 Male Condom.....08 Female Condom.....09 Ep Pills.....10 Standard Days Method.....11 Lactational Amenorrhea Method.....12 Rhythm Method.....13 Withdrawal.....14 Others **[Specify]**.....96
H37	Before you left the health facility, did anyone provide you with a contraceptive method?	Yes.....1 No..... **[Go to H39]**.....2
H38	Which contraceptive method was provided?	Female Sterilization.....01 Male Sterilization.....02 IUD.....03 Injectables.....04 Sayana Press.....05 Implants.....06 Oral Pills.....07 Male Condom.....08 Female Condom.....09 EP Pills.....10 Standard Days Method.....11 Lactational Amenorrhea Method.....12 Rhythm Method.....13 Withdrawal.....14 Others **[Specify]**.....96
H39	Were you referred to another facility or provider to obtain a family planning method?	Yes.....1 No.....2 Don't know.....7
H40	Did you face any serious health problems during the last delivery/ pregnancy loss?	Yes.....1 No..... **[Go to i01]**.....2

H41	What serious health problems have you faced during the last [delivery/ pregnancy loss?	Yes, spontaneous	Yes, prompted	No
	a) Excessive bleeding before birth	1	2	3
	b) Excessive bleeding after birth	1	2	3
	c) Convulsions	1	2	3
	d) Placenta does not come out	1	2	3
	e) High fever	1	2	3
	f) High blood pressure	1	2	3
	g) Prolonged duration of labor	1	2	3
	h) Breech	1	2	3
	i) Low hemoglobin count	1	2	3
	j) Others **[Specify]**	1	2	3

Q.No.	Questions and Filters	Responses and Codes
H42	Where did you go first to seek treatment of the problems yOU have faced during the last delivery/ pregnancy loss?	Nowhere..... **[Go to H46]**.....00 **Public facility** Teaching Hospital.....01 DHQ.....02 THQ.....03 Type-D Health Facility.....04 RHC.....05 BHU.....06 MCH Center/ FH Center.....07 Government/ Civil Dispensary.....08 Family Welfare Centre [FWC].....09 Family Welfare Worker [FWW].....10 Family Welfare Counselor [FWC].....11 Family Welfare Assistant [FWA].....12 Lady Health Worker [LHW].....13 Community Midwife [CMW].....14 **Private facility** Private Hospital with Inpatient Facility...15 Private Male MBBS Doctor Clinic.....16 Private Female MBBS Doctor Clinic.....17 Nurse Clinic.....18 LHV Clinic.....19 Dispenser Clinic.....20 GSM Clinic.....21 NGO Clinic.....22 **Workers** Nutrition Assistant.....23 Vaccinator.....24 Suraj Worker.....25 Pehli Kiren Worker.....26 Marvi Worker.....27 Hakim/ Homeopath.....28 Pharmacy/ Chemist.....29 Others **[Specify]**.....96
H43	Is this the same health facility where your delivery took place?	Same facility.....1 Referred to higher facility.....2 Sent from home to facility.....3
H44	Were you referred somewhere else to seek treatment?	Yes.....1 No..... **[Go to H46]**.....2

Q.No.	Questions and Filters	Responses and Codes
H45	Where were you referred?	Teaching Hospital .....01 DHQ.....02 THQ.....03 Private hospital with inpatient facility.....04 Private Male MBBS Doctor Clinic.....05 Private Female MBBS Doctor Clinic....06 LHV Clinic.....07 Nurse Clinic.....08 Midwife Clinic.....09 Others **[Specify]**.....96
H46	Would you recommend the last health facility you visited for delivery/ pregnancy loss or treatment of health problem to your friends or relatives?	Yes.....1 No.....2

Section I: Postnatal care [Last Delivery/ Pregnancy loss in last 3 years]

Now I would like to talk to you about your health-checks after the last delivery or pregnancy loss within the [last 3 years], for example, someone asking you questions about your health or examining you.

Q.No.	Questions and Filters	Responses and Codes
LPSU	Enter the PSU code [will be auto entered in CAPI]	__|__|__|__
LHH	Enter the house number from the list of houses [will be auto entered in the CAPI]	__|__|__|__
LB02	Enter the name of the respondent [will be auto entered in CAPI]	
I01	Write line number of respondent from household roster?	Line number .....__|__
I02	Write pregnancy number from D01.	Pregnancy number .....__|__
I03	Did the delivery/ pregnancy loss take place at a health facility or at home? **[Interviewer: Check from H06]**	Health facility.....1 At home.....**(Go to I08)** 2
I04	Is that the same facility where delivery/ pregnancy loss took place?	Same.....1 Another .....2 Didn't go to any health facility.....**(Go to I12)** 3
I05	How long after delivery/ pregnancy loss did the first checkup take place?	a) Number of hours ..... __|__ b) Number of days ..... __|__ Don't know/Do not remember.....97
I06	Who checked on your health at that time?	MBBS Doctor .....01 Lady health worker (LHW) .....02 Community midwife (CMW).....03 Lady health worker (LHV) .....04 Family welfare worker (FWW).....05 Family welfare councilor (FWC).....06 Family welfare assistant (FWA) .....07 Nurse.....08 Suraj Worker.....09 Pehli Kiren Worker.....10 Marvi Worker.....11 Dispenser.....12 Others **[Specify]** .....96 Don't know.....97
I07	How many times did you have check-ups within 40 days after delivery/ pregnancy loss?	Number of times..... __|__
[Go to I09 after asking I11]		
I08	Did anyone check on your health after your delivery/ pregnancy loss took place at home?	Yes.....1 No..... **[Go to I12]** .....2 Delivered at health facility.....3
I09	How long after delivery/ pregnancy loss did that check-up take place?	a) Number of hours.....__|__ b) Number of days .....__|__ Don't know.....97
I10	Who checked on your health at that time?	MBBS Doctor .....01 Lady health worker (LHW) .....02 Community midwife (CMW).....03 Lady health worker (LHV) .....04 Family welfare worker (FWW).....05 Family welfare councilor (FWC).....06 Family welfare assistant (FWA) .....07 Nurse.....08 Suraj Worker .....09 Pehli Kiren Worker.....10 Marvi Worker.....11 Relative/ Friend/ Neighbor .....12 Dispenser.....13 Others **[Specify]** .....96 Don't know.....97

Q.No.	Questions and Filters	Responses and Codes
I11	Where did the health check-up take place?	**Public facility** Teaching Hospital....01 DHQ....02 THQ....03 Type-D Health Facility....04 RHC....05 BHU....06 MCH Center/ FH Center....07 Government/ Civil Dispensary....08 Family Welfare Centre [FWC]....09 Family Welfare Worker [FWW]....10 Family Welfare Counselor [FWC]....11 Family Welfare Assistant [FWA]....12 Lady Health Worker [LHW]....13 Community Midwife [CMW]....14 **Private facility** Private Hospital with Inpatient Facility....15 Private Male MBBS Doctor Clinic....16 Private Female MBBS Doctor Clinic....17 Nurse Clinic....18 LHV Clinic....19 Dispenser Clinic....20 GSM Clinic....21 NGO Clinic....22 **Workers** Nutrition Assistant....23 Vaccinator....24 Suraj Worker....25 Pehli Kiren Worker....26 Marvi Worker....27 Hakim/ Homeopath....28 Pharmacy/ Chemist....29 Others **[Specify]**....96
I12	Did anyone counsel you on family planning during a postnatal or post pregnancy loss [during checkup / apart from checkup]? **[Read]**	a) Within 48 hours — Yes 1 / No 2 b) 49 hours to 6 weeks — Yes 1 / No 2 c) > 6 weeks to 1 year — Yes 1 / No 2
I13	Did anyone provide you with a contraceptive method during a postnatal or post pregnancy loss [during check-up/apart from check-up]?	Yes....1 No....**[Go to I16]**....2
I14	When were you offered a contraceptive method during your postnatal or post-pregnancy loss [during check-up/apart from check-up]? **[Read]**	a) Within 48 hours — 1 / 2 b) 49 hours to 6 weeks — 1 / 2 c) > 6 weeks to 1 year — 1 / 2

If i14a, b and c = 2 then "**Go to i16**".

I15	If yes to anyone in I14, which contraceptive method was provided to you during a postnatal or post pregnancy loss [during check-up/apart from check-up]?	Female Sterilization....01 Male Sterilization....02 IUD....03 Injectables....04 Sayana Press....05 Implants....06 Oral Pills....07 Male Condom....08 Female Condom....09 EP Pills....10 Standard Days Method....11 Withdrawal....12 Others **[Specify]**....96
I16	Did you face serious health problems during the 40 days after delivery/ pregnancy loss?	Yes....1 No....**[Go to I21]**....2

	I17 What serious health problems did you face during your last postnatal/ post pregnancy-loss period?	Yes, spontaneous	Yes, prompted	No
a)	Convulsions	1	2	3
b)	Blurred vision	1	2	3
c)	Severe headache	1	2	3
d)	High fever	1	2	3
e)	Smelly discharge/ Dysuria	1	2	3
f)	Abdominal pain with high fever	1	2	3
g)	Lumps in breast	1	2	3
h)	Excessive bleeding	1	2	3
i)	Weakness	1	2	3
j)	Anemia	1	2	3
k)	Continued bleeding	1	2	3
l)	Post-partum depression	1	2	3
m)	Others **[Specify]**	1	2	3

Q.No.	Questions and Filters	Responses and Codes
I18	Where did you go first to seek treatment?	Nowhere ..... 00 **Public facility** Teaching Hospital ..... 01 DHQ ..... 02 THQ ..... 03 Type-D Health Facility ..... 04 RHC ..... 05 BHU ..... 06 MCH Center/ FH Center ..... 07 Government/ Civil Dispensary ..... 08 Family Welfare Centre [FWC] ..... 09 Family Welfare Worker [FWW] ..... 10 Family Welfare Counselor [FWC] ..... 11 Family Welfare Assistant [FWA] ..... 12 Lady Health Worker [LHW] ..... 13 Community Midwife [CMW] ..... 14 **Private facility** Private hospital with inpatient facility ..... 15 Private Male MBBS Doctor Clinic ..... 16 Private Female MBBS Doctor Clinic ..... 17 Nurse Clinic ..... 18 LHV Clinic ..... 19 Dispenser Clinic ..... 20 GSM Clinic ..... 21 NGO Clinic ..... 22 **Workers** Nutrition Assistant ..... 23 Vaccinator ..... 24 Suraj Worker ..... 25 Pehli Kiren Worker 26
		Marvi Worker ..... 27 Hakim/ Homeopath ..... 28 Pharmacy/ Chemist ..... 29 Others **[Specify]** 96
I19	Were you referred somewhere else to seek treatment?	Yes ..... 1 No ..... **[Go to I21]** 2
I20	Where were you referred?	Teaching Hospital ..... 01 DHQ ..... 02 THQ ..... 03 Family Welfare Center (FWC) ..... 04 Private hospital with inpatient facility ..... 05 Private Male MBBS Doctor Clinic ..... 06 Private Female MBBS Doctor Clinic ..... 07 LHV Clinic ..... 08 Nurse Clinic ..... 09 Midwife Clinic ..... 10 Others **[Specify]** 96

Q.No.	Questions and Filters	Responses and Codes
I21	Would you recommend the last facility you visited for treatment of health problem [s] to any of your relatives or friends?	Yes ..... 1 No 2

Section J: Quality of care [Last visit for Maternal Care]

Now I would like to ask some questions about your experience of getting care during your last visit to a health facility whether it was for antenatal care or for delivery care or for postnatal care.

Q.No.	Questions and Filters	Responses and Codes		
MPSU	Enter the PSU code [will be auto entered in CAPI]	__|__|__|__		
MHH	Enter the house number from the list of houses [will be auto entered in the CAPI]	__|__|__|__		
MB01	Enter the respondent's line number [will be auto entered in CAPI]	__|__		
MB02	Enter the name of the respondent [will be auto entered in CAPI]			
J01	**Did the provider:**	**Yes**	**No**	**Don't know**
	a) Obtain your consent before performing any procedure?	1	2	7
	b) Treat you with courtesy and respect?	1	2	7
	c) Give you clear and complete information about your health care?	1	2	7
	d) Give you clear and complete information about your contraceptive choices?	1	2	7
	e) Listen to your concerns and take them seriously?	1	2	7
	f) Respect your choices and preferences?	1	2	7
	g) Treat you fairly and without discrimination?	1	2	7
	h) Provide privacy during all the procedures performed?	1	2	7
J02	**Did you:**	**Yes**	**No**	**Don't know**
	a) Feel included/ involved in making decisions about your care?	1	2	7
	b) Feel comfortable asking questions/ concerns?	1	2	7
	c) Express your preferences?	1	2	7
	d) Feel safe during your care?	1	2	7
	e) Feel that the provider would maintain confidentiality?	1	2	7
J03	Were you completely satisfied with the staff at the health facility; were they able to address your needs?	Yes ..... 1 No ..... 2 Don't know 7		

Q.No.	Questions and Filters	Responses and Codes
J04	How long did you have to wait at the facility before you received care?	No waiting time ..... 01 5 – 10 minutes..... 02 11 – 20 minutes..... 03 21 – 30 minutes..... 04 31 – 60 minutes..... 05 More than 1 hour..... 06 Don't know 97
J05	What type of transport did you use to reach the health facility? **[Multiple responses are allowed]**	On foot ..... 01 Motorcycle ..... 02 Rickshaw/ Chingchi (QingQi) ..... 03 Bus/ Van..... 04 Tonga/ Cart ..... 05 Car..... 06 Ambulance ..... 08 Boat..... 09 Others **[Specify]**..... 96
J06	Who accompanied you to the health facility? **[Multiple responses are allowed]**	No one ..... 01 Husband ..... 02 Mother-in-law..... 03 Father-in-law ..... 04 Mother ..... 05 Sibling..... 06 Sister-in-law ..... 07 Relative/ Friend..... 08 Others **[Specify]**..... 96
J07	Was there a separate waiting area for male and female patients available in the health facility?	Yes..... 1 No..... 2 Don't know 7
J08	Was there a separate toilet facility for male and female patients available in the health facility?	No toilet facility..... 1 Yes, separate..... 2 Yes, combine ..... 3 Don't know 7
J09	What were the expenses your household had to bear for getting services? **[Interviewer: Probe for each one]** **If there is no expense write "0000000".** **If don't know expense write "9999997".** **If not applicable write "9999998".**	a) Expenses on travel..... __|__|__|__|__|__ b) Expenses on fee..... __|__|__|__|__|__ c) Expenses on medicine..... __|__|__|__|__|__ d) Expenses on lab tests ..... __|__|__|__|__|__ e) Expenses on operation ..... __|__|__|__|__|__ f) Bed charges ..... __|__|__|__|__|__ g) other expenses..... __|__|__|__|__|__ h) Total..... __|__|__|__|__|__

Q.No.	Questions and Filters	Responses and Codes
J10	Who paid the amount?	Self..... 01 Husband..... 02 Household member..... 03 Through health card ..... 04 Private/ employer based insurance ..... 05 Others **[Specify]**..... 96

Section K: Child treatment and nutrition [Youngest child 0-59 months]

Now I would like to ask you some questions about common child ailments like diarrhea, malaria, and acute respiratory infection. First, we start with diarrhea. Please note that I am asking you about the youngest child who is less than 5 years old.

Q.No.	Questions and Filters	Responses and Codes
NPSU	Enter the PSU code [will be auto entered in CAPI]	__|__|__|__
NHH	Enter the house number from the list of houses [will be auto entered in the CAPI]	__|__|__|__
NB02	Enter the name of the respondent [will be auto entered in CAPI]	
K01	Name of the child from household roster	
K02	Line number from the household roster	
K02a	Line number of the respondent from the household roster	
K02b	What is the relationship of the respondent to the child?	Mother ..... 01 Father..... 02 Grandmother ..... 03 Grandfather ..... 04 Ant..... 05 Uncle ..... 06 Sister..... 07 Brother..... 08 No relation ..... 09 Others **[Specify]** 96
K03	Sex of the child	Male ..... 1 Female ..... 2 Transgender..... 3
K04	Age of the child, in months [in days if less than 1 month, in months if 1 or more months old]	a) Days ..... __|__ b) Months..... __|__
DIARRHEA		
K05	Did the child have diarrhea in the last two weeks?	Yes ..... 1 No..... **[Go to K14]**..... 2

Q.No.	Questions and Filters	Responses and Codes
K06	What were the symptoms of diarrhea? **[Multiple responses are allowed]**	3 Loose motions....01 Vomiting....02 Child refuses to take food....03 Lethargy....04 Blood/ Mucus in stools....05 Dehydration....06 Others **[Specify]**....96 Others **[Specify]**
	Instructions for Interviewer: 1. Check if H28=1 then ask K07 2. Check if H28=2 then ask K08	
K07	**If currently breastfeeding:** Now I would like to know how much your child was given to drink during the diarrhea, including breast milk. Was the child given less than usual to drink, about the same amount, or more than usual to drink?	Much less .... 1 Somewhat less .... 2 About the same .... 3 More.... 4 Nothing to drink.... 5
[Go to K09 after asking K07]		
K08	**If not currently breastfeeding**: Now I would like to know how much the child was given to drink during the diarrhea. Was the child given less than usual to drink, about the same amount, or more than usual to drink?	Much less .... 1 Somewhat less .... 2 About the same .... 3 More.... 4 Nothing to drink.... 5
K09	While the child had diarrhea, was he/she given less than usual to eat, about the same amount, more than usual, or nothing to eat?	Much less ....01 Somewhat less....02 About the same ....03 More....04 Stopped food....05 Never initiated food....06
K10	Did you seek any advice or treatment for the diarrhea from any source?	Yes .... 1 No..... **[Go to K12]**....2

Q.No.	Questions and Filters	Responses and Codes
K11	Where did you go to seek advice or treatment for your child's diarrhea? **[Multiple responses are allowed]**	**Public facility** Teaching Hospital ....01 DHQ ....02 THQ....03 Type-D Health Facility....04 RHC....05 BHU....06 MCH Center/ FH Center ....07 Government/ Civil Dispensary ....08 Family Welfare Centre [FWC] ....09 Family Welfare Worker [FWW]....10 Family Welfare Counselor [FWC]....11 Family Welfare Assistant [FWA]....12 Lady Health Worker [LHW] ....13 Community Midwife [CMW]....14 **Private facility** Private hospital with inpatient facility....15 Private male MBBS doctor clinic....16 Private female MBBS doctor clinic....17 Nurse clinic....18 LHV clinic....19 Dispenser clinic....20 GSM Clinic....21 NGO Clinic ....22 **Workers** Nutrition assistant ....23 Vaccinator....24 Suraj worker ....25 Pehli Kiren worker....26 Marvi worker ....27 Hakim/ Homeopath....28 Pharmacy/ Chemist....29 Others **[Specify]**....96
K12	Was anything given to the child during the diarrhea? **[Interviewer: Probe for each one]** **[Multiple responses are allowed]**	Fluid form ORS packet .... 01 ORS liquid .... 02 Homemade fluid .... 03 Zinc syrup/ tablets .... 04 Others **[Specify]**....96 Don't know.... 97

Q.No.	Questions and Filters	Responses and Codes
K13	What was given to treat the diarrhea? **[Multiple responses are allowed]**	Antibiotic [pill or syrup] ..... 01 Antimotility [Anti-Diarrhea) - [pill or syrup] ..... 02 Other [pill or syrup] ..... 03 Unknown [pill or syrup] ..... 04 Antibiotic [Injection] ..... 05 Non-Antibiotic [Injection] ..... 06 Unknown Injection [Injection] ..... 07 Intravenous [IV] - [Injection] ..... 08 Drip ..... 09 Home Remedy ..... 10 Others **[Specify]** 96
Cough/ Acute Respiratory Infection (ARI)		
K14	Has the child had an illness with a cough at any time in the last 2 weeks?	Yes ..... 1 No 2
K15	Has the child had fast, short, rapid breaths or difficulty breathing at any time in the last 2 weeks?	Yes ..... 1 No ..... **[Go to K23]** 2
K16	Was the fast or difficult breathing due to a problem in the chest or to a blocked or runny nose?	Chest only ..... 1 Nose only ..... 2 Both ..... 3 Others **[Specify]** 6
K17	What were the symptoms of ARI? **[Multiple responses are allowed]**	High temperature ..... 01 Sore throat ..... 02 Runny nose ..... 03 Irritation in the throat ..... 04 Indrawing ribs ..... 05 Rapid breathing ..... 06 Child refuses to take food ..... 07 Cough ..... 08 Others **[Specify]** ..... 96 Don't know 97
K18	Did you seek any advice or treatment for ARI?	Yes ..... 1 No ..... **[Go to K21]** 2

Q.No.	Questions and Filters	Responses and Codes
K19	Where did you first seek advice or treatment for ARI?	**Public facility** Teaching Hospital ..... 01 DHQ ..... 02 THQ ..... 03 Type-D Health Facility ..... 04 RHC ..... 05 BHU ..... 06 MCH Center/ FH Center ..... 07 Government/ Civil Dispensary ..... 08 Family Welfare Centre [FWC] ..... 09 Family Welfare Worker [FWW] ..... 10 Family Welfare Counselor [FWC] ..... 11 Family Welfare Assistant [FWA] ..... 12 Lady Health Worker [LHW] ..... 13 Community Midwife [CMW] ..... 14 **Private facility** Private hospital with inpatient facility ..... 15 Private Male MBBS Doctor Clinic ..... 16 Private Female MBBS Doctor Clinic ..... 17 Nurse Clinic ..... 18 LHV Clinic ..... 19 Dispenser Clinic ..... 20 GSM Clinic ..... 21 NGO Clinic ..... 22 **Workers** Nutrition Assistant ..... 23 Vaccinator ..... 24 Suraj Worker ..... 25 Pehli Kiren Worker ..... 26 Marvi Worker ..... 27 Hakim/ Homeopath ..... 28 Pharmacy/ Chemist ..... 29 Others **[Specify]** 96
K20	How many days after the illness did you first seek advice or treatment for ARI?	Number of days ..... __|__
K21	At any time during the ARI, was the child given any medicine for the illness?	Yes ..... 1 No ..... **[Go to K23]** 2

Q.No.	Questions and Filters	Responses and Codes
K22	What medicine was given to treat ARI? **[Multiple responses are allowed]**	Amoxicillin ..... 01 Cotrimoxazole ..... 02 Other Antibiotic Pill/Syrup ..... 03 Other Antibiotic Injection/IV ..... 04 Paracetamol/Panadol/ Acetaminophen ..... 05 Aspirin ..... 06 Ibuprofen ..... .07 Other **[Specify]** ..... 96 Don't know 97
K23	Was the child given any drug for intestinal worms in the last six months?	Yes ..... 1 No ..... 2 Don't know 7

NUTRITION

K24	Has the child been given any iron supplements in the last 24 hours?	Yes ..... 1 No ..... **[Go to K26]** ..... 2 Don't know ..... **[Go to K26]** 7		
K25	How many doses of Iron supplementation were given?	Number of doses ..... __|__		
K26	Has the child been given any vitamin A supplementation in the last 24 hours?	Yes ..... 1 No ..... **[Go to K28]** ..... 2 Don't know ..... **[Go to K28]** 7		
K27	How many dosages of vitamin-A supplementation have been given in the last 24 hours?	Number of doses ..... __|__		
K28	Has the child taken any Multi micronutrient powder [MNP] [picture] in the last 24 hours?	Yes ..... 1 No ..... **[Go to K30]** ..... 2 Don't know ..... **[Go to K30]** 7		
K29	How many doses of the multi-micronutrient powder [MNP] have been given?	Number of doses ..... __|__		
K30	Did the child eat [food group items] yesterday during the day or the night? [**Read one by one**]	Yes	No	Don't know
	a) Any baby food, such as cerelac fortified baby food etc.	1	2	7
	b) Bread, rice, noodles, porridge, or other foods made from grains	1	2	7
	c) Pumpkin, carrots, squash, or sweet potatoes that are yellow or orange inside	1	2	7
	d) White potatoes, or any other foods made from roots	1	2	7
	e) Vitamin A, rich dark green leafy vegetables	1	2	7
	f) Ripe mangoes, papayas, peaches, apricots, vitamin A-rich fruits	1	2	7
	g) Other fruits and vegetables like cabbage, cauliflower, brinjal, apple, banana, pomegranate, potato, etc.	1	2	7
	h) Liver, kidney, heart, or other organ meats	1	2	7
	i) Any other meat, such as beef, lamb, goat, chicken, or duck	1	2	7
	j) Eggs	1	2	7
	k) Fish or shellfish, either fresh or dried	1	2	7
	l) Beans, peas, lentils, or nuts, including any foods made from these	1	2	7
	m) Cheese or other food made from animal milk	1	2	7
	n) Other solid, semi-solid, or soft food	1	2	7

Section L: Women's empowerment

Now, I would like to ask some questions about your exposure to the media, the work you do, and other related topics.

Q.No.	Questions and Filters	Responses and Codes
EXPOSURE TO MEDIA		
OPSU	Enter the PSU code [will be auto entered in CAPI]	__|__|__|__
OHH	Enter the house number from the list of houses [will be auto entered in the CAPI]	__|__|__|__
OB01	Enter the respondent's line number [will be auto entered in CAPI]	__|__
OB02	Enter the name of the respondent [will be auto entered in CAPI]	
L01	Do you read a newspaper or magazine at least once a week, less than once a week or not at all?	At least once a week ..... 1 Less than once a week ..... 2 Not at all ..... 3 Unable to read 4
L02	Do you listen to the radio/ FM radio at least once a week, less than once a week or not at all?	At least once a week ..... 1 Less than once a week ..... 2 Not at all 3
L03	Do you watch television at least once a week, less than once a week or not at all?	At least once a week ..... 1 Less than once a week ..... 2 Not at all 3
L04	Have you ever used the internet?	No ..... 1 Yes, fixed (Wi-Fi) ..... 2 Yes, on mobile ..... 3 Both 4

Q.No.	Questions and Filters	Responses and Codes
L05	Do you own a mobile telephone?	Yes..... 1 No…… **[Go to L08]** 2
L06	Do you use your mobile phone for any financial transactions?	Yes..... 1 No..... 2
L07	What purpose do you use your mobile phone for? **[Multiple responses are allowed]**	For calling, messaging, and chatting..... 01 For emails and internet ..... 02 For financial transaction..... 03 To get information about health interventions ..... 04 To get information about various events..... 05 For learning/ educational purpose..... 06 For using social media ..... 07 For news purposes ..... 08 For children education..... 09 For sports..... 10 For online earnings ..... 11 For online shopping ..... 12 Others **[Specify]**..... 96
L08	Can you be reached through your mobile phone/ land line?	Yes ..... 1 No 2

SOCIAL PROTECTION

I will now ask you some questions about social security guarantees, such as insurance and related topics.

L09	Do you have any type of insurance?	Yes ..... 1 No…… **[Go to L11]** 2

L10 What type[s] of insurance do you have? **Prompt for each one.**

	Private company	Government	Office	Not applicable
a) Life insurance	1	2	3	8
b) Health insurance	1	2	3	8
c) Child education	1	2	3	8
d) Child marriage plan	1	2	3	8
e) Accidental insurance	1	2	3	8
f) Car insurance	1	2	3	8
g) Home insurance	1	2	3	8
h) Others **[Specify]**	1	2	3	8

L11	Are you a beneficiary of the Benazir Income Support Program [BISP]?	Yes..... 1 No…… **[Go to L13]**... 2
L12	How do you utilize the money you receive from BISP? **[Multiple responses are allowed]**	Purchase food items..... 01 Purchase clothes..... 02 Purchase mobile/ recharge..... 03 Purchase HH items ..... 04 On education ..... 05 Manage children marriage expenses..... 06 Health expenditures ..... 07 Buying livestock ..... 08 Setting up small scale business ..... 09 Others **[Specify]** 96

ECONOMIC WORK

Some people work multiple jobs to support their family and increase their income. Now, I will ask you some questions about this topic.

L13	Aside from your own housework, have you ever worked to earn money?	Yes..... 1 No…… **[Go to L17]** 2
L14	Aside from your own housework, have you worked elsewhere in the last 30 days?	Yes…… **[Go to L16]**..... 1 No 2
L15	Please tell me the main reason you haven't worked in the last 30 days. **[If more than one reason, ask for the main]**	Don't want to work..... 00 Limited mobility ..... 01 Safety concerns ..... 02 Attitudes towards women working ..... 03 Lack of education & skills ..... 04 Illness or injury ..... 05 Off-season..... 06 On leave..... 07 Maternity leaves ..... 08 Harassment on the way/ at workplace..... 09 Transport issue, to and from workplace..... 10 Housekeeping/ child/ elderly/ care giver..... 11 Retired ..... 12 Lockdown/ Strike..... 13 Finding no work/job ..... 14 Currently pregnant..... 15 Breastfeeding the baby..... 16 Not allowed ..... 17 Others **[Specify]** 96

[Go to L17 after asking L15]

L16	What kind of work do you mainly do? [**Interviewer:** If more than one, please ask which one occupation or activity she is most engaged in. **[Circle one response only]**	Agricultural work .....01 Raising poultry / livestock.....02 Producing ghee / cheese / butter .....03 Collecting fuel / wood-cutting .....04 Preparing food .....05 Sewing / embroidery /crocheting .....06 Producing raw products/carpets/textile/ ropes ..... 07 Offering services for others in HH/shop/hotel.....08 Own business .....09 Buying/selling goods in market/street/home.....10 Helping in construction work.....11 Learning a skill.....12 Government service.....13 Private service .....14 Abroad.....15 Retired.....16 Unemployed.....17 Others **[Specify]**.....96
L17	Do you have an account [other than BISP] in a bank or other financial institution that you yourself use?	Yes.....1 No.....2

DECISION MAKING

Now I will ask you about your involvement in big and small household decisions and your role in making those decisions.

L18	**Who usually makes decisions about? [Prompt each one]**	**You**	**Your husband**	**You and your husband jointly**	**Someone else**	**NA**
	a) Making large household purchases	1	2	3	4	8
	b) Household purchases for daily needs	1	2	3	4	8
	c) Getting medical treatment for yourself	1	2	3	4	8
	d) Getting medical treatment for your son	1	2	3	4	8
	e) Getting medical treatment for your daughter	1	2	3	4	8
	f) Regarding education of your son	1	2	3	4	8
	g) Regarding education of your daughter	1	2	3	4	8
	h) Using your household earnings	1	2	3	4	8
	i) Using your own earnings	1	2	3	4	8

MOBILITY

Now I would like to ask you about your ability to go to places outside the house. I will list some places. Please tell me whether you can go to these places on your own or whether you have to ask permission from your husband or can go only if accompanied by someone or whether you cannot go at all:

L19	**Can you visit these places:** **[Ask about each one]**	**Can go out on my own**	**Can go only with husband's permission**	**Can go only with someone**	**Cannot go at all**	**Does not go**
	a) Hospital/ doctor inside community	1	2	3	4	5
	b) Hospital/ doctor outside community	1	2	3	4	5
	c) Market/ shop inside community	1	2	3	4	5
	d) Market/ shop outside community	1	2	3	4	5
	e) Relative/ Friend inside community	1	2	3	4	5
	f) Relative/ Friend outside community	1	2	3	4	5

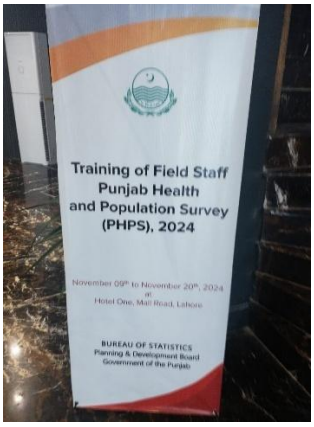
Section M: Permission for revisit/ call

Sometimes it is necessary to go back to the respondent after the interview to clarify a point or consolidate information. If the need arises:

Q.No.	Questions and Filters	Responses and Codes
PPSU	Enter the PSU code [will be auto entered in CAPI]	__|__|__|__
PHH	Enter the house number from the list of houses [will be auto entered in the CAPI]	__|__|__|__
PB01	Enter the respondent's line number [will be auto entered in CAPI]	__|__
PB02	Enter the name of the respondent [will be auto entered in CAPI]	
M01	Can we revisit/ call you again?	Yes ..... 1 No……**(Go to M03)** .. 2
M02	Please give me a phone number that we can use to reach you should the need arise?	
M03	Would you like to give us any suggestions on the topics we have covered in this interview, or do you have any questions for us?	Yes ..... 1 No……**(Go to M05)** .. 2
M04	If yes, what are the suggestions or questions?	a) Suggestions: b) Questions:
M05	Time to end the interview.	Hours__|__ Minutes __|__ [24-hour format]
M06	What was the result of the interview	Interviewed **[End interview]** 01 Partially interviewed ..... 02 No one at home..... 03 Entire household absent for extended period ..... 04 Refused..... 05 Dwelling vacant or address not a dwelling ..... 06 Dwelling destroyed..... 07 Dwelling not found..... 08 Incomplete interview due to age over 49 yrs ..... 09 Others **[Specify]** 96
M07	If the interview could not be completed, please provide detailed reasons.	

Thank You

Annex D: Training and Field Pictures



HEALTH & POPULATION
DEPARTMENT

BUREAU OF STATISTICS

POPULATION
COUNCIL
Ideas. Evidence. Impact.

POPULATION
CENTER
PAKISTAN
From Evidence to Action