

Khyber Pakhtunkhwa Health and Population Survey (KPHPS) 2024-25

April 2025

Key Findings Report



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Summary of Key Indicators

Indicator	Overall Province	Lagging districts	Non-lagging districts
1. Service Coverage Index	39.2	37.6	39.5
2. % of women with at least one antenatal care (ANC) visit in last pregnancy	73.0	53.3	81.1
3. % of women with 4 or more ANC visits in last pregnancy	20.2	13.7	22.8
4. % of women with “effective” ANC visit in last pregnancy	6.1	3.9	7.0
5. % of women delivering last pregnancy at a health facility	79.4	64.3	85.7
6. % of women delivering last pregnancy with assistance from skilled birth attendants	86.6	72.2	92.6
7. % of currently married women using any method of family planning	22.9	23.0	22.9
8. % of currently married women using a modern method of family planning	14.8	13.4	15.4
9. % of children aged 12-23 months who had received Penta-1 vaccine	81.4	70.3	86.2
10. % of children aged 12-23 months who are fully immunized	68.3	56.2	73.4
11. % of children <5 years who experienced symptoms of acute respiratory infection (ARI)	6.1	7.8	5.4
12. % of household members aged 5 years or older who had tuberculosis (TB)	0.23	0.26	0.21
13. % of household members aged 30-79 years who had hypertension (high blood pressure)	7.2	6.7	7.4
14. % of household members aged 30-79 who had diabetes	4.9	4.2	5.2
15. % of households with improved water services	91.9	92.4	91.7
16. % of households with improved sanitation services	87.8	82.3	90.1

Table of Contents

Acknowledgements	viii
1. The Khyber Pakhtunkhwa Health and Population Survey (KPHPS) 2024-2025	1
Introduction	1
Aims and Objectives.....	1
Sample Design	2
Sample Size Determination.....	4
Survey Implementation.....	6
2. Characteristics of Ever Married Women	8
Socio-economic and Demographic Background Characteristics of Ever Married Women	8
3. Maternal Health Care	10
Antenatal Care (ANC) Coverage	10
Institutional Deliveries	13
Skilled Assistance During Delivery.....	15
4. Family Planning	17
Current Contraceptive Use	17
Type of Contraceptive Method Currently Used.....	18
5. Infant-Child Health and Immunization	20
Acute Respiratory Infection (ARI)	20
Immunization.....	21
Coverage of Specific Vaccines Among Children Aged 12-23 Months	23
6. Prevalence and Treatment of Infectious and Noncommunicable Diseases	25
Tuberculosis (TB).....	25
Hypertension (high blood pressure).....	26
Diabetes	27
7. Water, Sanitation and Hygiene (WASH)	29
8. Service Coverage Index (SCI)	31
9. Conclusions	33
10. Annexures	34

List of Tables

Table 1.1: List of Lagging and Non-lagging districts in KP	3
Table 1.2: Type of allocation method for each domain/stratum	4
Table 1.3: Sample size, number of interviews conducted and response rate	5
Table 2.1: Percentage distribution of ever married women by background characteristics, KPHPS 2024-25	9
Table 3.1: Percentage of women who had a complete pregnancy in the last three years reporting at least one visit for antenatal care (ANC) during the last pregnancy, KPHPS 2024-25	10
Table 3.2: Percentage of women who had a complete pregnancy in the last three years, by number of antenatal care (ANC) visits during the most recent pregnancy, KPHPS 2024-25	11
Table 3.3: Percentage of women with one or more antenatal care (ANC) visit during the most recent pregnancy in the last three years, by place of visit and area, KPHPS 2024-25	13
Table 3.4: Percentage of deliveries in the 3 years before the survey, by place of delivery and by area, KPHPS 2024-25	14
Table 4.1: Percentage of currently married women using any method (CPR), modern method (mCPR) or a traditional method, KPHPS 2024-25	18
Table 4.2: Percentage of currently married women by type of contraceptive method using, KPHPS 2024-25	19
Table 5.1: Percentage of children aged 24-35 months who were fully immunized by urban-rural and district type, KPHPS 2024-25	22
Table 5.2: Percentage of children aged 12-23 months having had vaccination, by type of vaccine, KPHPS 2024-25	23
Table 5.3: Percentage of children aged 12-23 months having had vaccination, by type of vaccine, lagging and non-lagging districts, KPHPS 2024-25	24
Table 6.1: Percentage of household members aged 5 years or above (Prevalence) with TB and percentage taking medicine for TB, KPHPS 2024-25	26
Table 6.2: Percentage of household members aged 30-79 with hypertension (Prevalence) and percentage taking treatment/medicine(s) for hypertension, KPHPS 2024-25	27
Table 6.3: Percentage of household members aged 30-79 years with diabetes (Prevalence) and percentage taking treatment/medicines for diabetes, KPHPS 2024-25	28
Table 8.1: Service Coverage Index, KPHPS 2024-25	32

List of Figures

Figure 3.1: Percentage of women with a complete pregnancy in the last three years who report 4 or more antenatal care (ANC) visits during the most recent pregnancy, by area, KPHPS 2024-25	11
Figure 3.2: Percentage of women with a complete pregnancy in the last three years who received effective* antenatal care (ANC) during the most recent pregnancy, by area, KPHPS 2024-25.....	12
Figure 3.3: Percentage of women with one or more antenatal care (ANC) visit during the most recent pregnancy in the last three years, by place of visit and area, KPHPS 2024-25	13
Figure 3.4: Percentage of women who delivered the most recent pregnancy in the 3 years before the survey in a health facility, by area, KPHPS 2024-2025.....	15
Figure 3.5: Percentage of women who delivered the last pregnancy at a health facility in the 3 years before the survey, by type of facility and area, KPHPS 2024-25	15
Figure 3.6: Percentage of deliveries in the 3 years before the survey that were assisted by skilled birth attendants, by area, KPHPS 2024-25	16
Figure 4.1: Percentage of currently married women using a modern or traditional contraceptive method, by area, KPHPS 2024-25	18
Figure 5.1: Percentage of children younger than 5 years who had symptoms of acute respiratory infection (ARI) in the two weeks before survey and percentage receiving ARI treatment from a health facility, by area, KPHPS 2024-25	21
Figure 5.2: Percentage of children aged 12-23 months who received Penta-1 at any time before the survey and percentage who are fully immunized, KPHPS 2024-25	22
Figure 7.1: Percentage with availability of improved water and improved sanitation services, KPHPS 2024-25	29
Figure 7.2: Percentage of households with the availability of Improved Water Services, by District, KPHPS 2024-25	30
Figure 7.3: Percentage of households with availability of Improved Sanitation Services, by District, KPHPS 2024-25	30
Figure A.1: Percentage of women with at least one antenatal care (ANC) visit during the last pregnancy in three years before the survey, by district, KPHPS 2024-25.....	34
Figure A.2: Percentage of women with 4 or more antenatal care (ANC) visits during the last pregnancy in three years before the survey, by district, KPHPS 2024-25.....	35
Figure A.3: Percentage of women receiving effective antenatal care (ANC) during the last pregnancy in three years before the survey, by district, KPHPS 2024-25.....	36
Figure A.4: Percentage of deliveries in the last three years that took place in a health facility, by district, KPHPS 2024-25	37
Figure A.5: Percentage of deliveries in the last three years attended by skilled birth attendants, by district, KPHPS 2024-25	38
Figure A.6: Percentage of currently married women using a modern or traditional method, by district, KPHPS 2024-25.....	39
Figure A.7: Percentage of children younger than 5 years who had acute respiratory infection (ARI) Affected and Treated during the two weeks before the survey, by district, KPHPS 2024-25	40

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1. The Khyber Pakhtunkhwa Health and Population Survey (KPHPS) 2024-2025

Introduction

The Khyber Pakhtunkhwa Health and Population Survey 2024-25 (KPHPS) was envisaged under the National Health Support Program (NHSP). Improving the quality of health care provision is the main objective of the NHSP. This objective is to be achieved through evidence-informed policies and interventions and by measuring their impact. The KPHPS was designed to generate the required evidence of baseline markers that is representative of the province and the districts.

Khyber Pakhtunkhwa (KP) province, formerly known as the North-West Frontier Province (NWFP), is the third most populous province of Pakistan with an estimated population of 40.9 million according to the 2023 Population and Housing Census. Formerly divided into NWFP and the Federally Administered Tribal Areas (FATA), the current province represents both. It had an intercensal average population growth rate of 2.82 per cent per annum between 1998-2017 and 2.38 percent between 2017 and 2023. Located in the north-west part of Pakistan bordering Afghanistan, KP has experienced significant migration across its border and has the largest contingent of international migrants working abroad.

Aims and Objectives

The primary aim of the KPHPS was to provide high quality data of international standards, measuring the baseline indicators, implementation and impact of NHSP. The survey was conducted in KP from September 2024 to January 2025. The newly merged Districts are included in the KPHPS 2024-25.

More specifically, KPHPS was designed to measure indicators related to three of the NHSP Project Development Objectives (PDOs) and one Disbursement Linked Indicator (DLI) as well as high priority indicators identified by the provincial stakeholders. It also focused on access (coverage), quality of services for universal health coverage (UHC), modern contraceptive use (mCPR), antenatal care (ANC), and immunization with equity and gender as cross-cutting consideration for all themes. Additionally, topic(s) suggested by the provincial stakeholders were included.

It is important to point out that this report covers only the immediate release of the main indicators. The results are weighted using sampling weights provided by the Pakistan Bureau of Statistics (PBS) while the “Ns” presented in the tables are unweighted. The detailed analysis of the survey will be presented in the main report to be released in May 2025. In this report we provide some of the details of the survey’s design, questionnaires, sampling, data collection, and other relevant information. The KPHPS was guided by a provincial Technical Coordination Committee comprising representatives of Planning and Development (P&D), Health and Population Welfare departments, and the KP Provincial Bureau of Statistics. Inputs on questionnaire design was provided by the Population Council, Population Center Pakistan, the Global Financing Facility, the World Bank, and the Bill and Melinda Gates Foundation (BMGF).

The survey employed two separate questionnaires: (1) household; and (2) ever married women. The eligible respondents for interview were a knowledgeable and responsible¹ adult household member, preferably household head for household level information and ever married women of reproductive age (15-49 years) for the women questionnaire.

The household questionnaire collected household level information required for equity-based analysis and included the Third-Party Verification Immunization Coverage Survey (TPVICS) immunization module. Additionally, the household survey allowed some level of comparability with TPVICS round 2 in terms of methodology to estimate the level of child immunization. The sample sizes of the KPHPS, at district level are, however, smaller than what is required to match TPVICS sample at district-level. The intent is to increase the sample of children in the second round of survey to get district levels estimates at that point.

For the detailed women questionnaire, information was collected directly from all ever married women of reproductive age in the sampled households and about health and nutrition of all children aged 0-59 months. The ever married questionnaire survey is comparable to the Pakistan Demographic and Health Survey (PDHS) 2017-18.

To develop these questionnaires, the core team drew modules from the PDHS and other validated tools. The draft questionnaires were reviewed by several professionals with multidisciplinary expertise and experience and went through several iterations. These questionnaires were pre-tested and further revised. The final questionnaires were translated into Urdu.

The KPHPS is designed to measure change in the above-mentioned indicators, giving special considerations to a) equity, b) gender, and c) lagging behind districts (defined as districts that were defined by the KP Health Department based on their low ranking in terms of immunization coverage, more specifically of Penta-1 vaccine. The KPHPS was designed to measure change, from baseline to endline, in the following result indicators of NHSP:

- PDO-1. UHC SCI (adjusted to reflect essential health services at PHC level)
- PDO-2. Use of modern contraceptives among currently married women of reproductive age 15-49 years
- PDO-4. Effective antenatal care (ANC) coverage
- DLI-5. a) Coverage of Penta-1 and b) coverage of fully immunized children

This round of survey is designed as a baseline with full anticipation of an endline survey in 2026 or 2027. The endline survey is expected to be conducted in the same clusters as the baseline.

Sample Design

The analytical needs of measuring the impact of NHSP inputs demanded stratification of households by residence (urban/rural) and particularly by Lagging Behind/Zero-dose Districts and other districts. The point of distinction across lagging and non-lagging districts in KP is based on each district's

¹ Responsible adult, for this survey means a person, female or male, at least 18 years of age.

performance on immunization coverage (the districts with highest percentages of children who had never received vaccinations (according to the TPVICS) were classified as lagging.² The 11 Zero-dose Districts (also stated as lagging districts) and 24 non-lagging districts are listed in Table 1.1.

Table 1.1: List of Lagging and Non-lagging districts in KP

Lagging Districts		Non-Lagging Districts	
1.	Bannu	1.	Abbottabad
2.	Dera Ismail Khan	13.	Malakand Protected
3.	Hangu	2.	Bajaur
4.	Kolai Palas Kohistan	14.	Mansehra
5.	Lakki Marwat	3.	Batagram
6.	Lower Kohistan	15.	Mardan
7.	North Waziristan	16.	Mohmand
8.	Peshawar	17.	Nowshera
9.	South Waziristan	18.	Orakzai
10.	Torghar	19.	Shangla
11.	Upper Kohistan	20.	Swabi
		21.	Swat
		22.	Tank
		23.	Upper Chitral
		24.	Upper Dir

The sample design used in KPHPS is a probability-based stratified, cluster, two-stage sample design. To meet the objective of measuring change in outcome indicators over time and to obtain provincial and district level representative indicators, we needed sufficient number of respondents to measure from baseline to endline.

The population frame used in this design is provided by the Pakistan Bureau of Statistics (PBS) and is based on the 2023 Population and Housing Census. Each census block (enumeration area) comprising 200-350 households is uniquely identified in the frame along with the number of households and persons. The official urban and rural classification is built into the enumeration code and is used to identify rural-urban classification of each cluster.

The KPHPS is representative of urban and rural areas for each province. The sample allocation to urban and rural areas, in a district, is based on the share of urban and rural population of the district. This allocation at district level, also called probability proportionate to the size (PPS) of urban-rural population, will by default be representative of urban-rural population of province.

The sample, at the provincial level, is stratified by the share of urban and rural populations of each district, thus making all indicators representative at provincial urban and rural levels. By default, a larger sample size is proposed for lagging districts that will measure a change of 5 percentage-point in two child immunization indicators (DLI5) from baseline.

² The sample size for lagging Districts/Zero-dose needed to be higher than other Districts to measure a 5 percentage-point change in the lagging districts and 10 percentage-point change in non-lagging districts in the modern contraceptive prevalence (mCPR) which was the measure used for calculating sample sizes sufficient to reflect the change.

Sample Size Determination

District level representation is the main feature of the KPHPS. The sample size (number of households) is also determined by incorporating the following considerations, listed by order of their importance and influence on the calculation of sample size.³ The event of interest selected to calculate sample sizes was the change in mCPR, expressed in percentage-point change.⁴

The multi-stage sample design entailed drawing clusters at the first stage and households at the second stage. At the first stage clusters (also called primary sampling units - PSUs) were selected with probability proportionate to the size of cluster, while at the second stage 20 households per PSU (also called secondary sampling units - SSUs) were drawn using systematic sampling with a random start. Since the sample in KPHPS is representative of overall district level, it is, by default, also provide provincial representative results. Table 1.2 presents allocation methods for each domain.

Table 1.2: Type of allocation method for each domain/stratum

Domain/ stratum	Type of allocation*	Selection of Primary Sampling Units (PSUs) within district
Urban and rural households in all districts in the province Higher size for lagging behind district	Allocate number of PSUs proportionately by urban and rural population of district	Proportionality to the size of PSU. Use number of households in PSU as Measurement of Size (MoS)

* At least 2 PSUs are required per rural/urban stratum

The Population Council and the Population Center Pakistan proposed the sampling strategy based on the requirements of the NHSP program. The KP Bureau of Statistics (KPBoS) then communicated with the Pakistan Bureau of Statistics in Islamabad to generate a sample of PSUs based on their sampling frame.

Table 1.3 below provides details of the sample size, the actual number of interviews conducted and response rate. The response rates overall and by urban-rural and lagging and non-lagging districts were over 96%. Overall, 23,536 households were successfully interviewed with a response rate of 98.1% and 28,063 ever married women were interviewed giving a response rate of 98.2%. The response rates for urban-rural and lagging and non-lagging districts were broadly similar and high.

³ While all indicators are representative at district level, the child immunization indicators are smaller than TPVICS requirement. The immunization indicators are representative at aggregate level of lagging districts and province.

a) ⁴ Precision requirements of estimates and power of sample (alpha = 0.05, power = 0.80).

b) Available time and finance. The Parameters for Initial Sample Size Determination are as follows:

The event of interest is change/difference in mCPR. To determine sample for **Lagging Behind Districts/Zero dose**, 5 percentage-point change is assumed and for **Other Non-lagging Districts**, the 10 percentage-point change is taken as the event of interest.

As per PDHS 2017-18, mCPR for Khyber Pakhtunkhwa was 23.2%.

The precision parameters are alpha = 0.05 and power = 0.80.

The first required stratification is by urban and rural, and then by identified Lagging vs. Non-lagging Districts.

Table 1.3: Sample size, number of interviews conducted and response rate

PSUs and Type of Interviews	Sampled/Total	Interviewed	Response Rate (%)
Primary Sampling Units (PSUs)			
Overall	1,200	1,199	99.9
Rural	1,035	1,034	99.9
Urban	165	165	100.0
Lagging Districts			
Overall	535	535	100.0
Rural	468	468	100.0
Urban	67	67	100.0
Non-lagging Districts			
Overall	664	663	99.9
Rural	566	565	99.9
Urban	98	98	100.0
Households			
Overall	24,000	23,536	98.1
Rural	20,700	20,359	98.4
Urban	3,300	3,177	96.3
Lagging Districts			
Overall	10,700	10,515	98.3
Rural	9,360	9,249	98.8
Urban	1,340	1,266	94.5
Non-lagging Districts			
Overall	13,280	13,021	98.0
Rural	11,320	11,110	98.1
Urban	1,960	1,911	97.5
Ever married Women			
Overall	28,583	28,063	98.2
Rural	25,006	24,573	98.3
Urban	3,577	3,490	97.6
Lagging Districts			
Overall	12,991	12,825	98.7
Rural	11,599	11,471	98.9
Urban	1,392	1,354	97.3
Non-lagging Districts			
Overall	15,592	15,238	97.7
Rural	13,407	13,102	97.7
Urban	2,185	2,136	97.8

Survey Implementation

The Survey administration and data collection was carried out by KP Bureau of Statistics (KPBoS) from 16 September 2024 to 7 January 2025. The KPBoS was responsible for field implementation, data collection using tablets, hiring of enumerators and making training arrangements. In addition, supervision of enumerators and of the field work was the responsibility of the KPBoS. The KPBoS engaged 172 female interviewers and 43 male field workers. Male field workers did not conduct interviews but were responsible for logistical support, including locating the area and ensuring safety and privacy of the respondent and the interviewer. In addition, 43 male supervisors were deployed to monitor and oversee the field work. In total, 43 teams conducted the field work in 35 districts. Many of the enumerators had master's degree, while some had a bachelor's degree. Some of the enumerators had previously worked on other surveys by KPBoS.

The KPBoS survey managers adapted survey manuals⁵ and localized them for KP context and language. This includes training interviewers in computer-assisted personal interviewing (CAPI), deployment of field operation in sampled areas, communication, adequate transportation, and lodging arrangements.

The Population Center Pakistan (PCP) and Population Council (PC) were responsible for the survey design, questionnaire design, CAPI tool, sample design, survey manual, training of master trainers and support during training of enumerators, quality assurance of data, analysis and write-up of results.

PC and PCP teams conducted two Trainings of Master Trainers in Islamabad. The first training of master trainers was conducted from January 2 - January 5, 2024, and the follow up second Training of master trainers was conducted from May 27 to June 1, 2024.

Subsequently, the PC and PCP teams participated during training of first batch of enumerators as technical observers and in remaining trainings of enumerators PC and PCP facilitated the CAPI sessions. All enumerators were trained before the pre-test and data collection.

PC and PCP teams also facilitated the arrangement of resource persons through coordination with the Health and Population Welfare Department in KP to deliver the sessions on the complex sections of the questionnaires such as pregnancy history and contraception.

Overall quality measures were ensured by the PC and the PCP. The PCP placed a team of experienced interviewers who were familiar with the questionnaires and could respond to any queries of the interviewers alongside each of the teams to provide guidance if requested during the entire field operations. These quality assurance teams moved alongside the KPBoS teams and provided additional support to the interviewers in addition to the direct supervision of the KPBoS. In addition, constant channels of communication about challenges in the field were available with the PCP and PC project team in Islamabad that also included being on a KPHPS-dedicated WhatsApp group.

⁵ The guiding principles for the KPHPS come from the UN's "principles governing international statistical activities" that call for surveys done with ethical principles and reviews. The technical and statistical aspects of the survey are guided by the Demographic and Health Survey (DHS) methodology manuals. These sources offer comprehensive information on field operations to guide surveys.

A customized KPHPS Dashboard was developed and access to the real-time data was provided to KPBoS for tracking survey progress and monitoring field activities to improve quality of data. In addition, the survey data was made available to the KPBoS during the fieldwork to perform preliminary checks to track survey progress and ensure data quality.

No serious challenges were encountered during data collection. By using CAPI with in-built quality checks for consistency and completeness, rigorous training and supervision, and promptly addressing fieldwork challenges, the integrity and quality of data were strengthened. The response rates also indicate no selectivity by area, district or by household and women respondents. However, the possibility of intentional under-reporting and/or misreporting and unintentional recall errors cannot be entirely ruled out.

2. Characteristics of Ever Married Women

This chapter describes the socio-economic and demographic background characteristics of ever married women in reproductive age (15-49 years). We provide information for the overall province and by urban-rural, lagging and non-lagging districts.

Socio-economic and Demographic Background Characteristics of Ever Married Women

Overall, 65.6% of 28,063 ever married women interviewed in KPHPS 2024-25 had no education (Table 2.1) - 45.1% in urban compared to 68.9% in rural areas. However, the highest level of illiteracy was found among women in lagging districts (79.4%) compared to non-lagging districts (59.9%). For all other levels of education, more women in urban compared to rural and those in non-lagging than lagging districts were educated. This disparity in higher educational attainment is substantial - women 2-3 times in greater number in urban and non-lagging districts compared to their counterparts in rural and lagging districts.

During the last 30 days before the KPHPS 2024-25, less than 5% of women worked. More women in rural areas reported working (4.6%), probably in agriculture, than in urban areas (3.3%). However, the highest proportion of working women was in non-lagging areas though it was still low (5%).

Percentage distribution of women by age groups was broadly similar across rural-urban and lagging/non-lagging districts for the 15–24 age group. However, the proportion of women aged 25–34 was relatively higher compared to those aged 35–49 in all regions.

The percentage with no children ever born was reported to be around 12% and broadly similar across rural-urban and non-lagging districts except in lagging districts, where it was slightly lower at 11.6%. However, in the highest fertility group of women with 5 or more children, women in rural areas were five percentage points higher than those in urban areas. The difference between the lagging and non-lagging districts was however more modest in this parity group (24.1% vs 23.3%).

The background characteristics of women interviewed in KPHPS 2024-25 indicate high level of illiteracy (over 66%), except for women in urban areas, low percentage of women working (5% or less) and high level of fertility (over 20% of women having 5 or more children ever born), except in urban areas.

Table 2.1: Percentage distribution of ever married women by background characteristics, KPHPS 2024-25

	Total	Rural	Urban	Lagging	Non-lagging
Education					
No education	65.6	68.9	45.1	79.4	59.9
Primary	16.8	16.0	21.8	9.7	19.7
Secondary and higher	17.7	15.2	33.1	10.9	20.5
Total	100	100	100	100	100
Currently Working*					
Yes	4.5	4.6	3.3	3.1	5.0
No	95.5	95.6	96.7	96.9	95.0
Current Age (years)					
15-24	23.0	23.4	20.3	21.8	23.4
25-34	41.8	42.1	40.4	43.9	41.0
35-49	35.2	34.6	39.4	34.2	35.7
Total	100	100	100	100	100
Number of children ever born					
0	12.2	12.3	12.1	11.6	12.5
1-2	30.0	29.6	32.2	28.0	30.8
3-4	34.3	33.9	36.8	36.2	33.5
5 or more	23.5	24.2	18.9	24.1	23.3
Total	100	100	100	100	100
Number of women	28,063	24,573	3,490	12,824	15,238

*Refers to women responding “yes” to question: “Aside from your own housework, have you done any work for income in the last 30 days?”

3. Maternal Health Care

This chapter covers three critical services for pregnant women – antenatal care (ANC), institutional delivery and skilled attendance of delivery. Together, these essential services make a difference for the survival and wellbeing of pregnant women and their newborns. KP has a provincial policy, and guidelines focused on reproductive, maternal, newborn, child and adolescent Health (RMNCAH&N), and the KP Health Policy 2018-2025. In 2005, the Federal government adopted a comprehensive National Maternal, Neonatal, and Child Health (MNCH) Strategic Framework and in 2007 it launched the MNCH program. The MNCH program focused mainly on providing emergency obstetric services and community midwives, and on promoting institutional deliveries and skilled birth attendance.

Antenatal Care (ANC) Coverage

Women who have completed a pregnancy in three years preceding the survey were asked questions about the number of ANC visits, type of care provider, place where care was received, and the ANC components received during the most recent pregnancy. Overall, the ANC coverage of at least one visit was 73% for KP (Table 3.1). With a difference of 20 percentage points, the lagging districts lagged substantially (53.3%) from the non-lagging districts (81.1%). Urban non-lagging districts had the highest ANC coverage (90.4%), and the rural lagging districts the least (49.3%).

Among the 35 districts in KP, the lowest levels of at least one ANC visit were in Kolai Palas Kohistan (5.1%) and Upper Kohistan (13.2%) both lagging districts (Figure A.1). Among the non-lagging districts, the lowest ANC coverage was in Orakzai (14.6%). While Hangu and Peshawar among the lagging districts had over 80% ANC coverage, 12 non-lagging districts (Abbottabad, Lower Dir, Mardan, Shangla, Swabi, Swat, Charsada, Haripur, Malakand Protected, Kohat, Bajaur and Nowshera) had this level. As expected, lagging districts had lower ANC coverage than non-lagging districts.

Table 3.1: Percentage of women who had a complete pregnancy in the last three years reporting at least one visit for antenatal care (ANC) during the last pregnancy, KPHPS 2024-25

	%	N
Overall	73.0	12,471
Rural	71.4	11,006
Urban	83.2	1,465
Lagging Districts		
Overall	53.3	5,666
Rural	49.3	5,063
Urban	72.2	603
Non-lagging Districts		
Overall	81.1	6,805
Rural	79.9	5,943
Urban	90.4	862

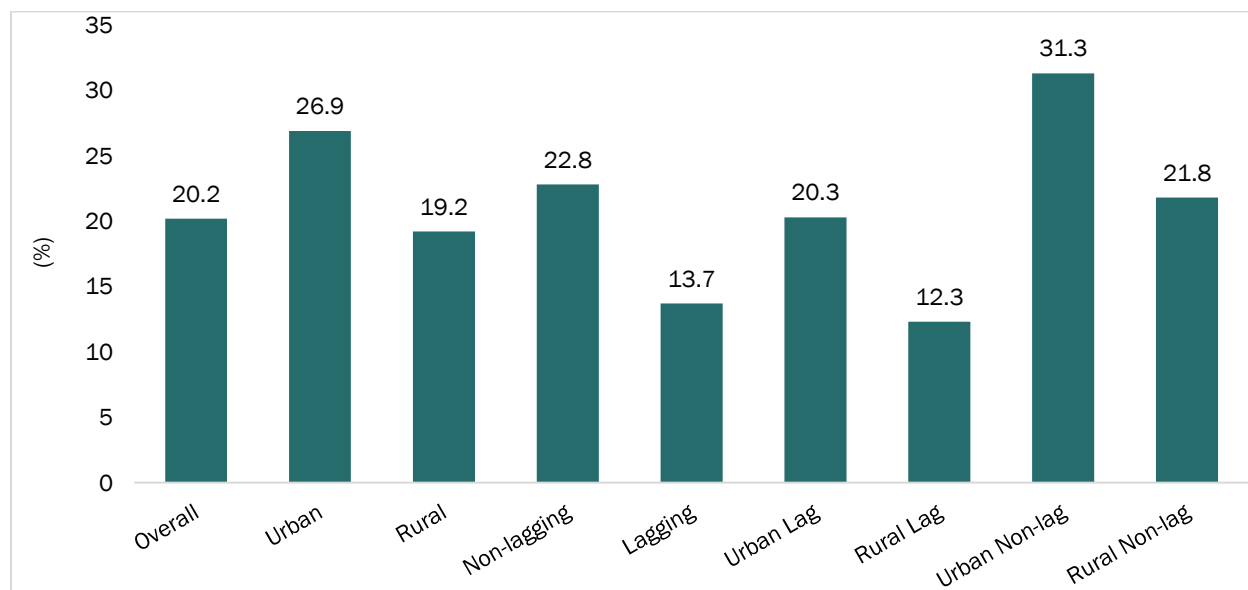
While the coverage of at least one ANC visit is relatively high though not universal, the coverage of WHO recommended eight ANC visits is uncommon. Overall, 20.2% of women who had a complete

pregnancy in three years preceding the survey reported four or more ANC visits during the last pregnancy (Table 3.2). The urban-rural differentials in four or more ANC visits were marked as well as between lagging and non-lagging districts (Figure 3.1). The large percentage of women with no ANC visit (50.8% in lagging rural and 28.6% in rural overall) and the divide between lagging and non-lagging districts (46.7% vs 18.9%) is a matter of concern. This gap in the overall coverage of four or more ANC visits and the inequity in urban-rural and lagging-non lagging districts need to be addressed as a priority.

Table 3.2: Percentage of women who had a complete pregnancy in the last three years, by number of antenatal care (ANC) visits during the most recent pregnancy, KPHPS 2024-25

	No visit	1-3 visits	4 or more	Don't know	N
Overall	27.0	51.6	20.2	1.2	12,471
Rural	28.6	51.1	19.2	1.2	11,006
Urban	16.8	55.1	26.9	1.2	1,465
Lagging Districts					
Overall	46.7	38.6	13.7	0.9	5,666
Rural	50.8	36.0	12.3	0.9	5,063
Urban	27.8	50.7	20.3	1.2	603
Non-lagging Districts					
Overall	18.9	56.9	22.8	1.3	6,805
Rural	20.1	56.8	21.8	1.4	5,943
Urban	9.6	58.0	31.3	1.1	862

Figure 3.1: Percentage of women with a complete pregnancy in the last three years who report 4 or more antenatal care (ANC) visits during the most recent pregnancy, by area, KPHPS 2024-25

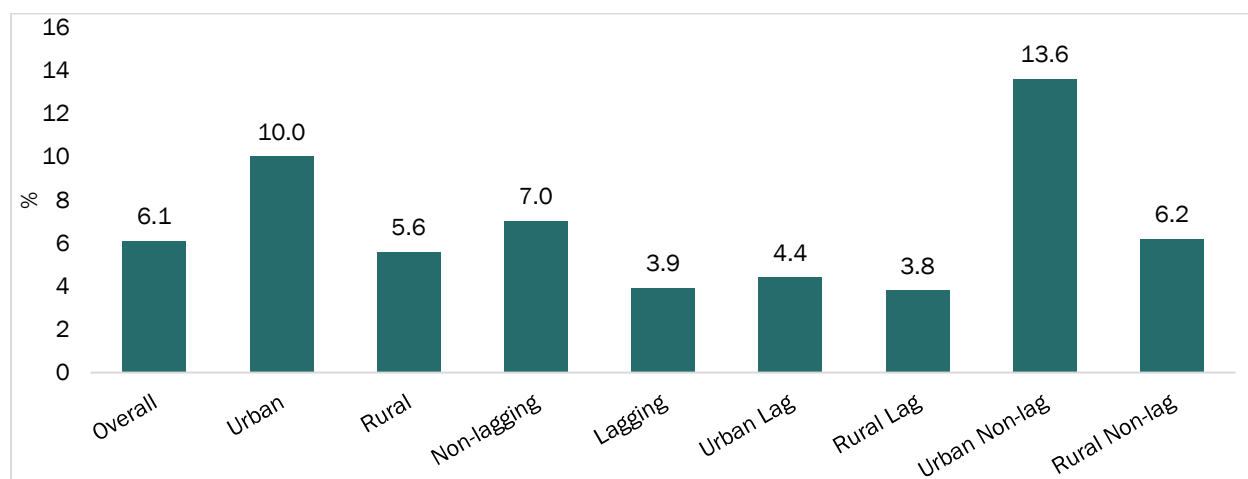


The percentage of women with four or more ANC visits ranged from less than 1% in Kolai Palas Kohistan, South Waziristan and Upper Kohistan to 27% in Peshawar in the group of lagging districts and from 2.5% in Tank to 52% in Haripur (Figure A.2). While Lakki Marwat had the highest coverage level of 20.9% among the lagging districts, 10 of non-lagging districts achieved or surpassed this level.

Effective antenatal care (ANC) coverage

While the number of ANC visits is important, the components of care received indicate the quality of care. “Effective ANC” was defined when coverage included: (1) at least four ANC visits; (2) receipt of iron supplements; (3) receipt of at least two tetanus injections; (4) blood pressure taken; and (5) urine samples taken. Effective ANC coverage was below 10% overall and for most groups, except for urban (10.0%) and urban non-lagging (13.6%) districts (Figure 3.2). The difference in effective coverage between urban and rural lagging districts was modest (4.4% vs 3.8%) as compared to urban and rural in non-lagging districts (13.6 % vs 6.2 %).

Figure 3.2: Percentage of women with a complete pregnancy in the last three years who received effective* antenatal care (ANC) during the most recent pregnancy, by area, KPHPS 2024-25



*Include at least 4 ANC visits, receipts of iron supplements and two tetanus injections, and blood pressure and urine samples taken.

All lagging districts had effective coverage of antenatal care of less than 5% (Figure A.3), except in Peshawar (9.5%). On the other hand, five non-lagging districts (Abbottabad, Kohat, Lower Dir, Swabi, and Haripur) had effective coverage of 10% or higher with the highest in Haripur (31.7%).

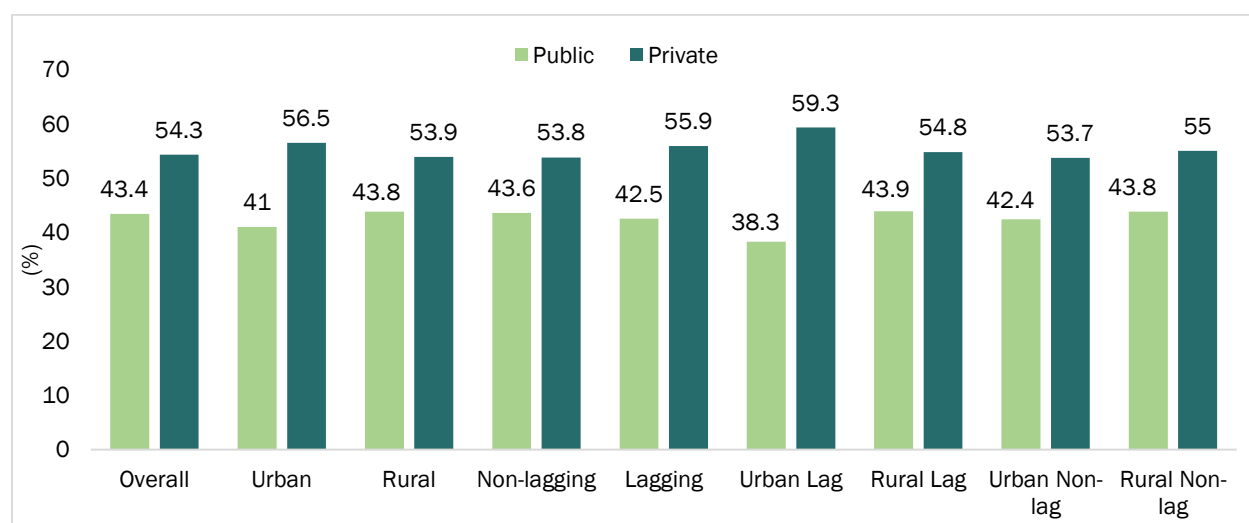
Place where antenatal care received

Most of the women who received antenatal care during the most recent pregnancy in the last three years, received it at a private (54.3%) than a public (43.4%) facility (Table 3.3). This trend cuts across all groups including rural areas and lagging districts where one would have expected more reliance on public sector facilities (Figure 3.3). Somewhat similar proportions were reported to have accessed public sector facilities for ANC in urban and rural areas (41.0% vs 43.8%) and lagging and non-lagging districts (42.5% vs 43.6%). The use of private sector facilities for ANC was the highest (59.3%) in urban areas of the lagging districts.

Table 3.3: Percentage of women with one or more antenatal care (ANC) visit during the most recent pregnancy in the last three years, by place of visit and area, KPHPS 2024-25

	Public	Private	Worker	Other	Total	N
Overall	43.4	54.3	0.6	1.8	100	7,472
Rural	43.8	53.9	0.5	1.8	100	6,297
Urban	41.0	56.5	1.3	1.3	100	1,175
Lagging Districts						
Overall	42.5	55.9	0.2	1.4	100	2,403
Rural	43.9	54.8	0.3	1.1	100	1,988
Urban	38.3	59.3	0.0	2.5	100	415
Non-lagging Districts						
Overall	43.6	53.8	0.8	1.9	100	5,069
Rural	43.8	53.7	0.6	2.0	100	4,309
Urban	42.4	55.0	2.0	0.6	100	760

Figure 3.3: Percentage of women with one or more antenatal care (ANC) visit during the most recent pregnancy in the last three years, by place of visit and area, KPHPS 2024-25



Institutional Deliveries

Deliveries that take place in a health facility are less prone to the risk of complications and infections that can cause death of the mother, baby or both. The WHO recommends that women deliver with a skilled birth attendant at a health facility to ensure quality intrapartum and postnatal care. The national and KP MNCH programs emphasize delivery at a health facility and promote it through community health workers such as lady health workers (LHWs). Traditionally, women in Pakistan, especially in rural areas of KP, deliver at home but with concerted efforts and expansion of services, their percentage has declined though one in five births are still delivered at home.

KPHPS 2024-25 indicates that 8 in 10 deliveries in three years before the survey in KP took place in a public (43.9%) or private (35.5%) health facility (Table 3.4). In urban non-lagging districts, the proportion of institutional deliveries was 94.1% (Figure 3.4). Except for urban non-lagging districts, more women delivered at a public than private health facility (Figure 3.5). Even for urban lagging districts, the percentage of deliveries in public sector facility (42.7%) was higher than in a private sector facility (37.2%). The disparity between urban-rural and lagging and non-lagging districts continues to be visible as for other indicators. It is, however, noteworthy that private health facilities are more often used for ANC and public health facilities for delivery. By district, the percentage of institutional deliveries was low in Upper Kohistan (9.2%) and Torghar (13%) among the lagging districts (Figure A.4). In this group, Hangu had the highest percentage of institutional deliveries (92.6%). The level of institutional deliveries was high among the non-lagging districts ranging from 40.8% in Orakzai to 97.9% in Shangla and Tank.

Table 3.4: Percentage of deliveries in the 3 years before the survey, by place of delivery and by area, KPHPS 2024-25

	At home	Public facility	Private facility	Other	N
Overall	18.6	43.9	35.5	2.0	11,417
Rural	20.0	43.9	34.2	1.9	10,071
Urban	9.4	43.9	44.4	2.2	1,346
Lagging Districts					
Overall	34.3	38.1	26.2	1.4	5,206
Rural	37.9	37.1	23.9	1.2	4,645
Urban	18.0	42.7	37.2	2.2	561
Non-lagging Districts					
Overall	12.1	46.3	39.4	2.2	6,211
Rural	13.1	46.5	38.1	2.2	5,426
Urban	3.7	44.8	49.3	2.3	785

Figure 3.4: Percentage of women who delivered the most recent pregnancy in the 3 years before the survey in a health facility, by area, KPHPS 2024-2025

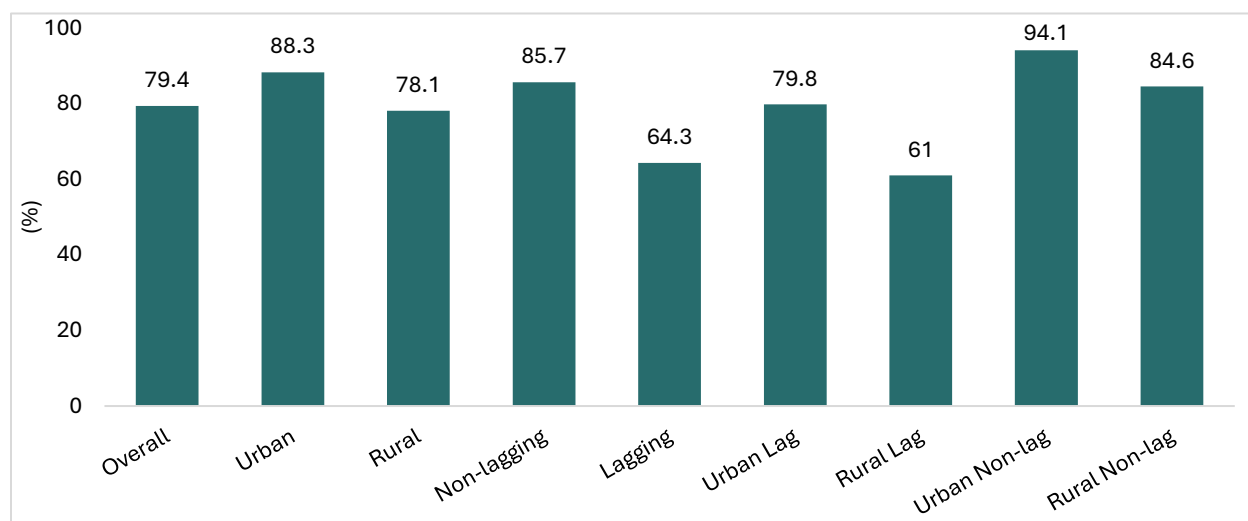
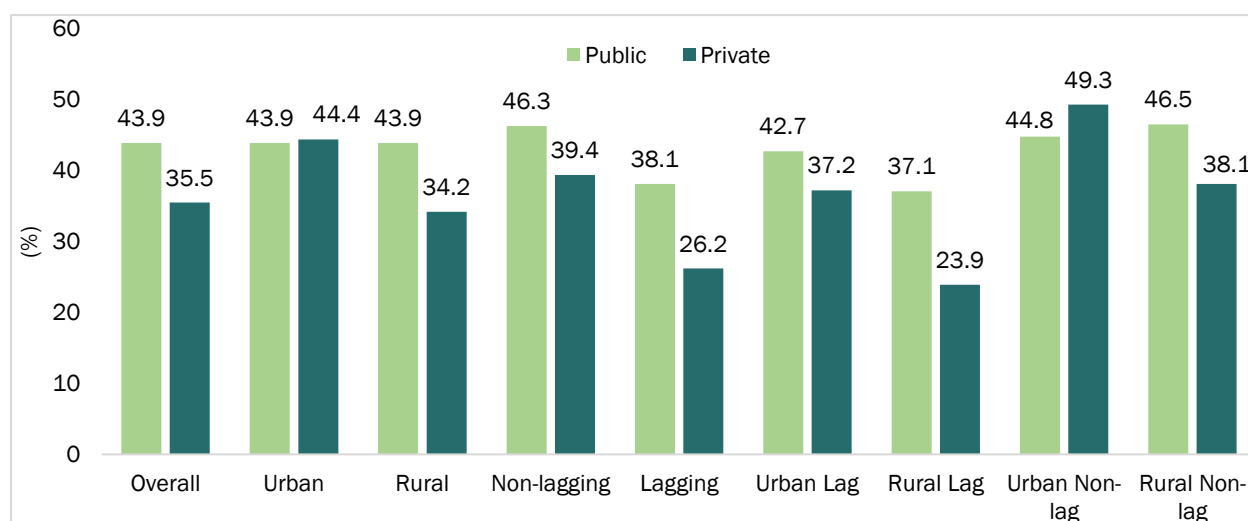


Figure 3.5: Percentage of women who delivered the last pregnancy at a health facility in the 3 years before the survey, by type of facility and area, KPHPS 2024-25

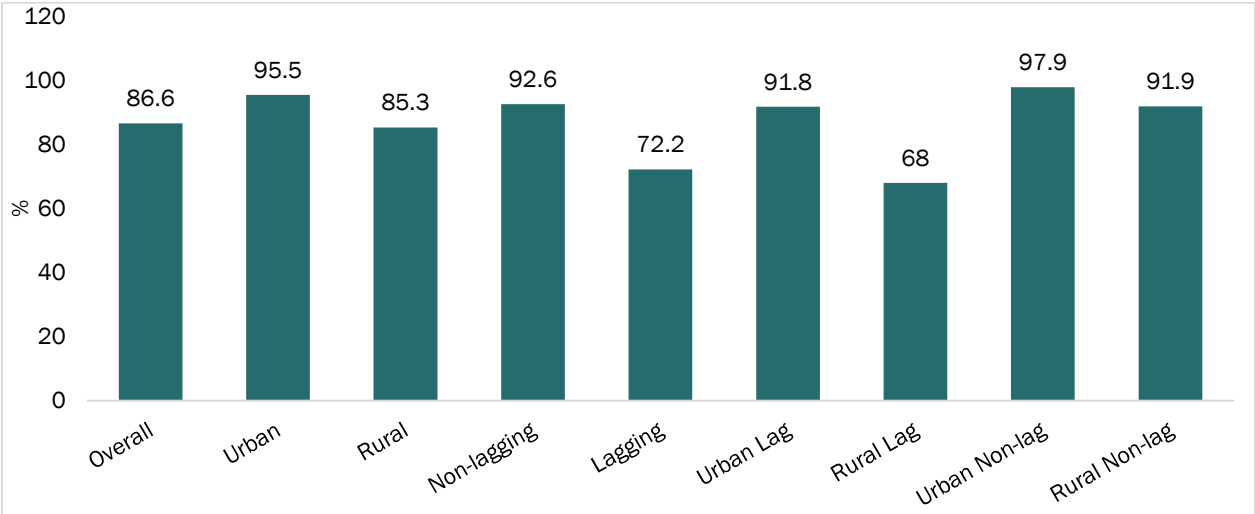


Skilled Assistance During Delivery

Assistance from a skilled birth attendant during delivery is vital for maternal and newborn health. Overall, 86.6% of deliveries during the last 3 years before the survey in KP were conducted by a skilled health provider (Figure 3.6). The gap between urban and rural (95.5% vs 85.3%) and between lagging and non-lagging districts (72.2% and 92.6%), however, prevails. Over 90% of deliveries were conducted by skilled birth attendants, except in rural (85.3%), lagging (72.2%) and rural lagging districts (68.0%). The difference in the percentage of deliveries by skilled birth attendants between urban and rural areas is more pronounced in lagging districts than in non-lagging districts.

Over 80% of deliveries were assisted by the skilled attendants in all non-lagging districts, except Orakzai (55.7%) and Batagram (76.4%). Deliveries by skilled birth attendants were universal in Abbottabad (99.6%). The lowest coverage by skilled birth attendants among lagging districts was in Torghar (13.6%) and Upper Kohistan (14.6%) while 88.2% of deliveries in Peshawar and 98.3% in Hangu were assisted by skilled birth attendants (Figure A.5).

Figure 3.6: Percentage of deliveries in the 3 years before the survey that were assisted by skilled birth attendants, by area, KPHPS 2024-25



4. Family Planning

Couples use family planning (FP) methods to limit or space childbearing. The health and socio-economic benefits of contraception are well documented for women, couples, and children. **Traditional** methods include periodic abstinence (rhythm method), withdrawal, and folk methods while **modern** methods include male and female sterilization, injectables, Syana Press, intrauterine devices (IUDs), contraceptive pills, implants, male and female condoms, the standard days method, lactational amenorrhea method, and emergency contraception. Contraceptive prevalence rate (CPR) was measured as the percentage of currently married women using any method and separately for traditional and modern methods (mCPR).

Current Contraceptive Use

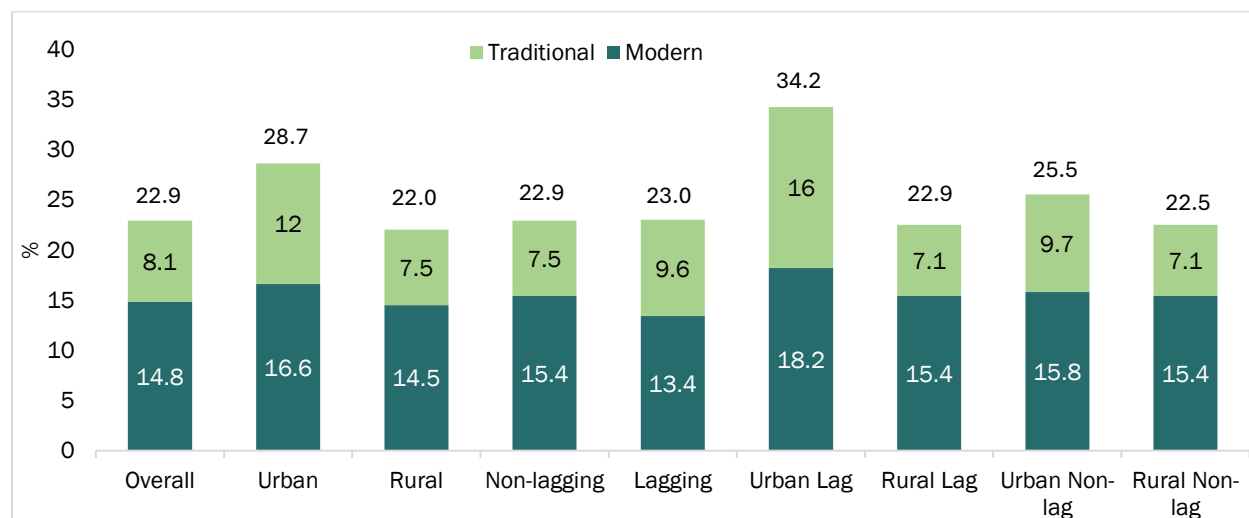
Overall, 23% of currently married women were using any method of contraception, 8.1% using traditional and 14.8% using modern methods (Table 4.1). CPR is higher (28.7%) in urban areas than in rural areas (22%) but similar in lagging (23%) and non-lagging (22.9%) districts (Figure 4.1). Unexpectedly urban areas in lagging districts show a higher level of prevalence (34.2%) than urban areas in non-lagging districts (25.5%). Use of modern methods (mCPR) is higher in urban areas (16.6%) than in rural areas (14.5%). However, urban-rural differences in the use of traditional methods are modest in non-lagging districts (15.8% vs 15.4%). The prevalence of traditional methods is higher (16%) in urban areas of lagging districts than in lagging rural areas (8.3%). Overall, 12% of urban women were 'currently' using a traditional method compared to 7.5% of rural women. Lagging districts overall have higher use of traditional methods (9.6%) than non-lagging districts (7.5%). Overall, contraceptive prevalence of any method (CPR) is low with little difference between lagging and non-lagging districts.

Use of modern methods (mCPR) was higher than of traditional methods (Figure A.6), except in Peshawar where the use of traditional methods was slightly higher than the use of modern methods (19.8% vs 19.6%). While no lagging district had an mCPR over 20%, three non-lagging districts had a mCPR over 30% - Bajaur (34%), Lower Chitral (31.9%) and Upper Chitral (33.2%). mCPR was the lowest in the lagging district of Kalai Palas Kohistan (0.3%).

Table 4.1: Percentage of currently married women using any method (CPR), modern method (mCPR) or a traditional method, KPHPS 2024-25

	Type of method			N
	Modern	Traditional	Any	
Overall	14.8	8.1	22.9	27,506
Rural	14.5	7.5	22.0	24,107
Urban	16.6	12.0	28.7	3,399
Lagging Districts				
Overall	13.4	9.6	23.0	12,602
Rural	12.4	8.3	20.6	11,284
Urban	18.2	16.0	34.2	1,318
Non-lagging Districts				
Overall	15.4	7.5	22.9	14,904
Rural	15.4	7.1	22.5	12,823
Urban	15.8	9.7	25.5	2,081

Figure 4.1: Percentage of currently married women using a modern or traditional contraceptive method, by area, KPHPS 2024-25



Type of Contraceptive Method Currently Used

With low contraceptive prevalence, method mix is narrow. Withdrawal is the most used method in KP overall, in urban and rural areas and in lagging and non-lagging districts (Table 4.2). The prevalence of withdrawal was 8% in KP, 11.7% in urban areas compared to 7.4% in rural areas. In lagging districts withdrawal was used by 9.4% compared to 7.3% in non-lagging districts. No other method reaches the level of use of withdrawal. The second most used method is the male condom used by 4.9% of all couples in the province. The use of the condom is higher in urban areas (7.6%) than in rural areas (4.5%). The condom use was higher in lagging districts (5.5%) than in non-lagging districts (4.7%). In the non-lagging districts, the use of injectables was about the same as of the condom (4.7%). No other

spacing method exceeded use over 2%. Female sterilization was higher in urban areas of lagging districts (3.7%) than elsewhere.

Overall, despite a long history of family planning program in Pakistan, the current use of any method, modern or traditional, remains low and the method mix narrow. Withdrawal and the male condom are the most used methods, followed by injectables in rural areas. The failure rate of withdrawal is high. Besides, unless condoms are used correctly and consistently the risk of an unintended pregnancy can be high.

Table 4.2: Percentage of currently married women by type of contraceptive method using, KPHPS 2024-25

				Lagging Districts			Non-lagging Districts		
	Overall	Rural	Urban	Overall	Rural	Urban	Overall	Rural	Urban
Female Sterilization	1.4	1.2	2.5	1.7	1.2	3.7	1.3	1.2	1.9
Male Sterilization	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.2
IUD	1.1	1.1	1.1	1.0	0.9	1.3	1.1	1.2	0.9
Injectable	4.0	4.3	2.5	2.4	2.5	1.7	4.7	5.0	2.9
Sayana press	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0
Implants	0.4	0.4	0.5	0.4	0.3	0.6	0.4	0.4	0.5
Oral pills	2.0	2.1	1.5	1.4	1.4	1.4	2.2	2.3	1.6
Male condom	4.9	4.5	7.6	5.5	4.9	8.6	4.7	4.3	7.0
Female condom	0.0	0.1	0.0	0.0	0.0	0.0	0.1	0.1	0.0
ECP	0.1	0.1	0.0	0.1	0.1	0.0	0.0	0.0	0.0
Standard Days Method	0.1	0.1	0.0	0.0	0.1	0.0	0.1	0.1	0.0
Lactational amenorrhoea method	0.7	0.7	0.7	0.9	0.9	0.6	0.6	0.6	0.7
Rhythm method	0.1	0.1	0.3	0.2	0.1	0.4	0.1	0.1	0.3
Withdrawal	8.0	7.4	11.7	9.4	8.1	15.7	7.3	7.1	9.4
Others	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Not using currently	77.1	78.0	71.4	77.0	79.4	65.8	77.1	77.5	74.5
Missing	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100	100	100	100	100	100	100	100	100
<i>Using Any Modern Method</i>	14.8	14.5	16.6	13.4	12.4	18.2	15.4	15.4	15.8
<i>Using Any Traditional Method</i>	8.1	7.5	12.0	9.6	8.3	16.0	7.5	7.1	9.7
<i>Using Any Method</i>	22.9	22.0	28.7	23.0	20.6	34.2	22.9	22.5	25.5
Number of women (N)	27,506	24,107	3,399	12,602	11,284	1,318	14,904	12,823	2,081

5. Infant-Child Health and Immunization

Child health is a major concern for parents. It is also a provincial and national priority. The national MNCH program launched the Integrated Management of Newborn and Childhood Illness (IMNCI) as an integrated approach to management of infectious diseases such as pneumonia, diarrhea, malaria, and measles as well as chronic malnutrition among children younger than 5 years.

Acute Respiratory Infection (ARI)

KPHPS 2024-25 asked respondents about ailments (diarrhea, malaria, and acute respiratory infection) and their treatment. The respondents were asked about their youngest child below age 5 years: “Has the child had fast, short, rapid breaths or difficulty breathing at any time in the last 2 weeks?” For children that had symptoms of acute respiratory infection (ARI), a follow up question was asked: “Did you seek any advice or treatment for ARI?”

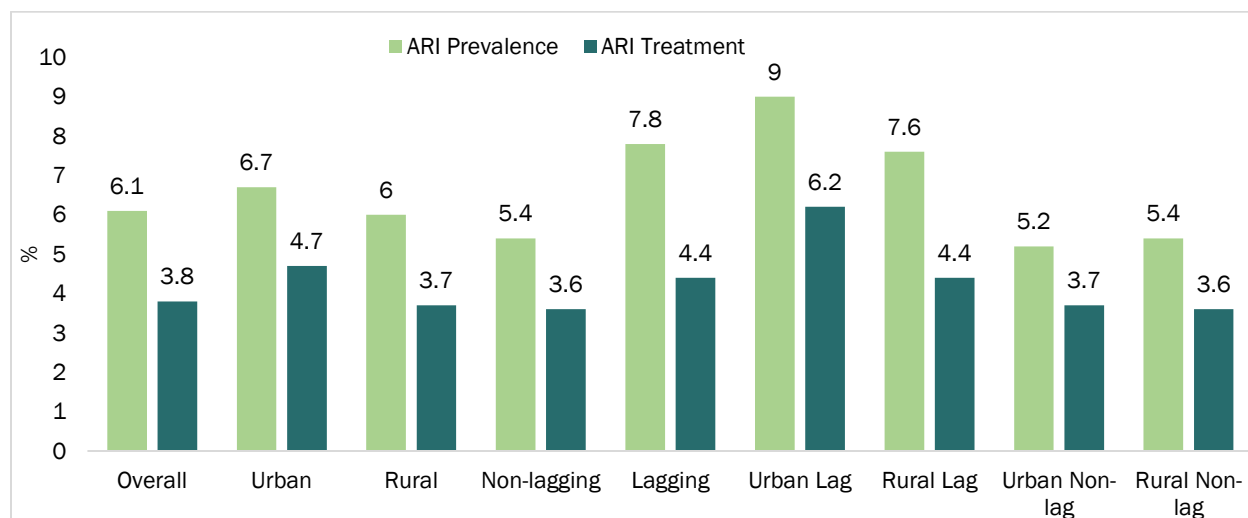
Overall, 6.1% of children younger than 5 years had an ARI during the two weeks before the survey (Figure 5.1). The highest prevalence (9%) was reported in urban areas of lagging districts and the lowest in urban areas of non-lagging districts (5.2%). Overall, more children in lagging districts had ARI in two weeks preceding the survey (7.8%) compared to non-lagging districts (5.4%).

The lagging and non-lagging districts divide in the prevalence of ARI was not as marked as for other indicators (Figure A.7). Among the lagging districts, Peshawar (10.3%) and Dera Ismail Khan (16.0%) had high ARI prevalence rates. Shangla (14.6%) and Batagram (11.1%) were the non-lagging districts with high prevalence. The three districts with low prevalence were all non-lagging (Karak, Kohat, and Tank).

The treatment with medicine or advice for ARI was low. The highest treatment rate was 6.2% of all children below age 5 in urban lagging districts. Overall, 3.8% were treated - 4.7% in urban areas and 3.7% in rural areas. In lagging districts, 4.4% were treated compared to 3.6% in non-lagging districts. Note that pattern of treatment is closely related to the level of ARI prevalence.

When focused only on children who have had ARI, unlike for all children discussed above and shown in Figure 5.1, the treatment rates were 62.9% for KP overall, 70% for urban areas and 61.7% for rural areas. The ARI treatment rate among those with ARI was 10 percentage points lower in lagging than non-lagging districts (56.4% vs 66.9%). However, the treatment rate was close in urban lagging (69.4%) and urban non lagging districts (70.7%). The gap between rural lagging (53.5%) and rural non-lagging districts (66.5%) was wider.

Figure 5.1: Percentage of children younger than 5 years who had symptoms of acute respiratory infection (ARI) in the two weeks before survey and percentage receiving ARI treatment from a health facility, by area, KPHTS 2024-25



Immunization

Recognizing that the universal immunization of children below age one year to prevent vaccine-preventable diseases is a cost-effective intervention to reduce infant and child morbidity and mortality, the Government of Pakistan launched the Expanded Program on Immunization (EPI) in 1978. Over time, the Government introduced additional vaccines and updated its policies and recommendations to align with those of WHO. Children are considered “fully immunized” by WHO when they have received one dose of the vaccine against tuberculosis (BCG), three doses of vaccine against diphtheria, pertussis, and tetanus (DPT), three doses of polio vaccine (excluding polio vaccine given at birth), and one dose of measles vaccine. All children should receive these vaccines during their first year of life.

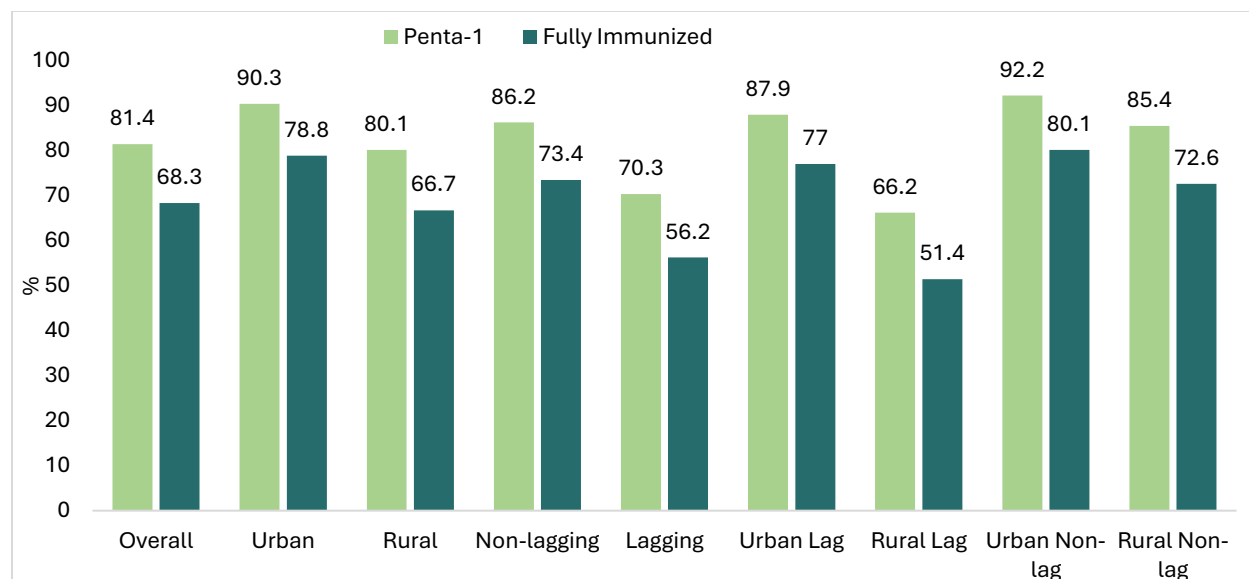
Detailed questions on immunization were included in the household questionnaire and were asked about all children in the household aged 0-48 months.

The Penta-1 vaccine, also known as a pentavalent vaccine, is a combination vaccine that protects babies against five serious diseases: diphtheria, tetanus, pertussis (whooping cough), hepatitis B, and Haemophilus influenzae type b (Hib). The coverage of Penta-1 among children 12-23 months was high (81.4%) but not universal (Figure 5.2). The coverage was ten percentage points lower in rural areas compared to urban areas (80.1% vs 90.3%). Lagging districts had lower coverage (70.3%) than non-lagging districts (86.2%). Rural areas in lagging districts had the lowest coverage of Penta-1 (66.2%) and urban areas in the non-lagging districts had the highest (92.2%).

The percentage of children aged 12-23 months who were fully immunized amounted to 68.3% for KP, 78.8% in urban areas and 66.7% in rural areas (Figure 5.2). The coverage of full immunization was 56.2% in lagging as compared to 73.4% in non-lagging districts. As for other indicators, the coverage of Penta-1 and of full immunization is lower in rural areas and in lagging districts. Rural areas in the

lagging districts are the most disadvantaged where 51.4% of children 12-23 months were fully immunized compared to 80.1% in urban areas of non-lagging districts.

Figure 5.2: Percentage of children aged 12-23 months who received Penta-1 at any time before the survey and percentage who are fully immunized, KPHPS 2024-25



When full immunization among children aged 24-35 months is examined, the pattern for children aged 12-23 months is replicated, though with lower coverage levels (Table 5.1), suggesting an improvement in full immunization rate, albeit modest. Overall, 65.8% of children aged 24-35 months were fully immunized.

Table 5.1: Percentage of children aged 24-35 months who were fully immunized by urban-rural and district type, KPHPS 2024-25

	%	N
Overall	65.8	6,244
Rural	64.4	5,551
Urban	75.3	693
Lagging Districts		
Overall	49.0	3,132
Rural	45.6	2,852
Urban	67.9	280
Non-lagging Districts		
Overall	73.4	3,112
Rural	72.5	2,699
Urban	79.9	413

Coverage of Specific Vaccines Among Children Aged 12-23 Months

Finally, we examine the immunization status of specific vaccine for KP (Table 5.2) and for lagging and non-lagging districts (Table 5.3). Over 80% of 5,292 children 12-23 months have had six vaccines: BCG, polio vaccine at birth, polio 1st dose, pentavalent 1st dose, pneumococcal 1st dose and rotavirus 1st dose. Other vaccines have also been administered to 70% or more children. However, the percentage of fully immunized children receiving all eight basic EPI doses was 68.3%.

Vaccination of children was 15-17 percentage points lower in lagging districts than in non-lagging districts (Table 5.3). For example, 71.3% of children in lagging districts had BCG vaccine compared to 88.5% in non-lagging districts. Similarly, polio vaccination at birth was 69.4% in lagging compared to 86.7% in non-lagging districts. Fully immunized children with eight doses of EPI vaccines were 56.2% in lagging compared to 73.4% in non-lagging districts.

Concerted efforts to achieve universal immunizations coverage are needed. Also, the coverage of polio 3rd dose, pneumococcal 3rd dose and of pentavalent 3rd dose in lagging districts need to be enhanced. Lower coverage of 3rd dose of different vaccines requires follow up strategies to provide full coverage of protection with immunization.

Table 5.2: Percentage of children aged 12-23 months having had vaccination, by type of vaccine, KPHPS 2024-25

	%
Overall	68.3
BCG vaccination	83.4
Polio at birth vaccination	81.5
Polio 1 st dose vaccination	83.0
Pentavalent 1 st dose vaccination	81.4
Pneumococcal 1 st dose vaccination	81.1
Rotavirus 1 st dose vaccination	80.7
Polio 2 nd dose vaccination	78.2
Pentavalent 2 nd dose vaccination	78.3
Pneumococcal 2 nd dose vaccination	77.2
Rotavirus 2 nd dose vaccination	74.8
Polio 3 rd dose vaccination	70.7
Pentavalent 3 rd dose vaccination	72.0
Pneumococcal 3 rd dose vaccination	70.1
IPV1 vaccination according	79.5
Measles1 vaccination (at 9 months)	78.7
FIC-1* Received All 8 classic EPI doses	68.3
Number of children	5,292

*FIC-1= Fully vaccinated with 8 classic EPI doses: BCG, Polio 3 doses, Penta 3 doses, MCV 1 dose

Table 5.3: Percentage of children aged 12-23 months having had vaccination, by type of vaccine, lagging and non-lagging districts, KPHPS 2024-25

	Lagging	Non-lagging
BCG vaccination	71.3	88.5
Polio at birth vaccination	69.4	86.7
Polio 1 st dose vaccination	72.5	87.5
Pentavalent 1 st dose vaccination	70.3	86.2
Pneumococcal 1 st dose vaccination	70.1	85.8
Rotavirus 1 st dose vaccination	69.3	85.5
Polio 2 nd dose vaccination	65.9	83.5
Pentavalent 2 nd dose vaccination	66.5	83.2
Pneumococcal 2 nd dose vaccination	66.3	81.8
Rotavirus 2 nd dose vaccination	64.2	79.3
Polio 3 rd dose vaccination	58.8	75.8
Pentavalent 3 rd dose vaccination	61.2	76.6
Pneumococcal 3 rd dose vaccination	58.4	75.0
IPV1 vaccination	68.0	84.4
Measles1 vaccination according (at 9 months)	67.8	83.4
FIC-1* Received all 8 classic EPI doses	56.2	73.4
Number of children	2,436	2,857

*FIC-1= Fully vaccinated with 8 classic EPI doses: BCG, Polio 3 doses, Penta 3 doses, MCV 1 dose

6. Prevalence and Treatment of Infectious and Noncommunicable Diseases

The PDOs of the NHSP aim to make progress in reducing the incidence of infectious and non-communicable diseases as well as in raising the coverage of their treatment. KPHPS 2024-25 household (HH) questionnaire, therefore, sought the baseline information on the prevalence of these diseases for all members of the HH aged 5 years or older. Results on the prevalence of specific infectious and non-communicable diseases and their treatment rates are presented in the following. The prevalence of HIV/AIDS was very low (only 9 persons reported HIV/AIDS in KP) to permit a meaningful analysis.

Tuberculosis (TB)

The HH roster of HH members included a question: “Have any person/persons aged 5 years or above ever suffered from communicable or non-communicable/long term/chronic/acute disease”. Those responding “yes” to this question were then asked about what illness(es) the HH member had with codes for a list of respiratory, neurological, heart, non-communicable and communicable diseases to select from. A question was further asked if the HH member with illness was taking the treatment (medicines) for the said illness.

The Section E of the HH questionnaire included the question: “Has any member of your household suffered from TB during the last 2 years (from 01 July 2022 till date)”. Those responding “yes” to this question were then asked: “How many members of your household have suffered from TB during the last 2 years (from 01 July 2022 till date).” For those with TB, another question asked was whether the person was taking any medicine(s) for the illness. The percentage of TB cases in household members aged five or older were below 0.5% for overall KP province (0.23%) and for urban (0.14%) and rural (0.24%) areas with the highest percentage of 0.29% in rural areas of lagging districts (Table 6.1). The TB prevalence was lower in urban areas overall and for non-lagging districts than in rural areas and lagging districts.

When the analysis is limited to those who had TB, over 95% were taking the medicine for TB ranging from the lowest figure of 95.2% in non-lagging districts to 100% in urban overall and urban areas in lagging and non-lagging districts. No differentials in TB treatment-seeking behaviours were noticed by urban-rural areas or by lagging and non-lagging districts.

Table 6.1: Percentage of household members aged 5 years or above (Prevalence) with TB and percentage taking medicine for TB, KPHPS 2024-25

Tuberculosis	Prevalence	Taking medicine	N
Overall	0.23	0.22	181,700
Rural	0.24	0.23	159,166
Urban	0.14	0.14	22,534
Lagging Districts			
Overall	0.26	0.25	82,972
Rural	0.29	0.28	73,670
Urban	0.14	0.14	9,302
Non-lagging Districts			
Overall	0.21	0.20	98,728
Rural	0.22	0.21	85,496
Urban	0.13	0.13	13,232

Hypertension (high blood pressure)

Hypertension (high blood pressure) is defined when the pressure in blood vessels is too high (140/ 90 mmHg or higher). If left untreated, hypertension can have profound consequences, including heart attack, stroke, heart failure, kidney disease, vision loss, and even death.

KPHPS 2024-25 indicates that 7.2% of all household members aged 30-79 years had symptoms of hypertension (Table 6.2) with a range from 6.5% in rural lagging districts to 7.5% in rural non-lagging areas. The overall percentage of people 30-79 with hypertension in lagging districts was 6.7% compared to 7.4% in non-lagging districts. Overall, the percentage with hypertension is in a narrow range with one percentage-point difference between the lowest and the highest values. Hypertension is one of the two (the other being diabetes) indicators among all indicators that show a slightly better health status (that is, lower prevalence) in rural areas compared to urban areas and in lagging districts compared to non-lagging districts.

The level of treatment for all household members aged 30-79 years ranged from 6.1% for rural lagging districts to 7.0% for non-lagging overall and for its urban and rural areas. Unlike prevalence, the treatment rates were higher for urban (6.9%) than for rural areas (6.8% overall, 6.6% in urban lagging and 7.0% in urban non-lagging) as compared to rural areas (6.8% overall, 6.1% rural lagging), except in non-lagging districts.

When analysis is focused only on those who have had hypertension, the treatment rates range from 91.7% for urban lagging districts to 95.9% for urban non-lagging districts. For the overall KP, the treatment rates for urban and rural areas are close (94.4% vs 94.5%). However, the treatment rate in non-lagging districts is slightly higher (94.6%) than in lagging districts (92.5%).

Table 6.2: Percentage of household members aged 30-79 with hypertension (Prevalence) and percentage taking treatment/medicine(s) for hypertension, KPHPS 2024-25

Hypertension	Prevalence	Taking medicine	N
Overall	7.2	6.8	58,646
Rural	7.2	6.8	50,617
Urban	7.3	6.9	8,029
Lagging Districts			
Overall	6.7	6.2	26,068
Rural	6.5	6.1	22,852
Urban	7.2	6.6	3,216
Non-lagging Districts			
Overall	7.4	7.0	32,578
Rural	7.5	7.0	27,765
Urban	7.3	7.0	4,813

Diabetes

Diabetes was reported prevalent among 4.9% of household members aged 30-79 (Table 6.3), ranging from 3.8% in rural lagging districts to 7.0% in urban non-lagging districts. Low prevalence of diabetes is found in rural (4.7%) compared to urban (6.5%) areas of KP and in lagging districts (4.2%) than non-lagging districts (5.2%). The prevalence of diabetes in urban lagging (5.7%) is lower than for urban non-lagging districts (7.0%).

The treatment rates ranged from 3.7% for rural lagging districts to 6.9% for urban non-lagging districts. The treatment rate is lower in rural (4.5%) than in urban areas (6.3%) and for lagging (4.0%) compared to non-lagging districts (5.1%).

When analysis is limited only to those who have had diabetes, over 95% were taking medication for diabetes, irrespective of urban-rural and lagging and non-lagging districts. Overall, urban-rural difference is of 1.2 percentage points lower rate of treatment in rural compared to urban areas (96.9% vs 95.7%) and 2.9 percentage points lower for lagging compared to non-lagging districts (95.2% vs 98.1%). Overall, the treatment by taking medicine for diabetes was 98.0% for KP.

Table 6.3: Percentage of household members aged 30-79 years with diabetes (Prevalence) and percentage taking treatment/medicines for diabetes, KPHPS 2024-25

Diabetes	Prevalence	Taking medicine	N
Overall	4.9	4.8	58,646
Rural	4.7	4.5	50,617
Urban	6.5	6.3	8,029
Lagging Districts			
Overall	4.2	4.0	26,068
Rural	3.8	3.7	22,852
Urban	5.7	5.4	3,216
Non-lagging Districts			
Overall	5.2	5.1	32,578
Rural	5.0	4.9	27,765
Urban	7.0	6.9	4,813

The KPHPS 2024-25 data show that the prevalence of infectious and non-communicable diseases was low, and the treatment (taking medicine) was high among those who had the illness. As found in other studies, the prevalence of diabetes and hypertension was higher in urban and better off non-lagging districts than in rural and lesser off lagging districts. On the other hand, the treatment-seeking behaviours are more frequent in urban and non-lagging districts. While interventions are needed to reduce these diseases everywhere, they need to focus on promoting health-seeking behaviours especially among those living in rural areas and in lagging districts.

7. Water, Sanitation and Hygiene (WASH)

Water, sanitation, and hygiene are the underlying determinants of several morbidities. The household questionnaire of KPHPS 2024-2025 included a series of questions on improved water, sanitation and hygiene (WASH) conditions of the household. Improved drinking water sources are those which have the potential to deliver safe water. Improved sources include piped water, boreholes or tube wells, protected dug wells, protected springs, rainwater and packaged or delivered water. Improved sanitation facilities included 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. Overall, improved water services were found for 91.9% of households (Figure 7.1). As for other indicators, urban-rural differences persist by eight percentage points lower services in rural areas than urban areas. However, the difference between lagging and non-lagging districts is modest (92.4% in lagging vs 91.7% in non-lagging districts).

Most lagging and non-lagging districts had over 75% availability of improved water services (Figure 7.2). Lower Kohistan had the least availability of improved water services.

Improved sanitation services are also common though less than improved water services. Overall, 87,8% had improved sanitation services. Once again, we notice rural areas and lagging districts (Figure 7.1) having fewer improved sanitation services than those in urban and non-lagging districts.

Most districts show a high availability of improved sanitation services, except Torghar and Kolai Palas Kohistan (Figure 7.3)

Figure 7.1: Percentage with availability of improved water and improved sanitation services, KPHPS 2024-25

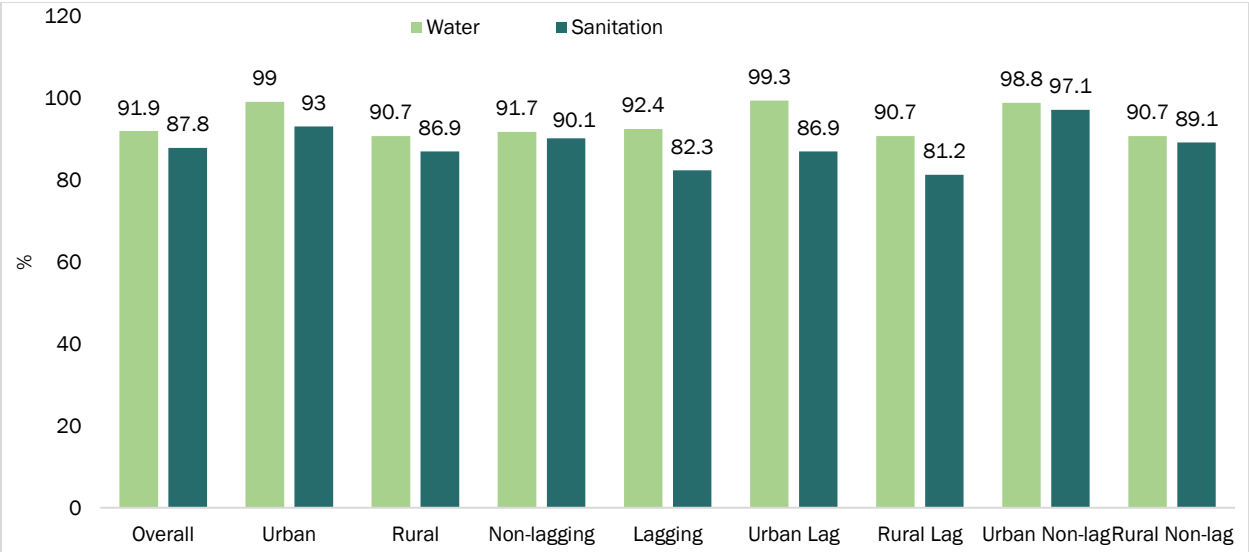


Figure 7.2: Percentage of households with the availability of Improved Water Services, by District, KP HPS 2024-25

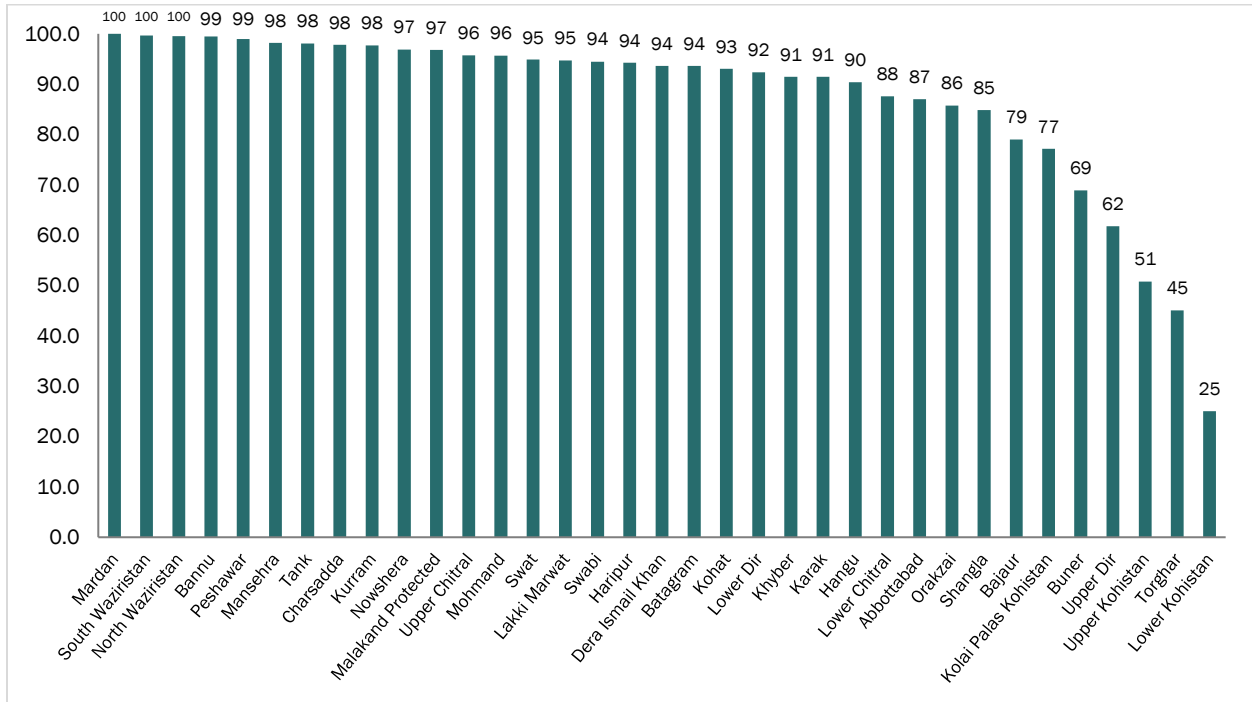
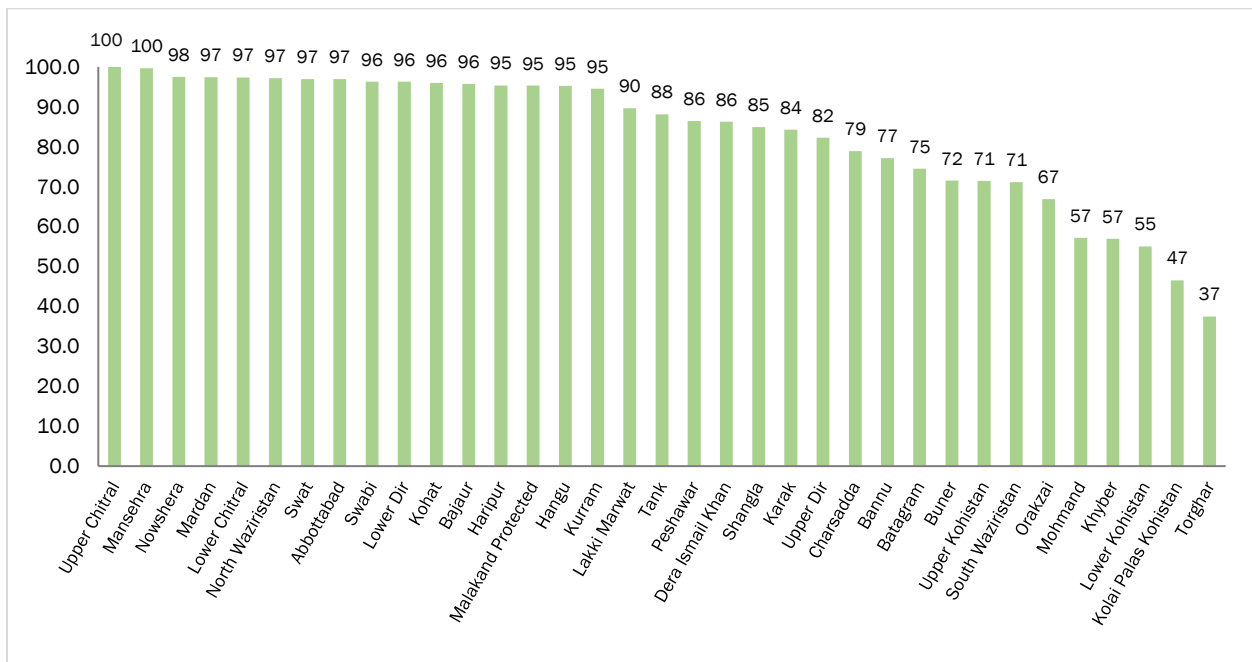


Figure 7.3: Percentage of households with availability of Improved Sanitation Services, by District, KP HPS 2024-25



8. Service Coverage Index (SCI)

The first output indicator of NHSP PDOs is the Service Coverage Index (SCI). It is a composite measure of access to essential health services package. The PDO-1, namely NHSP SCI, is constructed from independent indicators pooled together under the following three dimensions to develop a viable index of health sector performance and achievement. The NHSP household and ever married women questionnaires collected data on several tracer indicators of health seeking behaviour that allowed the construction of NHSP SCI⁶. First, for each of the dimensions a score is prepared using indicators and finally the SCI is estimated by taking geometric mean of each dimension's score. Higher values, expressed as points ranging from 0 to 100, show better performance. The dimensions and independent indicators are expressed as below:

Dimension I. Reproductive, maternal, newborn and child health (RMNCH core)

1. Family planning: Percentage need satisfied with modern methods
2. Pregnancy and delivery care: Percentage of women who received antenatal care 4 or more times during the pregnancy
3. Child immunization: Percentage of infants receiving three doses of DPT containing vaccine
4. Child treatment. Percentage of children under 5 years taken to health facility/provider

Dimension II. Infectious diseases (ID Score)

5. Tuberculosis. Percentage of cases detected and treated
6. Malaria. Percentage of population slept under an insecticide-treated net
7. Water and sanitation. Percentage of households using improved sanitation facilities⁷

Dimension III. Noncommunicable diseases (NCD Score)

8. Hypertension. Percentage taking medicine for hypertension
9. Diabetes. Percentage taking medicine for Diabetes
10. Tobacco: Percentage not smoking tobacco

The baseline data on each dimension score and overall SCI is presented in Table 8.1. The overall SCI for the province is 39.2 points. The Infectious Diseases Score is the lowest (33.5 points), suggesting that KP needs strategies and interventions to control infectious diseases. The RMNCH Score is moderate (37.7 points) overall, indicating a need for continued improvements in the use of modern

⁶ The Universal Health Coverage, Service Coverage Index is ideally based on 14 independent health sector surveys as mentioned in the SDG indicator 3.8.1 methodology. Since KPHPS is a household-based survey, the three indicators hospital beds per capita, health workforce and health security were unavailable. While NHSP SCI follows computation methodology of SDG 3.8.1, it is limited to the indicators available in the KPHPS.

⁷ 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.

contraceptive methods and in maternal, newborn, and child health services. The performance in addressing NCD appears better, relative to other health dimensions in the province.

Table 8.1: Service Coverage Index, KP HPS 2024-25

	RMNCH Score	Infectious Diseases Score	Non- Communicable Disease Score	NHSP SCI Value
Overall	37.7	33.5	47.7	39.2
Residence				
Rural	36.7	35.7	46.6	39.4
Urban	44.9	24.5	53.2	38.8
District type				
Lagging	33.1	37.5	43.0	37.6
Non-lagging	39.5	31.6	49.5	39.5

The overall rural versus urban differentials are minimal (Table 8.1), yet the RMNCH score is 8 percentage points lower in rural areas (36.7 points), indicating that rural areas face greater challenges in family planning, maternal, newborn, and child health than urban areas (44.9 points). The infectious diseases score shows baseline performance of the health sector is better among rural residents (35.7 points) than urban residents (24.5 points) signifying higher risks or challenges in managing infectious diseases in urban areas. The NCDs, however, appear to be addressed better in urban areas (53.2 points) as compared to rural (46.6 points) areas.

The lagging districts have the lowest SCI value (37.6 points). The lagging districts face challenges particularly in aspects of RMNCH (33.1 points) which has contributed to the lower performance in KP and is followed by NCD score (43.0 points). The score for infectious diseases appears better in lagging districts (37.5) as compared to non-lagging districts (31.6 points)

It appears from the overall SCI and its individual scores that targeted interventions in lagging and rural areas would be necessary to improve healthcare access, quality, and outcomes for maternal, newborn, and child health, as well as to address infectious diseases more effectively. Infectious diseases must receive much more concentrated attention than they have received so far.

9. Conclusions

KPHPS 2024-25 indicates that most (72%) of the 28,064 women interviewed in KP had no education and few (4.5%) were working. On most health indicators, a glaring disparity between urban and rural and between lagging and non-lagging districts is noted. Rural areas of lagging districts are at most disadvantage. One-in-two women in rural areas of lagging districts receive no ANC service. In general, the same districts are at disadvantages on multiple indicators.

Regarding specific indicators: contraceptive use of any method (CPR) and especially of modern methods (mCPR) was low – 22.5% and 14.5%, respectively. Interestingly, the use of traditional methods was more prevalent in urban areas than in rural areas. The contraceptive methods most used are withdrawal and the condom, both associated with high failure rates especially when not used correctly or consistently or both. Injectables are also used, especially in rural areas of non-lagging districts.

The coverage of antenatal care (ANC), measured by at least one visit during the last pregnancy, was relatively high (73.3%), but the coverage of “effective” ANC was very low (6.9%). One-in-five women still deliver at home. Skilled assistance at delivery was high (86.6%). More of interviewed women rely on private sector facilities for ANC but public facilities for delivery.

The vaccination of children 12-23 months who had the first dose of Penta-1 was 81.4%. However, 68.3% were fully immunized. The coverage of the third dose of different vaccines falls short of the levels achieved for the first dose suggesting the need for efficient follow up.

KPHPS 2024-25, conducted under NHSP, succeeded in providing the baseline information. It has also identified gaps in health services and outcomes requiring interventions and investments to ameliorate the conditions, especially in rural areas and in lagging districts.

10. Annexures

Figure A.1: Percentage of women with at least one antenatal care (ANC) visit during the last pregnancy in three years before the survey, by district, KPHPS 2024-25

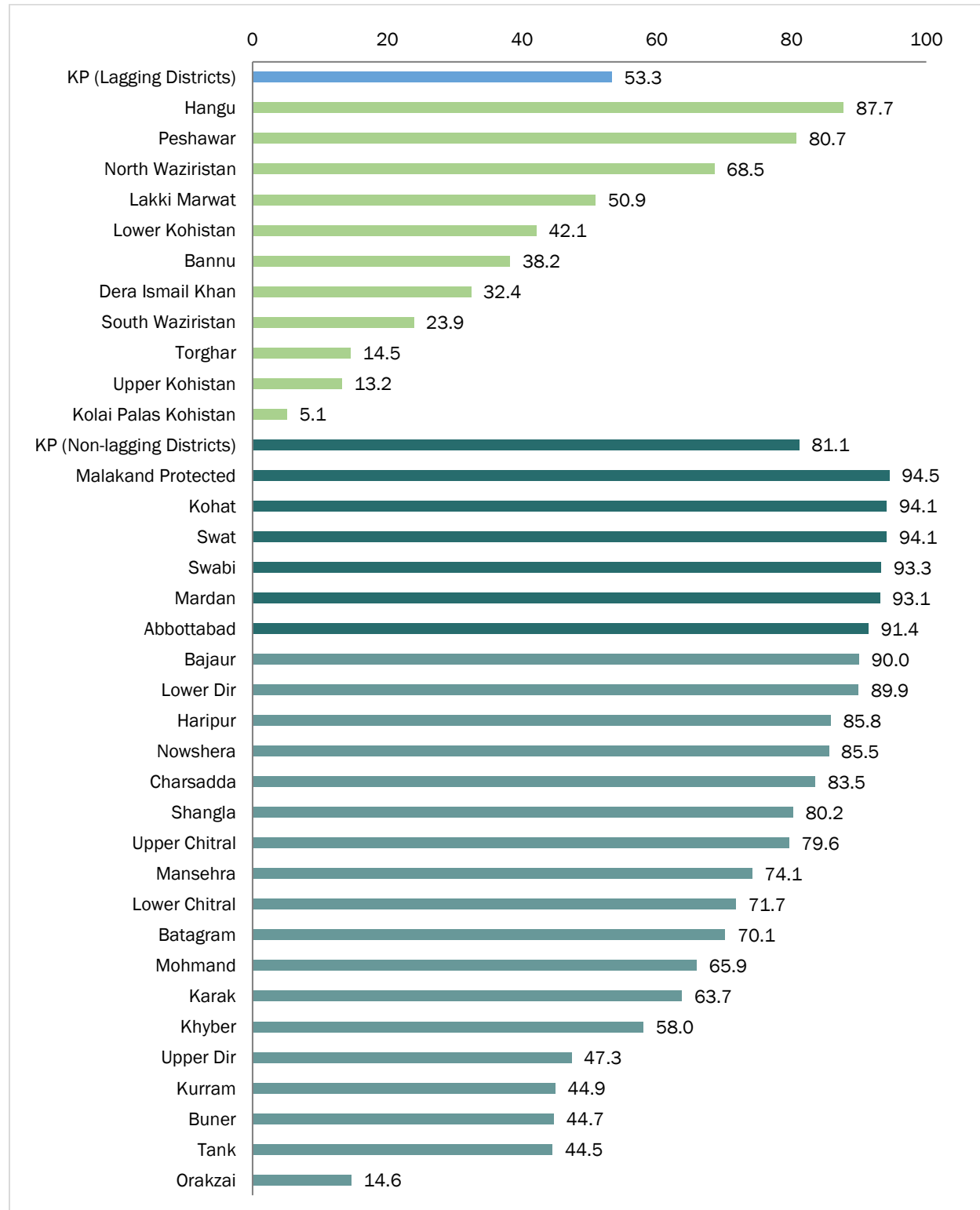


Figure A.2: Percentage of women with 4 or more antenatal care (ANC) visits during the last pregnancy in three years before the survey, by district, KPHPS 2024-25

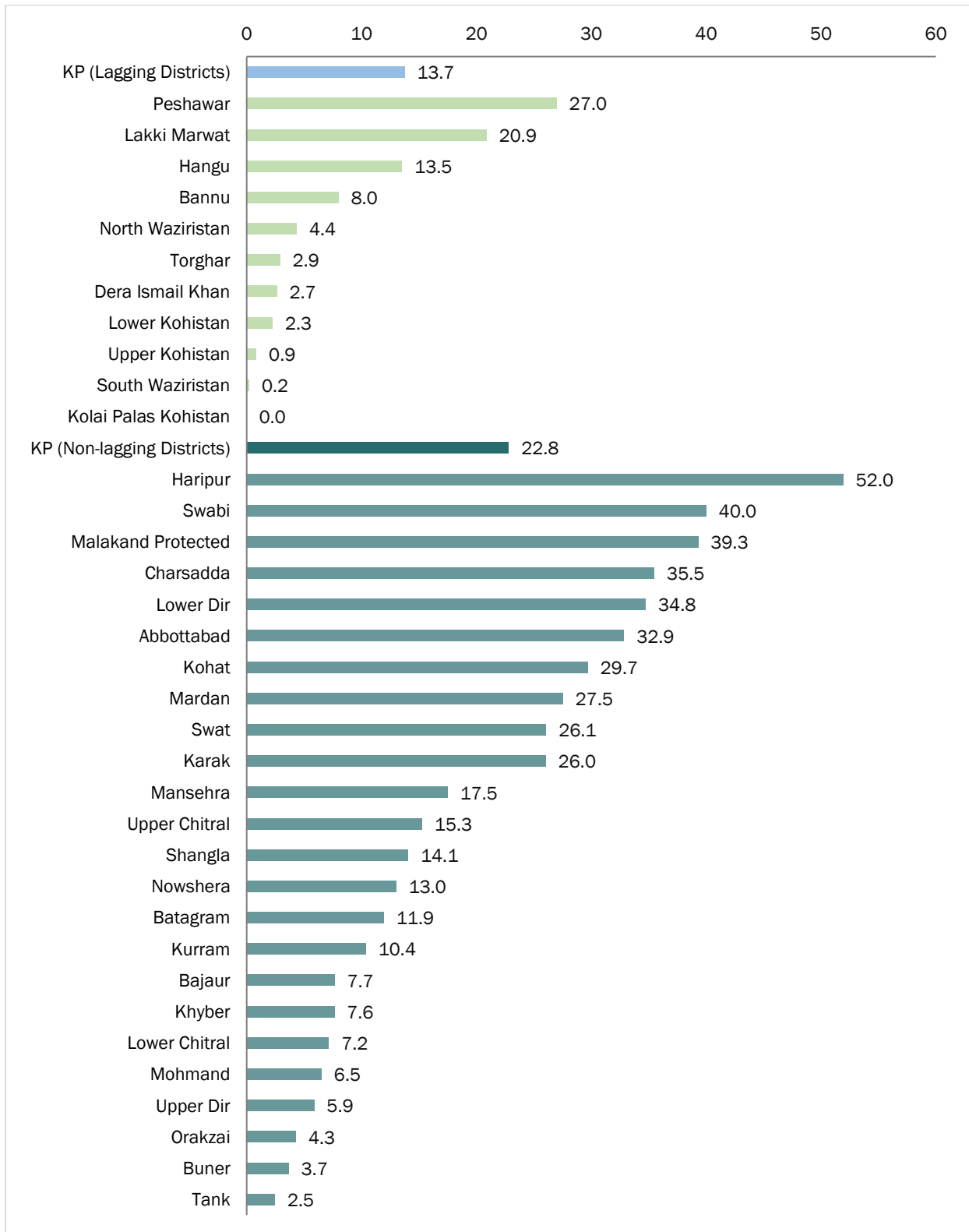


Figure A.3: Percentage of women receiving effective antenatal care (ANC) during the last pregnancy in three years before the survey, by district, KPHPS 2024-25

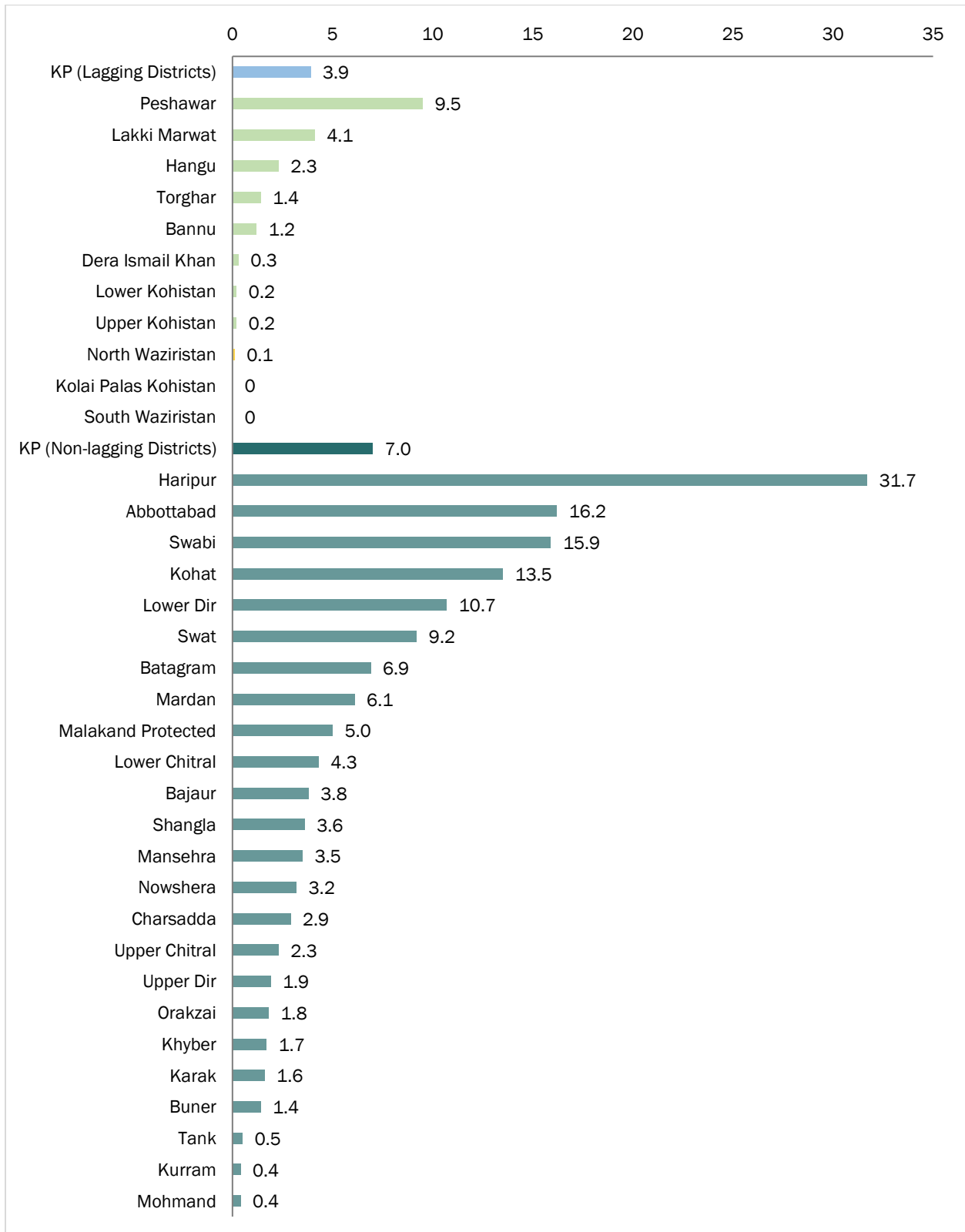


Figure A.4: Percentage of deliveries in the last three years that took place in a health facility, by district, KPHPS 2024-25

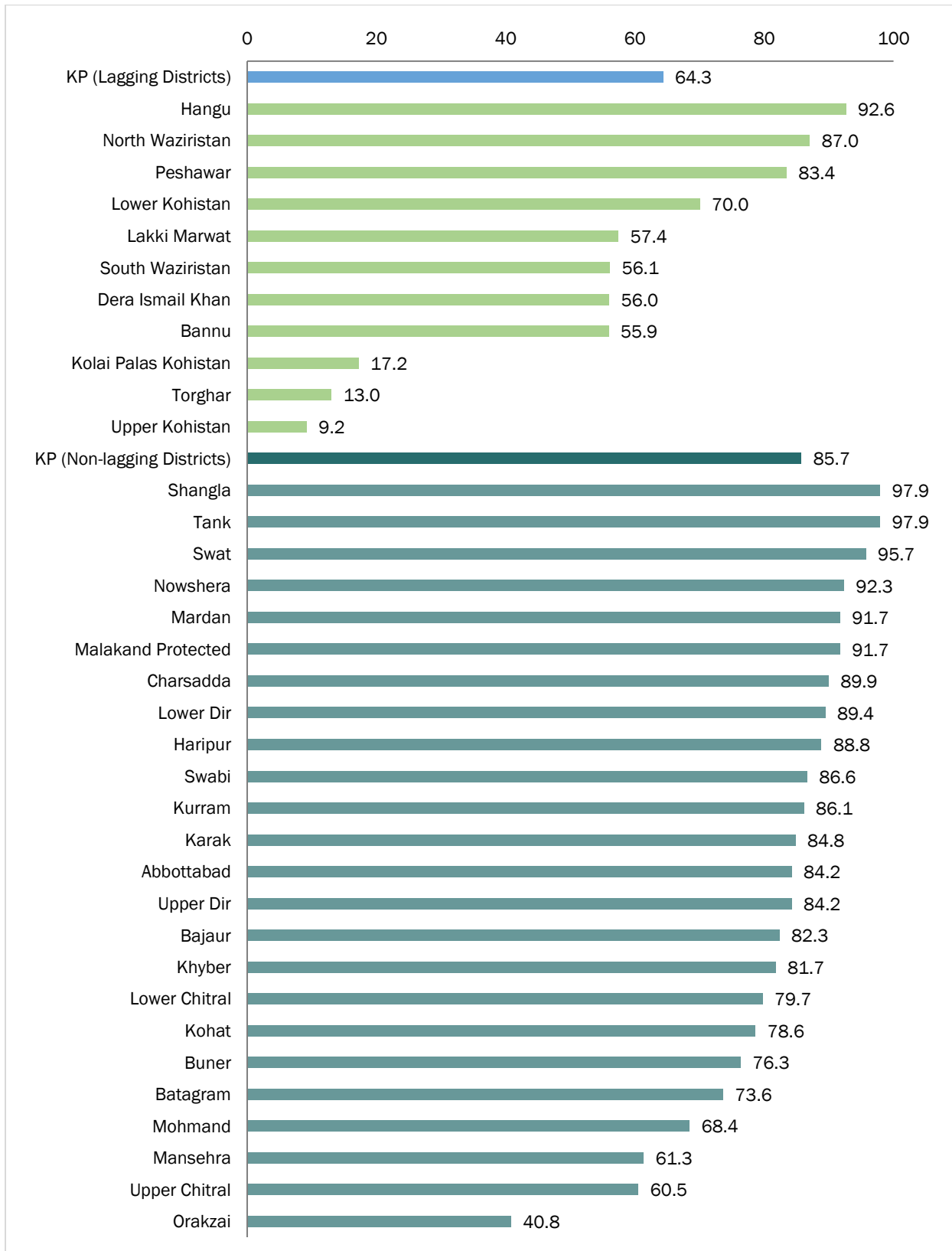


Figure A.5: Percentage of deliveries in the last three years attended by skilled birth attendants, by district, KPHPS 2024-25

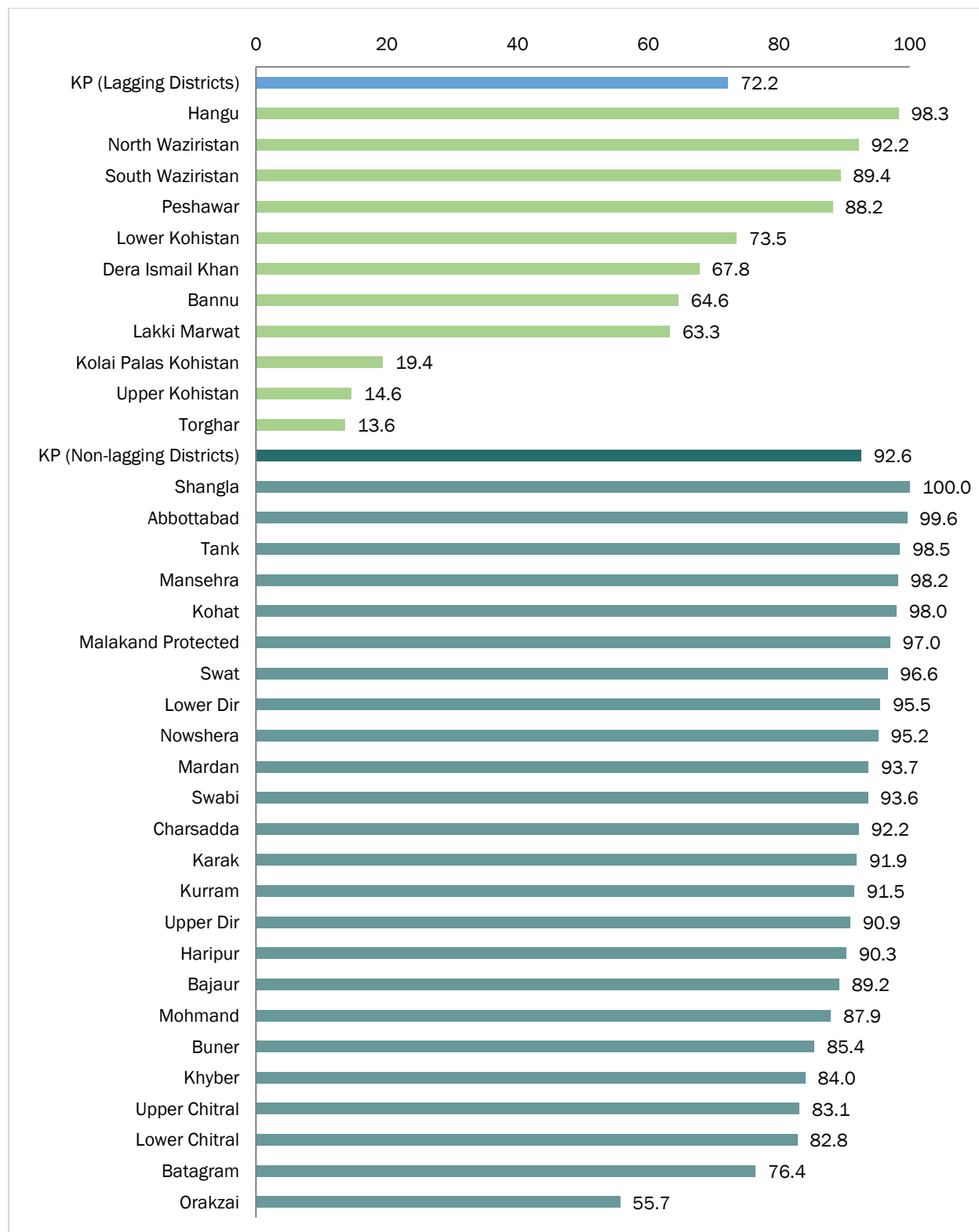


Figure A.6: Percentage of currently married women using a modern or traditional method, by district, KPHPS 2024-25

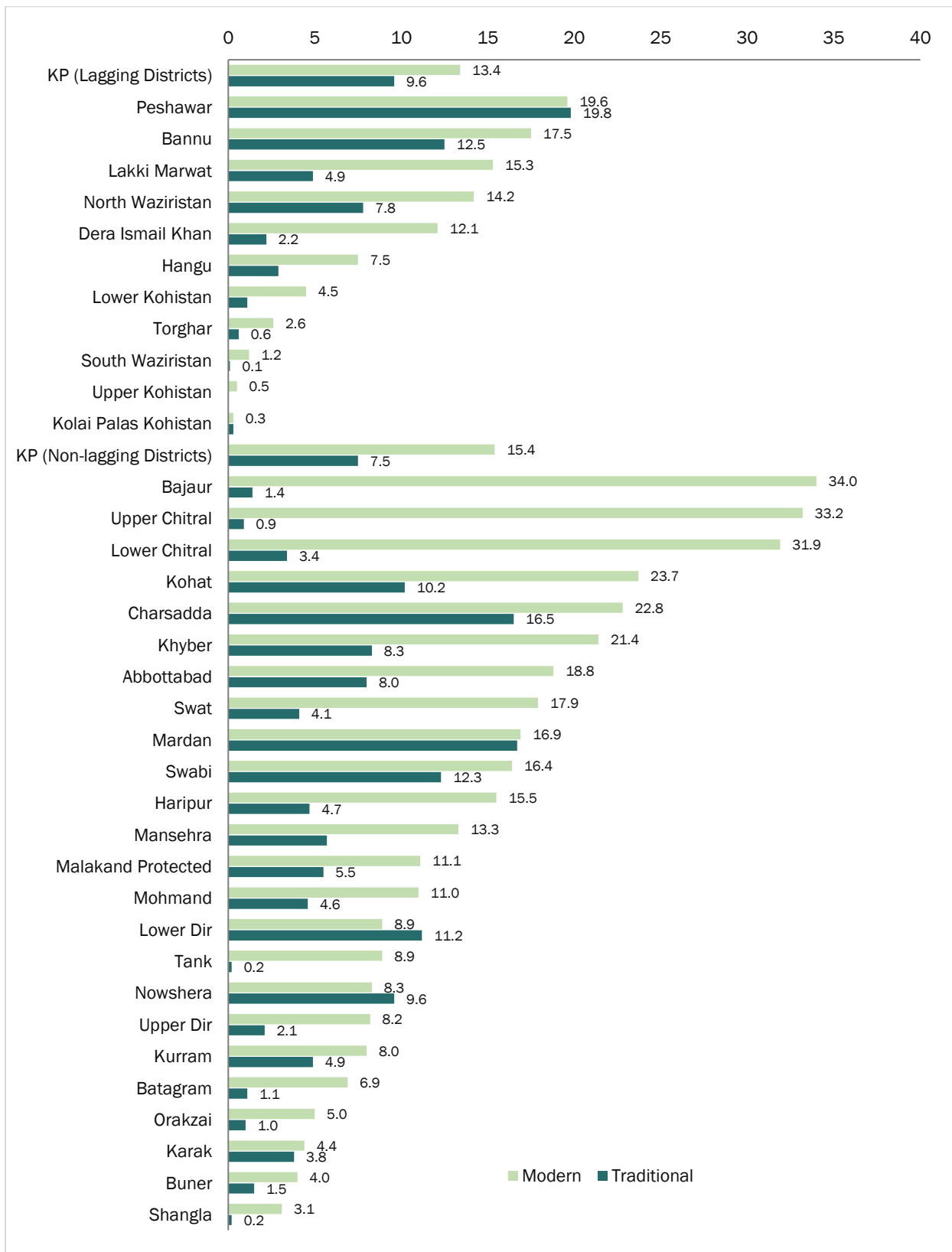


Figure A.7: Percentage of children younger than 5 years who had acute respiratory infection (ARI) Affected and Treated during the two weeks before the survey, by district, KP HPS 2024-25

