



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

June 2025

Baseline Survey Report



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HEALTH DEPARTMENT
KHYBER PAKHTUNKHWA



**POPULATION
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Khyber Pakhtunkhwa Health and Population Survey (KPHPS) 2024–25: Baseline Survey Report

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About the Khyber Pakhtunkhwa Bureau of Statistics

The Khyber Pakhtunkhwa Bureau of Statistics (KPBoS) was established in 1971 for the collection, consolidation, processing, analysis, publication, and dissemination of statistics on economic, social, demographic, and other important dimensions. A premier provincial statistical organization attached to the Department of Planning and Development, the KPBoS caters to the data needs of the diverse populace of data users while meeting national and international standards of data classifications and protocols. It generates timely and reliable statistics through surveys and secondary data.

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.

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Acknowledgments

The **Khyber Pakhtunkhwa Health and Population Survey (KPHPS) 2024–25** under the National Health Support Program (NHSP) was successfully conducted as a result of dedicated efforts by the Department of Health, Planning and Development Department, and Population Welfare Department, with technical support from the Population Council (PC) and Population Center Pakistan (PCP). The World Bank also played a pivotal role in ensuring effective coordination within the broader NHSP partnership.



The Pakistan Bureau of Statistics (PBS) provided the sample for the survey. The Khyber Pakhtunkhwa Bureau of Statistics (KPBoS) conducted the fieldwork, deploying 40 data collection teams in all 35 Khyber Pakhtunkhwa (KP) districts. Each team comprised four female interviewers, one male field worker, and one supervisor. Computer-assisted personal interviewing (CAPI) applications were adopted for efficient data collection.

Robust monitoring mechanisms were established to ensure high data quality. They included oversight by senior government officials from the Planning and Development Department, the core group of the KPBoS, and quality control supervisors from the PC, Islamabad.

A technical coordination committee was instituted for the effective coordination of survey activities by engaging the PBS, PC, World Bank, district administration, and relevant government departments. Headed by Mr. Arifullah Awan, Chief Economist of the Planning and Development Department, the committee's support was instrumental in addressing fieldwork challenges.

As head of the core group, Mr. Khaliq-ur-Rehman, Director of the KP Bureau of Statistics, led the survey at the operational level. Mr. Samiullah Khan, Mr. Faiz-ur-Rahman, Mr. Akbar Khan, and Mr. Abdullah provided additional technical support at the Bureau of Statistics.

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(SHAHID ULLAH)
Secretary
Health Department
Government of Khyber Pakhtunkhwa

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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
CAP	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
KP	Khyber Pakhtunkhwa
KPBoS	Khyber Pakhtunkhwa Bureau of Statistics
KPHPS	Khyber Pakhtunkhwa Health and Population Survey
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
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

Introduction

National Health Support Program

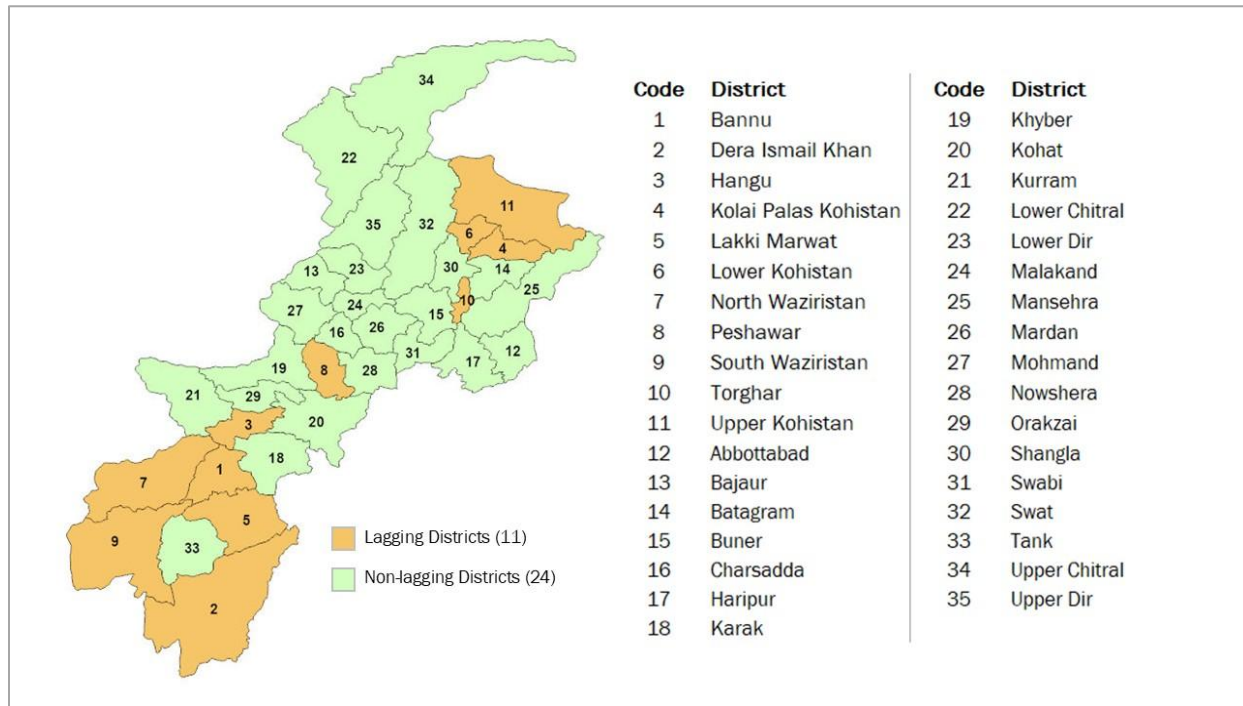
The National Health Support Program (NHSP) is a nationwide initiative designed to support the Ministry of National Health Services, Regulations, and Coordination (MoNHSR&C) as well as the provinces of Khyber Pakhtunkhwa (KP), Punjab, and Sindh. Although the government of Pakistan’s broader health program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

Building on PHC reforms, the NHSP aims to address 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 will be primarily responsible for implementing the NHSP, the World Bank’s support extends to strengthening the MoNHSR&C’s capacity for coordination, research, and reporting to advance progress toward universal health coverage (UHC).

A core NHSP element 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—e.g., 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).

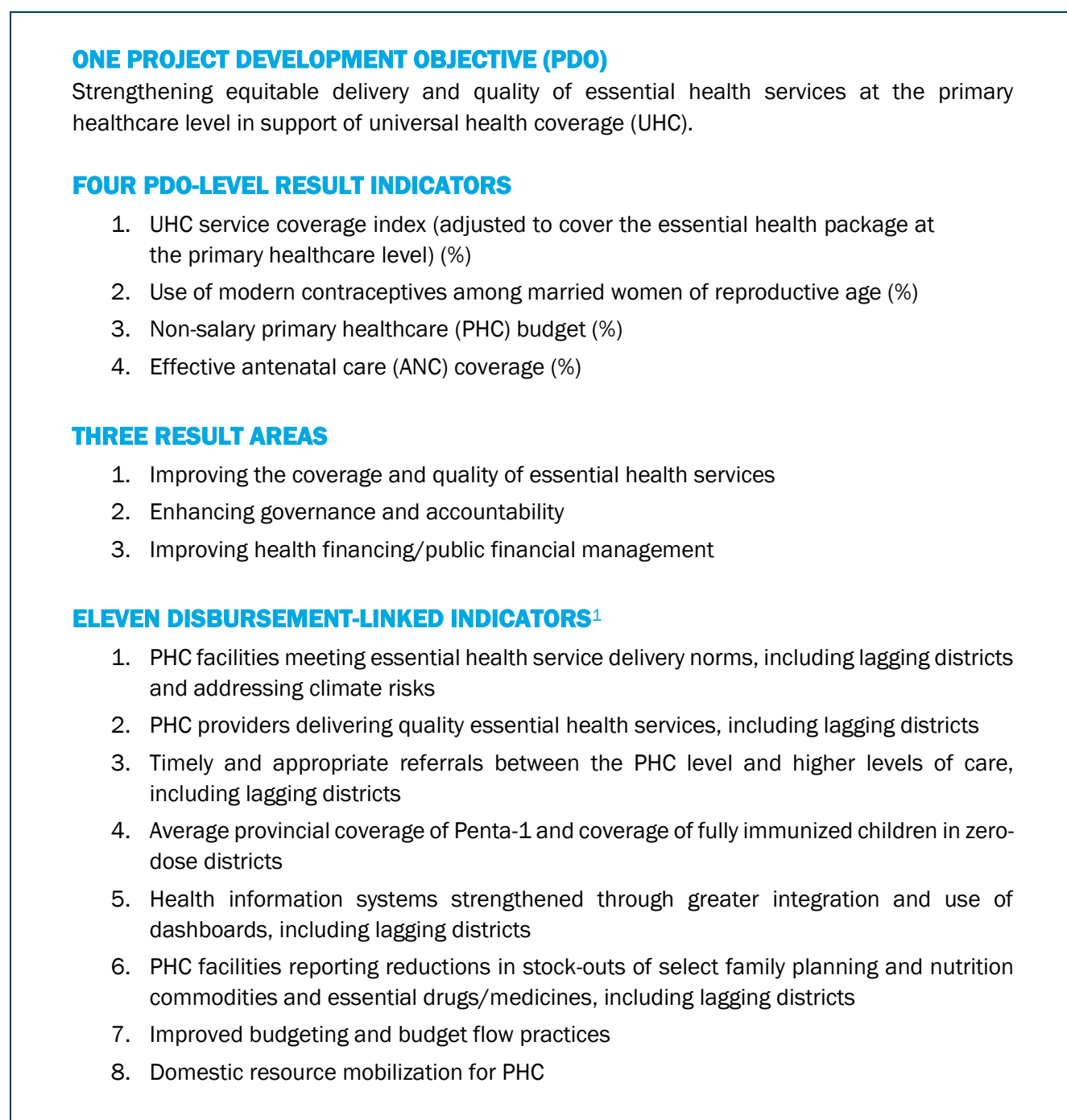
The NHSP employs an innovative approach to identifying underserved areas by analyzing district-level service coverage and access indicators, such as the UHC service coverage index or the “proportion of zero-dose children”—those who have not received a single dose of the diphtheria, pertussis, and tetanus-containing vaccine. Districts are ranked based on these metrics, and those falling behind are designated as “lagging districts” (Figure 1.1).

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



Financing under the NHSP is based on the achievement of performance against Disbursement Linked Indicators (DLIs) which will be measured through household surveys, health facility assessments, and facility-based routine monitoring systems by the provincial health departments. The program mandates that at least 20% of the results for each relevant disbursement-linked result be achieved in lagging districts. The NHSP is built on a structured results framework (Figure 1.2) designed to translate its progress through a project development objective (PDO), four PDO-level result indicators, three result areas, and 11 DLIs.

Figure 1.2: Structured results framework



¹ Two of 11 DLIs are specific to Punjab and are, therefore, not mentioned here.

Khyber Pakhtunkhwa Health and Population Survey

The Khyber Pakhtunkhwa Health and Population Survey (KPHPS) 2024–25 was envisioned as part of the NHSP to use data to assess coverage and healthcare levels and provide a basis for change in design, ultimately measuring impact in an end-line survey at the end of the project. This report presents baseline results aimed at meeting NHSP needs in KP.

The KPHPS is a population-based household survey designed to generate reliable data on key health, demographic, and population indicators across districts using district-level representative samples. It collects information from households and individuals—particularly women of reproductive age and children under five—on a wide range of topics, including the UHC service coverage index, use of modern contraceptives, effective ANC, and coverage of Penta-1 and fully immunized children. The KPHPS is designed to measure changes in these key indicators, along with a range of variables, to capture women’s empowerment and equity and the background characteristics that explain and influence health-seeking behavior.

Organization of the Report

CHAPTER 1 introduces the household survey, covering its background, objectives, provincial profile, roles and responsibilities, and location. It also elaborates on sample design, sampling, tools, training, and data quality measures.

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

CHAPTER 3 focuses on the characteristics of ever-married women, including exposure to media, 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 ANC, delivery, and post-natal care. The focus is on the number of visits, sources of seeking services, content of visits, quality of care, costs, and post-partum family planning.

CHAPTER 5 focuses on fertility, fertility preferences, contraceptive use, and unmet need for family planning. More specifically, it covers fertility rates, preferences for spacing and stopping, the number of children desired, additional children desired, ideal family size, and the current use of any method (whether modern or traditional) by type of method and sector (public or private). It also discusses the quality of visits, associated costs, and reasons for non-use, particularly regarding unmet need for family planning and modern methods.

CHAPTER 6 examines the current use of any method (whether modern or traditional) by type of method and sector (public or private). It also discusses the quality of visits, associated costs, and reasons for non-use, particularly regarding unmet need for family planning and modern methods.

CHAPTER 7 focuses on infant and child health, emphasizing breastfeeding practices for newborns, the prevalence of diarrhea, and acute respiratory infection.

CHAPTER 8 discusses immunization of children through various vaccinations, considering factors like age group, gender of the child, mother's education, location, healthcare provider, verification of immunization cards, and child nutrition.

CHAPTER 9 focuses on the self-reported prevalence and treatment of communicable and non-communicable diseases, including tuberculosis, malaria, hypertension, and diabetes, by gender and place of treatment.

CHAPTER 10 focuses on treatment availed by household members for general ailments and particularly whether the last facility visited was in the public or private sector. Time taken to reach the facility last visited and mode of transportation are also presented. Additionally, costs (when paid) by type of service are also included.

CHAPTER 11 presents the Service Coverage Index comprising three components of RMNCH, infectious diseases, and non-communicable diseases for rural and urban areas and lagging and non-lagging districts.

Roles and Responsibilities

Supported by the Gates Foundation (formerly the Bill and Melinda Gates Foundation), the Population Council (PC) provided technical advice on the Health and Population Survey (HPS). The Population Center Pakistan (PCP) guided survey implementation. Both organizations were responsible for survey, questionnaire, sample design, the survey manual, the training of master trainers, and ensuring data quality and analysis.

The government of KP financed the survey through the Department of Health. The Khyber Pakhtunkhwa Bureau of Statistics (KPBoS) handled administration and data collection. It was also responsible for field implementation, data collection using tablets, hiring enumerators, arranging training, and supervising enumerators and fieldwork.

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

KPHPS-specific Project Development Objectives and Disbursement-linked Indicators Under NHSP

The NHSP's structured results framework allows provinces to receive performance-based disbursements upon verification of progress, with data often sourced from provincial surveys such as the KPHPS. While the overall NHSP framework has been outlined above, the KPHPS was specifically designed to measure three of the NHSP's PDOs and one DLI, as well as high-priority indicators

identified by provincial stakeholders. The KPHPS 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 for all themes. The topics suggested by provincial stakeholders were also included. The details of relevant PDOs and DLIs measured through the HPS are presented below.

Project Development Objectives (PDOs)

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 communicable and non-communicable diseases.

PDO-2: Use of modern contraceptives

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

PDO-4: Effective ANC coverage

This indicator goes beyond merely counting ANC visits; it assesses the quality and content of care received by women during pregnancy and considers whether essential ANC components (screenings, counseling, and vaccinations) were provided, ensuring that care is timely and effective.

Disbursement-linked indicators

DLI-5: Child immunization coverage

This DLI comprises two sub-indicators that are critical for measuring child health outcomes and the performance of the Expanded Programme on Immunization.

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 proportion of children in the same age group who have received all recommended routine immunizations.

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

Aims and Objectives of KPHPS

KPHPS's primary aim is to provide baseline and end-line data for the NHSP. It was carried out in 2024–25 due to delays but still serves to benchmark key indicators and track progress on the NHSP's health-related goals. In addition, it is assessing the implementation and impact of programmatic interventions to inform planning, resource allocation, and policymaking in KP's health and population sectors.

The KPHPS was conducted from September 2024 to January 2025 and included the newly merged districts. This round of surveys 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 conducting the KPHPS were:

1. To provide high-quality data that meets international standards for evaluating the baseline and end-line indicators, implementation status, and impact of the NHSP.
2. To 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 KP's Department of Health, PWD, and Department of Planning and Development to meet KPHPS's second objective. The KPHPS gathered information on the provincial priorities identified during these consultations,² and included the following topics in the HPS:

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

Methodology

To achieve survey measurement objectives, the design aims to facilitate the comparison of baseline and end-line indicators across various population groups over time. These groups included female vs. male children, male illness vs. female illness, urban vs. rural residence, zero-dose/lagging districts vs. non-lagging districts, as well as considerations of gender and other equity variables. We plan to conduct the end-line survey in the same clusters as the baseline survey as this will allow a statistically robust measurement of change attributable to the NHSP.

² After incorporating provincial information needs in the first draft of the questionnaire, it was shared with the provinces for their review. This allowed another chance for all relevant provincial departments to provide their information needs for HPS.

Respondents eligible 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 0–23 months.

Sample Design

The survey sample was drawn from the sampling frame developed by the Pakistan Bureau of Statistics (PBS) based on the 7th Population and Housing Census 2023. In urban areas, each city or town has been divided into a number of small, compact areas called Enumeration Blocks (EBs). Each enumeration block consists of an average of 200 to 250 houses, with well-defined boundaries recorded in prescribed forms and corresponding maps, along with physical features available within the blocks. The rural areas are also broken into Enumeration Blocks (EBs), where an Enumeration Block can be either an entire village or a part of a village. These EBs are also referred to as Primary Sampling Units (PSUs). The stratification for both urban and rural areas, for each administrative district has been treated as an independent and explicit stratum.

The sample size and its allocation is made by taking into account the variability of the key variables, population distribution, and field resources, various exercises were conducted to determine the appropriate sample size for the survey. The focus was 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 used with different margins of error (MOE) of 12% and 15% at 95% Confidence Interval.

The survey targeted eleven districts identified as zero-dose children based on the number of immunization doses they received, emphasizing the need for focused stratification of the survey. 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 modern contraceptive prevalence rate (mCPR) and other PDOs. In contrast, non-zero dose districts required a sample size sufficient to detect a ten percentage-point change.

Based on these exercises, a total sample of 24,000 households covering 1,200 Primary Sampling Units (PSUs) with 20 households per PSU, was considered sufficient to produce reliable estimates using the modern contraceptive prevalence rates as the key prevalence indicator, with a 15% relative margin of error at a 95% level of confidence.

A two-stage stratified sampling design was adopted for the survey. Enumeration Blocks in rural and urban areas were selected at the first stage, while households within the selected Enumeration Blocks were chosen at the second stage. The detailed allocation plan for the sample size across the 35 districts of Khyber Pakhtunkhwa is provided in Table 1.2.

Table 1.1: List of zero-dose/lagging and non-lagging districts in KP

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

The selection of primary sampling units/ enumeration blocks in the selected districts of both rural and urban domains were taken as Primary Sampling Unit (PSUs). The sampled PSUs from each stratum were selected using the Probability Proportionate to Size (PPS) method, where the total numbers of households within a PSU was considered the measure of size (MOS).

The households are considered as the secondary sampling units for the survey. The complete household listing was carried out in each sampled PSU by the field staff of the Bureau of Statistics. Twelve (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 provided by PBS, including the number of interviews conducted and the response rate. A total of 23,536 households were successfully interviewed, with a response rate of 98.1%. In addition, 28,063 ever-married women were interviewed, resulting in a response rate of 98.2%. The response rates for urban-rural and lagging and non-lagging districts were generally similar and high.

Table 1.2: Number of sampled PSUs and households (by stratum and district)

S. No.	Name of Districts	Sampled PSUs			Sampled Household*		
		Rural	Urban	Total	Rural	Urban	Total
1	Bannu	60	6	66	1,200	120	1,320
2	Lakki Marwat	52	6	58	1,040	120	1,160
3	North Waziristan	48	2	50	960	40	1,000
4	Dera Ismail Khan	43	10	53	860	200	1,060
5	South Waziristan	56	0	56	1,120	0	1,120
6	Tank	27	3	30	540	60	600
7	Abbottabad	20	10	30	400	200	600
8	Batagram	33	0	33	660	0	660
9	Haripur	22	8	30	440	160	600
10	Kolai Palas Kohistan	35	0	35	700	0	700
11	Lower Kohistan	35	0	35	700	0	700
12	Mansehra	19	8	27	380	160	540
13	Torghar	35	0	35	700	0	700
14	Upper Kohistan	35	0	35	700	0	700
15	Hangu	28	7	35	560	140	700
16	Karak	28	2	30	560	40	600
17	Kohat	19	8	27	380	160	540
18	Kurram	24	2	26	480	40	520
19	Orakzai	30	0	30	600	0	600
20	Bajaur	26	0	26	520	0	520
21	Buner	26	0	26	520	0	520
22	Lower Chitral	21	4	25	420	80	500
23	Lower Dir	28	2	30	560	40	600
24	Malakand Protected Area	22	4	26	440	80	520
25	Shangla	26	0	26	520	0	520
26	Swat	17	10	27	340	200	540
27	Upper Chitral	25	0	25	500	0	500
28	Upper Dir	27	3	30	540	60	600
29	Mardan	20	8	28	400	160	560
30	Swabi	19	8	27	380	160	540
31	Charsadda	19	7	26	380	140	520
32	Khyber	23	3	26	460	60	520
33	Mohmand	26	0	26	520	0	520
34	Nowshera	19	8	27	380	160	540
35	Peshawar	42	36	78	840	720	1,560
Total		1,035	165	1,200	20,700	33,00	24,000

*20 households per PSU.

Note: It is important to note that only one (1) block in North Waziristan district was excluded from the survey due to security reasons.

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

PSUs and type of interview	Sampled/total	Interviewed	Response rate (%)
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 Questionnaires

The survey employed two separate questionnaires: a household questionnaire and a detailed questionnaire for eligible women.

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

Relevant survey questionnaires, such as those used in large international survey programs, including the Demographic and Health Survey, Multiple Indicator Cluster Survey, and PC-tested questionnaires, were used to design the questionnaires. We drew extensively from the Pakistan Demographic and Health Survey, 2017–18³ for the household and individual women survey, complementing them with questions from other validated tools. Various professionals with multidisciplinary expertise and experience reviewed the draft questionnaires. Key contributors included the World Bank, Global Financing Facility, Gates Foundation, and Global Alliance for Vaccines and Immunization. The questionnaires were pre-tested in the field over three times and underwent multiple rounds of revision before finalization. The provincial technical committee on HPS approved the final questionnaires.

Data Management and Use of Technology

A comprehensive, technology-driven system was implemented to enhance data management and ensure the collection of high-quality data for the KPHPS 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 System (CSPro), a piece of software that is designed to handle the survey’s complex structure and incorporate robust quality assurance protocols. The CAPI application supported both English and Urdu, ensuring ease of use in the field. A secure server environment was established to facilitate real-time data transmission while maintaining offline functionality to ensure uninterrupted data collection in areas with limited or no internet connectivity.

In addition, integrating listing data with the CAPI system streamlined the identification and assignment of households, reducing errors and improving operational efficiency.

A customized HPS dashboard was developed and made available to the Bureau of Statistics. This dashboard enabled real-time monitoring of fieldwork progress, tracking of completed interviews, and oversight of data quality indicators. These tools significantly enhanced data accuracy and timeliness, improved supervision, and supported adherence to the survey methodology. Together, these

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>.

innovations, which were introduced for the first time to the provincial bureaus of statistics, aimed to support a more efficient data collection process. Further technical details are provided in Annex A.

Field Staff Training

The survey's primary data collection phase began in the last week of July 2024 with the hiring of survey staff and concluded with the production of a clean dataset in the first week of January 2025. 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 possessed 16 years of education, were fluent in a regional language, and had over five years of survey experience. The criteria for field and data managers were previous experience with panel and/or multi-topic household surveys and four to five years of experience as supervisors.

The KPBoS engaged 172 female interviewers and 43 male field workers through advertisements and walk-in interviews. Male field workers did not conduct interviews but were responsible for logistical support, locating survey areas, and ensuring the safety and privacy of both respondents and interviewers. In addition, 43 male supervisors were deployed to monitor and oversee the fieldwork. In all, 43 teams conducted fieldwork in 35 districts.

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

The KPBoS trained enumerators in three batches. The first batch began in the first week of September 2024, and the last batch was completed by the end of October 2024.

Fieldwork officially commenced in the Malakand division on 16 September 2024 and continued until the first week of January 2025, following a phased rollout across divisions. The PC and PCP teams participated as technical observers in the first batch of enumerator training and facilitated CAPI sessions in the remaining training sessions. All enumerators were trained prior to the pre-test and data collection. The PC and PCP teams coordinated with the Department of Health and PWD in KP to arrange resource persons who delivered sessions on complex sections of the questionnaires, including pregnancy history and contraception.

Survey Monitoring for Quality

The PCP implemented measures to ensure adherence to standards during data collection by deploying an experienced quality assurance team comprising 10 members that were well-versed in the questionnaires. These team members were placed alongside the KPBoS teams to directly supervise, support, and address interviewer queries, and provide guidance during field operations. In addition, lines of communication remained open with the PCP and PC project teams in Islamabad, allowing field teams to provide updates and discuss field challenges. There was also a dedicated KPHPS WhatsApp group.

A customized KPHPS dashboard (Annex A) was developed to provide the KPBoS with access to real-time data for conducting preliminary checks, tracking survey progress, monitoring 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, which, along with rigorous training and supervision, allowed prompt redressal of fieldwork challenges. The response rates showed no selectivity by area, district, household, or women respondents. However, we cannot entirely rule out the possibility of intentional underreporting, misreporting, or unintentional recall errors.

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 the protection of participants' rights and wellbeing.

The study's ethical framework included comprehensive informed consent procedures designed to uphold participant autonomy and safeguard their rights. Participants were fully briefed on the study'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 want to respond to and to withdraw from the interview at any time without facing negative consequences.

Before obtaining 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

A data analysis plan was developed alongside the questionnaire. The analysis plan for the KPHPS consisted of two parts.

1. The first part included headline indicators to provide baseline values and release survey results soon after the completion of the baseline survey. The purpose was to disseminate key findings and enable provincial stakeholders and NHSP program managers to use the results in determining baseline values for indicators. This part consisted of five headline indicators at the provincial level, disaggregated by urban-rural status and lagging vs. non-lagging areas, as well as overall district-level indicators. The immediate results were presented in a key findings report, which explained each indicator.
2. Included in this report, the second part of the analysis plan focused on a detailed analysis of each indicator by individual and household characteristics. This analysis involved the segregation of results by socioeconomic variables, particularly age, gender, and wealth quintile. The plan was tailored to highlight equity in coverage, access to facilities, and the cost

of receiving health services. This detailed analysis contributed to a comprehensive baseline report with extensive tabulation to identify areas for improvement.

After completing the fieldwork, the final CSPro-based dataset was downloaded from the central server and converted into SPSS and Stata formats for further processing. A comprehensive set of internal and external consistency checks was conducted prior to analysis to ensure data accuracy, completeness, and reliability. Analysis syntax was written in both SPSS and Stata for transparency and accuracy. Multiple team members reviewed each other'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 KP on 20 March 2025, during which the technical coordination committee formally approved the survey findings.

A detailed analysis was then conducted, followed by the production of a report on key findings, which was shared with the Bureau of Statistics and Department of Health. Note that all percentages, means, and medians shown in this report are weighted and the number of cases are unweighted.

After submitting the key findings report, 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—a detailed analysis was performed for most sections to provide deeper insights and support evidence-based decision-making.

Characteristics of Households and Household Members

Key Findings

Housing characteristics

- 88.3% of households in rural areas and 78.4% in urban areas were owner-occupied.
- 40.9% of rural households had finished floors, compared to 80.8% of urban households.
- 22.4% of rural households had either no exterior walls or walls made of dirt, compared to 4.1% of urban households.
- Wood was the primary cooking fuel for 68.9% of rural households, whereas 62.7% of urban households used natural gas.

Main sources of household income and international remittances

- Daily wages were the main source of income for 45.4% of rural households, compared to 29.3% of urban households.
- Remittances from abroad were the main source of household income for 14.1% of rural households and 13.4% of urban households.

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

- Rain and floods were the primary disasters experienced by 10.5% of rural households in the last 24 months, while 10.5% of urban households faced economic shocks.
- 47.3% of rural households and 37% of urban households had to take loans to cope with economic, health, or natural shocks.

Social protection support

- 17.1% of rural households and 7.9% of urban households had a household member who benefited from the Benazir Income Support Programme (BISP).
- 19.3% of rural households and 19.4% of urban households possessed a Sehat Sahulat card.
- Nutritional support for pregnant and lactating women was minimal, with only 12.3% of women in rural areas and 1.7% in urban areas benefiting from such programs.
- Private insurance plans were non-existent.

Water, Sanitation, and Hygiene (WASH)

- 99% of urban households and 90.7% of rural households had improved water sources. Additionally, 93% of urban households and 86.9% of rural households had improved sanitation, while 76.5% of urban households and 68.1% of rural households had a washing facility available with soap for hand washing.

School attendance of children aged 5–9 and 10–14 years (by sex)

- In rural areas, 42% of girls aged 5–9 years were found to be out of school, compared to 29.6% of boys.
- For the age group of 10–14 years in rural areas, 43% of girls were found to be out of school, compared to 19.1% of boys.

Districts in KP vary on all indicators examined

To interpret population and health data, it is important to consider people's context and living conditions. The KPHPS household questionnaire collected data on indicators related to households and their members. The first half of this chapter presents the province's profile using different data sources. The second half offers insights from the KPHPS on characteristics that are critical for an understanding of the population and health conditions of people in urban and rural KP.

Khyber Pakhtunkhwa's Profile

KP is the third most populous province of Pakistan, with an estimated population of 40.86 million, according to the 2023 Population and Housing Census.⁴ Formerly divided into the North-West Frontier Province and the Federally Administered Tribal Areas (FATA), KP is home to snow-capped peaks in the north and west and lush green plains in the south. It is Pakistan's most diverse province, both in terms of topography and ethnic composition. Most of KP's population is Pashtun, but other ethnic groups, such as Hazaras, Hindkowan, Saraikis, and Chitralis, account for a third of the population. Located in the northwestern part of Pakistan, bordering Afghanistan, KP has experienced significant migration across its border and has the largest contingent of international migrants working abroad. In 2018, the province underwent a major administrative transformation through the constitutional merger of the FATA with KP, adding seven newly merged districts (NMDs) and six frontier regions to its jurisdiction. This historic integration aimed to bring these previously semi-autonomous areas under the formal legal, administrative, and political framework of the province, though full operationalization of services and governance structures remains a work in progress.

⁴ 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_kp_province.pdf.

Demographic Overview

Table 2.1 shows key demographic and social indicators for KP, providing insight into the province's population dynamics and human development challenges. Recent estimates indicate that KP's population accounts for 16.9% of Pakistan's total population and exhibits a high population density of 401.6 persons per square kilometer. The average annual population growth rate during the period 2017–2023 stood at 2.38%, indicating steady growth. Notably, KP remains predominantly rural, with 85% of its population living in rural areas, and households averaging 6.9 members—among the largest in the country. Literacy rates⁵ show a sharp gender disparity: while 64.6% of males aged 10 and above are literate, only 37.2% of females in the same age group are literate, reflecting significant gaps in educational access and attainment for women. These indicators underscore the need for targeted interventions in rural development, population management, and female education to ensure more equitable and sustainable progress in the province.

Table 2.1: KP's key sociodemographic indicators

Indicator	
Population (million)	40.86
Density (persons per sq. km)	401.60
Avg. annual population growth rate % (2017–23)	2.38
Population share of Pakistan (%)	16.90
Rural population (%)	85.00
Average HH size	6.90
Males literate % (aged 10+)	64.60
Females literate % (aged 10+)	37.20

Source: Pakistan Population and Housing Census, 2023.

Data from the Pakistan Labour Force Survey, 2020–21⁶ show substantial gender disparities in KP's workforce (Table 2.2). The employment-to-population ratio is 71.1% for men but just 15.5% for women. In addition, men are more concentrated in informal employment (57.7%) and women work predominantly in agriculture (63%).

⁵ Table 12, Ibid.

⁶ 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.

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

Labor force indicators	Male	Female
Employment-to-population ratio (%)	71.1	15.5
Employment by sector		
Total	100.0	100.0
Formal	17.5	14.1
Informal	57.7	22.1
Agriculture	24.9	63.8
Employment by sector		
Total	100.0	100.0
Agriculture	24.9	63.8
Industry	29.9	13.9
Services	45.2	22.3

Source: Pakistan Labour Force Survey, 2020–21.

KP's migration profile reveals that the province has a predominantly native population, with 97% of residents originally from KP. Total migration accounts for only 3.01% of the population,⁷ indicating limited population mobility within the province. The data highlights KP's relatively low levels of inward migration, with migration patterns largely localized, suggesting that population pressures and service delivery challenges are driven more by natural growth than by in-migration.

KP's health indicators highlight persistent challenges in improving maternal and child health outcomes. According to the Pakistan Demographic and Health Survey, 2017–18,⁸ the province's neonatal mortality rate is 42 deaths per 1,000 live births, the infant mortality rate is 53, and the under-five mortality rate is 64. These figures indicate that a significant proportion of child deaths occur within the first year of life. Additionally, the maternal mortality ratio, as reported in the Pakistan Maternal Mortality Survey, 2019,⁹ is 165 deaths per 100,000 live births, highlighting ongoing 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.

⁷ 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.

⁸ 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>.

⁹ 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 23,534 households interviewed across KP, 86.9% were owner-occupied (Table 2.3), more so in rural areas (88.3%) than urban areas (78.4%). The primary materials used for the floors and exterior walls varied widely between rural and urban settings. In rural areas, 58.1% of dwellings featured natural floors, i.e., earth/sand (57.5%) or dung (0.6%), while only 19.1% of urban dwellings had natural floors.

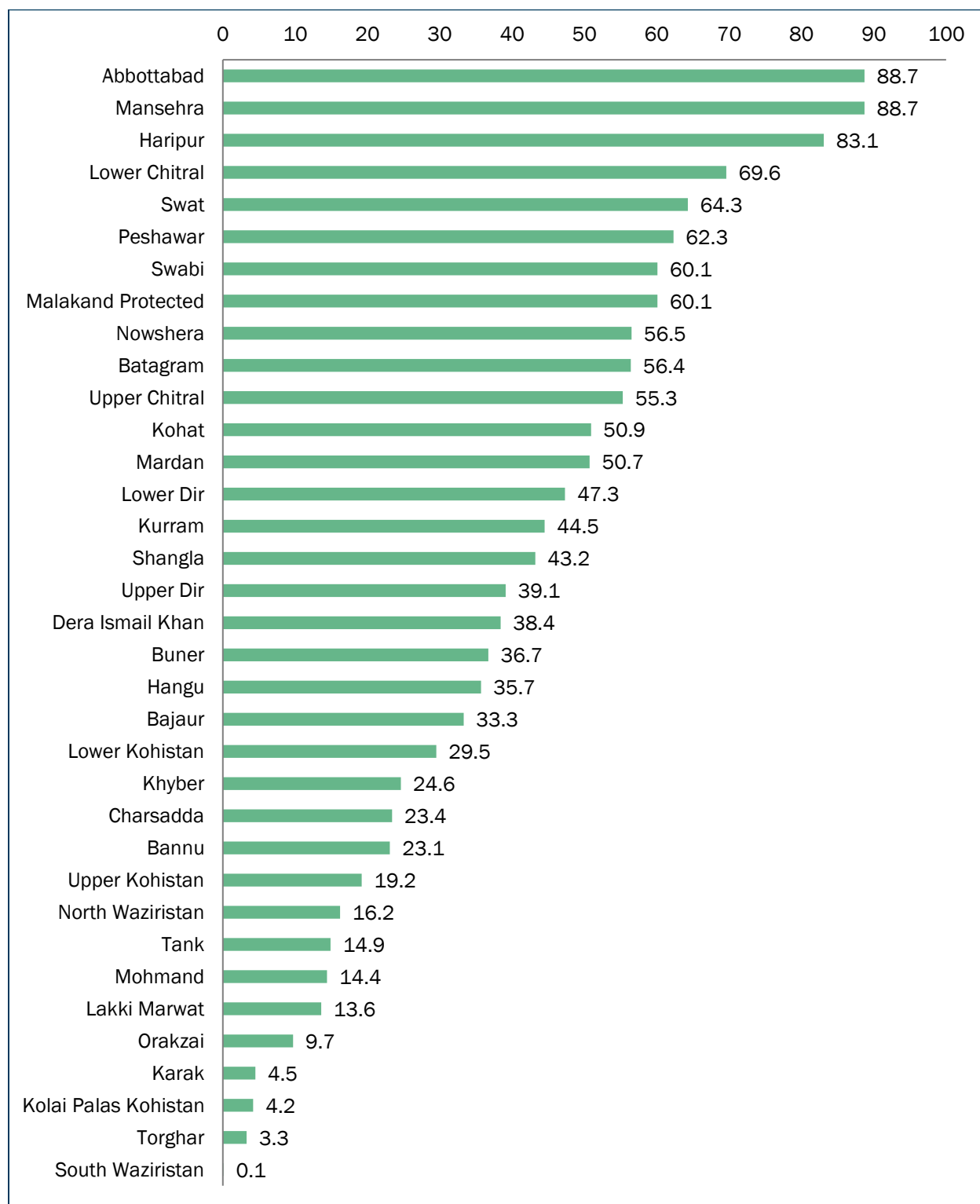
Conversely, 80.8% of urban dwellings had finished floors of parquet or polished wood, ceramic tiles, cement, chips/concrete, bricks, or marble, with cement (44.1%) and marble (16.2%) being the most common. In rural areas, 40.9% of dwellings had finished floors, with 30.2% made of cement and 4.1% made of marble.

The percentage of dwellings with finished floors varied widely by district, ranging from 0.1% in South Waziristan to 88.7% in Mansehra and Abbottabad (Figure 2.1). Less than 10% of dwellings in five districts (Orakzai, Karak, Kolai Palas Kohistan, Torghar, and South Waziristan) had finished floors, while the proportion exceeded 80% in three districts (Haripur, Mansehra, and Abbottabad). The proportions ranged from 50% to 70% in ten districts—Mardan, Kohat, Upper Chitral, Batagram, Nowshera, Malakand Protected, Swabi, Peshawar, Swat, and Lower Chitral.

Table 2.3: Percentage of households by housing characteristics

	Total	Rural	Urban
Dwelling's ownership status			
Rented	7.9	6.2	17.4
Rent-free	4.5	4.6	3.8
Mortgaged	0.6	0.6	0.1
Owned	86.9	88.3	78.4
Other	0.2	0.2	0.3
Total	100.0	100.0	100.0
Floor's primary material			
Natural floor	52.4	58.1	19.1
Rudimentary floor	0.9	1.0	0.2
Finished floor	46.7	40.9	80.8
Total	100.0	100.0	100.0
Exterior walls' primary material			
Natural walls	19.7	22.4	4.1
Rudimentary walls	10.6	12.0	2.4
Finished walls	69.7	65.7	93.6
Total	100.0	100.0	100.0
Fuel for cooking			
Electricity	0.8	0.8	0.8
liquefied petroleum gas (LPG)	8.9	7.7	16.0
Natural gas	19.8	12.5	62.7
Wood	61.5	68.9	17.9
Straw/shrubs/grass	5.9	6.6	1.7
Other	3.1	3.5	0.9
Total	100.0	100.0	100.0
No. of HH (Unweighted)	23,534	20,357	3,177

Figure 2.1: Percentage of dwellings with finished floors (by district)



There is a noticeable urban-rural contrast in the primary materials used for the exterior walls of dwellings. Nearly a fourth of dwellings (22.4%) in rural areas had natural walls—no walls (4%) and dirt (18%). The corresponding figures for urban areas were 0.3% and 3.6%, respectively. Over 90% of urban dwellings (93.6%) featured finished walls of cement (43.6%) or bricks (33.1%). The corresponding figure for rural dwellings was 65.7%, of which 22.5% were cement and 19.5% were bricks.

The urban-rural contrast was evident from the types of cooking fuels used (Table 2.3). The three main types of fuel were wood (61.5%), natural gas (19.8%), and LPG (8.9%). In rural households, 68.9% used wood. The corresponding figure for urban households was 17.9%. Urban households used natural gas much more (62.7%). LPG was found to be used twice as much in urban households (16%) than rural households (7.7%).

Main source of household income and remittances

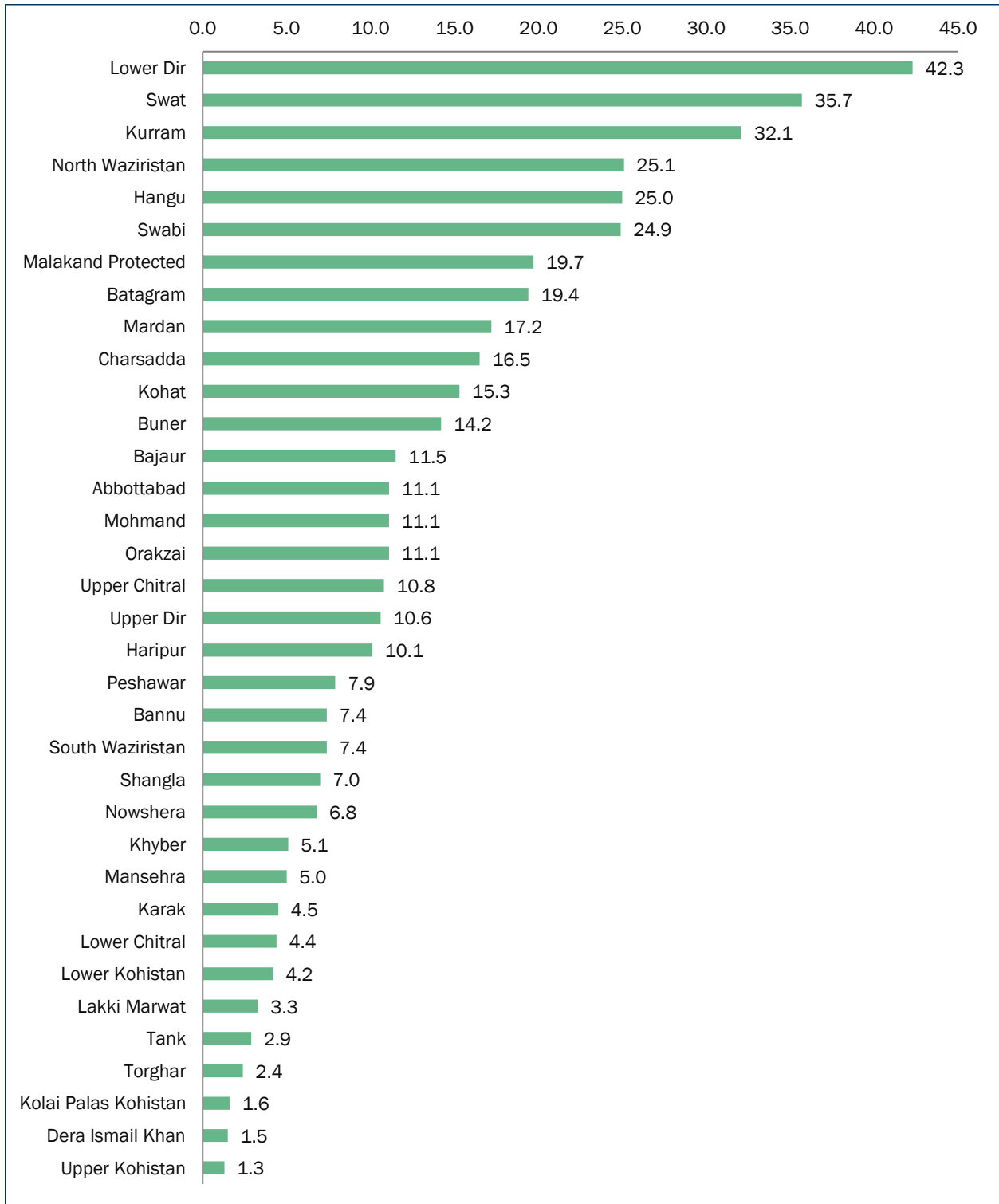
Daily wages were the primary source of household income overall (43.1%), as well as for urban (45.4%) and rural households (29.3%) (Table 2.4). Government service was the second main source of income in both urban (14.1%) and rural areas (10.2%). About 10% of households relied on remittances as their main source of income overall and in rural areas, compared to 8.4% in urban areas.

KP is characterized by a significant percentage of people working abroad, in other provinces, and in Islamabad. Overall, 14% of households in KP were receiving remittances from abroad, with only a small difference in proportions between urban (13.4%) and rural (14.1%) households. Remittances by district (Figure 2.2) indicated that less than 5% of households in nine districts (Upper Kohistan, Dera Ismail Khan, Kolai Palas Kohistan, Torghar, Tank, Lakki Marwat, Lower Kohistan, Lower Chitral, and Karak) were receiving remittances from abroad, while 25% or more of households in five districts (Hangu, North Waziristan, Kurram, Swat, and Lower Dir) were receiving remittances from abroad. The proportion of households receiving remittances from abroad in the remaining 21 districts ranged from 5% to 24.9%.

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

	Total	Rural	Urban
Main source of income			
Agriculture/livestock/poultry	6.1	6.7	2.4
Government service (permanent)	10.8	10.2	14.4
Government service (contract)	1.3	1.2	1.6
Private service (permanent)	3.4	2.9	6.2
Private service (contract)	7.4	7.1	8.9
Business (with employees)	2.4	1.9	5.3
Business (without employees)	7.7	6.9	12.6
Daily wages	43.1	45.4	29.3
Remittances	9.6	9.8	8.4
Pension	3.2	3.1	3.7
Raising birds	0.1	0.1	0.0
Rent	0.2	0.1	0.5
Others	5.0	4.7	6.8
Total	100.0	100.0	100.0
Have you received remittances from abroad during the last year?			
Yes	14.0	14.1	13.4
No	86.0	85.9	86.6
Total	100.0	100.0	100.0
Have you received remittances from within Pakistan during the last year?			
Yes	15.5	15.8	13.5
No	84.5	84.2	86.5
Total	100.0	100.0	100.0
No. of HH (Unweighted)	23,534	20,357	3,177

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



Compared to remittances from abroad, those received from individuals working in other parts of Pakistan were slightly higher, totaling 15.5% overall, 15.8% for rural households, and 13.5% for urban households. Taken together, about 30% of households in KP receive remittances either from abroad or from within Pakistan, with only a modest difference between urban and rural households.

Vulnerability to disasters and hardship

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

Overall, 76.3% of respondents indicated that they had faced none of these issues (Table 2.5). More households in rural areas (24.1%) than in urban areas (21.6%) experienced some form of disaster or hardship. While rain and floods were the primary disasters reported by households in rural areas, economic shocks were the main concern for urban households. Health issues were also noted in both urban (6.4%) and rural areas (5.5%). A higher percentage of rural households (47.5%) took out loans in the last 24 months compared to urban households (37%). “Buying food” was the predominant reason for taking out loans in both rural (37.2%) and urban areas (29.6%). The second leading reason was health shocks, such as accidents, mentioned by 27.2% of rural respondents and 21.2% of urban respondents. Taking out loans to pay off debt was also a significant reason in both rural (20.3%) and urban (17.8%) areas.

The percentage of households experiencing disasters or hardship varied by district (Figure 2.3). Less than 10% of households in eight districts (Hangu, Kolai Palas Kohistan, Kohat, Mansehra, Mohmand, Buner, Haripur, and Shangla) experienced disasters and hardship, while 50% or more experienced them in Upper Chitral, North Waziristan, and Tank.

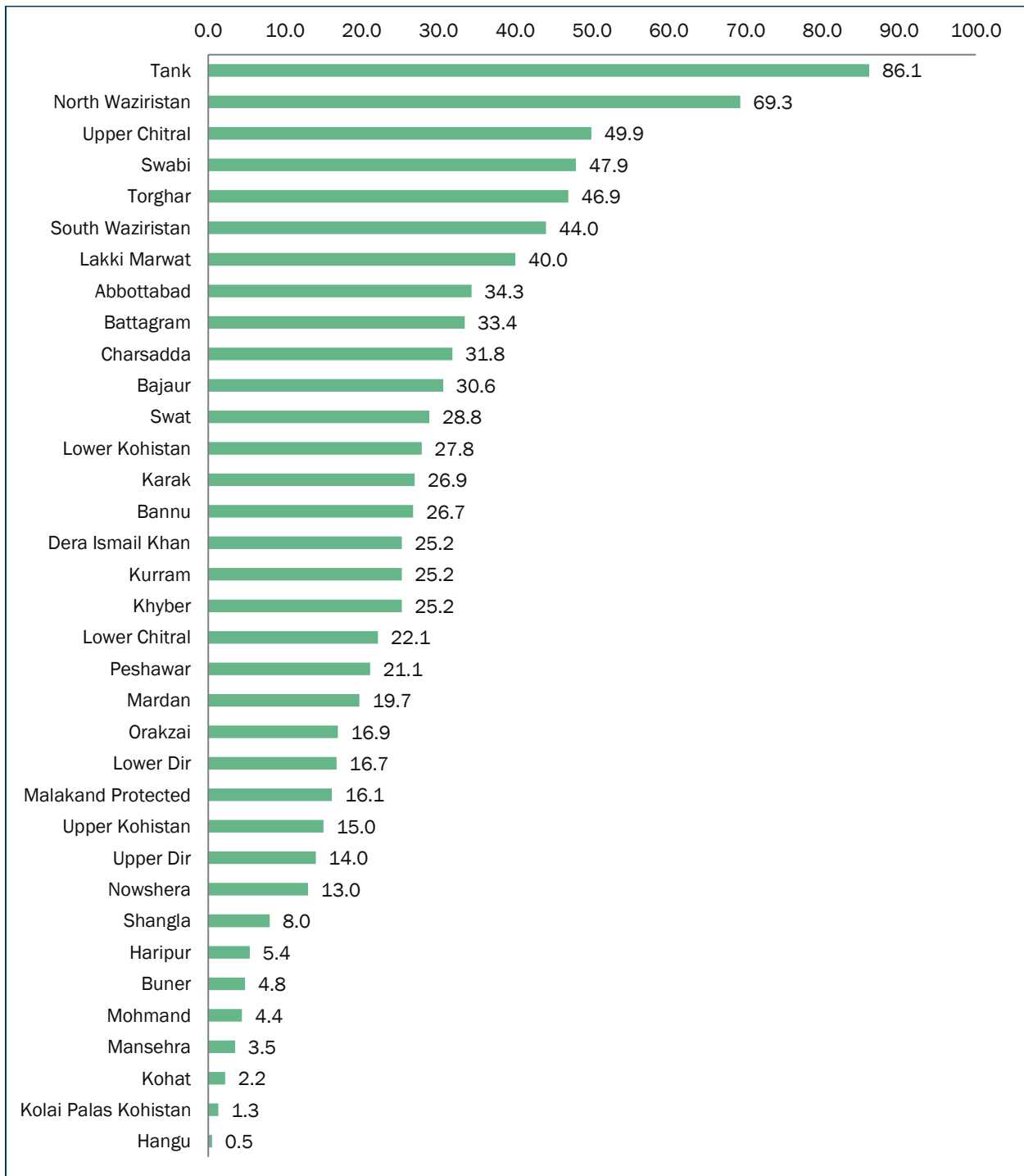
Nearly half of all households in KP and in rural areas had to take out loans to buy food, deal with health shocks, or pay off debts. The incidence of borrowing in urban areas was ten percentage points lower than in rural areas, but the reasons were largely similar.

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

	Total	Rural	Urban
Have you experienced disasters/hardship in the last 24 months?*			
None	76.3	75.9	78.4
Rain/floods	9.9	10.5	5.9
Agricultural shocks	1.9	2.1	0.9
Economic shocks	9.4	9.2	10.5
Law and order	3.3	3.6	1.5
Displacement	1.6	1.7	1.0
Accident/injury	2.3	2.3	1.9
Health issues	5.7	5.5	6.4
COVID-19	0.1	0.1	0.2
Earthquakes	0.8	0.8	0.6
Droughts	0.3	0.3	0.0
Death of working member	0.5	0.4	1.1
Others	0.4	0.4	0.4
Total	100.0	100.0	100.0
Have you taken out a loan in the last 24 months?			
Yes	46.0	47.5	37.0
No	54.0	52.5	63.0
Total	100.0	100.0	100.0
What was the reason for your loan? *			
Other health shocks, e.g., accidents	26.5	27.2	21.2
Floods or earthquakes	1.6	1.8	0.4
Buying food	36.3	37.2	29.6
Maintaining stable spending	15.6	14.9	20.7
Education costs	3.6	3.5	4.3
Buying an asset	7.0	7.5	3.5
To start a business	10.8	10.5	13.0
To pay for a wedding	9.2	8.9	11.3
To pay for a funeral	2.2	2.2	2.4
To pay off past debt	9.0	8.7	11.7
Family member illness	20.0	20.3	17.8
Others (specify)	5.6	5.8	4.4
Total	100.0	100.0	100.0
N (Unweighted)	9,440	8,346	1,094
No. of HH (Unweighted)	23,534	20,357	3,177

*Multiple responses allowed.

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 KP and the federal government have social protection programs to support poor and underprivileged families. BISP was launched in 2008 as a federal unconditional cash transfer initiative for poverty reduction. In KP, 15.8% of households included a member who was a BISP beneficiary (Table 2.6). In rural areas, 17.1% of households had a BISP beneficiary, compared to 7.9% in urban households. The coverage of the Sehat Sahulat Program, which provides free or subsidized healthcare services for underprivileged families, was slightly higher, at 19.3% overall, with 19.4% in urban areas. However, only a small percentage of pregnant or lactating women (1.7–2.5%) benefited from nutrition programs, and similarly, few benefitted from nutritional programs for immunization.

Despite a significant number of households experiencing disasters and health emergencies, the coverage of social protection programs remains limited. Health insurance coverage, whether through employers or private means, is virtually absent, with only a small fraction (2.8%) of urban residents benefiting from employer-sponsored plans. Consequently, most people are 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 HH?			
Yes	15.8	17.1	7.9
No	84.2	82.9	92.1
Total	100.0	100.0	100.0
Is anyone benefiting from the Sehat Sehat card?			
Yes	19.3	19.3	19.4
No	80.7	80.7	80.6
Total	100.0	100.0	100.0
Are pregnant or lactating women benefitting from nutritional programs?			
Yes	2.4	2.5	1.7
No	88.2	88.5	86.6
Don't know	2.0	2.2	1.1
Not applicable	7.4	6.9	10.6
Total	100.0	100.0	100.0
Is anyone benefiting from nutritional programs for immunization?			
Yes	2.6	2.7	1.8
No	88.1	88.3	86.9
Don't know	2.5	2.7	1.7
Not applicable	6.9	6.4	9.6
Total	100.0	100.0	100.0
Is anyone insured through an employer's insurance plan?			
Yes	1.3	1.0	2.8
No	89.0	89.3	87.3
Don't know	3.4	3.6	2.6
Not applicable	6.3	6.1	7.3
Total	100.0	100.0	100.0
Is anyone insured by privately purchased insurance?			
Yes	0.4	0.4	0.5
No	92.7	92.4	93.9
Don't know	3.6	3.9	2.2
Not applicable	3.3	3.3	3.4
Total	100.0	100.0	100.0
No. of HH (Unweighted)	23,534	20,357	3,177

Water, Sanitation, and Hygiene (WASH)

Unsafe water, poor sanitation, and inadequate hygiene are the underlying determinants of morbidity. The KPHPS 2024–25 household questionnaire included a series of questions on households' WASH conditions. Relevant definitions include the following:

- **Improved drinking water sources:** Those that have the potential to provide safe water.
- **Improved sources:** These include piped water, boreholes or tube wells, protected dug wells, protected springs, rainwater, and packaged or delivered water.
- **Improved sanitation facilities:** These encompass wet sanitation technologies, such as flush and pour-flush toilets connected to sewers, septic tanks, or pit latrines, as well as dry sanitation technologies like dry pit latrines with slabs and composting toilets.

Hygiene was assessed based on the self-reported availability of a handwashing facility with soap and water on the premises. This definition implies that water is accessible when needed. Handwashing facilities include both fixed (tap) and mobile (bucket) options, designed to contain, transport, or regulate the flow of water to facilitate handwashing within the dwelling, yard, or plot. Soap can include bar soap, liquid soap, or detergent (powder/liquid/paste).

Improved Water

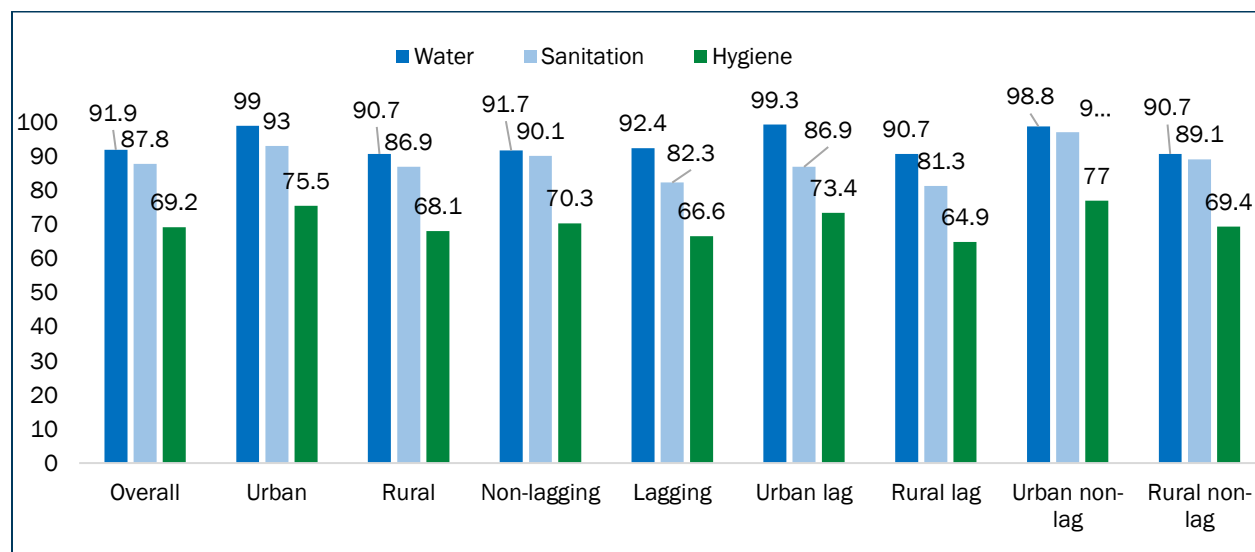
Overall, 58% of households had a water source located within their own dwellings, while another 20.9% had a source in their own yard or plot (Table 2.7). A higher percentage of urban dwellings (69.8%) had water sources compared to rural dwellings (56%). At least one in five households relied on water sources that were neither in their own dwellings nor in their yards or plots.

The shortage of drinking water was more pronounced in urban areas (81.7%) than in rural areas (70.2%). In urban areas, power failures were the primary reason for water shortages, while in rural areas, the unavailability of water from sources was the main issue. Treating water to make it safe was uncommon, with only 12.5% of households overall engaging in this practice—12.5% in rural areas and 12.4% in urban areas.

Improved water sources were available to 91.9% of households overall, with 90.7% in rural areas and 99% in urban areas (Figure 2.4). This indicates an eight-percentage-point lower availability of improved water sources in rural areas compared to urban areas. However, the difference between lagging and non-lagging districts was modest, with improved water availability at 92.4% in lagging districts vs. 91.7% in non-lagging districts.

Most lagging and non-lagging districts had over 75% availability of improved water services (Figure 2.5). Lower Kohistan had the lowest availability of improved water sources, at just 2.5%.

Figure 2.4: Percentage of households with improved water and improved sanitation and hygiene* 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 with water source location, availability, and treatment

	Total	Rural	Urban
Location of water source			
In own dwelling	58.0	56.0	69.8
In own yard/plot	20.9	20.9	20.8
Elsewhere	21.2	23.2	9.4
Total	100.0	100.0	100.0
Shortage of drinking water last month			
No shortage	71.9	70.2	81.7
Water not available from source	8.9	9.8	3.6
Water too expensive	0.8	0.9	0.5
Source not accessible	4.6	5.0	1.9
Household person not available to get water	3.7	4.1	1.0
Power failure	9.5	9.3	10.5
Others	0.8	0.8	0.8
Total	100.0	100.0	100.0
Treating water to make it safe			
Yes	12.5	12.5	12.4
No	87.5	87.5	87.6
Total	100.0	100.0	100.0
No. of HH (Unweighted)	23,534	20,357	3,177

Improved Sanitation

About a fourth of households overall (and in rural areas) and a fifth in urban areas shared toilet facilities with other households (Table 2.8). A greater percentage of dwellings in urban areas (81.8%) had toilet facilities for men located within the dwelling compared to rural areas (72.6%). A similar trend was observed for toilet facilities for women. It should be noted that 4.1% of women did not have toilet facilities in their own dwellings or within their yards or plots.

Improved sanitation services were also common, though they were less prevalent than improved water services. Overall, 87.8% of households had access to improved sanitation services. Once again, rural areas and lagging districts exhibited fewer improved sanitation facilities compared to urban and non-lagging districts (Figure 2.4).

Most districts showed a high availability of improved sanitation services, with the exceptions of Torghar and Kolai Palas Kohistan (Figure 2.6).

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

	Total	Rural	Urban
Sharing toilet facilities with other HHS?			
Yes	24.9	25.5	21.1
No	75.1	74.5	78.9
Total	100.0	100.0	100.0
Location of toilet facility for men			
In own dwelling	74.0	72.6	81.8
Own yard/plot	20.7	21.2	17.6
Elsewhere	5.4	6.2	0.6
Total	100.0	100.0	100.0
Location of toilet facility for women			
In own dwelling	76.2	75.2	82.4
Own yard/plot	20.3	20.8	17.5
Elsewhere	3.5	4.1	0.1
Total	100.0	100.0	100.0
No. of HH (Unweighted)	23,534	20,357	3,177

*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.

Hygiene

Among the three indicators, good hygiene, defined as the availability of a handwashing facility with soap inside the dwelling, was the least prevalent, with an overall rate of 69.2%. This figure included 68.1% in rural areas and 75.5% in urban areas (Figure 2.4). Lagging districts reported a handwashing facility in 66.6% of households, compared to 91.2% in non-lagging districts. The lowest availability was found in the rural areas of lagging districts (64.9%), while the highest was in urban non-lagging districts (77%).

The availability of water when needed for washing and bathing was 81.6% overall, with 80.8% in rural areas and 86.4% in urban areas (Table 2.9). The availability of soap was also high, exceeding 80% in

both rural and urban areas. However, 15.8% of households in rural areas had no soap and relied solely on water for handwashing.

Orakzai, a non-lagging district, recorded the lowest availability of handwashing facilities at 18%. In contrast, six districts (Shangla, Nowshera, Kurram, Abbottabad, Hangu, and Lower Chitral) boasted over 80% availability (Figure 2.7). Notably, Hangu, a lagging district, had the second-highest availability of handwashing facilities with soap in dwellings (89%).

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

	Total	Rural	Urban
Water available when needed for washing and bathing?			
Yes	81.6	80.8	86.40
No	18.4	19.2	13.70
Total	100.0	100.0	100.00
Type of soap used for washing hands*			
Soap	81.4	80.7	85.27
Liquid soap	2.9	2.4	5.84
Detergent (powder/liquid/paste)	0.4	0.4	0.24
Ash/mud/sand	0.3	0.3	0.07
Water only	14.7	15.8	8.29
Others	0.4	0.4	0.29
Total	100.0	100.0	100.00
No. of HH (Unweighted)	23,534	20,357	3,177

* 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 services availability (by district)

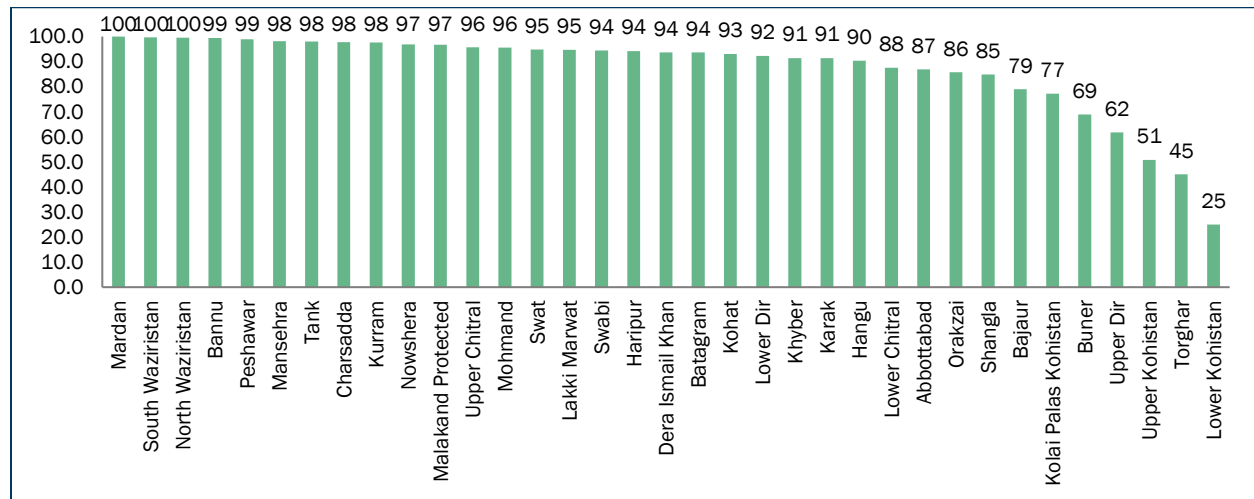


Figure 2.6: Percentage of households with improved sanitation services availability (by district)

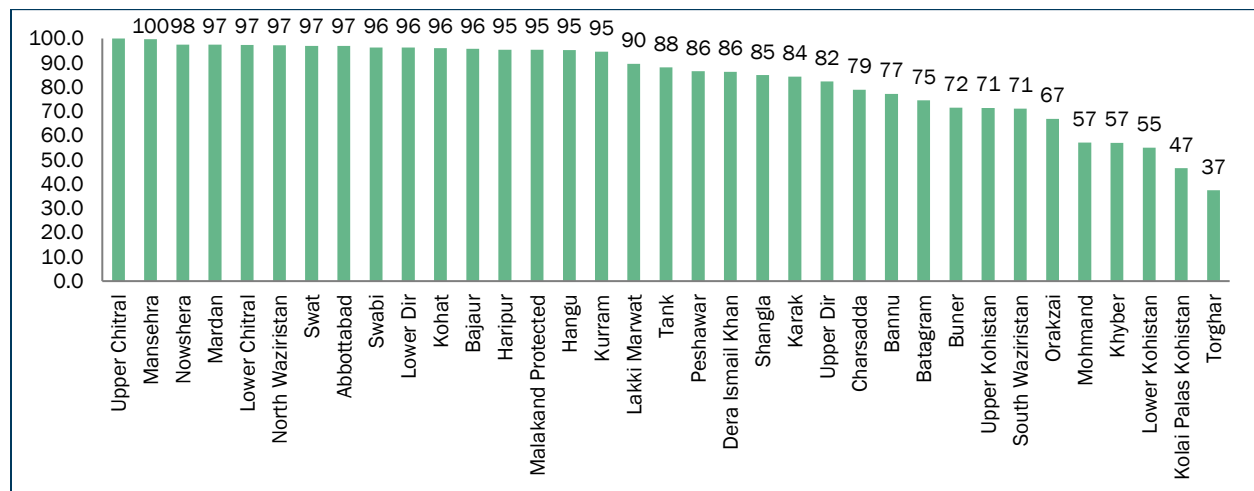
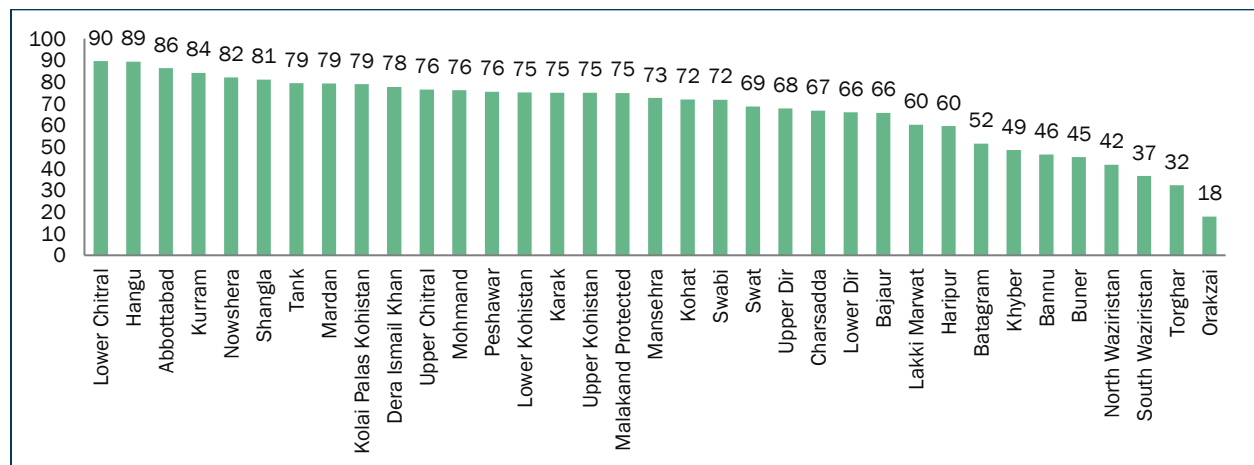


Figure 2.7: Percentage of households with on-premises washing facilities with soap for handwashing (by district)



Background Characteristics of Household Members

A total of 180,407 permanent members were identified in households surveyed in KPHPS 2024–25, resulting in an average family size of 7.78 members per household. In rural areas, there were 158,004 permanent members, with an average family size of 7.86, compared to 22,403 members in urban households, which had an average of 7.33 members per household. Approximately half of the household members were male, while the other half were female (Table 2.10).

The economically active age group of 15–64 years was 54.7%, while 4% were 65 years or older. The dependency ratio—percentage of individuals under 15 years and over 65 years—was high at 45.3% in KP. Due to higher fertility in rural areas, the percentage of children under five years was higher in these regions, resulting in a dependency ratio of 45.8%. In urban areas, the under-five age group was 13.2%, and the dependency ratio was 42.3%. The median age for male household members in rural areas was two years younger for both men and women than their counterparts in urban areas.

The coverage of computerized national identity cards (CNICs) or forms B (for children) was high, though not universal. CNICs are issued by the National Database and Registration Authority (NADRA) to citizens and are required for most transactions. Overall, 85.6% of males and 83.4% of females were registered with NADRA and possessed a CNIC. In rural areas, the proportions were 85% for males and 82.7% for females, while in urban areas, the proportions were 89.4% for males and 87.6% for females.

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

	Total	Rural	Urban
Sex			
Male	50.60	50.50	50.90
Female	49.40	49.50	49.10
Total	100.00	100.00	100.00
Current age (years)			
under 5	14.20	14.40	13.20
5-14	27.10	27.40	25.10
15-64	54.70	54.20	57.70
65+	4.00	4.00	4.00
Total	100.00	100.00	100.00
Average HH size by age group (years)			
	7.78	7.86	7.33
Average no. of people by age group			
Under 5	1.11	1.13	0.97
5-14	2.11	2.15	1.84
15-64	4.26	4.26	4.23
65+	0.31	0.32	0.29
Median age (in years)			
Males	19.00	18.00	20.00
Females	19.00	19.00	21.00
Have CNIC or form B?			
Males			
Yes	85.60	85.00	89.40
No	14.30	14.80	10.50
Don't know	0.20	0.20	0.10
Total	100.00	100.00	100.00
N (Unweighted)	91,428	80,008	11,420
Females			
Yes	83.40	82.70	87.60
No	16.40	17.10	12.30
Don't know	0.20	0.20	0.10
Total	100.00	100.00	100.00
N (Unweighted)	88,975	77,994	10,981
No. of HH members	180,407	158,004	22,403

School attendance by 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, 28.5% of boys and a staggering 40.5% of girls aged 5–9 in rural areas have never attended school (Table 2.11). In urban areas, the gender difference was modest, with 19.7% of boys and 20.3% of girls not attending school. The gender disparity persisted for children aged 5–9 currently in school in rural areas, where 70.5% were boys and 58.1% were girls. In contrast, there was little difference in school attendance between boys and girls in urban areas, with 78.7% of boys and 78.5% of girls attending.

For the 10–14-year age group, which is also covered by free and compulsory education, the percentage of girls who have never attended school was 30.8%—28 percentage points higher than the 12.8% of boys in rural areas. The difference was less pronounced in urban areas, with 7.7% of boys

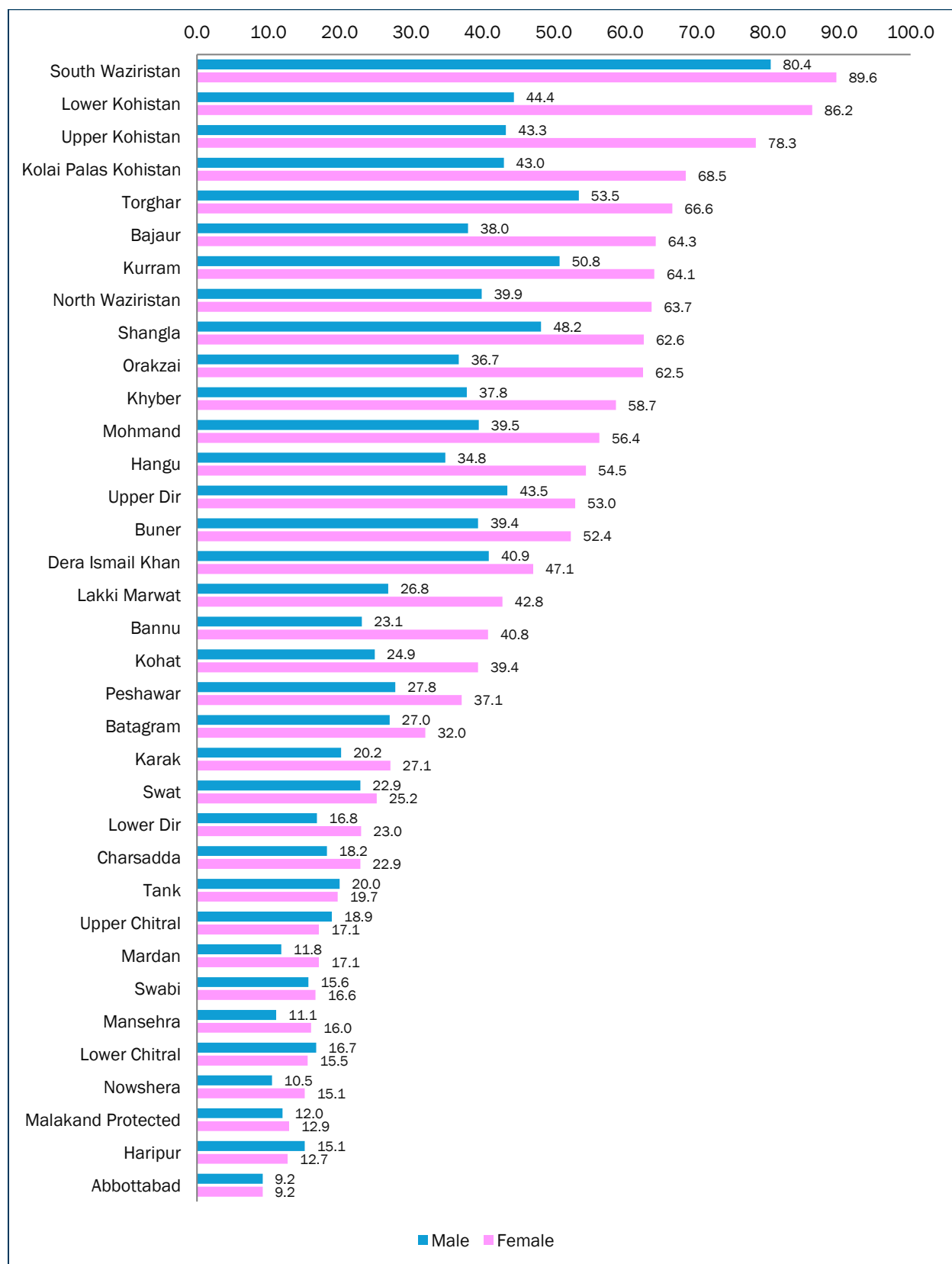
and 11.3% of girls not attending school. Among 10–14-year-olds, 84.9% of boys and 77.6% of girls were attending school. Table 2.11 shows a glaring inequity in schooling by gender and urban-rural areas.

In 30 of 35 districts, more girls than boys aged 5–9 years were out of school (Figure 2.8). In Abbottabad and Tank districts, the percentages of boys and girls out of school were equal, while Upper Chitral, Lower Chitral, and Haripur showed a slightly lower percentage of girls out of school compared to boys.

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	70.5	78.7	58.1	78.5	80.7	84.9	57.0	77.6
Attended in past	1.1	1.5	1.5	1.2	6.5	7.4	12.2	11.0
Never attended	28.5	19.7	40.5	20.3	12.8	7.7	30.8	11.3
Out of school	29.6	21.2	42.0	21.5	19.3	15.1	43.0	22.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of children (Unweighted)	13,387	1,665	12,625	1,486	9,237	1,244	8,972	1,190

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



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

Key Findings

Socioeconomic and demographic background characteristics of ever-married women

- Two-thirds of ever-married women in KP had no education (65.6%). In rural areas, the percentage without education was 68.9%, compared to 45.1% in urban areas. The lack of education was particularly high in lagging districts (79.4%) compared to non-lagging districts (59.9%). The percentage of women with primary or higher educational attainment was 0.7% in South Waziristan and 0.6% in Lower Kohistan, compared to 73.2% in Haripur and 76.8% in Abbottabad.
- Just 4.5% of women reported having worked for income in the 30 days prior to the survey, with the highest percentage being 5% in non-lagging districts and the lowest at 3.1% in lagging districts.
- In rural areas, 8.4% of women were BISP beneficiaries, compared to 4.6% in urban areas.
- A significant 28.1% of women married before the age of 18, and 60.7% married before the age of 20, depriving them of opportunities for education and work while exposing them to high risks associated with early childbearing.
- Consanguineous marriages continued to prevail at 41.8% overall. This included 41.7% in rural areas and 42.5% in urban areas marrying first cousins. Upper Dir had the lowest proportion (19.4%) of consanguineous marriages, while Lower Kohistan had the highest (74.2%).
- 23% of ever-married women were aged 15–24 years.
- While 12.2% of women had not yet started childbearing, 23.5% had five or more children ever born. The districts with the highest fertility rates were Torghar (mean parity 3.8), Lower Kohistan (mean parity 3.7), and Kolai Palas Kohistan (mean parity 3.6). The lowest-fertility districts were Abbottabad (mean parity 2.6) and Upper Chitral (mean parity 2.5).

Exposure to mass media, internet access, and mobile phone ownership

- Less than ten percent of women reported reading newspapers or listening to the radio at least once a week or less than once a week. In contrast, watching TV at least once a week or less than once a week was more common in urban areas (28.9%) compared to rural areas (10.3%).
- Overall, 23.4% of women had access to the internet, primarily through mobile devices (21.7%). Internet access was more prevalent in urban areas, with 38.9% of women connected, compared to 20.8% in rural areas.
- One in three women owned a mobile phone, with ownership at 31.3% in rural areas and 48.9% in urban areas.

Women's empowerment

- More women in urban areas could visit places on their own compared to their counterparts in rural areas. For example, 17.1% of urban women could visit a hospital or doctor in the community independently, while only 9.6% of rural women could do the same.
- Decisions regarding household purchases, daily expenses, medical treatment, and the use of household or individual earnings were often made by the husband or jointly by both husband and wife. Joint decision-making for medical treatment among respondents ranged from 7.6% in Upper Kohistan to 86.7% in Tank.

The background characteristics of 28,063 ever-married women interviewed across KP provided valuable insights into their profiles and the context for understanding population and health outcomes. This chapter describes the socioeconomic and demographic backgrounds of these women, as well as their exposure to mass media, access to the internet, and ownership of mobile phones, which are rapidly expanding sources of information and networking. We also present their degree of autonomy and empowerment in movements outside the home and in decision-making regarding important personal and family matters.

Socioeconomic and Demographic Background Characteristics

Nearly all ever-married women aged 15–49 years (98%) were currently married at the time of the survey, while 1.5% were widowed (Table 3.1). The percentage of ever-married women who were divorced or separated was less than one percent. The differences in marital status between urban and rural areas, as well as between lagging and non-lagging districts, were negligible.

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

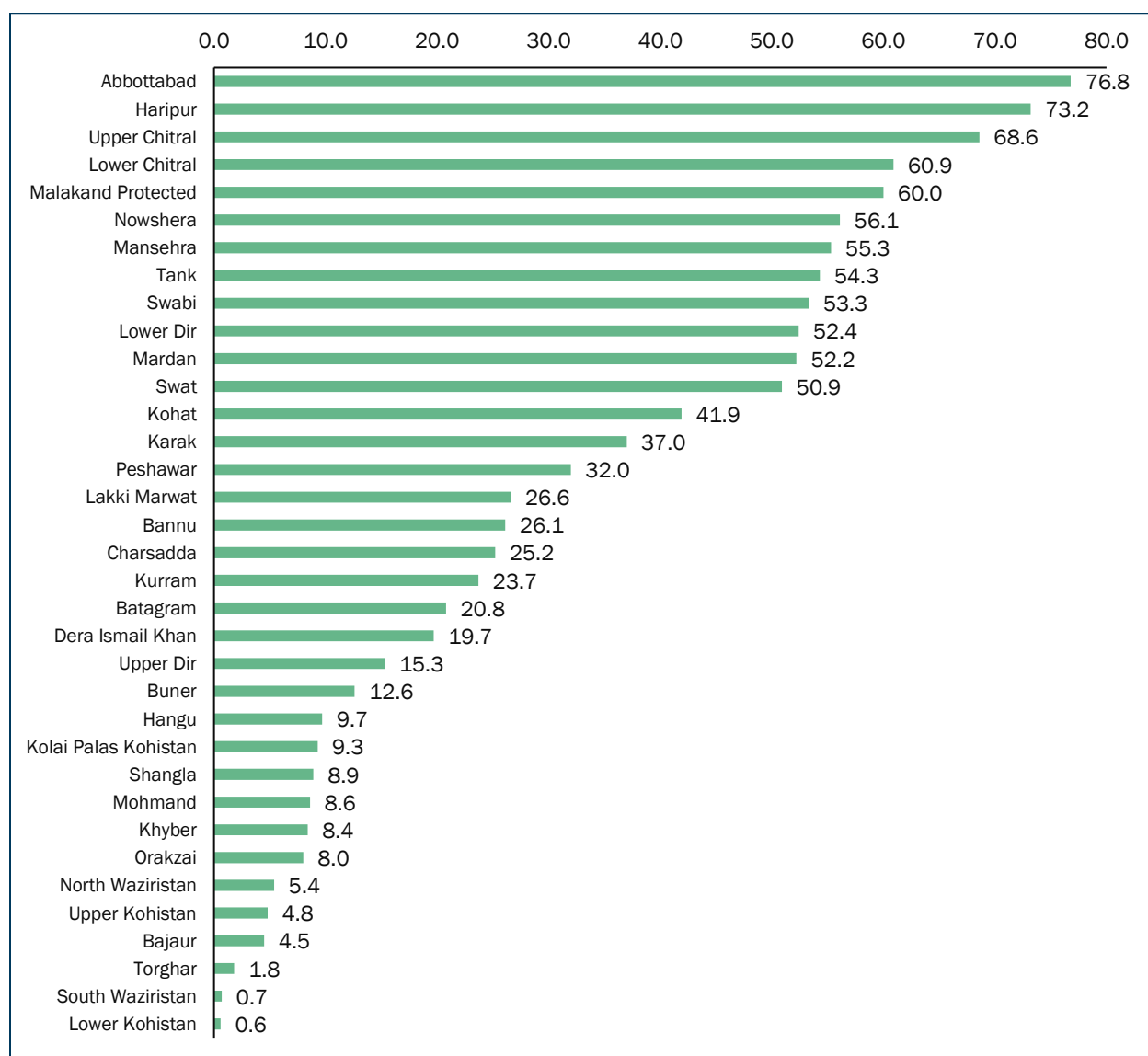
Background characteristics	Total	Rural	Urban	Lagging districts	Non-lagging districts
Current marital status					
Currently married	97.7	97.8	97.7	98.0	97.8
Widowed	1.5	1.5	1.4	1.4	1.5
Divorced	0.5	0.5	0.5	0.3	0.5
Separated	0.3	0.2	0.4	0.3	0.2
Total	100.0	100.0	100.0	100.0	100.0
Education					
No education	65.6	68.9	45.1	79.4	59.9
Primary and middle	16.8	16.0	21.8	9.7	19.7
Secondary and higher	17.7	15.2	33.1	10.9	20.5
Total	100.0	100.0	100.0	100.0	100.0
Currently working*					
Yes	4.5	4.6	3.3	3.1	5.0
No	95.5	95.4	96.7	96.9	95.0
Total	100.0	100.0	100.0	100.0	100.0
BISP beneficiary					
Yes	7.9	8.4	4.6	10.3	6.9
No	92.1	91.6	95.4	89.7	93.1
Missing	2.2	2.2	2.2	2.0	2.3
Total	100.0	100.0	100.0	100.0	100.0
Age at first marriage (years)					
<18	28.1	28.4	26.2	27.9	28.2
18–20	32.6	32.8	31.6	30.4	33.5
21–24	22.3	22.0	24.4	25.0	21.2
25 or older	13.7	13.3	16.0	15.2	13.0
Don't know/missing	3.3	3.5	1.8	1.4	4.0
Total	100.0	100.0	100.0	100.0	100.0
Marriage was consanguineous					
No	50.0	50.1	49.1	49.1	50.4
Yes, with first cousin	41.8	41.7	42.5	43.1	41.3
Yes, with other relative	6.1	6.0	6.1	5.9	6.1
Total	100.0	100.0	100.0	100.0	100.0
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	100.0	100.0	100.0	100.0	100.0
No. 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	100.0	100.0	100.0	100.0	100.0
No. of women (Unweighted)	28,063	24,573	3,490	12,825	15,238

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

Overall, two-thirds of ever-married women (65.6%) had received no education. As expected, more women in rural areas were uneducated compared to urban areas (68.9% vs. 45.1%) and in lagging districts compared to non-lagging districts (79.4% vs. 59.9%). The proportion of women with secondary or higher education was 33.1% in urban areas compared to 15.2% in rural areas, and 20.5% in non-lagging districts compared to 10.9% in lagging districts.

The percentage of women with primary or higher education varied significantly, ranging from over 70% in Haripur and Abbottabad to less than 10% in Hangu, Kolai Palas Kohistan, Shangla, Mohmand, Khyber, Orakzai, North Waziristan, Upper Kohistan, Bajaur, Torghar, South Waziristan, and Lower Kohistan (Figure 3.1). In South Waziristan and Lower Kohistan, less than one percent of women had primary or higher education. In ten districts (Swat, Mardan, Lower Dir, Swabi, Tank, Mansehra, Nowshera, Malakand Protected, Lower Chitral, and Upper Chitral), the proportions of women with primary or higher education ranged from 50% to 70%.

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

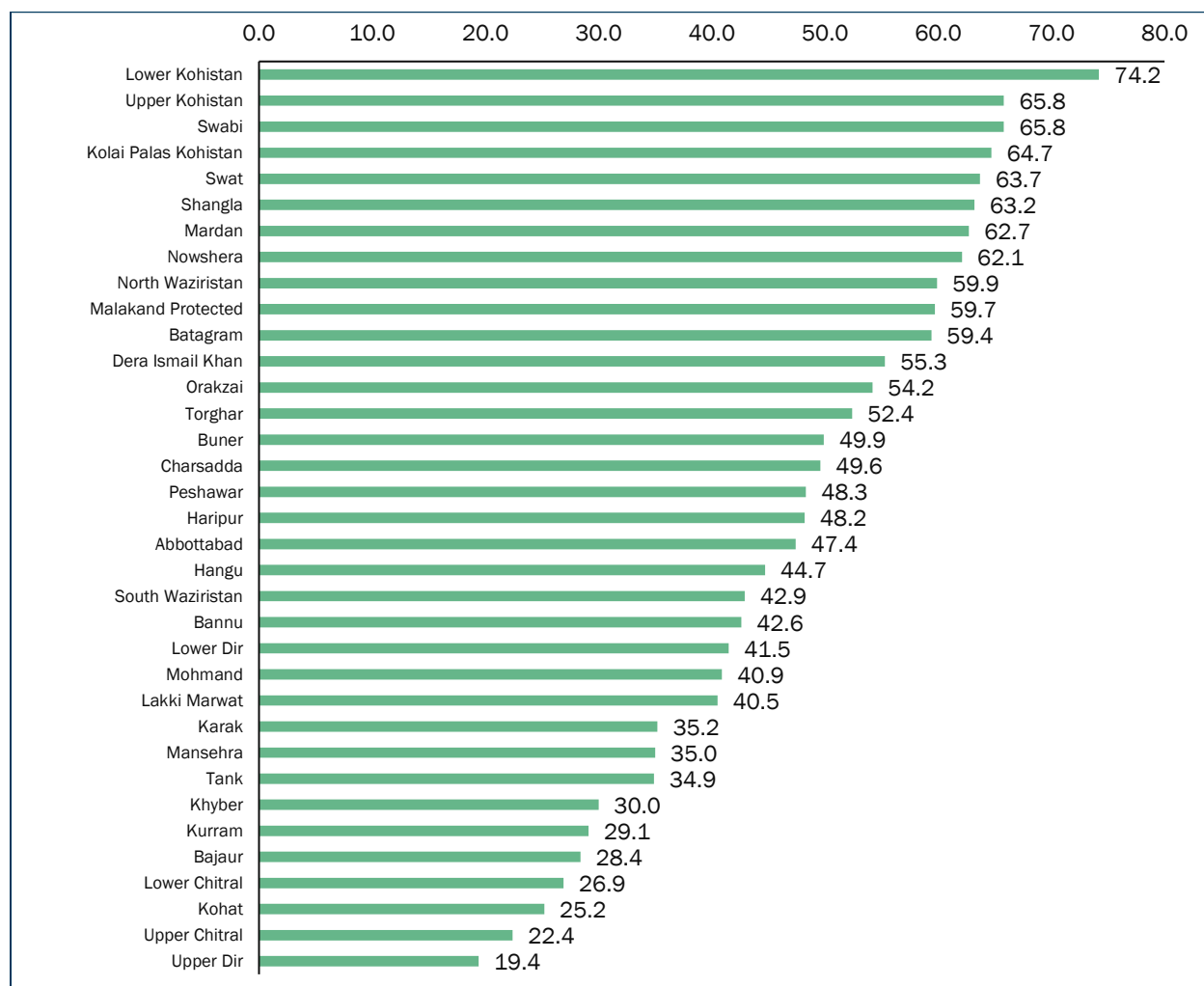


Few women, overall and by urban-rural and lagging and non-lagging districts, reported having worked for income in the 30 days prior to the survey. A slightly higher percentage of women in rural areas (4.6%) worked compared to those in urban areas (3.3%). However, more women in non-lagging districts (5%) were employed than in lagging districts (3.1%). Overall, 7.9% of women reported being BISP beneficiaries, with a higher percentage in rural areas (8.4%) compared to urban areas (4.6%), and in lagging districts (10.3%) compared to non-lagging districts (6.9%).

The Child Marriage Restraint (Amendment) Bill of 2018 stipulated a minimum legal age of 18 years for females, although it has yet to be passed nationwide. One in four ever-married women reported their age at first marriage as below 18 years. A higher proportion of child marriages occurred in rural areas (28.4%) compared to urban areas (26.2%). The difference between lagging and non-lagging districts was modest, with rates of 27.9% and 28.2%, respectively. Approximately a third of women married between the ages of 18 and 20. Thus, 60% of women in KP married before the age of 20, depriving them of educational and employment opportunities while exposing them to the serious health risks associated with early childbearing.

The prevalence of consanguineous marriages (cross cousins) was high, with 41.8% of women in KP married to their first cousins. The difference in the prevalence of cousin marriages was modest: 41.7% in rural areas compared to 42.5% in urban areas, and 43.1% in lagging districts compared to 41.3% in non-lagging districts. Consanguineous marriages were observed in all districts, although the level varied (Figure 3.2). In Kohat, Upper Chitral, and Upper Dir, 25% or fewer marriages were consanguineous. Conversely, over 60% of marriages in Nowshera, Mardan, Shangla, Swat, Kolai Palas Kohistan, Swabi, Upper Kohistan, and Lower Kohistan were consanguineous.

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

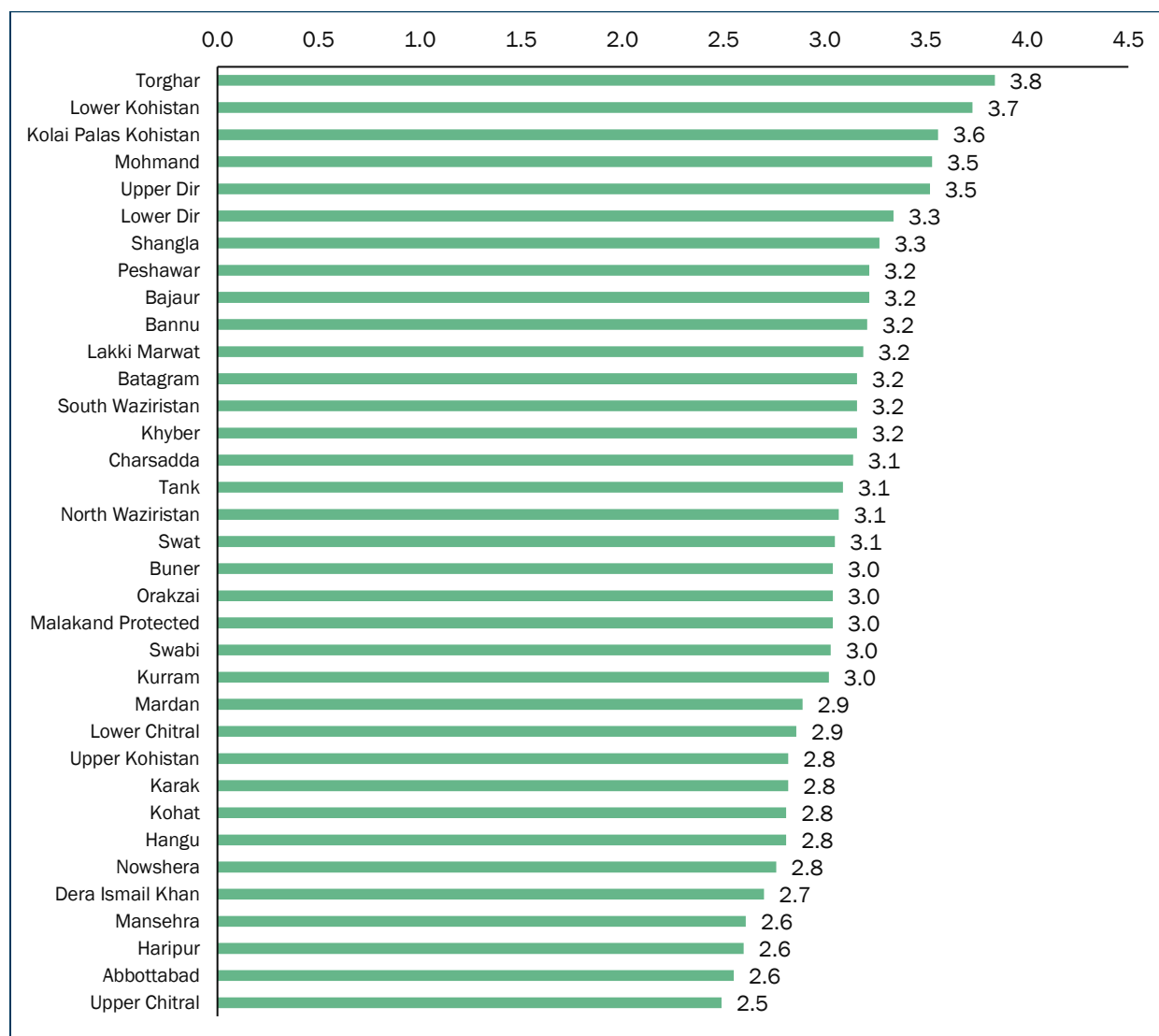


The proportion of young women aged 15–24 years was 23% in KP, 23.4% in rural and non-lagging districts, 20.3% in urban areas, and 21.8% in lagging districts. The proportion of women in the prime reproductive age of 25–34 years was 41.8%, with minor differences between urban-rural areas and lagging and non-lagging districts. Approximately a third of all ever-married women were aged 35–49 years.

Regarding the average number of children ever born, about 12% were childless at the time of the survey, with little variation in proportions across urban-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 23.5% for KP, 24.2% for rural areas, and 18.9% for urban areas. The difference between lagging and non-lagging districts was modest, with 24.1% in lagging districts and 23.3% in non-lagging districts.

In contrast to other characteristics, such as education and consanguineous marriages among ever-married women, the range of the mean number of children by district was narrow, varying from a low of 2.5 in Upper Chitral to a high of 3.8 in Torghar (Figure 3.3). In Kohat, Karak, and Upper Kohistan, the mean parity was 2.8 children, while it was 3.7 in Kohistan and 3.8 in Torghar.

Figure 3.3: Mean no. of children ever born (by district)



Exposure to Mass Media

Women's exposure to mass media can potentially enhance their agency and provide them with information to make informed choices.

Only 4.9% of women in KP read newspapers at least once a week or less than once a week (Table 3.2). The proportion was 4.2% in rural areas and 9.4% in urban areas. Listening to the radio was also infrequent, with only 5.4% of women in KP tuning in at least once a week, and 5.3% in rural areas compared to 6.7% in urban areas. More women watched TV than listened to the radio or read newspapers, with 5.6% watching TV at least once a week and 7.2% watching less than once a week. In rural areas, these figures were 4.4% and 5.9%, respectively, compared to 13.3% and 15.6% 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	1.7	1.4	3.5
Less than once a week	3.2	2.8	5.9
Not at all	49.6	47.6	62.3
Unable to read	45.5	48.3	28.3
Total	100.0	100.0	100.0
Listening to the radio			
At least once a week	1.2	1.2	1.6
Less than once a week	4.2	4.1	5.1
Not at all	94.6	94.8	93.3
Total	100.0	100.0	100.0
Watching TV			
At least once a week	5.6	4.4	13.3
Less than once a week	7.2	5.9	15.6
Not at all	87.2	89.7	71.1
Total	100.0	100.0	100.0
Having internet access			
No	75.0	77.7	58.2
Yes, fixed (WiFi)	1.7	0.9	6.1
Yes, on mobile	21.7	19.9	32.8
Both	1.6	1.4	3.0
Total	100.0	100.0	100.0
Owning a mobile phone			
Yes	33.7	31.3	48.9
No	66.3	68.7	51.1
Total	100.0	100.0	100.0
Reachable via mobile phone*			
Yes	76.1	77.1	71.9
No	23.9	22.9	28.1
Total	100.0	100.0	100.0
No. of ever-married women (Unweighted)	28,063	24,573	3,490

* Applies only to those who own a mobile phone.

In KP, 75% of ever-married women had no access to the internet. A higher percentage of women in urban areas (41.8%) reported having internet access compared to those in rural areas (22.3%). The primary source of internet access was mobile phones, with an overall rate of 21.7%—19.9% in rural areas and 32.8% in urban areas. A third (33.7%) of ever-married women in KP owned a mobile phone, with ownership rates of 48.9% in urban areas compared to 31.3% in rural areas. Among women who owned a mobile phone, three-fourths indicated that they could be reached via this device. Mobile phone ownership and the ability to be contacted suggested a degree of autonomy for these women. In addition, owning a mobile phone provides them with a valuable resource for information.

Empowerment

Empowerment is a dynamic and context-specific process, making a universally applicable standard definition elusive. The 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 a positive association between at least one of these domains and contraceptive use.¹⁰

The KPHPS included a series of questions to measure the degree of women's empowerment in KP. As reported, one in three women owned a mobile phone, and three in four indicated they could be reached via a mobile phone. When asked, "Do you have an account (other than BISP) in a bank or other financial institution that you yourself use?" only 2.2% of ever-married women responded in the affirmative.

We further examined the freedom of movement among ever-married women. The overall percentage of women who could visit on their own, whether within or outside the community, was below 12%, particularly in rural areas (Table 3.3).

The ability to visit independently was somewhat greater in urban areas, though not significantly so. For example, 10.6% of women overall, 9.6% in rural areas, and 17.1% in urban areas reported that they could visit a hospital or doctor in the community alone.

A high proportion of 54.1% overall, 54.2% in rural areas, and 53.5% in urban areas indicated that they could do so with their husband's permission. The ability to visit a hospital or doctor outside the community independently was mentioned less frequently. Notably, twice as many women in urban areas (15.8%) could visit a shop within the community compared to women in rural areas (7.9%).

A similar pattern emerged for visiting shops outside the community. Overall, 11% of women reported visiting friends or relatives within the community on their own, with 10% in rural areas and 17.2% in urban areas. These figures were two percentage points lower for visits to friends or relatives outside the community.

¹⁰ 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/>.

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	10.6	9.6	17.1
With husband's permission	54.1	54.2	53.5
With someone only	32.1	32.8	27.7
Cannot go at all/do not go	3.2	3.4	1.7
Total	100.0	100.0	100.0
Ability to visit hospital/doctor outside community			
On own	8.8	7.7	15.5
With husband's permission	49.1	49.2	48.8
With someone only	38.4	39.2	33.4
Cannot go at all/do not go	3.7	3.9	2.3
Total	100.0	100.0	100.0
Ability to go to a shop within community			
On own	9.0	7.9	15.8
With husband's permission	43.6	43.8	42.8
With someone only	33.1	33.2	33.1
Cannot go at all/do not go	14.3	15.2	8.4
Total	100.0	100.0	100.0
Ability to go to a shop outside community			
On own	7.8	6.8	13.9
With husband's permission	44.2	44.3	43.7
With someone only	33.6	33.7	33.5
Cannot go at all/do not go	14.4	15.3	8.9
Total	100.0	100.0	100.0
Ability to visit friends/relatives within community			
On own	11.0	10.0	17.2
With husband's permission	48.2	48.5	46.2
With someone only	36.2	36.6	33.5
Cannot go at all/do not go	4.6	4.9	3.1
Total	100.0	100.0	100.0
Ability to visit friends/relatives outside community			
On own	9.0	8.0	15.2
With someone only	48.8	49.0	47.0
With chaperone	37.8	38.3	34.6
Cannot go at all/do not go	4.5	4.7	3.2
Total	100.0	100.0	100.0
No. of ever-married women (Unweighted)	28,030	24,543	3,487

In the context of KP and the rest of Pakistan, women's freedom to visit independently, whether for a hospital appointment or to see a friend or relative, is uncommon. However, visiting with the husband's permission is the norm. Accompanying someone else is another option reported by a third or more of women. Generally, women in urban areas enjoy slightly greater freedom of movement, although the difference compared to their rural counterparts is minimal.

Regarding participation in decision-making, KPHPS inquired about who typically makes decisions about 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: 2.5%
2. Daily household purchases: 3.9%
3. Getting medical treatment for the respondent: 3.3%
4. Getting medical treatment for son: 2.3%
5. Getting medical treatment for daughter: 2.2%
6. Using household earnings: 2.7%
7. Using the respondent’s own earnings: 3.1%

It was interesting to note that even for decisions regarding their own earnings, only 3.1% reported making the choices independently, while husbands reportedly made decisions in 40.8% of cases. Due to the low numbers indicating “self” as the usual decision-makers, we grouped them into the category of “self or 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 HH purchases?			
Self or jointly with husband	39.3	38.4	45.5
Husband	42.8	43.5	38.4
Someone else	17.9	18.2	16.1
Total	100.0	100.0	100.0
Who usually makes decisions about daily HH purchases?			
Self or jointly with husband	41.3	40.2	48.0
Husband	41.1	41.9	36.3
Someone else	17.6	18.0	15.7
Total	100.0	100.0	100.0
Who usually makes decisions about getting medical treatment for the respondent?			
Self or jointly with husband	51.4	50.5	57.3
Husband	38.3	39.2	32.8
Someone else	10.3	10.3	9.9
Total	100.0	100.0	100.0
Who usually makes decisions about getting medical treatment for the son?			
Self or jointly with husband	53.2	52.2	59.6
Husband	39.0	39.9	33.6
Someone else	7.8	7.9	6.8
Total	100.0	100.0	100.0
Who usually makes decisions about getting medical treatment for the daughter?			
Self or jointly with husband	53.8	52.7	60.5
Husband	38.7	39.6	32.9
Someone else	7.6	7.8	6.5
Total	100.0	100.0	100.0
Who usually makes decisions about using HH earnings?			
Self or jointly with husband	51.9	51.0	57.8
Husband	41.1	41.9	36.2
Someone else	6.9	7.1	6.1
Total	100.0	100.0	100.0
Who usually makes decisions about using your own earnings?			
Self or jointly with husband	45.7	44.6	52.8
Husband	40.8	41.6	35.6
Someone else	13.6	13.9	11.6
Total	100.0	100.0	100.0
No. of ever-married women* (Unweighted)	27,848	24,377	3,471

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

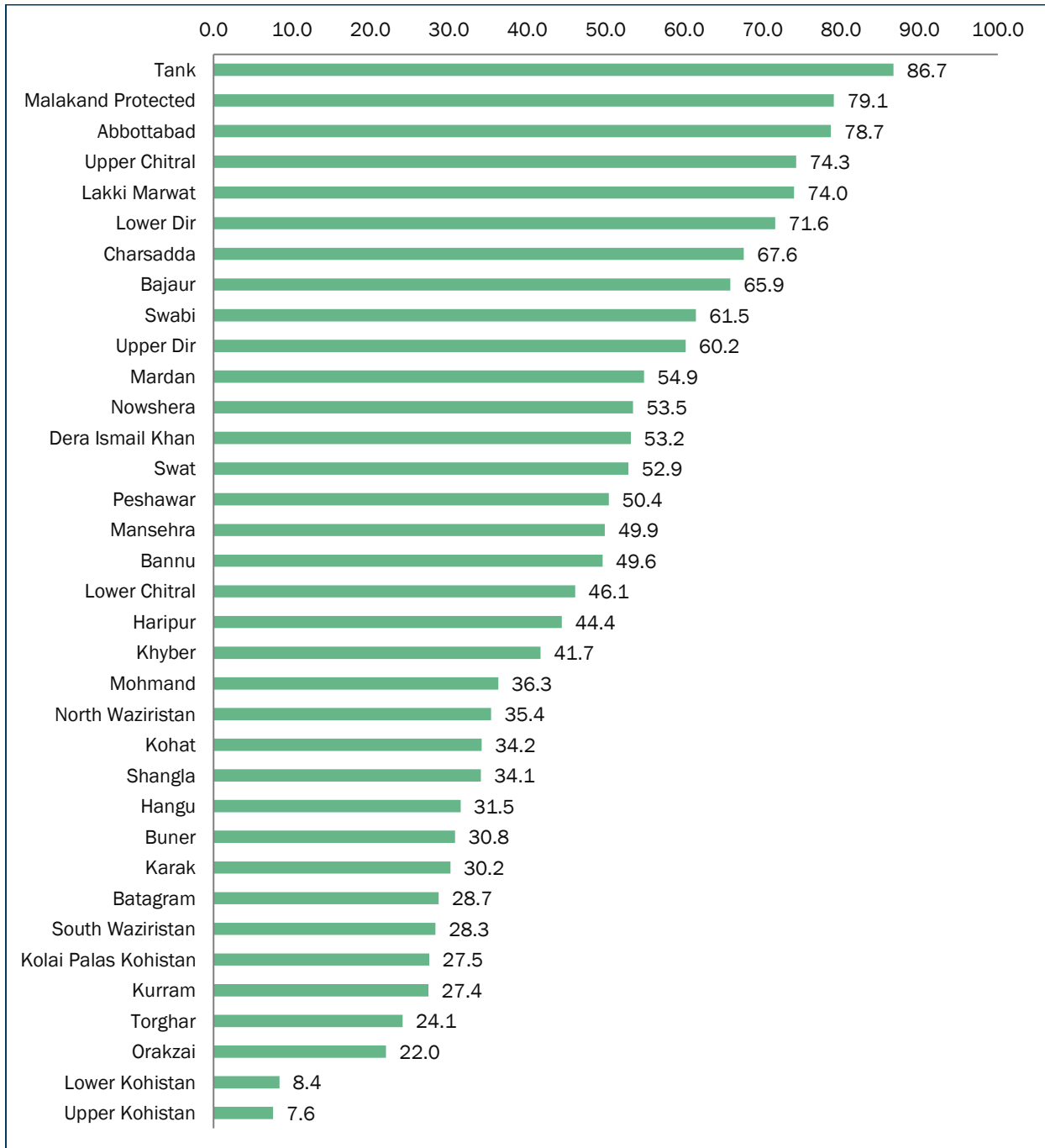
Women reported that husbands typically made decisions regarding major household purchases, accounting for 42.8% overall, and 43.5% in rural areas compared to 38.4% in urban areas. The second major category, “self or jointly with husband,” represented 39.3% overall, with 38.4% in rural areas and 45.5% in urban areas, indicating that joint decision-making was more prevalent in urban areas. Daily purchase decisions were made by husbands and jointly with respondents in nearly equal proportions (41.1% vs. 41.3%) overall. In urban areas, joint decision-making for daily purchases was higher (48%) than in rural areas (40.2%). Decisions regarding medical treatment for the respondent were made jointly in 51.4% of cases overall, while husbands were reported as the sole decision-makers in 38.3% of cases. A similar pattern was seen for decisions about medical treatment for sons and daughters.

Decisions about the use of household earnings were reportedly made by husbands alone in 41.1% of cases overall, with 41.9% in rural areas and 36.2% in urban areas. It is noteworthy that 40.8% of respondents reported that their husbands alone decided on the use of their [respondents'] earnings. Joint decision-making on the use of respondents' earnings was reported by 45.7% of women overall, with 44.6% in rural areas and 52.8% in urban areas.

The proportion of women making decisions about their medical treatment by themselves or jointly with their husbands varied significantly, ranging from less than 10% in Lower Kohistan and Upper Kohistan to over 70% in Lower Dir, Lakki Marwat, Upper Chitral, Abbottabad, Malakand Protected, and Tank (Figure 3.4).

Overall, few women typically make decisions independently on any matter, including the use of their own earnings. More women in urban areas than in rural areas reported joint decision-making across all matters. Husbands alone made most decisions, including those related to medical treatment for respondents. The self-reported data from women indicated a low degree of participation in decision-making and limited freedom of movement. It is possible that women attribute decision-making to their husbands even when they participate in joint decisions due to cultural norms.

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



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

Key Findings

Antenatal Care (ANC)

- 73% of women who had their last pregnancy within three years prior to the survey had at least one ANC visit.
- Only 22.2% women in KP, 19.2% of rural women, and 27% of urban women had four or more ANC visits during their last pregnancy.
- The coverage of “effective” ANC was low, at 6.1% overall, and remained below 10% for all subgroups except in urban areas (10%)—among women with secondary or higher education (12.6%) and among women in the highest wealth quintile (11.6%).
- Measuring blood pressure during ANC visits was widespread (71.5% overall; 69.9% in rural areas and 82% in urban areas), but breast examinations and weight measurements were less common (25.1% and 34.3%, respectively).
- Two doses of tetanus toxoid were received by 48.5% of women overall, 47.3% of rural women, and 55.6% of urban women.
- For all subgroups, except the poorest women, more women received ANC services from private facilities than from public ones.
- When ANC was received, doctors were the providers in 57.4% of the cases.

Delivery Care

- Overall, 81% of deliveries in the three years preceding the survey were attended by skilled health professionals.
- Two-thirds of deliveries with a skilled birth attendant (SBA) were assisted by a doctor.
- Cesarean sections accounted for 10.3% of deliveries.
- 24% of babies experienced skin-to-skin contact—Kangaroo mother care (KMC)—immediately after birth.

Postnatal Care

- 73% 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 had the lowest levels of postnatal care, at 57.9%. This was followed by women living in lagging districts at 59.2%, and those with no education at 69%.

Pakistan has made steady progress in reducing the maternal mortality ratio (MMR) from 419 per 100,000 live births in 2000 to 155 in 2023 (Figure 4.1).¹¹ However, an estimated 11,000 women died during pregnancy or within 42 days of pregnancy termination in 2023.¹² The 2019 Pakistan Maternal Mortality Survey estimated the MMR for KP (excluding the former Federally Administered Tribal Areas) at 165 per 100,000 live births. In comparison, the MMRs were 157 in Punjab, 224 in Sindh, and 298 in Balochistan.¹³

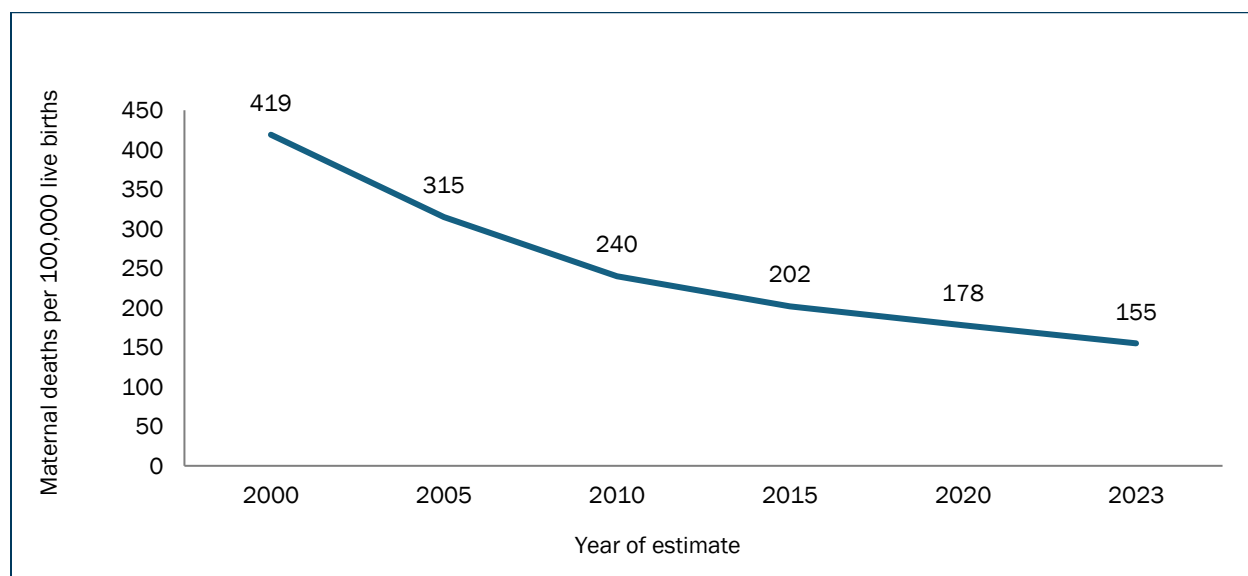
KP has a provincial policy and guidelines focused on reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH&N), as well as the KP Health Policy 2018–2025. Most maternal deaths are preventable. The World Health Organization (WHO) recommends access to reproductive health services, skilled birth attendance, and a continuum of quality care throughout all stages of pregnancy, childbirth, and the postpartum period. This chapter discusses three critical services for pregnant women: ANC, delivery care, and PNC. Together, these essential services significantly impact the survival and wellbeing of pregnant women and their newborns.

¹¹ Source: 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>.

¹² 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.”

¹³ National Institute of Population Studies (Pakistan) and ICF. (2020). *2019 Pakistan maternal mortality survey summary report*. <https://dhsprogram.com/pubs/pdf/SR267/SR267.pdf>.

Figure 4.1: MMR per 100,000 live births, 2000–2023



Source: 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>.

Antenatal Care (ANC)

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

Number of ANC Visits

There are encouraging signs regarding ANC utilization in KP. Seventy-three percent of women who had their last pregnancy within three years prior to the survey and those who were currently pregnant attended at least one ANC visit.

Nearly one-in-five women (20.2%) had four or more ANC visits during their most recent pregnancy, which aligns with progress towards the WHO's recommendation of a minimum of eight visits. Coverage was notably higher among specific groups, including women with secondary or higher education (34%) and those in the highest wealth quintile (32.9%). Additionally, urban women (27%), women in non-lagging districts (22.8%), and younger women aged 15–24 years (22.3%) exhibited relatively higher levels of ANC coverage (Figure 4.2). At the district level, Haripur excelled, with over half of pregnant women (52%) receiving four or more ANC visits (Figure 4.3).

Despite these positive trends, significant disparities persist (Table 4.1). A substantial 27% of women in KP had no ANC visit during their most recent pregnancy. Coverage of four or more ANC visits remains

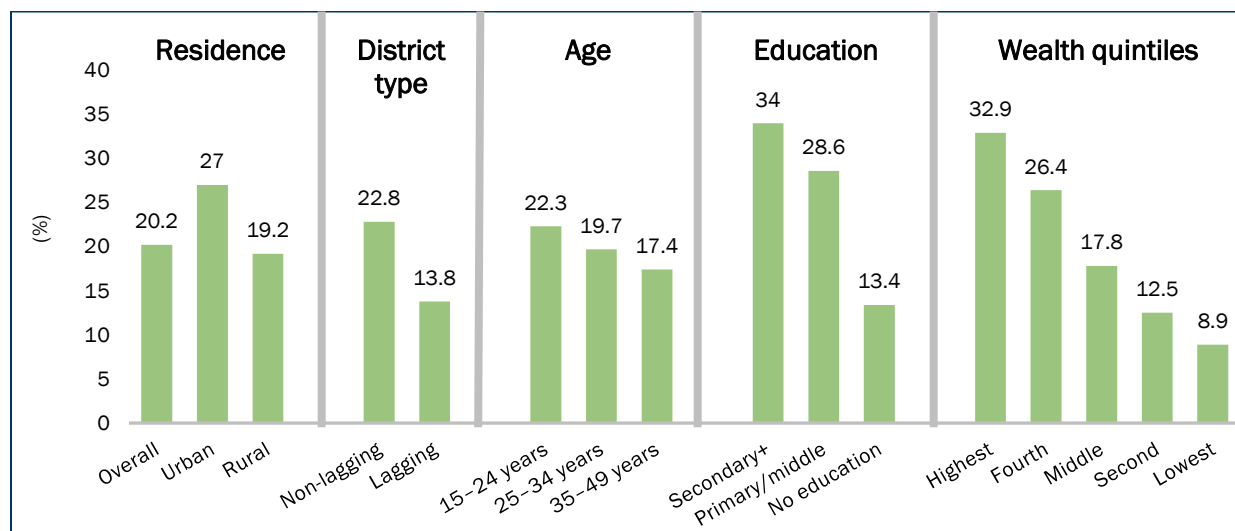
particularly low in rural areas (19.2%), lagging districts (13.8%), among older women aged 35–49 years (17.4%), women with no education (13.4%), and those in the poorest wealth quintile (8.9%). Stark district-level differences further illustrate these gaps: in Kolai Palas Kohistan, no woman reported having four or more ANC visits, compared to 52% in Haripur. In 16 of 35 districts, less than ten percent of women had four or more ANC visits, while in Kolai Palas Kohistan, South Waziristan, Upper/Lower Kohistan, Tank, and Dera Ismail Khan, less than three percent of women with a pregnancy in the three years preceding the survey met the minimum threshold of four ANC visits.

Table 4.1: Percentage distribution of women (by no. of ANC visits during their last pregnancy and background characteristics)

Background characteristics	No. of ANC visits				Total	No. of women (Unweighted)
	0 visits	1–3 visits	4 or more visits	Don't know		
Residence						
Overall	27.0	51.6	20.2	1.2	100	12,471
Rural	28.6	51.1	19.2	1.2	100	11,006
Urban	16.8	55.0	27.0	1.2	100	1,465
District type						
Lagging	46.7	38.6	13.8	0.9	100	5,666
Non-lagging	18.9	56.9	22.8	1.3	100	6,805
Age (years)						
15–24	21.8	54.7	22.3	1.3	100	3,883
25–34	28.9	50.3	19.7	1.1	100	6,301
35–49	32.1	49.1	17.4	1.4	100	2,287
Education						
No education	35.3	49.9	13.4	1.5	100	8,539
Primary/middle	13.3	57.2	28.6	0.9	100	1,736
Secondary or higher	13.8	51.5	34.0	0.8	100	2,196
Wealth quintiles						
Lowest	51.3	37.9	8.90	1.9	100	3,624
Second	32.5	53.2	12.5	1.8	100	2,478
Middle	26.8	54.6	17.8	0.8	100	2,320
Fourth	18.0	54.7	26.4	0.9	100	2,188
Highest	10.1	56.3	32.9	0.7	100	1,860

Note: The proportions 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 proportions 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 KP, 48.1% of the 7,472 women who were pregnant at the time of the survey or had been pregnant in the three years preceding the survey had their first ANC visit at two months of pregnancy or earlier (Table 4.2). This percentage increased to 52.9% when excluding the 9% of women who did not remember the timing of their visit. Additionally, 10.5% of women had their first ANC visit during the six-to-nine months period of pregnancy, which rose to 11.5% when excluding those who could not recall the timing. Urban-rural differences in the timing of the first ANC visit were modest.

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

Month of pregnancy when ANC received for first time	Total	Rural	Urban
≤ 2 months	48.1	48.1	47.8
3-5 months	32.5	32.1	34.9
6-9 months	10.5	10.7	9.5
Don't remember	9.0	9.2	7.8
Total	100.0	100.0	100.0
No. of women (Unweighted)	7,472	6,297	1,175

Note: The proportions 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) receipt of iron and folic acid supplements; (3) at least two tetanus injections; (4) blood pressure measurement; and (5) the collection of urine samples. Overall, effective ANC coverage was below ten percent for most groups (Table 4.3). The exceptions were urban areas (10%), women with secondary or higher education (12.6%), and women in the highest wealth quintile (11.6%). Effective ANC coverage in urban areas was twice that of rural areas, four 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.

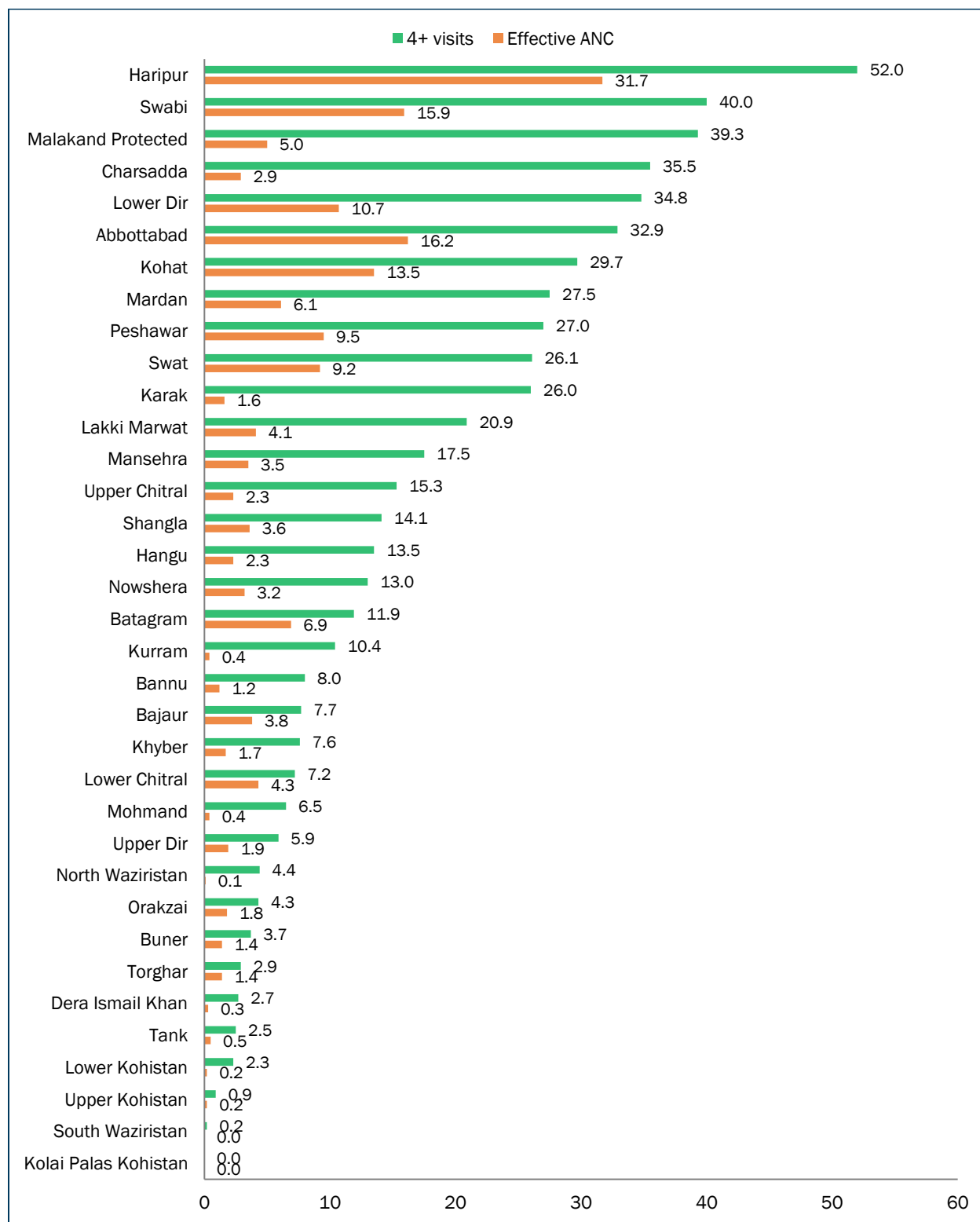
Low coverage of effective ANC was observed across all districts, although the levels varied (Figure 4.3). In nine of 35 districts (Kolai Palas Kohistan, South Waziristan, Mohmand, Kurram, North Waziristan, Dera Ismail Khan, Tank, Lower Kohistan, and Upper Kohistan), the proportion of women receiving effective ANC was less than one percent. In contrast, 15.2% of women received effective ANC in Swabi, and 31.7% in Haripur.

Table 4.3: Percentage of women with a completed pregnancy who received effective ANC during their last pregnancy (by background characteristics)

	Effective ANC coverage*	No. of women
Residence		
Overall	6.1	12,471
Rural	5.6	11,006
Urban	10.0	1,465
District type		
Lagging	3.9	5,666
Non-lagging	7.0	6,805
Age (years)		
15–24	6.8	3,883
25–34	5.9	6,301
35–49	5.6	2,287
Education		
No education	3.3	8,539
Primary/middle	8.8	1,736
Secondary or higher	12.6	2,196
Wealth quintiles		
Lowest	1.8	3,624
Second	3.5	2,478
Middle	5.0	2,320
Fourth	7.9	2,188
Highest	11.6	1,860

Note: The proportions 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 with a completed pregnancy who had four or more ANC visits and “effective ANC” during their last pregnancy (by district)



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

Quality of Antenatal Care

The majority of women (71.5%) reported that their blood pressure was measured during their last ANC visit in their most recent pregnancy (Table 4.4). Additionally, blood and urine samples were taken in 65.5% and 62.4% of cases, respectively. In 69.1% of cases, the provider performed an ultrasound, while a genital examination was conducted in 61.1% of cases, and fetal heart sounds were reportedly checked in 56%. However, a much lower proportion of women (34.3%) reported that providers measured their weight, 37.6% underwent a pelvic examination, and only 25.1% received a breast examination.

Table 4.4: Percentage of women who had a completed pregnancy (by type of service received during last ANC visit of their last pregnancy and by place of residence)

	Total	Rural	Urban
During visit to provider			
Blood pressure	71.5	69.9	82.0
Blood sample	65.5	64.1	75.2
Urine sample	62.4	61.3	69.8
Weight measured	34.3	33.1	42.7
Breast exam	25.1	24.5	29.3
Pelvic exam	37.6	36.4	45.5
Fetal heart sound	56.0	54.2	67.8
Ultrasound/anomaly scan	69.1	67.4	80.4
Condition of genitals checked	61.1	59.4	72.6
No. of women (Unweighted)	12,471	11,006	1,465

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

Tetanus Toxoid Injection

The WHO especially recommends that pregnant women receive at least two doses of tetanus toxoid during pregnancy to protect both the mother and the neonate against 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. Overall, 52.6% of women received one dose of tetanus toxoid, while 48.5% received the second dose (Table 4.5). A higher proportion of women in urban areas received two doses of tetanus toxoid compared to those in rural areas—55.6% versus 47.2%.

Table 4.5: Percentage of women with a pregnancy (by no. of tetanus injections received during last or current pregnancy)

	Total	Rural	Urban
Percentage receiving at least one tetanus injection			
Percentage of women	52.6	51.9	57.0
Times tetanus injection received during last or current pregnancy			
Once	30.9	31.9	26.0
Twice	48.5	47.2	55.6
Three or more times	11.5	11.2	13.0
Don't know	9.1	9.8	5.5
Total	100.0	100.0	100.0
No. of women (Unweighted)	3,797	3,140	657
No. of women (Unweighted)	7,472	6,297	1,175

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

Antenatal Care Service Provider

The place of last ANC visit during the previous pregnancy is shown in Table 4.6. Among all women who had a pregnancy in the three years preceding the survey, 31.3% received ANC care from a public sector provider, compared to 39.6% from a private provider. When excluding those who did not have an ANC visit, the proportions increased to 43.3% for public and 54.2% for private care. In all subgroups, except for the poorest women in the lowest and second-lowest wealth quintiles, more women accessed ANC from private sector facilities rather than public ones. The richest women in the highest wealth quintile used private facilities at a rate 30.2 percentage points higher than public facilities. This indicates that while the private sector is the preferred option, poorer women are constrained to choose public sector care due to their inability to pay additional fees in the private sector. Similarly, 51.6% of women with secondary or higher education received ANC from a private facility, compared to 31.8% who accessed care at a public facility.

Table 4.6: Percentage of women with one or more ANC visits during their most recent pregnancy (by type of ANC service provider and background characteristics)

	No visit	Public	Private	Community health worker*	Other	Total	No. of women (Unweighted)
Residence							
Overall	27.0	31.6	39.6	0.5	1.3	100	12,471
Rural	28.6	31.3	38.5	0.4	1.3	100	11,006
Urban	16.8	34.1	47.0	1.1	1.0	100	1,465
District type							
Lagging	46.7	22.7	29.8	0.1	0.8	100	5,666
Non-lagging	18.9	35.3	43.7	0.6	1.5	100	6,805
Age (years)							
15–24	21.8	31.9	44.5	0.7	1.2	100	3,883
25–34	28.9	31.8	37.5	0.5	1.5	100	6,301
35–49	32.1	30.8	36.1	0.1	1.0	100	2,287
Education							
No education	35.3	31.3	32.1	0.3	1.1	100	8,539
Primary/middle	13.3	32.7	52.2	1.0	0.7	100	1,736
Secondary/higher	13.8	31.8	51.6	0.5	2.3	100	2,196
Wealth quintiles							
Lowest	51.3	29.9	17.6	0.4	0.8	100	3,624
Second	32.5	35.5	30.9	0.3	0.8	100	2,478
Middle	26.7	31.3	40.3	0.8	0.9	100	2,320
Fourth	18.0	33.1	46.8	0.2	1.8	100	2,188
Highest	10.1	28.6	58.8	0.6	1.9	100	1,860

Note: The proportions 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 two-thirds of women received ANC from a skilled provider (Table 4.7). The proportion was higher among women in urban areas (74.4%) compared to those in rural areas (63.8%). Among the various healthcare providers, most women received ANC services from doctors: 57.4% overall, 68.8% in urban areas, and 55.7% in rural areas. Mid-level healthcare providers accounted for 15% of ANC services provided to women overall. A positive finding is the almost complete absence of traditional birth attendants (*dais*) as antenatal care providers, reflecting 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 ANC provider)

	% receiving ANC from skilled providers ^a	Skilled		Unskilled		Other ^c	No ANC visit reported	Total	No. of women (Unweighted)
		Doctor	CMW, LHV, FWW, nurse, Suraj worker ^b	LHW ^b	Dai/ traditional birth attendant				
Total	65.2	57.4	7.8	7.2	0.00	0.5	27.0	100	12,471
Rural	63.8	55.7	8.2	7.1	0.01	0.6	28.6	100	11,006
Urban	74.4	68.8	5.7	8.4	0.00	0.4	16.8	100	1,465

^a Doctors, CMWs, LHVs, FWWs, nurses, and Suraj workers.

^b CMW = community midwife; LHV = lady health visitor; FWW = family welfare worker; LHW = lady health worker.

^c Family welfare counselors, family welfare assistants, Pehli Kiren workers, Marvi workers, and dispensers/ compounders.

Type of Advice Received During Antenatal Checkup

Table 4.8 shows that women in KP do not fully benefit from ANC check-ups regarding essential advice and information on critical aspects of pregnancy care. Among women who completed a pregnancy in the three years preceding the survey, 53.9% reported receiving information and advice on nutrition and healthy eating, while 50.9% received guidance on the use of iron tablets or syrup. Advice on anemia and tetanus toxoid injections was reported by 44.1% and 42.1% of women, respectively. Information on danger signs during pregnancy and appropriate responses was reported by 31.6% and 29% of women, respectively. Additionally, 32.5% received advice on breastfeeding, and 30.1% on birth preparedness and delivery planning. Information on birth spacing and PFP was notably lacking; only 19% reported receiving advice on the importance of birth spacing, 18% on contraceptive use, and 12.4% on PFP. Furthermore, only 17.2% of women reported receiving information and advice on childhood anemia. The data indicated that more women in urban areas received information on each topic compared to those in rural areas, highlighting the inequity in the provision of advice and information.

Table 4.8: Percentage of women who had a complete pregnancy and 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	53.9	52.6	63.0
Anemia among mothers	44.1	43.2	50.1
Tetanus toxoid shots	42.1	40.9	50.6
Use of iron tablets/syrup	50.9	49.3	61.4
Danger signs during pregnancy	31.6	30.2	41.0
What to do if danger signs seen	29.0	28.0	36.0
Birth preparedness/delivery plan (money, transport, attendant, place of delivery)	30.1	29.1	36.3
Importance of birth spacing	19.0	18.0	25.2
Importance of contraceptive use	18.0	17.2	23.2
PPFP	14.2	13.8	16.7
Counseling for husbands regarding family planning	12.4	12.1	14.4
Child's anemia	17.2	16.7	20.8
Breastfeeding	32.5	31.1	41.8
No. of women (Unweighted)	12,471	11,006	1,465

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

Health Problem(s) Experienced During Last Pregnancy

A small proportion of 7.1% of women who were currently pregnant or had recently completed a pregnancy within three years before the survey reported experiencing serious health problems. The main health issues reported were: (1) weakness (35%); (2) severe or prolonged vomiting (31.9%); (3) a diagnosis of anemia (28.9%); and (4) high blood pressure and/or severe headaches (19.9%) (Table 4.9). Urban-rural differences were evident in the types of health problems reported. More rural women experienced severe or prolonged vomiting, blurred vision, facial swelling, severe lower abdominal pain, spotting, heavy vaginal bleeding, seizures or convulsions, weakness, and unconsciousness. In contrast, more urban women reported shortness of breath, severe headaches, and diagnoses of anemia compared to their rural counterparts.

Among those who experienced a health problem, 38.4% sought initial treatment from a public facility, while 38.6% sought treatment from a private facility. Approximately 20.5% did not seek any treatment for their pregnancy-related issues.

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			
	7.1	7.0	8.1
Health problems faced during current or last pregnancy among those who reported problems			
Severe/prolonged vomiting	31.9	32.6	27.3
Shortness of breath	10.7	9.8	16.6
Severe headache	19.9	19.8	21.0
Blurred vision	9.0	10.4	1.1
Facial swelling	9.5	10.2	5.3
Severe lower abdominal pain	11.8	12.7	6.6
Spotting	6.4	7.1	2.4
Heavy vaginal bleeding	3.2	3.8	0.0
High fever with or without rigors	3.6	3.5	4.1
High blood pressure	19.9	20.4	16.8
Fits/convulsions	1.0	0.9	1.5
Unconsciousness	5.1	5.7	1.3
Weakness	35.0	37.5	21.0
Anemia	28.9	27.9	34.6
Others	4.3	4.0	6.3
Total	100.0	100.0	100.0
First source of treatment for any serious health problems among those who experienced problems			
Nowhere	20.5	20.8	19.1
Public facility	38.4	38.6	37.0
Private facility	38.6	38.6	38.7
Community health workers*	0.9	0.4	3.6
Others	1.7	1.7	1.6
Total	100.0	100.0	100.0
No. of women (Unweighted)	12,471	11,006	1,465

Note: The proportions 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, which encompasses newborn care and the management of complications during pregnancy, labor, or the postpartum period. KPHPS gathered information on key aspects of delivery care, summarized below.

Institutional Deliveries

The WHO recommends that women deliver with a skilled birth attendant (SBA) at a health facility, as deliveries in such settings are less likely to encounter complications and infections that could endanger the lives of the mother, baby, or both. The national and KP MNCH programs emphasize the importance of facility-based deliveries and promote this through community health workers, such as LHWs. Traditionally, women in Pakistan, especially in rural areas of KP, have delivered at home. However, due to concerted efforts and the expansion of services, home deliveries have declined, with only one in five 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	18.7	43.9	35.5	2.0	100	11,417
Rural	20.0	43.9	34.2	1.9	100	10,071
Urban	9.6	43.8	44.3	2.2	100	1,346
District type						
Lagging	34.4	38.1	26.2	1.4	100	5,206
Non-lagging	12.1	46.3	39.4	2.2	100	6,211
Age (years)						
15–24	15.1	45.1	38.3	1.5	100	3,381
25–34	19.3	44.3	34.2	2.3	100	5,904
35–49	23.7	40.4	33.9	2.1	100	2,132
Education						
No education	24.2	44.7	29.4	1.7	100	7,903
Primary/middle	11.1	43.9	43.6	1.4	100	1,536
Secondary or higher	7.5	41.1	48.0	3.4	100	1,978
Wealth quintiles						
Lowest	36.8	44.4	16.7	2.1	100	3,393
Second	20.1	48.9	29.1	1.9	100	2,290
Middle	19.4	44.6	35.0	1.0	100	2,112
Fourth	12.5	44.3	40.9	2.2	100	1,956
Highest	6.2	37.6	53.6	2.6	100	1,666

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

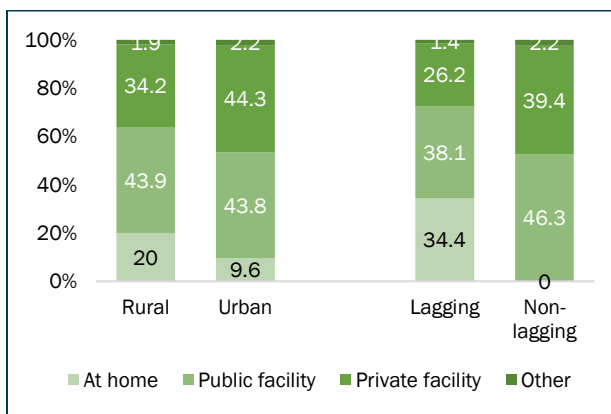
*Nutrition assistants, vaccinators, Suraj workers, Pehli Kiren workers, Marvi workers, *hakims*/homeopaths, and pharmacists/chemists.

Institutional deliveries are prevalent in KP. This marks a significant shift away from the tradition of home deliveries. Home deliveries are twice as common in rural areas compared to urban areas (20% vs. 9.6%) and three times more likely in lagging districts than in non-lagging districts (34.4% vs. 12.1%).

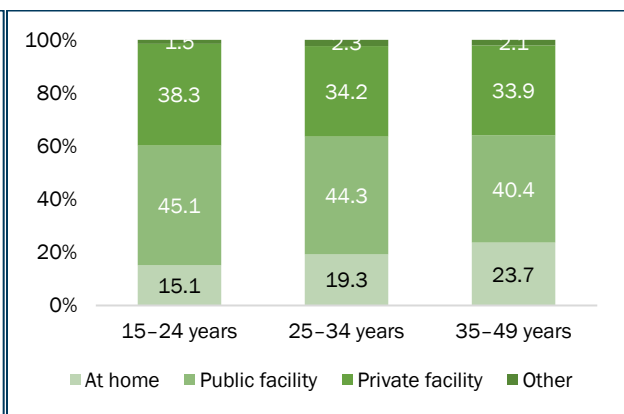
Older women aged 35–49 years are more likely to have home deliveries than younger women aged 15–24 years (23.7% vs. 15.1%). In addition, more women with no education report delivering at home (24.2%) compared to those with primary/middle or secondary/higher education (11.1% and 7.5%, respectively). The most significant disparity was observed by wealth quintile, with 36.8% of women in the lowest wealth quintile delivering at home versus 6.2% in the highest quintile. Importantly, more women across all subgroups—except those with secondary or higher education and those in the highest wealth quintile—delivered their last birth at a public facility rather than a private one. Figure 4.4 illustrates the differences in the place of the last delivery based on background characteristics.

Figure 4.4: Percentage of deliveries (by place of residence and district type and women’s age, education, and wealth quintile)

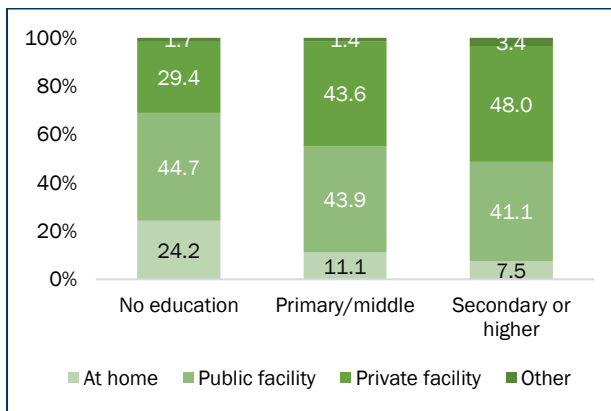
(a) Place of residence and district



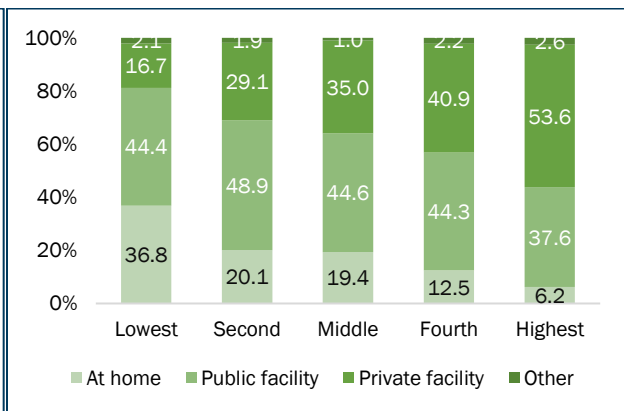
(b) Women’s age (years)



(c) Women’s educational level



(d) 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, midwives) ensures timely management and treatment of complications. Due to its critical role in saving mothers' lives, Sustainable Development Goal (SDG) 3.1 aims to reduce the global MMR to less than 70 per 100,000 live births by 2030. To monitor progress towards this goal, the proportion of births attended by SBAs has been adopted as a key indicator.

In KP, an impressive 81% of deliveries in the three years preceding the survey were attended by SBAs (Table 4.11). The proportion of births attended by SBAs was 11.4 percentage points higher in urban areas compared to rural areas, and 20.1 percentage points higher in non-lagging districts than in lagging districts. A greater percentage of young women aged 15–24 years (84%) received assistance from skilled attendants during delivery, compared to those aged 35–49 years (76.4%). Differences by education and wealth quintile were even more pronounced: 75.6% of women with no formal education compared to 91.8% of women with secondary or higher education, and 60.8% of women in the lowest wealth quintile compared to 93.2% in the highest wealth quintile. Deliveries at health facilities, whether public or private, were closely linked to those attended by SBAs. Figure 4.5 illustrates the percentage of deliveries attended by SBAs and those occurring in health facilities, broken down by background characteristics.

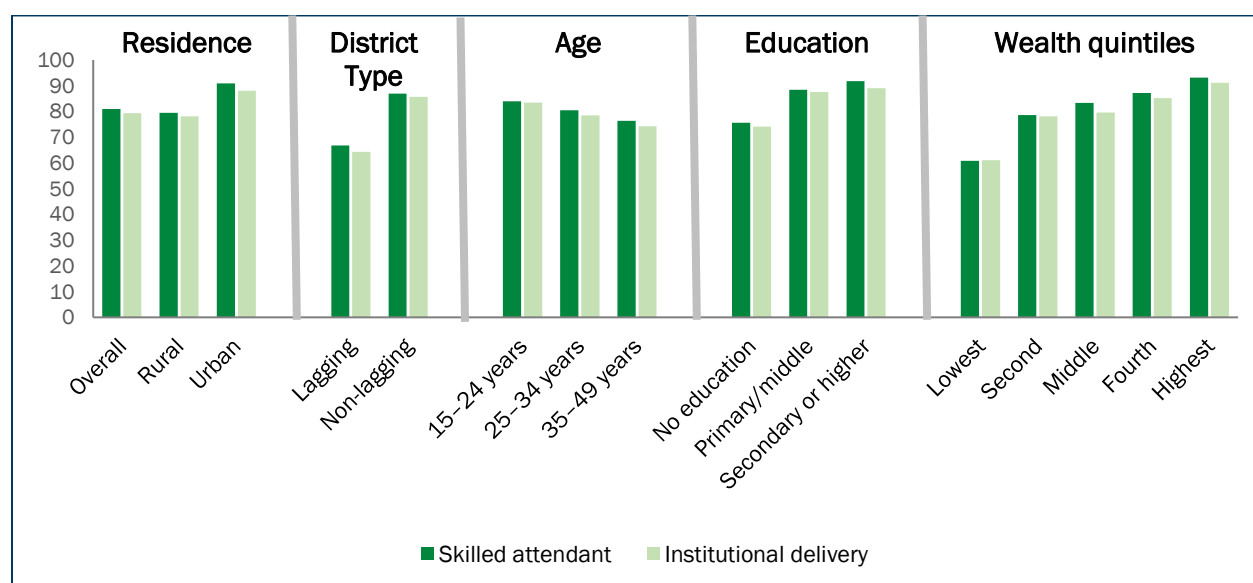
By district, the proportion of deliveries assisted by SBAs varied significantly, from a low of 8.8% in Upper Kohistan to a high of 99.7% in Shangla (Figure 4.6). In Upper Kohistan, Torghar, and Kolai Palas Kohistan, fewer than 20% of deliveries were assisted by SBAs. In contrast, nine districts—Mardan, Tank, Swabi, Swat, Lower Dir, Kohat, Hangu, Abbottabad, and Shangla—reported proportions exceeding 90%. In the remaining 23 districts, the percentages ranged from 49% in South Waziristan to 89.9% in Haripur.

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	79.4	81.0	11,417
Rural	78.1	79.5	10,071
Urban	88.1	90.9	1,346
District type			
Lagging	64.3	66.8	5,206
Non-lagging	85.7	86.9	6,211
Age (years)			
15–24	83.5	84.0	3,381
25–34	78.5	80.5	5,904
35–49	74.3	76.4	2,132
Education			
No education	74.1	75.6	7,903
Primary and middle	87.5	88.4	1,536
Secondary or higher	89.1	91.8	1,978
Wealth quintiles			
Lowest	61.1	60.8	3,393
Second	78.1	78.6	2,290
Middle	79.6	83.3	2,112
Fourth	85.2	87.2	1,956
Highest	91.2	93.2	1,666

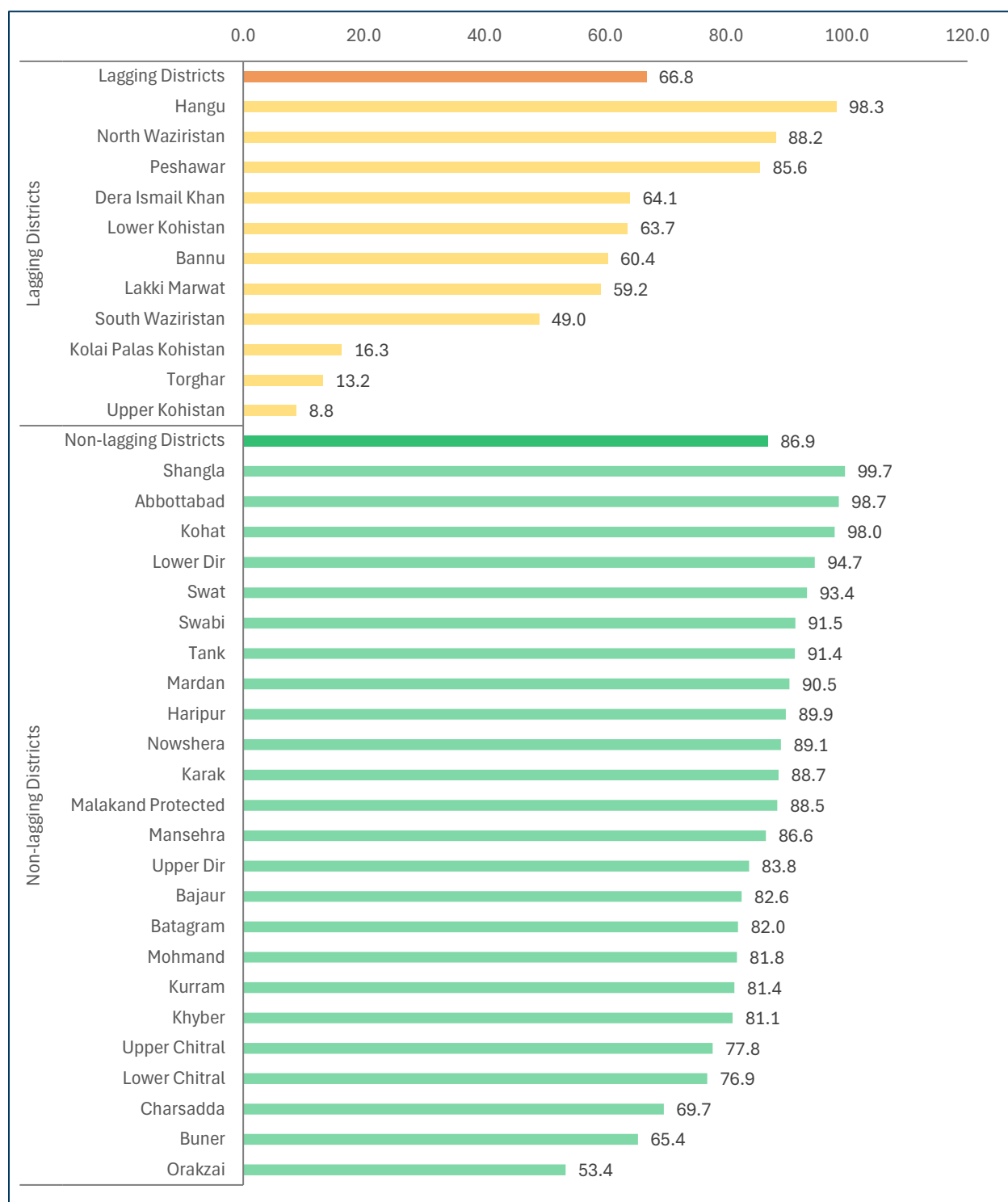
Note: The proportions in this table were calculated for women who had a delivery in the three years preceding the survey.

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



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

Type of Birth Attendants

Two-thirds of deliveries were assisted by doctors (Table 4.12), followed by mid-level healthcare providers, including CMWs, LHVs, FWWs, nurses, and Suraj workers. In 12.3% of cases overall, deliveries were assisted by a female friend, relative, or neighbor, with the percentage rising to 13.6% in rural areas and dropping to 3.5% in urban areas. Deliveries by doctors were 15.2 percentage points more common in urban areas compared to rural areas. In rural regions, a greater proportion of women received assistance from a female relative, friend, or neighbor (13.6%) than from a mid-level healthcare professional.

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

	Percentage delivered by a skilled provider ^a	Skilled		Unskilled			Other ^b	Total	No. of women (Unweighted)
		Doctor	CMW, LHV, FWW, nurse, Suraj worker	LHW	Dai/traditional birth attendant	Female relative, friend, neighbor			
Total	81.0	68.9	12.1	5.3	0.8	12.3	0.6	100	11,417
Rural	79.5	66.9	12.6	5.4	0.9	13.6	0.7	100	10,071
Urban	90.9	82.1	8.8	4.8	0.8	3.6	0.0	100	1,346

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

^a Doctors, CMWs, LHVs, FWWs, nurses, and Suraj workers.

^b Family welfare counselors, family welfare assistants, Pehli Kiren workers, Marvi workers, and others.

Type of Delivery by Place of Delivery

According to a WHO statement on Cesarean section rates since 1985, the international healthcare community has deemed the ideal rate for Cesarean sections to be 10–15%. Table 4.13 shows that 10.3% of all deliveries in KP were conducted by Cesarean section, with a significantly higher prevalence in urban areas (14.9%) compared to rural areas (9.6%). This urban-rural difference likely reflects better availability of surgical obstetric services and greater health-seeking behavior in urban settings. When examined by facility type, the rate of Cesarean sections was higher in private facilities (15.2%) than in public facilities (10.2%). This disparity may be attributed to several factors, including differences in clinical practices, financial incentives, and patient preferences in private settings. Although the rates fell within the acceptable range, the data suggested a need for closer monitoring of Cesarean section rates, especially in urban areas, to ensure that the procedure is performed based on medical necessity rather than provider convenience or non-clinical considerations (Table 4.13).

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	89.7	0.3	100	11,417
Rural	90.4	9.6	100	10,071
Urban	85.1	14.9	100	1,346
Place of delivery				
At home	100.0	0.0	100	3,246
Public facility	89.8	10.2	100	4,757
Private facility	84.8	15.2	100	3,216

Note: The proportions 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 5.1%, who reported experiencing at least one serious health complication. The prevalence was slightly higher in rural areas (5.2%) compared to urban areas (4.5%) (Table 4.14)

Among the women who reported complications, high fever (61.7%) and high blood pressure (50.6%) were the most frequently cited problems. These were followed by prolonged labor (40.8%), excessive bleeding after birth (38.1%), and excessive bleeding before birth (38.6%). A notable share of women also reported low hemoglobin levels (anemia) (35.9%), breech presentation (24.4%), convulsions (21.4%), and retained placenta (18.5%).

Among women in rural areas who reported health problems, 62.5% experienced high fever, 50.1% had high blood pressure, 41.1% faced prolonged labor, 38.5% encountered excessive bleeding before birth, and 38.1% experienced excessive bleeding after birth. In urban areas, the most common health issues reported were high fever and high blood pressure (55.1%), followed by complications from anemia (42.6%), excessive bleeding after birth (42.1%), and excessive bleeding before birth (9.9%).

Among women in rural areas who reported experiencing health problems, 62.5% experienced high fever, 50.1% had high blood pressure, 41.1% faced prolonged labor, 38.5% encountered excessive bleeding before birth (38.5%), and 38.1% experienced excessive bleeding after birth. In urban areas, the most common health issues reported were high fever and high blood pressure 55.1%, followed by complications from anemia (42.6%), excessive bleeding after birth (42.1%), and excessive bleeding before birth (9.9%).

When asked about their first source of treatment for any serious health problems, 44.6% of women sought care from public facilities, while 27.0% approached private providers. A significant one-fourth

(25.2%) did not seek care from any source, reflecting potential barriers to access, awareness, or affordability. Urban women showed slightly higher reliance on public facilities (46.9%) compared to rural women (44.3%), and a lower reliance on private care (23.0% vs. 27.5%).

The data reveal that the majority of the respondents who reported experiencing serious complications during their last delivery cited high-grade fever as one of the symptoms. The self-reported prevalence was 7 percentage points higher among rural women compared to their urban counterparts. This high incidence of postpartum fever is a significant public health concern, as it often signals underlying maternal infections and, if not managed promptly, can lead to severe morbidity or even mortality.

High-grade fever following childbirth may result from a variety of underlying conditions, most of which are infectious in nature. The most common cause includes puerperal sepsis, a bacterial infection of the genital tract that occurs after delivery, usually due to poor hygiene during labor and delivery or retained placental fragments.

While the overall incidence of reported complications may appear low, the notably high frequency of high-grade fever among postpartum women in Khyber Pakhtunkhwa points to serious gaps in 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			
	5.1	5.2	4.5
Type of health problems faced (MRV)			
Excessive bleeding before birth	38.6	38.5	39.9
Excessive bleeding after birth	38.1	37.5	42.1
Convulsions	21.4	20.5	28.1
Retained placenta	18.5	17.2	29.1
High fever	61.7	62.5	55.1
High blood pressure	50.6	50.1	55.1
Prolonged labor	40.8	41.1	38.7
Breech	24.4	23.5	31.3
Low hemoglobin count	35.9	35.0	42.6
No. of women reporting health problem(s)	615	545	70
First source of treatment for any serious health problems			
No where	25.2	25.2	25.1
Public	44.6	44.3	46.9
Private	27.0	27.5	23.0
Other	3.2	3.0	5.1
Total	100.0	100.0	100.0
No. of women (Unweighted)	11,417	10,071	1,346

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

Postnatal Care (PNC)

Postnatal care (also termed postpartum) is a critical phase for both the mother and newborn. Therefore, the continuation of high-quality care during this period is essential for ensuring their wellbeing, monitoring progress, and preventing and treating complications such as severe bleeding and infections. The WHO’s recommendations on maternal and newborn care for a positive postnatal experience, published in 2022, advise that the first postnatal checkup should occur within 24 hours of birth, followed by three additional checkups on day 3 (48–72 hours), between 7 and 14 days, and six weeks later. These postnatal checkups are designed to assess various physical and emotional symptoms, including vaginal bleeding and micro-nutritional needs, while also monitoring the baby’s growth.

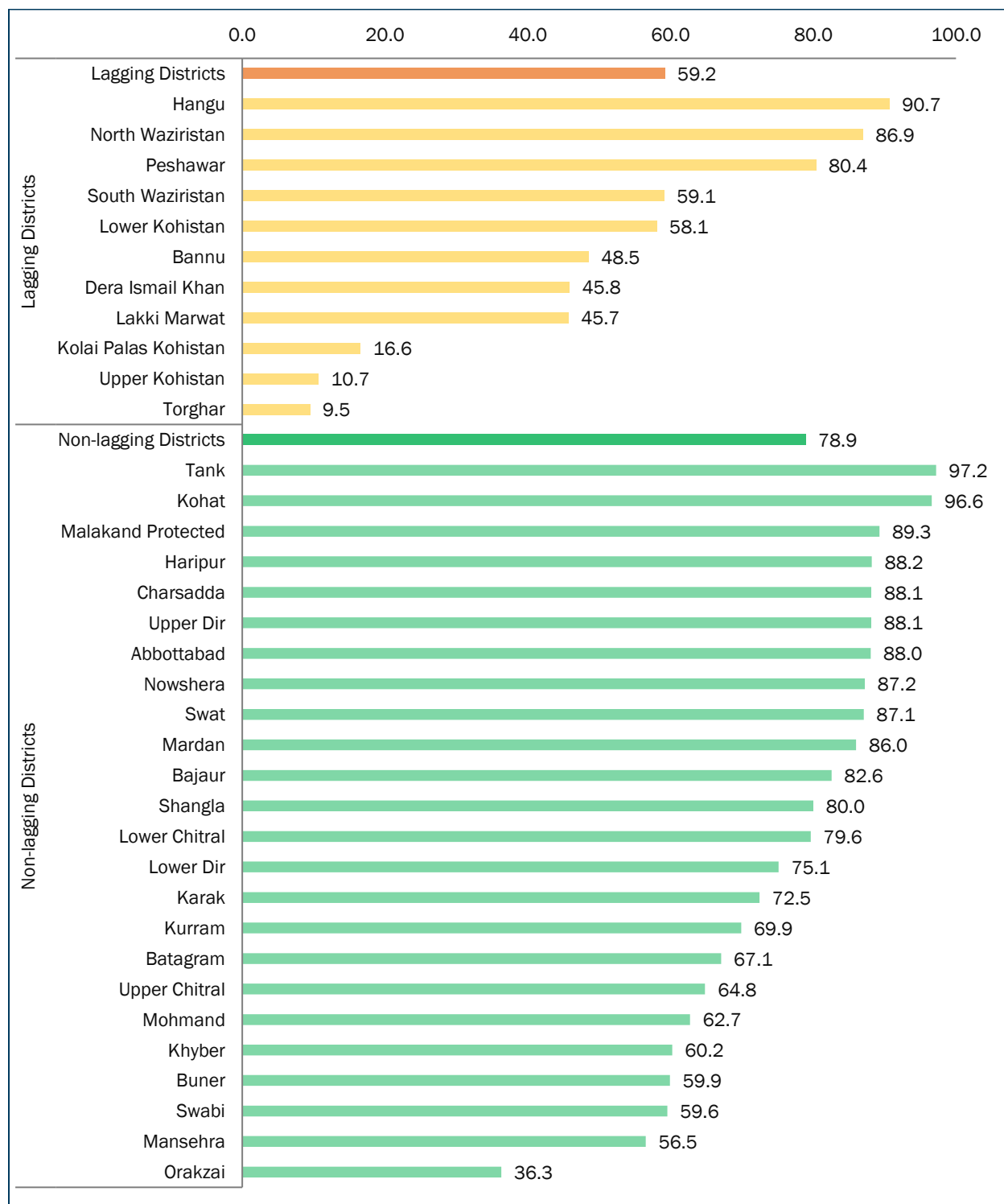
In alignment with WHO recommendations, 73.1% of women who had a live birth in the three years prior to the survey received a PNC checkup (Table 4.15). However, nearly a quarter did not receive this care. Among women who delivered at a healthcare facility, 11.7% did not receive a PNC checkup. The corresponding figure for women who delivered at home was 93.4%. The percentage of women who had a live birth in the three years preceding the survey and received postnatal care varied significantly by district (Figure 4.7). In Kolai Palas Kohistan, Upper Kohistan, and Torghar, less than 20% of women with a live birth during this period had a postnatal checkup. Conversely, over 90% of women received a postnatal checkup in Hangu, Kohat, and Tank.

Table 4.15: Percentage of women who had a live birth (by receipt of PNC and place of last delivery)

	PNC received		PNC not received		Total	
	%	N (Unweighted)	%	N (Unweighted)	%	N (Unweighted)
Overall	73.1	7,345	26.9	4,078	100.0	11,423
Health facility	88.3	7,190	11.7	984	100.0	8,174
At home	6.6	155	93.4	3,094	100.0	3,249

Note: The proportions 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 PNC following their last birth (by district)



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

Timing of First Postnatal Checkup

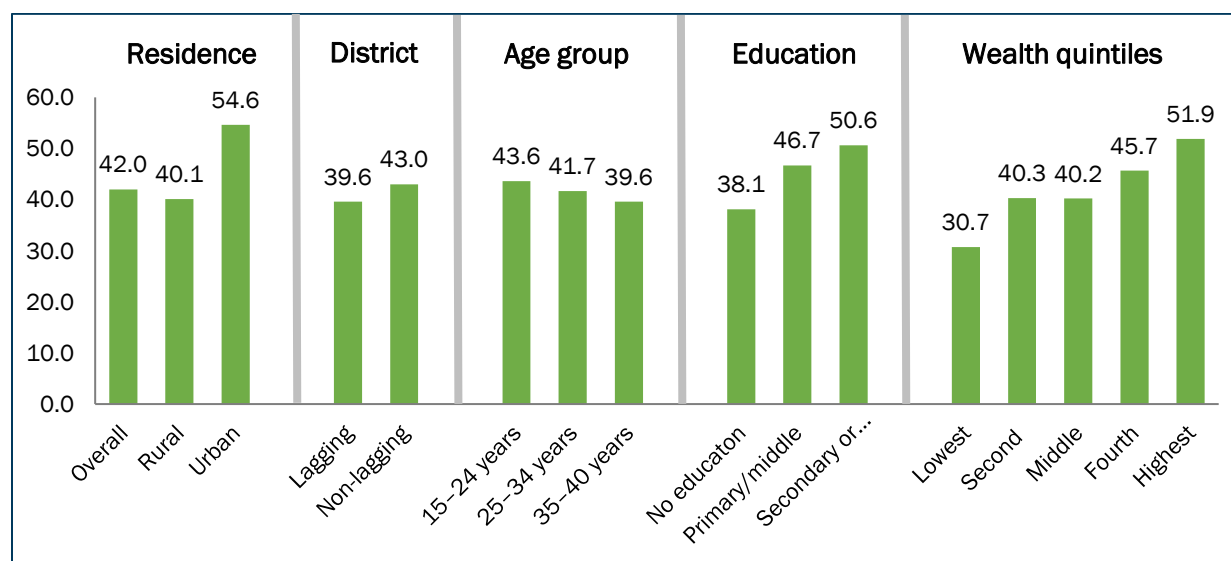
Overall, 42% of women who delivered had their first postnatal checkup within 24 hours (Figure 4.8). However, the timing of the first checkup varied by background characteristics (Table 4.16). The largest difference in the percentage of women having their first postnatal checkup within 24 hours of birth was found between those in the lowest and highest wealth quintiles—30.7% vs. 51.9%, a gap of 21.2 percentage points. While 54.6% of women in urban areas had their first postnatal checkup within 24 hours, the figure for rural women was 40.1%. Women with no education were 12.5 percentage points less likely to have their first postnatal checkup within 24 hours compared to those with secondary or higher education. It is important to note that fewer than four percent of women overall received a fourth or fifth PNC visit. These visits are particularly 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.

An analysis by wealth quintile revealed significant disparities. Among women in the lowest wealth quintile, only 1.9% received a fourth PNC visit, and 1.1% received a fifth. In comparison, among women in the highest wealth quintile, the proportions were slightly higher, at 3% for the fourth visit and 3.2% for the fifth.

Three groups of women had large proportions without any postnatal checkup: women in the lowest wealth quintile (42.1%), women living in lagging districts (40.8%), and those with no education (31%).

Among all women who received at least one postnatal checkup, doctors were the most cited providers, accounting for 71.5% overall, 70.5% for rural women, and 77.7% for urban women (Table 4.17). Nurses were the next most frequently cited providers of postnatal care, representing 9.2% of all women, 9.9% of rural women, and 5% of urban women.

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 proportions 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	7–41 days	Don't know/ remember	No PNC	Overall	No. of women (Unweighted)	% of women with postnatal check on first day after delivery
Overall	38.3	3.7	15.7	2.3	2.5	10.5	26.9	100.0	11,423	42.0
Residence										
Rural	36.6	3.5	15.7	2.3	2.5	10.9	28.4	100.0	10,093	40.1
Urban	49.4	5.2	16.0	2.3	3.0	7.5	16.7	100.0	1,330	54.6
District type										
Lagging	35.1	4.5	8.7	1.7	1.1	8.1	40.8	100.0	5,210	39.6
Non-lagging	39.6	3.4	18.7	2.6	3.1	11.4	21.1	100.0	6,213	43.0
Age (years)										
15–24	40.0	3.6	16.3	2.4	3.1	10.5	24.1	100.0	3,382	43.6
25–34	38.0	3.7	15.4	2.1	2.3	10.6	27.8	100.0	5,905	41.7
35–49	35.7	3.9	15.9	3.0	1.9	10.1	29.5	100.0	2,132	39.6
Education										
No education	34.8	3.3	15.4	2.2	2.1	11.3	31.0	100.0	7,908	38.1
Primary/middle	41.8	4.9	14.5	2.2	3.4	9.9	23.3	100.0	1,536	46.7
Secondary or above	46.6	4.0	18.2	2.8	3.1	8.4	16.9	100.0	1,979	50.6
Wealth quintiles										
Lowest	27.6	3.2	14.2	1.9	1.1	10.0	42.1	100.0	3,409	30.8
Second	36.7	3.6	15.8	2.0	2.3	12.6	27.1	100.0	2,280	40.3
Middle	37.1	3.2	16.2	2.3	2.3	10.7	28.2	100.0	2,112	40.3
Fourth	41.3	4.3	16.1	2.3	3.5	9.7	22.7	100.0	1,969	45.6
Highest	47.6	4.3	16.3	3.0	3.2	9.5	16.0	100.0	1,653	51.9

Note: The proportions 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				
MBBS doctor	71.5	5,624	70.5	77.7
LHW	2.8	234	2.9	2.0
CMW	3.7	299	3.8	3.4
Suraj worker	0.3	37	0.4	0.1
Nurse	9.2	966	9.9	5.0
Others ^a	12.5	1,055	12.6	11.8
Overall	100.0	8,215	100.0	100.0

Note: The proportions 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 FWWs, Pehli Kiren workers, Marvi workers, LHVs, untrained traditional birth attendants/*dais*, and dispensers.

Postpartum Family Planning Counseling and Family Planning Service Provision

The proportion of women who delivered in a facility and reported receiving counseling on family planning before leaving was 7.6% overall, with 7.4% in rural areas and 9.2% in urban areas (Table 4.18). Among the women who received counseling, 32.6% overall and 35.4% in rural areas were informed about injectables. In urban areas, the withdrawal method was the most commonly discussed (26.1%), followed by condoms (18.4%) and injectables (17.3%).

While the adoption of family planning is an individual choice, providing information falls squarely within the responsibilities of healthcare providers. Not only is information and counseling lacking for the overwhelming majority of women who delivered in facilities, but when counseling is provided, it is limited to a narrow range of methods.

Table 4.18: Percentage of women who delivered at a health facility and reported on post-delivery family planning (by rural/urban residence)

	Total	Rural	Urban
Percentage that received family planning counseling before leaving facility	7.6	7.4	9.2
No. that received family planning counseling for method before leaving facility (Unweighted)	757	644	113
Counseling for contraceptive methods*			
Injectables	32.6	35.4	17.3
Condoms	18.1	18.0	18.4
Withdrawal	14.1	11.9	26.1
Oral pills	11.6	12.3	8.1
Intrauterine devices (IUDs)	6.6	6.8	5.3
Sterilization	6.6	6.4	7.5
Lactational amenorrhea	4.6	3.3	11.2
Syana Press	2.2	2.3	1.4
Others	3.8	3.6	4.7
Total	100.0	100.0	100.0
Percentage referred to another facility for family planning services	4.4	4.5	3.7
No. of women (Unweighted)	11,417	10,071	1,346

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

* Multiple response variable.

Postpartum Family Planning Counseling and Method of Provision by Place of Residence

Table 4.19 presents data from the KPHPS 2024–25 on the receipt of PFP counseling and contraceptive methods among women who had a live birth in the three years preceding the survey, disaggregated by place of residence.

Less than one in five women (19.3%) reported receiving family planning counseling after delivery, whether during a postnatal check-up or separately. The proportion was slightly higher in urban areas (20.7%) compared to rural areas (19.1%). A vast majority of women (80.7%) reported not receiving any PFP counseling, with minimal differences across residence types.

In terms of timing, counseling most frequently occurred within 48 hours of delivery (14.8%), followed by more than six weeks to one year postpartum (11.1%) and between 49 hours and six weeks (10.8%). Urban women were slightly more likely to receive counseling within 48 hours compared to their rural counterparts (17.4% vs. 14.5%).

When examining the provision of contraceptive methods, only 5.5% of women overall reported receiving a method after delivery, with almost no difference between rural (5.5%) and urban (5.1%) women. This reflects a significant missed opportunity in postpartum contraceptive service delivery.

The timing of method provision followed a similar trend, with the majority of women who received a method doing so within 48 hours (4.8%), followed by 49 hours to six weeks (4.5%), and after six weeks up to one year (4.1%). Urban-rural differences in timing were negligible.

Regarding the types of contraceptive methods provided, injectables (1.7%) and male condoms (1.2%) were the most commonly received methods. Female sterilization (0.3%), IUDs (0.4%), and oral pills (0.6%) were far less common, and virtually no women reported receiving implants. Urban women were more likely to receive male condoms, while injectables were more commonly reported in rural areas.

These findings highlight substantial gaps in both the counseling and provision of family planning services during the postpartum period, particularly for rural women.

Table 4.19: Percentage of women who had a delivery and reported receiving PFP services during the check-up or otherwise, and timing of receiving counseling (by rural/urban residence)

	Total		Rural		Urban	
	%	N (Unweighted)	%	N (Unweighted)	%	N (Unweighted)
Family planning counseling received						
Counseling provided	19.3	1,994	19.1	1,721	20.7	273
Counseling not provided	80.7	9,429	80.9	8,372	79.3	1,057
Overall	100.0	11,423	100.0	10,093	100.0	1,330
Timing of receiving family planning counseling after delivery						
Within 48 hours	14.8	1,475	14.5	1,257	17.4	218
49 hours to 6 weeks	10.8	1,164	10.6	1,011	11.9	153
More than 6 weeks to one year	11.1	1,231	11.0	1,071	11.8	160
Family planning methods provided						
Methods provided	5.5	653	5.5	571	5.1	82
Methods not provided	94.5	10,770	94.5	9,522	94.9	1,248
Overall	100.0	11,423	100.0	10,093	100.0	1,330
Timing when family planning method was provided after delivery						
Within 48 hours	4.8	572	4.8	498	4.6	74
49 hours to 6 weeks	4.5	530	4.5	458	4.3	72
More than 6 weeks to one year	4.1	479	4.1	415	3.8	64
Overall	100.0	11,423	100.0	10,093	100.0	1,330
Contraceptive methods provided after delivery (MRV)						
Female sterilization	0.3	18	0.2	13	0.7	5
IUDs	0.4	57	0.4	47	0.4	10
Injectables	1.7	190	1.8	180	0.8	10
Implants	0.0	2	0.0	2	0.0	0
Oral pills	0.6	75	0.7	69	0.3	6
Male condoms	1.2	163	1.0	136	2.1	27
Others*	1.3	130	1.3	110	1.1	20
Methods not provided	94.5	10,788	94.5	9,536	94.8	1,252
Overall	100.0	11,423	100.0	10,093	100.0	1,330

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

*Male sterilization, Sayana Press, female condoms, emergency contraceptive pills, standard days method, and others.

Health Problems Encountered 40 Days Postpartum

Among women who gave birth in the three years prior to the survey, 4.3% reported experiencing serious health problems during the 40 days following childbirth. The most common issues reported were weakness (56.6%), severe headache (55.5%), and high fever (53.9%) (Table 4.20). Urban-rural differences in the incidence of health problems were modest, except for weakness, which was reported by 67.7% of urban women compared to 55.1% of rural women. Most women experiencing health problems (60%) sought treatment from a public facility, with higher rates in urban areas (68.3%) than in rural areas (58.8%).

Table 4.20: Percentage of women who had a live birth and reported serious health problem(s) within 40 days of delivery (by type of health problem and place of residence)

	Total	Rural	Urban
Percentage of women who experienced serious complication(s) within 40 days of delivery	4.3	4.4	4.0
Type of health problems faced*			
Weakness	56.5	55.2	66.4
Severe headache	54.2	54.0	55.7
High fever	53.5	54.1	49.3
Blurred vision	36.3	36.7	33.2
Anemia	33.0	33.5	29.3
Abdominal pain with high fever	31.9	33.1	22.6
Excessive bleeding	19.2	18.8	22.5
Smelly discharge/dysuria	17.4	17.3	18.2
Continued bleeding	11.8	12.2	8.5
Lumps in breast	9.2	8.7	13.5
Others, e.g., convulsions, postpartum depression	16.8	15.7	25.7
First source of seeking treatment for complications			
Public	60.0	58.8	68.3
Private	37.9	38.9	31.1.4
Others	2.1	2.4	0.6
Total	100.0	100.0	100.0
No. of women (Unweighted)	8,477	7,258	1,219

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

* Multiple response variable.

Quality of Neonatal Care Following Last Live Birth

In this section, we examine various dimensions of early neonatal care, including kangaroo mother care (KMC), cord-cutting practices, and the application of substances to the umbilical cord.

Table 4.21 presents information on key aspects of neonatal care practices for women who had a live birth within the three years preceding the survey, disaggregated by place of residence.

Kangaroo mother care 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, offers numerous benefits for both baby and mother. These include temperature regulation, improved breathing, reduced stress, and enhanced bonding.

- Only a third (32.8%) of women reported that their baby was placed on their chest immediately after birth, with a slightly higher uptake in urban areas (35.0%) compared to rural areas (32.4%).
- Actual skin-to-skin contact between the mother and newborn was reported by just 24% of women overall, with no significant differences between urban and rural settings.
- A high percentage (78.7%) reported that the baby was not wrapped before being placed on the mother's chest, which aligns with recommended KMC practices. However, this also indicates that 21% reported wrapping the baby, which is not recommended.

Cord-cutting practices

Safe and hygienic cord-cutting practices are essential for preventing neonatal infections, which are among the leading causes of newborn mortality.

- New blades were the most commonly reported instrument used to cut the cord (37.6%), followed by scissors (24.0%). However, 37.4% of respondents were unsure about which instrument was used, with urban women (41.4%) more likely to report uncertainty than rural women (36.8%).
- In terms of sterilization of the cutting instrument, 47.1% reported that a sterilized instrument was used. However, nearly a fourth (24.4%) indicated it was not sterilized, and 28.6% were unsure, highlighting significant 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.

- Over half (51.6%) of women reported that something was applied to the cord after cutting. Urban women (53.1%) were slightly more likely to report this compared to rural women (51.4%).
- Common substances included the following:
 - Chlorhexidine, the antiseptic recommended by the WHO, was reported by 27.9% of respondents, with higher usage in urban areas (39.2%) compared to rural areas (26.2%).
 - Mustard oil, a traditional yet potentially harmful practice, was the most frequently reported substance overall at 38.6%, with significantly higher use in rural areas (40.4%) than in urban areas (27.0%).
 - Other antiseptics, such as spirit and gentian violet, were used by 19% of respondents.
 - A small but concerning proportion reported using ash (2.0%) or animal dung (0.2%), both of which are high-risk practices.

Table 4.21: Percentage of women with a live birth (by quality of neonatal care received)

	Total	Rural	Urban
KMC			
Was baby put on chest immediately after birth?			
Yes	32.8	32.4	35.0
No	61.3	61.3	61.3
Don't know	6.0	6.3	3.7
Total	100.0	100.0	100.0
Did skin-to-skin contact between baby and mother take place?			
Yes	24.0	24.1	23.7
No	74.8	74.8	74.9
Don't know	1.2	1.1	1.4
Total	100.0	100.0	100.0
Was baby wrapped up before being placed on bare skin on mother's chest?			
Yes	21.0	21.0	21.1
No	78.7	78.8	78.3
Don't know	0.3	0.3	0.6
Total	100.0	100.0	100.0
Cord-cutting practices			
Instrument used to cut cord			
New blade	37.6	38.0	35.0
Blade used for other purposes	0.8	0.8	0.5
Scissors	24.0	24.1	23.2
Others	0.2	0.3	0.0
Don't know	37.4	36.8	41.4
Total	100.0	100.0	100.0
Was the instrument sterilized?			
Yes	47.1	46.1	54.1
No	24.4	24.8	21.4
Don't know	28.6	29.1	24.5
Total	100.0	100.0	100.0
Was anything applied to the cord after cutting?			
Yes	51.6	51.4	53.1
No	15.8	16.0	14.2
Don't know	32.6	32.6	32.7
Total	100.0	100.0	100.0
What was applied to the cord? (MRV)*			
Chlorhexidine – tube	27.9	26.2	39.2
Other antiseptics (spirit, gentian violet)	19.0	18.9	19.9
Mustard oil	38.6	40.4	27.0
Ash	2.0	2.1	0.9
Animal dung	0.2	0.2	0.4
Others	6.4	6.3	7.4
Don't know	5.9	6.1	5.2
Total	100.0	100.0	100.0
No. of women with a live birth (Unweighted)	11,417	10,071	1,346

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

* Multiple response variable.

Recommendations

The findings of the KPHPS 2024–25 revealed both encouraging progress and persistent gaps in maternal and newborn healthcare in KP. A notable positive shift was the declining role of traditional birth attendants, indicating a movement toward skilled maternal healthcare. Additionally, an increasing proportion of women were accessing ANC and delivery services from skilled professionals. However, despite the majority of women now seeking facility-based maternal care, significant challenges remain in ensuring the quality, continuity, and equity of services. Disparities based on geography, education, and socioeconomic status continue to hinder universal access to essential MNCH services.

1. **Strengthening 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. Early registration and the first ANC visit within 12 weeks of gestation should be promoted through community mobilization and engagement of community health workers.
2. **Increasing effective ANC coverage:** Beyond the number of visits, the quality and content of ANC services must be improved. Standardizing protocols and ensuring the delivery of core services, including fetal health monitoring, is critical.
3. **Improving quality of delivery and newborn care:** Institutional delivery protocols should be revisited to ensure the universal practice of evidence-based interventions, such as KMC (skin-to-skin contact) and delayed cord clamping. Staff training, supportive supervision, and accountability mechanisms must be reinforced.
4. **Expanding and strengthening postnatal care:** More 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 can support continuity of care.
5. **Integrating PFP:** The postpartum period presents a strategic opportunity for introducing family planning. Efforts must be made to integrate PFP into routine postnatal care, with counseling and method provision initiated before discharge from health facilities.
6. **Addressing harmful traditional practices:** Behavioral change communication strategies, including community-based social and behavior change communication campaigns, must be deployed to 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.
7. **Tackling inequities through targeted interventions:** The disparities in service uptake based on wealth, education, and geography necessitate a focused prioritization of interventions in lagging districts. These should include capacity building for service providers, improving facility readiness, and implementing targeted social protection schemes to reduce financial barriers.

Fertility and Fertility Preferences

Key Findings

Pregnancy and pregnancy outcomes

- Most pregnancies in KP resulted in live births, while 1% ended in stillbirths.
- A very small proportion of pregnancies ended in spontaneous abortions (3.3% overall, 3.1% in rural areas, and 4.3% in urban areas), with an additional 0.2% ending in induced abortion.

Fertility rates

- Fertility rates in KP were high, with women bearing an average of 3.6 children each.
- Fertility was higher in rural areas at 3.6 children per woman, compared to 3.1 children per woman in urban areas.
- The poorest women had an average of 4.0 children, while the richest group had 3.3 children.
- Many women began childbearing early, with one-tenth of women having a child during their adolescence.

Wantedness of pregnancies and births

- About two-third of women in KP, both in urban and rural areas, who had at least one pregnancy, reported that their last pregnancy was wanted and planned.
- About a third of women with at least one pregnancy indicated that their last pregnancy was mistimed or not wanted at all.

Desire for additional children

- The desire for additional children declined with parity: 81% of women with one living child wanted more children, compared to 9.7% of women with six or more children.
- The median ideal family size in KP was four children: 4.4 in rural areas and 3.8 in urban areas.

Information on fertility and fertility preferences allows for the assessment of policies and programs designed to help couples achieve their fertility goals. It also identifies the prevalence of mistimed and unwanted pregnancies, as well as the demand for children. The KPHPS gathered data on pregnancies, fertility, and desired fertility from ever-married and currently married women interviewed in the survey. 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

Information on all pregnancies was collected from ever-married women. A total of 89,511 pregnancies were reported by the women surveyed in KPHPS, with 78,915 in rural areas and 10,596 in urban areas (Table 5.1). Most of these pregnancies (95.7% in KP, 95.8% in its rural areas, and 94.9% in its urban areas) ended in live births. The proportion of pregnancies resulting in stillbirths was 0.9% overall and in rural areas, compared to 0.8% in urban areas. The proportion of all pregnancies ending in miscarriages (spontaneous abortions) was 3.2%, with 3.0% among rural women and 4.1% among urban women.

Induced abortions, similar to other demographic inquiries that ask direct questions, are often either not reported or significantly underreported. The KPHPS indicated that only 0.2% of all pregnancies ended in induced abortion. In addition, some induced abortions may have been misclassified as spontaneous abortions (miscarriages) due to the social stigma associated with the former.

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	95.7	95.8	94.9
Stillbirths	0.9	0.9	0.8
Induced abortions	0.2	0.2	0.3
Miscarriages	3.2	3.0	4.1
No. of pregnancies (Unweighted)	89,511	78,915	10,596

Total Fertility Rate and Adolescent Fertility Rate

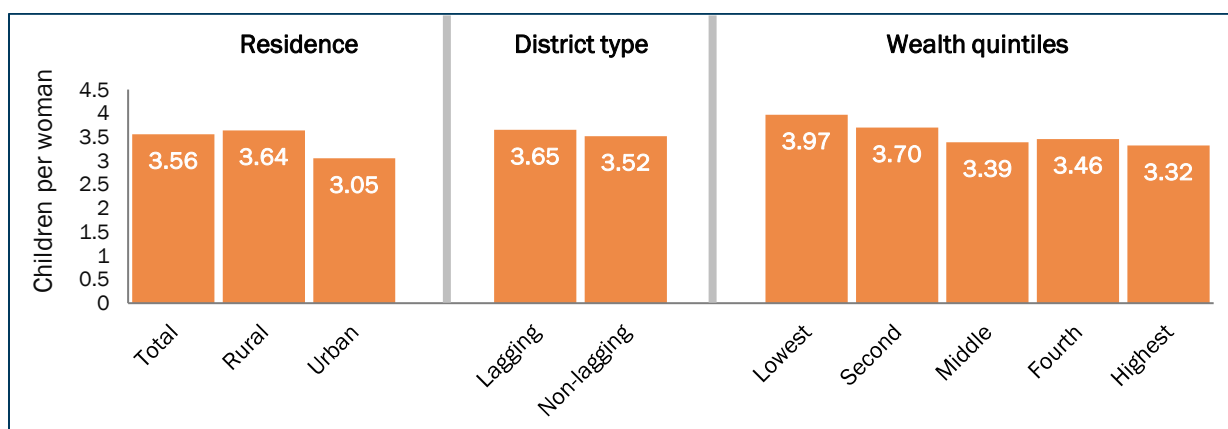
The TFR represents the average number of children a woman would have during her lifetime if she were to experience the age-specific fertility rates observed at the time of the survey. The KPHPS showed that a woman in KP was likely to have an average of 3.56 children by the end of her reproductive life at age 49 (Table 5.2). Women in rural areas were likely to have 3.64 children, compared to 3.05 in urban areas. In addition, women in lagging districts were likely to have 3.65 children, while those in non-lagging districts an average of 3.52 (Figure 5.1). Women in the lowest wealth quintile tended to have the highest number of children (3.97), while those in the highest wealth quintile had the lowest (3.32).

The AFR, defined as the number of births per 1,000 adolescents aged 15–19, ranged from 97 in urban areas to 114 in the lowest wealth quintile. Regardless of the subgroup, early initiation of fertility during adolescence is common in KP. Early childbearing poses significant health risks for both mother and baby and limits their educational and employment opportunities.

Table 5.2: Total Fertility Rate (TFR) per woman aged 15–49 years and adolescent fertility rate (AFR) (by background characteristics)

	TFR (children per woman)	AFR (children per 1,000 women aged 15–19 years)
Residence		
Overall	3.56	108
Rural	3.64	110
Urban	3.05	97
District type		
Lagging	3.65	102
Non-lagging	3.52	110
Wealth quintiles		
Lowest	3.97	114
Second	3.70	107
Middle	3.39	109
Fourth	3.46	108
Highest	3.32	103

Figure 5.1: Total Fertility Rate (TFR) per woman (by background characteristics)



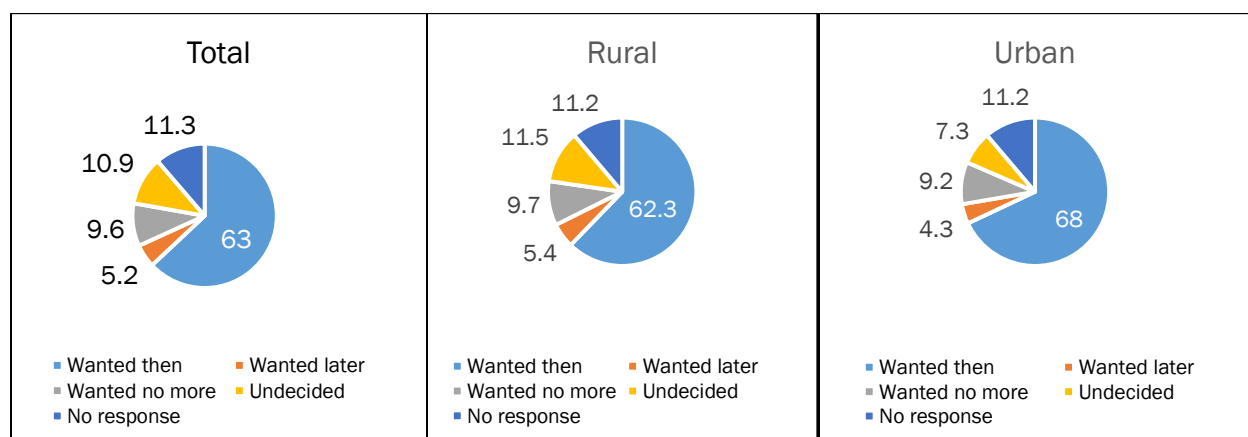
Mistimed or Unwanted Last Pregnancy

The KPHPS included the question, “During your last pregnancy, did you want to become pregnant at that time, did you wish to wait until later, or did you not want to have any more children at all?” Of the 28,063 women who had experienced at least one pregnancy, including those who were pregnant at the time of the interview, 63% overall (62.3% in rural areas and 68% in urban areas) reported that their pregnancy was planned and wanted. Mistimed pregnancies (those that were “wanted later”) accounted for 5.2% overall, with 5.4% in rural areas and 4.3% in urban areas. However, unwanted pregnancies were reported more frequently than mistimed pregnancies, at 9.6% overall, 9.7% in rural areas, and 9.2% in urban areas. Over 20% of women either did not respond to the question or were undecided. Excluding these non-responses, we found that 6.7% of pregnancies were wanted later (7% in rural areas and 5.3% in urban areas), while 12.3% of last pregnancies overall (12.5% in rural areas and 11.3% in urban areas) were unwanted. Therefore, approximately 80% of the last pregnancies were desired and appropriately timed among those who answered the question (Table 5.3 and Figure 5.2).

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	63.0	62.3	68.0
Wanted later	5.2	5.4	4.3
Wanted no more	9.6	9.7	9.2
Undecided/ don't know	10.9	11.5	7.3
Missing (no response)	11.2	11.2	11.3
Total	100.0	100.0	100.0
No. of ever-married women (Unweighted)	28,063	24,573	3,490

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



Fertility Preferences

Two indicators were used to measure fertility preferences: (1) desire for additional children and (2) ideal number of children.

Desire for More Children

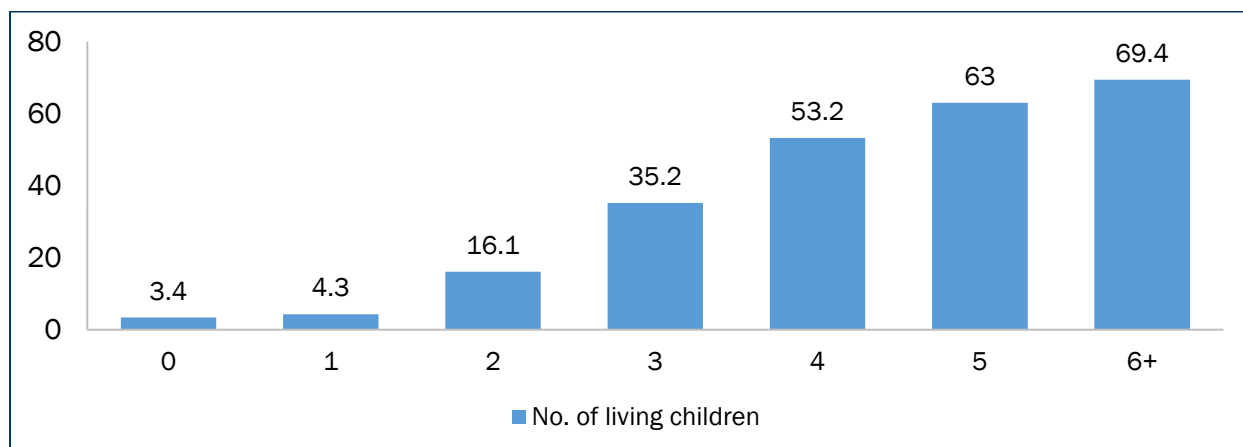
When asked about their desire for additional children, 46.1% of respondents indicated they wanted more, while 34.3% did not (Table 5.4). The desire for additional children was strongly related to achieved parity. Over two-thirds of women with fewer than two living children expressed a wish for more children. Approximately one-in-two women with three living children also desired more. However, the proportion of women with four or more living children who wanted additional children declined to just 19.5% (Figure 5.3).

Table 5.4: Percentage of currently married women desiring more children (by no. of living children)

	No. of living children							Total
	0	1	2	3	4	5	6+	
Desire for more children								
Want more	67.3	81.4	66.2	46.4	27.2	19.4	9.7	46.3
Don't want more	3.4	4.3	16.1	35.2	53.2	63.0	69.4	34.3
Cannot get pregnant	18.0	4.5	4.7	5.4	7.2	6.9	9.2	7.6
Don't know/unsure	11.3	9.8	12.9	13.1	12.4	10.8	11.7	11.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of currently married women (Unweighted)	3,114	3,553	4,586	5,186	4,487	3,143	3,412	27,481
No. of desired sons								
None	0.8	0.1	0.3	0.3	0.8	0.5	1.4	0.4
1-2	21.9	24.2	29.5	38.0	45.2	46.1	38.1	31.0
3-4	50.9	50.6	46.4	35.4	19.3	16.4	15.2	41.4
5+	26.4	25.1	23.7	26.3	34.7	36.9	45.3	27.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of currently married women (Unweighted)	2,118	2,856	3,067	2,633	1,452	735	431	13,292
No. of desired daughters								
None	1.1	2.8	5.4	9.4	10.1	7.3	7.1	5.4
1-2	68.8	64.3	62.4	54.5	52.4	52.9	45.8	60.7
3-4	25.5	29.0	28.7	32.8	31.5	29.6	30.7	29.3
5+	4.7	3.9	3.4	3.3	6.1	10.2	16.4	4.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of currently married women (Unweighted)	2,118	2,856	3,067	2,633	1,452	735	431	13,292

The desired number of sons and daughters revealed a distinct preference for sons. Overall, the median number of sons desired was four. This figure remained consistent in rural areas, while in urban areas, the desire for sons decreased to three, indicating a lower preference in urban areas. The desired number of daughters was consistently two, both overall and in both rural and urban areas.

Figure 5.3: Percentage of currently married women wanting no more children (by no. of living children)



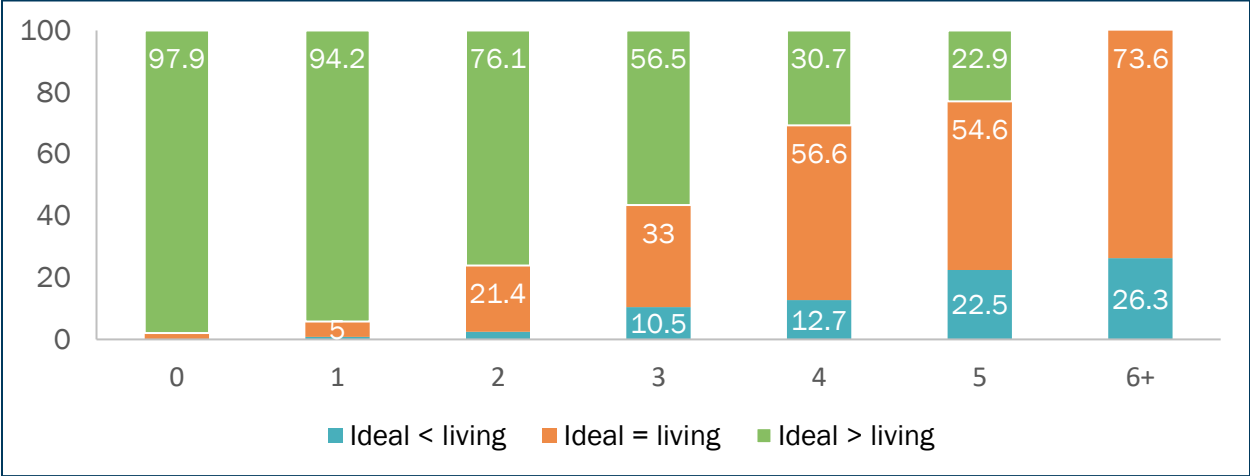
Ideal Number of Children

All currently married women at the time of the survey were asked, “If you could choose the exact number of children to have in your whole life, how many would that be, and how many of them would be sons and how many daughters?” The ideal family size reported by 29.9% of currently married women was four children, while 23.8% preferred six or more children (Table 5.5). When comparing the ideal number of children to the number of living children, 94.2% of women with one child and 76.1% of those with two children stated that their ideal number was greater than their current number of living children. Among those with three living children, 56.5% reported that their ideal family size was larger than the number of children they had. Nearly 74% of currently married women with six or more living children indicated that their ideal family size is equal to the number of living children (Figure 5.4).

Table 5.5: Percentage distribution of currently married women (by ideal family size according to no. of living children)

	No. of living children							Total
	0	1	2	3	4	5	6+	
Ideal no. of children								
0	2.1	0.8	1.6	2.6	3.5	3.6	4.3	2.6
1	1.3	5.0	0.9	1.2	1.5	1.4	1.7	1.8
2	22.4	15.0	21.4	6.7	4.6	4.1	2.9	11.1
3	13.4	18.5	13.5	33.0	3.1	2.8	1.8	13.4
4	35.0	32.1	35.2	24.2	56.6	10.6	6.6	29.9
5	10.6	13.1	13.2	17.3	11.2	54.6	9.0	17.5
6+	15.1	15.5	14.2	15.0	19.6	22.9	73.6	23.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of currently married women (Unweighted)	3,120	3,557	4,590	5,191	4,491	3,146	3,414	27,509

Figure 5.4: Percentage of women whose ideal no. of children was less than, equal to, or greater than their living children (by no. of living children)



Contraceptive Use and Unmet Need for Family Planning

Key Findings

Contraceptive prevalence rate (CPR) and prevalence of modern methods (mCPR)

- Contraceptive prevalence in KP was low, with only 22.9% of currently married women using a contraceptive method. Of these, 14.8% used modern methods, and 8.1% used traditional methods.
- Contraceptive use was higher in urban areas than in rural areas.
- The prevalence of any contraceptive method (modern plus traditional) was similar in lagging (23%) and non-lagging districts (22.9%).
- Educated women were more likely to use traditional methods than those with no education.
- Women in the highest wealth quintile were more likely to use both modern and traditional methods compared to women in the lowest quintile.

Type of contraceptive method currently used: Method mix

- The method mix in KP was dominated by three methods: withdrawal, male condoms, and injectables.
- Withdrawal (coitus interruptus) was the most widely used method among couples, with usage rates of 40.8% in urban areas and 40.9% in lagging districts.
- Highly educated couples and those in higher wealth quintiles were more likely to use withdrawal than couples with less education or in lower wealth quintiles.

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

- “Easy availability” was the leading reason, followed by “convenient to use,” for choosing popular methods such as withdrawal, male condoms, and injectables.
- Most users were satisfied with their chosen method and intended to continue their use.

Demand for family planning and unmet need

- Total demand for family planning in KP was quite high at 53.6%.
- The proportion of demand satisfied by any method (modern or traditional) was 42.7%, with modern methods accounting for 27.6% of the demand satisfied.
- The gap between contraceptive demand and actual use, representing unmet need for family planning in KP, was significant at 30.7% overall.
- The unmet need for spacing was 12.4%, while the unmet need for limiting childbearing was 18.3%.

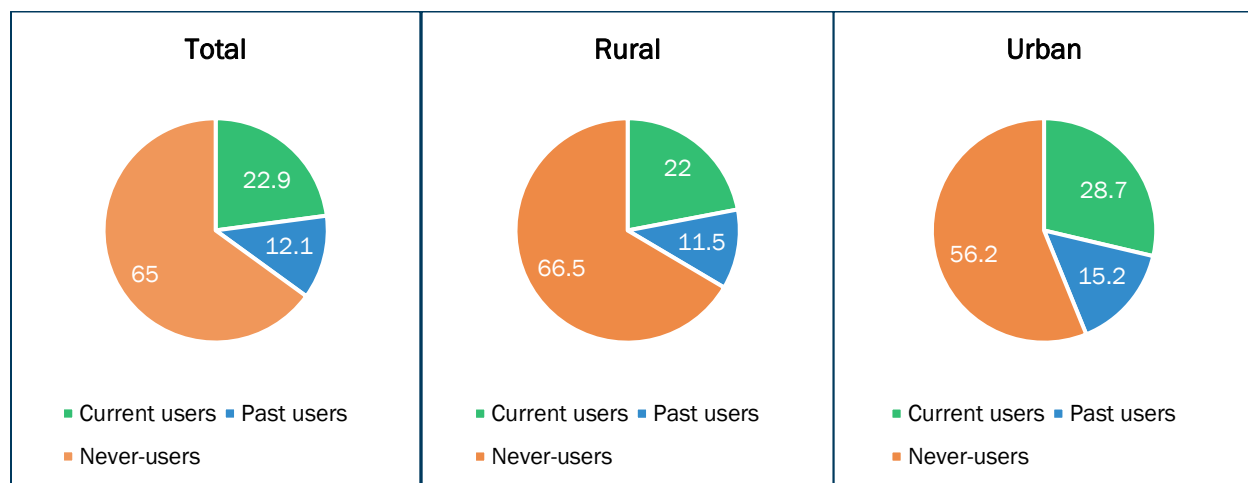
Evidence is well-established regarding the numerous medical and non-medical benefits of family planning, particularly its critical role in improving women's health by reducing unintended and high-risk pregnancies. This reduction decreases the number of women exposed to the risk of maternal death or morbidity. Family planning can also enhance newborn and child health by enabling women to practice healthy timing and spacing of pregnancies, allowing them to focus on their own health and on caring for their newborns, infants, and children. In addition to these maternal and child health benefits, the use of family planning can contribute to women's socioeconomic status by enabling girls and young women to continue their studies, achieve higher education, 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, Syana Press, IUDs, contraceptive pills, implants, male and female condoms, the standard days method, lactational amenorrhea method, and emergency contraception. The CPR is measured as the percentage of currently married women using a contraceptive method, while the percentage using *modern* methods is referred to as mCPR. The KPHPS collected detailed information from women interviewed in the survey regarding their use of and perspectives on family planning methods. This chapter describes the levels and differences in the use of family planning in KP.

Contraceptive Use Status of Currently Married Women

Two-thirds of currently married women in KP and its rural areas had never used any method of contraception, whether traditional or modern (Figure 6.1). In urban areas, the percentage of women who had never used a contraceptive method was lower at 56.2%. Overall, 12.1% of currently married women had used a method in the past but were not using it at the time of the survey, with 11.5% in rural areas and 15.2% in urban areas.

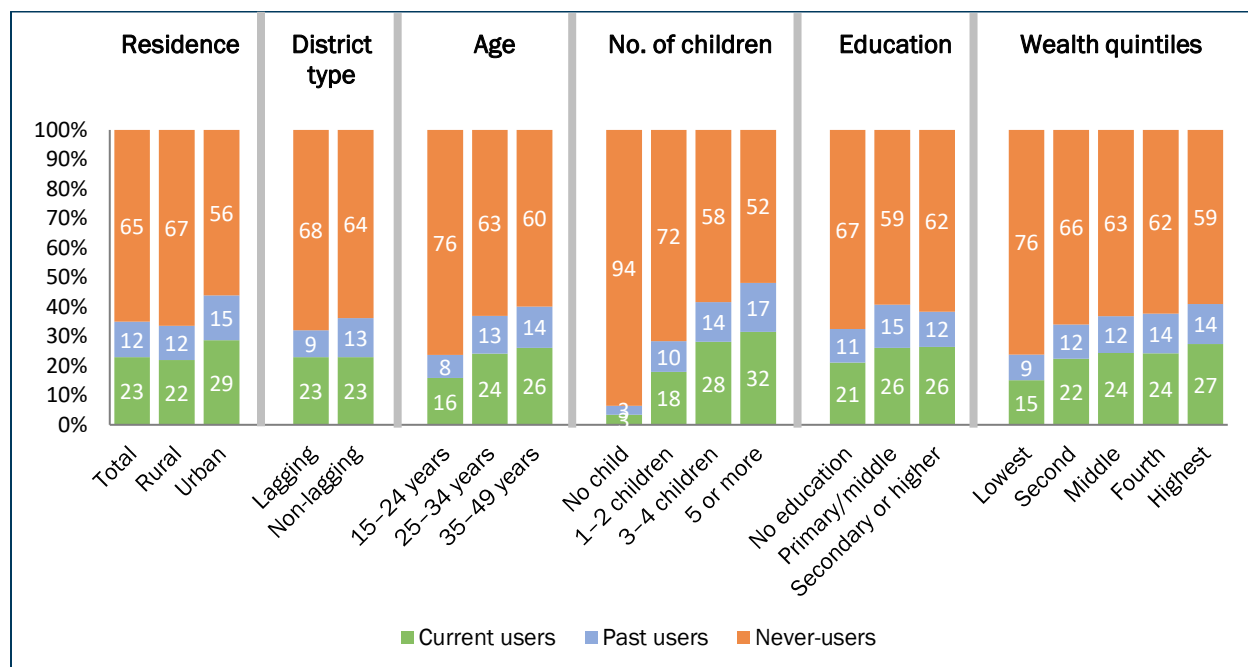
Figure 6.1: Percentage distribution of currently married women (by contraceptive use status and place of residence)



The composition of users—categorized as never, past, or current—varied by background characteristics (Figure 6.2). Current users were 6.7 percentage points higher in urban areas than in rural areas (28.7% vs. 22.0%). Additionally, current use was 10.2 percentage points higher among women aged 35–49 years compared to those aged 15–24 years (26.1% vs. 15.9%). Current use was also 28.1 percentage points higher among women with five or more children than among those with no children (31.5% vs. 3.4%), and 13.5 percentage points higher than among those with one to two children (18.0%). The difference in current use between women in the lowest and highest wealth quintiles was 12.3 percentage points (15.1% vs. 27.4%). There was little difference in current use among women in lagging versus non-lagging districts, and a modest difference between women with no education (21.3%) and those with secondary or higher education (26.4%). Groups with a high level of current use also showed a high number of past users.

The significantly higher current use among women aged 35–49 and among those with five or more children suggested that contraception was likely being used more for limiting than for spacing childbearing, and it appeared to be a response to high fertility rather than a means of regulating fertility.

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



Contraceptive Prevalence

Overall, 22.9% of currently married women in KP were using a contraceptive method: 14.8% used a modern method, and 8.1% used a traditional method (Table 6.1). As expected, contraceptive use was higher in urban areas (28.7%) than in rural areas (22%). The use of modern methods was also slightly higher in urban areas (16.6%) compared to rural areas (14.5%). Surprisingly, the use of traditional methods was much higher in urban areas (12%), where access to modern methods may not be as challenging as in rural areas, where the prevalence of traditional methods was 7.5%. The prevalence of any method was similar in lagging and non-lagging districts (23% and 22.9%, respectively), but the use of modern methods was two percentage points higher in the latter. Traditional method use was 9.6% in rural areas compared to 7.5% in urban areas. A steady rise in contraceptive use was observed by age, increasing from 15.9% among women aged 15–24 years to 26.1% among those aged 35–49 at the time of the survey. Both modern and traditional method usage also increased with the age of women.

Female education was strongly associated with contraceptive use: 21.1% of women with no education used a method, compared to 26.4% of those with secondary or higher education. The use of modern methods was 14.1% among the former and 16.5% among the latter. The percentages of women using traditional methods were 7% for those with no education, 10.3% for those with primary/middle education, and 9.9% for those with secondary or higher education. The differences in use by wealth quintile were more pronounced: 15.1% of women in the lowest wealth quintile used a contraceptive method (11% modern and 4.1% traditional), compared to 27.4% (18.1% modern and 9.3% traditional) in the highest 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)

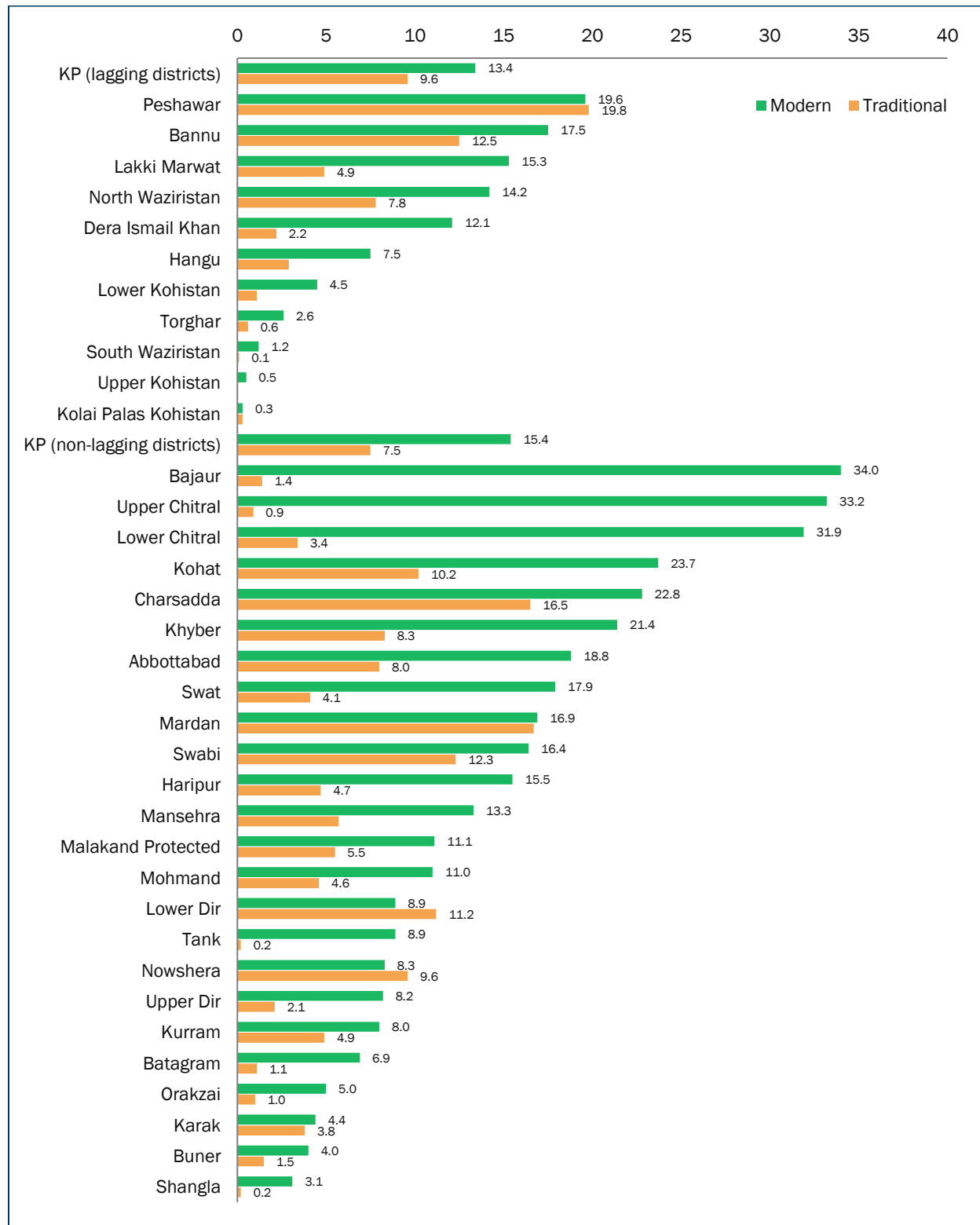
	Any method	Modern method ^a	Traditional method ^b	No. of women (Unweighted)
Overall	22.9	14.8	8.1	27,506
Residence				
Rural	22.0	14.5	7.5	24,107
Urban	28.7	16.6	12.0	3,399
District type				
Lagging	23.0	13.4	9.6	12,602
Non-lagging	22.9	15.4	7.5	14,904
Age (years)				
15–24	15.9	10.3	5.6	6,133
25–34	24.1	15.4	8.7	11,859
35–49	26.1	17.1	9.0	9,514
Education				
No education	21.1	14.1	7.0	19,819
Primary/middle	26.1	15.8	10.3	3,371
Secondary or higher	26.4	16.5	9.9	4,316
Wealth quintiles				
Lowest	15.1	11.0	4.1	7,673
Second	22.4	14.7	7.7	5,547
Middle	24.4	14.9	9.5	5,272
Fourth	24.2	14.8	9.4	4,901
Highest	27.4	18.1	9.3	4,113

^a Male and female sterilization, injectables, Syana 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 prevalence of modern methods (mCPR) was higher than that of traditional methods across KP (Figure 6.3), except in Peshawar (19.6% vs. 19.8%), Lower Dir (8.9% vs. 11.2%), and Nowshera (8.3% vs. 9.6%), where the use of traditional methods was higher than that of modern methods. Modern contraceptive use was extremely low, at less than one percent in Upper Kohistan and Kolai Palas Kohistan.

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



Method Mix: Contraceptive Method Choice

The availability of a wider range of contraceptive methods is essential for meeting the diverse needs and preferences of women and couples. A contraceptive 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 instrumental in providing method choice and facilitating greater uptake of contraception. This mix also enables users to switch methods when necessary, rather than abandoning contraception altogether.

The mix of contraceptive methods in KP is very limited. Table 6.2 presents the percentage of current users by method type and background characteristics. Withdrawal (*coitus interruptus*) is the most used method among contraceptive users in KP, whether in urban or rural areas and in lagging or non-lagging districts. Overall, 34.9% of contraceptive users in KP practice withdrawal, with 40.8% in urban areas compared to 33.6% in rural areas. In lagging districts, withdrawal was used by 40.9% of users, while only 31.9% of users in non-lagging districts relied on it. Users aged 15–24 and 25–34 also predominantly depended on withdrawal for protection against unintended pregnancy, with rates of 43.4% and 42.3%, respectively. Notably, users with higher educational levels were more likely to use withdrawal than those with no education. A similar trend was observed across wealth quintiles.

Male condoms were the second-most widely used contraceptive, utilized by 21.4% of users in the province. Their use was higher in urban areas (26.5%) compared to rural areas (20.5%). Additionally, condom use was greater in lagging districts (23.9%) than in non-lagging districts (20.5%). Overall, the use of injectables was 17.5%, with rates significantly higher among users aged 15–24 years (27.7%) compared to those aged 35–49 (10%). In rural areas, injectable use was 19.5%, while it was only 8.7% in urban areas. No other spacing method exceeded a usage rate of nine percent among all users in KP.

Overall, despite a long history of family planning programs in Pakistan, the current use of any method, modern or traditional, remains low, and the method mix narrow. Withdrawal and male condoms are the most used methods, followed by injectables in rural areas. The failure rate of withdrawal is high, and even condoms, if not used correctly and consistently, carry the risk of unintended pregnancy.

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	Rhythm method	Withdrawal	Others	Total
Overall	6.1	0.4	4.8	17.5	0.0	1.7	8.7	21.4	0.0	0.4	0.4	3.1	0.4	34.9	0.0	100
Residence																
Rural	5.5	0.5	5.0	19.5	0.0	1.8	9.5	20.5	0.5	0.5	0.5	3.2	0.5	33.6	0.0	100
Urban	8.7	0.7	3.8	8.7	0.0	1.7	5.2	26.5	0.0	0.0	0.0	2.4	1.0	40.8	0.0	100
District type																
Lagging	7.4	0.4	4.3	10.4	0.0	1.7	6.1	23.9	0.0	0.4	0.0	3.9	0.9	40.9	0.0	100
Non-lagging	5.7	0.4	4.8	20.5	0.4	1.7	9.6	20.5	0.4	0.0	0.4	2.6	0.4	31.9	0.0	100
Age (years)																
15-24	8.8	0.6	5.7	27.7	0.6	1.9	13.2	25.2	0.0	0.6	0.6	4.4	0.6	43.4	0.0	100
25-34	5.4	0.4	6.6	17.4	0.0	2.1	7.1	23.2	0.0	0.0	0.4	3.3	0.4	42.3	0.0	100
35-49	6.1	0.0	5.0	10.0	0.0	2.3	8.0	29.1	0.4	0.4	0.4	2.3	0.8	37.2	0.4	100
Education																
No education	0.9	0.5	2.8	14.7	0.0	0.9	7.6	17.1	0.0	0.0	0.5	4.3	0.5	26.1	0.0	100
Primary/middle	3.1	0.4	4.6	16.9	0.0	1.1	8.4	19.5	0.4	0.4	0.4	3.4	0.4	33.0	0.0	100
Secondary or higher	11.4	0.4	4.9	15.9	0.4	2.3	7.6	20.8	0.0	0.0	0.4	0.8	0.4	33.3	0.4	100
Wealth quintiles																
Lowest	6.6	2.0	5.3	23.2	0.0	1.3	12.6	17.9	0.0	0.0	0.0	2.6	1.3	25.8	0.0	100
Second	6.7	0.0	4.0	24.1	0.4	2.2	7.6	16.5	0.4	0.4	0.4	3.6	0.4	33.9	0.4	100
Middle	5.7	0.4	4.9	17.2	0.0	1.6	9.4	18.4	0.0	0.0	0.8	2.5	0.4	38.5	0.0	100
Fourth	5.0	0.4	5.0	15.3	0.4	1.2	9.1	21.5	0.0	0.4	0.0	3.7	0.4	38.0	0.4	100
Highest	6.9	0.0	5.1	13.1	0.0	2.2	6.6	28.8	0.4	0.0	0.0	2.6	0.4	33.6	0.0	100

Contraceptive Method Preference

The survey inquired about the reasons for selecting specific contraceptive methods. Focusing on the three most used ones (injectables, male condoms, and withdrawal), Table 6.3 indicates that “easily available” was the primary reason for choosing injectables (53.2%), followed by “convenient to use” (13.7%) and “low cost” (8.9%). In addition, “advice from a friend or relative” was mentioned by 7.4% of injectable users overall, with 7.7% among rural women. In urban areas, the long protection period of injectables was the third-most important reason.

For male condom users, the top three reasons were “easily available” (54.1%), “convenient to use” (19.5%), and “no or fewer side effects” (9.5%). “Low cost” was also a reason for choosing this method.

Users of withdrawal cited “easy availability” (39.8%), “no or few side effects” (20.1%), “convenient to use” (18%), and “suitability for the woman or couple” (10.1%) as their main reasons. Notably, “no or few side effects” was the second-most frequently reported reason by 25.1% of urban users for choosing withdrawal.

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

Reasons (MRV)	Injectables			Male condoms			Withdrawal		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
Easily available	53.2	53.0	54.5	54.1	54.7	51.8	39.8	41.2	34.2
Low cost	8.9	9.3	5.2	9.4	10.4	5.7	2.6	2.8	1.8
Convenient to use	13.7	13.8	12.3	19.5	19.0	21.5	18.0	17.5	19.8
Suitable for respondent/ husband	2.6	2.4	4.6	3.5	3.4	3.6	10.1	9.5	12.7
No/ fewer side effects	2.5	2.5	3.2	9.5	8.9	11.9	20.1	18.8	25.1
Can be used for long period	5.9	5.6	9.4	0.2	0.2	0.6	0.9	0.7	1.7
No other method available	1.3	1.3	1.3	0.1	0.1	0.0	0.6	0.8	0.0
Method always available	0.5	0.5	0.0	0.8	0.5	1.7	2.9	3.4	0.6
Provider advised	3.1	2.9	5.2	0.3	0.3	0.4	0.1	0.1	0.0
Female friend/ relative advised	7.4	7.7	4.3	1.1	0.9	1.9	4.0	4.4	2.4
Others	0.8	0.9	0.0	1.5	1.5	1.2	1.1	0.9	1.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of users	942	849	93	1,149	874	275	1,149	874	275

Satisfaction With and the Intention to Continue Using the Method

Over 90% of users of injectables, male condoms, and withdrawal methods were satisfied with their chosen method and intended to continue using it. The only exception was among injectable users in urban areas, where 85.5% reported satisfaction and 88% intended to continue using it (Table 6.4). Urban-rural differences in satisfaction levels and intentions to continue using each method were negligible. A high level of satisfaction and the intention to continue using was 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.

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	94.6	95.4	85.5	93.3	93.7	91.8	94.8	94.7	95.5
No	5.4	4.6	14.5	6.7	6.4	8.2	5.2	5.3	4.5
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	90.9	91.2	88.0	94.4	94.1	95.5	95.2	95.3	94.5
No	9.1	8.8	12.1	5.6	5.9	4.5	4.8	4.7	5.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N (Unweighted)	942	849	93	1,149	874	275	1,149	874	275

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	93.7	94.7	93.1
No	6.3	5.3	6.9
Total	100.0	100.0	100.0
Intend to continue using method?			
Yes	92.9	95.2	91.6
No	7.1	4.8	8.4
Total	100.0	100.0	100.0
No. of women (Unweighted)	5,060	1,583	3,477

Side Effects

A relatively small proportion of women, 15.2%, reported experiencing any side effects while using a contraceptive method (Table 6.6). The most perceived method-related side effects included weakness (30%), heavy bleeding (18.7%), and headaches (11.5%) (Table 6.7). The differences in the type or level of side effects between public and private sources of methods 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	15.2	13.6	16.5
No	84.8	86.4	83.5

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 (MRV)	Total	Public	Private
Heavy bleeding	18.7	18.4	18.9
Irregular bleeding	1.8	2.3	1.5
Weight gain	4.9	5.6	4.4
Weakness	30.0	28.4	31.2
Spotting	2.1	0.3	3.3
Infections	8.6	7.0	9.7
Nausea/dizziness	1.5	0.3	2.4
Headaches	4.5	8.7	1.4
Backaches	11.5	13.1	10.3
Irritation	0.9	0.1	1.4
Lower abdomen pain	0.7	0.5	0.8
Swelling (body)	4.8	4.1	5.3
Menopause	6.5	6.9	6.3
Face freckles	0.8	0.5	1.1
Others	2.8	3.9	2.1
Total	100.0	100.0	100.0

The overall experience of side effects attributed to injectables was 19.3%, with 19.5% reported in rural areas compared to 17.9% in urban areas (Table 6.8). Side effects associated with the oral pill were reported by 19.9% of all users and 21.5% of rural users. In urban areas, the percentage of oral pill users reporting side effects was considerably lower at 4.3%. Among the three short-term spacing methods (pills, condoms, and injectables), side effects attributed to condom use were the lowest, reported at 8.3% overall, 8.5% in rural areas, and 7.5% in urban areas.

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	19.3	19.5	17.9	8.3	8.5	7.5	19.9	21.5	4.3
No	80.7	80.5	82.1	91.7	91.5	92.5	80.1	78.5	95.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source of Current Contraceptive Method

The sources of current methods varied by type (Table 6.9). Sterilization/tubectomies and IUDs were primarily obtained from public health facilities, accounting for 66% and 59.7%, respectively, compared to private health facilities, which provided 24% and 32.3%. The public sector was also the main source for implants, with 59.7% coming from this sector compared to 25.2% from the private sector. Pharmacies were the leading suppliers of condoms (31%), emergency contraceptive pills (28.1%), oral pills (25.7%), and Sayana Press (19.4%).

Table 6.9: Percentage of currently married women currently using a method (by source of method and current contraceptive method)

	Public	Private	Pharmacy	Others ^a	Don't know	Missing	Total
Sterilization	66.0	24.0	0.0	1.3	4.8	4.0	100
IUDs	59.7	32.3	0.5	0.2	6.2	1.3	100
Injectables	44.7	36.0	10.0	1.8	7.0	0.5	100
Sayana press	18.7	36.1	19.4	11.2	14.5	0.0	100
Implants	59.7	25.2	9.4	0.0	2.3	3.4	100
Oral pills	37.3	24.6	25.7	4.3	7.7	0.4	100
Condoms	18.6	10.7	31.0	13.3	24.6	1.8	100
ECPs	29.2	19.5	28.1	18.1	5.2	0.0	100
Total	38.2	23.5	17.9	6.0	12.9	1.5	100

^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, staff attitude and behavior were rated as cooperative or friendly by 51.5% of users. However, the percentage of users reporting staff as cooperative or friendly was lower in rural public facilities (59.1%) compared to urban public facilities (70.3%). The difference between private and public facilities in urban areas was modest. In rural areas, staff in private facilities were found to be friendlier than those in urban private facilities. Additionally, the availability of a doctor was five percentage points lower in rural public and private facilities compared to their urban counterparts: 94.4% in rural public versus 99.6% in urban public, and 91.2% in rural private versus 96.1% in urban private.

No waiting time was reported by 20.9% of visitors to rural public facilities, compared to 36.8% of visitors to urban public facilities. The corresponding figures for private facilities were 22% for rural and 25.7% for urban. Waiting for more than an hour was uncommon, particularly in private urban facilities, where it occurred in only 2.9% of cases.

Table 6.10: Percentage of currently married women using modern contraceptive methods reporting on quality of care of family planning services as assessed at the time of last visit to a facility (by type of facility and area)

	Total	Public		Private	
		Rural	Urban	Rural	Urban
Staff attitude and behavior					
Cooperative/friendly	51.5	59.1	70.3	46.6	47.7
Polite attitude	43.2	39.7	27.6	47.3	41.5
Non-cooperative/unfriendly/hostile	1.2	1.0	1.7	1.0	0.3
Missing	4.2	0.1	0.4	5.1	10.5
Total	100.0	100.0	100.0	100.0	100.0
Availability of doctor/worker					
Yes	92.9	94.4	99.6	91.2	96.1
No	7.2	5.6	0.4	8.8	3.9
Total	100.0	100.0	100.0	100.0	100.0
Wait time (minutes)					
No wait time	22.4	20.9	36.8	22.0	25.7
1–30	55.8	57.2	49.4	59.3	54.8
31–60	7.5	8.7	7.3	6.2	7.6
60+	6.2	8.2	2.1	5.2	2.9
Don't remember	8.1	5.1	4.4	7.2	9.0
Total	100.0	100.0	100.0	100.0	100.0

Information received during the first consultation for family planning is crucial for making informed choices about methods and for ensuring continued use. Table 6.11 shows the percentage of clients who received information on key topics. Clients at public facilities received information on all topics at a higher rate than those at private facilities. For example, 76.1% of clients at public facilities were informed about their preferred method, compared to only 58.8% of clients at private facilities. Additionally, important information on what to do if a woman experiences side effects was provided to 55.6% of public sector clients, while only 36.2% of private facility clients received this information. Contrary to common belief, the provision of information on a range of topics was greater in public facilities than in private ones.

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 type and place of facility)

Received information about:	Total	Public	Private
a) Method of client's preference	66.8	76.1	58.8
b) How method works	64.1	74.2	55.5
c) How to use method	62.7	73.6	53.4
d) Contraindications	55.6	65.7	47.0
e) Effectiveness and duration of effectiveness	54.2	65.8	44.4
f) Advantages compared to other methods	50.6	62.1	40.8
g) Disadvantages compared to other methods	47.1	57.3	38.4
h) Possible side effects	44.2	53.4	36.4
i) What to do if side effects experienced	45.1	55.6	36.2
j) Where to go in case of side effects	43.8	54.1	35.2
k) Possibility of switching	45.9	55.5	37.8
l) Other methods that could be used	40.3	50.0	32.1

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% of clients reported receiving their preferred method (Table 6.12), with a slightly higher percentage among clients of private facilities (97.9%) compared to those in public facilities (96.5%).

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	97.3	96.5	97.9
No	2.7	3.5	2.1

Past Users of Contraceptive Methods

A substantial 12.1% of currently married women had used a contraceptive method in the past but discontinued its use. This proportion was higher in urban areas, at 15.2%, compared to 11.6% in rural areas. Understanding the experiences of past users is valuable for identifying which methods were discontinued and the reasons for their discontinuation. Over 70% of past users stopped using their method within the first year. Approximately 32% cited the desire to have another child as their reason for discontinuation (Table 6.14). Notably, a significant 23.5% of past users reported no reason for stopping their last method.

The last method that currently married women were using but not currently using, included mainly short-term contraceptive methods such as injectables (26.8%), male condoms (21.8%), withdrawal (19.7%), and oral pills (13.4%) (Table 6.13). Past use of injectables (28.9%) and oral pills was higher in rural areas compared to urban areas (16.3% and 8.9%), while the use of condoms and withdrawal was more prevalent in urban areas (29.7% and 26.1%) than in rural areas (20.3% and 18.4%).

The lower percentage of past IUD users expressing a desire for another child confirmed that IUDs were primarily used as a long-acting reversible method by women wishing to limit childbearing. Side effects were the second leading reason for discontinuing IUDs (0.5%), injectables (6.7%), and oral pills (6.8%). Interestingly, among the five methods mentioned above, contraceptive failure was the least reported reason by past withdrawal users (1.1%) compared to IUD users (1.4%), injectable users (1.2%), oral pill users (3.5%), and male condom users (1.3%). This suggested that past users of withdrawal either used it effectively or were selective in choosing partners with low fecundity or infrequent sexual activity.

Table 6.13: Percentage of currently married women who were past users reporting their last used method and duration of use

	Total	Rural	Urban
Last method used			
IUDs	4.5	4.7	3.5
Injectables	26.8	28.9	16.3
Implants	1.5	1.4	1.8
Sayana Press	0.7	0.8	0.2
Oral pills	13.4	14.3	8.9
Male condoms	21.8	20.3	29.7
Female condoms	0.4	0.5	0.3
ECPs	0.3	0.3	0.2
Standard days method	0.2	0.1	0.6
Lactational amenorrhea method	3.0	2.9	3.4
Rhythm method	0.3	0.3	0.5
Withdrawal	19.7	18.4	26.1
Current method being used continuously	1.3	1.3	1.0
Others	6.2	6.0	7.7
Total	100.0	100.0	100.0
Percentage stating duration of use (months)			
0-12	73.8	74.1	72.7
13-24	10.8	10.8	10.7
25+	15.4	15.1	16.6
Total	100.0	100.0	100.0

Table 6.14: 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	32.0	32.9	27.5
Side effects	4.1	4.3	3.4
Method failure	1.5	1.5	1.7
Source of method was too far	1.0	1.0	0.9
Travel/travel cost	0.4	0.3	1.2
Health issues other than side effects	2.9	2.8	3.1
Method unavailable	0.5	0.4	0.6
Too expensive	0.7	0.8	0.6
Method inconvenient	1.1	1.1	1.5
Rest from method	4.7	4.4	6.2
Missed a dose	0.7	0.7	0.7
Provider advised ceasing use	0.6	0.6	0.6
Infrequent sexual activity/husband away	6.1	6.4	4.6
Husband's advice	6.8	7.1	5.2
In-laws opposed	0.4	0.4	0.5
Menopause	4.4	4.7	3.2
Others	8.5	8.1	10.6
Don't know	23.5	22.6	28.1
Total	100.0	100.0	100.0

The leading reasons for not using a modern contraceptive method were primarily concerns about side effects (21.7% overall, 20.9% in rural areas, and 24.7% in urban areas) reported by users of traditional methods (Table 6.15). Fatalism (“up to God”) and infrequent sexual activity were other reasons cited for not using modern methods. Approximately ten percent of traditional method users reported their husbands’ opposition to modern methods.

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

	Total	Rural	Urban
Reason (MRV)			
No sexual activity	3.0	2.8	4.0
Infrequent sexual activity	12.5	12.3	13.3
Menopausal	1.1	1.2	1.0
Cannot get pregnant	1.9	2.1	1.4
Not menstruated since last birth	0.2	0.2	0.0
Breastfeeding	2.7	2.9	1.9
Up to God (fatalistic)	13.3	14.5	8.5
Respondent opposed	0.3	0.4	0.0
Husband opposed	9.9	9.9	9.6
In-laws opposed	0.4	0.5	0.0
Religious prohibition	2.6	2.0	4.9
Unaware of modern methods	1.7	1.8	1.3
Unaware of modern method sources	0.7	0.8	0.3
Inconvenient to use	6.5	6.5	6.8
Changes in menstrual bleeding	0.7	0.7	0.8
Methods could cause infertility	1.0	1.0	0.8
Modern methods interfere with body's normal processes	5.1	4.9	6.1
Lack of access/too far	0.3	0.2	0.6
Too expensive	2.1	2.2	1.7
Not a preferred method	0.0	0.1	0.0
Methods unavailable	0.3	0.4	0.0
Side effects	21.7	20.9	24.7
Want (more) children	8.4	8.4	8.2
Hysterectomy	0.4	0.4	0.2
Others	3.1	2.9	4.0
Total	100.0	100.0	100.0

Among never-users, the main reasons for not using any method were the desire for more children (24.2%) and fatalism (24.3%) (Table 6.16). Additionally, about 11% of never-users mentioned the perception that they could not get pregnant.

Table 6.16: Percentage of currently married women who had never used any family planning method and reporting reasons for non-use

Reasons for never using any family planning method*	Total	Rural	Urban
No sexual activity	6.1	6.1	6.5
Infrequent sexual activity	11.2	11.7	8.1
Menopausal	2.2	2.1	2.9
Cannot get pregnant	11.0	11.1	10.6
Not menstruated since last birth	0.8	0.8	0.5
Breastfeeding	3.0	3.2	1.6
Up to God (fatalistic)	24.3	24.8	20.5
Respondent opposed	0.4	0.5	0.1
Husband opposed	2.9	2.8	3.7
Others opposed	0.4	0.4	0.3
Religious prohibition	3.2	3.2	2.9
Unaware of methods	0.6	0.6	0.5
Unaware of method sources	0.2	0.2	0.1
Inconvenient to use	0.1	0.1	0.0
Changes in menstrual bleeding	0.4	0.4	0.6
Methods could cause infertility	0.2	0.2	0.4
Methods interfere with body's normal processes	0.3	0.3	0.8
Health issues	1.2	1.1	1.7
Fear of side effects	1.9	1.9	1.6
Source of method difficult to reach	0.1	0.1	0.0
Travel/travel cost	0.2	0.2	0.0
Too expensive	0.1	0.1	0.0
Preferred method unavailable	0.0	0.0	0.0
No methods available	0.1	0.2	0.1
Respondent/husband infertile	0.6	0.6	0.5
Want (more) children	24.2	23.5	29.9
Hysterectomy	1.7	1.6	2.5
Others	2.7	2.5	4.0
Total	100.0	100.0	100.0

* Multiple response variable.

Access and Affordability of Family Planning Services

Access to family planning services was measured by the one-way travel time to family planning facilities. An overwhelming majority of family planning clients—72.2% overall, 70.7% in rural areas, and 81.2% in urban areas—took 30 minutes on average or less to reach a facility. Notably, a higher proportion of clients in rural areas could reach a private facility within 30 minutes (76.8%) compared to a public facility (66.6%). In urban areas, access was even better; 87% of users reached a public facility within 30 minutes, while 83.7% reached a private facility (Table 6.17). Only 4.3% of all respondents reported a one-way travel time of over one hour, with 4.6% in rural areas and 2.6% in urban areas. Therefore, the time required to reach a family planning facility did not appear to be a significant constraint for most women.

Table 6.17: Percentage distribution of currently married women using a modern contraceptive method and reporting how long it takes (one-way) to access the method's source

	Total	Public		Private	
		Rural	Urban	Rural	Urban
One-way time to reach facility (mins.)					
1-30	72.2	66.6	87.0	76.8	83.7
31-60	13.6	20.0	8.1	10.1	6.0
60+	4.3	6.2	1.6	3.5	3.6
Don't know	10.0	7.2	3.4	9.7	6.8
Total	100.0	100.0	100.0	100.0	100.0

The cost of accessing services is a significant barrier to both the uptake and continuation of contraceptive use. The expense associated with family planning services varies depending on the method chosen, transportation costs, and whether the service was obtained from a public or private facility. While public family planning services are free, clients often incur expenses on transportation, fees, medicines, and tests. Overall, 83.8% of current users of modern methods reported incurring costs for obtaining family planning services (Table 6.18). A higher percentage of women with no education (85.8%) faced these costs compared to those with secondary or higher education (78%). Similarly, more women in the lowest wealth quintile (85.6%) incurred costs than those in the highest quintile (79%).

Current users were asked about the costs associated with various aspects of procuring their chosen method during the KPHPS. The mean cost estimates were influenced by extreme values; therefore, we present both mean and median values, focusing on the latter for comparisons. It is important to note that the modern methods predominantly used in KP were male condoms, injectables, and oral pills, which are less expensive than male or female sterilization, implants, or IUDs.

On average, women spent PKR 850 on their current method. The median cost was higher in urban areas (PKR 1,000) compared to rural areas (PKR 800), and in lagging districts (PKR 1,100) compared to non-lagging districts (PKR 700). By age, women aged 35–49 spent PKR 1,000, which was twice as much as women aged 15–24 years (PKR 500), likely due to their preference for long-term methods. Women with secondary or higher education and those in the highest wealth quintile also spent more

on their current method than women with no education or those in the lowest wealth quintile. However, 22.7% of women aged 35–49 years, 20.1% of women with secondary or higher education, and 21.8% of women in urban areas spent over PKR 5,000 on their current method.

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	83.8	2,429	850	4,483	19,015	1,969
Residence						
Rural	84.1	2,073	800	4,333	19,580	1,684
Urban	81.9	356	1,000	5,535	14,386	285
District type						
Lagging	81.5	734	1,100	5,248	23,110	586
Non-lagging	84.4	1,695	700	4,300	17,893	1,383
Current age (in years)						
15–24	83.9	367	500	3,953	31,484	291
25–34	83.5	1,083	700	3,528	13,453	876
35–49	84.1	979	1,000	5,729	17,377	802
Education						
No education	85.8	1,454	800	4,231	16,644	1,218
Primary/middle	83.4	371	500	3,182	8,041	299
Secondary and above	78.0	599	1,000	6,653	30,626	448
Wealth quintile						
Lowest	85.6	406	600	3,789	17,772	335
Second	86.6	473	510	4,880	17,775	392
Middle	86.5	554	710	4,743	18,120	445
Fourth	83.2	498	750	3,138	7,275	406
Highest	79.3	498	1,300	5,490	26,615	391

* 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 Future

Married women who had previously used a contraceptive method but were either not currently using one or had never used any method were asked about their intentions to use a method in the future. Among past users, 26.5% overall, 26.1% in rural areas, and 28.7% in urban areas indicated they were “very definitely” or “most likely” to use a method in the future (Table 6.19). In contrast, among never-users, the intention to use a method was low, with only 7.1% overall (6.9% in rural areas and 8.5% in urban areas) stating they would “very definitely” or “most likely” to use a method in the future.

Table 6.19: Percentage of currently married women who had never used a method and those who had used a method in the past (by intention to use in future)

	Total	Rural	Urban
Intention to use family planning in future			
Past users			
Very definitely	16.8	16.4	19.1
Most likely	9.7	9.7	9.6
Not sure/maybe	35.1	36.5	28.5
No	26.0	25.4	28.7
Cannot get pregnant	12.4	12.0	14.2
Missing	0.0	0.0	0.0
Total	100.0	100.0	100.0
Never-users			
Very definitely	3.9	3.8	4.7
Most likely	3.2	3.1	3.8
Not sure/maybe	29.9	29.5	33.0
No	48.3	48.9	44.1
Cannot get pregnant	14.7	14.7	14.3
Missing	0.0	0.0	0.0
Total	100.0	100.0	100.0

The three most preferred methods for future use were injectables (22.7%), male condoms (20.1%), and withdrawal (12.4%) overall (Table 6.20). Injectables were more preferred in rural areas (24.1%) than in urban areas (15.6%), while male condoms were favored more in urban areas (23.8%) compared to rural areas (19.4%). Withdrawal was also slightly more preferred in urban areas (14.8%) than in rural areas (12%).

Table 6.20: Percentage of currently married women who used a method in the past but are not using one currently, or those who never used one but intend to do so in future (by future method preference)

	Total	Rural	Urban
Preferred method to use in future			
Female sterilization	3.3	3.2	4.3
Male sterilization	0.2	0.3	0.0
IUDs	6.1	6.3	4.7
Injectables	22.7	24.1	15.6
Sayana Press	1.8	1.7	2.8
Implants	0.1	0.1	0.0
Oral pills	9.0	9.5	6.2
Male condoms	20.1	19.4	23.8
Female condoms	0.3	0.3	0.6
ECPs	0.1	0.1	0.0
Standard days method	0.1	0.1	0.1
Lactational amenorrhea	0.2	0.2	0.1
Rhythm method	0.3	0.2	1.0
Withdrawal	12.4	12.0	14.8
Others (specify)	0.3	0.3	0.1
Don't know	22.8	22.2	26.1
Total	100.0	100.0	100.0

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 use of any contraceptive method to prevent pregnancy. It serves as an indicator for SDG 3.7, which aims for 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) who have their need for family planning satisfied with modern methods.”¹⁴ This indicator reflects the progress a country or province is making in ensuring that women have access to the necessary services for family planning and reproductive health management, which is a core SDG objective. In general, low contraceptive use correlates with high unmet need for family planning.

In KP, 30.7% of currently married women aged 15–49 had an unmet need for family planning— 12.4% for spacing and 18.3% for limiting (Table 6.21). The overall unmet need was higher in rural areas (31.0%) than in urban areas (28.5%), among women aged 35–49 years (37.7%) compared to those aged 15–24 years (21.6%), for women with no education (32.4%) versus those with secondary or higher education (27.9%), and among women in the lowest wealth quintile (36.2%) compared to those in the highest wealth quintile (28.0%).

Table 6.21 and Figure 6.4 show diverse patterns of unmet need for spacing and limiting by subgroups. The unmet need for spacing was lower in urban areas (9.7%) compared to rural areas (12.8%), while the need for limiting was fairly similar (18.8% vs. 18.2%). Lagging districts exhibited comparable levels of unmet need for spacing (15.3%) and limiting (15.6%), whereas non-lagging districts had a higher unmet need for limiting (19.4%) than for spacing (11.2%).

By age, the unmet need for spacing declined from 16.7% among women aged 15–24 to 8.9% among those aged 35–49, while the unmet need for limiting increased from 5.1% to 28.8%, respectively. The differences in unmet need for spacing across education categories were modest; however, the need for limiting was 19.6% for women with no education, compared to 15.4% for women with secondary or higher education. By wealth quintile, 17.1% of women in the lowest quintile had an unmet need for spacing, compared to 10.3% in the highest wealth quintile. The need for limiting across wealth categories showed moderate variation.

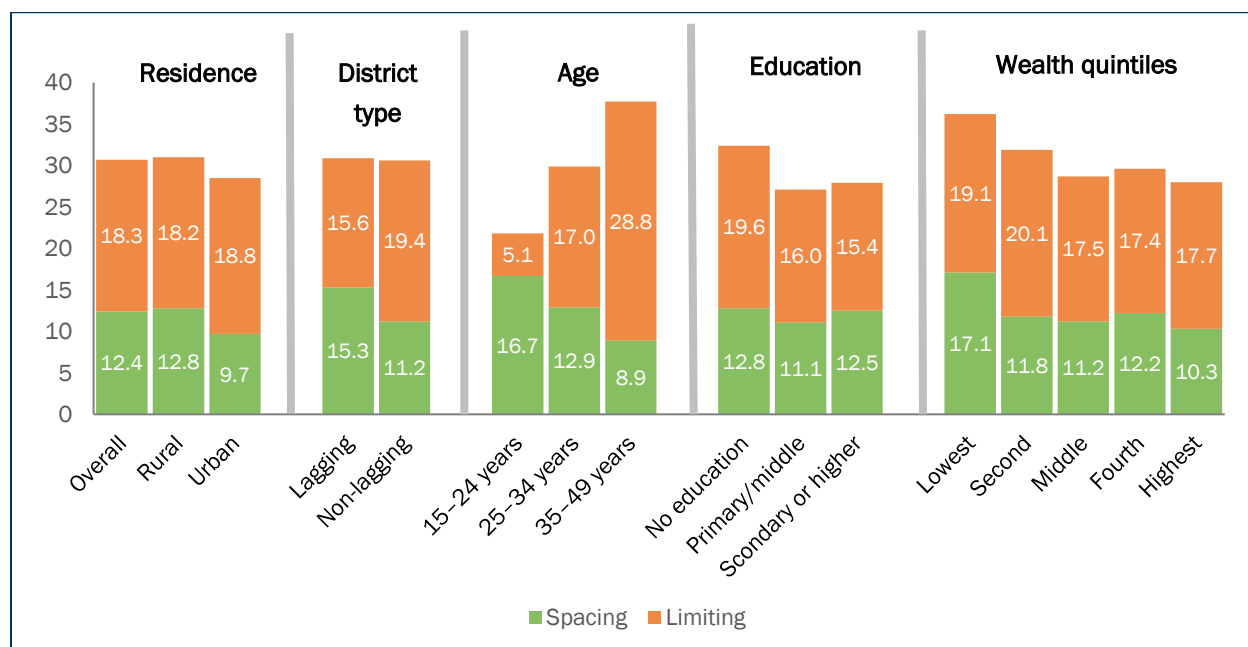
Total unmet need overall, as well as the unmet need for spacing and limiting, varied significantly by district (Figure 6.5). Buner, Karak, and Kolai Palas Kohistan reported an unmet need exceeding 50%. The need for limiting was more widespread than that for spacing, except in Kolai Palas Kohistan and Upper Kohistan. The lowest unmet need for family planning was found in North Waziristan (12%) and Bajaur (13%).

¹⁴ 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>.

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			N (Unweighted)
	Total unmet need	Unmet need for spacing	Unmet need for limiting	
Overall	30.7	12.4	18.3	27,506
Residence				
Rural	31.0	12.8	18.2	24,107
Urban	28.5	9.7	18.8	3,399
District type				
Lagging	30.8	15.3	15.6	12,602
Non-lagging	30.6	11.2	19.4	14,904
Current age (years)				
15–24	21.8	16.7	5.1	6,133
25–34	29.9	12.9	17.0	11,859
35–49	37.7	8.9	28.8	9,514
Education				
No education	32.4	12.8	19.6	19,819
Primary/middle	27.1	11.1	16.0	3,371
Secondary and above	27.9	12.5	15.4	4,316
Wealth quintile				
Lowest	36.2	17.1	19.1	7,673
Second	31.9	11.8	20.1	5,547
Middle	28.7	11.2	17.5	5,272
Fourth	29.6	12.2	17.4	4,901
Highest	28.0	10.3	17.7	4,113

Figure 6.4: Percentage of currently married women with unmet need for spacing and limiting

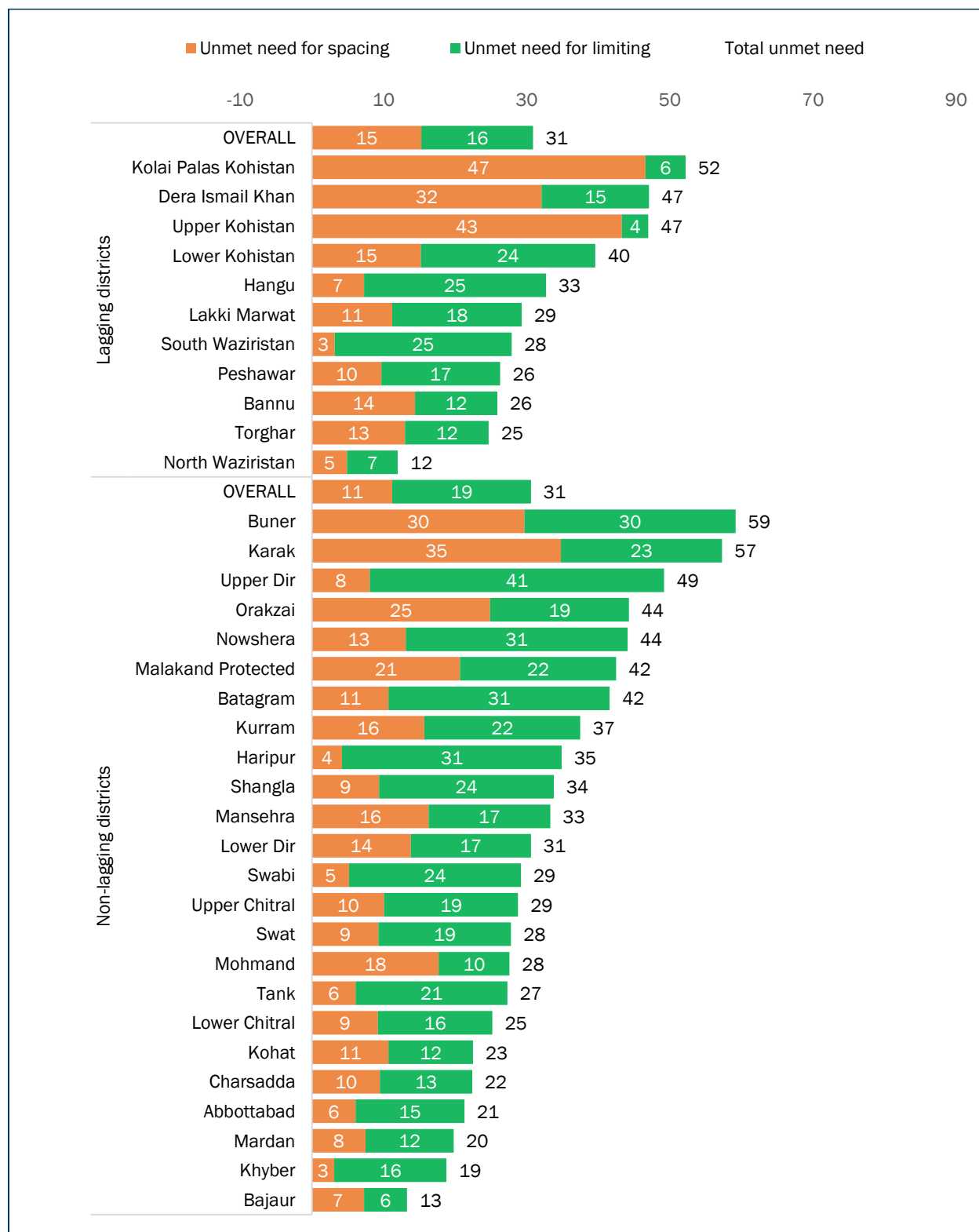


The total demand for family planning, which is defined as the percentage of individuals using a contraceptive method plus the percentage of unmet need for family planning, was estimated at 53.6% for KP overall (Table 6.22). The proportion of demand satisfied was 42.7%. The highest demand for family planning was observed among women aged 35–49 years (63.8%), while the lowest was among those aged 15–24 years (37.7%). Total demand for other subgroups hovered around 54%. The percentage of demand satisfied by modern methods was 32.7% for women in the highest wealth quintile and 30.4% for women with secondary or higher education. Therefore, the potential for meeting family planning demand through modern methods remains largely untapped.

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)
Overall	30.7	22.9	53.6	42.7	27.6	27,506
Residence						
Rural	31.0	22.0	53.0	41.5	27.4	24,107
Urban	28.5	28.7	57.2	50.2	29.0	3,399
District type						
Lagging	30.9	23.0	53.9	42.7	24.9	12,602
Non-lagging	30.6	22.9	53.5	42.8	28.8	14,904
Current age (years)						
15–24	21.8	15.9	37.7	42.2	27.3	6,133
25–34	29.9	24.1	54.0	44.6	28.5	11,859
35–49	37.7	26.1	63.8	40.9	26.8	9,514
Education						
No education	32.4	21.1	53.5	39.4	26.4	19,819
Primary/middle	27.1	26.1	53.2	49.1	29.7	3,371
Secondary and above	27.9	26.4	54.3	48.6	30.4	4,316
Wealth quintile						
Lowest	36.2	15.1	51.3	29.4	21.4	7,673
Second	31.9	22.4	54.3	41.3	27.1	5,547
Middle	28.7	24.4	53.1	46.0	28.1	5,272
Fourth	29.6	24.2	53.8	45.0	27.5	4,901
Highest	28.0	27.4	55.4	49.5	32.7	4,113

Figure 6.5: Percentage of currently married women with unmet need for family planning for spacing and limiting (by district)



Infant and Child Health

Key Findings

Breastfeeding practices

- Breastfeeding was nearly universal, with 95% of women in KP breastfeeding their children—94.8% in rural areas and 95.8% in urban areas.
- Two-thirds of newborns (74.4%) received colostrum.
- About half (52%) of babies were put to the breast within two hours of delivery.
- 55% of the babies were exclusively breastfed for four to six months.
- Additionally, 53.5% of babies were given liquids other than breast milk during the first three days.

Diarrhea prevalence and treatment

- The prevalence of diarrhea in the two weeks prior to the survey was 13.3% among male children and 14% among female children.
- Treatment for diarrhea was sought for 60% of male children and 53% of female children under the age of 60 months.
- Private facilities were the source of treatment for 60% of diarrhea cases.
- Antibiotic pills or anti-diarrhea medications were the primary treatments for diarrhea.

Acute respiratory infection (ARI) prevalence and treatment

- The prevalence of acute respiratory infection (ARI) among children during the two weeks prior to the survey was 6.1%, with 3.8% of children in KP receiving treatment.
- The primary source of treatment, in 62.7% of cases, was private sector facilities.
- The prevalence of ARI in non-lagging districts was 5.4%, compared to 7.8% in lagging districts.

Nutrition

- In the 24 hours prior to the survey, only 5% of children aged 0–59 months received iron supplements, 2% received vitamin A supplements, and 1.9% received multi-micronutrient powder.
- The consumption of these supplements was more closely associated with mothers' education and household wealth than with place of residence.

The SDGs, particularly SDG 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 WHO and UNICEF recommend that breastfeeding be initiated within the first hour of birth and that infants be exclusively breastfed for the first six months of life. Breastfeeding is widely practiced in KP, with 95% of mothers reporting that they breastfed their child (94.8% in rural areas and 95.8% in urban areas). Colostrum, the first milk produced by a mother’s breasts, is a highly nutritious substance crucial for newborns.

Three-fourths of all women who gave (live) birth in the three years preceding the survey provided colostrum to their last newborns—74.4% overall, 74.6% in rural areas, and 72.9% in urban areas (Table 7.1). Among those who were breastfed, 19.8% were put to the breast immediately, with 20.6% in rural areas and 14.3% in urban areas. One-thirds of women initiated breastfeeding five or more hours after delivery. Exclusive breastfeeding for four to six months was practiced by 55% of women in KP, with 54.9% in rural areas and 55.3% in urban areas (Table 7.2).

Table 7.1: Percentage of women by breastfeeding patterns for their last-born child

	Total	Rural	Urban
No. of women (Unweighted)	11,423	10,093	1,330
Percentage who breastfed	95.0	94.8	95.8
Was baby given colostrum?			
Yes	74.4	74.6	72.9
No	25.6	25.4	27.1
Total	100.0	100.0	100.0
Time the child was put to breast after birth <i>(based on women who breastfed their babies)</i>			
Immediately	19.8	20.6	14.3
1–2 hours	32.0	31.2	37.7
3–4 hours	13.2	13.2	13.6
5+ hours	33.3	33.3	33.2
Don’t know	1.6	1.7	1.3
Total	100.0	100.0	100.0
No. of women who breastfed (Unweighted)	10,827	9,559	1,268

Table 7.2: Percentage of women* by duration of exclusive breastfeeding and age when weaning was initiated

	Total	Rural	Urban
Duration of exclusive breastfeeding (months)			
<1	4.4	4.7	2.7
1-3	10.7	10.4	12.9
4-6	55.0	54.9	55.3
7+	29.9	30.0	29.1
Total	100.0	100.0	100.0
No. of women (Unweighted)	10,827	9,559	1,268
Age at start of weaning (months)			
1-3	3.2	3.3	2.4
4-6	51.3	51.1	52.7
7+	40.9	40.8	41.3
Not applicable	4.6	4.7	3.7
Total	100.0	100.0	100.0
No. of women (Unweighted)	6,835	5,983	852

*Based on all women with a birth in the three years preceding the survey.

Breastfeeding for one to three months, which is shorter than the WHO-UNICEF-recommended duration, was practiced by 10.7% overall, 10.4% in rural areas, and 12.9% in urban areas. Approximately 30% of mothers exclusively breastfed their last child for seven or more months. The age at which weaning was initiated was four to six months for 51.3% overall, 51.1% in urban areas, and 52.7% in rural areas, aligning with global recommendations.

Half of the women provided fluids in addition to breast milk during the first three days after delivery (Table 7.3). Tea or herbal preparations were the most common drinks, given by 47% of women in KP, 47.3% of rural women, and 45.5% of urban women. *Ghutty*, a mild laxative for infants not medically recommended, which is believed to relieve constipation and is perceived to be effective against diarrhea, dysentery, and griping, was the second-most common liquid given, consumed by 30.1% of women in KP, 30.3% of women in rural areas, and 28.8% of women in urban areas. The use of infant formula during the first three days was relatively uncommon, with only 7.5% overall, 7.1% in rural areas, and 10% in urban areas.

Breastfeeding, which is nearly universal in KP, is a positive finding, further supported by the high proportion of mothers who provided colostrum. Additionally, one in two women practiced exclusive 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 practice that undermines the benefits of exclusive breastfeeding.

Table 7.3: 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)	11,423	10,093	1,330
Percentage given liquid(s) other than breast milk	53.5	53.0	57.0
Types of drinks given during the first three days after delivery*			
Tea/traditional herbal preparations	47.0	47.3	45.5
<i>Ghutti</i>	30.1	30.3	28.8
Milk—other than breast milk	20.3	20.1	22.0
Plain water	12.9	12.8	14.0
Honey	12.5	12.5	12.5
Gripe water	8.8	8.7	9.3
Infant formula	7.5	7.1	10.0
Sugar/glucose water	4.9	5.0	4.1
Others ^a	6.7	6.7	6.7
Total	100.0	100.0	100.0
No. of women (Unweighted)	5,681	4,334	747

^a 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.

*Multiple response variable.

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

Diarrhea is a leading cause of death and malnutrition in children under five years of age. The KPHPS collected data on the incidence of diarrhea among children aged 0–59 months. In the two weeks preceding the survey, 13.9% of children in this age group experienced diarrhea. The incidence was slightly higher among female children (14.6%) compared to male children (13.3%), based on a total sample of 17,018 children (Table 7.4).

Among those who had diarrhea, 56.8% sought treatment, with a difference by sex of the child (60.2% for males and 52.7% for females).

The most reported symptom was loose stools, cited by 79.7% of cases, followed by vomiting (34.8%), lethargy (34.3%), refusal to eat (23.1%), and dehydration (16%). A small proportion (4.2%) reported other symptoms, such as blood or mucus in stools.

In terms of treatment sources, 40.1% reported seeking care from public facilities, while 60.7% relied on private providers. Treatment-seeking patterns were consistent across the sexes, with 42% seeking treatment for female children and 39% for male children.

Table 7.4: Percentage of children aged 0–59 months who had diarrhea in the two weeks preceding the survey, along with symptoms and treatment sought (by sex of child)

	Total	Male child	Female child
Children who had diarrhea in the last two weeks			
Incidence (%)	13.9	13.3	14.6
Treatment sought (%)	7.9	8.0	7.7
N (Unweighted)	17,018	9,060	7,958
Symptoms of diarrhea of those who had diarrhea (MRV)*			
Three loose motions	79.7	79.0	80.5
Vomiting	34.8	34.4	35.3
Child refusing food	23.1	24.2	21.9
Lethargy	34.3	33.9	34.6
Dehydration	16.0	17.4	14.5
Others ^a	4.2	4.8	3.6
N (Unweighted)	2,279	1,170	1,109
Source of treatment among those who sought treatment			
Public	40.1	38.8	41.6
Private	60.7	61.8	59.5
Others	0.7	1.0	0.2
Total	100.0	100.0	100.0
No. of women (Unweighted)	1,336	704	632

^a Blood/mucus in stools, and others.

* Multiple response variable

Antibiotic pills or syrups and anti-diarrheal medications were the most used treatments (Table 7.6). Anti-diarrheal pills or syrups were used more frequently in private facilities (34.3%) compared to public facilities (30.3%).

The differentials in the incidence of diarrhea and the treatment sought are shown in Table 7.5 and illustrated in Figures 7.1 and 7.2. The incidence and treatment rates were higher in the first year of life (29.2% and 17.3%, respectively) and decreased with age (Figure 7.1). Although treatment rates were lower than incidence rates, they followed a similar pattern. The incidence of diarrhea in rural areas was 14.2%, compared to 11.7% in urban areas (Figure 7.2). The difference in incidence and treatment rates between lagging and non-lagging districts was minimal. Diarrhea among the children of young mothers aged 15–24 years was higher (15.5%) compared to children of mothers aged 35–40 years (12.3%). Both incidence and treatment rates were higher for children of mothers with primary or middle education than for those with no education or with secondary or higher education. Children of mothers in the middle wealth quintile exhibited the highest incidence and treatment rates of diarrhea compared to children of mothers in other wealth quintiles.

Table 7.5: 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		13.9	8.4	17,018
Sex	Male child	13.3	8.4	9,060
	Female child	14.6	8.3	7,958
Child's age in months	0–6	13.8	8.2	4,239
	7–12	15.4	9.1	3,393
	13–18	17.8	11.4	1,385
	19–24	13.8	8.6	1,674
	25–36	15.1	9.8	2,554
	37–48	10.1	5.6	2,596
	49–59	10.1	5.6	1,177
Residence	Rural	14.2	8.6	15,080
	Urban	11.7	6.7	1,938
District type	Lagging	14.5	9.1	8,124
	Non-lagging	13.6	8.0	8,894
Mother's age (years)	15–24	15.5	9.4	4,125
	25–34	13.7	8.2	8,948
	35–49	12.3	7.5	3,940
Mother's education	No education	13.8	8.1	12,197
	Primary and middle	15.5	10.4	2,139
	Secondary or higher	12.5	7.3	2,682
Wealth quintiles	Lowest	12.8	6.7	5,028
	Second	14.1	8.3	3,496
	Middle	16.5	10.8	3,207
	Fourth	13.5	8.4	2,937
	Highest	12.6	7.7	2,350

Table 7.6: 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)

	Total	Public	Private	N (Unweighted)
Treatment given to child				
Antibiotic pills/syrups	32.5	30.3	34.3	460
Antimotility (anti-diarrhea) pills/syrups	32.6	26.0	36.4	427
Other* (pills/syrups)	6.2	9.2	4.4	87
Unknown pills/syrups	11.1	12.8	9.9	155
Antibiotic injections	15.7	13.7	16.9	189
Unknown injections	9.3	9.1	9.4	131
Intravenous injections	4.3	4.9	4.0	79
Drips	24.1	30.9	19.9	375
Others*	6.6	8.0	5.7	142

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

The incidence of diarrhea in the two weeks preceding the survey was 31% among children in North Waziristan, 28% in Shangla, and 27% in Charsadda (Figure 7.3). It was four percent among children in Karak and two percent in Kolai Palas Kohistan.

The findings indicated that the public sector remains the most sought source for treatment, although the quality of care in private facilities may be perceived as better. Reliance on community-based health workers for diarrhea treatment was notably low. A positive finding was the consistency in treatment-seeking behavior across both male and female children. Analysis by maternal age suggested that younger mothers, possibly due to limited experience, had a higher incidence of diarrhea among their children.

Figure 7.1: 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)

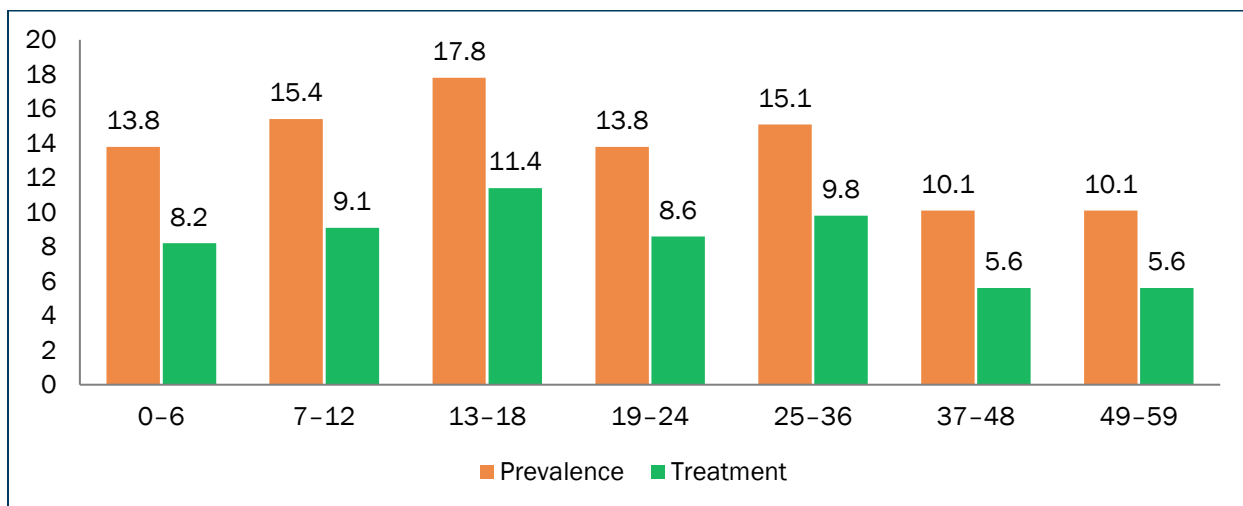


Figure 7.2: Percentage of children aged 0–59 months who had diarrhea in the two weeks preceding the survey and the percentage who received treatment (by background characteristics)

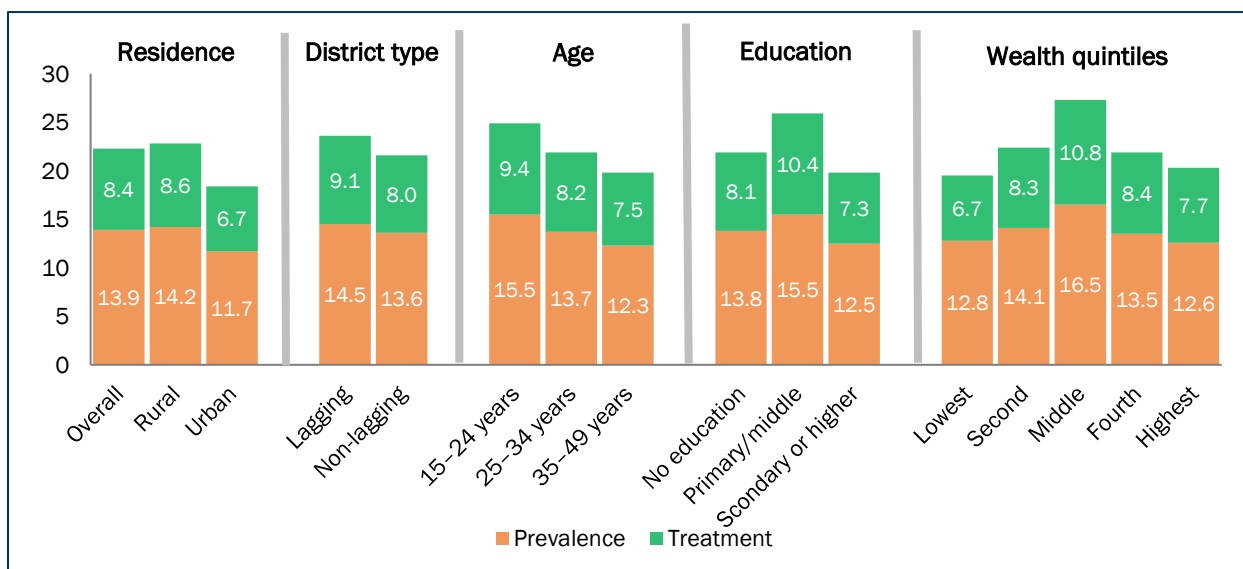
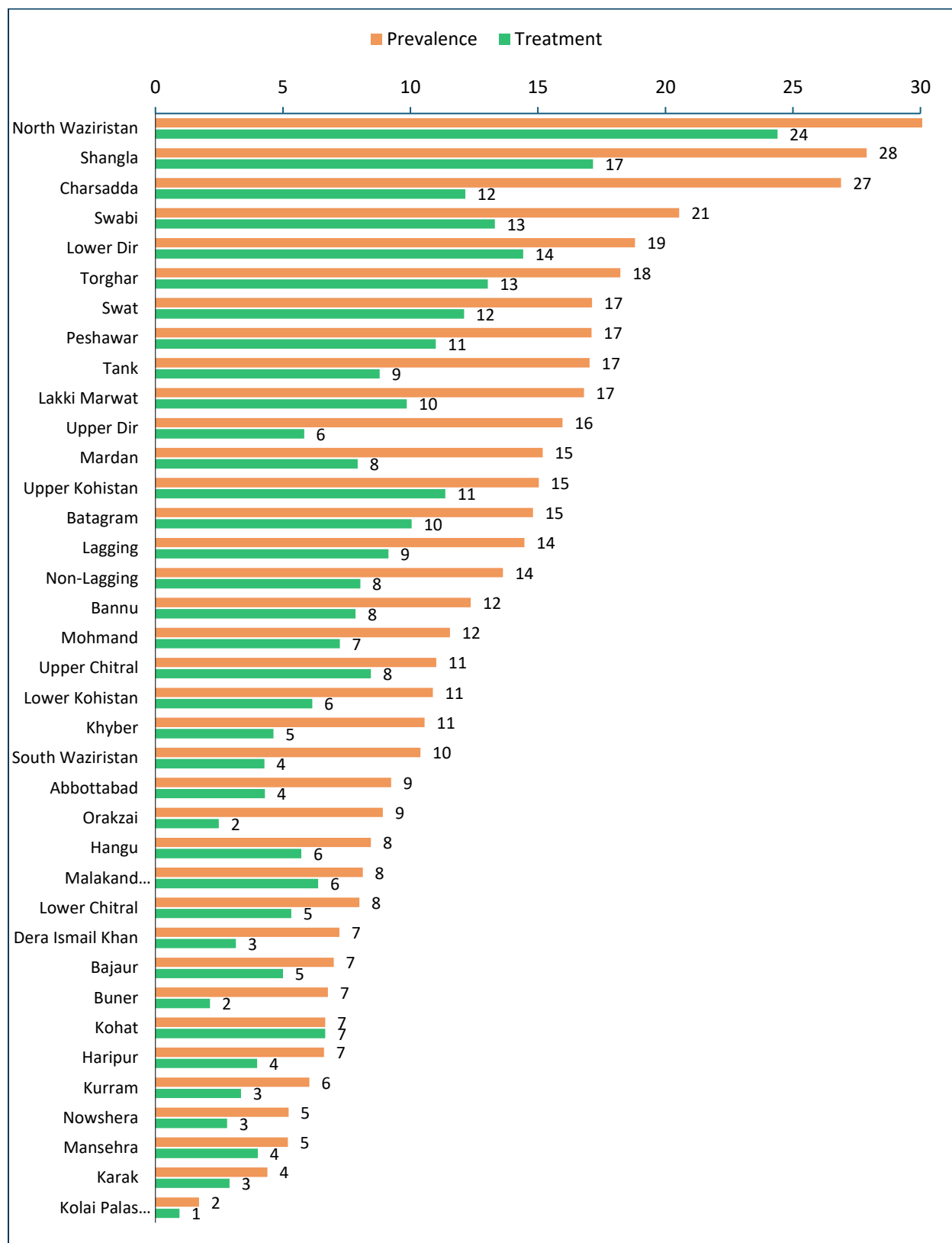


Figure 7.3: Percentage of youngest children aged 0–59 months who had diarrhea in the two weeks preceding the survey and the percentage who received treatment (by district)



Home-based Practices in Dealing with Children with Diarrhea

Several changes in feeding practices were reported during episodes of diarrhea among children aged 0–59 months who experienced diarrhea in the two weeks prior to the survey. Among breastfeeding children, 45.1% of mothers maintained the same liquid intake as usual, while 27.6% slightly reduced it. Notably, 24.8% of female children received significantly less liquid than usual, compared to 21.5% of male children. Among non-breastfeeding children, a higher proportion of males (30%) received less liquid than usual compared to females (25.3%) (Table 7.7).

Table 7.7: Percentage of youngest children aged 0–59 months who had diarrhea in the two weeks preceding the survey (by practices followed at home to manage diarrhea and by sex of child)

	Total	Male	Female	N (Unweighted)
Among breastfeeding children: The amount of liquid given compared to usual amount during diarrhea				
Much less	23.1	21.5	24.8	222
Somewhat less	27.6	27.6	27.5	256
About the same	45.1	45.1	45.1	338
More	2.7	3.7	1.5	32
Nothing to drink	1.6	2.1	1.1	26
N (Unweighted)	100.0	452	422	874
Among non-breastfeeding children: The amount of liquid given compared to usual amount during diarrhea				
Much less	27.6	30.0	25.3	146
Somewhat less	29.5	27.6	31.3	162
About the same	35.6	37.2	34.2	168
More	4.3	1.7	6.8	23
Nothing to drink	3.0	3.5	2.4	17
N (Unweighted)	100.0	263	253	516
Among all children: The amount of liquid given compared to usual amount during diarrhea				
Much less	21.0	19.9	22.1	521
Somewhat less	27.9	30.5	25.2	627
About the same	34.8	35.6	34.1	741
More	3.7	3.0	4.3	105
Stopped food	5.8	5.1	6.5	139
Never initiated food	6.8	5.9	7.8	146
N (Unweighted)	100.0	1,170	1,109	2,279
Treatments administered during diarrhea				
Fluid form of oral rehydration solution (ORS) (packet)	31.8	33.9	29.6	871
ORS liquid	21.1	18.9	23.4	511
Homemade fluid	20.2	21.3	19.1	466
Zinc syrup/tablets	40.1	38.1	42.1	923
Others	1.8	1.7	1.8	42
Don't know	16.9	16.9	17.0	322
N (Unweighted)	100.0	1,170	1,109	2,279

Food intake also declined during illnesses. Overall, 34.8% of children continued to consume the same amount of food, while 21% consumed much less. By sex, 35.6% of male children and 34.1% of female children maintained their usual food intake. A concerning finding was that food was stopped altogether in 5.1% of male cases and 6.5% of female cases.

Regarding oral rehydration, 31.8% of children were given ORS in packet form, and 40.1% received zinc tablets or syrup, with slightly higher zinc usage among females. A higher percentage of male children (32.7%) received fluid ORS packets compared to female children (26%), while more females (18.9%) than males (23.4%) received ORS liquid. In addition, zinc syrup or tablets were given to 42.1% of female children compared to 38.1% of male children. Overall, the differences in the provision of liquids or food by the child's sex were minor.

These findings highlight areas where caregiver education could improve home-based diarrhea management, particularly regarding the maintenance of adequate fluid and food intake.

Acute Respiratory Infections (ARI)

KPHPS respondents were asked about their youngest child under the age of five regarding symptoms of ARI, specifically: "Has the child had fast, short, or rapid breaths, or difficulty breathing at any time in the last two weeks?" For children exhibiting symptoms of ARI, a follow-up question was posed: "Did you seek any advice or treatment for ARI?" Overall, 6.1% of children under five had symptoms of ARI in the two weeks prior to the survey (6.3% for males and 5.9% for females). The treatment-seeking rate was low at 3.8% (Table 7.8), with most care accessed through private facilities (65.5% for males and 59.4% for females). The incidence of ARI peaked among children aged 13–18 months (Figure 7.4, Figure 7.5, and Table 7.9), with lower rates observed in infants and older children. Unlike diarrhea, ARI rates were lower in the 0–6- and 7–12-month age groups, as well as among those aged 49–59 months. ARI incidence was higher in lagging districts (7.8%) compared to non-lagging districts (5.4%). Similarly, younger mothers (15–24 years) reported a higher incidence of ARI among their children (6.5%) than older mothers aged 35–49 years (4.6%). By wealth quintile, children of women in the top two quintiles exhibited a higher rate of ARI than those in the two lowest quintiles.

High temperature was the leading symptom of ARI, affecting 74.1% of male children and 66.9% of female children. Sore throats, runny noses, and rapid breathing were also common symptoms in both male and female children.

Figure 7.5 and Table 7.9 show that the incidence of and treatment for ARI among male and female children are broadly similar, as are the patterns observed in rural and urban areas.

Table 7.8: Percentage of youngest children aged 0–59 months who had ARI in the two weeks preceding the survey, including symptoms and treatment sought (by sex of child)

	Total	Male child	Female child
Children who had ARI			
Incidence	6.1	6.3	5.9
Treatment sought	3.8	4.1	3.6
Symptoms of ARI*			
High temperature	70.9	74.1	66.9
Sore throat	26.7	30.1	22.7
Runny nose	40.7	38.2	43.6
Throat irritation	16.0	16.4	15.6
Indrawing ribs	5.7	7.5	3.4
Rapid breathing	25.9	27.6	23.9
Child's refusal to eat	7.3	7.8	6.6
Cough	52.7	55.1	49.8
Others	0.1	0.1	0.2
Don't know	3.5	2.2	4.9
Total	100.0	100.0	100.0
N (Unweighted)	916	510	406
Source of treatment (among those treated)			
Public	33.6	31.5	36.2
Private	62.8	65.5	59.4
Workers	3.1	2.5	3.9
Others	0.5	0.5	0.6
Total	100.0	100.0	100.0
N (Unweighted)	570	333	237
No. of children (Unweighted)	16,952	9,020	7,932

* Multiple response variable.

Table 7.9: Percentage of youngest children aged 0–59 months who had ARI in the two weeks preceding the survey and the percentage receiving treatment (by background characteristics)

		Incidence	Taking medicine	N (Unweighted)
Sex of child	Both sexes	6.1	3.8	16,952
	Male	6.3	4.1	9,020
	Female	5.9	3.6	7,932
Child age (months)	0–6	4.9	3.0	4,240
	7–12	6.1	3.9	3,386
	13–18	8.6	5.6	1,385
	19–24	5.2	3.7	1,681
	25–36	6.2	4.1	2,810
	37–48	7.4	4.0	2,514
	49–59	5.6	3.4	936
Residence	Overall	6.1	3.8	16,952
	Rural	6.0	3.7	15,014
	Urban	6.7	4.7	1,938
District type	Lagging	7.8	4.4	8,101
	Non-lagging	5.4	3.6	8,851
Mother's age (years)	15–24	6.5	4.2	4,109
	25–34	6.6	4.0	8,919
	35–49	4.6	2.9	3,918
Mother's education	No education	6.0	3.5	12,153
	Primary and middle	6.2	4.3	2,132
	Secondary or higher	6.3	4.6	2,667
Wealth quintile	Lowest	5.5	2.9	5,005
	Second	4.9	2.6	3,479
	Middle	6.8	4.5	3,198
	Fourth	6.0	3.9	2,922
	Highest	7.2	5.1	2,348

By district, Dera Ismail Khan had the highest ARI incidence at 16% and the lowest treatment rate at 0.4% (Figure 7.6). In five districts (Karak, Kohat, Khyber, Orakzai, and Tank), the incidence of ARI was one percent or lower.

Figure 7.4: Percentage of children aged 0–59 months who had ARI in the two weeks preceding the survey and the percentage receiving treatment (by age of child in months)

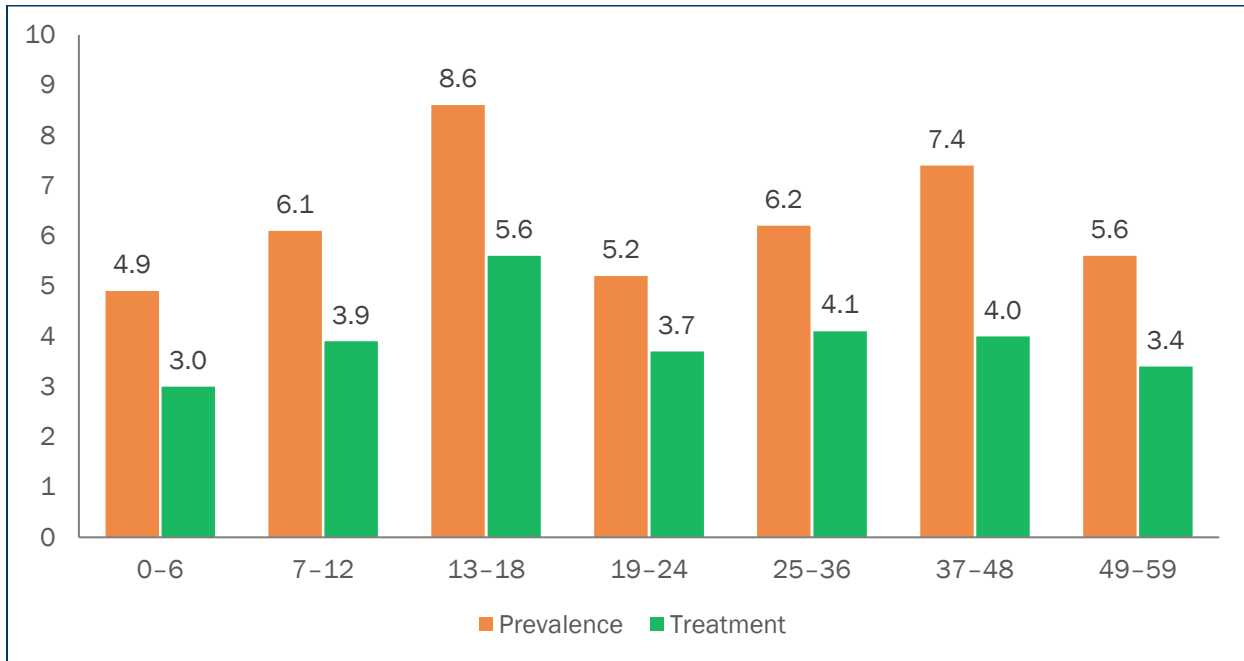


Figure 7.5: Percentage of children aged 0–59 months who had ARI in the two weeks preceding the survey and the percentage receiving treatment (by background characteristics)

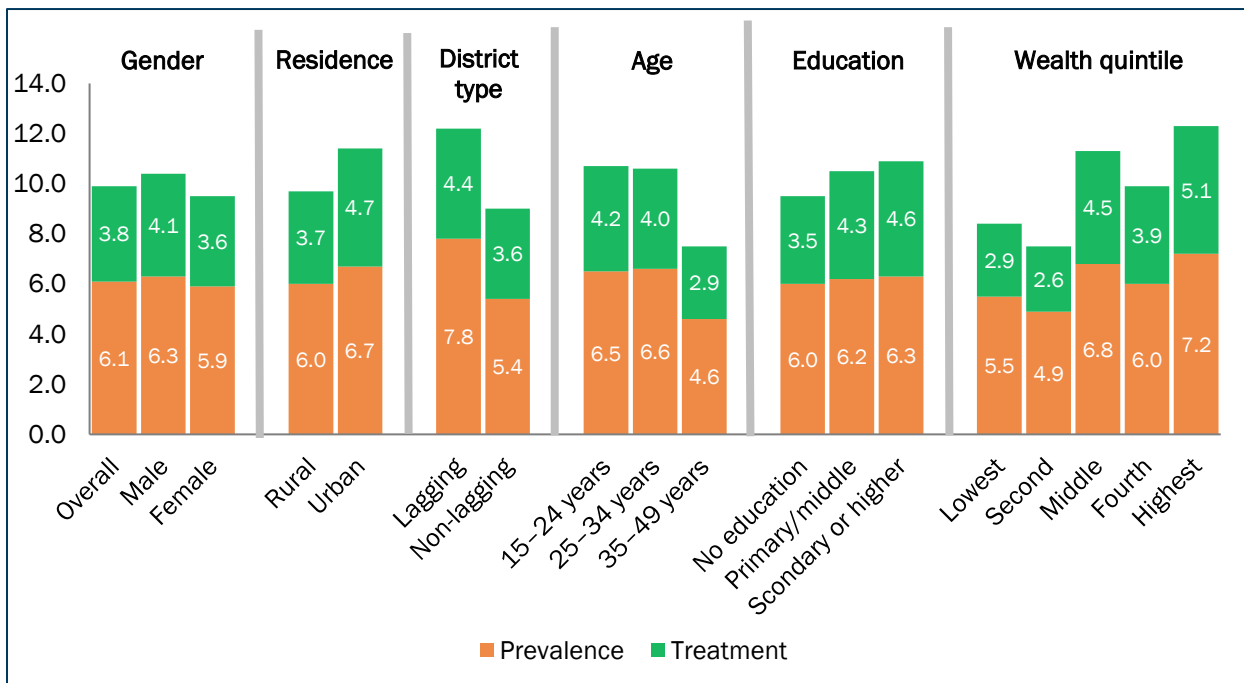
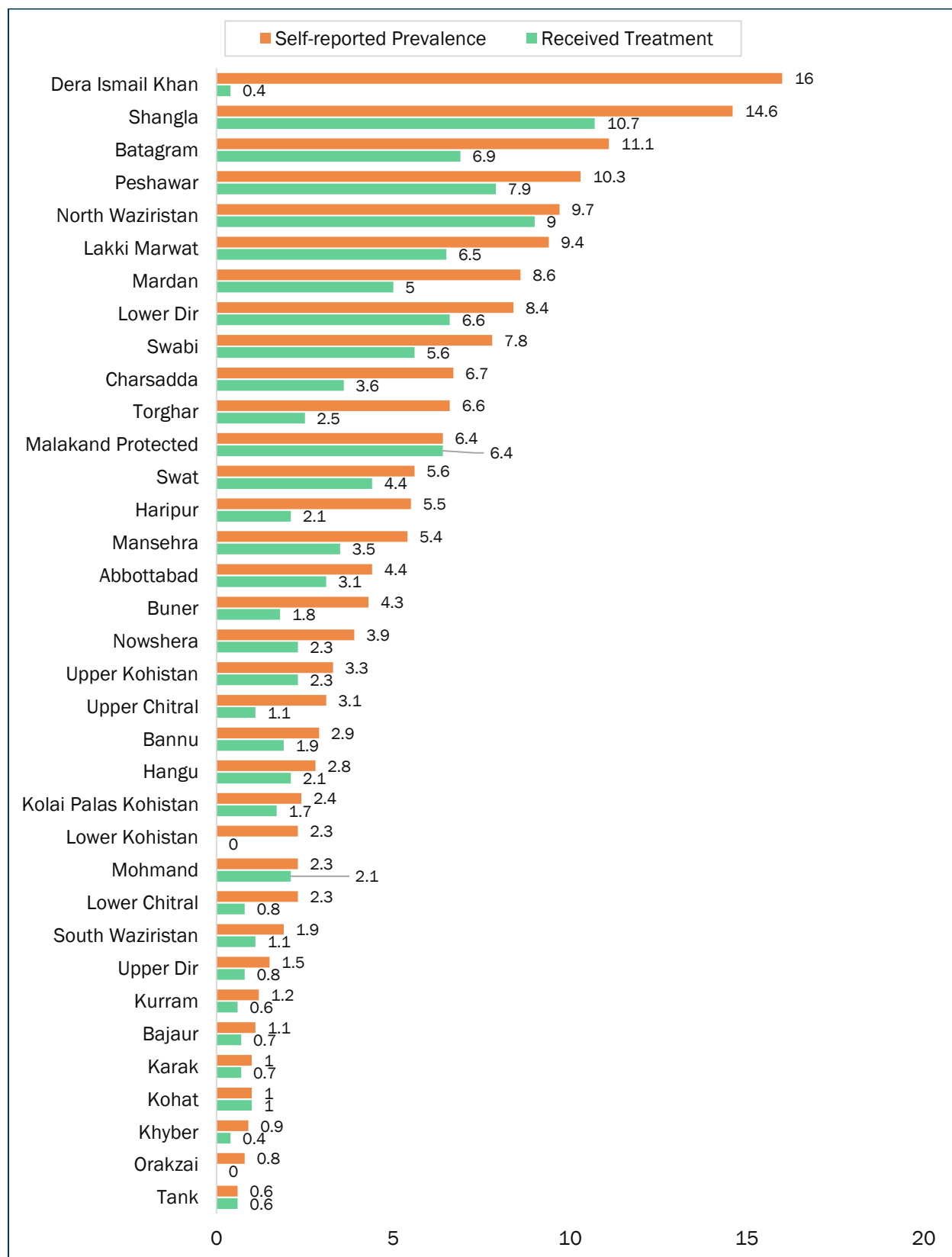


Figure 7.6: Percentage of children aged 0–59 months who had ARI in the two weeks preceding the survey and percentage received treatment (by district)



For 66.1% of males and 69.2% of females with ARI advice or treatment were sought within one to three days of the onset of symptoms (Table 7.10), with a slightly higher proportion among female children (69.2%) compared to male children (66.1%). Delays of more than five days were relatively uncommon and reported for only 7.5% of cases, while a significant proportion of caregivers (25%) was uncertain about when care was first sought.

Table 7.10: Treatment-seeking behavior and type of medication administered for ARI among 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	67.5	66.1	69.2
4–5	3.5	4.1	2.8
6+	4.0	4.7	3.0
Don't know	25.0	25.1	24.9
Total	100.0	100.0	100.0
Child given any medicine for illness at any time during ARI			
Yes	92.3	94.0	90.1
No	7.7	6.0	9.9
Total	100.0	100.0	100.0
Treatment given to child (among those taking medicine for ARI)*			
Amoxicillin	35.8	37.6	33.5
Cotrimoxazole	3.8	4.0	3.6
Other antibiotic pills/syrups	46.3	42.3	51.7
Other antibiotic injections/IVs	24.2	28.1	18.9
Paracetamol/Panadol/acetaminophen	32.4	32.4	32.4
Aspirin	4.8	3.7	6.3
Ibuprofen	28.2	25.4	32.0
Other	1.6	2.4	.6
Don't know	13.3	13.4	13.2
Total	100.0	100.0	100.0
N (Unweighted)	519	304	215

* Multiple response variable.

Nearly all children (92.3%) received some form of medication for ARI. A slightly higher proportion of male children (94%) received medication compared to female children (90.1%).

Regarding specific treatments, the most administered medications were other antibiotic pills or syrups (46.3%), followed by amoxicillin (35.8%) and ibuprofen (28.2%). Male children were more likely to receive injectable antibiotics (28.1%) than female children (18.9%). The use of common fever-reducing medications, such as paracetamol, was reported equally for both sexes (32.4%).

Child Nutrition

Micronutrient Supplementation Among Children Under Five

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

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

The KPHPS surveyed respondents about the supplements given to children under the age of five. Overall, the consumption of key micronutrients was low: only 5% of children received iron supplements, 2% received vitamin A, and 1.9% received multi-micronutrient powder in the 24 hours prior to the survey (Table 7.11). The provision of iron supplements was higher than that of vitamin A or multi-micronutrient powder. The differences in supplement provision based on the child’s sex, urban or rural residence, lagging or non-lagging district, and the mother’s age were modest. Children in urban areas had slightly higher consumption of iron supplements (5.4%) compared to those in rural areas (4.9%), while rural children were more likely to receive vitamin A (2.1%) than urban children (0.9%). Children in non-lagging districts consistently had higher intake of all three supplements compared to those in lagging districts, particularly for multi-micronutrient powder (2% vs. 1.5%).

Supplement use varied by the mother’s age and education level. Children of mothers aged 35–49 had the highest intake of multi-micronutrient powder (2.5%), while iron and vitamin A intake remained fairly consistent across maternal age groups.

Children of mothers with secondary or higher education exhibited higher consumption of iron supplements (6.2%) compared to those with no education (4.2%). Interestingly, vitamin A intake was slightly higher among children of mothers with no education (2.1%) than among those with higher education (1.7%).

Slightly more female children (5.4%) than male children (4.7%) received iron supplements. This pattern was also observed for vitamin A and multi-micronutrient powder, although the differences were marginal.

Micronutrient intake varied significantly by age. Children aged 9–11 months had the highest intake of iron supplements (7.2%), while those aged 24–35 months showed the highest consumption of vitamin A (3%). Consumption of multi-micronutrient powder peaked at 6–8 months (2.8%) and declined sharply among older children, especially those aged 48–59 months, where all three supplement types were minimally consumed.

Children of women in the highest wealth quintile had the highest consumption of iron (8%), compared to just 3.5% in the lowest quintile. For vitamin A and multi-micronutrient powder, the differences across wealth quintiles were less pronounced but still notable.

Table 7.11: 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		5.0	2.0	1.9	11,186
Sex of child	Male	4.7	2.0	1.6	5,878
	Female	5.4	2.1	2.2	5,308
Child's age (months)	0–1	3.7	1.3	0.8	1,164
	2–3	3.9	1.7	1.6	937
	4–5	3.7	1.0	1.9	806
	6–8	4.6	1.9	2.8	1,273
	9–11	7.2	2.0	2.0	1,426
	12–17	4.8	2.2	2.3	1,600
	18–23	4.8	1.8	1.6	1,111
	24–35	5.6	3.0	2.0	2,000
	36–47	6.8	2.7	1.4	741
48–59	1.1	0.5	0.4	365	
Residence	Rural	4.9	2.1	1.9	10,093
	Urban	5.4	0.9	1.7	1,330
District type	Lagging	4.4	1.6	1.5	5,210
	Non-lagging	5.1	2.1	2.0	6,213
Mother's age (years)	15–24	4.9	2.2	2.0	3,382
	25–34	4.9	1.8	1.5	5,905
	35–49	5.0	2.1	2.5	2,132
Mother's education	No education	4.2	2.1	2.0	7,908
	Primary and middle	6.1	1.6	1.2	1,536
	Secondary or higher	6.2	1.7	1.9	1,979
Wealth quintile	Lowest	3.5	2.1	1.8	3,409
	Second	4.1	2.6	2.3	2,280
	Middle	4.6	1.8	2.1	2,112
	Fourth	4.2	1.6	1.6	1,969
	Highest	8.0	1.8	1.4	1,653

Conclusions and Recommendations

The KPHPS 2024–25 offers 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:** Public 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 quality or accessibility in the public sector. Notably, there was gender parity in treatment-seeking behavior, indicating equal access to care for both boys and girls.
- **Home-based management:** Suboptimal home care practices persisted. A significant proportion of caregivers reduced or stopped food and fluid intake during episodes of diarrhea, which is contrary to WHO guidelines. This underscored the need for improved caregiver education on the effective home management of childhood illnesses.
- **Micronutrient supplementation:** Despite the known benefits of iron, vitamin A, and multi-micronutrient powders in preventing malnutrition and boosting immunity, the uptake of these supplements remained very low across all population groups. The poorest households, those in lagging districts, and children of less-educated mothers were particularly underserved.
- **Infant feeding practices:** Breastfeeding was nearly universal (a positive finding), supported by high rates of colostrum feeding and exclusive breastfeeding for the first 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 the quality of public sector services:** Invest in enhancing the quality, responsiveness, and accessibility of public health services, particularly for childhood illnesses, to reduce unnecessary out-of-pocket expenses associated with private care.
2. **Strengthen community-based health education:** Scale up 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, especially in underperforming districts and among disadvantaged groups. Prioritize integration into maternal and child health contacts (e.g., Expanded Programme on Immunization [EPI] visits and growth monitoring sessions).
4. **Promote exclusive breastfeeding:** Intensify efforts to advocate for exclusive breastfeeding for the first six months, addressing misconceptions and harmful cultural practices that encourage the early introduction of other liquids. Lady Health Workers (LHWs) should emphasize counseling mothers during antenatal and postnatal visits.
5. **Address socioeconomic and educational disparities:** Target interventions toward younger mothers, those with no formal education, and lower-income households, which consistently showed poorer outcomes in child health and nutrition. Consider tailored communication strategies and the establishment of mother support groups.

Child Immunization

Key Findings

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

- Vaccination coverage of Penta-1 was high in KP, with 81.4% of children aged 12–23 months receiving the vaccine. Coverage was higher in urban areas (90.3%) compared to rural areas (80.1%).
- Lagging districts exhibited much lower coverage (70.3%) than non-lagging districts (86.2%).
- Households in the lowest wealth quintile had significantly lower coverage (66.2%) compared to 90.4% for children from households in the highest wealth quintile.
- Children of mothers with secondary or higher education had much higher coverage (93.3%) compared to 75.9% for children of women with no education.

Full immunization coverage

- Full immunization coverage (FIC) for all eight doses of the vaccines in the EPI was lower at 68.3% (67.7% of boys and 68.9% of girls) for children aged 12–23 months.
- Coverage for children aged 12–23 months was higher in urban areas at 78.8% compared to 66.7% in rural areas.
- Children in lagging districts were less likely to receive all eight vaccine doses compared to those in non-lagging districts (56.2% vs. 73.4%, respectively).
- A higher level of maternal education and higher household wealth positively correlated with full immunization. In contrast, children of mothers with no education and those from households in the lowest wealth quintile lagged behind in FIC.

Source of immunization

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

Type of vaccine by week since birth

- Most children received BCG, Polio, and HepB vaccinations at birth.
- There was a significant gap in coverage for specific vaccine doses between lagging and non-lagging districts, particularly for the Polio vaccine at birth (69.4% in lagging districts compared to 86.7% in non-lagging districts).

Children with no vaccine coverage (zero dose)

- A significant 16% of children were unvaccinated, with 16.1% of boys and 15.9% of girls not receiving any vaccines.
- 21.9% of children of mothers with no education were unvaccinated, compared to just 3.5% of children with mothers who had secondary or higher education.
- The three leading reasons for not vaccinating children were perceived distance to immunization sites, lack of faith in immunization, and fear of vaccine reactions.

The government of Pakistan launched the EPI in 1978. Since then, it has introduced additional vaccines and updated its policies and recommendations to align with those of the WHO. According to the WHO, children are considered “fully immunized” when they have received one dose of the vaccine against tuberculosis (BCG), three doses of vaccine against DPT, 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 about immunization were included in the KPHPS household questionnaire and were asked of all children in the household aged 0–48 months. The immunization data were based on 11,536 children aged 12–35 months, including 5,292 in the 12–23-month age group and 6,244 in the 24–35-month age group (Table 8.1). Among children aged 12–23 months, 78.4% reported having a vaccination card, compared to 73.2% of those aged 24–35 months. The primary reason for not having a vaccination card was “never visiting a facility,” followed by “did not think the card was important.”

At the time of the survey, interviewers checked for the availability of vaccination cards and recorded immunization status for each dose after physically observing the card. The vaccination cards of children aged 12–23 months were found and observed by interviewers in 44.7% of cases, compared to 34.2% for those aged 24–35 months. The results for children aged 12–23 months were based on data gathered from both the observation of vaccination cards and respondents’ recall when the cards were not available.

Table 8.1: Percentage of children 12–35 months (by age group, sex, and vaccination card status)

	12–23 months	24–35 months
Sex		
Boy	52.3	50.5
Girl	47.7	49.5
Total	100.0	100.0
Vaccination card status		
Ever had a vaccination card	78.4	73.2
Never had a vaccination card	21.6	26.8
Reasons:		
Don't think it's important	5.5	6.2
Never visited a facility	7.0	7.8
Card was not available	0.9	1.2
The vaccinator/facility did not provide a card	1.6	1.7
Not aware of such cards	2.8	3.7
Others (specify)	3.8	6.1
Total	100.0	100.0
Card available at time of interview?		
Yes (observed by interviewer)	44.7	34.2
No (card not available)	55.3	65.8
Total	100.0	100.0
No. of children (Unweighted)	5,292	6,244

Coverage of Pentavalent-1st Dose and Full Immunization

The Pentavalent-1st dose, also known as the Penta-1 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 aged 12–23 months was high at 81.4%, based on recall and recorded information from vaccination cards reviewed by interviewers (Table 8.2). Overall coverage was similar for boys and girls, at 81.1% and 81.8%, respectively (Figure 8.1). Coverage was lower in rural areas compared to urban areas, with rates of 80.1% and 90.3%, respectively. Lagging districts exhibited significantly lower coverage at 70.3%, compared to 86.2% in non-lagging districts.

There was a strong relationship between mothers' education and children's immunization coverage. The coverage of Penta-1 for children whose mothers had a secondary education or higher was as high as 93.3%, compared to 75.9% for children of mothers with no education. There was little difference in Penta-1 coverage by the sex of the child across various maternal education groups. The widest gap in

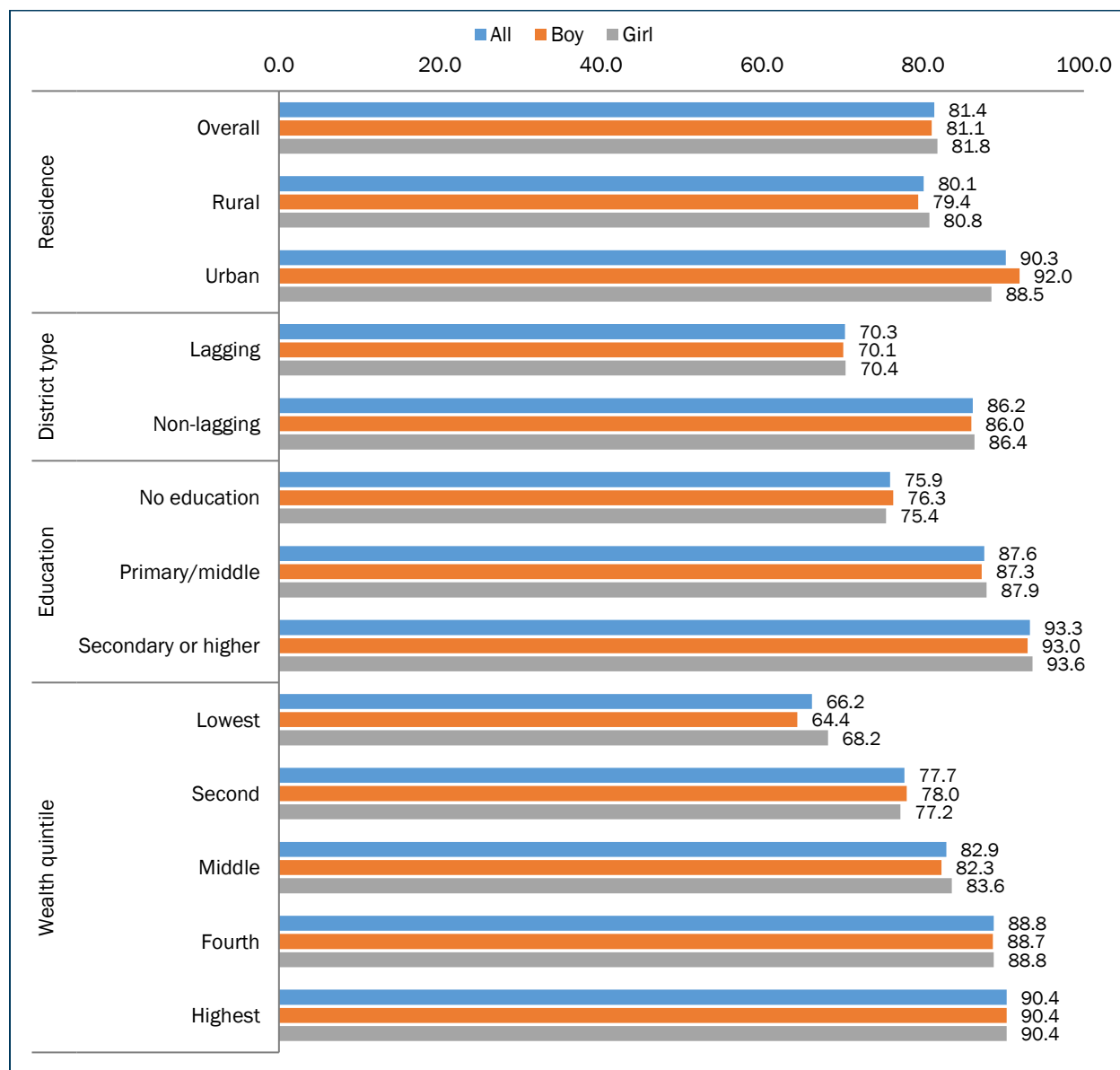
coverage was observed by household wealth. Coverage of Penta-1 increased with wealth quintile, rising from 66.2% for children in the lowest wealth quintile and 77.7% in the second-lowest quintile, to 90.4% for children from households in the highest wealth quintile.

Table 8.2: Percentage of children aged 12–23 months who received Pentavalent-1st dose (at any time before the survey) and percentage who were fully immunized (by background characteristics)

	Pentavalent 1st dose			Received all eight EPI doses ^a			N (Unweighted)
	Boy	Girl	Overall	Boy	Girl	Overall	
Recall only	37.4	35.9	36.7	24.0	23.0	23.5	3,440
Card only	43.7	45.9	44.7	43.7	45.9	47.7	1,852
Card plus recall	81.1	81.8	81.4	67.7	68.9	68.3	5,292
Residence							
Rural	79.4	80.8	80.1	65.7	67.8	66.7	4,648
Urban	92.0	88.5	90.3	81.3	76.1	78.8	644
District type							
Lagging	70.1	70.4	70.3	56.4	55.9	56.2	2,435
Non-lagging	86.0	86.4	86.2	72.8	74.1	73.4	2,857
Mother's education							
None	76.3	75.4	75.9	63.4	62.7	63.1	3,160
Primary/middle	87.3	87.9	87.6	75.2	77.7	76.5	611
Secondary+	93.0	93.6	93.3	80.3	79.3	79.8	803
Wealth index							
Lowest	64.4	68.2	66.2	50.2	54.5	52.3	1,519
Second	78.0	77.2	77.7	63.1	62.6	62.9	1,107
Middle	82.3	83.6	82.9	66.4	70.7	68.5	998
Fourth	88.7	88.8	88.8	78.0	74.5	76.4	894
Highest	90.4	90.4	90.4	79.0	80.9	79.9	774

^a 8 doses = 1 dose (BCG), 3 doses of DPT, 3 doses of polio vaccine (excluding polio vaccine given at birth), and 1 dose of measles vaccine. It is also considered full immunization coverage (FIC).

Figure 8.1: Percentage of children aged 12–23 months who received Penta-1 at any time before the survey (by background characteristics)

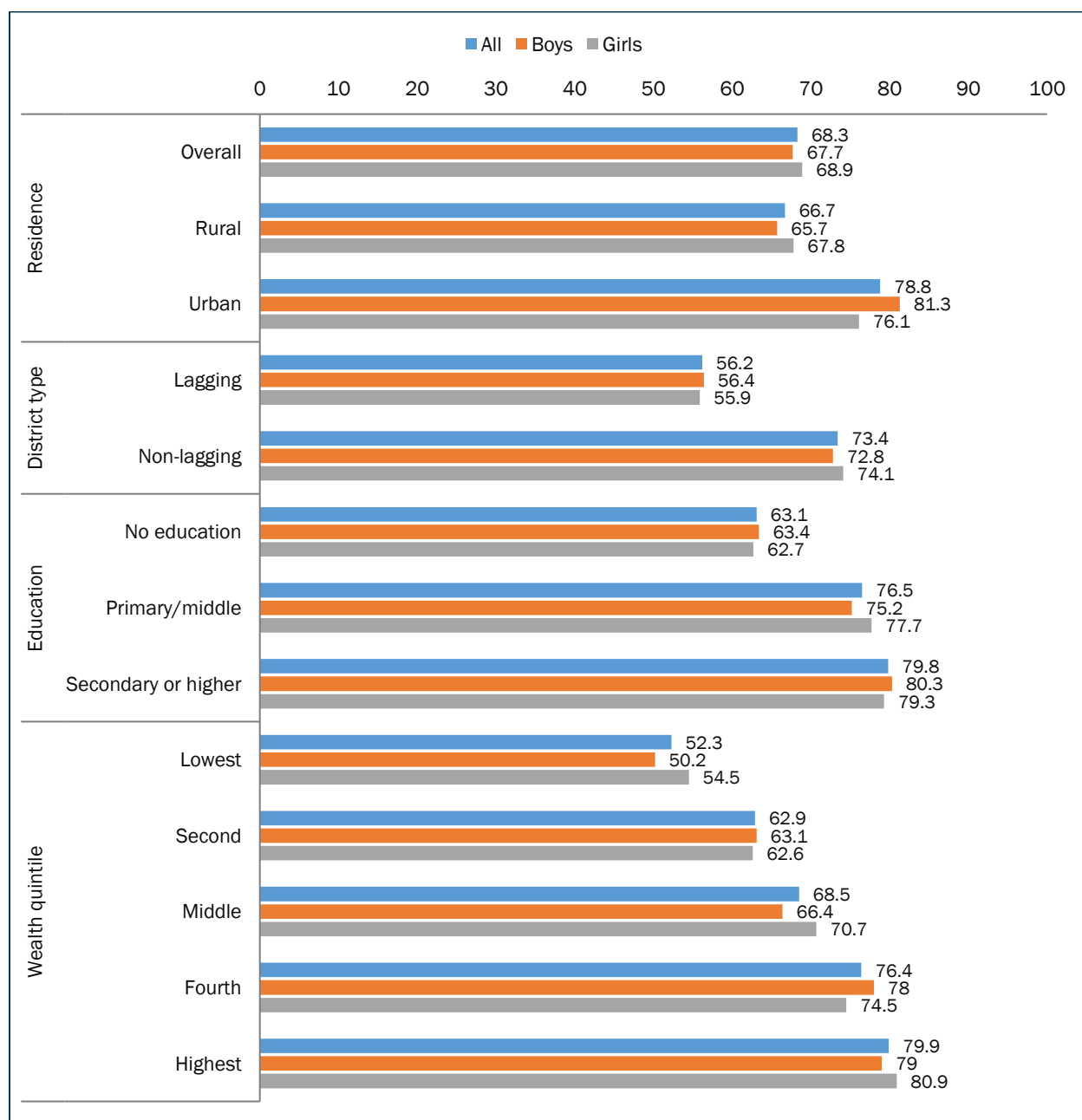


The coverage of all eight doses of EPI vaccines was 68.3%, with 67.7% for boys and 68.9% for girls aged 12–23 months (Figure 8.2). The differences in coverage by the child’s sex were minor, except in urban areas where coverage was higher for boys than for girls (81.3% vs. 76.1%, respectively). Conversely, full immunization coverage was higher for girls from the poorest households at 54.5%, compared to 50.2% for boys.

Inequities in vaccine coverage were pronounced based on location, district of residence, mother’s education, and wealth quintile. Children aged 12–23 months in rural areas were less likely to have received all eight doses than those in urban areas (66.7% vs. 78.8%, respectively). Similarly, children in lagging districts were 17.2 percentage points less likely to receive all eight vaccine doses than those in non-lagging districts (56.2% vs. 73.4%, respectively).

A mother's education significantly impacted full immunization coverage: 63.1% of children of women with no education were fully immunized, compared to 79.8% of children of women with secondary or higher education. The gap in full coverage was widest by wealth quintile, with only 52.3% of the poorest children (lowest wealth quintile) receiving all eight doses of vaccines, compared to 79.9% of the wealthiest (highest wealth quintile).

Figure 8.2: 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 polio vaccine given at birth), and one dose of the measles vaccine.

By district, Peshawar was the only lagging district to exceed 90% coverage of Penta-1 among children aged 12–23 months (Figure 8.3), while 11 of 23 non-lagging districts reached this milestone (Tank, Upper Chitral, Khyber, Lower Chitral, Malakand Protected, Swat, Abbottabad, Nowshera, Swabi, Kohat, and Haripur). Tank and Upper Chitral achieved complete coverage at 100%. However, 6 of 11 districts (Hangu, Kolai Palas Kohistan, Upper Kohistan, Lower Kohistan, South Waziristan, and Torghar) had Penta-1 coverage below 50%, with the lowest at 23% in Torghar. Among the 24 non-lagging districts, only Orakzai and Kurram reported low Penta-1 coverage rates of 50% and 48%, respectively.

Full immunization coverage (FIC) for children aged 12–23 months showed a similar pattern to that of Penta-1 (Figure 8.4). Peshawar had the highest coverage (88%) among lagging districts, while seven districts reported coverage rates of 30% or lower (Hangu, North Waziristan, Lower Kohistan, Upper Kohistan, Torghar, South Waziristan, and Kolai Palas Kohistan). In contrast, non-lagging districts such as Khyber, Shangla, Lower Chitral, Swat, Swabi, Abbottabad, and Nowshera all achieved coverage rates above 80%. The lowest coverage rates were found in Karak and Orakzai (44%) and Kurram (40%).

Figure 8.3: Percentage of children aged 12–23 months who received Penta-1 (by district)

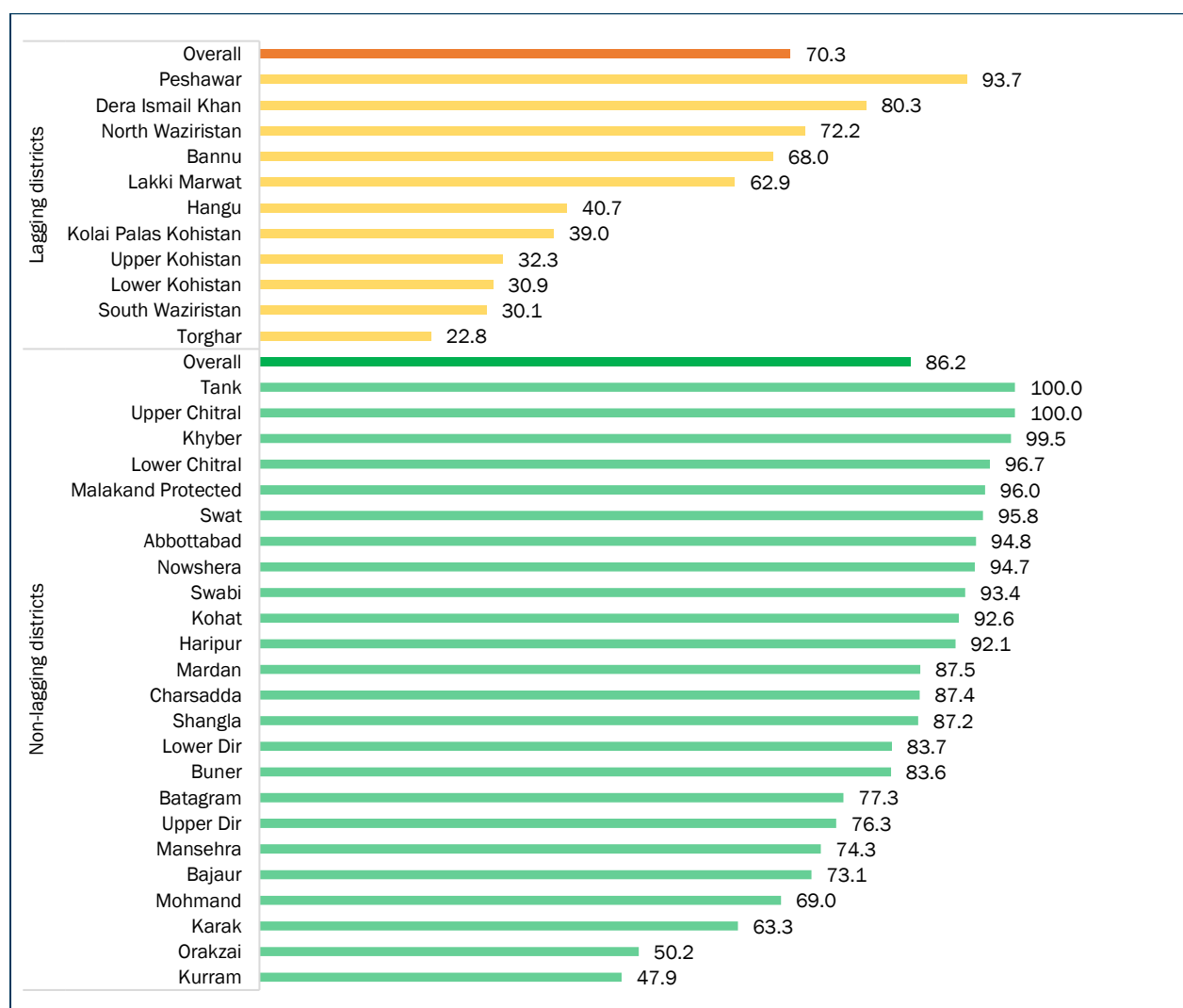
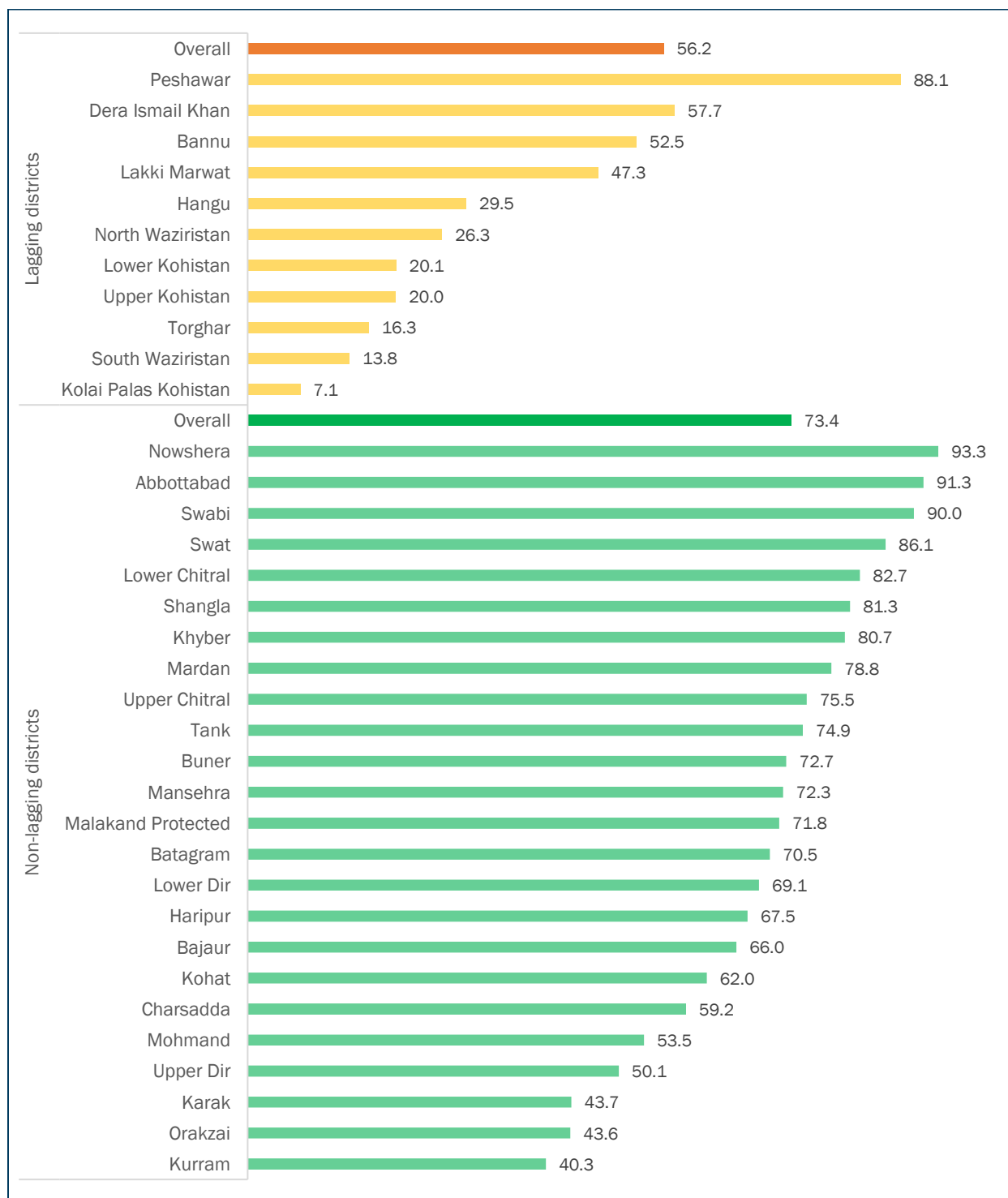


Figure 8.4: Percentage of children aged 12–23 months who received all eight doses of EPI vaccines (by district)



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

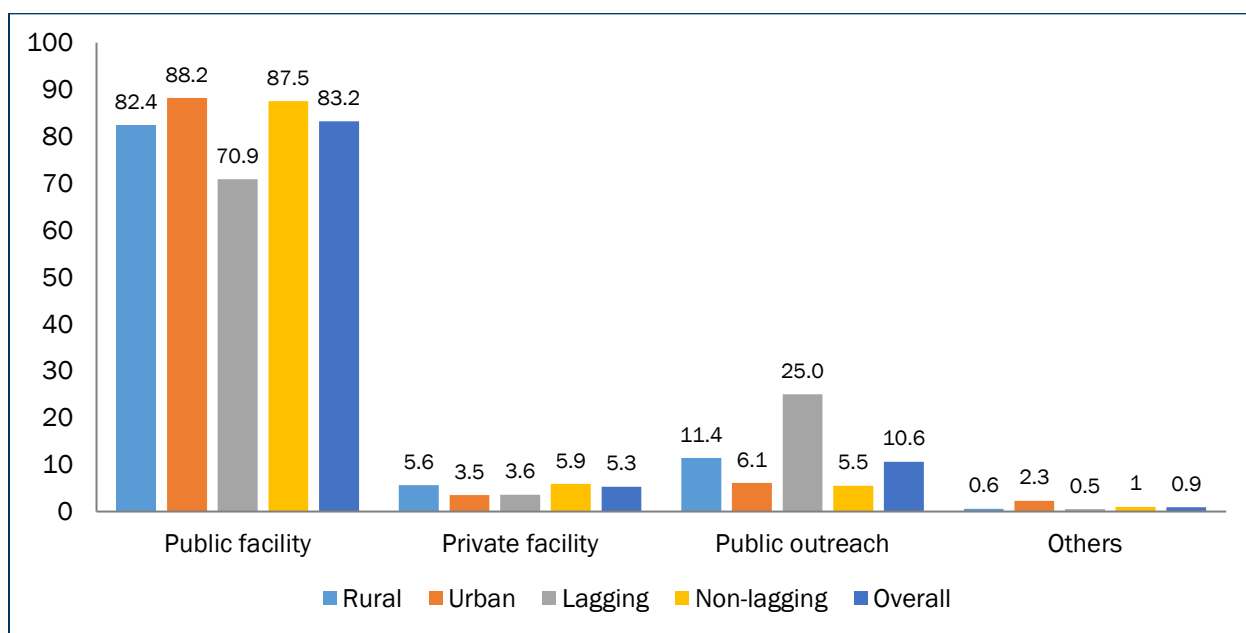
Source of Vaccines for Children Aged 12–23 Months

Government health facilities were identified as the primary source of vaccines for children aged 12–23 months, accounting for 83.2% (Table 8.3 and Figure 8.5). Notably, government health facilities were more frequently reported as the source of vaccines in urban areas (88.2%) compared to rural areas (82.4%), and in non-lagging districts (87.5%) compared to lagging districts (70.9%). Government outreach immunization programs were the second-most reported source, particularly in rural areas (11.4%) and lagging districts (25%). Private health facilities were cited as the source for 5.3% of immunization vaccinations overall, with 5.6% in rural areas versus 3.5% in urban areas, and 3.6% in lagging districts compared to 5.9% in non-lagging districts.

Table 8.3: Percentage distribution of source of vaccination among children aged 12–23 months

	Residence		District type		Overall
	Rural	Urban	Lagging	Non-lagging	
Place vaccines administrated					
Government health facility	82.4	88.2	70.9	87.5	83.2
Private health facility	5.6	3.5	3.6	5.9	5.3
Government outreach	11.4	6.1	25.0	5.5	10.6
Others	0.6	2.3	0.5	1.0	0.9
Total	100.0	100.0	100.0	100.0	100.0
No. of children (Unweighted)	3,434	588	1,541	2,481	4,022

Figure 8.5: Percentage distribution of immunization coverage (by source of vaccines) for vaccinated children aged 12–23 months



Vaccinations by Schedule

The vaccine schedule followed EPI guidelines (Table 8.4). Newborns receive the BCG, Polio, and HepB vaccines at birth. In KP, 83.4% of newborns received BCG, 81.5% received Polio, and 81.5% received HepB at birth (Table 8.4). There were significant variations in coverage for all three vaccinations, with rural areas showing lower coverage compared to urban areas. The gap in coverage for specific doses of vaccines was substantial between lagging and non-lagging districts, particularly for Polio at birth (69.4% in lagging districts vs. 86.7% in non-lagging districts).

Table 8.4: Percentage distribution of children aged 12–23 months (by type and dose of vaccine given and timing in weeks since birth)

	Residence		District type		Overall
	Rural	Urban	Lagging	Non-lagging	
First round (at birth)					
BCG	82.0	92.4	71.3	88.5	83.4
Polio at birth	80.3	89.9	69.4	86.7	81.5
HepB	80.1	88.6	70.2	86.0	81.3
Second round (6 weeks)					
Polio 1st dose	81.7	91.8	72.5	87.5	83.0
Pneumococcal 1st dose	79.8	89.7	70.1	85.8	81.1
Rotavirus 1st dose	79.5	88.9	69.3	85.5	80.7
Pentavalent 1st dose	80.1	90.3	70.3	86.2	81.4
Third round (10 weeks)					
Polio 2nd dose	76.8	87.9	65.9	83.5	78.2
Pneumococcal 2nd dose	75.9	85.4	66.3	81.8	77.2
Rotavirus 2nd dose	73.4	83.7	64.2	79.3	74.8
Pentavalent 2nd dose	77.0	86.3	66.5	83.2	78.3
Fourth round (14 weeks)					
Polio 3rd dose	69.1	81.1	58.8	75.8	70.7
Pneumococcal 3rd dose	68.6	80.0	58.4	75.0	70.1
IPV1	78.2	88.1	68.0	84.4	79.5
Pentavalent 3rd dose	70.6	81.5	61.2	76.6	72.0
Fifth round (36 weeks)					
Measles 1 dose (at 9 months)	77.4	87.3	67.8	83.4	78.7
TCV	74.5	86.1	64.0	81.2	76.0
IPV2	71.1	81.5	58.8	78.3	72.5
Sixth round (60 weeks)					
Measles 2nd dose (at 15 months)	60.2	73.6	53.8	65.4	61.9
Received all eight classic EPI doses	66.7	78.8	56.2	73.4	68.3
N (Unweighted)	4,648	644	2,435	2,857	5,292

The gap in vaccination coverage between lagging and non-lagging districts widened with each subsequent vaccination after birth. For example, the coverage for the first dose of Rotavirus at six weeks after birth was 69.3% in lagging districts compared to 85.5% in non-lagging districts. For the second dose of Polio at ten weeks after birth, coverage was 65.9% in lagging districts versus 83.5% in

non-lagging districts. The third dose of Polio at 14 weeks after birth showed 58.8% coverage in lagging districts compared to 75.8% in non-lagging districts. By the 60th week after birth, the FIC rate for the eight classic EPI doses was 68.3% overall, with 66.7% in rural areas compared to 78.8% in urban areas, and 56.2% in lagging districts compared to 73.4% in non-lagging districts.

Therefore, immunization efforts are needed to increase coverage in all areas and close the gap between rural and urban populations, as well as between lagging and non-lagging districts.

Children with No Vaccines: “Zero-dose” Coverage

Overall, 16% of the 5,292 children aged 12–23 months had received no vaccines and were classified as ‘zero-dose’ children (Table 8.5). There was little difference in vaccination status by the sex of the child, with 16.1% of boys and 15.9% of girls being unvaccinated. Zero-dose children were more prevalent in rural areas (17.6% of boys and 16.4% of girls) compared to urban areas (6% of boys and 8.7% of girls). Additionally, there were twice as many zero-dose children in lagging districts (26.3% overall, 27% boys, and 25.4% girls) than in non-lagging districts (11.3% overall, 11.1% boys, and 11.4% girls).

The disparities in zero-dose children based on mothers’ education and wealth quintile were more pronounced. Among children of women with no education, 21.9% were unvaccinated, compared to only 3.5% of children whose mothers had secondary education. Similarly, 29.6% of children from the lowest wealth quintile were unvaccinated, while only 5.8% of children from the highest wealth quintile fell into this category. Zero-dose status was largely similar for boys and girls in most subgroups, except in the lowest wealth quintile, where 31.4% of boys and 27.6% of girls were unvaccinated.

Table 8.5: Percentage of children aged 12–23 months who did not receive any vaccinations (zero dose) (by background characteristics)

	Boys	Girls	Overall
Overall	16.1	15.9	16.0
Residence			
Rural	17.6	16.4	17.0
Urban	6.0	8.7	7.3
District type			
Lagging	27.0	25.4	26.3
Non-lagging	11.1	11.4	11.3
Mother’s education			
No education	21.5	22.4	21.9
Primary and middle	10.7	7.5	9.1
Secondary and above	3.4	3.6	3.5
Mother’s wealth quintile			
Lowest	31.4	27.6	29.6
Second	19.7	20.8	20.2
Middle	15.6	14.6	15.1
Fourth	9.6	9.1	9.3
Highest	5.6	6.0	5.8
No. of children (Unweighted)	2,766	2,526	5,292

Reasons for Non-vaccination

Respondents cited various reasons for households and parents not vaccinating their children aged 12–23 months. The three leading reasons were: (a) “the place of immunization is too far” (25.5%); (b) “fear of reactions to vaccine” (19.8%); and (c) “no faith in immunization” (14.5%). The perception that immunization locations were too far was more common in rural areas (26.6%) compared to urban areas (9.1%) and, paradoxically, in non-lagging districts (35.7%) versus lagging districts (15.1%).

The percentage of respondents expressing a lack of faith in immunization was broadly similar in rural and urban areas (14.3% & 16.8%, respectively). However, a higher percentage of parents in lagging districts (19.6%) cited this as a reason for not vaccinating their child compared to non-lagging districts (9.5%). Fear of reactions to vaccines was more prevalent in urban areas (27.8%) than in rural areas (19.3%) and in lagging districts (28.2%) compared to non-lagging districts (11.6%).

To improve immunization coverage, efforts should target areas where coverage is lacking. Issues such as lack of faith in immunization and fear of vaccine reactions require focused behavior change communication, along with information and counseling initiatives. In contrast, logistical issues like not knowing the place and time of immunization, lack of available vaccines, absence of vaccinators, and non-vaccination days fall within the health system’s purview and can be easily rectified through improved supervision and monitoring.

Table 8.6: Percentage distribution of unvaccinated (zero-dose) children aged 12–23 months (by reasons for not vaccinating)

Reason for not vaccinating child	Residence		District type		Overall
	Rural	Urban	Lagging	Non-lagging	
Place of immunization too far	26.6	9.1	15.1	35.7	25.5
Time of immunization not convenient	2.7	2.8	1.4	3.9	2.7
Mother too busy	6.0	10.4	5.0	7.6	6.3
Family problems, including mother being ill	8.9	11.2	10.7	7.4	9.0
Child ill, not brought for vaccination	4.4	1.2	4.0	4.5	4.2
Child ill, brought but not vaccinated	2.2	3.4	2.0	2.5	2.3
Long wait times	0.6		0.4	0.8	0.6
Rumors about vaccination	5.9	0.7	4.2	7.0	5.6
No faith in immunization	14.3	16.8	19.6	9.5	14.5
Fear of reaction	19.3	27.8	28.2	11.6	19.8
Place of immunization unknown	2.9	1.0	1.7	4.0	2.8
Time of immunization unknown	1.0		0.7	1.3	1.0
Brought child, vaccine unavailable	0.2	1.0	0.4	0.1	0.2
Brought child, vaccinator unavailable	0.9			1.6	0.8
Brought child, facility closed	0.5		0.2	0.7	0.4
Brought child, but not a vaccination day	0.2		0.1	0.3	0.2
Others	5.9	1.9	5.7	5.7	5.7
Don't know	16.3	24.7	18.7	14.9	16.8
Total	100.0	100.0	100.0	100.0	100.0
No. of children (Unweighted)	1,241	58	896	403	1,299

Communicable and Non-communicable Diseases

Key Findings

Reported prevalence and treatment of diseases

- The reported prevalence of non-communicable diseases overall was 8.6% among female and 5.2% among male household members aged above 5.
- Reported prevalence was higher in rural areas than in urban areas and in lagging districts than in non-lagging districts, with the exception of heart diseases.
- Reported prevalence of each major type of disease was higher among females compared to males.
- High/low blood pressure was the most prevalent ailment both for males and females, followed by diabetes.
- Treatment rates were above 90% for non-communicable, heart, and respiratory diseases.

Tuberculosis (TB)

- The reported prevalence of TB was 0.22% among household members aged 5 or above—0.23% among rural and 0.15% among urban residents.
- Treatment rates were very high for males (96.3%) and for females (94.3%).
- About two-thirds of TB patients seek treatment from a public health facility.

Household use of tobacco, drugs, and substances

- A quarter of households had at least one member above age 15 who smoked daily or occasionally.
- The use of drugs or substances other than tobacco was negligible (2%).

Malaria

- Reported prevalence of malaria was 0.23% overall, 0.26% in rural and 0.07% in urban areas.
- 25.3% of all households (26.8% in rural areas and 16.3% in urban areas) had a mosquito net available as a form of prevention against malaria.
- A substantial proportion (45.9%) of malaria patients sought treatment from a public health facility.

Hypertension

- Reported hypertension is more prevalent among women (3.8%) than among men (2.2%).
- Reported prevalence of hypertension increases with age, reaching 10.1% among those aged 45–59 and 13.7% among those 60 or above.
- A high proportion (94%) of those with hypertension seek treatment, equally from public and private facilities.

Diabetes

- The reported prevalence of diabetes was 2% overall, with 2.8% in urban areas compared to 1.9% in rural areas.
- Like hypertension, the reported prevalence of diabetes rises with age, reaching 10.8% for those aged 60 or over.
- More than half (51.3%) of diabetic patients sought treatment from private facilities.

The NHSP aims to reduce the reported prevalence and raise the treatment rate of communicable (also termed infectious), and non-communicable diseases. The KPHPS 2024–25 household (HH) questionnaire, therefore, sought baseline information on the reported prevalence of these diseases for all members of the household (HH) aged 5 years or older. The HH roster of HH members included a question: “Have any person/persons aged 5 years or above ever suffered from a 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 further question was asked whether the HH member with the particular illness was taking the treatment (medicines).

Results on the reported prevalence of specific communicable and non-communicable diseases and their treatment rates are presented in the following sections. Only 9 HH members across KP were reported to have HIV/AIDS; therefore, no meaningful analysis on the reported prevalence and treatment-seeking for HIV/AIDS was feasible.

Reported Prevalence and Treatment of Diseases

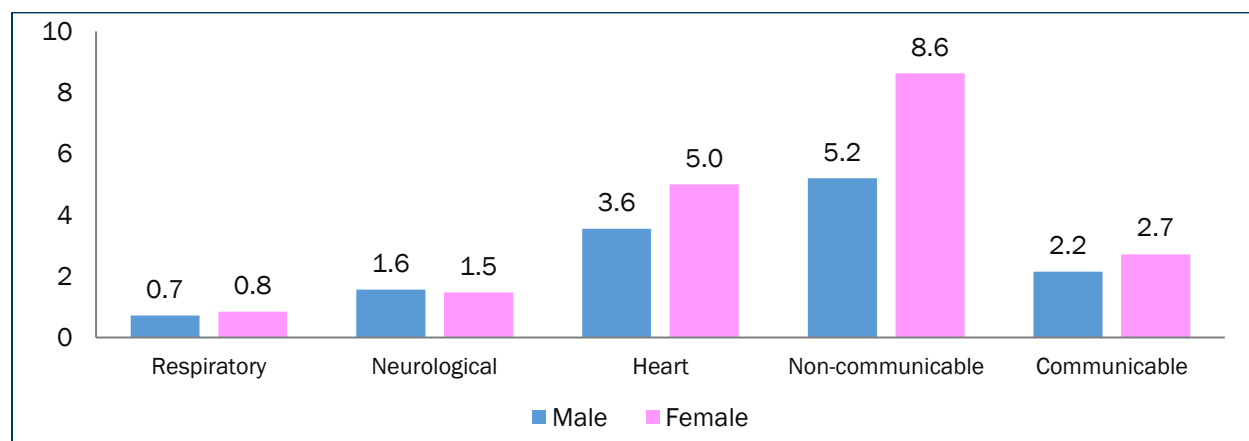
Altogether, there were 153,684 HH members who were 5 years or older and applicable for most questions regarding communicable and non-communicable diseases. The overall reported prevalence of various types of diseases is shown in Table 9.1. The reported prevalence of non-communicable diseases was highest at 5.3% for male and 8.6% for female members in rural areas and 4.6% for males and 8.5% for females in urban areas. Heart diseases was the second most reported ailment, with a prevalence of 3.5% among males in rural areas and 3.9% among males in urban areas. The corresponding figures for females were 4.9% and 5.7% respectively. Among the five major types of diseases, the reported prevalence of respiratory diseases was the lowest.

Table 9.1: Percentage of household members aged 5 years or above who had a disease and who were taking medicine (by major groups of illnesses and by sex and place of residence)

Major groups of illness	Reported prevalence				Taking medicine			
	Male		Female		Male		Female	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Respiratory diseases	0.8	0.5	0.9	0.7	0.7	0.5	0.8	0.6
Neurological diseases	1.6	1.4	1.5	1.5	1.4	1.1	1.3	1.2
Heart diseases	3.5	3.9	4.9	5.7	3.2	3.6	4.5	5.1
Non-communicable diseases	5.3	4.6	8.6	8.5	4.7	4.0	7.6	7.4
Communicable diseases	2.2	1.9	2.7	2.6	1.9	1.5	2.4	2.2

In general, the reported prevalence of each major type of diseases is higher among females than among males (Figure 9.1). The one exception is neurological diseases in rural areas, where the reported prevalence is slightly higher among males (1.5%) compared to females (1.4%). Notably, reported non-communicable diseases are significantly more prevalent among females (8.6%) than among males (5.2%).

Figure 9.1: Percentage of household members aged 5 years or above who had a disease (by major group of illnesses and by sex)



The reported prevalence of disease was also higher in rural areas compared to urban areas, except for heart diseases. For heart diseases, the reported prevalence was higher in urban areas, affecting 3.9% of males and 5.7% of females, compared to 3.5% of males and 4.9% of females in rural areas.

Treatment rates, which are based on all HH members aged 5 years or older who had a particular ailment or disease, are linked to reported prevalence rates and broadly reflect similar patterns across urban-rural and male-female sub-groups.

The reported prevalence of specific diseases and treatment rates are shown in Table 9.2. Reported high/low blood pressure is the leading disease prevalent for both males and females, followed by diabetes. High/low blood pressure was reported by 2.2% of males and 3.8% of females, among HH members aged 5 years or older. Diabetes was reported by 1.6% of males and 2.4% of females.

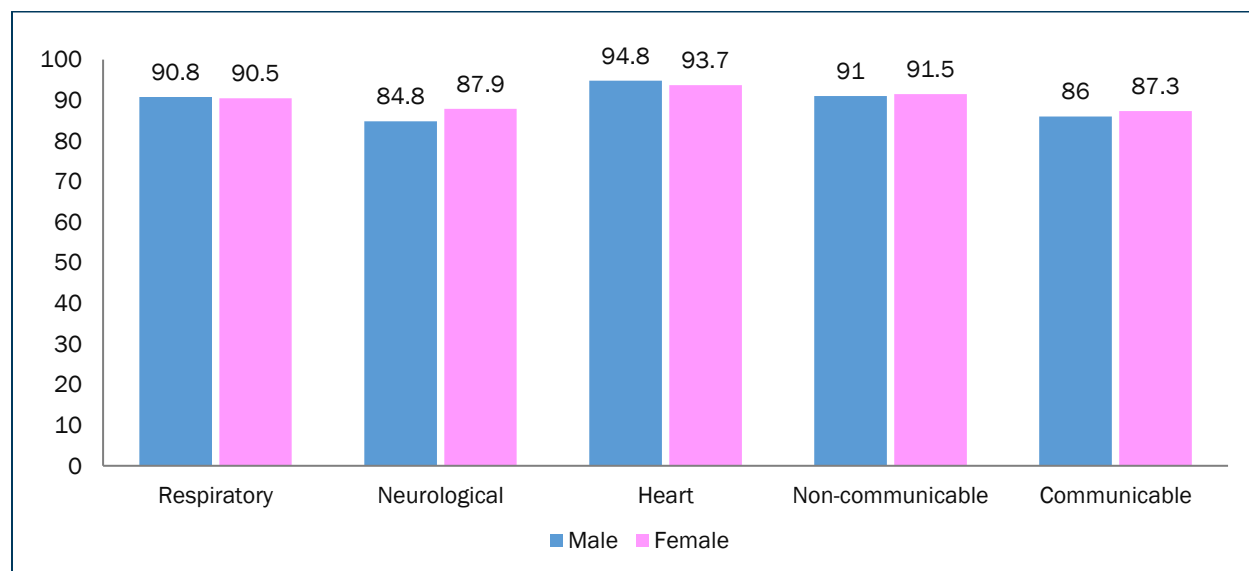
Table 9.2: Percentage of household members aged 5 years or above who had a disease and percentage who were taking medicine (by type of disease and sex)

	Reported prevalence		Taking Medicine	
	Male	Female	Male	Female
Respiratory diseases	0.72	0.84	0.65	0.76
Tuberculosis	0.16	0.17	0.13	0.13
Asthma	0.29	0.40	0.27	0.39
Any respiratory disease	0.27	0.26	0.25	0.24
Neurological diseases	1.57	1.47	1.33	1.29
Epilepsy	0.21	0.14	0.18	0.12
Nerve disorder	0.49	0.44	0.40	0.38
Mental health	0.39	0.42	0.32	0.37
Stroke/Paralysis	0.37	0.36	0.34	0.34
Other neurological diseases	0.11	0.11	0.09	0.09
Heart diseases	3.55	5.01	3.37	4.69
High/Low blood pressure	2.19	3.80	2.06	3.56
Other heart related diseases	1.35	1.21	1.31	1.13
Non-communicable diseases	5.20	8.63	4.74	7.89
Stomach/Gastrointestinal illness	0.88	1.79	0.81	1.69
Diabetes	1.60	2.44	1.56	2.36
Kidney	0.87	1.10	0.81	0.98
Liver illness	0.13	0.14	0.11	0.13
Arthritis/Gout/Swelling of joints	0.76	1.72	0.69	1.57
Blood disease	0.07	0.15	0.06	0.12
Anaemia	0.20	0.50	0.17	0.42
Skin condition	0.23	0.27	0.21	0.23
Cancer	0.07	0.08	0.06	0.08
Goitre	0.02	0.11	0.02	0.11
Congenital diseases	0.27	0.20	0.17	0.12
Others non-communicable	0.12	0.13	0.08	0.10
Communicable diseases	2.15	2.72	1.85	2.38
Malaria	0.22	0.25	0.19	0.23
Pneumonia	0.06	0.04	0.04	0.03
Typhoid	0.14	0.27	0.12	0.25
HIV/AIDS	0.01	0.00	0.01	0.00
Hepatitis B or C	0.28	0.19	0.25	0.15
COVID	0.02	0.01	0.02	0.01
Febrile condition	0.34	0.61	0.31	0.54
Thalassemia	0.02	0.04	0.02	0.04
Others	1.08	1.30	0.90	1.14
No. of HH members ≥ 5 years	77,436	76,248	77,436	76,248

Treatment rates based on all HH members aged 5 years or older show a pattern like that for Reported prevalence. Among those who had the disease, treatment rates were above 90% for non-communicable, heart, and respiratory diseases (Figure 9.2). In general, the treatment rates among

those with the disease were broadly similar for males and females, except for neurological diseases, which were 87.9% among females compared to 84.8% among males, and communicable diseases (87.3% vs. 86.0% respectively).

Figure 9.2: Percentage of household members aged 5 years or above who were taking medicine for the disease (by major group of illnesses and sex)



Communicable Diseases

Tuberculosis (TB)

The HH questionnaire included the question: “Has any member of your household suffered from TB during the last 2 years (from July 1, 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 July 1, 2022, till date)?” For those with TB, an additional question asked was whether the person was taking any medicine(s) for the illness. The percentage of TB cases among household members aged five or older was 0.22% for the overall KP province, 0.23% for rural areas, and 0.15% for urban areas (Table 9.3). Reported prevalence of TB was lower in non-lagging (0.21%) than in lagging districts (0.26%) and among those below age 50 compared to those aged 45–59 and 60 or older. No difference was found in the reported prevalence of TB among males and females (0.22% for each). A higher proportion of women with no education had TB (0.27%) than those with secondary or higher education (0.15%). The poorest women had a higher proportion (0.28%) than rich in the highest wealth quintile (0.17%).

Table 9.3: Percentage of household members aged 5 years or above with tuberculosis (TB) and percentage seeking treatment for TB (by background characteristics)

	Reported prevalence	Treatment	N (Unweighted)
Overall	0.22	0.21	153,684
Residence			
Rural	0.23	0.22	134,254
Urban	0.15	0.15	19,430
District type			
Lagging	0.26	0.25	69,225
Non-lagging	0.21	0.19	84,459
Age			
05-14 yrs	0.20	0.19	49,806
15-29 yrs	0.18	0.17	44,880
30-44 yrs	0.15	0.13	30,771
45-59	0.32	0.30	17,072
60+	0.53	0.53	11,155
Sex			
Male	0.22	0.22	77,436
Female	0.22	0.21	76,248
Education			
No education	0.27	0.25	78,617
Primary/Middle	0.20	0.20	44,061
Secondary or higher	0.15	0.15	31,006
Wealth quintiles			
Lowest	0.28	0.26	42,534
Second	0.24	0.23	31,851
Middle	0.28	0.28	29,748
Fourth	0.15	0.14	27,007
Highest	0.17	0.16	22,544

Cigarette smoking is strongly linked to an increased risk of TB. Among the 428 HH members with TB, 7.7% were smokers and 87.2% were non-smokers (Table 9.4). The proportion of smokers among men was 13.9% compared to 0.7% among women.

Table 9.4: Percentage of household members (aged 5 years or above) with tuberculosis (TB) (by smoking behavior)

	Total	Male	Female
Whether cigarettes smoker?			
No	87.2	81.2	94.1
Yes	7.7	13.9	0.7
Don't know/Missing/unsure	5.1	5.0	5.3
Total	100	100	100
No. of people with TB (Unweighted)	428	237	191

Treatment sought for TB was slightly higher among men (96.3%) than among women (94.3%) when we exclude missing cases of “No TB” from the analysis (i.e., 84.7/88.0 for males and 91.4/96.9 for females) (Table 9.5). About two-thirds of TB patients (64.4%) sought treatment from public health facilities—more men (67.3%) than women (61.3%).

Table 9.5: Percentage of household members (aged 5 years or above) with tuberculosis (TB) (by treatment seeking and place of treatment)

	Total	Male	Female
Whether treatment sought			
Yes	87.8	84.7	91.4
No	4.3	3.3	5.5
Missing	7.8	12.0	3.1
Total	100	100	100
Source of treatment			
Public	64.4	67.3	61.3
Private	35.5	32.4	38.7
Other	0.2	0.3	0.0
Total	100	100	100
No. of people with TB (Unweighted)	428	237	191

Household Use of Tobacco, Drugs, and Substances

Exposure to secondhand smoke, also known as passive smoking, is associated with an increased risk of developing TB, especially in children. Overall, one-in-four households in KP have at least one member aged 15 or above who smoked daily or occasionally (Table 9.6). The proportion in rural areas was 25.1% compared to 22.6% in urban areas. Smoking among females was almost non-existent. At least one male member smoked in 18.2% of households: 18.3% in rural and 17.9% in urban areas.

“Naswar,” a moist, powdered form of smokeless tobacco, is the most common type of tobacco used by 76.2% of all tobacco users: 77.6% in rural areas and 66.6% in urban areas. Cigarettes are the second most used tobacco by 37.6% of all users: 36.6% of rural and 45.7% of urban users.

Table 9.6: Percentage of household members (aged 15 years and above) (by use of tobacco)

	Total	Rural	Urban
Tobacco used daily or occasionally by any HH member			
Yes	24.7	25.1	22.6
No	74.4	74.1	76.5
Don't know	0.9	0.9	0.9
Total	100.0	100.0	100.0
Number of household members using any type of tobacco			
Male (aged 15 or older)			
No male member	76.1	75.9	77.8
1 male member	18.2	18.3	17.9
2 male members	4.4	4.5	3.5
3 or more male members	1.3	1.4	0.9
Total	100.0	100.0	100.0
Female (aged 15 or older)			
No female member	99.0	99.0	99.6
1 female member	0.9	1.0	0.4
2 female members	0.1	0.1	0.0
3 or more female members	0.02	0.02	0.00
Total	100.0	100.0	100.0
Type of tobacco used*			
Cigarette	37.8	36.6	45.7
Hukkah	1.2	1.3	.8
Chewing tobacco	.9	.9	1.5
Snuff by mouth	1.0	.9	1.8
Snuff by nose	.5	.5	.3
Paan with tobacco	.1	.1	.5
Berri	.0	.0	.1
Gutka	.3	.3	.1
Naswar	76.2	77.6	66.6
Mawa tobacco	.3	.2	.7
Naas and man pori	.0	.0	0.0
Pipes full of tobacco	.3	.3	.1
Cigars, cheroots, or cigarillos	.2	.1	.7
Others	.6	.5	1.0
Total	100.0	100.0	100.0
No. of users (Unweighted)	6,036	5,395	641
No. of HH members ≥15 years (Unweighted)	23,534	20,357	3,177

*Multiple response variable.

Reported use of drugs other than tobacco was negligible. However, underreporting cannot be ruled out as such behaviors are illegal and socially stigmatized. Only 2% of HH members aged 15 or above were reported to have used drugs/substances other than tobacco (Table 9.7). Among those who used drugs/substances, Ice and Hashish were more common, used by 39.8% and 38.7% of users.

Marijuana/cannabis were used by 9.2% and alcohol by 8.0% of users overall. Both Hashish and Ice are more used in urban than rural areas, while alcohol is used more in rural than urban areas.

Table 9.7: Percentage of household members aged 15 years and above (by use of drugs/substances)

	Total	Rural	Urban
Use of any other drug besides smoking			
Yes	1.9	2.0	1.6
No	97.0	96.9	97.5
Don't know	1.1	1.2	0.9
Total	100.0	100.0	100.0
Type of drugs used other than tobacco*			
Alcohol	8.0	8.6	4.7
Marijuana/ Cannabis	9.2	9.4	8.1
Hashish	38.7	37.1	48.1
Heroin	12.9	13.8	7.5
Cocaine	.7	.7	.5
Sheesha	2.5	2.6	1.7
Ice	39.8	38.8	45.9
Others [Specify]	3.5	4.1	0.0
Total	100.0	100.0	100.0
N (Unweighted)	271	225	46
No. of HH members ≥15 years (Unweighted)	23,534	20,357	3,177

*Multiple response variable.

Malaria

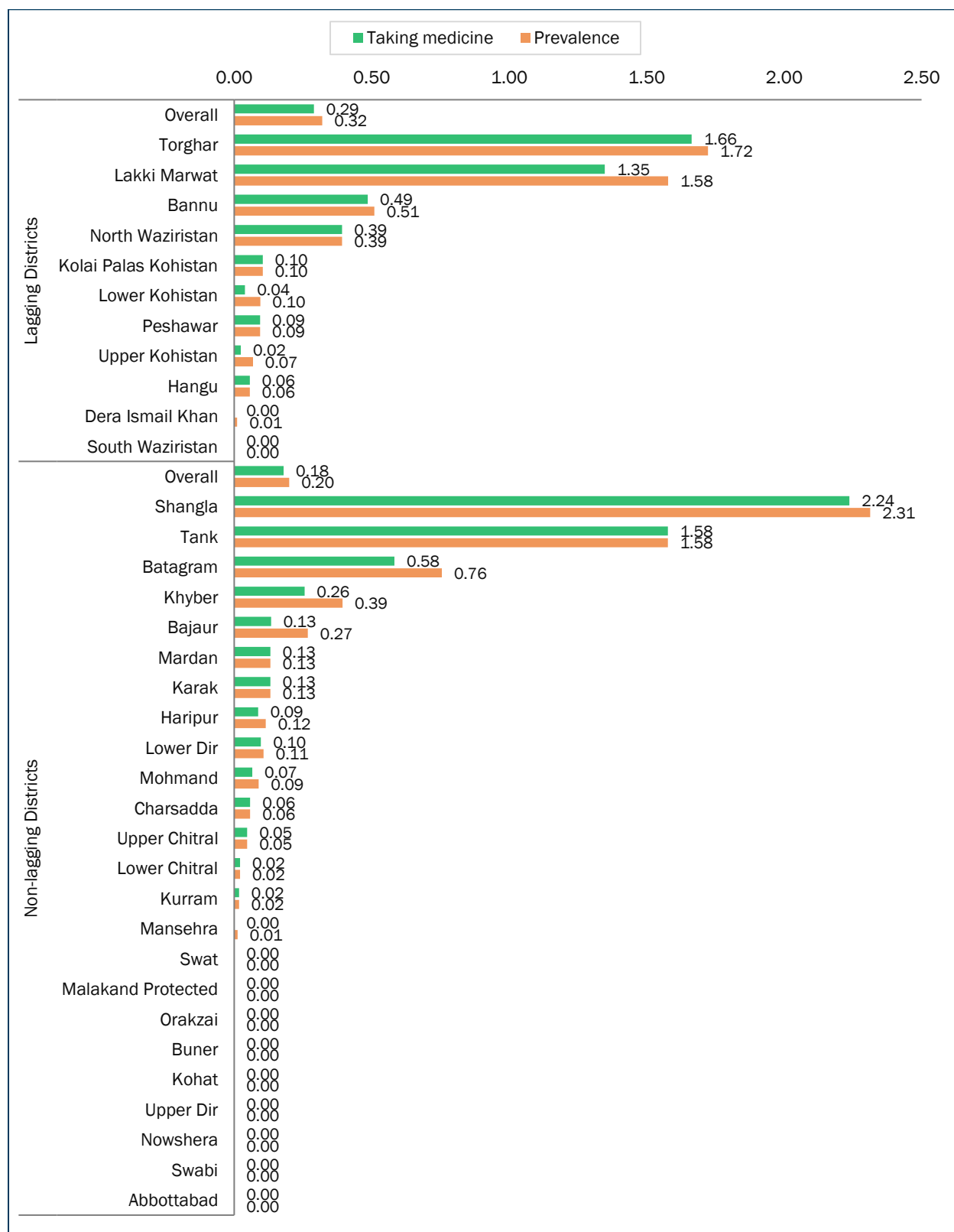
With 177 million people at risk, malaria is endemic in Pakistan according to the World Health Organization (WHO). The reported prevalence of malaria among HH members aged 5 years old or above was 0.23%: 0.26% in rural areas and 0.07% in urban areas (Table 9.8). Lagging districts had higher reported prevalence (0.32%) than non-lagging districts (0.20%). Age pattern in reported prevalence of malaria shows an increase to age 30–44 years and then a decline with the lowest prevalence among those 60 or older. Reported prevalence of malaria among females was slightly higher (0.25%) than among males (0.22%), and among women with no education or primary/middle than among women with secondary or higher education. As expected, women in the highest wealth quintile had the lowest reported prevalence, but it was the households in the second quintile than the lowest that had the highest reported prevalence of malaria.

Table 9.8: Percentage of household members (aged 5 years or above) who had malaria (reported prevalence) and percentage seeking treatment (by background characteristics)

	Reported prevalence	Treatment	N (Unweighted)
Overall	0.23	0.21	153,684
Residence			
Rural	0.26	0.23	134,254
Urban	0.07	0.07	19,430
District type			
Lagging	0.32	0.29	69,225
Non-lagging	0.20	0.18	84,459
Age			
05-14 yrs	0.23	0.20	49,806
15-29 yrs	0.24	0.21	44,880
30-44 yrs	0.28	0.24	30,771
45-59	0.19	0.19	17,072
60+	0.17	0.17	11,155
Sex			
Male	0.22	0.19	77,436
Female	0.25	0.23	76,248
Education			
No education	0.24	0.22	78,617
Primary/Middle	0.24	0.21	44,061
Secondary or higher	0.22	0.19	31,006
Wealth quintiles			
Lowest	0.23	0.20	42,534
Second	0.32	0.29	31,851
Middle	0.23	0.20	29,748
Fourth	0.21	0.18	27,007
Highest	0.19	0.18	22,544

In 10 of 35 districts (Swat, Malakand Protected, Orakzai, Buner, Kohat, South Waziristan, Upper Dir, Nowshera, Swabi, and Abbottabad), no reported prevalence of malaria was reported in KPHPS (Figure 9.3). Torghar and Shangla were districts with high reported prevalence, at 1.7% and 2.2% respectively.

Figure 9.3: Percentage of household members aged 5 years or above who had malaria (by district)



Among HH members aged 5 and above who had malaria, 89.7% overall, 89.4% in rural areas, and 85.7% in urban areas sought treatment (Table 9.9). Public health facilities were the source of treatment for 45.9% overall: 45.43% in rural areas and 55.7% in urban areas. The use of private facilities was less (35.2%) in urban areas than in rural areas (51.6%).

Table 9.9: Percentage of household members (aged 5 years or above) who had malaria and who sought treatment

	Total	Rural	Urban
Treatment sought among those who reported malaria			
Yes	89.7	89.4	95.7
No	10.3	10.6	4.3
Total	100.0	100.0	100.0
N (Unweighted)	520	491	29
Source of treatment			
Public	45.9	45.4	55.7
Private	50.8	51.6	35.2
Workers	1.8	1.5	9.1
Missing	1.5	1.6	0.0
Total	100.0	100.0	100.0
N (Unweighted)	476	448	28

A major preventive measure is the use of mosquito nets. Yet, only 25.3% of all households (26.8% in rural and 16.3% in urban areas) report the availability of mosquito nets that can be used while sleeping (Table 9.10). The availability of two and three nets was 7.5% and 5.6% overall. In rural areas, where the average family size and reported prevalence of malaria are higher, 7.6% of households had two nets and 6.0% had three nets. In urban areas, 6.6% had two nets and 3.0% had three nets. The availability of nets probably does not fully meet the household's needs to protect all its members. About one-third of nets are already sprayed with mosquito repellent, and 5.9% have medicine to treat malaria at home.

Besides nets, household members use different ways to keep mosquitoes away. The more common ways were through smoke (37.4%), spray (32.4%), coil (22.5%), and mat (20.1%). Note that often multiple ways are employed to keep mosquitoes away.

Table 9.10: 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	25.3	26.8	16.3
No	74.7	73.2	83.7
Total	100.0	100.0	100.0
Number of mosquito nets available at household			
No Net	74.7	73.2	83.7
1 Net	3.8	3.9	2.9
2 Nets	7.5	7.6	6.6
3 Nets	5.6	6.0	3.0
4 Nets	3.8	4.2	1.3
5 or more nets	4.7	5.1	2.5
Total	100.0	100.0	100.0
Do you have medicine to treat malaria at home?			
Yes	5.9	6.3	3.7
No	91.9	91.4	94.7
Don't know	2.2	2.3	1.6
Total	100.0	100.0	100.0
Whether net already sprayed with mosquito repellent?			
Yes	37.6	38.8	25.7
No	52.1	51.0	62.9
Don't Know	10.4	10.3	11.4
Total	100.0	100.0	100.0
Ways used to keep mosquitoes away other than nets			
Coil	22.5	20.9	30.1
Mat	20.1	19.4	23.4
Spray	32.4	28.8	49.6
Electric spray repellent	1.5	1.1	3.3
Insect repellent	2.5	2.5	2.3
Electric Racket	1.2	.9	2.3
Through Smoke	37.4	42.3	13.7
Kri Kri Mosquito Killer	1.6	1.7	.7
Others [Specify]	3.1	3.0	3.6
Total	100.0	100.0	100.0
N (Unweighted)	8,823	7,314	1,509
No. of HH (Unweighted)	23,534	20,357	3,177

*Multiple response variable.

All family members in 49% of households used nets, 50.0% of rural households and 39.6% in urban households (Table 9.11). Children were the only ones using nets in 19.8% of all households, 19.5% in rural areas and 23.2% in urban areas

Table 9.11: Percentage of households with mosquito nets (by type of household members using)

	Total	Rural	Urban
Household member(s) using*			
All family members	49.0	50.0	39.6
Only male family members	6.6	6.4	8.9
Only female family members	3.5	3.3	5.4
Only adult male and female family members	6.4	6.3	8.1
Only children	19.8	19.5	23.2
Male family member and children	5.2	5.2	5.2
Female family member and children	8.0	8.0	7.9
Nobody uses it	1.5	1.4	1.9
Total	100.0	100.0	100.0
No. of HH member(s) using (Unweighted)	6,398	5,799	599
No. of HH (Unweighted)	23,534	20,357	3,177

*Multiple response variable.

Non-communicable Diseases

Hypertension (high blood pressure)

Hypertension is defined as 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. The KPHPS shows that 3.0% of HH members aged 5 years or above in KP and in its rural areas had hypertension (Table 9.12 and Figure 9.4); reported prevalence was higher at 3.2% in urban areas. Similarly, the reported prevalence of hypertension was lower in lagging (2.8%) than in non-lagging districts (3.1%). The reported prevalence increases by age and reaches 10.1% among those aged 45–59 years and 13.7% among those 60 or older. Hypertension is more prevalent among women (3.8%) than among men (2.2%). Hypertension was also more prevalent among those with no education (4.6%) than among those who had primary or middle or secondary or higher education. Hypertension is more prevalent among wealthy households (3.5%) than among the poorest (2.0%).

Table 9.12: Percentage of household members (aged 5 years or above) with hypertension and percentage seeking treatment for hypertension (by background characteristics)

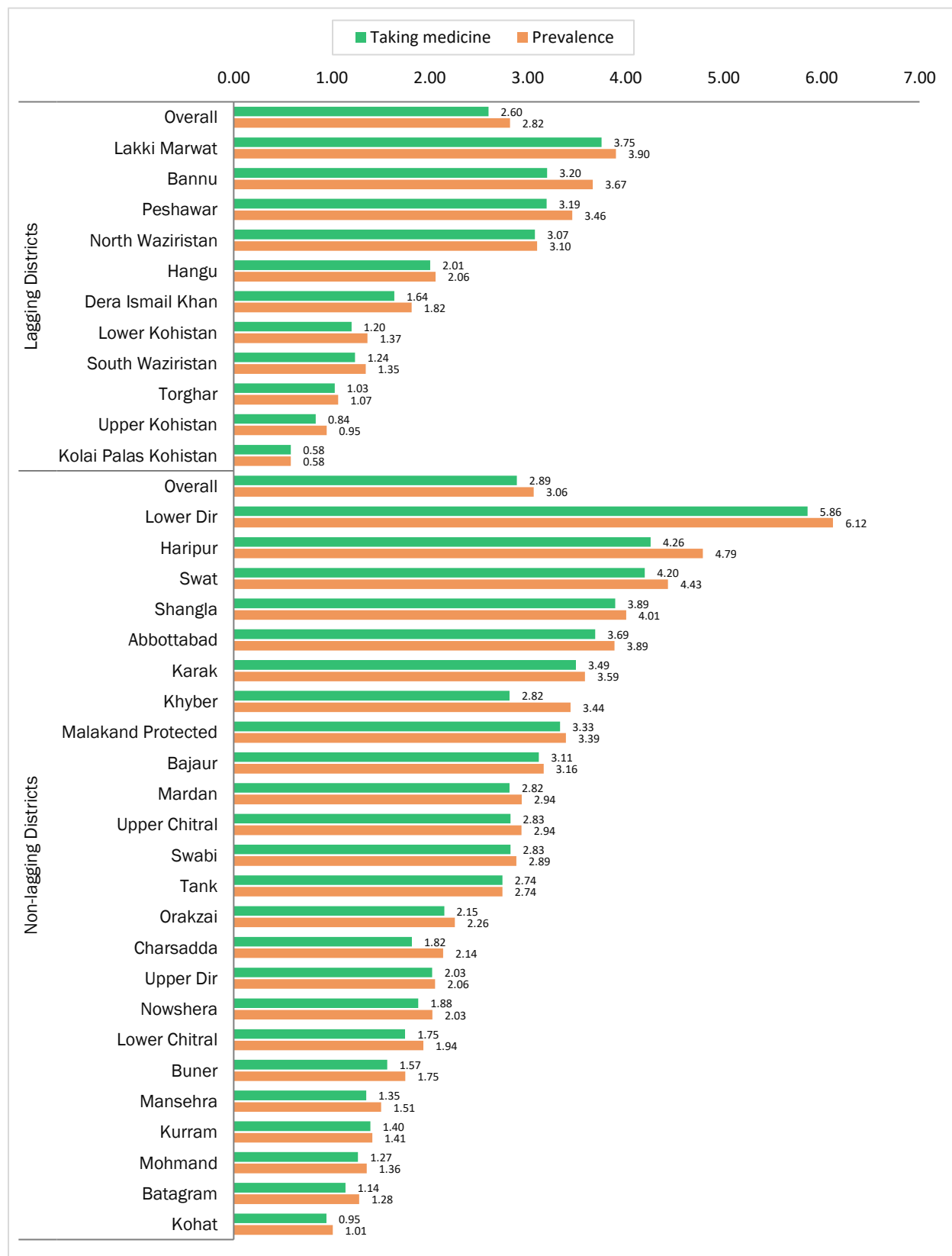
	Reported prevalence	Treatment	N (Unweighted)
Overall	3.0	2.8	153,684
Residence			
Rural	3.0	2.8	134,254
Urban	3.2	3.0	19,430
District type			
Lagging	2.8	2.6	69,225
Non-lagging	3.1	2.9	84,459
Age			
05–14 years	0.0	0.0	49,806
15–29 years	0.5	0.4	44,880
30–44 years	3.4	3.1	30,771
45–59	10.1	9.6	17,072
60+	13.7	13.1	11,155
Sex			
Male	2.2	2.1	77,436
Female	3.8	3.6	76,248
Education			
No education	4.6	4.3	78,617
Primary/Middle	1.2	1.1	44,061
Secondary or higher	2.2	2.1	31,006
Wealth quintiles			
Lowest	2.0	1.8	42,534
Second	3.0	2.7	31,851
Middle	3.0	2.9	29,748
Fourth	3.4	3.3	27,007
Highest	3.5	3.4	22,544

Treatment rates were high (94.0%) with similar rates observed in urban and rural areas (Table 9.13). About equal proportions of HH members with hypertension sought treatment from public and private facilities (44.8%), both in rural areas (45.0%) and in urban areas (43.4% vs. 43.7%). Figure 9.4 shows variation in reported prevalence and treatment of hypertension by district.

Table 9.13: Percentage of household members (aged 5 years or above) who had hypertension disease and who sought treatment of hypertension (by rural/urban)

	Total	Rural	Urban
Treatment sought?			
Yes	93.8	93.8	94.1
No	6.2	6.2	5.9
Total	100.0	100.0	100.0
N (Unweighted)	4,173	3,529	644
Source of treatment			
Public facility	44.8	45.0	43.4
Private facility	44.8	45.0	43.7
Workers	3.3	3.2	3.5
Others	0.4	0.4	0.5
Missing	6.7	6.4	8.9
Total	100.0	100.0	100.0

Figure 9.4: Percentage of household members aged 5 years or above who had hypertension disease (by district)



Diabetes

Diabetes was prevalent among 2.0% of HH members aged 5 or above (Table 9.14, Figure 9.5). It was more prevalent in urban areas (2.8%) than in rural areas (1.9%) and in non-lagging districts (2.1%) than in lagging districts (1.7%). Like hypertension, the reported prevalence of diabetes rises with age, reaching 7.2% for the group aged 45–59 years and 10.8% for ages 60 or older. The reported prevalence of diabetes among HH members with no education was 3.0% compared to 1.7% among those who had secondary or higher education. Reported prevalence was lowest among the poorest (1.0%) and the highest among the richest (3.5%).

Table 9.14: Percentage of household members (aged 5 years or above) with diabetes and percentage seeking treatment (by background characteristics)

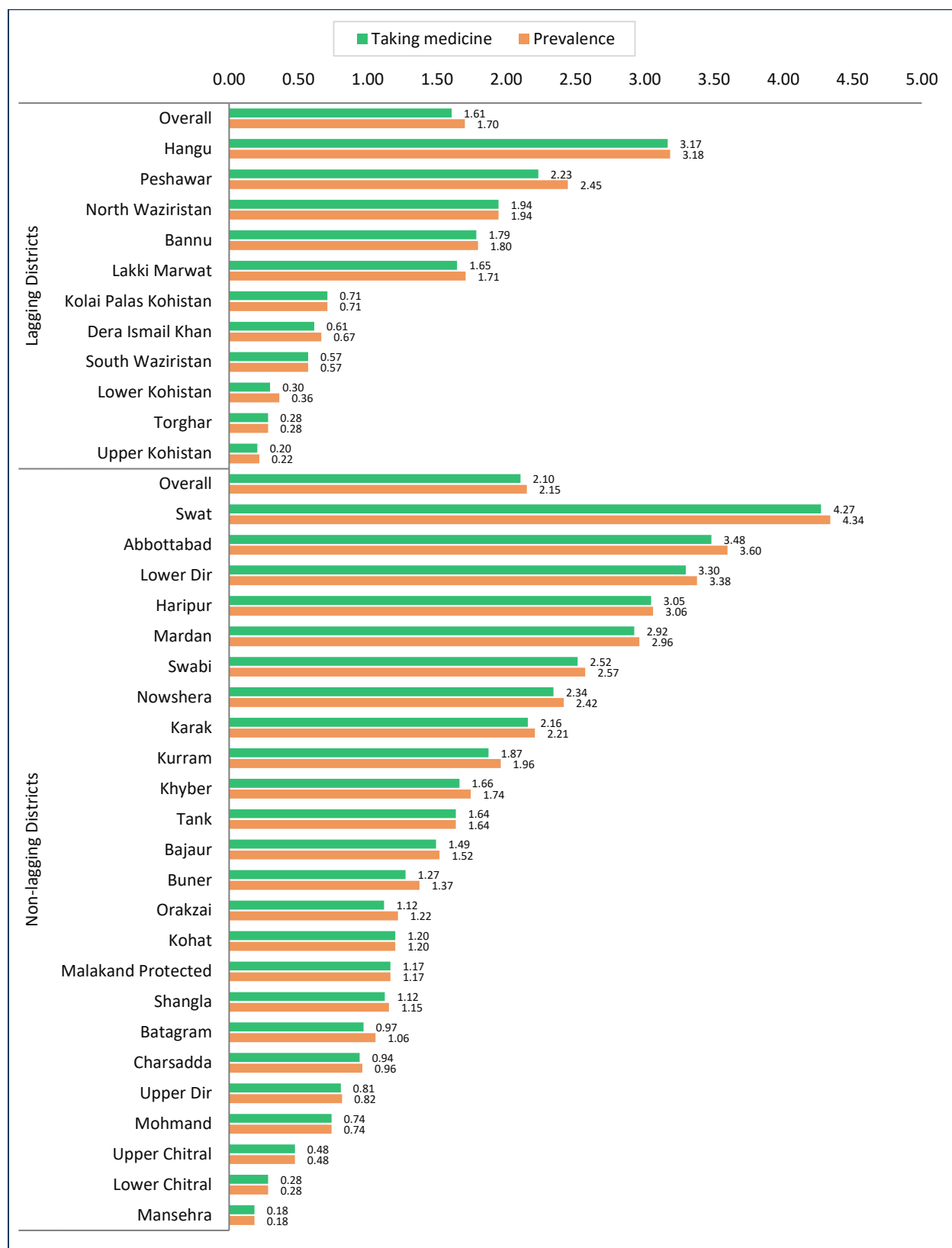
	Reported prevalence	Treatment	N (Unweighted)
Overall	2.02	1.96	153,684
Residence			
Rural	1.88	1.83	134,254
Urban	2.84	2.73	19,430
District type			
Lagging	1.70	1.61	69,225
Non-lagging	2.15	2.10	84,459
Age			
05–14 yrs	0.03	0.03	49,806
15–29 yrs	0.21	0.20	44,880
30–44 yrs	1.67	1.57	30,771
45–59	7.16	6.92	17,072
60+	10.81	10.67	11,155
Sex			
Male	1.60	1.56	77,436
Female	2.44	2.36	76,248
Education			
No education	2.98	2.89	78,617
Primary/Middle	0.83	0.80	44,061
Secondary or higher	1.70	1.65	31,006
Wealth quintiles			
Lowest	0.96	0.89	42,534
Second	1.34	1.28	31,851
Middle	1.88	1.84	29,748
Fourth	2.30	2.22	27,007
Highest	3.50	3.44	22,544

Among those who had diabetes, 97.0% overall, 97.2% in rural areas, and 96.2% in urban areas sought treatment (Table 9.15). Private facilities were used for seeking treatment by 51.3% of patients, compared to 42.5% who used public health facilities. In rural areas, 50.7% used private facilities compared to 42.8% who used public facilities. In urban areas, the gap was wider, with 53.6% using private and 41.4% using public health facilities.

Table 9.15: Percentage of household members (aged 5 years or above) with diabetes who sought treatment of diabetes

	Total	Rural	Urban
Treatment sought			
Yes	97.0	97.2	96.2
No	3.0	2.8	3.8
Total	100.0	100.0	100.0
N (Unweighted)	2,490	1,968	522
Source of treatment			
Public facility	42.5	42.8	41.4
Private facility	51.3	50.7	53.6
Health Workers	2.6	2.7	2.1
Others	0.7	0.7	0.6
Missing	2.9	3.1	2.3
Total	100.0	100.0	100.0

Figure 9.5: Percentage of household members aged 5 years or above who had diabetes (by district)



General Health

Key Findings

Type of health facility frequently visited

- More household members (57.4%) visited public health facilities than private health facilities (29.8%) during their last health ailment.
- A notable 11.3% of household members did not visit any facility for healthcare.
- The poorest households relied more on public (60.1%) than private facilities (21.1%) compared to the wealthiest households (51.1% and 38.6%, respectively).
- Use of private facilities was more frequent in lagging than non-lagging districts—32.9% vs. 28.5%.
- The range of types of facilities visited was wider in the private sector.

Travel time to health facility

- On average, it took 30 minutes to reach a public health facility compared to 25 minutes to reach a private facility.
- In rural areas, it took 10 minutes longer on average than in urban areas to reach the facility last used.
- There was no difference in the average time to reach the facility last used in lagging compared to non-lagging districts.

Costs of visit for healthcare

- Overall, the costs incurred on the last healthcare visit were PKRs 5,000.
- The overall cost is the same for visiting a public or a private facility.
- The overall cost of the visit was lower in urban areas than in rural areas and in lagging districts than in non-lagging districts.
- Fees and operation cost more in private than in a public facility.
- Medicine and beds cost more in public than in private facilities.
- Costs for transport and lab/tests were similar in public and private facilities.

Mode of transport

- Walking distance was availed in 23.5% of cases for reaching a private facility and 16.1% for reaching a public facility.
- Rickshaw/Chingchi is the most common mode of transport, used by 29.1% of household members, especially in urban areas (38.8%) than in rural areas (27.5%).
- Cars were used to reach a facility by 26.8% of household members, more in rural areas (27.9%) than in urban areas (20.7%).

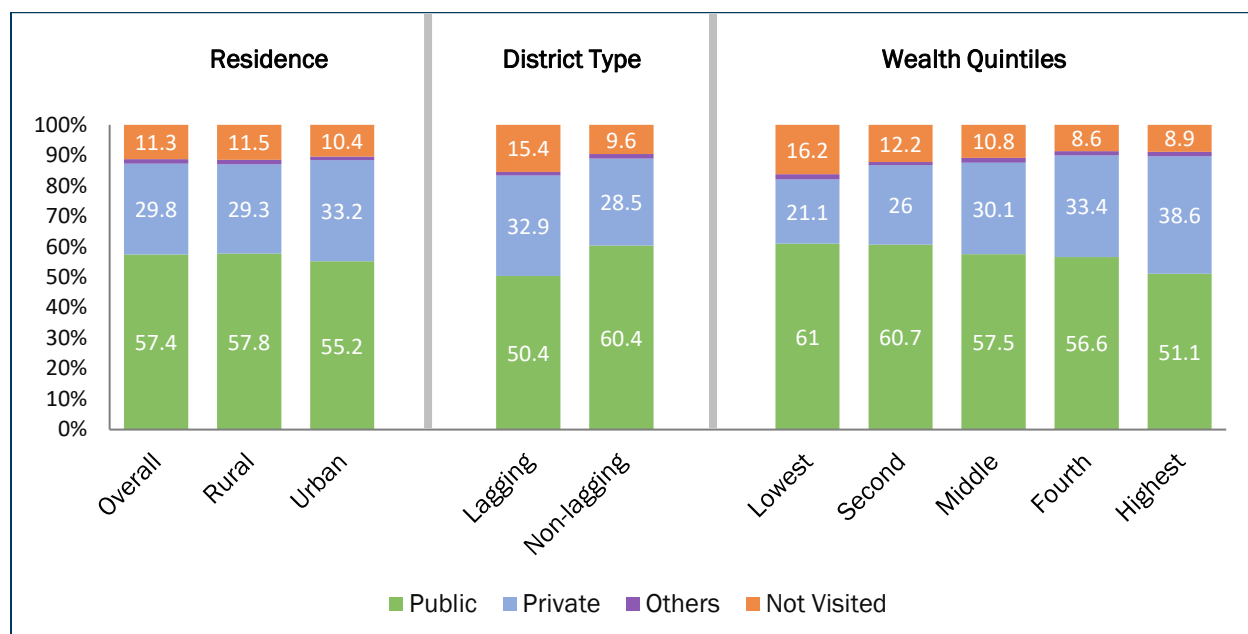
The KPHPS 2024–25 household questionnaire sought information about the contact of the household (HH) member(s) with the health system and their access, affordability, and preference for types of facilities within the broader public and private health system. It is important to point out that while the chapters on maternal health, family planning, and infant and child health were based on information provided by the woman herself, here the respondent could be any responsible member of the household. While there is the important caveat that a particular respondent in the household is reporting on a proxy basis for other household members, the information is still valuable for assessing their contact with the health system in KP.

The first set of information pertains to where the last HH member who had a problem sought health care. Table 10.1 and Figure 10.1 show a comprehensive picture that the public health system was utilized in the majority of cases: 57.4% of HH members visited public facilities on their last visit. The private sector was quite dominant, with 29.8% of household members visiting a private facility or source. Of great concern is the substantial proportion of 11.3% household members who did not visit any healthcare facility for their general health issues.

Table 10.1: Percentage of household members visiting a facility most frequently during the last year (by type of facility and background characteristics)

	Type of facility				Total	n
	Public	Private	Others	Not Visited		
Overall	57.4	29.8	1.4	11.3	100.0	23,534
Residence						
Rural	57.8	29.3	1.5	11.5	100.0	20,377
Urban	55.2	33.2	1.2	10.4	100.0	3,157
District Type						
Lagging	50.4	32.9	1.2	15.4	100.0	10,515
Non-lagging	60.4	28.5	1.5	9.6	100.0	13,019
Wealth Index						
Lowest	61.0	21.1	1.7	16.2	100.0	6,874
Second	60.7	26.0	1.1	12.2	100.0	4,914
Middle	57.5	30.1	1.6	10.8	100.0	4,486
Fourth	56.6	33.4	1.4	8.6	100.0	3,950
Highest	51.1	38.6	1.4	8.9	100.0	3,310

Figure 10.1: Percentage of facilities most frequently visited during the last year, (by type of facility)



There are slight differences across rural and urban areas in this pattern. However, the differences by the wealth quintile of the household were quite dramatic, with 61.0% of the poorest households using public facilities, 21.1% using private facilities, and 16.2% not using any facility at all. In the wealthiest household in the highest income quintile, 51.1% were using public facilities, 38.6% were using private facilities, and a low 8.9% did not seek healthcare from the health system. Differences across lagging and non-lagging districts show an anomalous pattern, with lagging districts presenting a higher use of private facilities compared to non-lagging districts. The explanation may lie in the inclusion of Peshawar in the lagging districts, which may be distorting the differences across lagging and non-lagging districts.

When public and private facilities are further subdivided into type of facilities visited, we find that among the public facilities a first-level hospital was visited most by HH members in rural areas (30.1%), followed by the primary healthcare facility and tertiary level/care facility (13.1% and 13.0%, respectively) (Table 10.2). In urban areas, 26.6% of HH members visited tertiary level/care public facility, followed by a first-level hospital. In the private sector, a range of facilities were visited, with the main being primary healthcare-level facilities, by 11.2% of rural and 13.6% of urban HH members.

Table 10.2: Percent distribution of type of most frequently visited facility (by member of household during last year)

EHSP Coding	Residence		District type		
	Rural	Urban	Lagging	Non-lagging	Overall
Public	57.8	55.2	50.4	60.4	57.4
Community level	1.6	0.8	0.8	1.6	1.4
Primary health care level	13.1	5.0	14.0	11.5	12.0
First level hospital	30.1	22.8	23.0	30.4	29.0
Tertiary level/care	13.0	26.6	8.0	16.6	15.0
Private	29.3	33.2	32.9	28.5	29.8
Community level	0.1	0.0	0.0	0.1	0.1
Pharmacy/chemist	3.6	4.8	9.5	2.5	3.8
Dispenser clinic	5.1	4.5	5.0	5.0	5.0
LHV/Nurse clinic	2.1	1.0	1.3	2.1	2.0
Primary health care level	11.2	13.6	10.8	11.8	11.6
First-level hospital	6.6	8.5	3.2	7.7	6.9
Hakim/Homeopath	0.5	0.8	1.2	0.4	0.5
Not Visited	11.5	10.4	21.8	8.9	11.3
Total	100.0	100.0	100.0	100.0	100.0
Number of household members	20,377	3,157	9,036	14,498	23,534

Essential Health Services Package (EHSP) Coding Scheme

PUBLIC—Community level: Mobile service unit (MSU), Lady Health Worker (LHW), Community Midwife (CMW). **Primary health care level:** RHC, BHU, MCH Center/ FH Center, Government/ Civil Dispensary. **First level hospital:** DHQ, THQ, Type-D Health Facility, Reproductive health services center (RHSA), Family Welfare Centre (FWC), Family Welfare Worker (FWW), Family Welfare Counselor (FWC), Family Welfare Assistant (FWA). **Tertiary level/care:** Teaching Hospital.

PRIVATE—Community level: Vaccinator, NGO worker, etc. **Primary health care level:** Private Male/Female MBBS Doctor Clinic, GSM Clinic, NGO Clinic. **First-level hospital:** Private hospital with inpatient facility. Pharmacy/chemist, Dispenser clinic, LHV/Nurse clinic, Hakim/Homeopath.

The second set of findings from the household survey regarding access to the health system provides information on how long it takes to reach the facility. Importantly, we find in Table 10.3 that there is not much difference in the time that it takes to reach facilities whether in the public or private sectors. The median travel time was 30 minutes regardless of government or private facility in lagging and non-lagging districts. However, urban and rural residence did make a difference of ten minutes in median time taken to reach a facility, with shorter time for the former. Less than one-fourth (21.4%) of rural inhabitants, as compared to 44.1% of urban inhabitants, had visited a facility within 15 minutes of travelling time. Furthermore, 20.2% of rural inhabitants had to travel more than an hour to get to the health facility compared to 3.1% of urban inhabitants.

Table 10.3: Percentage of household members by time taken (in minutes) to reach most frequently visited health facility (by background characteristics)

HH Characteristics	One-way time to reach (in minutes)				Total		Median (in Min)
	0-15	16-30	31-60	61-hi	%	n	
Residence							
Rural	21.4	30.8	27.6	20.2	100.0	16,055	30.0
Urban	44.1	35.9	16.9	3.1	100.0	2,647	20.0
District type							
Lagging	31.7	26.4	25.1	16.7	100.0	6,483	30.0
Non-lagging	23.4	32.5	26.2	17.9	100.0	12,219	30.0
Facility type							
Public	18.7	32.3	30.2	18.7	100.0	12,517	30.0
Private	35.8	30.1	18.3	15.8	100.0	5,884	25.0
Wealth Index							
Lowest	20.1	28.2	27.1	24.7	100.0	4,939	36.0
Second	23.6	32.1	24.9	19.4	100.0	3,854	30.0
Middle	25.9	30.9	26.1	17.0	100.0	3,694	30.0
Fourth	25.9	31.6	26.2	16.2	100.0	3,357	30.0
Highest	27.7	34.5	25.7	12.2	100.0	2,858	30.0

More importantly, the findings show that private facilities are more likely to be at a shorter distance of travel compared to public facilities, with a median travel time of 25 minutes for private and 30 minutes for public facilities. This confirms one of the reasons for the preference of using the private sector for health needs—that a private facility is more likely to be located nearer than a public facility.

Furthermore, there is a strong association between travelling time and household wealth quintile. Members from households in the poorest income quintile spent 36 minutes travelling to reach a health facility, compared to 30 minutes by those in all other wealth quintiles.

The median time required to reach healthcare, by type of public facility, varies from 25 minutes to reach a community level or primary healthcare level, 38 minutes to reach a first-level hospital, and 45 minutes to reach a tertiary level/care facility (Table 10.4). This contrasts with much shorter travel time to private facilities: 20 minutes to community level and dispenser clinic, 15 minutes to a pharmacy/chemist and hakim or homeopath, 20 minutes to a lady health visitor (LHV) and nurse clinic, 30 minutes to a primary healthcare level, and 45 minutes to a first-level hospital. The only exception is the first-level hospital, which takes the same travel time (45 minutes) in both public and private sectors. Despite the shorter travel time to private facilities, more HH members visit public facilities for treatment and care than private facilities.

Table 10.4: Percentage of household members by time taken (in minutes) to reach a most frequently visited health facility (by type of facility)

EHSP Coding	One-way time to reach (in minutes)				Total		Median (in Min)
	0-15	16-30	31-60	61-hi	%	n	
Public	18.7	32.3	30.2	18.7	100.0	12,517	30.0
Community level	33.5	39.8	19.6	7.1	100.0	290	25.0
Primary health care level	33.3	40.7	17.8	8.2	100.0	3,157	25.0
First level hospital	14.4	32.5	33.7	19.5	100.0	6,735	38.0
Tertiary level/ care	14.5	25.2	34.0	26.3	100.0	2,335	45.0
Private	35.8	30.1	18.3	15.8	100.0	5,884	25.0
Community level	73.7	23.2	3.1	0.0	100.0	29	10.0
Pharmacy/ chemist	69.5	25.8	3.0	1.7	100.0	843	15.0
Dispenser clinic	71.0	21.7	6.4	0.9	100.0	997	10.0
LHV/ Nurse clinic	43.9	45.5	8.4	2.2	100.0	396	20.0
Primary health care level	21.2	32.5	26.6	19.7	100.0	2,186	30.0
First level hospital	12.6	30.1	24.8	32.6	100.0	1,358	45.0
Hakim/ Homeopath	52.5	33.6	10.1	3.8	100.0	75	15.0

The KPHPS 2024-25 collected unique information on costs incurred for general health ailments by HH members in KP in the last year. We came across a striking finding that household members who utilized a government or a private facility both had to pay an equal median cost of PKRs 5,000 for seeking healthcare (Table 10.5). The average cost in seeking healthcare for rural residents was higher (PKRs 5,000) than for urban residents (PKRs 4,370). The median cost in lagging districts was lower

(PKRs 4,000) than in non-lagging districts (PKRs 5,000). The availability of free care was low— 4.3% overall, 4.9% in public and 2.7% in private facilities. The proportions of HH members spending over PKRs 3,500 were 60.3% in rural areas compared to 55.6% in urban areas; 52.3% in lagging compared to 62.4% in non-lagging districts. Interestingly, the proportion of those who spend such a level of money was 60.5% among those who visited a public health facility compared to 58.3% who visited a private facility for general healthcare.

Table 10.5: Percentage of household members of those who last visited a health care facility (by costs incurred by background characteristics)

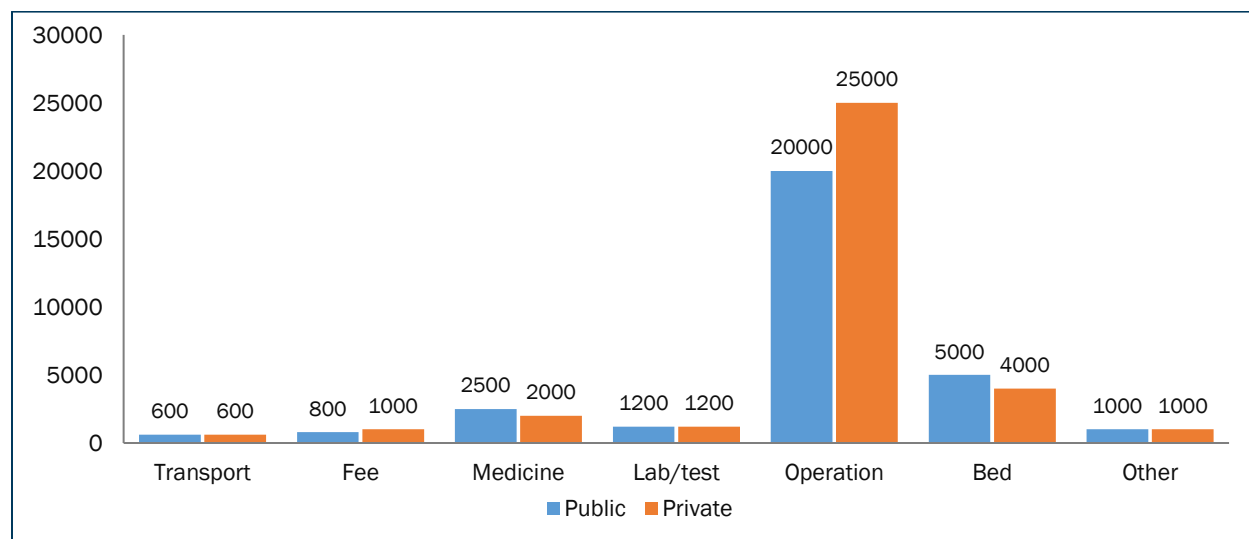
	Total Cost (in Rs.)						Total		Total Cost
	Free	500 or less	501–1,500	1,501–2,500	2,501–3,500	3,501 or more	%	n	Median Total cost
Residence									
Rural	4.6	3.3	12.0	9.9	9.8	60.3	100.0	14,452	5,000
Urban	2.7	3.9	12.7	13.9	11.2	55.6	100.0	2,412	4,370
Overall	4.3	3.4	12.1	10.5	10.0	59.6	100.0	16,864	5,000
District type									
Lagging	5.0	5.7	17.1	10.5	9.4	52.3	100.0	7,040	4,000
Non lagging	4.1	2.6	10.2	10.5	10.2	62.4	100.0	9,824	5,000
Last facility type									
Public	4.9	2.5	11.2	10.4	10.5	60.5	100.0	11,525	5,000
Private	2.7	5.0	13.8	10.9	9.4	58.3	100.0	4,881	5,000

The percentage of HH members expending costs for various items did not vary greatly by type of facility in either the public or private sector (Table 10.6). The median amount for any category of treatment, transport, or lab/test was the same for both public and private facilities: PKRs 5,000, 600, and 1,200 respectively (Figure 10.2). However, the fee and operation cost more in private compared to public facilities (PKRs 1,000 vs. 800 and PKRs 25,000 vs. 20,000 respectively). On the other hand, medicine and beds were more costly in public than private facilities: PKRs 2,500 vs. 2,000 and PKRs 5,000 vs. 4,000. Therefore, visiting a private facility does not seem an exceptionally more costly option than a public facility.

Table 10.6: Percentage of household members who incurred costs (by services paid for, and type of facility last visited)

Type of cost	Percentage who paid at:			Median amount (in Rs) paid at:		
	Public	Private	Overall	Public	Private	Overall
Any Cost	95.1	97.3	95.8	5,000	5,000	5,000
Transport	66.6	61.4	65.0	600	600	600
Fee	57.1	63.1	59.0	800	1,000	1,000
Medicine	75.5	78.2	76.4	2,500	2,000	2,500
Lab/ test	44.9	42.5	44.1	1,200	1,200	1,200
Operation	3.9	4.3	4.0	20,000	25,000	20,000
Bed	2.3	2.7	2.4	5,000	4,000	5,000
Other	27.2	29.4	27.9	1,000	1,000	1,000
N (Unweighted)	15,909	6,165	22,074	15,909	6,165	22,074

Figure 10.2: Median amount paid in PKR (by type of facility and expense category)



The relative accessibility of facilities can be measured by the mode of transport used to reach them, besides the time it takes or the cost. Overall, one-in-five accessed the facility on foot: 23.5% to a private and 15.1% to a public facility (Table 10.7). The proportions were 17.9% in rural areas and 21.9% in urban, and 25.5% in lagging compared to 17.1% in non-lagging districts. Rickshaw/Chingchi was the mode of transport most used by 29.1% of all HH members: 30.3% to reach a public facility and 26.6%

to reach a private facility. The use of this mode of transport was more common in urban areas (38.8%) than in rural areas (27.5%) but differed little in lagging and non-lagging districts (30.2% and 28.9% respectively). A car was the second most used mode of transport, especially in rural areas (27.9%) than in urban areas (20.7%) and in non-lagging districts (28.6%) than in lagging districts (17.7%). The use of a car to reach a public (28.1%) or private facility (25.3%) did not vary greatly.

In summary, more HH members (57.4%) access healthcare from a public health facility in both rural and urban areas despite a greater range of private facilities available at shorter travel distances. On average, reaching a facility takes 30 minutes in rural areas and 20 minutes in urban areas, but there is no difference between lagging and non-lagging districts. Reaching a private facility takes on average 5 minutes less than reaching a public facility. The overall cost for availing a public or private facility is the same (PKRs 5,000), but fee and operation costs are less in public facilities. However, medicine and beds cost less in private than public facilities. Overall, based on total or individual cost, public facilities do not seem to offer a hugely cheaper option in KP.

Table 10.7: Percent distribution of household members (by type of transport used last time)

	Last facility type		Residence		District type		Overall
	Public	Private	Rural	Urban	Lagging	Non lagging	
On foot	16.1	23.5	17.9	21.9	25.5	17.1	18.4
Motorcycle	6.1	7.7	6.3	8.9	9.9	6.1	6.7
Rickshaw/ Chingchi	30.3	26.6	27.5	38.8	30.2	28.9	29.1
Bus/ Van	16.6	14.6	17.3	7.6	14.4	16.2	15.9
Car	28.1	25.3	27.9	20.7	17.7	28.6	26.8
Others [Specify]	1.9	1.4	2.0	1.3	0.6	2.2	1.9
Don't know	1.0	0.8	1.1	0.8	1.7	0.9	1.0
Overall %	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N (Unweighted)	14,950	5,794	18,453	2,935	7,486	13,902	21,388

Service Coverage Index (SCI)

Key Findings

Overall Performance (SCI)

- The Service Coverage Index (SCI) for the province is 39.2 points, indicating low overall access to essential health services.
- The SCI is calculated using the geometric mean of scores on three dimensions: reproductive, maternal, newborn and child health (RMNCH), Infectious Diseases, and Noncommunicable Diseases.

Dimension – Reproductive, Maternal, Newborn, and Child Health (RMNCH)

- The RMNCH score is 37.7 points (moderate).
- Urban areas perform better (44.9 points) than rural areas (36.7 points), a difference of 8 percentage points.
- Lagging districts have a lower RMNCH score (33.1 points), indicating significant gaps in family planning, antenatal care, immunization, and child treatment services.

Dimension II – Infectious Diseases (ID Score)

- Infectious diseases is the lowest-performing dimension at 33.5 points.
- Rural areas score higher (35.7 points) than urban areas (24.5 points)
- Surprisingly, lagging districts score higher (37.5 points) than non-lagging districts (31.6 points), possibly reflecting focused efforts or the inclusion of Peshawar in lagging districts.

Dimension III – Noncommunicable Diseases (NCD Score)

- The score for NCDs overall is relatively high.
- The NCD scores is higher in urban areas at 53.2 points vs. 46.6 points in rural areas.

The first output indicator of NHSP PDOs is the Service Coverage Index (SCI). It is a composite measure of access to an 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 behavior that allowed the construction of the NHSP SCI.¹⁵ First, for each of the dimensions, a score is prepared using indicators and finally, the SCI is estimated by taking the 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 a 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 water and sanitation facilities¹⁶

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 11.1 and Figure 11.1. 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

¹⁵ 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 the computation methodology of SDG 3.8.1, it is limited to the indicators available in the KPHPS.

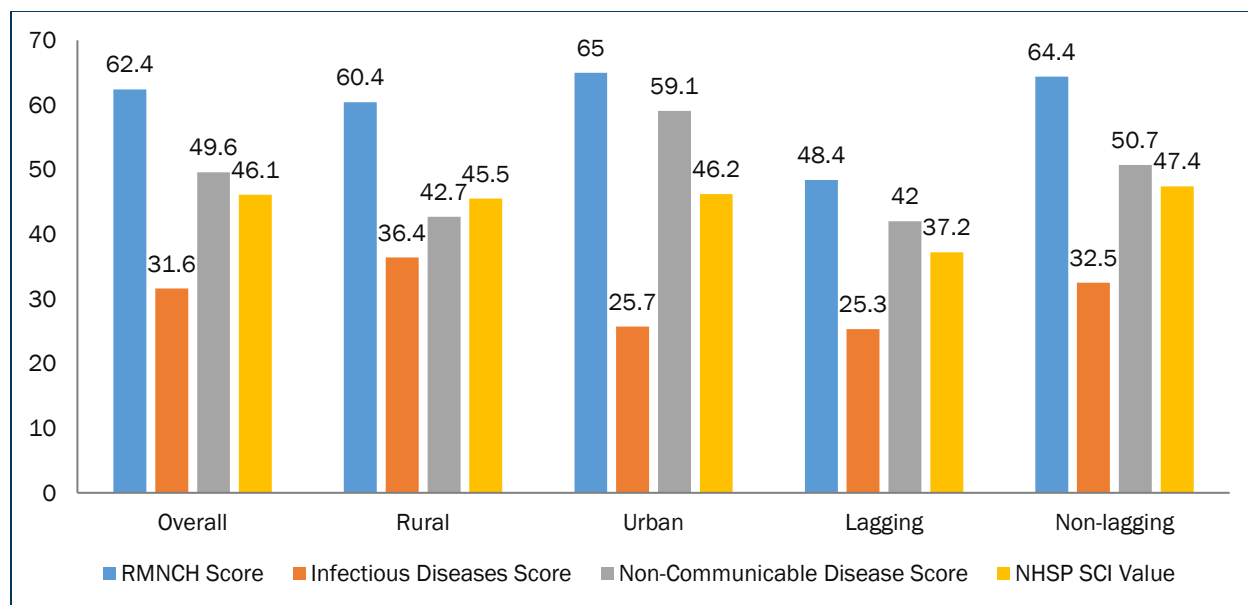
¹⁶ Improved sanitation facilities include wet sanitation technologies such as flush and pour flush toilets connected to sewers, septic tanks or pit latrines, and dry sanitation technologies such as dry pit latrines with slabs and composting toilets.

RMNCH Score is moderate (37.7 points) overall, indicating a need for continued improvements in the use of modern 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 11.1: Service Coverage Index

	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

Figure 11.1: Service Coverage Index



The overall rural versus urban differentials are minimal (Table 11.1 and Figure 11.1), 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 overall 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.

Annex A: Data Management and Use of Technology

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:

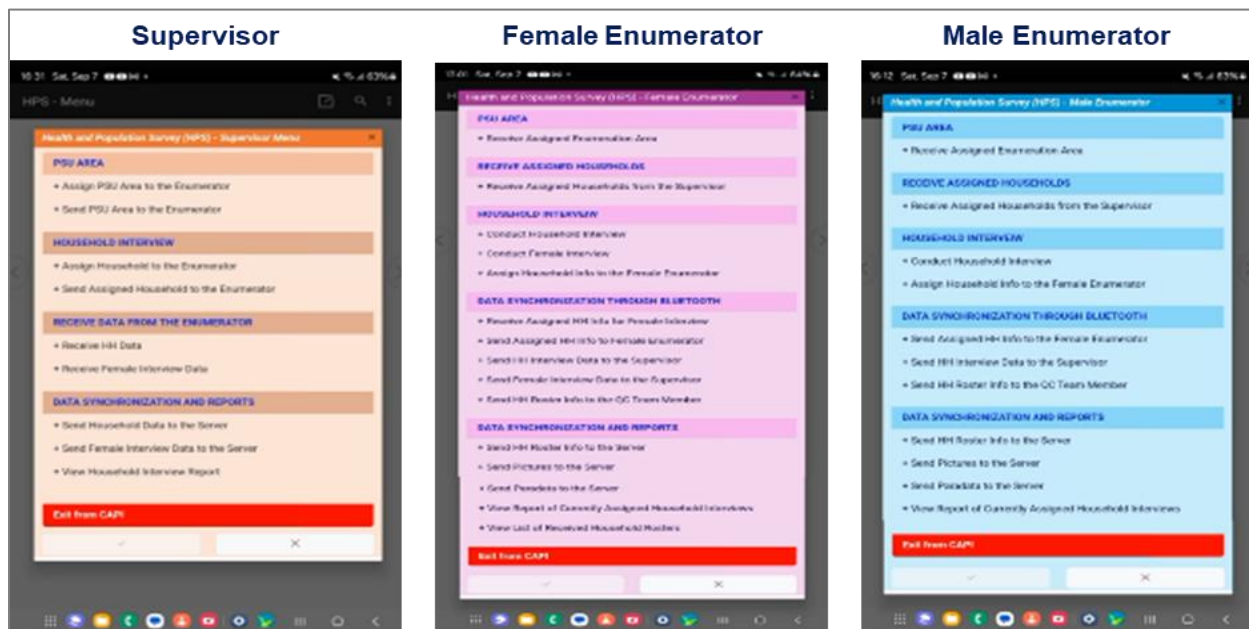
- Range checks; skip-and-fill rules
- Inter- and intra-record consistency checks with a table lookup function
- Support for long strings for verbatim responses of “others”
- Screen design to minimize scrolling strain and match the questionnaire layout
- Error alerts (beeps) with user and system messages
- 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 no-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

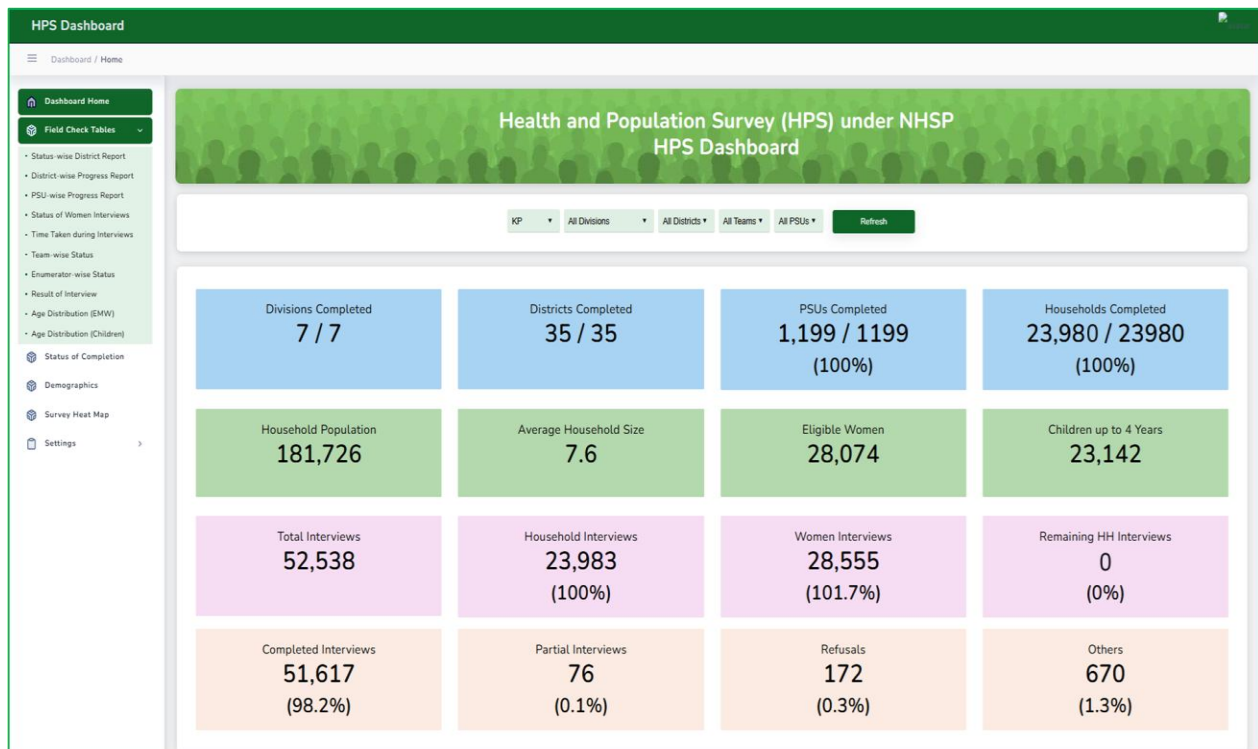
Listing data was received from the KPBoS during the preparatory phase. This data included the complete list of households within each selected PSU. The listing information was processed centrally to ensure accuracy, completeness, and consistency. Subsequently, using a systematic random sampling technique, 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, KPBoS, 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	7.827	0.069	7.691	7.962	7.074	23,535
Residence						
Rural	7.904	0.076	7.754	8.054	7.335	20,378
Urban	7.366	0.161	7.051	7.681	6.038	3,157
District type						
Lagging	7.834	0.094	7.650	8.019	4.109	10,516
Non-lagging	7.823	0.090	7.646	8.001	8.310	13,019

Table B-2: Antenatal Care (ANC): Any Visit (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	72.971	1.053	70.905	75.037	7.014	12,472
Residence						
Rural	71.446	1.172	69.147	73.746	7.310	11,006
Urban	83.205	2.372	78.551	87.860	6.512	1,466
District type						
Lagging	53.313	1.916	49.553	57.073	5.382	5,667
Non-lagging	81.096	1.022	79.092	83.101	6.007	6,805

Table B-3: Effective Antenatal Care (eANC)* (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	6.140	0.408	5.339	6.940	3.603	12,472
Residence						
Rural	5.572	0.434	4.721	6.423	3.878	11,006
Urban	9.950	1.182	7.631	12.268	2.520	1,466
District type						
Lagging	3.942	0.532	2.898	4.987	2.730	5,667
Non-lagging	7.048	0.533	6.003	8.093	3.821	6,805

* 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	22.908	0.647	21.639	24.177	6.518	27,510
Residence						
Rural	21.979	0.696	20.614	23.344	6.694	24,110
Urban	28.715	2.017	24.758	32.672	7.537	3,400
District type						
Lagging	23.001	1.147	20.750	25.252	6.005	12,605
Non-lagging	22.869	0.784	21.331	24.407	6.772	14,905

Table B-5: Contraceptive Prevalence of Modern Methods (mCPR) (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	14.812	0.491	13.849	15.775	5.257	27,510
Residence						
Rural	14.521	0.530	13.482	15.560	5.358	24,110
Urban	16.633	1.401	13.884	19.381	5.369	3,400
District type						
Lagging	13.378	0.704	11.997	14.758	3.453	12,605
Non-lagging	15.408	0.630	14.173	16.644	5.908	14,905

Table B-6: Acute Respiratory Infection (ARI) Prevalence (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	6.108	0.332	5.456	6.759	3.256	16,940
Residence						
Rural	6.026	0.358	5.323	6.730	3.358	15,004
Urban	6.670	0.879	4.945	8.396	2.659	1,936
District type						
Lagging	7.782	0.611	6.582	8.982	2.679	8,099
Non-lagging	5.378	0.389	4.614	6.142	3.515	8,841

Table B-7: Acute Respiratory Infection (A) Treatment (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	3.839	0.243	3.363	4.315	2.702	16,940
Residence						
Rural	3.719	0.258	3.212	4.226	2.761	15,004
Urban	4.671	0.708	3.282	6.060	2.409	1,936
District type						
Lagging	4.389	0.417	3.571	5.207	2.131	8,099
Non lagging	3.599	0.296	3.018	4.180	2.979	8,841

Table B-8: Pentavalent 1st Dose Vaccination, age 12–23 months (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	81.412	1.006	79.439	83.385	3.536	5,292
Residence						
Rural	80.058	1.133	77.835	82.280	3.693	4,648
Urban	90.349	1.809	86.800	93.898	2.613	644
District Type						
Lagging	70.256	1.912	66.504	74.009	2.768	2,435
Non-Lagging	86.169	1.178	83.857	88.480	4.320	2,857

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	68.272	1.172	65.973	70.572	3.356	5,292
Residence						
Rural	66.677	1.314	64.100	69.255	3.568	4,648
Urban	78.795	2.201	74.477	83.114	2.019	644
District Type						
Lagging	56.183	2.261	51.747	60.618	3.284	2,435
Non-Lagging	73.427	1.358	70.764	76.091	3.504	2,857

Table B-10: Improved Water Source (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	91.908	0.558	90.813	93.003	9.857	23,535
Residence						
Rural	90.707	0.651	89.429	91.985	10.139	20,378
Urban	99.035	0.310	98.428	99.643	3.410	3,157
District type						
Lagging	92.383	0.777	90.858	93.909	6.075	10,516
Non lagging	91.703	0.729	90.273	93.134	11.497	13,019

Table B-11: Improved Sanitation (%)

	Estimate	Standard Error	95% Confidence Interval		Design Effect	Unweighted Count
			Lower	Upper		
Overall	87.751	0.557	86.659	88.843	6.784	23,535
Residence						
Rural	86.867	0.631	85.629	88.105	7.034	20,378
Urban	93.001	1.032	90.976	95.026	5.553	3,157
District type						
Lagging	82.342	0.961	80.456	84.228	4.494	10,516
Non lagging	90.075	0.655	88.791	91.360	7.895	13,019

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]	Yes1 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]	Yes1 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 household04 [Name] have recently passed away05 [Name] passed away a long time ago06 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 coincidentally as a study site, and your household was selected, also coincidentally, 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, respondent 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 their 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 month.
- 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.

COO: 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 Punjabi02 Sindhi03 Pashto04 Balochi05 Saraiki06 Hindko.....07 Pothowari08 Brahvi09 Persian10 Shina11 Kohistani.....12 Kashmiri.....13 Balti14 Burushaski15 Domaaki.....16 English.....17 Kalasha18 Khowar19 Wakhi20 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

Q.No.	Questions and Filters	Responses and Codes
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 dwelling01 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 soap01 Liquid soap.....02 Detergent (Powder / Liquid / Paste).....03 Ash/ Mud / Sand04 Nothing water only05 Others [Specify]96
D16	Is water available when needed for washing and bathing?	Yes 1 No2
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	<p>What is the main material of the floor of the dwelling?</p> <p>Interviewer: If the interview is being conducted on the premises of the house, then observe, otherwise ask.</p>	<p>Natural floor Earth/ sand01 Dung.....02</p> <p>Rudimentary floor Wood planks03 Palm/ bamboo.....04</p> <p>Finished floor Parquet or polished wood.....05 Vinyl or asphalt strips06 Ceramic tiles07 Cement.....08 Carpet.....09 Chips/ Concrete.....10 Bricks floor11 Matt12 Marble13 Others [Specify]96</p>
D20	<p>What is the main material of the roof of the dwelling?</p> <p>[Interviewer: If the interview is being conducted on the premises of the house, then observe, otherwise ask.]</p>	<p>Natural roofing No roof..... 01 Thatch/ Palm leaf 02</p> <p>Rudimentary roofing sticks and twigs roof 03 Palm/ Bamboo..... 04 Wood planks 05 Cardboard 06</p> <p>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</p>

Q.No.	Questions and Filters	Responses and Codes
D21	<p>What is the main material of the exterior walls of the dwelling?</p> <p>[Interviewer: If the interview is being conducted on the premises of the house, then observe, otherwise ask.]</p>	<p>Natural walls No walls 01 Wood/ Palm/ Trunks 02 Dirt..... 03</p> <p>Rudimentary walls Bamboo with mud..... 04 Stone/ Bricks with mud 05 Uncovered adobe..... 06 Plywood 07 Cardboard..... 08 Reused wood..... 09</p> <p>Finished walls Cement..... 10 Stone with lime/ Cement..... 11 Bricks..... 12 Cement blocks 13 Covered adobe..... 14 Wood planks/ Shingles..... 15 Others [Specify] 96</p>
D22	<p>What type of fuel does your household mainly use for cooking?</p>	<p>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</p>
D23	<p>Does your household use iodized salt?</p>	<p>Yes..... 1 No 2 Don't know 7</p>
D24	<p>Does any male or female member of this household own any agricultural land?</p>	<p>Yes..... 1 No..... (Go to D26)..... 2 Don't know..... (Go to D26) 7</p>

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 acres95 Don't know97
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
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 shocks03 HH economic shocks04 Law and order05 Displacement.....06 Accident/ Injury.....07 Health issues08 COVID09 Earthquake10 Drought11 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., accident01 Flood or earthquake02 Buy food03 Consumption smoothing04 Education costs05 To buy an asset.....06 To start business07 To pay for wedding.....08 To pay for funeral.....09 Pay-off past debt.....10 Illness of family member11 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 <i>Nashonuma</i> program?	None 00 a) Number of women _ _ b) Number of children..... _ _
D43	How many girls and boys are receiving educational support from BISP <i>Waseela-e-taleem program</i> ?	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

		Gutka08 Naswar.....09 Mawa tobacco10 Naas and man pori11 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?	Yes1 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)	Alcohol01 Marijuana/ Cannabis02 Hashish.....03 Heroin04 Cocaine.....05 Sheesha.....06 Ice07 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 during the last 2 years (From 01 July 2022 till date)?	Number of HH members __ __

Q.No.	Questions and Filters	Responses and Codes
[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 Workers Nutrition Assistant 25

Q.No.	Questions and Filters	Responses and Codes
		Vaccinator26 Suraj Worker27 Pehli Kiren Worker.....28 Marvi Worker29 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 Grandmother03 Grandfather 04 Aunt.....05 Uncle06 Sister..... 07 Brother08 No relation09 Others [Specify] 96
F04	Name of child (aged 0-48 months) from HH roster (B02)	Full Name: _____
F05	Line number of child (aged 0-48 months) from HH roster (B01)	Line number __ __

Q.No.	Questions and Filters	Responses and Codes
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 roster95
F08	Sex of child	Male 1 Female2 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 important01 Never visited a facility02 Card was not available with the health facility03 The vaccinator/ facility didn't provide the card04 Not aware of such cards05 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 time01 Card Misplaced.....02 Card is at vaccination center/ with vaccinator03 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.
 . 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 know97
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 know97
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 know97
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 know97
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 No2 Don't know7
F42	Observe BCG scar.	Scar present.....1 Scar absent.....2 Child not available3 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

Q.No.	Questions and Filters	Responses and Codes
	[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) 1 st _ _ b) 2 nd _ _ c) 3 rd _ _
G03	How long does it usually take one way to reach this health facility?	Time in minutes – if not visited write 98 a) 1 st _ _ b) 2 nd _ _ c) 3 rd _ _

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) 1 st _ _ b) 2 nd _ _ c) 3 rd _ _
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) 1 st _ _ b) 2 nd _ _ c) 3 rd _ _

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 during 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 "000000". If don't know expense write "999999". 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]	__ __ __ __
IBO1	Enter respondent's line number [will be auto entered in CAPI]	__ __
IBO2	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)	__ __

Q.No.	Questions and Filters	Responses and Codes
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 month97 Don't know year9997
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]	Yes1 No.....2
B05	Are you currently married?	Yes.....[Go to B07].....1 No.....2
B06	What is your current marital status now?	Widowed1 Divorced\ Khula2 Separated3
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?	Urdu01 Punjabi02 Sindhi03 Pashto04 Balochi05

Q.No.	Questions and Filters	Responses and Codes
		Saraiki.....06 Hindko07 Pothowari.....08 Brahvi.....09 Persian.....10 Shina.....11 Kohistani12 Kashmiri13 Balti.....14 Burushaski.....15 Domaaki16 English17 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 secondary4
B11	What is the highest grade have you completed?	Less than Class 1..... 00 Class 1.....01 Class 202 Class 303 Class 404 Class 505 Class 606 Class 707 Class 808 Class 909 Class 10.....10 FA/ FSc/ ICOM.....12 BA/ BBA/ BSc/ BCOM/ BED.....14 MA/ MBA/ MSc/ MED.....16 Degree in Engineering.....17 Degree in Medicine18 Degree in Agriculture.....19 Degree in Law.....20 MPhil / PhD21

Q.No.	Questions and Filters	Responses and Codes
		Polytechnic Diploma.....22 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 Middle2 Secondary.....3 Above secondary4 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/ BED14 MA/ MBA/ MSc/ MED16 Degree in Engineering.....17 Degree in Medicine18 Degree in Agriculture.....19 Degree in Law.....20 MPhil / PhD21 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 / livestock02 Producing ghee / cheese / butter03 Collecting fuel / wood-cutting04

Q.No.	Questions and Filters	Responses and Codes
	<p>[Interviewer: If more than one, please ask which one occupation or activity he is most preoccupied with.]</p> <p>[Circle one response only.]</p>	Preparing food.....05 Sewing / embroidery / crocheting.....06 Producing raw products/carpets/textile/ropes 07 Offering services for others in HH/shop/hotel08 Independent paid work09 Buying/selling goods in market/street/home.....10 Helping in construction work 11 Learning a skill12 Government service13 Private service14 Abroad15 Retired16 Unemployed.....17 Others [Specify]96
B17	Is there a blood relationship between you and your husband?	Yes1 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 side2 Second cousin3 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	_ _

Q.No.	Questions and Filters	Responses and Codes
CB02	Re-enter the respondent's name from the roster	
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 her1 Lives elsewhere in Pakistan2 Currently living abroad.....3
C02	Are you currently pregnant?	Yes.....1 No2 Don't know7
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)1 st 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)2 nd pregnancy	__ __ __ Months after 1 st 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)3 rd pregnancy	__ __ __ Months after 2 nd 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)4 th pregnancy	__ __ __ Months after 3 rd 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)5 th pregnancy	__ __ __ Months after 4 th 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]	__ __ __ __
EBO 1	Enter the respondent's line number [will be auto entered in CAPI]	__ __
EBO 2	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 <i>in the future</i> 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 will95 Undecided/ Don't know97
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 number1 More children2 Fewer children3 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 hysterectomy93 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 month97 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 available01 Low cost.....02 Convenient to use03 Suitable for respondent/ husband04 No/ fewer side effects.....05 Can be used for long period.....06 No other method available07 Method always available.....08 Provider advised.....09 Female friend/ relative advised.....10 Others [Specify] 96
F08	[Interviewer: check F03]	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 sex02 Menopausal.....03 Can't get pregnant.....04 Not menstruated since last birth.....05 Breastfeeding.....06 Up to God/ Fatalistic07 Respondent opposed08 Husband opposed09 In laws opposed10 Religious prohibition11 Knows no method12 Knows no source13 Inconvenient to use.....14 Changes in menstrual bleeding.....15 Methods could cause infertility16 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 DHQ02 THQ03 Type-D Health Facility.....04 RHC.....05 BHU.....06 MCH Center/ FH Center07 Government/ Civil Dispensary08 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 facility15 Private Male MBBS Doctor Clinic.....16 Private Female MBBS Doctor Clinic.....17 Nurse Clinic18 LHV Clinic.....19 Dispenser Clinic20 GSM Clinic21 NGO Clinic22 Workers Nutrition Assistant23 Vaccinator.....24 Suraj Worker.....25 Pehli Kiren Worker26 Marvi Worker27 Hakim/ Homeopath.....28 Pharmacy/ Chemist.....29 Others [Specify]96 Not applicable98
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
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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 Motorcycle02 Rickshaw/ Chingchi (QingQi).....03 Bus/ Van04 Tonga/ Cart05 Car06 Ambulance 07 Boat08 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?	Husband1 In-laws2 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 No2
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?	Yes1 No2
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?	Easily1 With difficulty2 Has to wait for husband to initiate discussion3 Can't talk at all4

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 month00
F44	What were the reasons to choose the last method you used? [Multiple responses are allowed]	It is easily available01 Low cost.....02 Convenient to use.....03 Suitable for myself.....04 Suitable for husband.....05 Fewer side effects06 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 Hospital01 DHQ 02 THQ..... 03 Type-D Health Facility 04 RHC..... 05 BHU..... 06 MCH Center/ FH Center07 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 facility15 Private Male MBBS Doctor Clinic.16 Private Female MBBS Doctor Clinic..... 17 Nurse Clinic.....18 LHV Clinic19 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 use12 Infrequent sex/ husband away.13		

		Husband's advice14 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 bleeding01 Irregular bleeding..... 02 Weight gain 03 Weakness..... 04 Spotting 05 Infection..... 06 Nausea/ dizziness07 Headache..... 08 Back ache 09 Allergy10 Irritation11 White discharge 12 IUD expelled13 Pain in low abdomen.....14 Body swelled15 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 Center07 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 relative06 UTBA/ DAI07 LHW/ Nurse08 LHV/ CMW09 FWW/ FWC/ FWA.....10 MBBS Doctor11 Suraj Worker12 Pehli Kiren Worker.....13 Marvi Worker14 Others [Specify]96		
F59	Whom did you speak with last?	Husband01 Mother-in-law02 Sister-in-law03 Sister04 Mother05 Friend/ Neighbor/ Other relative06 UTBA/ DAI07 LHW/ CMW08 LHV/ Nurse09 FWW/ FWC/ FWA.....10 MBBS Doctor11 Suraj Worker12 Pehli Kiren Worker.....13 Marvi Worker14 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 sex01 Infrequent sex.....02 Menopausal.....03 Can't get pregnant.....04 Not menstruated since last birth05 Breastfeeding06 Up to God/ Fatalistic07 Respondent opposed08 Husband opposed09 Others opposed10 Religious prohibition.....11 Knows no method12 Knows no source13 Inconvenient to use14 Changes in menstrual bleeding.15 Methods could cause infertility.16 Interferes with body's normal processes.....17 Health issues18 Fear of side effects.....19 Source of method was too far...20		

		Due to travel/ travel cost21 Costs too much22 Preferred method not available 23 No method available24 Respondent/ Husband infertile 25 Wanted [more] children26 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 Hospital01 DHQ 02 THQ 03 Type-D Health Facility..... 04 RHC..... 05 BHU..... 06 MCH Center/ FH Center07 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 Clinic17 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 IUD03 Injectables04 Sayana Press05 Implants06 Oral Pills07 Male Condom08 Female Condom09 EC Pills10 Standard Days Method11 Lactational Amenorrhea Method12 Rhythm Method13 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]	__ __ __ __
IBO1	Enter the respondent's line number [will be auto entered in CAPI]	__ __
IBO2	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?	Yes1 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?	Yes1 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 Hospital01 DHQ 02 THQ 03 Type-D Health Facility 04 RHC 05 BHU 06 MCH Center/ FH Center07 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 Vaccinator24 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	2 nd last visit	3 rd last visit	4 th last visit	5 th last visit	6 th last visit
				a) Measured blood pressure	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
				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]?	Yes	No
	[Interviewer: Read one by one]		
	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) Counselling 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 vision04 Swelling over face05 Severe lower abdominal pain06 Spotting07 Heavy vaginal bleeding08 High fever with or without rigors09 Diagnosed high blood pressure10 Fits or convulsions11 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 hospital01
		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		
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 counseling 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

Q.No.	Questions and Filters	Responses and Codes		
	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
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 Hospital01 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 Another2 Didn't go to any health facility..... (Go to I12)3

Q.No.	Questions and Filters	Responses and Codes
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 remember97
I06	Who checked on your health at that time?	MBBS Doctor01 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 Worker09 Pehli Kiren Worker.....10 Marvi Worker.....11 Dispenser12 Others [Specify]96 Don't know97
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 know97
I10	Who checked on your health at that time?	MBBS Doctor01 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 Worker09 Pehli Kiren Worker.....10 Marvi Worker.....11 Relative/ Friend/ Neighbor12 Dispenser13 Others [Specify]96 Don't know97

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]		Yes	No	
		a) Within 48 hours	1	2	
		b) 49 hours to 6 weeks	1	2	
		c) > 6 weeks to 1 year	1	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			Yes	No	

Q.No.	Questions and Filters	Responses and Codes			
	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 Hospital01
		DHQ02
		THQ.....03
		Type-D Health Facility.....04
		RHC.....05
		BHU.....06
		MCH Center/ FH Center07
		Government/ Civil Dispensary08
		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 facility15
		Private Male MBBS Doctor Clinic.....16
		Private Female MBBS Doctor Clinic.....17
		Nurse Clinic18
		LHV Clinic19
		Dispenser Clinic20
		GSM Clinic.....21
		NGO Clinic22
		Workers
Nutrition Assistant23		
Vaccinator.....24		
Suraj Worker.....25		
Pehli Kiren Worker26		
		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 Hospital01
		DHQ.....02
		THQ03
		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 Clinic10
		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 know7

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 less01 Somewhat less02 About the same03 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 Hospital01 DHQ 02 THQ03 Type-D Health Facility..... 04 RHC.....05 BHU.....06 MCH Center/ FH Center07 Government/ Civil Dispensary08 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 clinic17 Nurse clinic.....18 LHV clinic.....19 Dispenser clinic.....20 GSM Clinic.....21 NGO Clinic22 Workers Nutrition assistant23 Vaccinator.....24 Suraj worker25 Pehli Kiren worker.....26 Marvi worker27 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 Drip09 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?	Yes1 No.....2
K15	Has the child had fast, short, rapid breaths or difficulty breathing at any time in the last 2 weeks?	Yes1 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 only1 Nose only2 Both3 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?	Yes1 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 Hospital01 DHQ02 THQ03 Type-D Health Facility..... 04 RHC.....05 BHU.....06 MCH Center/ FH Center07 Government/ Civil Dispensary08 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 Clinic17 Nurse Clinic18 LHV Clinic19 Dispenser Clinic20 GSM Clinic21 NGO Clinic22 Workers Nutrition Assistant23 Vaccinator.....24 Suraj Worker.....25 Pehli Kiren Worker26 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?	Yes1
		No.....2
		Don't know.....7

NUTRITION

K24	Has the child been given any iron supplements in the last 24 hours?	Yes1			
		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?	Yes1			
		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

Q.No.	Questions and Filters	Responses and Codes			
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
		j) Eggs		1	2
		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	Gover nment	Office	Not applicabl e
	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	<p>What kind of work do you mainly do?</p> <p>[Interviewer: If more than one, please ask which one occupation or activity she is most engaged in.</p> <p>[Circle one response only]</p> <p>Agricultural work01 Raising poultry / livestock02 Producing ghee / cheese / butter03 Collecting fuel / wood-cutting04 Preparing food05 Sewing / embroidery /crocheting06 Producing raw products/carpets/textile/ropes 07 Offering services for others in HH/shop/hotel.....08 Own business09 Buying/selling goods in market/street/home10 Helping in construction work11 Learning a skill12 Government service13 Private service14 Abroad15 Retired16 Unemployed.....17 Others [Specify]96</p>
L17	<p>Do you have an account [other than BISP] in a bank or other financial institution that you yourself use?</p> <p>Yes.....1 No.....2</p>

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:	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
	[Ask about each one]					
	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 DEPARTMENT
KHYBER PAKHTUNKHWA



Bureau of Statistics
Khyber Pakhtunkhwa



POPULATION
COUNCIL

Ideas. Evidence. Impact.



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From Evidence to Action