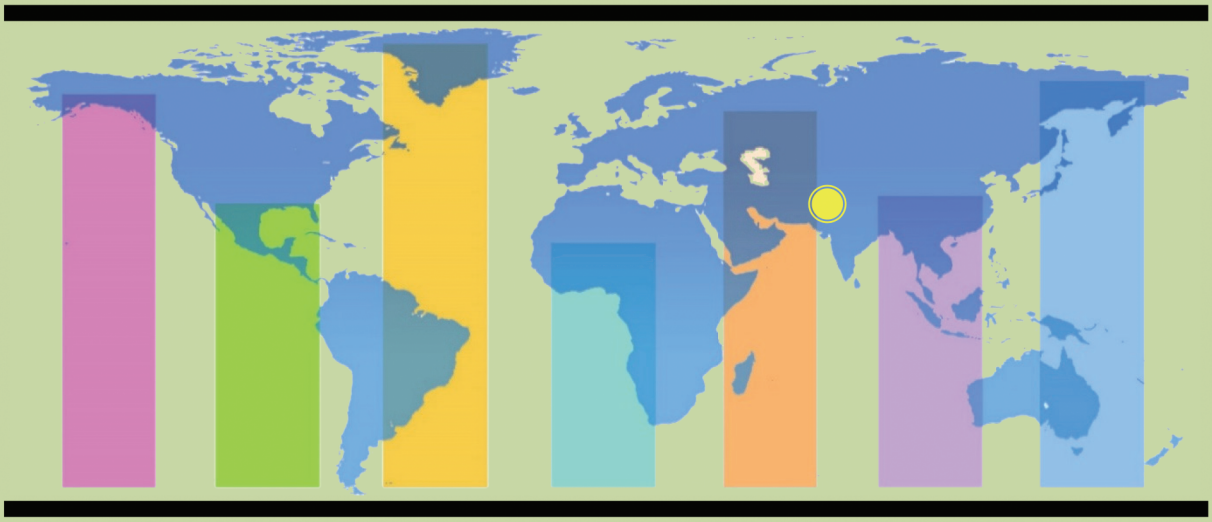
Pakistan



Demographic and Health Survey 2017-18

Key Indicators

Pakistan

Demographic and Health Survey 2017-18

Key Indicators Report

National Institute of Population Studies
Islamabad, Pakistan

The DHS Program
ICF
Rockville, Maryland, USA

August 2018

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The 2017-18 Pakistan Demographic and Health Survey (2017-18 PDHS) was implemented by the National Institute of Population Studies (NIPS), Islamabad, Pakistan. ICF provided technical assistance through The DHS Program, a project funded by the United States Agency for International Development (USAID) that provides support and technical assistance in the implementation of population and health surveys in countries worldwide.

Additional information about the 2017-18 PDHS may be obtained from National Institute of Population Studies, Ministry of National Health Services, Regulations and Coordination, National Institute of Health (NIH), Park Road, Chak Shahzad, Islamabad, Pakistan; Telephone: +92-51-9255937; Fax: +92-51-9255932; Internet: www.nips.org.pk.

Information about The DHS Program may be obtained from ICF, 530 Gaither Road, Suite 500, Rockville, MD 20850, USA; Telephone: +1-301-407-6500; Fax: +1-301-407-6501; E-mail: info@DHSprogram.com; Internet: www.DHSprogram.com.

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CONTENTS

TABLES AND FIGURES

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
AJK	Azad Jammu and Kashmir
ANC	antenatal care
ARI	acute respiratory infection
ASFR	age-specific fertility rate
BCG	Bacille Calmette-Guérin
CAFÉ	computer-assisted field editing
CBR	crude birth rate
CPR	contraceptive prevalence rate
CSPro	Censuses and Surveys Processing
DFID	Department for International Development
DHS	Demographic and Health Survey
DPT	diphtheria, pertussis, and tetanus vaccine
EB	enumeration block
FATA	Federally Administered Tribal Areas
GB	Gilgit Baltistan
HepB	hepatitis B
Hib	haemophilus influenzae type B
HIV	human immunodeficiency virus
ICT	Islamabad Capital Territory
IFSS	internet file streaming system
IPV	inactivated poliomyelitis vaccine
IUD	intrauterine contraceptive device
IYCF	infant and young child feeding
LAM	lactational amenorrhoea method
MMR	measles, mumps, and rubella
MNHSRC	Ministry of National Health Services, Regulations and Coordination
NIPS	National Institute of Population Studies
NN	neonatal mortality
ORS	oral rehydration salts
ORT	oral rehydration therapy
PCV	pneumococcal conjugate vaccine
PDHS	Pakistan Demographic and Health Survey
PNC	postnatal care
PNN	postneonatal mortality
PSU	primary sampling unit

SD	standard deviation
SDG	Sustainable Development Goal
SDM	standard days method
STI	sexually transmitted infection
TFR	total fertility rate
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

FOREWORD

The fourth round of the Pakistan Demographic and Health Survey (PDHS) has been completed successfully with the collaborative and consultative efforts involving several stakeholders. The National Institute of Population Studies (NIPS) implemented the PDHS project under the supervision of the Ministry of National Health Services, Regulations and Coordination. Support for the survey was also provided by the United Nations Population Fund (UNFPA), United States Agency for International Development (USAID), ICF, and the Department For International Development (DFID). Pakistan Bureau of Statistics (PBS) provided assistance in the sample design and identification of clusters. The survey was also facilitated by a number of other organisations at the national and provincial levels. The planning and implementation of the 2017-18 PDHS involved efforts of more than 45 national experts from the fields of population, development, and health with their representation on the Technical Advisory Committee (TAC).

The primary objective of the 2017-18 PDHS project is to provide the latest estimates of basic demographic and health indicators. Specifically, the 2017-18 PDHS collected information on marriages, fertility levels and preferences, awareness and use of family planning methods, reproductive health, nutrition, maternal and child health, awareness and behaviour regarding HIV/AIDS, disability, migration, women's empowerment, domestic violence, and other health-related issues. The study culminated in the writing of a final report after a long, laborious process of survey design, listing, training, fieldwork, data processing, and analysis.

It is my privilege to lead a professional and dedicated PDHS core team. I sincerely appreciate the dedication and contributions of Dr. Ghulam Muhammad Arif, Principal Investigator; Mrs. Azra Aziz, Director (R&S); Dr. Aysha Sheraz, Deputy Project Director (PDHS)/Senior Fellow (R&S); Mr. Zafar Zahir, Fellow; Mr. Ali Anwar Buriro, Fellow; Syeda Rabia Zafar, Fellow; and Mr. Mohammad Ali Raza, Data Processing Manager. The fieldwork held challenges in some areas—severe weather, a need for security, and reluctance to participate in the survey—and could not have been accomplished without teamwork, coordination, and vigilant monitoring by the survey and core teams. It is gratifying that despite all of the challenges and ordeals, the survey teams as well as the NIPS research and monitoring team travelled undaunted to different areas of the country without compromising the quality of data. On behalf of NIPS, we also acknowledge and thank the survey team members for demonstrating resilience in collecting data even under difficult circumstances and the Provincial Coordinators and Quality Control Interviewers for efficient monitoring of the field activities.

We, at NIPS, have always been aware of our responsibilities and are determined to generate accurate and reliable results. I am confident that the key indicators results are authentic on the basis of the extraordinary quality control measures. The findings, besides providing data for Sustainable Development Goals (SDGs), will facilitate research at local and institutional levels, and support the provincial/regional population and health and development policies and plans. We are indebted to Ms. Anjushree Pradhan, ICF Senior Technical Specialist for the PDHS, for providing immense technical support at all stages of the project. We extend our thanks to Dr. Ruilin Ren, Sampling Statistician, for his valuable advice on sample design; Mr. Ruben Hume, Data Processing Specialist, for his contribution on data processing and tabulation; and all other technical experts of ICF who provided suggestions on the final version of this report. I, on behalf of NIPS, express special thanks to the Ministry of National Health Services, Regulations and Coordination, Pakistan Bureau of Statistics, UNFPA, USAID, and DFID for their commitment and support for the 2017-18 PDHS.

Mr. Pervaiz Ahmed Junejo
Executive Director, NIPS/
Project Director *(PDHS*)

1 INTRODUCTION

The 2017-18 Pakistan Demographic and Health Survey (PDHS) is the fourth Demographic and Health Survey (DHS) conducted in Pakistan. It was implemented by the National Institute of Population Studies (NIPS) under the aegis of the Ministry of National Health Services, Regulations and Coordination (MNHSRC). Funding for the 2017-18 PDHS was provided by the United States Agency for International Development (USAID), the Department for International Development (DFID), and the United Nations Population Fund (UNFPA). ICF provided technical assistance through The DHS Program, which assists countries in the collection of data to monitor and evaluate population, health, and nutrition programmes. Data collection took place from 22 November 2017 to 30 April 2018, with the exception of two teams in Balochistan and FATA that completed their fieldwork in May 2018.

This key indicators report presents a first look at selected findings of the 2017-18 PDHS. A comprehensive analysis of the data will be presented in a final report in December 2018.

1.1 SURVEY OBJECTIVES

The primary objective of the 2017-18 PDHS project is to provide up-to-date estimates of basic demographic and health indicators. Specifically, the 2017-18 PDHS collected information on fertility, awareness and use of family planning methods, breastfeeding practices, nutrition, maternal and child health, childhood mortality, women's empowerment, domestic violence, awareness and behaviour regarding HIV/AIDS and other sexually transmitted infections (STIs), migration, disability, and other health-related issues such as smoking, knowledge of tuberculosis, and hepatitis.

The information collected through the 2017-18 PDHS is intended to assist policymakers and programme managers in the Ministry of National Health Services, Regulations and Coordination, and other organisations in designing and evaluating programmes and strategies for improving the health of the country's population. The 2017-18 PDHS also provides indicators relevant to the Sustainable Development Goals (SDGs) for Pakistan.

2 SURVEY IMPLEMENTATION

2.1 SAMPLE DESIGN

The sampling frame used for the 2017-18 PDHS is a complete list of enumeration blocks (EBs) created for the Pakistan Population and Housing Census 2017, which was conducted from March through May 2017. The Pakistan Bureau of Statistics (PBS) supported the sample design of the survey and worked in close coordination with NIPS. The 2017-18 PDHS represents the population of Pakistan, including Azad Jammu and Kashmir (AJK) and the former Federally Administrated Tribal Areas (FATA), which were not included in the 2012-13 PDHS. The results of the 2017-18 PDHS are representative at the national level and for the urban and rural areas separately. The survey estimates are also representative for four provinces, namely, Punjab, Sindh, Khyber Pakhtunkhwa and Balochistan, and four regions, Islamabad Capital Territory (ICT), FATA, AJK, and Gilgit Baltistan (GB), with a total of 13 second-level survey domains.

The 2017-18 PDHS followed a stratified two-stage sample design. The stratification was achieved by separating each of the eight regions into urban and rural areas. In total, 16 sampling strata were created. Samples were selected independently in every stratum, through a two-stage selection process. Implicit stratification and proportional allocation were achieved at each of the lower administrative levels by sorting the sampling frame within each sampling stratum before sample selection, according to administrative units in different levels, and by using a probability-proportional-to-size selection at the first stage of sampling.

The first stage involved selecting sample points (clusters) consisting of EBs. EBs were drawn with a probability proportional to their size, which is the number of households residing in the EB at the time of the census. A total of 580 clusters were selected.

The second stage involved systematic sampling of households. A household listing operation was undertaken in all of the selected clusters, and a fixed number of 28 households per cluster was selected with an equal probability systematic selection process, for a total sample size of approximately 16,240 households. The household selection was carried out centrally at the NIPS data processing office. The survey interviewers interviewed only the pre-selected households. To prevent bias, no replacements and no changes of the pre-selected households were allowed in the implementing stages.

Because of the non-proportional sample allocation, the sample was not a self-weighting sample. Weighting factors have been calculated, added to the data file, and applied so that results are representative at the national level for Pakistan (excluding Azad Jammu and Kashmir and Gilgit Baltistan) and the regions, and separately for Azad Jammu and Kashmir and Gilgit Baltistan.

The 2017-18 PDHS included all ever-married women age 15-49. Those who were either permanent residents of the selected households or visitors who stayed in the households the night before the survey were eligible to be interviewed. The man's survey was conducted in one-third of the sample households, and all ever-married men age 15-49 in these households were included. In these households, one eligible woman in each household was randomly selected to be asked additional questions about domestic violence. Similarly, height and weight information was collected from eligible women age 15-49 and children age 0-59 months only in those households selected for the man's survey.

The survey was successfully carried out in 561 clusters, after dropping 19 clusters that had deteriorating law-and-order situations during the fieldwork. These areas were in Balochistan (1), FATA (2), Gilgit Baltistan (6), Khyber Pakhtunkhwa (4), Azad Jammu and Kashmir (1), Punjab (2), Sindh (1), and ICT (2 restricted areas).

2.2 QUESTIONNAIRES

Six questionnaires were used for the 2017-18 PDHS: the Household Questionnaire, the Woman's Questionnaire, the Man's Questionnaire, the Biomarker Questionnaire, the Fieldworker Questionnaire, and the Community Questionnaire. The first five questionnaires, based on The DHS Program's standard Demographic and Health Survey (DHS-7) questionnaires were adapted to reflect the population and health issues relevant to Pakistan. The Community Questionnaire was based on the instrument used in the previous rounds of the Pakistan DHS. Comments were solicited from various stakeholders representing government ministries and agencies, nongovernmental organisations, and international donors. The survey protocol was reviewed and approved by the National Bioethics Committee, Pakistan Health Research Council, and ICF Institutional Review Board. After all questionnaires were finalised in English, they were translated into Urdu and Sindhi. The 2017-18 PDHS used paper-based questionnaires for data collection, while computer-assisted field editing (CAFE) was used to edit the questionnaires in the field.

The Household Questionnaire listed all members of and visitors to selected households. Basic demographic information was collected on each person listed, including age, sex, marital status, education, and relationship to head of household. For children under age 18, survival status of parents was determined. The data on age, sex, and marital status of household members were used to identify women and men who were eligible for individual interviews. The Household Questionnaire also collected information on characteristics of the household's dwelling unit, such as source of drinking water, type of toilet facilities, materials used for flooring, external walls and roofing, ownership of various durable goods, ownership of mosquito nets, migration, and disability.

The Woman's Questionnaire was used to collect information from all eligible ever-married women age 15-49. These women were asked questions on the following topics:

- Background characteristics (including age, education, and media exposure)
- Pregnancy history and child mortality
- Knowledge, use, and source of family planning methods
- Antenatal, delivery, and postnatal care
- Vaccinations and childhood illnesses
- Breastfeeding and infant feeding practices
- Marriage and sexual activity
- Fertility preferences (including desire for more children, ideal number of children)
- Women's work and husbands' background characteristics
- Knowledge, awareness, and behaviour regarding HIV/AIDS and sexually transmitted infections (STIs)
- Knowledge, attitudes, and behaviour related to other health issues (e.g., smoking, tuberculosis, hepatitis)
- Domestic violence

The Man's Questionnaire was administered to all ever-married men age 15-49 in the subsample of households selected for the man's survey. The Man's Questionnaire collected much of the same information as the Woman's Questionnaire but was shorter because it did not contain a detailed reproductive history or questions on maternal and child health.

The Biomarker Questionnaire was used to record the results of the anthropometry measurements of women and children. This questionnaire was administered only to a sub-sample selected for the men's survey. All children 0-59 months and all ever-married women age 15-49 were eligible for height and weight measurement.

The Fieldworker Questionnaire recorded background information from the interviewers that will serve as a tool in conducting analyses of data quality. Each interviewer completed a self-administered Fieldworker

Questionnaire after the final selection of interviewers and before the fieldworkers entered the field. No personal identifiers are attached to the 2017-18 PDHS fieldworkers' data file.

The Community Questionnaire was administered during the fieldwork to collect information on basic infrastructure in the clusters and access to health facilities and services. The Community Questionnaire was only implemented in rural clusters. Community representatives who provided information for the questionnaire included, among others, village leaders, counsellors, religious leaders, local teachers, lady health visitors, and lady health workers.

2.3 PRETEST

Thirty-one enumerators, eight members of the core team of the project, and two data processing personnel of NIPS, participated in the training to pretest the PDHS survey protocol over a 3-week period in August 2017. Most participants had previous experience carrying out the PDHS surveys and other household surveys. The idea to have the data processing staff participate in the pretest was to make them familiar with the survey instruments. ICF provided technical support for the training.

Along with discussion on the technical aspects of the survey, the pretest training was designed to train the trainers for the main training. The training focused on key components like age probing; interviewing techniques and procedures for completing the PDHS questionnaires; using a contraceptive calendar; completing the vaccination section; standardisation procedures for anthropometry; and disability. The hands-on training emphasised adult learning principles. The participants worked in groups using various training techniques, for example, interactive question-and-answer sessions, case studies, and role plays. Along with the enumerators, the trainers administered the questionnaires in the field, provided feedback on the content and language of the questionnaires, and learned the various techniques of training.

The fieldwork for the pretest was carried out in four locations focusing on the two language groups (Urdu and Sindhi). These locations were (1) Gujar Khan Tehsil in Rawalpindi, Punjab; (2) Haveli in Abbottabad, Khyber Pakhtunkhwa; (3) Panjaar in Kahuta Tehsil, Punjab; and (4) Sukkur in Sindh. Each team carried out the pretest in both an urban and a rural location. Following the fieldwork, a debriefing session was held with the pretest field staff, and modifications to the questionnaires were made based on lessons drawn from the exercise.

2.4 TRAINING OF FIELD STAFF

The main training of the 2017-18 PDHS started on 23 October 2017 in Islamabad. The training included 4 weeks of orientation on data collection instruments followed by field practice. The 169 participants for the main training were selected through a strict vetting process. Applicants took a written test and a computerised test, and also took part in a personal interview to qualify for participating in the main training. Attendees came from different parts of Pakistan and represented major language groups within the country. Most of the candidates had previous fieldwork experience, and some had experience gained through previous rounds of the Pakistan DHS.

Six members of the core project staff and one data processor participated in the main training as facilitators. ICF staff provided technical support during the training sessions. The participants were divided into three classrooms of about 56 participants each. The training sessions included discussion of concepts, procedures, and methodology of conducting the DHS survey. Participants were guided through the questionnaires. In-class exercises were carried out, keeping in mind that involving participants in the training process gives them a better understanding of the training content. Various techniques were used to facilitate the training. These included role playing on filling a household schedule, age probing in pairs, consistency checking for age and date of birth, correcting errors in the pregnancy history table, filling up a contraceptive calendar with given cases, and transcribing vaccination cards. The training also included training the field editors on using the CAFE system.

The 2017-18 PDHS involved collecting data on height and weight for eligible women and children. Two female members of each team were trained to take both measurements. The anthropometry training included lecture sessions, hands-on demonstrations, and practical exercises. Children were brought to the training venue for the participants to practice taking their measurements. After the training and practice sessions, a standardisation exercise was carried out for anthropometry, in which the designated 44 measurers weighed and measured the same group of children twice to assess the accuracy and precision of the measurements. The results of the standardisation exercise were presented. Inter-observer and intra-observer variations of the same measurements as well as the concept of accuracy and precision were explained to the participants. Those who were out of range three or more times were trained further. In addition, the supervisors and quality control staff were trained on anthropometry so that they would know how to monitor the fieldwork and provide appropriate feedback.

Throughout the training, participants were evaluated through in-class exercises, quizzes, and observations made during field practice. At the end of the training, the 22 fieldwork teams were formed by selecting supervisors, enumerators, and field editors based on their performance. Ultimately, 22 supervisors, 88 participants, and 22 field editors were identified, while the rest of the participants were kept as reserves. The supervisors received additional training in performing supervisory activities, data quality control procedures, fieldwork coordination, and management. The supervisors were trained on assigning households and reviewing the completed questionnaires. The field editors received the completed questionnaires and edited them with the CAFE system, recognising and dealing with error messages, providing feedback to the field teams, closing clusters, and transferring interviews to the central office via the secure internet file streaming system (IFSS) developed by The DHS Program. Four provincial coordinators and 13 quality controllers were trained along with the supervisors and also received additional training on supporting the teams and monitoring the fieldwork.

2.5 FIELDWORK

The fieldwork of the 2017-18 PDHS was launched under close supervision from three focal points, namely, Islamabad on 22 November 2017 and Sindh and Balochistan on 23 November 2017. Fourteen teams were deployed in clusters around Islamabad, four teams in Sindh, and four teams in Balochistan. Each team consisted of one supervisor, one field editor, one male interviewer, and three female interviewers. The NIPS core team, provincial coordinators, the quality controllers, and ICF staff closely monitored the teams. After the completion of the fieldwork in the first clusters, teams were brought back to the central locations for a review session where the teams got an opportunity to clarify any questions they had. The teams were then dispatched to their respective clusters. Data collection lasted until 30 April 2018. The fieldwork in some districts took longer than expected due to security challenges. As mentioned earlier, the fieldwork could not be carried out in 19 out of the 580 clusters.

Fieldwork monitoring was an integral part of the 2017-18 PDHS, and several rounds were carried out by the PDHS core team, the provincial coordinators, the quality controllers, and ICF staff. The monitors were provided with guidelines for overseeing the fieldwork. The quality and progress of data collection was also monitored through weekly field check tables and dashboards that were generated from completed interviews that were sent to the central office, and regular feedback was sent out to the teams.

2.6 DATA PROCESSING

The processing of the 2017-18 PDHS data began simultaneously with the fieldwork. As soon as data collection was completed in each cluster, all electronic data files were transferred via IFSS to the NIPS central office in Islamabad. These data files were registered and checked for inconsistencies, incompleteness, and outliers. The field teams were alerted for any inconsistencies and errors. Secondary editing was carried out in the central office and involved resolving inconsistencies and coding the open-ended questions. The NIPS data processing manager coordinated the exercise at the central office. The PDHS core team members assisted with the secondary editing. Data entry and editing were carried out

using the CSPro software package. The concurrent processing of the data offered a distinct advantage, because it maximised the likelihood of the data being error-free and accurate. The secondary editing of the data was completed in the first week of May 2018. The final cleaning of the data set was carried out by The DHS Program data processing specialist and was completed on 25 May 2018.

Throughout this report, numbers in the tables reflect weighted numbers. Percentages based on 25 to 49 unweighted cases are shown in parentheses, and percentages based on fewer than 25 unweighted cases are suppressed and replaced with an asterisk, which cautions readers that a percentage based on fewer than 50 cases may not be statistically reliable.

3 KEY FINDINGS

3.1 RESPONSE RATES

Table 1 shows response rates for the 2017-18 PDHS. A total of 15,671 households were selected for the survey, of which 15,051 were occupied. The response rates are presented separately for Pakistan (excluding Azad Jammu and Kashmir and Gilgit Baltistan); Azad Jammu and Kashmir, and Gilgit Baltistan. Of the 12,338 occupied households in Pakistan[1], 11,869 households were successfully interviewed, yielding a response rate of 96%. Similarly, the household response rates were 98% in Azad Jammu and Kashmir and 99% in Gilgit Baltistan.

Table 1 Results of the household and individual interviews

Number of households, number of interviews, and response rates, according to residence (unweighted), Pakistan DHS 2017-18

	Pakistan[1]			Azad Jammu and Kashmir			Gilgit Baltistan		
	Residence			Residence			Residence		
Result	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Household interviews									
Households selected	6,631	6,184	12,815	921	871	1,792	336	728	1,064
Households occupied	6,389	5,949	12,338	895	833	1,728	307	678	985
Households interviewed	6,091	5,778	11,869	877	820	1,697	304	670	974
Household response rate[2]	95.3	97.1	96.2	98.0	98.4	98.2	99.0	98.8	98.9
Interviews with ever-married women age 15-49									
Number of eligible women	6,545	6,573	13,118	871	898	1,769	330	713	1,043
Number of eligible women interviewed	6,098	6,266	12,364	846	874	1,720	310	674	984
Eligible women response rate[3]	93.2	95.3	94.3	97.1	97.3	97.2	93.9	94.5	94.3
Interviews with ever-married men age 15-49									
Number of eligible men	1,928	1,706	3,634	190	169	359	86	164	250
Number of eligible men interviewed	1,640	1,505	3,145	172	164	336	72	138	210
Eligible men response rate[3]	85.1	88.2	86.5	90.5	97.0	93.6	83.7	84.1	84.0

[1] Excludes Azad Jammu and Kashmir and Gilgit Baltistan
[2] Households interviewed/households occupied
[3] Respondents interviewed/eligible respondents

In the interviewed households, 94% of ever-married women age 15-49 in Pakistan, 97% in Azad Jammu and Kashmir, and 94% in Gilgit Baltistan were interviewed. In the subsample of households selected for the male survey, 87% of ever-married men age 15-49 in Pakistan, 94% in Azad Jammu and Kashmir, and 84% in Gilgit Baltistan were successfully interviewed.

Overall, the response rates are lower in urban than in rural areas. The difference is slightly less pronounced for Azad Jammu and Kashmir and Gilgit Baltistan. The response rates for men are lower than those for women, as men are often away from their households for work.

3.2 CHARACTERISTICS OF RESPONDENTS

Table 2.1, Table 2.2, and Table 2.3 show, by background characteristics, the weighted and unweighted numbers and the weighted percent distributions of ever-married women and men age 15-49 interviewed in the 2017-18 PDHS. Table 2.1 presents the information while excluding Azad Jammu and Kashmir, and also Gilgit Baltistan, while Table 2.2 presents information for Azad Jammu and Kashmir, and Table 2.3 presents information for Gilgit Baltistan.

Table 2.1 indicates that the percentage of ever-married women rises with age until age group 25-29, after which it declines. Among ever-married men, the percentage peaks at age group 35-39. This reflects the

[1] Unless otherwise specified, this report excludes Azad Jammu and Kashmir and Gilgit Baltistan when it refers to Pakistan.

occurrence of later marriages among men. Forty-one percent of ever-married women and 29% of ever-married men in the sample are under age 30.

As expected, almost all ever-married women (96%) and all ever-married men (98%) are currently married. Three percent of ever-married women are widowed, and 2% are divorced or separated. As men are more likely than women to remarry, a smaller proportion of them are widowed, or divorced or separated.

Thirty-seven percent of ever-married women and 40% of ever-married men live in urban areas. More than half of the respondents (54% of women and 53% of men) live in Punjab while about a quarter (23% of women and 25% of men) live in Sindh.

Table 2.1 Background characteristics of respondents (excluding Azad Jammu and Kashmir and Gilgit Baltistan)

Percent distribution of ever married women and men age 15-49 by selected background characteristics, Pakistan DHS 2017-18

	Women			Men		
Background characteristic	Weighted percent	Weighted number	Unweighted number	Weighted percent	Weighted number	Unweighted number
Age						
15-19	4.8	600	661	1.3	40	48
20-24	15.3	1,889	1,861	8.4	265	268
25-29	20.6	2,548	2,591	19.3	607	582
30-34	19.5	2,413	2,310	19.2	603	651
35-39	17.5	2,163	2,213	19.6	617	633
40-44	11.6	1,437	1,468	16.0	502	482
45-49	10.6	1,316	1,260	16.2	511	481
Marital status						
Married	95.7	11,831	11,902	98.1	3,084	3,091
Divorced/separated	1.6	203	157	1.4	43	34
Widowed	2.7	330	305	0.6	18	20
Residence						
Urban	36.8	4,550	6,098	40.2	1,264	1,640
Rural	63.2	7,814	6,266	59.8	1,881	1,505
Region						
Punjab	53.6	6,630	3,400	52.7	1,657	853
Sindh	23.1	2,850	2,739	24.9	784	778
Khyber Pakhtunkhwa	15.4	1,901	2,378	13.9	438	505
Balochistan	5.2	642	1,724	5.9	185	522
ICT Islamabad	0.9	107	1,111	1.0	32	265
FATA	1.9	234	1,012	1.5	49	222
Education						
No education	49.2	6,080	6,682	25.4	800	800
Primary[1]	16.5	2,037	1,693	20.3	640	545
Middle[2]	9.4	1,160	980	15.2	478	440
Secondary[3]	11.8	1,463	1,327	20.1	633	634
Higher[4]	13.1	1,624	1,682	18.9	594	726
Wealth quintile						
Lowest	17.5	2,159	2,323	17.0	536	563
Second	17.6	2,178	2,219	16.5	517	564
Middle	19.7	2,433	2,218	19.8	622	559
Fourth	22.0	2,716	2,573	22.4	705	678
Highest	23.3	2,878	3,031	24.3	765	781
Total[5]	100.0	12,364	12,364	100.0	3,145	3,145

Note: Education categories refer to the highest level of education attended.
[1] Primary refers to classes 1-5.
[2] Middle refers to classes 6-8.
[3] Secondary refers to classes 9-10.
[4] Higher refers to class 11 and above.
[5] Total excludes Azad Jammu and Kashmir and Gilgit Baltistan.

Forty-nine percent of ever-married women and 25% of ever-married men have no education. Thirteen percent of ever-married women and 19% of ever-married men have completed more than a secondary level of education, which is a rise from 9% among women and 16% among men as reported during the 2012-13 PDHS.

Table 2.2 shows that Azad Jammu and Kashmir is predominantly rural (83% of women and 81% of men). Thirty-three percent of women have no education compared with only 10% of men. Eighteen percent of ever-married men have completed more than a secondary level of education (18%) compared with a smaller percentage of women (16%).

Table 2.2 Background characteristics of respondents (Azad Jammu and Kashmir)

Percent distribution of ever married women and men age 15-49 by selected background characteristics, Pakistan DHS 2017-18

Background characteristic	Women			Men		
	Weighted percent	Weighted number	Unweighted number	Weighted percent	Weighted number	Unweighted number
Age						
15-19	1.8	31	30	0.0	0	0
20-24	13.5	232	207	5.7	19	15
25-29	21.1	363	361	16.2	54	45
30-34	20.4	350	362	20.3	68	69
35-39	19.1	329	338	19.3	65	66
40-44	12.0	206	219	15.1	51	59
45-49	12.1	208	203	23.4	79	82
Marital status						
Married	95.8	1,648	1,643	97.7	328	327
Divorced/separated	2.1	36	38	1.7	6	6
Widowed	2.1	35	39	0.5	2	3
Residence						
Urban	17.0	292	846	19.3	65	172
Rural	83.0	1,428	874	80.7	271	164
Education						
No education	33.1	569	480	10.4	35	34
Primary[1]	18.0	310	302	13.7	46	46
Middle[2]	16.1	276	265	22.7	76	76
Secondary[3]	17.1	294	328	34.9	117	105
Higher[4]	15.7	270	345	18.3	61	75
Wealth quintile						
Lowest	11.3	194	157	10.2	34	29
Second	24.3	419	384	18.6	63	67
Middle	28.2	485	477	35.2	118	104
Fourth	21.0	361	392	14.1	47	57
Highest	15.2	261	310	21.8	73	79
Total	100.0	1,720	1,720	100.0	336	336

Note: Education categories refer to the highest level of education attended.
[1] Primary refers to classes 1-5.
[2] Middle refers to classes 6-8.
[3] Secondary refers to classes 9-10.
[4] Higher refers to class 11 and above.

More than eight in ten ever-married women and men live in the rural areas of Gilgit Baltistan (Table 2.3). Fifty-four percent of ever-married women but only 23% of ever-married men had no education. Thirty percent of ever-married men have completed more than a secondary level of education compared with only 14% of ever-married women.

Table 2.3 Background characteristics of respondents (Gilgit Baltistan)

Percent distribution of ever-married women and men age 15-49 by selected background characteristics, Pakistan DHS 2017-18

Background characteristic	Women			Men		
	Weighted percent	Weighted number	Unweighted number	Weighted percent	Weighted number	Unweighted number
Age						
15-19	3.7	37	37	0.5	1	1
20-24	13.7	135	152	4.5	9	10
25-29	21.7	214	194	20.5	43	45
30-34	19.8	195	181	23.9	50	45
35-39	18.7	184	187	18.9	40	37
40-44	12.3	121	134	16.6	35	39
45-49	9.9	97	99	15.1	32	33
Marital status						
Married	97.4	958	957	100.0	210	210
Divorced/separated	0.9	9	6	0.0	0	0
Widowed	1.8	17	21	0.0	0	0
Residence						
Urban	17.0	168	310	19.6	41	72
Rural	83.0	816	674	80.4	169	138
Education						
No education	53.9	530	465	22.8	48	35
Primary[1]	11.1	110	108	19.2	40	37
Middle[2]	8.0	78	81	10.9	23	25
Secondary[3]	13.2	129	151	17.3	36	43
Higher[4]	13.9	137	179	29.8	63	70
Wealth quintile						
Lowest	36.7	361	291	38.5	81	60
Second	38.7	380	354	30.6	64	65
Middle	13.6	134	173	18.9	40	44
Fourth	6.6	65	96	4.5	9	13
Highest	4.4	44	70	7.4	16	28
Total	100.0	984	984	100.0	210	210

Note: Education categories refer to the highest level of education attended.
[1] Primary refers to classes 1-5.
[2] Middle refers to classes 6-8.
[3] Secondary refers to classes 9-10.
[4] Higher refers to class 11 and above.

3.3 FERTILITY

To generate data on fertility, all women who were interviewed were asked to report the total number of sons and daughters to whom they had ever given birth. To ensure that all information was reported, women were asked separately about children still living at home, those living elsewhere, and those who had died. A complete pregnancy history was then obtained, including information on the sex, date of birth, and survival status of each child; age at death for children who had died was also recorded. In addition to information on live births, the pregnancy history section incorporated questions on all pregnancies that did not end in a live birth, including information on the day, month, and year the pregnancy ended, the duration of pregnancy, and whether something was done deliberately to end the pregnancy.

Table 3 shows age-specific fertility rates (ASFRs) among women by 5-year age groups for the 3-year period preceding the survey. Age-specific and total fertility rates were calculated directly from the pregnancy history data taking into account live births[2]. The sum of age-specific fertility rates (known as the total fertility rate) is a summary measure of the level of fertility. It can be interpreted as the number of children a woman would have by the end of her childbearing years if she were to pass through those years bearing children at the currently observed age-specific rates. If fertility were to remain constant at current levels, a woman from Pakistan would bear an average of 3.6 children in her lifetime. Fertility is higher among rural women than among urban women; on average, rural women will give birth to about one child more during their reproductive years than urban women (3.9 and 2.9, respectively). As the ASFRs show, fertility peaks at 215 births per 1,000 women age 25-29 and decreases thereafter.

There has been a steady decline in fertility rates over time, from 5.4 births per woman as reported in the 1990-91 PDHS to 3.6 births per woman in the 2017-18 PDHS—a drop of about two births per woman in almost three decades (Figure 1). However, the decline is minimal in the recent period.

Table 3 Current fertility

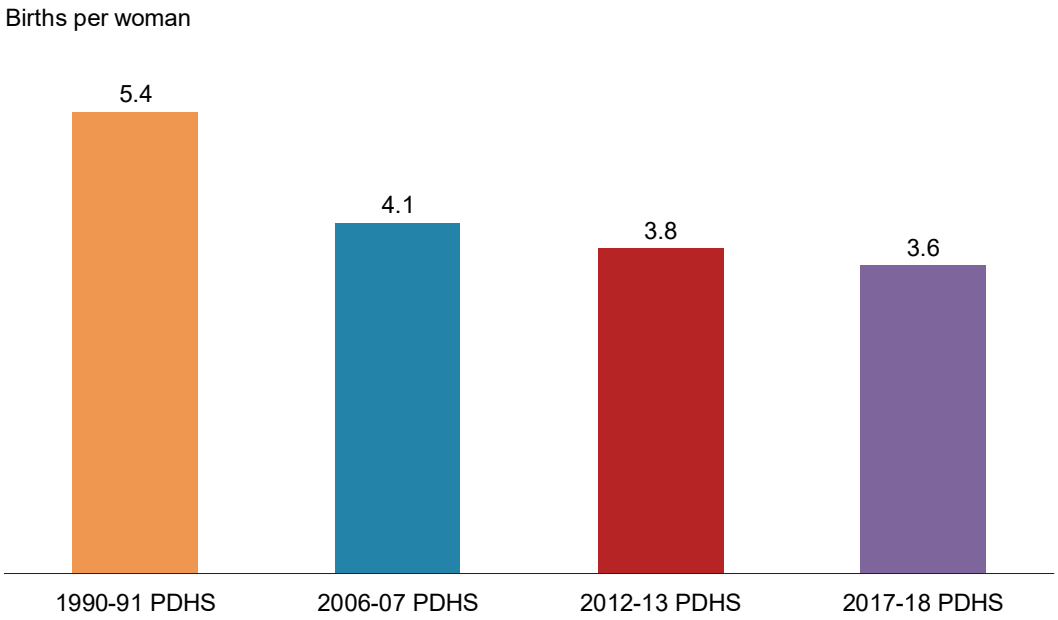
Age-specific and total fertility rates, general fertility rate, and the crude birth rate for the 3 years preceding the survey, according to residence, Pakistan DHS 2017-18

	Residence		
Age group	Urban	Rural	Total
10-14	[0]	[0]	[0]
15-19	42	47	46
20-24	142	186	171
25-29	200	224	215
30-34	133	177	160
35-39	56	95	79
40-44	11	40	28
45-49	[1]	[18]	[12]
TFR (15-49)	2.9	3.9	3.6
CBR	26	31	29

Notes: Age-specific fertility rates are per 1,000 women. Estimates in brackets are truncated. Rates are for the period 1-36 months prior to interview. Rates for women age 10-14 are based on retrospective data from women age 15-17. As the survey was based on an ever-married sample, the number of women was increased using a factor based on all de facto women listed in the household who had never been married. The 'all women' factors were based on age in the household level. Women who have never been married are presumed not to have given birth. Excludes Azad Jammu and Kashmir and Gilgit Baltistan.
TFR: Total fertility rate expressed per woman
CBR: Crude birth rate expressed per 1,000 population

[2] Numerators for the age-specific rates are calculated by summing the births that occurred during the 1-36 months preceding the survey, classified by the 5-year age group of the mother at the time of the birth. The denominators are the numbers of woman-years lived in each 5-year age group during the 1-36 months preceding the survey. Since only ever-married women were interviewed in the PDHS, it was necessary to inflate the number of person-years lived by ever-married women by factors representing the proportion of women who were ever married in each age group. These factors were calculated from the data collected in the household schedule. Never-married women were presumed not to have given birth. In Pakistan, very few births occur outside of marriage, so any underestimation of fertility from this source is likely to be negligible.

Figure 1 **Trends in total fertility rate**



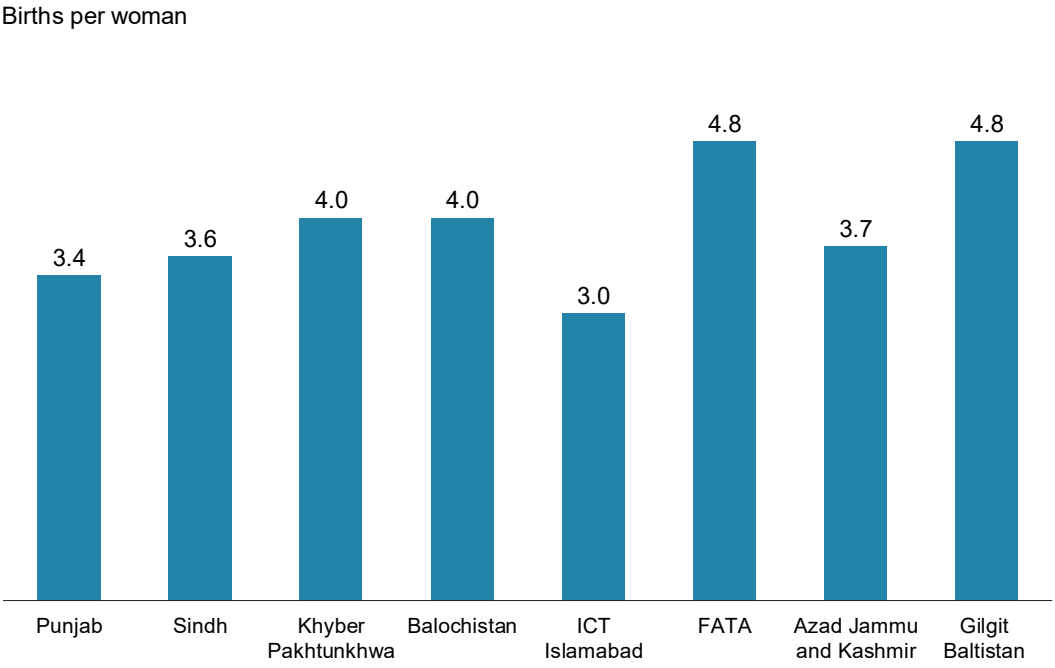
Note: Excludes Azad Jammu and Kashmir and Gilgit Baltistan

Figure 2 provides insight into the declining fertility trends in Pakistan as reflected in the ASFRs. There has been a consistent decrease in fertility among all age groups over the last four DHS surveys, though the decline is less pronounced recently.

Figure 2 **Trends in age-specific fertility**

Women in ICT Islamabad tend to have fewer children (3.0 births per woman) than those in any other regions. The total fertility rate is highest in Gilgit Baltistan and FATA, with 4.8 births per woman in each region (Figure 3).

Figure 3 **Total fertility rate by region**



3.4 AGE AT FIRST BIRTH

The onset of childbearing has a direct bearing on fertility. Early initiation into childbearing lengthens the reproductive period, which in turn increases the chances of higher fertility. Bearing children at a young age also entails risks to the health of the mother and the child.

Table 4 shows the median age at first birth as well as the percentage of women who gave birth by a given exact age, by 5-year age groups of women. The median age at first birth for women age 25-49 is 22.8 years, an increase of 0.6 years in the past 5 years since the 2012-13 PDHS, which was 22.2 years.

Table 4 Age at first birth

Percentage of women age 15-49 who gave birth by exact ages, percentage who have never given birth, and median age at first birth, according to current age, Pakistan DHS 2017-18

	Percentage who gave birth by exact age					Percentage who have never given birth	Number of women	Median age at first birth
Current age	15	18	20	22	25			
15-19	0.3	na	na	na	na	94.3	4,398	a
20-24	0.8	7.4	18.6	na	na	65.1	3,816	a
25-29	1.3	11.7	24.2	39.7	57.8	32.1	3,189	23.6
30-34	2.3	12.2	25.9	42.3	64.4	14.7	2,644	22.9
35-39	2.1	14.0	28.1	45.1	64.3	10.1	2,268	22.8
40-44	1.9	15.3	31.7	50.1	70.6	6.4	1,475	22.0
45-49	1.3	14.3	30.8	49.2	69.6	4.7	1,342	22.1
20-49	1.6	11.6	25.0	na	na	29.1	14,735	a
25-49	1.8	13.1	27.2	44.0	63.9	16.5	10,919	22.8

Note: Excludes Azad Jammu and Kashmir and Gilgit Baltistan
na = Not applicable due to censoring
a = Omitted because less than 50% of women had a birth before reaching the beginning of the age group

3.5 TEENAGE PREGNANCY AND MOTHERHOOD

The issue of adolescent fertility is important for both health and social reasons. Children born to very young mothers are at increased risk of sickness and death. Teenage mothers are more likely to experience adverse pregnancy outcomes and to be constrained in their ability to pursue educational opportunities than young women who delay childbearing.

Table 5 shows the percentage of women age 15-19 who had given birth or were pregnant with their first child at the time of the survey, according to background characteristics. Overall, 8% of women age 15-19 had begun childbearing: 6% had had a live birth, and 2% were pregnant at the time of the interview. The proportion of teenagers who had begun childbearing rises rapidly with age, from 1% at age 15 to 19% at age 19. Rural teenagers tend to start childbearing earlier than urban teenagers. Teenagers with more than a secondary education and those in the highest wealth quintile tend to start childbearing later than those with no education or with lower levels of education and those in other quintiles.

Fifteen percent of teenagers in Khyber Pakhtunkhwa had begun childbearing as compared with only 6% in Punjab.

Table 5 Teenage pregnancy and motherhood

Percentage of women age 15-19 who have had a live birth or who are pregnant with their first child, and percentage who have begun childbearing, according to background characteristics, Pakistan DHS 2017-18

Background characteristic	Percentage of women age 15-19 who: Have had a live birth	Percentage of women age 15-19 who: Are pregnant with first child	Percentage who have begun childbearing	Number of women
Age				
15	0.4	0.4	0.8	998
16	1.4	1.6	3.0	823
17	3.0	2.4	5.4	804
18	7.9	5.2	13.1	986
19	16.8	2.6	19.4	787
Residence				
Urban	5.0	1.6	6.6	1,344
Rural	6.0	2.8	8.8	3,042
Education				
No education	10.9	4.2	15.1	1,326
Primary	6.3	3.1	9.4	686
Middle	3.9	2.0	5.9	761
Secondary	2.7	1.4	4.1	1,014
Higher	(1.1)	(0.3)	(1.3)	528
Wealth quintile				
Lowest	7.7	2.1	9.8	809
Second	7.2	2.9	10.0	858
Middle	6.0	2.8	8.8	994
Fourth	4.9	2.8	7.7	813
Highest	3.2	1.7	4.8	878
Region				
Punjab	4.3	2.0	6.2	1,991
Urban	(3.9)	(1.5)	(5.4)	540
Rural	4.9	2.4	7.2	1,309
Sindh	7.5	2.4	9.9	854
Urban	6.9	1.8	8.7	473
Rural	8.2	3.0	11.2	387
Khyber Pakhtunkhwa	9.2	5.5	14.8	682
Urban	5.9	3.0	8.9	118
Rural	9.9	6.1	16.0	565
Balochistan	9.4	2.2	11.6	294
Urban	(6.7)	(1.3)	(8.0)	86
Rural	10.4	2.5	12.8	212
ICT Islamabad	(3.3)	(1.6)	(5.0)	29
FATA	9.8	3.4	13.2	103
Total[1]	5.7	2.4	8.1	4,398
Azad Jammu and Kashmir	9.2	1.8	10.9	146
Gilgit Baltistan	6.7	2.2	9.0	316

Note: As the survey was based on an ever-married sample, the number of women was increased using a factor based on all de facto women listed in the household who had never been married. The 'all women' factors were based on age in the household and background information available at the household level. Women who have never married are assumed to have never been pregnant. Because the number of all women is not normalised, the weighted numbers will not necessarily sum to the 'total'. Figures in parentheses are based on 25-49 unweighted cases.
[1] Total excludes Azad Jammu and Kashmir and Gilgit Baltistan.

3.6 FERTILITY PREFERENCES

Information on fertility preferences is used to assess the potential demand for family planning services for the purpose of spacing or limiting future childbearing. To elicit information on fertility preferences, several questions were asked of currently married women (pregnant or not) regarding whether they wanted to have another child and, if so, how soon.

Table 6 shows that 26% of women want to have another child soon (within the next 2 years), and 16% want to have another child later (after 2 or more years). Thirty-five percent of women want no more children, while 9% have already been sterilised. Therefore, there is a strong desire among 44% of currently married women to limit childbearing, while 16% want to delay childbearing. Nine percent have not decided if they want another child.

Fertility preferences are closely related to number of living children. Eighty-nine percent of women with no living children want a child soon, compared with only 14% of women with three children. In general, the more children a woman has, the higher is the likelihood that she does not want another child.

Table 6 Fertility preferences by number of living children

Percent distribution of currently married women age 15-49 by desire for children, according to number of living children, Pakistan DHS 2017-18

	Number of living children[1]							
Desire for children	0	1	2	3	4	5	6+	Total
Have another soon[2]	89.0	44.0	28.5	14.1	7.8	5.1	3.6	25.9
Have another later[3]	2.8	35.5	32.2	15.6	6.5	6.1	2.4	15.8
Have another, undecided when	0.9	4.7	3.5	1.5	1.0	0.5	0.7	2.0
Undecided	3.9	8.0	12.8	13.6	8.7	7.3	8.1	9.4
Want no more	0.3	5.2	19.0	42.5	56.1	61.7	61.8	35.1
Sterilised[4]	0.0	0.2	2.4	9.1	16.5	15.6	19.0	8.8
Declared infecund	3.1	2.2	1.5	3.7	3.2	3.7	4.2	3.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	1,312	1,726	2,091	1,957	1,826	1,300	1,619	11,831

Note: Excludes Azad Jammu and Kashmir and Gilgit Baltistan
[1] The number of living children includes the current pregnancy.
[2] Wants next birth within 2 years
[3] Wants to delay next birth for 2 or more years
[4] Includes both female and male sterilisation

3.7 FAMILY PLANNING

Family planning refers to a conscious effort by a couple to limit or space the number of children they have through the use of contraceptive methods. Contraceptive methods are classified as modern or traditional. Modern methods include female sterilisation, male sterilisation, intrauterine contraceptive device (IUD), implants, injectables, the pill, condoms, and lactational amenorrhea method (LAM). Methods such as rhythm, withdrawal, and folk methods are grouped as traditional.

Table 7 shows the percent distribution of currently married women by family planning method they currently use. Overall, 34% of currently married women use a method of family planning, with 25% using a modern method and 9% using a traditional method. Among currently married women, the most popular modern methods are the male condom and female sterilisation (each used by 9%). The contraceptive prevalence rate (CPR) among married women varies with age, rising from 7% among women age 15-19, peaking at 48% for women age 40-44, and then slightly declining to 37% among women age 45-49.

Women in urban areas are more likely to use a contraceptive method than women in rural areas (43% and 29%, respectively). Use of contraceptive methods, both modern as well as traditional methods, increases with education and wealth. For instance, 22% of currently married women with no education used a modern method of contraception compared with 30% of women with secondary or higher level of education. Similarly, 7% of currently married women with no education used a traditional method compared with 14% with a higher level of education who used a traditional method.

Table 7 Current use of contraception according to background characteristics

Percent distribution of currently married women age 15-49, by contraceptive method currently used, according to background characteristics, Pakistan DHS 2017-18

Background characteristic	Any method	Any modern method	Modern method									Any tradi-tional method	Traditional method			Not currently using	Total	Number of women
			Female sterilisa-tion	Male sterilisa-tion	Pill	IUD	Inject-ables	Implants	Male condom	LAM	Other[1]		Rhythm	With-drawal	Other			
Number of living children																		
0	0.7	0.3	0.0	0.0	0.1	0.0	0.0	0.0	0.3	0.0	0.0	0.4	0.0	0.4	0.0	99.3	100.0	1,679
1-2	24.8	16.9	1.4	0.0	1.1	0.8	1.9	0.3	11.3	0.1	0.0	7.9	1.0	6.8	0.1	75.2	100.0	3,668
3-4	46.4	33.8	13.0	0.0	2.2	3.3	2.8	0.6	11.7	0.3	0.0	12.5	1.4	11.0	0.1	53.6	100.0	3,681
5+	50.5	38.8	18.0	0.2	2.6	3.7	4.4	0.7	8.7	0.3	0.1	11.7	1.2	10.2	0.2	49.5	100.0	2,803
Age																		
15-19	7.4	5.9	0.0	0.0	0.5	0.3	1.8	0.3	3.0	0.0	0.0	1.5	0.0	1.5	0.0	92.6	100.0	592
20-24	18.3	13.4	0.2	0.0	1.3	0.8	2.2	0.5	8.0	0.3	0.0	5.0	0.6	4.3	0.0	81.7	100.0	1,855
25-29	28.4	20.9	3.4	0.0	1.7	2.0	2.5	0.5	10.7	0.2	0.0	7.5	1.0	6.3	0.2	71.6	100.0	2,494
30-34	42.1	30.1	8.4	0.0	2.5	3.3	3.2	0.6	12.0	0.3	0.0	12.0	1.3	10.5	0.2	57.9	100.0	2,344
35-39	44.1	32.7	12.7	0.1	1.7	3.4	2.7	0.3	11.3	0.3	0.2	11.4	0.9	10.5	0.1	55.9	100.0	2,043
40-44	47.7	36.0	21.2	0.1	1.6	2.1	2.3	0.7	7.9	0.0	0.1	11.6	1.3	10.2	0.1	52.3	100.0	1,323
45-49	36.6	25.8	17.9	0.2	1.2	1.1	1.8	0.0	3.7	0.0	0.0	10.8	1.6	9.2	0.1	63.4	100.0	1,180
Residence																		
Urban	42.5	28.8	9.7	0.1	1.5	2.2	1.6	0.4	12.8	0.2	0.1	13.7	1.3	12.3	0.1	57.5	100.0	4,350
Rural	29.4	22.8	8.2	0.0	1.7	2.1	3.0	0.4	7.1	0.2	0.0	6.5	0.9	5.6	0.1	70.6	100.0	7,481
Education																		
No education	28.6	21.6	9.5	0.1	1.8	1.7	3.2	0.6	4.4	0.2	0.0	7.0	0.9	6.1	0.1	71.4	100.0	5,773
Primary	37.0	28.2	10.0	0.0	1.5	3.0	2.6	0.2	10.6	0.2	0.2	8.7	1.1	7.4	0.3	63.0	100.0	1,947
Middle	35.2	24.0	7.5	0.0	1.2	1.8	1.7	0.1	11.6	0.1	0.0	11.2	1.2	10.0	0.0	64.8	100.0	1,105
Secondary	41.3	29.6	7.5	0.1	1.6	3.0	1.8	0.3	15.2	0.0	0.0	11.6	1.3	10.2	0.2	58.7	100.0	1,428
Higher	44.0	30.2	6.5	0.0	1.7	2.2	0.9	0.4	18.2	0.2	0.1	13.8	1.2	12.5	0.0	56.0	100.0	1,579
Wealth quintile																		
Lowest	20.3	17.3	7.4	0.0	1.9	1.4	3.6	1.0	1.8	0.2	0.0	3.0	0.5	2.2	0.2	79.7	100.0	2,065
Second	27.9	21.5	8.6	0.0	1.4	2.1	3.3	0.6	5.4	0.1	0.0	6.4	1.0	5.4	0.0	72.1	100.0	2,057
Middle	35.6	27.2	9.4	0.2	2.1	2.4	3.3	0.4	9.5	0.1	0.0	8.4	0.9	7.3	0.2	64.4	100.0	2,335
Fourth	38.3	27.0	8.9	0.0	1.3	2.5	2.0	0.2	11.7	0.4	0.2	11.3	1.3	10.0	0.0	61.7	100.0	2,593
Highest	44.1	29.6	9.3	0.1	1.8	2.1	0.9	0.2	15.1	0.1	0.0	14.5	1.4	13.0	0.1	55.9	100.0	2,782
Region																		
Punjab	38.3	27.2	10.5	0.1	1.0	2.9	1.6	0.2	10.6	0.2	0.1	11.1	1.3	9.7	0.1	61.7	100.0	6,277
Urban	45.9	30.2	11.0	0.1	1.1	2.9	0.9	0.2	13.8	0.1	0.2	15.7	1.3	14.2	0.1	54.1	100.0	2,283
Rural	33.9	25.4	10.3	0.1	0.9	2.9	1.9	0.3	8.8	0.3	0.0	8.5	1.3	7.1	0.1	66.1	100.0	3,994
Sindh	30.9	24.4	10.0	0.0	2.3	1.2	2.7	1.3	6.8	0.2	0.0	6.5	1.1	5.4	0.1	69.1	100.0	2,750
Urban	39.3	28.0	10.1	0.0	1.9	1.1	2.0	1.0	11.4	0.4	0.1	11.4	1.5	9.7	0.1	60.7	100.0	1,464
Rural	21.4	20.4	9.7	0.0	2.9	1.2	3.4	1.6	1.5	0.0	0.0	1.0	0.5	0.4	0.1	78.6	100.0	1,286
Khyber Pakhtunkhwa	30.9	23.2	4.0	0.0	2.3	1.7	5.3	0.1	9.6	0.0	0.0	7.7	0.3	7.2	0.2	69.1	100.0	1,846
Urban	42.0	27.5	3.7	0.1	1.9	3.2	4.0	0.1	14.4	0.0	0.1	14.5	0.9	13.5	0.1	58.0	100.0	356
Rural	28.2	22.1	4.1	0.0	2.4	1.4	5.7	0.1	8.5	0.0	0.0	6.1	0.2	5.7	0.2	71.8	100.0	1,490
Balochistan	19.8	14.0	2.4	0.0	2.7	0.6	2.3	0.1	5.4	0.5	0.0	5.8	0.3	5.5	0.1	80.2	100.0	627
Urban	25.3	18.8	3.5	0.0	3.7	0.2	3.1	0.1	8.0	0.2	0.0	6.5	0.6	5.8	0.1	74.7	100.0	181
Rural	17.6	12.1	1.9	0.0	2.4	0.7	2.0	0.1	4.4	0.5	0.0	5.6	0.1	5.3	0.1	82.4	100.0	446
ICT Islamabad	45.7	34.7	9.3	0.2	1.5	3.6	0.8	0.4	18.7	0.3	0.0	11.0	2.9	8.1	0.0	54.3	100.0	103
FATA	21.8	13.7	1.0	0.0	4.3	0.6	4.8	0.0	2.9	0.0	0.0	8.1	0.0	8.1	0.0	78.2	100.0	229
Total[2]	34.2	25.0	8.8	0.1	1.7	2.1	2.5	0.4	9.2	0.2	0.0	9.2	1.0	8.0	0.1	65.8	100.0	11,831

Continued…

Table 7—*Continued*

Background characteristic	Any method	Any modern method	Modern method									Any traditional method	Traditional method			Not currently using	Total	Number of women
			Female sterilisation	Male sterilisation	Pill	IUD	Injectables	Implants	Male condom	LAM	Other[1]		Rhythm	Withdrawal	Other			
Azad Jammu and Kashmir	27.6	19.1	6.2	0.0	0.4	2.0	2.5	0.3	7.6	0.1	0.0	8.5	1.2	7.3	0.0	72.4	100.0	1,648
Urban	35.2	23.6	7.0	0.0	0.2	2.1	2.5	0.3	11.2	0.2	0.2	11.6	2.1	9.5	0.0	64.8	100.0	278
Rural	26.1	18.2	6.0	0.0	0.5	1.9	2.5	0.3	6.8	0.1	0.0	7.9	1.1	6.8	0.0	73.9	100.0	1,370
Gilgit Baltistan	39.0	30.2	4.5	0.4	4.2	7.6	9.1	0.1	4.3	0.0	0.0	8.8	1.3	7.2	0.3	61.0	100.0	958

Note: If more than one method is used, only the most effective method is considered in this tabulation.
LAM = Lactational amenorrhoea method
[1] Includes emergency contraception and standard days method
[2] Total excludes Azad Jammu and Kashmir and Gilgit Baltistan.

The use of contraceptive methods has remained stagnant over the past 5 years (34% in the 2017-18 PDHS and 35% in the 2012-13 PDHS). An earlier rise in use of contraceptive methods was witnessed between 2006-07 PDHS and 2012-13 PDHS, mostly attributed to an increase in the use of traditional methods from 4% to 9% (NIPS and ICF International, 2013). The 2017-18 PDHS revealed that about 14% of currently married women had husbands living elsewhere (data not shown), which could impact the use of contraception.

3.8 NEED AND DEMAND FOR FAMILY PLANNING

Unmet need for family planning refers to fecund women who are not using contraception, but who wish to postpone their next birth (spacing) or stop childbearing altogether (limiting). An estimate of the size and composition of the population of women who have an unmet need for family planning services is useful for planning purposes in reproductive health programmes.

The criteria used within The DHS Program to identify women with an unmet need for family planning have recently been revised (Bradley et al. 2012). The revised definition was employed in determining the percentage of women who have an unmet need for family planning (Table 8).

Specifically, women are considered to have an unmet need for spacing if they are:

- At risk of becoming pregnant, not using contraception, and either do not want to become pregnant within the next 2 years or are unsure if or when they want to become pregnant
- Pregnant with a mistimed pregnancy
- Postpartum amenorrheic for up to 2 years following a mistimed birth and not using contraception

Women are considered to have an unmet need for limiting if they are:

- At risk of becoming pregnant, not using contraception, and want no (more) children
- Pregnant with an unwanted pregnancy
- Postpartum amenorrheic for up to 2 years following an unwanted birth and not using contraception

Women who are classified as infecund have no unmet need because they are not at risk of becoming pregnant.

Women using contraception are considered to have a met need. Women using contraception who say they want no (more) children are considered to have a met need for limiting, and women who are using contraception and say they want to delay having a child or are unsure if or when they want a (another) child are considered to have a met need for spacing.

Finally, total demand, percentage of demand satisfied, and percentage of demand satisfied by modern methods are defined as follows:

- **Total demand for family planning:** the sum of unmet need (for spacing and limiting) and total contraceptive use

- **Percentage of demand satisfied:** total contraceptive use divided by the sum of unmet need and total contraceptive use

- **Percentage of demand satisfied by modern methods:** use of modern contraceptive methods divided by the sum of unmet need and total contraceptive use

Table 8 presents data on unmet need, met need, and total demand for family planning among currently married women. These indicators help evaluate the extent to which family planning programmes in Pakistan meet the demand for services. Seventeen percent of currently married women have an unmet need for family planning services. Thirty-four percent of married women are currently using a contraceptive

method. Therefore, 52% of currently married women have a demand for family planning. At present, 66% of the potential demand for family planning is being met. Thus, if all married women who said they want to space or limit their children were to use family planning methods, the CPR would increase from 34% to 52%.

Table 8 Need and demand for family planning among currently married women

Percentage of currently married women age 15-49 with unmet need for family planning, percentage with met need for family planning, percentage with met need for family planning who are using modern methods, percentage with demand for family planning, percentage of the demand for family planning that is satisfied, and percentage of the demand for family planning that is satisfied with modern methods, according to background characteristics, Pakistan DHS 2017-18

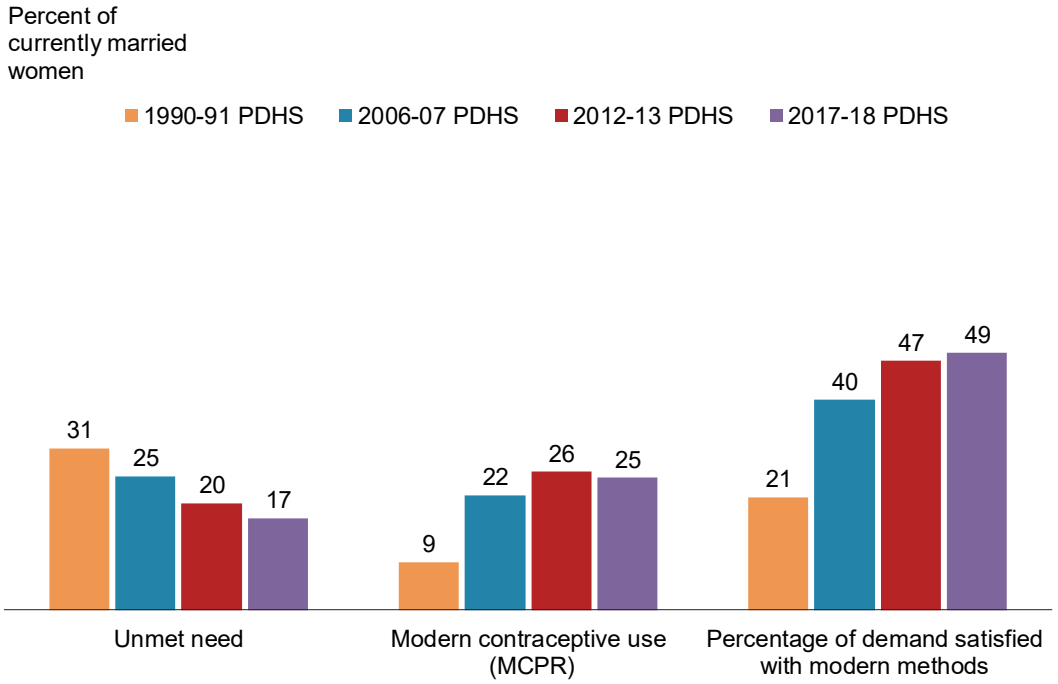
Background characteristic	Unmet need for family planning	Met need for family planning (currently using)		Total demand for family planning[3]	Number of women	Percentage of demand satisfied[1]	
		All methods	Modern methods[2]			All methods	Modern methods[2]
Age							
15-19	17.9	7.4	5.9	25.3	592	29.2	23.3
20-24	18.6	18.3	13.4	36.9	1,855	49.7	36.2
25-29	20.4	28.4	20.9	48.8	2,494	58.2	42.9
30-34	20.3	42.1	30.1	62.4	2,344	67.5	48.3
35-39	16.9	44.1	32.7	61.0	2,043	72.3	53.5
40-44	10.9	47.7	36.0	58.6	1,323	81.3	61.5
45-49	10.5	36.6	25.8	47.1	1,180	77.7	54.8
Residence							
Urban	14.8	42.5	28.8	57.3	4,350	74.2	50.2
Rural	18.8	29.4	22.8	48.1	7,481	61.0	47.5
Education							
No education	19.3	28.6	21.6	47.9	5,773	59.7	45.0
Primary	14.4	37.0	28.2	51.3	1,947	72.0	55.0
Middle	18.7	35.2	24.0	53.9	1,105	65.3	44.4
Secondary	14.7	41.3	29.6	56.0	1,428	73.7	52.9
Higher	15.0	44.0	30.2	59.0	1,579	74.6	51.3
Wealth quintile							
Lowest	22.1	20.3	17.3	42.4	2,065	47.9	40.9
Second	20.4	27.9	21.5	48.3	2,057	57.8	44.6
Middle	17.0	35.6	27.2	52.6	2,335	67.7	51.8
Fourth	15.5	38.3	27.0	53.9	2,593	71.2	50.2
Highest	13.4	44.1	29.6	57.5	2,782	76.6	51.4
Region							
Punjab	15.8	38.3	27.2	54.0	6,277	70.8	50.3
Urban	14.7	45.9	30.2	60.6	2,283	75.8	49.9
Rural	16.4	33.9	25.4	50.3	3,994	67.4	50.6
Sindh	17.7	30.9	24.4	48.6	2,750	63.6	50.2
Urban	13.7	39.3	28.0	53.0	1,464	74.2	52.7
Rural	22.3	21.4	20.4	43.6	1,286	49.0	46.7
Khyber Pakhtunkhwa	20.5	30.9	23.2	51.4	1,846	60.1	45.1
Urban	15.6	42.0	27.5	57.5	356	72.9	47.8
Rural	21.7	28.2	22.1	49.9	1,490	56.5	44.3
Balochistan	21.6	19.8	14.0	41.5	627	47.9	33.8
Urban	23.7	25.3	18.8	49.0	181	51.5	38.3
Rural	20.8	17.6	12.1	38.4	446	46.0	31.5
ICT Islamabad	17.3	45.7	34.7	62.9	103	72.6	55.1
FATA	17.0	21.8	13.7	38.8	229	56.1	35.3
Total[4]	17.3	34.2	25.0	51.5	11,831	66.4	48.6
Azad Jammu and Kashmir	21.9	27.6	19.1	49.6	1,648	55.7	38.5
Urban	17.8	35.2	23.6	53.1	278	66.4	44.5
Rural	22.8	26.1	18.2	48.8	1,370	53.4	37.2
Gilgit Baltistan	26.0	39.0	30.2	65.0	958	60.0	46.4

Note: Numbers in this table correspond to the revised definition of unmet need described in Bradley et al. 2012.
[1] Percentage of demand satisfied is met need divided by total demand.
[2] Modern methods include female sterilisation, male sterilisation, pill, IUD, injectables, implants, male condom, emergency contraception, standard days method (SDM), lactational amenorrhoea method (LAM), and other modern methods.
[3] Total demand is the sum of unmet need and met need.
[4] Total excludes Azad Jammu and Kashmir and Gilgit Baltistan.

The unmet need for family planning is higher in rural areas (19%) than in urban areas (15%). Women in the lowest wealth quintile have the highest unmet need (22%) for family planning, and unmet need decreases with wealth.

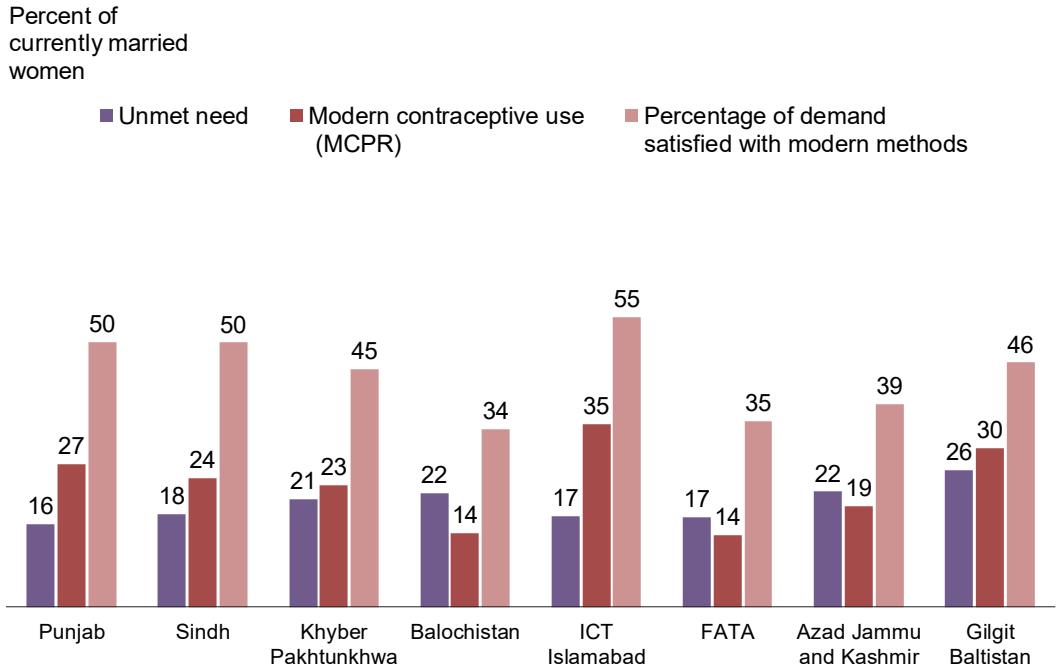
There has been a slight decline in unmet need for family planning, from 20% in 2012-13 to 17% in 2017-18 (Figure 4). However, the use of modern methods and the percentage of women with demand satisfied with modern methods have remained largely unchanged in the last 5 years.

Figure 4 **Trends in unmet need, modern contraceptive use, and percentage of demand satisfied with modern methods**



The unmet need for family planning is highest in Gilgit Baltistan (26%) followed by Balochistan and Azad Jammu and Kashmir (both at 22%) (Figure 5). ICT Islamabad has the highest percentage of women with demand for contraception satisfied with modern methods (55%) followed by Punjab and Sindh (both 50%).

Figure 5 **Unmet need, modern contraceptive use, and percentage of demand satisfied with modern methods, by region**



3.9 EARLY CHILDHOOD MORTALITY

Infant and child mortality rates are basic indicators of a country's socioeconomic situation and quality of life (UNDP 2007). Estimates of child mortality are based on information collected in the pregnancy history section of the Woman's Questionnaire, which includes questions about a woman's aggregate childbearing experience (that is, the number of sons and daughters who live with her, live elsewhere, or have died, and the number of pregnancies that did not end in a live birth). Table 9 presents estimates for three successive 5-year periods prior to the 2017-18 PDHS. The rates are estimated directly from the information in the pregnancy history on a child's birth date, survivorship status, and age at death for children who died. This information is used to directly estimate the following five mortality rates:

Neonatal mortality: the probability of dying within the first month of life
Postneonatal mortality: the difference between infant and neonatal mortality
Infant mortality: the probability of dying before the first birthday
Child mortality: the probability of dying between the first and the fifth birthday
Under-5 mortality: the probability of dying between birth and the fifth birthday

All rates are expressed per 1,000 live births, except for child mortality, which is expressed per 1,000 children surviving to age 12 months.

As shown in Table 9, during the 5 years immediately preceding the survey, the infant mortality rate was 62 deaths per 1,000 live births. The child mortality rate was 13 deaths per 1,000 children surviving to age 12 months, while the overall under-5 mortality rate was 74 deaths per 1,000 live births. Eighty-four percent of all deaths among children under age 5 in Pakistan take place before a child's first birthday, with 57% occurring during the first month of life (42 deaths per 1,000 live births).

Table 9 Early childhood mortality rates

Neonatal, postneonatal, infant, child and under-5 mortality rates for 5-year periods preceding the survey, Pakistan DHS 2017-18

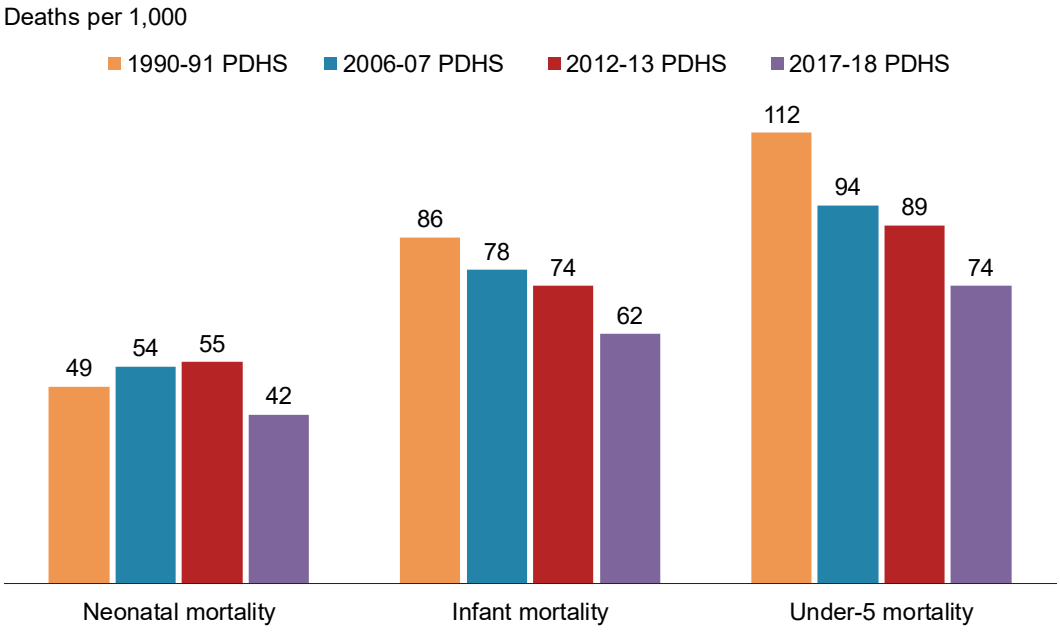
Years preceding the survey	Neonatal mortality (NN)	Postneonatal mortality (PNN)[1]	Infant mortality ($_1q_0$)	Child mortality ($_4q_1$)	Under-5 mortality ($_5q_0$)
0-4	42	20	62	13	74
5-9	46	21	68	15	81
10-14	43	23	66	13	78

Note: Excludes Azad Jammu and Kashmir and Gilgit Baltistan
[1] Computed as the difference between the infant and neonatal mortality rates

The results in Table 9 can be used to assess the trend in early childhood mortality in Pakistan. However, it should be noted that the rates in the table are derived from retrospective data in the 2017-18 PDHS. Thus, they are subject to omission and misreporting of the date of birth and age at death, which becomes more common for events further back in time. Another way of looking at the trends in mortality levels involves comparing estimates from surveys conducted at different points in time.

The 2017-18 PDHS documents a pattern of decreasing childhood mortality in the last 3 decades, based on results from the 1990-91, 2006-07, 2012-13, and 2017-18 PDHS surveys (Figure 6). The overall under-5 mortality rate declined steadily from 112 deaths per 1,000 live births during the 5 years immediately preceding the 1990-91 PDHS to 74 deaths per 1,000 live births in the most recent 5-year period. Infant mortality decreased from 86 to 62 deaths per 1,000 live births over the same periods. Though the neonatal mortality stagnated at 55 deaths per 1,000 live births for nearly a decade, as reported by 2006-07 PDHS and 2012-13 PDHS, it has declined to 42 deaths per 1,000 live births in the most recent 5-year period.

Figure 6 **Trends in childhood mortality**



Note: Excludes Azad Jammu and Kashmir and Gilgit Baltistan

3.10 MATERNAL CARE

Proper care during pregnancy and delivery is important for the health of both the mother and the baby. In the 2017-18 PDHS, women who had given birth in the 5 years preceding the survey were asked a number of questions about maternal care. Mothers were asked whether they had obtained antenatal care during the pregnancy for their most recent live birth in the 5 years preceding the survey and whether they had received tetanus toxoid injections while pregnant. For each live birth over the same period, mothers were also asked what type of assistance they received at the time of delivery. Finally, women who had a live birth in the 2 years before the survey were asked if they had received a postnatal check-up within 2 days of delivery. Table 10 summarises information on the coverage of these maternal health services.

Table 10 Maternal care indicators

Among women age 15-49 who had a live birth in the 5 years preceding the survey, percentage who received antenatal care from a skilled provider for the most recent live birth, percentage with four or more ANC visits for the most recent live birth, and percentage whose most recent live birth was protected against neonatal tetanus; among all live births in the 5 years before the survey, percentage delivered by a skilled provider and percentage delivered in a health facility; and among women age 15-49 who had a live birth in the 2 years preceding the survey, percentage who received a postnatal check during the first 2 days after giving birth, according to background characteristics, Pakistan DHS 2017-18

	Women who had a live birth in the 5 years preceding the survey				Live births in the 5 years preceding the survey			Women who had a live birth in the 2 years preceding the survey	
Background characteristic	Percentage receiving ante-natal care from a skilled provider[1]	Percentage with 4+ ANC visits	Percentage whose most recent live birth was protected against neo-natal tetanus[2]	Number of women	Percentage delivered by a skilled provider[1]	Percentage delivered in a health facility	Number of births	Percentage of women with a postnatal check during the first 2 days after birth[3]	Number of women
Mother's age at birth									
<20	84.8	43.4	60.7	491	68.2	65.9	972	52.9	358
20-34	87.7	53.6	71.4	5,370	70.4	67.1	8,482	63.6	3,154
35-49	77.5	42.5	57.8	849	61.8	58.7	1,040	54.2	424
Residence									
Urban	94.3	70.7	80.0	2,248	83.8	81.1	3,351	76.0	1,296
Rural	82.1	41.7	63.3	4,463	62.6	59.2	7,143	54.5	2,639
Mother's education									
No education	75.7	31.6	52.0	3,212	55.8	51.8	5,178	47.8	1,867
Primary	92.8	53.1	77.4	1,097	70.8	67.4	1,746	62.1	618
Middle	95.4	67.5	84.3	663	80.2	78.0	984	68.7	394
Secondary	96.3	74.4	86.8	828	88.7	86.2	1,268	80.9	500
Higher	99.4	86.6	90.6	911	94.1	93.0	1,319	85.1	556
Wealth quintile									
Lowest	67.7	22.9	43.8	1,389	46.6	42.8	2,280	44.1	800
Second	78.4	32.9	59.4	1,184	55.7	52.1	1,955	47.0	694
Middle	90.8	47.6	70.1	1,316	70.4	66.0	2,079	56.6	816
Fourth	94.7	65.8	80.3	1,420	82.3	79.7	2,136	70.8	788
Highest	98.2	84.4	89.0	1,403	93.1	91.8	2,044	86.7	837
Region									
Punjab	92.3	56.2	81.0	3,453	71.3	68.9	5,492	66.4	2,077
Urban	96.1	72.5	85.3	1,172	83.4	80.5	1,759	78.0	692
Rural	90.4	47.9	78.8	2,281	65.6	63.5	3,733	60.7	1,385
Sindh	85.7	54.1	61.9	1,571	74.8	71.8	2,420	71.0	909
Urban	94.5	76.8	77.7	733	89.6	88.7	1,076	81.7	418
Rural	77.9	34.2	48.2	838	63.0	58.2	1,345	61.8	491
Khyber Pakhtunkhwa	80.1	44.6	58.9	1,101	67.4	61.8	1,684	43.0	630
Urban	92.2	56.8	80.9	198	79.2	71.6	295	56.9	106
Rural	77.4	42.0	54.1	903	64.9	59.7	1,389	40.2	524
Balochistan	55.5	23.1	26.7	377	38.2	34.6	572	37.9	197
Urban	76.8	37.1	39.2	111	59.4	55.2	172	49.0	62
Rural	46.6	17.2	21.5	267	29.0	25.8	400	32.8	136
ICT Islamabad	93.6	80.2	79.8	54	86.6	84.0	77	78.1	32
FATA	71.0	25.6	38.5	156	52.1	49.1	248	31.8	90
Total[4]	86.2	51.4	68.9	6,711	69.3	66.2	10,494	61.6	3,935
Azad Jammu and Kashmir	89.6	46.5	80.0	906	64.1	62.3	1,390	57.7	545
Urban	97.2	72.5	87.0	135	88.4	87.2	203	79.9	76
Rural	88.3	41.9	78.8	771	60.0	58.0	1,186	54.2	470
Gilgit Baltistan	79.6	34.9	64.2	668	64.4	62.3	1,070	39.6	374

Note: If more than one source of assistance was mentioned, only the provider with the highest qualifications is considered in this tabulation.
[1] Skilled provider includes doctor, nurse, midwife, lady health visitor, and community midwife.
[2] Includes mothers with two injections during the pregnancy of her most recent live birth, or two or more injections (the last within 3 years of the most recent live birth), or three or more injections (the last within 5 years of the most recent live birth), or four or more injections (the last within 10 years of the most recent live birth), or five or more injections at any time prior to the last live birth
[3] Includes women who received a check from a doctor, midwife, nurse, lady health visitor, community midwife, lady health worker, or traditional birth attendant
[4] Total excludes Azad Jammu and Kashmir and Gilgit Baltistan.

3.10.1 Antenatal Care

Antenatal care (ANC) from a skilled provider is important to monitor pregnancy and reduce morbidity and mortality risks for the mother and child during pregnancy, at delivery, and during the postnatal period (42 days after delivery). The 2017-18 PDHS results show that 86% of women who gave birth in the 5 years preceding the survey received antenatal care from a skilled provider at least once for their last birth. Fifty-one percent of women had four or more ANC visits.

Urban women were more likely than rural women to have received ANC from a skilled provider (94% and 82%, respectively) and to have had four or more ANC visits (71% and 42%, respectively). Women with more education are more likely than those who have less education to receive ANC from a skilled provider. For instance, 76% of women with no education received ANC from a skilled provider, compared with more than 95% of women with middle or higher level of education. The proportion of women who receive ANC from a skilled provider increases steadily with wealth.

3.10.2 Tetanus Toxoid

Tetanus toxoid injections are given during pregnancy to prevent neonatal tetanus, a major cause of early infant death in many developing countries. Often the cause is failure to observe hygienic procedures during delivery. Table 10 shows that 69% of women with a birth in the 5 years before the survey received sufficient doses of tetanus toxoid to protect their last birth against neonatal tetanus. The percentage varies with level of education and wealth. Women with no education and those belonging to the lowest wealth quintile are substantially less likely to have had their last birth protected from tetanus. For instance, 52% of women with no education had their last birth protected from tetanus compared with 91% of women with a higher level of education.

3.10.3 Delivery Care

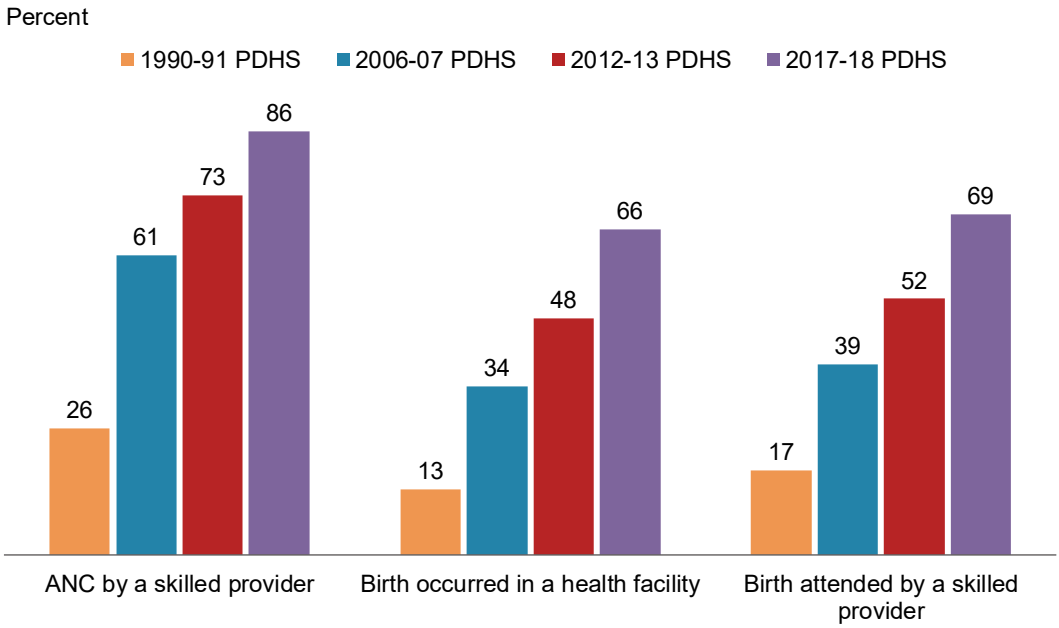
Access to proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that may lead to death or serious illness for the mother, baby, or both (Van Lerberghe and De Brouwere 2001; WHO 2006). Survey data show that in Pakistan, 69% of the births in the 5 years preceding the survey were delivered by a skilled provider, and 66% were delivered in a health facility (Table 10).

Urban women are far more likely to benefit from skilled delivery care than rural women. Eighty-four percent of births to urban mothers were assisted by a skilled provider, and 81% were delivered in a health facility, as compared with 63% and 59%, respectively, of births to rural women.

Mothers' educational status is highly related to whether their delivery is assisted by a skilled provider and whether the birth is delivered in a health facility. For example, 56% of births to mothers with no education were assisted by a skilled provider, and 52% were delivered in a health facility, as compared with 94% and 93%, respectively, of births to mothers with a higher level of education. A similar relationship is observed with wealth.

There has been steady improvement of the maternal health care indicator for women receiving ANC from a skilled provider, which increased from 26% in 1990-91 to 86% in 2017-18 (Figure 7). Similar improvement in the percentage of deliveries at health facilities has been witnessed; these deliveries increased from 13% to 66%. Also, the percentage of births attended by skilled providers increased from 17% to 69% over the same period of time.

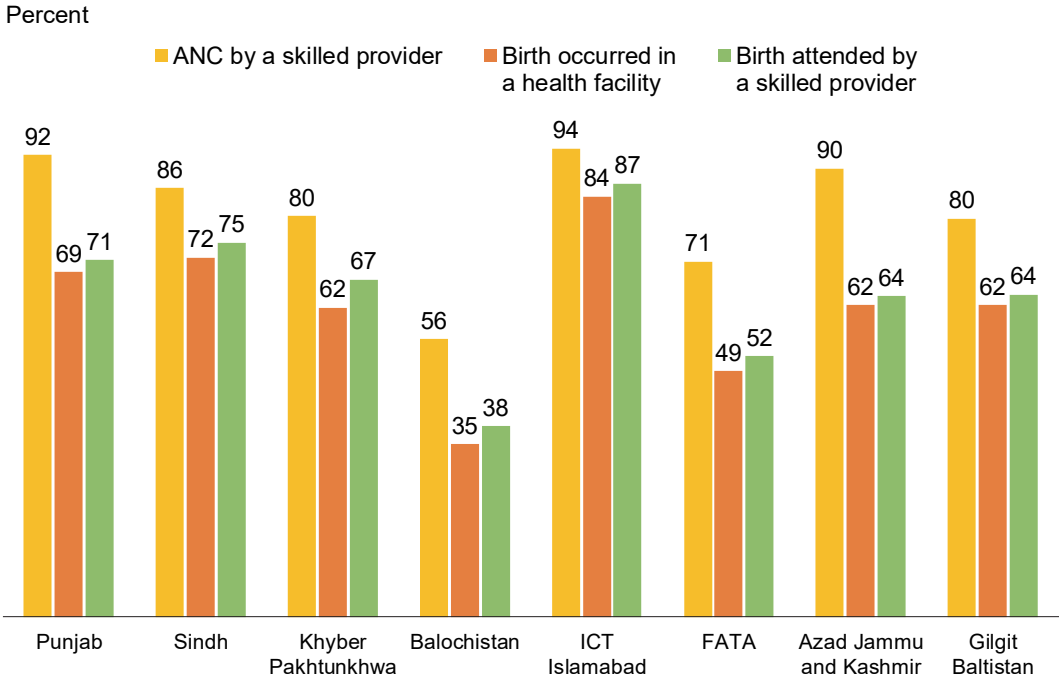
Figure 7 **Trends in maternal health care**



Note: Excludes Azad Jammu and Kashmir and Gilgit Baltistan

Women in ICT Islamabad (94%) and Punjab (92%) are more likely to receive antenatal care from a skilled provider and to receive more than four ANC visits than women in other regions (Table 10 and Figure 8). Only 56% of women in Balochistan receive ANC from a skilled provider, which is still an improvement in the last five years when it was 31% (NIPS and ICF International, 2013). However, only 23% of women in Balochistan receive four or more ANC visits as compared with 80% of women in ICT Islamabad.

Figure 8 **Maternal health care by region**



Eighty-seven percent of births in ICT Islamabad were assisted by a skilled provider, compared with only 38% of those in Balochistan. However, this is still an improvement for Balochistan, a region where the 2012-13 PDHS reported only 18% of the births were assisted by a skilled provider (NIPS and ICF International, 2013).

3.10.4 Postnatal Care for the Mother

A large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery. Thus, prompt postnatal care (PNC) for both the mother and the child is important to treat any complications arising from the delivery, as well as to provide the mother with important information on how to care for herself and her child. Safe motherhood programmes recommend that all women receive a check of their health within 2 days after delivery.

To assess the extent of postnatal care utilisation, respondents were asked, for their last birth in the 2 years preceding the survey, whether they had received a check-up after delivery and the timing of the first check-up. As shown earlier in Table 10, 62% of women reported having received a PNC check-up in the first 2 days after birth.

The proportion of women receiving a postnatal check-up within 2 days of delivery is higher in urban areas than rural areas (76% and 55%, respectively) and increases with increasing education and wealth.

3.11 CHILD HEALTH AND NUTRITION

The 2017-18 PDHS collected data on a number of key child health indicators, including vaccinations of young children, nutritional status as assessed by anthropometry, infant feeding practices, and treatment practices when a child is ill.

3.11.1 Vaccination of Children

Universal immunisation of children against six common vaccine-preventable diseases, namely, tuberculosis, diphtheria, whooping cough (pertussis), tetanus, polio, and measles, is crucial to reducing infant and child mortality. The vaccine given in Pakistan against diphtheria, whooping cough, and tetanus (DPT) also protects against hepatitis B (HepB) and *Haemophilus influenzae* type b (Hib), and is called the DPT-HepB-Hib or pentavalent vaccine. Pentavalent was introduced in Pakistan in 2009. In 2012, Pakistan introduced pneumococcal conjugate vaccine (PCV), which protects against *Streptococcus pneumoniae* bacteria that can cause severe pneumonia, meningitis, and other illnesses. In 2015, Pakistan also introduced as part of its national routine immunisation schedule one dose of inactivated poliomyelitis vaccine (IPV), to be given to infants at 14 weeks. The IPV does not replace the oral polio vaccine, but rather is used with the oral polio vaccine to strengthen a child's immune system and protect against polio.

Pakistan has established a schedule for the administration of all basic childhood vaccines based on the World Health Organization (WHO) guidelines. Historically, an important measure of vaccination coverage has been the proportion of children age 12-23 months who have received all `basic' vaccinations. A child is considered to have received all basic vaccinations if he or she has received a BCG vaccination against tuberculosis; three doses of DPT vaccine to prevent diphtheria, pertussis, and tetanus; at least three doses of polio vaccine; and one dose of measles vaccine. These vaccinations should be received during the first year of life. BCG should be given shortly after birth or at first clinical contact. Polio vaccine should be given at approximately age 6 weeks, 10 weeks, and 14 weeks. Pentavalent vaccine should also be given at approximately age 6, 10, and 14 weeks. Measles vaccine should be given at or soon after the child reaches age 9 months.

A second, more critical, measure of vaccination coverage is the proportion of children age 12-23 months and 24-35 months who have received all age-appropriate vaccinations. A child age 12-23 months is considered to have received all age-appropriate vaccinations if the child has received all basic

vaccinations, plus a birth dose of polio vaccine, one dose of inactivated polio vaccine, and three doses of pneumococcal vaccine (also given at age 6, 10, and 14 weeks). Similarly, a child who is age 24-35 months has received all age-appropriate vaccinations if they have received a second dose of measles/measles, mumps, and rubella (MMR) given at 15 months in addition to all the age-appropriate vaccinations relevant for a child age 12-23 months.

In the 2017-18 PDHS, information on vaccination coverage was obtained in two ways—from health cards and from mothers' verbal reports. All mothers were asked to show the interviewer the cards in which vaccination dates are recorded for all children born since January 2014. If the card was available, the interviewer then recorded from the card the dates of each vaccination received. In cases in which the card indicated the child had not received all basic vaccinations, the mother was asked whether the child had received other vaccinations that were not recorded on the card, and, if so, they too were recorded. If there was no card, or if the mother was unable to show the card to the interviewer, the child's vaccination information was based on the mother's recall. The mother was asked to recall whether the child had received BCG, polio, pentavalent, PCV, IPV, and measles vaccines. If she indicated that the child had received the polio, pentavalent, PCV, or measles vaccines, she was asked about the number of doses that the child received. The results presented in Table 11 are based on the vaccination card and, for those children without a card, information provided by the mother. In the 2017-18 PDHS, vaccination cards were seen for 63% of the children age 12-23 months and 48% of the children age 24-35 months (data not shown).

Table 11 presents data on vaccination coverage among children 12-23 months and 24-35 months, by background information. Children age 12-23 months are the youngest cohort to have reached the age by which a child should have received all basic vaccinations. Overall, 66% of children age 12-23 months have received all basic vaccinations, and 51% have received all age-appropriate vaccinations. Four percent of children age 12-23 months have not received any vaccinations.

Basic vaccination coverage differs slightly by residence. Urban children are more likely to receive all basic vaccinations than rural children (71% versus 63%). A similar pattern is seen for all age-appropriate vaccinations (56% and 49%, respectively). Vaccination coverage improves with mother's education and wealth. Overall, 88% percent of children have received BCG, 86% have received the first dose of pentavalent, and 95% have received polio 1. Seventy-five percent and 86% of children have received the third dose of the pentavalent and polio vaccines, respectively. Coverage of vaccination against measles is 73%.

Among children age 24-35 months, 67% have received the measles, mumps, and rubella vaccine. Overall, 40% of children in this cohort have received all age-appropriate vaccinations. Coverage is lower for those living in rural areas than those in urban areas (37% versus 45%).

Table 11 Vaccinations by background characteristics

Percentage of children age 12-23 months and children age 24-35 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report), percentage with all basic vaccinations, and percentage with all age appropriate vaccinations, according to background characteristics, Pakistan DHS 2017-18

	Children 12-23 months:																	Children 24-35 months:		
		DPT-HepB-Hib			Polio[1]					Pneumococcal										
Background characteristic	BCG	1	2	3	0	1	2	3	IPV	1	2	3	Measles	All basic vaccinations[2]	All age appropriate vaccinations[3]	No vaccinations	Number of children	Measles, mumps, and rubella	All age-appropriate vaccinations[4]	Number of children
Sex																				
Male	88.7	87.7	84.2	77.0	82.4	94.3	90.0	85.9	64.4	86.7	82.8	76.6	75.7	68.0	51.2	4.1	1,009	69.6	42.7	945
Female	87.0	84.9	81.3	73.6	84.0	95.5	89.7	85.9	63.2	83.6	79.4	72.6	70.5	63.1	51.5	3.3	966	63.7	36.4	974
Birth order																				
1	90.8	89.1	86.4	77.6	84.8	96.0	92.5	86.0	66.7	89.2	84.6	77.4	76.7	69.3	54.7	2.9	491	76.9	44.1	474
2-3	88.9	87.5	82.8	77.1	84.9	95.0	89.3	86.3	66.4	86.5	81.8	76.7	75.8	68.6	55.0	3.4	783	67.0	41.6	721
4-5	88.4	86.5	83.2	75.0	84.1	94.3	89.1	86.2	61.2	84.5	81.5	73.6	74.1	65.3	49.4	3.9	437	65.3	36.7	473
6+	78.4	77.4	75.4	66.5	73.7	93.2	87.6	84.1	55.2	74.7	72.4	65.1	57.3	50.4	37.3	5.8	263	48.9	30.1	251
Residence																				
Urban	93.9	92.1	89.7	82.2	88.8	94.6	90.7	84.0	70.5	91.5	89.0	81.9	78.9	70.8	56.1	3.3	678	78.2	44.8	592
Rural	84.7	83.4	79.2	71.8	80.3	95.0	89.4	86.9	60.3	81.8	77.0	70.9	70.2	63.0	48.8	3.9	1,297	61.5	37.1	1,327
Mother's education																				
No education	76.9	74.7	69.1	60.6	72.4	91.7	84.9	81.2	49.4	72.6	66.6	59.6	57.6	49.6	36.5	6.5	897	48.0	27.5	953
Primary	93.7	92.5	89.0	81.4	91.1	95.8	92.3	89.7	73.6	90.5	86.6	80.8	82.9	75.8	62.2	2.9	306	82.3	48.3	347
Middle	98.1	97.7	96.9	90.2	90.3	98.7	95.0	91.1	68.7	97.7	96.2	89.4	86.0	81.4	58.0	1.2	233	86.6	48.7	171
Secondary	97.5	95.0	92.7	87.2	93.8	98.4	95.5	89.7	77.1	95.5	92.4	86.9	82.6	77.6	65.1	1.0	257	86.5	59.2	219
Higher	99.5	99.5	99.0	92.6	93.8	97.3	93.4	89.1	83.0	99.4	99.0	92.5	93.1	81.8	68.7	0.3	281	86.8	50.2	228
Wealth quintile																				
Lowest	70.7	67.4	60.6	49.1	68.4	90.9	83.3	79.2	41.4	64.3	56.3	48.0	45.2	35.6	25.5	6.7	365	39.7	24.6	416
Second	84.3	84.5	79.6	72.1	78.8	94.6	88.3	86.0	59.0	82.7	77.5	70.6	70.3	65.4	48.4	4.7	335	62.3	35.5	375
Middle	88.8	86.5	82.1	73.6	81.9	94.2	88.7	84.5	63.9	86.0	81.4	73.3	73.7	64.5	53.0	4.7	433	68.4	36.6	353
Fourth	94.2	93.2	91.7	86.5	93.0	96.5	93.6	89.2	73.5	92.2	90.5	86.2	83.7	78.3	62.4	2.5	398	79.6	47.2	415
Highest	98.1	97.0	96.2	91.0	91.3	97.5	94.1	89.7	77.1	97.0	95.8	90.7	88.5	80.2	63.3	0.6	444	85.6	54.7	360
Region																				
Punjab	96.5	95.3	94.2	89.0	88.8	97.8	95.1	92.0	78.2	94.4	93.2	88.8	85.4	79.9	65.6	0.9	1,077	81.7	48.8	961
Urban	97.6	96.2	95.8	88.4	90.9	97.4	94.4	87.3	78.6	95.9	95.5	88.1	84.7	76.6	63.9	0.4	386	85.6	44.9	284
Rural	95.9	94.9	93.3	89.3	87.6	98.1	95.4	94.6	78.0	93.7	91.9	89.1	85.8	81.7	66.6	1.2	691	80.0	50.4	677
Sindh	82.3	80.6	73.2	59.2	81.7	92.4	84.0	79.1	51.5	78.0	69.7	57.7	61.2	48.8	35.4	6.2	432	59.8	38.8	448
Urban	90.6	88.3	82.8	74.5	88.9	91.7	85.9	79.5	62.0	87.3	81.6	74.3	72.6	62.9	48.6	6.0	199	73.8	51.1	207
Rural	75.3	74.1	65.0	46.2	75.6	93.0	82.3	78.7	42.6	70.0	59.6	43.6	51.5	36.8	24.1	6.3	233	47.7	28.2	241
Khyber Pakhtunkhwa	81.0	78.6	72.8	64.9	77.6	93.6	86.7	82.3	43.5	78.2	71.3	63.9	63.3	54.7	37.1	4.5	325	49.9	23.1	337
Urban	93.1	91.6	87.8	81.2	90.8	94.8	92.4	87.2	54.9	91.0	87.8	81.6	78.5	75.5	48.3	4.3	55	80.9	36.1	56
Rural	78.6	76.0	69.7	61.6	74.9	93.4	85.5	81.3	41.2	75.7	67.9	60.3	60.3	50.6	34.8	4.6	270	43.7	20.5	281
Balochistan	46.6	43.2	40.1	37.3	51.1	74.8	65.0	57.1	32.3	42.4	39.0	36.9	33.3	28.8	18.6	23.8	78	34.2	22.4	106
Urban	70.5	66.2	61.2	56.7	57.1	77.5	71.8	66.4	52.9	64.4	59.3	55.7	49.1	42.2	23.2	21.7	29	44.8	21.3	35
Rural	32.1	29.3	27.4	25.6	47.5	73.2	60.9	51.5	19.9	29.2	26.8	25.6	23.8	20.8	15.9	25.1	49	29.0	22.9	71
ICT Islamabad	95.4	94.4	91.2	84.0	88.2	94.7	90.4	83.1	76.0	94.4	90.5	83.3	82.8	67.8	51.6	1.7	16	76.7	49.1	14
FATA	54.9	55.3	46.7	42.6	60.4	91.5	86.5	82.5	36.0	53.9	45.3	42.0	34.5	30.4	23.4	7.0	47	20.8	13.5	53
Total[5]	87.9	86.3	82.8	75.4	83.2	94.9	89.8	85.9	63.8	85.2	81.2	74.7	73.2	65.6	51.3	3.7	1,975	66.6	39.5	1,919

Continued…

Table 11—*Continued*

Background characteristic	Children 12-23 months: BCG	DPT-HepB-Hib 1	DPT-HepB-Hib 2	DPT-HepB-Hib 3	Polio[1] 0	Polio[1] 1	Polio[1] 2	Polio[1] 3	IPV	Pneumococcal 1	Pneumococcal 2	Pneumococcal 3	Measles	All basic vaccinations[2]	All age appropriate vaccinations[3]	No vaccinations	Number of children	Children 24-35 months: Measles, mumps, and rubella	All age appropriate vaccinations[4]	Number of children
Azad Jammu and Kashmir	97.7	91.6	89.8	84.3	92.7	98.4	95.5	91.7	68.8	91.6	89.8	84.3	82.6	75.2	60.9	1.0	295	75.2	36.6	271
Urban	100.0	99.7	98.2	95.3	96.4	100.0	98.4	92.8	73.4	99.7	98.2	95.3	88.9	86.0	64.5	0.0	36	75.9	35.9	38
Rural	97.4	90.5	88.7	82.7	92.2	98.2	95.1	91.5	68.2	90.5	88.7	82.7	81.7	73.7	60.4	1.2	259	75.1	36.7	234
Gilgit Baltistan	80.4	72.6	70.9	61.1	73.6	88.9	87.5	73.2	40.6	72.7	71.0	59.0	66.1	57.0	27.8	4.7	193	61.7	28.6	208

BCG = Bacille Calmette-Guérin; DPT = Diphtheria-pertussis-tetanus; HepB = Hepatitis B; Hib = *Haemophilus influenzae* type b; IPV = Inactivated polio vaccine

Note: Children are considered to have received the vaccine if it was either written on the child's vaccination card or reported by the mother. For children whose vaccination information is based on the mother's report, date of vaccination is not collected. The proportions of vaccinations given during the first and second years of life are assumed to be the same as for children with a written record of vaccination.

[1] Polio 0 is the polio vaccination given at birth.

[2] BCG, three doses of DPT-HepB-Hib (pentavalent), three doses of oral polio vaccine (excluding polio vaccine given at birth), and one dose of measles

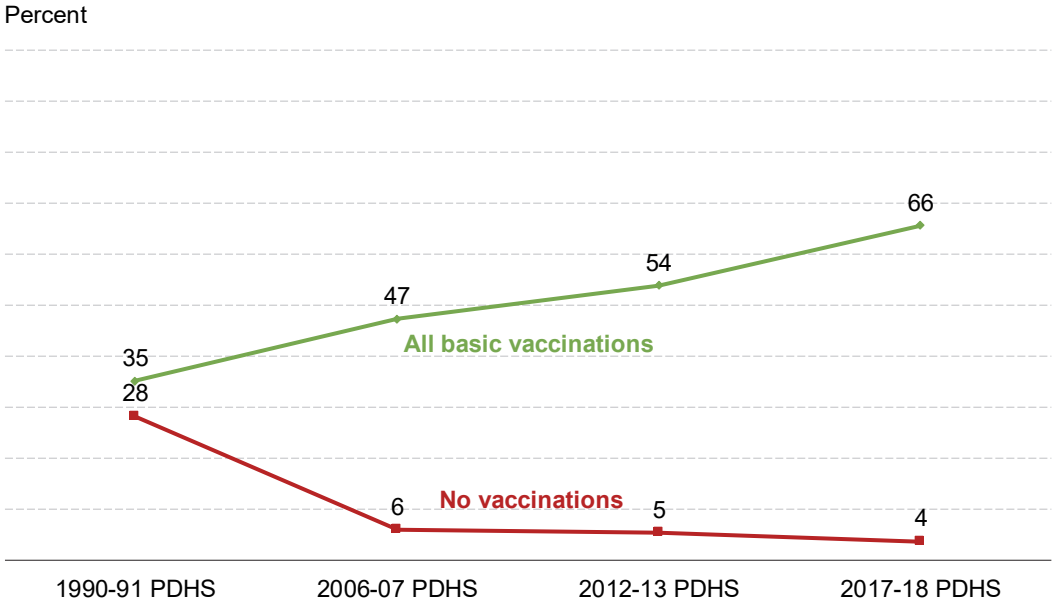
[3] BCG, three doses of DPT-HepB-Hib, four doses of oral polio vaccine, one dose of inactivated polio vaccine, three doses of pneumococcal vaccine, and one dose of measles

[4] BCG, three doses of DPT-HepB-Hib, four doses of oral polio vaccine, one dose of inactivated polio vaccine, three doses of pneumococcal vaccine, and two doses of measles/measles, mumps, and rubella

[5] Total excludes Azad Jammu and Kashmir and Gilgit Baltistan.

Figure 9 indicates that vaccination coverage has improved over the past 5 years from 54% to 66%. Overall, 4% of children 12-23 months have not received any of the basic vaccinations, a slight reduction in the past 5 years.

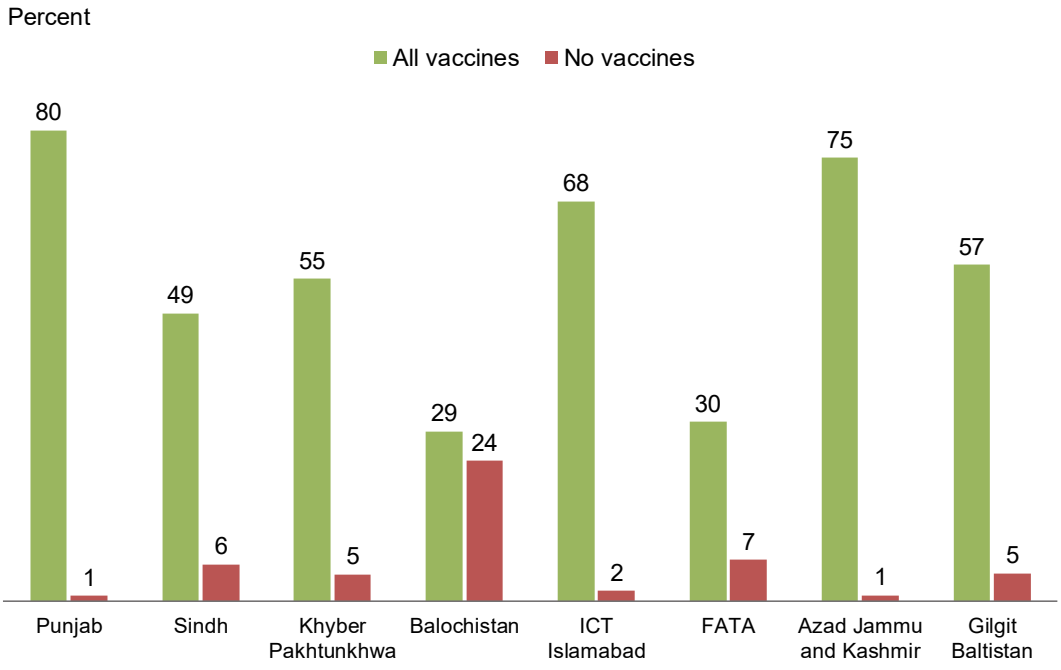
Figure 9 **Trends in childhood vaccinations**



Note: Excludes Azad Jammu and Kashmir and Gilgit Baltistan

As shown in Figure 10, children in Punjab (80%) are more likely to receive all basic vaccinations compared with children in Balochistan (29%) and FATA (30%). This percentage in Balochistan represents an improvement over the past 5 years, because previously only 16% of children had received all basic vaccinations, as reported in the 2012-13 PDHS (NIPS and ICF International 2013).

Figure 10 **Vaccination coverage by region**



3.11.2 Childhood Acute Respiratory Infection, Fever, and Diarrhoea

Acute respiratory infection (ARI), fever, and dehydration from diarrhoea are important contributing causes of childhood morbidity and mortality in developing countries (WHO 2003). Prompt medical attention when a child has the symptoms of these illnesses is, therefore, crucial in reducing child deaths. In the 2017-18 PDHS, for each child under age 5, mothers were asked if the child had experienced a cough accompanied by short, rapid breathing, or difficulty in breathing as a result of a chest-related problem (symptoms of ARI); a fever; or an episode of diarrhoea in the 2 weeks preceding the survey. Respondents were also asked if treatment was sought when the child was ill. Overall, 14% of children under age 5 showed symptoms of ARI, 38% had a fever, and 19% experienced diarrhoea in the 2 weeks preceding the survey (data not shown). It should be noted that the morbidity data collected are subjective because they are based on a mother's perception of illness without validation by medical personnel.

Table 12 Treatment for acute respiratory infection, fever, and diarrhoea

Among children under age 5 who had symptoms of acute respiratory infection (ARI) or had fever in the 2 weeks preceding the survey, percentage for whom advice or treatment was sought, and among children under age 5 who had diarrhoea during the 2 weeks preceding the survey, percentage for whom advice or treatment was sought, percentage given a fluid made from oral rehydration salt (ORS) packets or given pre-packaged ORS fluid, percentage given zinc, and percentage given ORS and zinc, according to background characteristics, Pakistan DHS 2017-18

	Children with symptoms of ARI[1]		Children with fever		Children with diarrhoea				
Background characteristic	Percentage for whom advice or treatment was sought[2]	Number of children	Percentage for whom advice or treatment was sought[2]	Number of children	Percentage for whom advice or treatment was sought[2]	Percentage given fluid from ORS packet or pre-packaged	Percentage given zinc	Percentage given ORS and zinc	Number of children
Age in months									
<6	82.1	156	76.3	384	64.6	17.1	6.1	2.6	246
6-11	88.9	142	87.6	388	75.7	36.8	9.1	4.8	254
12-23	88.6	328	84.4	896	77.9	45.8	14.2	9.5	553
24-35	77.8	241	80.5	729	67.3	38.3	14.0	9.4	384
36-47	83.9	283	81.3	681	63.2	36.7	12.7	8.8	267
48-59	85.3	203	80.9	608	72.1	39.9	17.2	11.1	170
Sex									
Male	84.6	685	83.6	1,851	72.0	38.2	12.7	8.8	993
Female	84.4	668	80.3	1,835	70.0	36.6	12.2	7.0	880
Residence									
Urban	87.4	407	85.3	1,200	75.3	39.2	13.7	8.5	608
Rural	83.2	946	80.3	2,486	69.0	36.6	11.9	7.7	1,266
Mother's education									
No education	80.7	672	80.4	1,576	69.6	37.9	10.3	7.8	828
Primary	86.0	269	82.2	675	71.5	34.7	13.7	6.4	341
Middle	88.4	136	81.7	420	77.4	38.3	10.7	5.8	215
Secondary	88.9	158	84.1	541	69.8	37.8	19.6	10.7	249
Higher	92.2	119	84.5	474	71.2	38.8	12.5	9.8	241
Wealth quintile									
Lowest	73.4	326	76.3	723	66.1	40.7	12.4	10.0	336
Second	83.7	303	81.1	686	68.1	35.4	9.1	8.2	356
Middle	88.5	256	84.0	712	68.3	33.9	12.5	6.8	429
Fourth	89.6	240	83.8	821	78.2	38.2	14.5	7.2	394
Highest	91.4	229	84.2	743	74.2	39.8	13.7	8.2	359
Region									
Punjab	86.7	662	85.9	2,079	75.5	34.2	13.0	7.3	1,048
Urban	89.0	204	88.1	674	79.9	32.3	15.9	9.1	334
Rural	85.7	458	84.9	1,406	73.4	35.1	11.7	6.4	715
Sindh	85.4	334	85.2	764	74.0	52.0	15.4	11.8	328
Urban	89.6	112	83.8	346	71.1	49.3	10.0	6.9	181
Rural	83.3	222	86.3	418	77.6	55.3	22.1	18.0	146
Khyber Pakhtunkhwa	84.3	260	72.2	581	59.7	31.2	9.1	6.5	340
Urban	86.4	59	82.2	112	65.0	36.9	11.1	7.0	53
Rural	83.7	201	69.9	470	58.7	30.2	8.7	6.4	287
Balochistan	62.2	58	60.0	159	65.0	51.0	9.4	7.6	95
Urban	70.4	25	69.3	53	70.2	57.4	15.6	13.8	31
Rural	56.1	33	55.3	105	62.5	47.8	6.4	4.6	64
ICT Islamabad	83.6	7	73.8	28	67.9	43.6	12.1	9.4	15
FATA	70.6	32	62.9	75	48.2	23.9	10.8	8.2	48
Total[3]	84.5	1,353	81.9	3,686	71.1	37.4	12.5	8.0	1,874
Azad Jammu and Kashmir	80.8	224	78.8	574	71.4	56.1	9.7	8.9	187
Urban	88.7	29	84.9	89	74.5	57.0	15.5	14.6	27
Rural	79.7	195	77.7	485	70.9	55.9	8.7	8.0	159
Gilgit Baltistan	76.3	119	70.7	365	64.9	52.1	23.2	19.6	159

[1] Symptoms of ARI include short, rapid breathing, which was chest-related, and/or difficult breathing, which was chest-related.
[2] Excludes advice or treatment from a traditional practitioner
[3] Total excludes Azad Jammu and Kashmir and Gilgit Baltistan.

Table 12 shows that treatment from a health facility or provider was sought for 85% of children with ARI symptoms and 82% of those with a fever. Treatment was sought from a health facility or health provider for 71% of children with diarrhoea. Thirty-seven percent of children with diarrhoea received a rehydration solution from an oral rehydration salt (ORS) packet; 13% of children with diarrhoea were given zinc supplements, and 8% received both ORS and zinc supplements.

3.11.3 Nutritional Status of Children

Anthropometric measurements (weight and height) for young children were collected in the 2017-18 PDHS to provide outcome measures of nutritional status. Each team of interviewers carried a scale and measuring board. Measurements were made using lightweight SECA scales (with digital screens) designed and manufactured under the authority of the United Nations Children's Fund (UNICEF). The measuring boards were specially made by Shorr Productions for use in survey settings. As recommended by WHO, evaluation of nutritional status in this report is based on a comparison of three indices for children in this survey with indices reported for a reference population of well-nourished children (WHO Multicentre Growth Reference Study Group 2006). The three indices (height-for-age, weight-for-height, and weight-for-age) are expressed as standard deviation units from the median for the reference group. Children who fall below minus two standard deviations (-2 SD) from the median of the reference population are regarded as moderately malnourished, while those who fall below minus three standard deviations (-3 SD) from the reference population median are considered severely malnourished. Marked differences, especially with regard to height-for-age and weight-for-age, are often seen between different subgroups of children within a country.

Every effort was made to successfully carry out the measurement of eligible children. A total of 4,794 children under age 5 (unweighted) in the entire PDHS subsample of households were eligible for anthropometric measurement. Table 13 and Figure 11 focus on the 90% for whom complete and credible anthropometric and age data were collected.

Table 13 shows nutritional status for children under age 5 according to the three anthropometric indices, by background characteristics. Height-for-age is a measure of linear growth. A child who is below -2 SD from the reference median for height-for-age is considered short for his or her age, or stunted, a condition reflecting the cumulative effect of chronic malnutrition. Thirty-eight percent of children in Pakistan are stunted (below -2 SD), and 17% are severely stunted (below -3 SD). Stunting increases with age, peaking at 48% among children age 24-35 months (Figure 11). A higher proportion of children in rural areas (41%) than urban areas (31%) are stunted. Children of women with no education are more likely to be stunted than those whose mothers are educated. Stunting is inversely related with wealth quintile; 57% of children in the lowest wealth quintile are stunted, as compared with 22% of children in the highest quintile.

Weight-for-height describes current nutritional status. A child who is below -2 SD from the reference median for weight-for-height is considered too thin for his or her height, or wasted, a condition reflecting acute or recent nutritional deficits. Overall, 7% of children are wasted and 2% are severely wasted.

Table 13 Nutritional status of children

Percentage of children under age 5 classified as malnourished according to three anthropometric indices of nutritional status: height-for-age, weight-for-height, and weight-for-age, according to background characteristics, Pakistan DHS 2017-18

	Height-for-age[1]				Weight-for-height					Weight-for-age				
Background characteristic	Percentage below -3 SD	Percentage below -2 SD[2]	Mean Z-score (SD)	Number of children	Percentage below -3 SD	Percentage below -2 SD[2]	Percentage above +2 SD	Mean Z-score (SD)	Number of children	Percentage below -3 SD	Percentage below -2 SD[2]	Percentage above +2 SD	Mean Z-Score (SD)	Number of children
Age in months														
<6	8.7	21.6	-0.8	406	7.5	15.0	3.6	-0.6	402	12.3	23.2	1.4	-1.1	419
6-8	7.1	17.5	-0.6	166	3.6	12.3	4.2	-0.3	166	6.9	14.3	0.9	-0.7	166
9-11	12.0	23.0	-0.9	125	5.8	12.5	3.9	-0.3	128	6.5	19.1	0.1	-0.8	132
12-17	7.7	29.4	-1.2	452	2.2	8.5	1.7	-0.4	458	5.1	15.9	1.4	-0.9	472
18-23	18.7	39.0	-1.7	281	1.9	5.0	3.0	-0.1	284	6.6	19.8	1.8	-1.0	288
24-35	23.5	48.1	-1.9	697	1.8	6.2	3.6	-0.2	702	9.2	26.7	1.6	-1.2	723
36-47	23.2	46.5	-2.0	705	1.5	4.3	1.3	-0.2	717	8.6	25.3	0.1	-1.3	728
48-59	19.5	39.7	-1.7	689	0.7	4.0	1.4	-0.3	691	8.5	25.9	0.5	-1.3	693
Sex														
Male	18.6	38.2	-1.6	1,802	2.7	7.6	2.3	-0.3	1,813	8.7	24.0	0.7	-1.2	1,840
Female	16.1	37.1	-1.5	1,720	2.1	6.6	2.6	-0.3	1,734	8.0	22.1	1.2	-1.1	1,783
Mother's interview status														
Interviewed	17.2	37.4	-1.6	3,440	2.3	7.0	2.5	-0.3	3,445	8.2	22.8	1.0	-1.1	3,536
Not interviewed, but in household	(27.4)	(57.1)	(2.3)	29	(1.7)	(3.4)	(0.9)	(-0.1)	45	(17.4)	(34.3)	(0.0)	(1.5)	31
Not interviewed, not in household[3]	(24.1)	(38.9)	(1.8)	54	(10.0)	(16.5)	(0.1)	(0.6)	57	(14.1)	(36.3)	(0.0)	(1.3)	55
Residence														
Urban	12.0	30.7	-1.3	1,135	2.4	6.7	3.0	-0.3	1,134	5.9	18.8	1.3	-1.0	1,170
Rural	19.9	40.9	-1.7	2,386	2.4	7.3	2.2	-0.3	2,413	9.6	25.1	0.8	-1.2	2,452
Mother's education[4]														
No education	25.2	47.8	-1.9	1,688	2.6	8.6	1.9	-0.4	1,715	12.8	31.9	0.2	-1.5	1,750
Primary	13.3	38.7	-1.6	519	2.8	5.4	1.5	-0.4	519	5.7	19.3	0.7	-1.1	533
Middle	9.4	27.0	-1.3	306	1.7	4.3	2.2	-0.4	303	4.7	15.2	1.5	-1.0	307
Secondary	8.9	29.0	-1.2	473	1.3	6.3	2.1	-0.3	472	3.4	14.0	1.3	-0.9	480
Higher	6.8	15.8	-0.7	482	2.2	5.0	6.2	0.1	481	2.2	8.2	3.2	-0.4	498
Wealth quintile														
Lowest	35.9	57.3	-2.3	712	3.0	9.7	1.9	-0.5	747	20.7	43.2	0.1	-1.8	752
Second	19.3	43.6	-1.8	652	3.6	7.8	1.9	-0.4	651	8.5	25.5	0.3	-1.3	659
Middle	12.7	33.5	-1.4	687	2.3	6.4	1.2	-0.3	681	5.0	18.0	1.2	-1.0	696
Fourth	12.1	32.5	-1.4	756	1.8	7.6	2.5	-0.3	757	4.5	17.9	0.7	-1.0	772
Highest	7.2	22.1	-0.9	715	1.6	3.8	4.8	-0.1	711	3.1	10.6	2.4	-0.6	743

Continued…

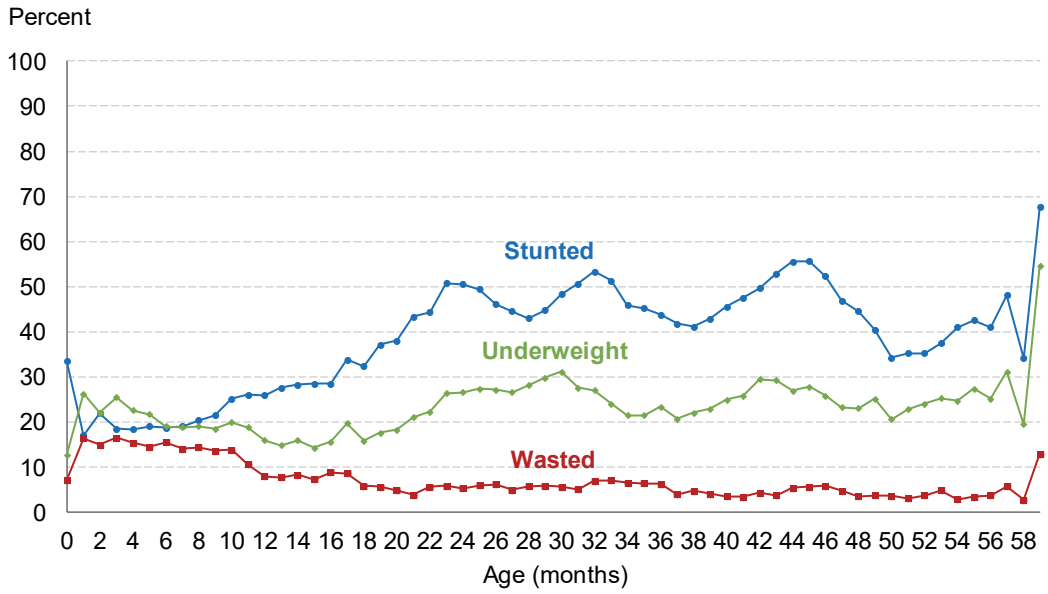
Table 13—*Continued*

Background characteristic	Height-for-age[1]				Weight-for-height					Weight-for-age				
	Percentage below -3 SD	Percentage below -2 SD[2]	Mean Z-score (SD)	Number of children	Percentage below -3 SD	Percentage below -2 SD[2]	Percentage above +2 SD	Mean Z-score (SD)	Number of children	Percentage below -3 SD	Percentage below -2 SD[2]	Percentage above +2 SD	Mean Z-Score (SD)	Number of children
Region														
Punjab	10.4	29.8	-1.3	1,862	0.8	4.0	2.0	-0.2	1,871	4.1	14.0	1.4	-0.9	1,890
Urban	8.4	25.7	-1.2	600	1.1	4.2	2.2	-0.2	602	3.5	13.4	2.0	-0.8	613
Rural	11.3	31.8	-1.4	1,262	0.6	3.9	1.9	-0.2	1,269	4.4	14.3	1.1	-0.9	1,277
Sindh	29.0	49.9	-2.0	844	4.4	11.7	2.2	-0.6	860	18.0	40.2	0.1	-1.7	889
Urban	15.4	35.5	-1.5	379	4.3	10.0	3.2	-0.6	376	9.1	26.4	0.2	-1.4	396
Rural	40.1	61.6	-2.4	465	4.6	13.0	1.4	-0.7	483	25.2	51.2	0.0	-2.1	493
Khyber Pakhtunkhwa	18.9	40.4	-1.5	536	3.1	7.5	3.0	-0.2	537	4.6	21.8	1.0	-1.0	552
Urban	13.8	33.7	-1.3	89	1.3	6.5	6.6	0.0	89	3.3	13.4	1.8	-0.7	91
Rural	20.0	41.7	-1.6	447	3.5	7.7	2.3	-0.2	447	4.9	23.4	0.8	-1.1	461
Balochistan	27.0	47.4	-1.6	174	8.6	18.3	5.3	-0.6	173	18.0	39.0	0.8	-1.6	183
Urban	25.7	48.0	-1.8	52	6.4	13.7	4.3	-0.4	52	15.1	35.9	1.0	-1.5	55
Rural	27.6	47.2	-1.5	121	9.6	20.2	5.7	-0.7	120	19.3	40.4	0.7	-1.7	128
ICT Islamabad	6.8	24.4	-1.0	20	0.9	2.8	2.3	-0.0	20	2.3	8.5	1.3	-0.6	22
FATA	27.6	52.3	-2.1	85	2.5	5.3	5.8	0.2	87	8.4	22.9	0.0	-1.2	87
Total[5]	17.4	37.6	-1.6	3,522	2.4	7.1	2.5	-0.3	3,547	8.4	23.1	0.9	-1.2	3,622
Azad Jammu and Kashmir	11.9	30.0	-1.3	466	0.9	6.4	0.5	-0.3	464	4.3	17.6	0.0	-1.0	469
Urban	6.6	24.9	-1.0	71	0.6	4.3	2.1	-0.0	72	2.5	9.1	0.3	-0.7	72
Rural	12.9	30.9	-1.4	395	1.0	6.8	0.2	-0.4	392	4.6	19.2	0.0	-1.1	396
Gilgit Baltistan	27.1	47.2	-1.8	319	0.2	1.1	3.3	0.4	321	7.4	18.2	1.1	-0.7	322

Note: Each of the indices is expressed in standard deviation (SD) units from the median of the WHO Child Growth Standards. Figures in parentheses are based on 25-49 unweighted cases.
[1] Recumbent length is measured for children under age 2; standing height is measured for all other children.
[2] Includes children who are below -3 SD from the WHO Growth Standards population median
[3] Includes children whose mothers are deceased
[4] For women who are not interviewed, information is taken from the Household Questionnaire. Excludes children whose mothers are not listed in the Household Questionnaire.
[5] Total excludes Azad Jammu and Kashmir and Gilgit Baltistan.

Weight-for-age is a composite index of weight-for-height and height-for-age and thus does not distinguish between acute malnutrition (wasting) and chronic malnutrition (stunting). Children can be underweight for their age because they are stunted, wasted, or both. Weight-for-age is an overall indicator of a population's nutritional health. The results show that 23% of all children under 5 are underweight, and 8% are severely underweight. The proportion of children who are underweight is greater in rural areas (25%) than urban areas (19%). Children of women with no education are more likely to be underweight than children whose mothers are educated (32% versus 8%). Underweight is inversely related with wealth quintile; 43% of children in the lowest wealth quintile are underweight, as compared with 11% of children in the highest quintile.

Figure 11 **Nutritional status of children by age**



Note: Excludes Azad Jammu and Kashmir and Gilgit Baltistan. *Stunting* reflects chronic malnutrition; *wasting* reflects acute malnutrition; *underweight* reflects chronic or acute malnutrition or a combination of both. Plotted values are smoothed by a five-month moving average.

The weight-for-height index also provides data on overweight and obesity. Children more than two standard deviations (+2 SD) above the median weight-for-height are considered overweight or obese. Three percent of children under age 5 are overweight in Pakistan.

Z-score means are calculated as summary statistics representing the nutritional status of children in a population. These mean scores describe the nutritional status of the entire population without the use of a cut-off. A mean Z-score of less than 0 (that is, a negative value for stunting, wasting, or underweight) suggests that the distribution of an index has shifted downward and, on average, children in the population are less well-nourished than children in the WHO Multicentre Growth Reference Study. As shown in Table 13, the mean stunting, wasting, and underweight Z-scores for children under age 5 are -1.6, -0.3, and -1.2, respectively.

These results indicate that the nutritional status of children in Pakistan has improved over the last 5 years. The percentage of stunted children declined from 45% in 2012-13 to 38% in 2017-18. A similar downward trend, from 30% to 23%, is observed for underweight children over the same period of time. Children who are wasted also declined from 11% to 7%, while children who are obese has remained at 3% over this period.

3.11.4 Infant and Young Child Feeding Practices

Breastfeeding is sufficient and beneficial for infant nutrition in the first 6 months of life. Breastfeeding immediately after birth also helps the uterus contract, hence reducing the mother's postpartum blood loss.

Giving any other foods and water (in addition to breast milk) before the child is age 6 months is discouraged because it may inhibit breastfeeding and expose the infant to illness. Infants older than 6 months need other food and drink while they continue to breastfeed until age 2 or older. Breastmilk still is an important source of energy, protein, and other nutrients such as vitamin A and iron. The food should include a variety of options, such as peeled, cooked, and mashed vegetables, grains, pulses and fruit, some oil, and also meat, eggs, chicken, and dairy products to provide adequate nourishment (Pan American Health Organization 2002).

Table 14 Breastfeeding status by age

Percent distribution of youngest children under age 2 who are living with their mother, by breastfeeding status, and the percentage currently breastfeeding; and percentage of all children under age 2 using a bottle with a nipple, according to age in months, Pakistan DHS 2017-18

	Breastfeeding status										
Age in months	Not breast-feeding	Exclusively breast-feeding	Breast-feeding and consuming plain water only	Breast-feeding and consuming nonmilk liquids[1]	Breast-feeding and consuming other milk	Breast-feeding and consuming comple-mentary foods	Total	Percentage currently breast-feeding	Number of youngest children under age 2 living with the mother	Percentage using a bottle with a nipple	Number of all children under age 2
0-1	4.0	55.9	6.5	1.3	28.9	3.3	100.0	96.0	367	33.5	367
2-3	7.5	52.1	7.1	1.9	24.5	6.9	100.0	92.5	387	39.6	392
4-5	10.0	34.8	11.3	0.7	15.5	27.7	100.0	90.0	385	37.9	388
6-8	17.7	7.1	10.5	1.4	9.7	53.5	100.0	82.3	458	49.3	462
9-11	25.5	1.8	8.7	0.5	5.5	58.0	100.0	74.5	345	50.6	354
12-17	32.2	0.7	2.3	0.4	3.0	61.4	100.0	67.8	1,067	51.6	1,135
18-23	43.7	2.8	1.8	0.1	0.7	50.9	100.0	56.3	719	56.4	840
0-3	5.8	54.0	6.8	1.6	26.7	5.2	100.0	94.2	754	36.7	759
0-5	7.2	47.5	8.3	1.3	22.9	12.8	100.0	92.8	1,139	37.1	1,147
6-9	18.9	6.6	11.0	1.2	8.1	54.3	100.0	81.1	569	48.6	578
12-15	30.4	0.6	2.2	0.4	4.0	62.5	100.0	69.6	737	52.8	769
12-23	36.8	1.6	2.1	0.3	2.1	57.2	100.0	63.2	1,786	53.6	1,975
20-23	46.6	3.4	1.5	0.0	0.0	48.5	100.0	53.4	473	56.2	557

Note: Breastfeeding status refers to a "24-hour" period (yesterday and last night). Children who are classified as breastfeeding and consuming plain water only consumed no liquid or solid supplements. The categories of not breastfeeding, exclusively breastfeeding, breastfeeding and consuming plain water, nonmilk liquids, other milk, and complementary foods (solids and semi-solids) are hierarchical and mutually exclusive, and their percentages add to 100. Thus children who receive breast milk and nonmilk liquids and who do not receive other milk and who do not receive complementary foods are classified in the nonmilk liquid category even though they may also get plain water. Any children who get complementary food are classified in that category as long as they are breastfeeding as well. Excludes Azad Jammu and Kashmir and Gilgit Baltistan.
[1] Nonmilk liquids include juice, juice drinks, or other liquids.

The 2017-18 PDHS collected data on infant and young child feeding (IYCF) practices for all children born in the 2 years preceding the survey. Table 14 shows breastfeeding practices by child's age. Contrary to the recommendation that children under age 6 months be exclusively breastfed, only 48% of the infants under age 6 months fell in this category. However, this shows improvement over the past 5 years when 38% of children under 6 months were exclusively breastfed. In addition to breast milk, 8% of these young infants consume plain water, 1% consume nonmilk liquids, 23% consume other milk, and 13% consume complementary foods. Thirty-seven percent of infants under age 6 months are fed using a bottle with a nipple, a practice that is discouraged because of the risk of illness to the child. Fifty-four percent of children age 6-8 months receive timely complementary foods, and 44% of children age 18-23 months have been weaned.

The minimum acceptable diet indicator is used to assess the proportion of children age 6-23 months who meet minimum standards with respect to IYCF practices. Specifically, children age 6-23 months who have a minimum acceptable diet meet all three IYCF criteria below:

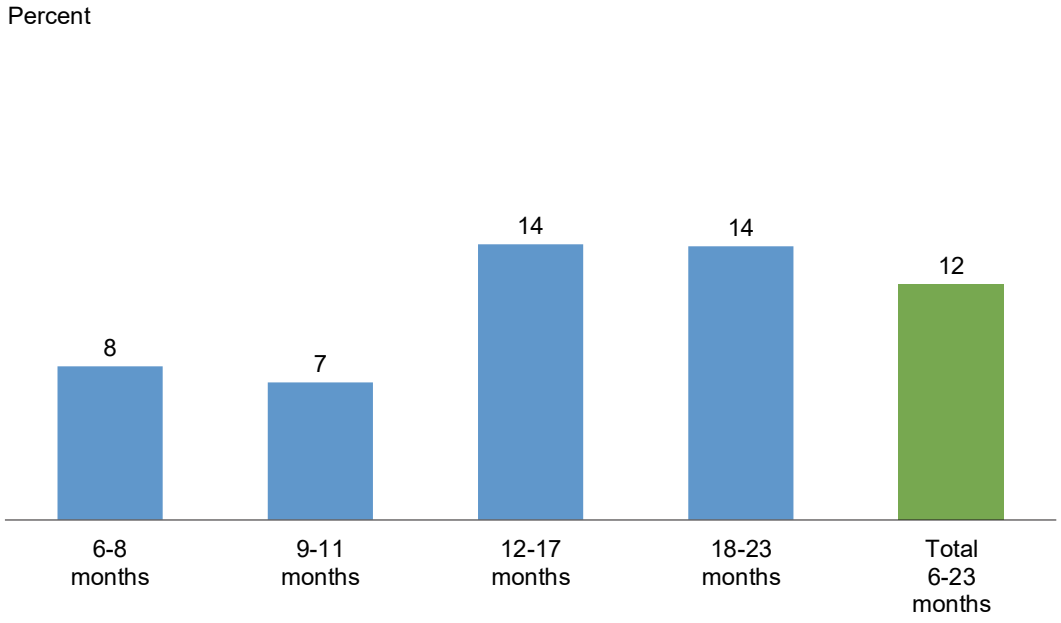
- Breastfeeding, or not breastfeeding and receiving two or more feedings of commercial infant formula; fresh, tinned, or powdered animal milk; or yogurt.
- Fed with foods from four or more of the following groups: (a) infant formula, milk other than breast milk, and cheese or yogurt or other milk products; (b) foods made from grains, roots, and tubers, including porridge and fortified baby food from grains; (c) vitamin A-rich fruits

and vegetables (and red palm oil); (d) other fruits and vegetables; (e) eggs; (f) meat, poultry, fish, and shellfish (and organ meats); and (g) legumes and nuts.

- Fed the minimum recommended number of times per day, according to their age and breastfeeding status:
  - For breastfed children, minimum meal frequency is receiving solid or semisolid food at least twice a day for infants age 6-8 months and at least three times a day for children age 9-23 months.
  - For nonbreastfed children age 6-23 months, minimum meal frequency is receiving solid or semisolid food or milk feeds at least four times a day.

Figure 12 shows the percentage of children being fed the minimum acceptable diet, by age. Among children 6-23 months, only 12% are fed in accordance with the criteria for a minimum acceptable diet.

Figure 12 **Minimum acceptable diet by age, in months**



Note: Excludes Azad Jammu and Kashmir and Gilgit Baltistan

3.12 HIV/AIDS AWARENESS AND KNOWLEDGE

The 2017-18 PDHS included a series of questions asked of both women and men that addressed respondents' knowledge of HIV prevention, their awareness of modes of HIV transmission, and behaviours that can prevent the spread of HIV.

Thirty-two percent of women and 67% of men have heard of AIDS (data not shown). Table 15 shows that 18% of women and 46% of men age 15-49 know that consistent use of condoms is a means of preventing the spread of HIV. Twenty-five percent of women and 58% of men know that limiting sexual intercourse to one faithful, uninfected partner can reduce the chance of contracting HIV. The proportions of women and men who know that both using condoms and limiting sexual intercourse to one uninfected partner are means of preventing HIV are 16% and 42%, respectively.

By residence, women and men who reside in urban areas are more likely to be knowledgeable about HIV prevention methods than their counterparts residing in rural areas. Better-educated respondents and those in the highest wealth quintile are considerably more knowledgeable of HIV prevention methods than other respondents.

Table 15 Knowledge of HIV prevention methods

Percentage of women and men age 15-49 who, in response to prompted questions, say that people can reduce the risk of getting HIV by using condoms every time they have sexual intercourse and by having one sex partner who is not infected and has no other partners, according to background characteristics, Pakistan DHS 2017-18

	Percentage of women who say HIV can be prevented by:				Percentage of men who say HIV can be prevented by:			
Background characteristic	Using condoms[1]	Limiting sexual intercourse to one uninfected partner[2]	Using condoms and limiting sexual intercourse to one uninfected partner[1,2]	Number of women	Using condoms[1]	Limiting sexual intercourse to one uninfected partner[2]	Using condoms and limiting sexual intercourse to one uninfected partner[1,2]	Number of men
Age								
15-24	8.6	13.5	6.7	2,489	30.5	37.3	26.7	305
15-19	6.1	8.8	4.9	600	(10.6)	(10.4)	(4.1)	40
20-24	9.4	15.0	7.3	1,889	33.5	41.4	30.1	265
25-29	18.2	26.2	16.1	2,548	43.5	53.3	39.5	607
30-39	22.1	29.1	19.0	4,575	47.9	62.9	45.3	1,220
40-49	18.9	25.4	17.0	2,752	48.1	59.9	43.5	1,013
Residence								
Urban	28.7	38.8	25.2	4,550	56.9	70.3	52.9	1,264
Rural	11.5	16.2	9.8	7,814	37.7	49.1	34.3	1,881
Education								
No education	4.4	6.3	3.6	6,080	19.3	26.6	17.3	800
Primary	15.6	21.9	13.5	2,037	37.4	47.9	31.9	640
Middle	23.3	31.0	19.9	1,160	46.7	61.9	42.2	478
Secondary	32.4	47.0	28.4	1,463	59.5	78.0	56.3	633
Higher	53.9	71.4	47.6	1,624	73.4	84.8	69.6	594
Wealth quintile								
Lowest	1.4	1.8	1.1	2,159	20.1	25.7	17.4	536
Second	5.2	7.2	4.4	2,178	30.7	39.8	27.4	517
Middle	12.6	17.5	10.1	2,433	42.4	55.7	38.3	622
Fourth	22.5	32.4	20.1	2,716	56.7	71.7	52.6	705
Highest	39.7	53.3	34.9	2,878	65.3	80.7	61.5	765
Region								
Punjab	22.0	31.9	19.6	6,630	51.0	66.3	47.3	1,657
Urban	33.8	47.0	30.5	2,402	63.7	77.8	59.9	660
Rural	15.3	23.4	13.5	4,228	42.5	58.6	39.0	997
Sindh	15.2	19.6	13.0	2,850	33.6	43.6	30.6	784
Urban	24.2	32.0	20.6	1,527	45.3	61.4	41.7	441
Rural	4.9	5.3	4.3	1,323	18.6	20.8	16.4	342
Khyber Pakhtunkhwa	12.0	13.6	9.4	1,901	42.5	53.4	37.7	438
Urban	22.0	25.8	17.9	366	62.2	69.1	56.9	87
Rural	9.6	10.7	7.4	1,535	37.6	49.5	33.0	350
Balochistan	6.2	6.5	4.3	642	46.1	44.7	42.3	185
Urban	12.2	14.2	8.4	188	56.3	53.5	49.2	56
Rural	3.7	3.4	2.7	454	41.7	40.8	39.3	129
ICT Islamabad	33.0	46.6	28.2	107	60.2	73.0	56.7	32
FATA	3.5	3.5	2.7	234	63.1	65.8	57.8	49
Total[3]	17.8	24.6	15.5	12,364	45.5	57.6	41.8	3,145
Azad Jammu and Kashmir	19.8	28.2	17.8	1,720	56.3	71.3	52.0	336
Urban	35.1	47.1	32.0	292	65.3	74.5	58.1	65
Rural	16.7	24.3	14.9	1,428	54.2	70.5	50.5	271
Gilgit Baltistan	9.8	11.6	8.1	984	36.7	39.5	30.2	210

Note: Figures in parentheses are based on 25-49 unweighted cases.
[1] Using condoms every time they have sexual intercourse
[2] Partner who has no other partners.
[3] Total excludes Azad Jammu and Kashmir and Gilgit Baltistan

3.13 DISABILITY

The 2017-18 PDHS included The DHS Program disability module, a series of questions based on the Washington Group on Disability Statistics Short Set that are based on the framework of the World Health Organization's International Classification of Functioning, Disability, and Health. The questions address six core functional domains, namely, seeing, hearing, communication, cognition, walking, and self-care, and provide basic necessary information on disability comparable to that being collected worldwide via the WG disability tools.

The respondent to the Household Questionnaire provided information on behalf of all household members and visitors age 5 and older on whether they had no difficulty, some difficulty, a lot of difficulty, or no ability at all in each domain. This information was gathered for 67,586 people.

About four in five (81%) of the de facto household population age 5 and older have no difficulty in any of the domains (Table 16). Thirteen percent have some difficulty in at least one domain, 5% have a lot of difficulty in at least one domain, and 1% cannot function at all in at least one domain. The proportion who have a lot of difficulty or cannot function at all in at least one domain ranges from 2% to 9% among those age 5-49 and then increases to 14% among those age 50-59 and 32% among those age 60 or above.

Table 16 Disability by domain and age

Percent distribution of de facto household population age 5 and over by the degree of difficulty in functioning according to domain, and percent distribution by the highest degree of difficulty in functioning in at least one domain by age, Pakistan DHS 2017-18

	Degree of difficulty						A lot of difficulty, or	
Domain and age	No difficulty	Some difficulty	A lot of difficulty	Cannot do at all	Don't know/ missing	Total	cannot do at all	Number of persons
Domain								
Difficulty seeing	89.9	8.0	1.9	0.1	0.1	100.0	2.0	67,586
Difficulty hearing	96.6	2.4	0.8	0.2	0.1	100.0	1.0	67,586
Difficulty communicating	98.0	1.2	0.5	0.3	0.1	100.0	0.8	67,586
Difficulty remembering or concentrating	94.1	4.5	1.0	0.3	0.1	100.0	1.3	67,586
Difficulty walking or climbing steps	90.7	5.9	2.9	0.5	0.1	100.0	3.4	67,586
Difficulty washing all over or dressing	96.8	1.9	0.8	0.4	0.1	100.0	1.2	67,586
Difficulty in at least one domain[1]								
5-9	93.7	4.2	1.3	0.6	0.3	100.0	1.9	10,469
10-14	93.7	3.9	1.5	0.6	0.2	100.0	2.2	9,153
15-19	92.7	4.8	1.8	0.6	0.1	100.0	2.4	8,486
20-29	91.3	6.0	1.9	0.6	0.1	100.0	2.6	13,677
30-39	83.5	12.6	3.1	0.7	0.1	100.0	3.8	9,531
40-49	66.5	24.9	7.6	1.0	0.1	100.0	8.5	6,004
50-59	48.7	36.9	12.8	1.4	0.1	100.0	14.2	5,039
60+	30.6	37.8	26.9	4.6	0.1	100.0	31.5	5,224
Age 15 and over	75.8	16.2	6.7	1.2	0.1	100.0	7.9	47,961
Total[2]	81.0	12.7	5.2	1.0	0.1	100.0	6.2	67,586

Note: Total includes four cases for which age is missing.
[1] If a person was reported to have difficulty in more than one domain, only the highest level of difficulty is shown.
[2] Excludes Azad Jammu and Kashmir and Gilgit Baltistan.

Table 17.1 and Table 17.2 present disability data among the de facto household population age 15 and older by background characteristics. Nine percent of women and 7% of men age 15 and older have a lot of difficulty or cannot function at all in *at least* one domain. Similarly, those having a lot of difficulty or who cannot function in *more than* one domain is 3% among women and 2% among men. Women and men with no education are more likely than their educated counterparts to have a lot of difficulty or to be unable to function at all in at least one domain.

Table 17.1 Disability among adults according to background characteristics: Women

Percentage of the de facto female household population age 15 and over who have difficulty in functioning according to domain, by the highest degree of difficulty in at least one domain, and percentage with a lot of difficulty or cannot do at all in more than one domain, according to background characteristics, Pakistan DHS 2017-18

Background characteristic	No difficulty in any domain	Domain						Difficulty in at least one domain[1]				A lot of difficulty or cannot do at all in more than one domain	Number of persons
		Seeing	Hearing	Commu-nicating	Remem-bering or concen-trating	Walking or climbing steps	Washing all over or dressing	Some difficulty	A lot of difficulty	Cannot do at all	A lot of difficulty or cannot do at all		
Marital status													
Never married	90.8	3.6	1.3	2.1	3.2	2.7	1.2	5.7	2.3	1.1	3.4	1.5	6,581
Married	71.5	16.1	4.0	1.3	8.9	14.9	3.5	20.5	7.2	0.7	7.9	2.2	15,582
Divorced or separated	67.7	22.3	3.6	4.1	10.3	19.2	8.0	22.8	7.6	1.9	9.5	3.2	282
Widowed	31.5	43.4	16.3	6.0	25.5	50.1	19.5	35.9	26.8	5.6	32.4	14.2	1,984
Residence													
Urban	73.3	13.7	3.6	1.7	7.4	16.3	4.1	18.5	7.1	1.0	8.1	2.7	9,239
Rural	73.5	15.8	4.7	2.1	9.6	13.4	4.3	17.4	7.7	1.4	9.1	3.2	15,198
Education													
No education	64.5	21.2	6.6	3.2	12.7	20.1	6.6	22.2	11.1	2.1	13.2	4.7	12,101
Primary	75.5	11.7	2.8	1.3	7.4	13.9	3.3	17.2	6.4	0.8	7.2	2.3	3,467
Middle	81.5	10.0	2.3	0.7	5.2	9.0	1.7	13.9	3.9	0.6	4.6	1.6	2,414
Secondary	84.2	7.7	1.9	0.6	4.1	7.5	1.5	12.1	3.4	0.3	3.6	1.1	2,935
Higher	87.5	6.6	1.0	0.2	2.6	5.3	0.8	10.4	1.9	0.2	2.1	0.4	3,511
Wealth quintile													
Lowest	76.1	14.5	5.8	2.4	10.3	11.3	5.1	14.9	7.3	1.5	8.9	3.4	4,077
Second	71.3	17.3	5.2	2.2	11.2	14.4	4.3	19.3	8.1	1.3	9.4	3.3	4,173
Middle	71.2	16.9	3.8	2.2	9.1	15.2	4.0	19.1	8.1	1.4	9.6	2.8	4,643
Fourth	71.7	15.8	4.4	1.7	8.3	16.0	4.2	19.1	8.0	1.1	9.1	3.3	5,468
Highest	76.1	11.5	2.8	1.5	6.1	14.8	3.7	16.5	6.2	1.0	7.2	2.4	6,077
Region													
Punjab	70.0	16.9	4.5	2.0	9.4	17.1	4.4	20.0	8.6	1.3	9.8	3.5	13,126
Urban	70.1	15.1	4.1	1.7	7.9	18.9	4.0	21.1	7.8	1.0	8.8	3.1	4,866
Rural	70.0	17.9	4.8	2.2	10.3	16.1	4.7	19.5	9.0	1.4	10.4	3.7	8,260
Sindh	78.8	11.6	3.7	1.8	6.8	11.9	3.9	14.4	5.6	1.1	6.7	2.4	5,680
Urban	77.4	11.4	2.9	1.8	5.8	13.8	4.2	15.1	6.5	1.0	7.4	2.3	3,124
Rural	80.4	11.9	4.7	1.7	8.1	9.7	3.5	13.6	4.6	1.3	5.9	2.5	2,556
Khyber Pakhtunkhwa	74.6	15.5	4.7	2.2	10.1	11.5	4.3	16.7	7.0	1.6	8.6	2.9	3,643
Urban	72.8	15.9	4.1	1.8	11.3	13.6	3.8	19.3	6.6	1.1	7.7	2.0	728
Rural	75.1	15.5	4.8	2.3	9.8	11.0	4.4	16.1	7.1	1.8	8.8	3.1	2,915
Balochistan	83.4	10.4	2.6	1.1	3.1	6.5	2.7	9.3	6.3	0.7	7.0	1.5	1,287
Urban	82.1	10.9	2.3	1.4	4.1	6.9	2.8	11.5	4.7	1.1	5.8	2.2	381
Rural	84.0	10.2	2.8	1.0	2.7	6.3	2.6	8.4	7.0	0.5	7.5	1.2	905
ICT Islamabad	66.6	16.8	5.3	2.6	12.7	19.6	7.0	22.4	9.8	1.0	10.8	4.4	225
FATA	67.8	11.5	5.2	1.0	17.3	13.9	4.3	25.1	6.1	0.9	7.1	2.2	476
Total[2]	73.4	15.0	4.3	1.9	8.8	14.5	4.2	17.8	7.5	1.2	8.7	3.0	24,437
Azad Jammu and Kashmir	67.0	17.6	6.4	2.2	13.3	20.4	5.3	21.8	9.5	1.5	11.0	3.9	3,697
Urban	68.7	15.0	6.1	2.4	12.3	19.9	4.8	20.7	8.4	2.2	10.6	3.8	658
Rural	66.7	18.1	6.4	2.2	13.5	20.4	5.4	22.0	9.8	1.4	11.1	4.0	3,039
Gilgit Baltistan	73.7	11.3	8.8	3.1	7.3	15.9	5.5	16.3	8.5	1.4	9.9	3.7	2,192

Note: Total includes seven cases for which marital status is missing and nine cases for which education is missing.
[1] If a person was reported to have difficulty in more than one domain, only the highest level of difficulty is shown.
[2] Total excludes Azad Jammu and Kashmir and Gilgit Baltistan.

Table 17.2 Disability among adults according to background characteristics: Men

Percentage of the de facto male household population age 15 and over who have difficulty in functioning according to domain, by the highest degree of difficulty in at least one domain, and percentage with a lot of difficulty or cannot do at all in more than one domain, according to background characteristics, Pakistan DHS 2017-18

Background characteristic	No difficulty in any domain	Domain						Difficulty in at least one domain[1]				A lot of difficulty or cannot do at all in more than one domain	Number of persons
		Seeing	Hearing	Commu-nicating	Remem-bering or concen-trating	Walking or climbing steps	Washing all over or dressing	Some difficulty	A lot of difficulty	Cannot do at all	A lot of difficulty or cannot do at all		
Marital status													
Never married	91.0	2.7	1.5	2.7	3.1	2.8	1.5	4.8	2.7	1.4	4.0	1.6	8,722
Married	72.5	16.0	4.9	1.6	7.7	13.9	3.5	19.7	6.8	0.9	7.7	2.3	13,877
Divorced or separated	68.7	18.1	13.2	1.4	13.6	13.1	2.8	20.3	8.1	2.7	10.9	3.6	168
Widowed	40.4	36.1	20.2	7.0	19.1	39.5	15.8	30.3	25.2	3.8	29.0	11.9	751
Residence													
Urban	81.3	9.4	3.2	1.7	4.8	9.4	2.5	13.6	4.2	0.8	5.0	1.6	9,326
Rural	76.4	13.3	4.9	2.5	7.5	11.4	3.6	15.1	7.0	1.4	8.4	2.9	14,198
Education													
No education	66.6	19.1	7.8	4.5	11.6	18.2	6.2	19.6	11.0	2.6	13.6	5.1	6,938
Primary	78.0	12.0	3.8	2.1	6.4	10.7	2.9	15.1	6.1	0.8	6.9	2.2	3,853
Middle	84.1	7.7	2.3	1.4	3.9	7.2	1.8	11.4	3.9	0.6	4.5	1.2	3,875
Secondary	84.2	8.5	2.7	0.9	3.7	6.5	1.6	12.1	3.1	0.6	3.7	1.2	4,506
Higher	86.2	6.7	2.0	0.6	3.2	5.4	1.4	11.1	2.2	0.2	2.4	0.5	4,349
Wealth quintile													
Lowest	74.2	15.2	5.9	3.1	9.1	12.1	4.1	16.2	7.6	1.8	9.4	3.4	4,017
Second	76.4	13.4	4.8	2.6	7.8	11.3	3.7	14.8	7.3	1.5	8.8	2.9	3,990
Middle	77.4	12.7	4.1	1.8	6.2	11.6	3.7	15.2	6.4	0.8	7.2	2.3	4,505
Fourth	78.6	11.2	3.7	2.1	6.4	10.2	3.0	14.6	5.7	1.1	6.8	2.3	5,256
Highest	83.0	7.9	3.0	1.6	3.7	8.5	1.9	12.5	3.5	0.9	4.3	1.4	5,756
Region													
Punjab	76.8	12.3	4.6	2.1	6.9	12.1	3.4	15.3	6.6	1.2	7.7	2.6	12,510
Urban	80.9	9.7	3.4	1.6	4.9	9.9	2.4	14.2	4.2	0.8	4.9	1.7	4,881
Rural	74.2	14.0	5.5	2.5	8.1	13.5	3.9	16.0	8.1	1.4	9.6	3.2	7,629
Sindh	81.1	10.1	3.7	2.3	5.8	8.8	2.7	12.9	4.7	1.2	5.9	1.8	5,799
Urban	82.6	8.3	2.7	1.8	4.5	8.9	2.6	12.2	4.3	0.9	5.2	1.4	3,232
Rural	79.2	12.3	4.9	2.9	7.5	8.7	2.9	13.8	5.3	1.6	6.9	2.2	2,567
Khyber Pakhtunkhwa	76.5	13.6	4.1	2.6	7.1	10.3	3.7	16.1	6.0	1.3	7.3	3.1	3,226
Urban	77.8	10.7	3.9	1.6	7.3	9.9	2.9	17.2	4.2	0.7	5.0	1.8	686
Rural	76.2	14.4	4.1	2.9	7.1	10.5	3.9	15.8	6.5	1.5	7.9	3.4	2,540
Balochistan	85.8	9.1	2.2	1.0	2.7	4.7	2.0	8.7	4.5	0.7	5.1	1.4	1,350
Urban	83.4	10.5	2.4	1.4	2.4	5.0	2.1	11.2	4.0	0.6	4.5	0.9	378
Rural	86.7	8.6	2.1	0.8	2.8	4.5	2.0	7.8	4.7	0.7	5.4	1.6	972
ICT Islamabad	75.3	13.6	4.4	1.8	6.7	11.5	2.8	17.7	5.4	1.1	6.5	2.4	231
FATA	76.9	11.2	4.7	2.4	7.9	9.8	3.0	17.1	5.2	0.9	6.0	1.7	407
Total[2]	78.3	11.7	4.2	2.2	6.4	10.6	3.2	14.5	5.9	1.2	7.0	2.4	23,523
Azad Jammu and Kashmir	71.3	14.8	7.0	2.7	9.2	16.2	3.8	18.7	8.1	1.8	10.0	4.0	2,903
Urban	72.6	12.7	5.8	2.9	8.6	14.4	3.4	19.4	5.9	2.1	8.0	3.5	546
Rural	71.0	15.3	7.3	2.7	9.3	16.6	3.8	18.5	8.7	1.8	10.5	4.1	2,357
Gilgit Baltistan	72.5	11.4	8.6	4.6	8.4	13.6	4.7	18.2	7.5	1.6	9.2	3.9	1,835

Note: Total includes 5 cases for which marital status is missing and 2 cases for which education is missing.
[1] If a person was reported to have difficulty in more than one domain, only the highest level of difficulty is shown.
[2] Total excludes Azad Jammu and Kashmir and Gilgit Baltistan.

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