LONGITUDINAL PANEL STUDY IN PUNJAB

USING PERFORMANCE MONITORING FOR ACTION (PMA) FRAMEWORK

PHASE-V, 2024

Government of Pakistan
M/o National Health Services, Regulations & Coordination
National Institute of Population Studies, Training & Research (NIPST&R)

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National Institute of Population Studies, Training & Research (NIPST&R)
Islamabad

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LIST OF ACRONYMS

ANC	Antenatal Care
BHU	Basic Health Unit
CCI	Council of Common Interest
cLMIS	contraceptive Logistics Management Information System
CMWs	Community Midwives
CPR	Contraceptive Prevalence Rate
DHIS	District Health Information System
DoH	Department of Health
DPM	Data Processing Manager
EAs	Enumeration Areas
EC	Emergency Contraception
FHC	Family Health Clinic
FP	Family Planning
FWC	Family Welfare Centre
FWWs	Family Welfare Workers
FLFP	Female Labour Force Participation
FLFPR	Female Labour Force Participation Rate
GoP	Government of Punjab
IUD	Intra Uterine Device
LHWs	Lady Health Workers
LHVs	Lady Health Visitors
mCPR	modern Contraceptive Prevalence Rate
MDGs	Millenium Development Goals
MCH	Maternal and Child Health
MNCH	Maternal, Neonatal, And Child Health
MSU	Mobile Service Units
NGO	Non -Governmental Organization
NIPST&R	National Institute for Population Studies, Training & Research
OE	Office Editor
PBS	Pakistan Bureau of Statistics
PMA	Performance Monitoring for Action
PNC	Postnatal Care
PWD	Population Welfare Department
PDHS	Pakistan Demographic and Health Survey
RH	Reproductive Health
RHC	Rural Health Center
RTIs	Regional Training Institutes
SBA	Skilled Birth Attendant
SDPs	Service Delivery Points
SDGs	Sustainable Development Goals
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund

PREFACE

The Punjab Government has pledged to raise the Contraceptive Prevalence Rate (CPR) to 64 percent by the year 2030, to fulfill the commitments made by Pakistan at the ICPD25+ and FP-2030 forums. This initiative aims to lower fertility rates to 2.1 births and enhance the CPR to 60 percent by 2030. All stakeholders must engage in collaborative efforts by formulating strategies and activities that address emerging needs and enhance implementation efficiency at the grassroots level. Timely evaluation of the progress and performance of family planning services is crucial for gauging the direction and momentum of progress, enabling any necessary corrective actions. The commencement of the Longitudinal Panel Study by the National Institute of Population Studies, Training & Research (NIPST&R) in Islamabad marks a significant step in capturing the state and dynamics of important family planning indicators. Phase I of the survey, conducted in 2020, established a baseline for key family planning indicators, which includes not only currently married women aged 15-49 but also information regarding the nearest service delivery points and the quality of service through client exit interviews. The institute has successfully conducted all five phases of the survey (at one-year intervals) to compare the progress of critical indicators, assess the direction of change, and guide family planning program managers in implementing necessary corrective actions. Such corrective actions are intended to address the gaps that arise in fulfilling provincial family planning commitments.

The Institute is keenly anticipating the engagement of key stakeholders to take ownership of the results and utilize them for remedial actions, the Health and Population Department, and civil society organizations based in Punjab.

NIPST&R is highly obliged and appreciates the guidance and technical support of Tauseef Ahmed Ph.D., Technical Advisor throughout the project activities from study design, strategies, indicators, tools finalization and report writing.

The institute acknowledges the tireless efforts and valuable contributions of Ms. Rabia Zafar, Director, for her dedication, effectiveness, and technical proficiency throughout the project. She played a pivotal role in proposal design, questionnaire development, recruitment and supervision of field staff, monitoring data collection activities, and finalizing the report. Her leadership and deep involvement at every stage, along with the support of her skilled team at the NIPST&R office and project staff, have been instrumental in ensuring the successful completion of the project. Her insights and commitment continue to be a remarkable asset to the institute.

The Institute acknowledges the financial support by UNFPA to undertake Phase-V of this crucial exercise. Furthermore, the input of Mr. Muqaddar Shah, Programme Analyst, UNFPA at the layout plan of the survey are highly commendable.

(Samina A. Hasan)
Executive Director

ACKNWLEDGMENTS

The Longitudinal Panel study in Punjab, utilizing the Performance Monitoring for Action Framework, was executed by the National Institute of Population Studies, Training & Research (NIPST&R) and carried out under the auspices of the Ministry of National Health Services, Regulations and Coordination.

Performance Monitoring for Action (PMA) Framework is the culmination of the dedicated efforts of various individuals and organizations. We sincerely hope and anticipate that the findings and dataset from this survey will be utilized by the public, particularly by policy-makers, planners, researchers, development partners, and Non-Governmental Organizations (NGOs), to develop and monitor policies, programs, and strategies aimed at creating targeted services for Family Planning. This initiative emphasizes affordable, easily accessible community-based approaches that will enhance service access for this underserved population and significantly contribute to addressing the issue of population growth in the country.

I would like to express my gratitude and recognition for the persistent efforts, enthusiasm, and commitment of Mrs. Samina A. Hasan, Executive Director of NIPST&R. Her encouragement and support empowered the core team to exert their maximum efforts and successfully complete the survey within the designated timeframe. I am thankful for her genuine leadership and professional conduct.

Special thanks are extended to Ms. Farah Ashraf, Programme Management Analyst at UNFPA, for her unwavering support throughout the survey. NIPST&R is profoundly grateful and acknowledges the dedication and hard work of Mr. Ali Raza, Data Processing Manager (DPM).

Ms. Rizwana Timsal, Fellow, is highly commended for her role in recruitment of Project Staff, facilitating training and field monitoring. Ms. Saarma Saeed, Associate Fellow, and Dr. Muhammad Mohsin Latif Kiani, Researcher, are acknowledged for their assistance in preparing the report.

Mr. Muhammad Arif, Accounts Officer, and Mr. Asif Amin Khan, PS to ED/Staff Officer, are acknowledged for their exemplary services in administration and financial management. Mr. Farman Ali and Mr. Qamer Ur Rasool, Data Entry Operators, are highly acknowledged for facilitation in data entry, error checking and maintaining data files. Mr. Mustafa Ali Khan, Office Coordinator and the Provincial Field Coordinators efficiently managed coordination tasks. The Office Editors are appreciated for their meticulous editing and validation of field questionnaires to ensure the quality of data.

(Rabia Zafar)
Director

EXECUTIVE SUMMARY

Government of Punjab made several commitments over the years as part of national endeavour to address rising population growth rate by strengthening family planning activities among key stakeholders. Government evolved necessary policies and strategies for enabling environment, strengthen institutions, and improving coverage and access of the services to gear family planning performance and progress. Government of Punjab also expressed the need of moving forward with functional integration and prioritizing strategies to enhance access and coverage to address growing number of new users besides enhancing resources to overcome regional inequities. Department of Health over the years expanded the services of Rural Health Centers and Basic Health Units for 24/7 especially in maternal and child health and primary health care across Punjab. To support the measurement of progress on the Commitments the National Institute of Population Studies, Training & Research (NIPST&R), Islamabad established a Longitudinal Panel Study using Performance Monitoring for Action (PMA) framework to provide an annual stream of information on critical family planning indicators using representative sample. The exercise was initiated in year 2020 and has conducted five surveys on annual basis to capture performance of family planning activities by key stakeholders, as it provides process level field evidence needed to bring programme improvements to address policy commitments of enhancing access to services, improving quality of services, and strengthening enabling environment.

The Phase-V of the Longitudinal Panel study in Punjab (2024) using Performance Monitoring for Action (PMA) Framework, collects provincial level data using 52 clusters selected from 11 districts across Punjab, visiting representative household sample of 1981 households and 2,339 currently married women in selected households and 247 selected health facilities. The survey involves interviewing a sample of currently married women aged 15 to 49 years and selected Department of Health and Population Welfare Department (PWD) facilities and retail outlets that serve family planning services to the selected enumeration areas. The Phase-V survey encompassed a large majority of same households that was initiated in 2020 and same women except those who had either migrated, or moved above age 49, and those widowed and divorced. Information was also collected from 2,440 clients/patients exiting various health facilities located within five kilometers of selected clusters.

Key findings:

Currently Married Women on Family Planning and Maternal Health:

- The contraceptive prevalence rate (CPR) in Punjab has risen over the years and recorded at 50.5 percent in 2024 relative to 38 percent as reported in phase-1 in 2020.
- The modern contraceptive use rate stands at 33.4 percent in 2024 relative to 28.6 percent reported in 2020. The percent women using traditional methods increased from 11 percent in 2020 to 17 percent in 2024 thus raising serious concern.

- The source of modern contraception is predominantly private sector facilities together serving almost more than 60 percent of women.
- Public sector is attributed by a third of all users (39 - 34% over five phases) as the source of modern FP methods. Population Welfare facilities provided services to a quarter of all women (26 percent) while Dept of Health facilities was acknowledged by only 11 percent women.
- Three contraceptive methods are reported as currently popular among women in Phase-V including: Tubaligation (16.3%), condoms (11.6%) and traditional methods (17.1%). IUD is a distant fourth method of choice (2.9 percent in 2024).
- The percentage of women who were visited by a Lady Health Worker (LHW) to talk about family planning rose sharply from 17.2% in Phase I to 45.5% in Phase V. But visit of LHWs to women's households does not show any noticeable change in CPR over the surveys (51% vs 50% among women with no LHW visit).
- In-depth analysis of contraceptive prevalence by programme interventions reveals ANC visits and LHVs interaction with woman substantially effects CPR positively. The CPR is noted to be 55 percent for women undergoing ANC and 39 percent for those with no ANC visits.
- Percent women reporting (in Phase-V) their first method used reflects condoms (23%) and traditional methods (21%) was higher than all other methods. The trend of these two methods is more prominent in the last few years. Tubaligation is reported by 7.6 percent women as first method, followed by injectables (5.4%) and IUD (4.9%) during phase-V.
- Unmet need for contraception has gradually declined from 18.6 percent in Phase-1 to around 16.9 percent in Phase-V. Percent women seeking to limit births appears to be increased over the years (from 7.4 percent in 2020 to 8.3 percent in 2024).
- Discontinuing contraceptives for fertility-related reasons are more common than contraceptive - related reasons. Rural women discontinue more so for fertility related reasons while urban women give method specific reasons for discontinuation.
- Survey results show increase in percent women experiencing unintended pregnancies in the four years. Women experienced unintended pregnancy in their lifetime increased from 9.7 percent in Phase to 15.5 percent in Phase-V. Furthermore, it is noted that more than half of all unintended pregnancies take place between ages 25-34.
- Over the past three years, there have been significant improvements in key maternal health indicators. Survey findings show a positive increase over the years: antenatal care (ANC) coverage increased from 81.9% in 2022 to 98.2% in 2024, skilled personnel providing ANC rising from 77.3% to 96%. Assistance at delivery improved from 71.7% in 2022 to 88.1% in 2024, and facility-based deliveries increased from 70.9% to 86%.
- Women's interaction with health staff regarding FP reveals to give marginal increase to percent women using contraception (56% vs 50%) but hardly any difference in the use of modern methods (34% vs 33).

Family Planning Service Delivery Points:

- Four modern methods (IUDs, oral pills, injectables and condoms) are universally available at facilities of Heath, PWD and private sector while implants and vasectomy services are available at only limited number of Health, PWD and private facilities.
- A large proportion of all facilities report to be well prepared for delivering IUCD services.
- Only a selected few facilities are prepared to provide implants (where supplies are a serious constraint).
- Survey reveals the stocks of various key contraceptives have improved tremendously. PWD facilities consistently show stocks of five contraceptives in all facilities. Overall IUCD stock situation has improved in public sector. As compared to 2023 survey report, Health Dept. facilities show a slight increase in percent facilities that reflect stocks-outs of condoms, oral pills, IUCDs and injectables. The number of days of stock outs of these items from Health facilities also reflect a major increase, which is a concern. Implants are available only in a few private facilities but lack of stocks in some facilities for several months need attention for improved availability to enhance accessibility and continuity of use.
- A review of three month record shows that 81,830 family planning clients were served by 245 public and private facilities during 2024. Thirty percent of these FP clients are served by Dept of Health facilities. There is hardly any change in overall number of FP clients served by all stakeholders – 79,660 in 2022 (by 247 facilities), 82 thousand in 2023 (by 246 facilities), and 81,830 in 2024 (by 245 facilities). The proactive pursuit of FP agenda by Health facilities is yet to seen aspect of enhancing access and availability of contraception to women in Punjab.
- Integration of family planning in maternal health services: All facilities claimed to provide FP counseling and services at each of these maternal health stages. Facility registers reveal a total of 137 thousand MCH visits recorded over the three months in the 245 facilities. Nineteen percent of all ANC maternal health visits are recorded by private facilities for ante-natal care, 16 percent for delivery and 10 percent for post-natal care. In addition, nearly 322 thousand visits are recorded for general ailment health issues during these months. All these visits reflect tremendous potential for FP counseling and PNC patients for post-pregnancy FP.
- Technical knowledge pertaining to disposable syringes, oral pills, IUCDs, and Depo-Provera appears to be lacking among several service providers based on the questions asked. Trend analysis reflects persistent low scores over three surveys in seven areas of enquiry which is worrisome. The low percentage of correct responses across all entities is a serious concern and highlights an urgent need for refresher training for all service providers. Enhancing competencies through refresher training for FP staff across all sectors is essential to improve the quality-of-service delivery.
- To evaluate the technical knowledge of service providers eight specific questions covering various aspects of family planning, contraceptive technology were presented. The Population Department staff rating suggests their enhanced understanding due to focused contraceptive training, while Health Department staff exhibit better pre-service training in maternal health issues, particularly related to miscarriage, postpartum care, and delivery.

- A dedicated segment was incorporated in the survey to assess the pricing charged by different facilities. DOH and PWD facilities uniformly offer FP commodities and services either free of charge or at nominal rates. Private sector facilities charges are recorded as:
    - Provision of injectables on charges, is recorded for an average cost of Rs 284 (2024), which was Rs 220 in 2022 survey. It is noted that though charges have slightly increased but the percent of facilities charging for injectables has also increased over the years.
    - Implants are provided by private facilities are the most costly item, priced at Rs. 4,250 (2024) which was Rs 2,250 in 2022 survey. A large proportion of private facilities (79%) make IUCD available and their charges are on average are Rs. 1,372 which were less than half this price (Rs. 738 per unit) in 2022.
    - The survey indicates oral pills, and condoms, made available by private sector are notably low priced than other commodities. The percent of facilities charging for pills and condoms has also increased over the years.

User's Voices / Clients Exiting Facilities:

- Clients exiting facilities reported that prescribed/ suggested methods by service providers included condoms on top of the list, followed by oral pills, injectables, and IUD.
- More than half of all clients are prescribed same method that they were using prior to their visit. About a quarter are new users most of whom visit rural health facilities.
- Exiting clients reported 65% of private facilities charge for the IUCD, with an average charge of Rs. 988, and 42% charge for the service, with an average charge of Rs. 479. For the Depo-Provera injection charges are made by 65 percentages private facilities, charging Rs 261 for commodity and Rs 232 as service fee. Trend data over two years reflect small changes in commodity prices and service charges.
- Counseling women is an interesting area of the survey. Assessment reveals that DoH staff are not properly and fully advising or counseling women clients as per quality of service needs. Switching methods appears not to be discussed with clients by all service providers.
- Trend of three surveys reflect that four out of five clients acknowledged to have been explained how the method works, three-fourths (> 76 percent) clients were told about the side effects, and also told what to do in case of problems faced by them and slightly lower percent clients were informed regarding when to return to the facility for seeking queries or resupplies
- Trend of exiting clients reveals that more than three-fourth (77%) women were informed about contraceptive methods other than the method given to them, a high percent of women (90-95%) were asked about their 'preference of method', and more than half (55%) were informed that they could switch to another method too
- Large majority of clients exiting facilities acknowledge to three areas including: service providers allowed them questions, responded to their queries, and informed those regarding advantages and disadvantages of various methods to benefit women clients reflect quality of services.

BACKGROUND OF THE SURVEY 1

Punjab is the largest of four provinces of Pakistan in terms of population with 127.7 million persons (Population Census 2023) rising from 110 million (Population Census 2017) at a high growth rate of 2.53 per annum. The population of Punjab is estimated to double in just 27 years, which is an alarming rate that challenges economic growth and development. High population growth not only added pressures on all social services and infrastructure needs like housing, roads, schools and colleges, drinking water and sanitation but seriously affected maternal health in terms of frequent unintended pregnancies and in the absence of easy access to contraception induced abortions are recorded that run in millions. To address the envisioned influences of high population growth rate on socio-economic development, Pakistan committed and emphasized enhancing contraceptive prevalence rates.

Punjab Government, in line with national commitment towards Sustainable Development Goals (SDGs) 2030 and FP2030 has resolved to achieve higher level of contraceptive prevalence through increased investment to enhance coverage and availability of FP, increase number of users and enhance resources to address regional inequities. This was committed under FP2020 Declaration in 2012, Millennium Development Goals (MDGs) 2015, CCI Recommendations 2018, and FP2030 Commitments in 2021. Punjab pledged to achieve CPR 54 percent and 64 percent by 2025 & 2030 by lowering unmet need for contraception by two-thirds by 2030 and raising the total users. Under FP2030 Commitments, government expressed the need of moving forward with functional integration and prioritizing strategies to enhance access and coverage to address growing number of new users besides enhancing resources to overcome regional inequities. Fulfilling these commitments require a comprehensive and detailed plans that translates Population Policies into people centered programs for spread of information, and services that are easily accessible to the people within their communities, especially to rural poor and dwellers of urban slums in an environment of trust and care.

Punjab under FP2030 Commitments pledged to evolve plans to carry forward the strategies: (i) enabling Policy Reforms to achieve the FP Goals for 2025 and 2030; (ii) achieve 'universal access to safe and quality reproductive health care and family planning services; (iii) increase information and services access to the most remote; and (iv) Ensure zero stock outs and secure availability of contraceptive supplies. Lowering fertility rate remains the key goal through provision of family planning services and women focused initiatives on health, education, social development, and legal sectors. Strategies include lowering unmet need for contraception by two-thirds by 2030 and raising the total users. Moving forward with functional integration and prioritizing strategies to enhance access and coverage to address growing number of new users besides enhancing resources to overcome regional inequities.

The stagnation of contraceptive use over a decade in Punjab against the expectation of rise in CPR is serious challenge as it counters the plans and strategies set for lowering growth rate. The

presence of high unmet need for contraception, high unintended pregnancies, high missed opportunities for family planning etc. consistently point towards the need to improve the situation by regular review programme activities. Prior studies of family planning programmes note four areas as critical for achievement of FP goals that are set under FP2030 Commitments: Access, Equity, Quality and Choice, contraceptive security, and coverage. Access to FP information, commodities, and services was highlighted as a basic right for every woman and individual in the community to enable them to exploit their full potential. These areas have challenges and need regular critical assessments to help understand the ways to ensure best practices are implemented. The existing challenges vary from low uptake of family planning, poor quality of services and counselling, stock outs of contraceptives, weak communication of service providers with clients, low knowledge of effective methods reflecting poor choice, poor availability of contraceptives is remote facilities and areas, and large unserved areas.

1.1 Introduction to Performance Monitoring for Action Framework

Performance monitoring is a function that is performed by planners and implementers at different levels of organization including assessment of outcomes, process and efficiency of activities, including quality and knowledge valuation. The current status of family planning in Punjab seeks attention of performance monitoring to help managers evolve strategies for programme improvements. Though the public sector spearheads family planning activities but the scope of performance monitoring is much wider today due to active role of private sector in dispensing FP across the province. For effective family planning decision making, this exercise provides information on outcome indicators (based on user's perspective), facility service data, and client satisfaction information.

The PMA framework is multifaceted as it gathers information at household level; from women in households to assess use of contraceptives; family planning service delivery points serving local women; and women clients exiting facilities after receiving services. The framework allows tracking of users both as a cross-section and as a panel over time to see their behavioural and attitudinal changes, and willingness to use contraception and access facilities, preparedness and availability and choices at facilities, measures taken to address missed opportunities, and to maintain stocks of all needed commodities, and finally assess quality of service using responses of women exiting health facilities. Furthermore, PMA results have an edge over the routine service statistics because of its roots in the beneficiaries and greater reliability towards decision making to address emerging needs besides eliminating exaggerated services statistics by linking field data with users' responses. The uniqueness of PMA is frequent availability of data to see progress and steer programme activities. This Phase of this PMA exercise in Punjab undertaken during 2024 provides a good database to track trend of several key reproductive health indicators. The exercise is a bit different from Pakistan Demographic Health Survey due to its research design and sample selection process, thus results are not comparable.

The framework provides a unique design that links users to FP service delivery points nearest to their community. The survey provides information about women's access to contraceptive

methods in both public and private facilities and how that affects their method choice options. Quality of services has remained central to contraceptive uptake and sustaining CPR. This exercise tries to assess quality of services from users and service provider's perspective but also assesses knowledge about FP among service providers across sectors to relate it to service delivery standards. The survey framework focuses on current users (…their most recent visit), discontinued users for reasons, and women with unmet need, identify access and quality barriers, service accessibility, and service quality and integration (where provided). Ownership of the government of this exercise results is vital to bring necessary improvements and to align with the FP/RH goals. The support by UNFPA to address this critical research gap lays the basis of long-term improvements in the FP enabling environment.

1.2 Objectives of the Study

The aim of the Panel Study is to produce reliable estimates for family planning and reproductive health on a regular basis. The following are the objectives:

1. To generate reliable point estimates of key indicators that provides evidence to family planning programme managers for improvements and track programme performance
2. To analyze contraceptive dynamics and cause factors to identify areas needing attention for remedial initiatives
3. To monitor core indicators over time as a guide and advise on performance monitoring and improve systems to meet FP2030 Commitments including enhancing access and quality services
4. To assess feedback on:
    - Policy Commitments on strategies to lower unmet need for contraception, improve service quality and ensure easy access to family planning services and facilities
    - Service integration at facility level for enabling environment to boost FP and MCH services to address missed opportunities and enhancing modern CPR

1.3 Survey Methodology

Sample Design and Size

The Panel Study focused exercise to collect province level data using a representative sample of households and women in selected clusters. The design involves (i) interviewing a sample of currently married females aged 15 to 49 years in selected households; and (ii) identifying a sample of facilities that provide family planning services including public sector (Health and Population Welfare facilities), and outlets of private sector serving the selected communities/clusters. The currently married female respondents are asked questions about their use and experiences of family planning, reproduction, and fertility preferences.

1.4 Sample Selection

Target Clusters / Areas and Households

This Phase-V of the Punjab Panel Study 2024 household selection used a two-stage cluster design. Sixty-four (52) enumeration areas (EA) were drawn from the Pakistan Maternal Mortality Survey (PMMS) 2019 master sampling frame, of which 29 clusters from rural and 23 clusters from urban areas. Following the general sampling rule laid down by PMA2020, 42 households from urban and 35 from rural are selected. The survey aimed for sample size of 1,981 households. Data collection of this Phase was conducted in September and October 2024.

In this Phase, five (5) health service delivery points (SDPs) were visited that lie within 5 kilometers from each selected EA. These SDPs were obtained from the community that served FP-RH to the selected EAs at all three levels. The SDP sample design is linked to the household survey design, the SDP sample size is determined by two factors: the number of EAs selected for the population-based survey, and the family planning service system in Punjab. The public sector system included facilities of Department of Health (that include District Hospital, Rural Health Centres, Basic Health Units, and MCH Centres), and of Population Welfare Department (Reproductive Health Service Centres and Family Welfare Centres). Three public sector facilities were selected from available with 5 kilo meters from the EA. Two non-public SDPs were selected which are run by non-government organizations (NGOs), private formal health facilities, such as hospitals and clinics, and non-formal health facilities, such as pharmacies and drug shops. The survey aimed for sample of 252 SDPs. Data gathering of SDPs focused on type of FP services, stocks, skills of service providers, quality of service aspects, and knowledge of service providers regarding FP. The SDP survey monitors service availability and quality, understand attributes for the availability and readiness, and explore the association of these SDP results with individual behaviors in the cluster, by linking data from both the SDP and household surveys.

Ten (10) client exit interviews are included for each SDP to cover ample information from users who visited SDPs for family planning and MCH services. The client exit surveys provides data to understand service provision (i.e., the process dimension of quality) and perceived quality among FP and RH service users.

Survey follows three-stage sample selection design:

(i) Random selection of districts from each division of Punjab covering all ecological zones.

(ii) Random selection of 52 enumeration areas (clusters) from all districts (see table 1.1 below); and random selection of households 42 from urban and 35 from rural clusters. The exercise produces province level estimates of key indicators.

Table 1.1: Sample Selection

Divisions	Selected Districts	Total EAs	Urban	Rural
GUJRANWALA	Sialkot	5	2	3
	Gujranwala	6	3	3
LAHORE	Sheikhupura	8	3	5
RAWALPINDI	Rawalpindi	5	2	3
SAHIWAL	Pakpattan	3	1	2
D.G. KHAN	Layyah	3	1	2
	Muzaffargarh	4	2	2
FAISALABAD	Jhang	5	3	2
MULTAN	Khanewal	5	2	3
BAHAWALPUR	Bahawalnagar	4	2	2
SARGODHA	Bhakkar	4	2	2
Total		**52**	**23**	**29**

The survey includes a sample size that allows to calculate province level estimates for all indicators, including computing the modern contraceptive prevalence rate (mCPR) with a margin of error of ±5 percentage points. Sample weights were estimated by the Pakistan Bureau of Statistics (PBS), based on non-response at the cluster, household, and individual level and were applied to the women dataset for analysis.

Table 1.2: Household Coverage and Interviews

Household Coverage	Phase V
Number of households contacted	**1,981**
Number of currently married eligible women interviewed	**2,339**
Number of facilities visited for interview	**247**
Number of client exit interviews held	**2,440**

In this phase, 167 households (8.5%) were replaced for various reasons including: Not found/ migrated - 3.7% or No eligible women in household – 3%, or Refused – 0.8%, and Others – 0.9%. A total of 1814 households were same which were interviewed in the previous survey.

The study selected 1,981 households, of which all were successfully contacted and interviewed. A total of 2,339 eligible women participated in the interviews. On average, 1.2 women were interviewed per selected household.

This report summarizes cross-sectional data collected from selected households of EAs, service delivery points that were reached out in this Phase of the survey, summarizing readiness to provide FP services and reproductive health services, and clients exiting facilities reflecting their experiences and satisfaction regarding services.

HOUSEHOLD CHARACTERISTICS AND BACKGROUND OF RESPONDENTS 2

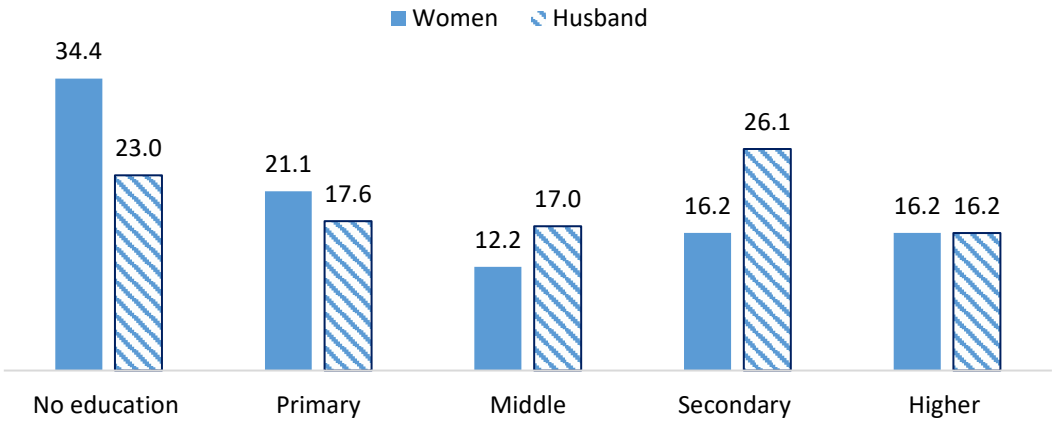
2.1 Profile of the Woman Respondents

The fifth round of the Panel Study, using Performance Monitoring for Action (PMA) in Punjab, is based on a comprehensive household selection process targeting 52 enumeration areas (EAs) across both urban and rural regions. The sample included 23 clusters from urban areas and 29 clusters from rural areas, encompassing a total of 1,981 households. Within these households, a total of 2,378 eligible women were identified, out of which 2,339 women were successfully interviewed, achieving a high response rate.

The survey also highlighted the socioeconomic dynamics of household composition and headship. Female-headed households accounted for 10.2% of the total, reflecting the gender distribution of household leadership in the region. This detailed enumeration provides a robust foundation for analyzing demographic and health indicators in Punjab.

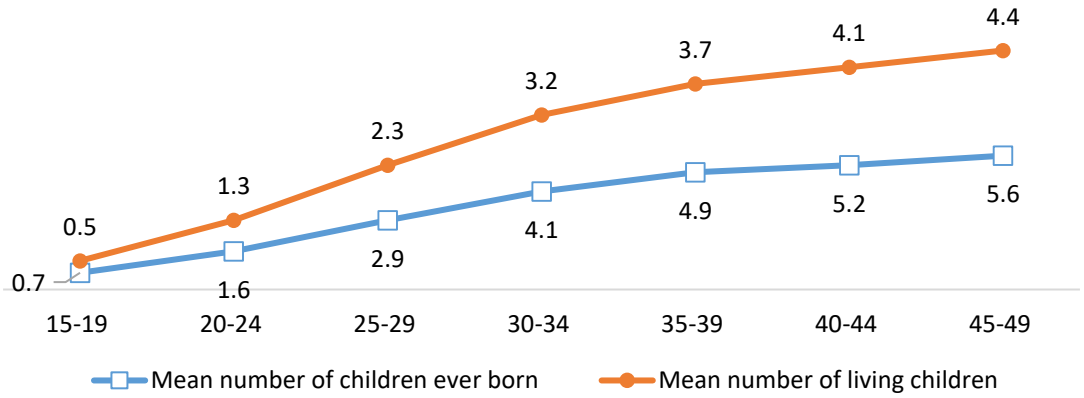
The Figure below highlights the educational attainment levels of currently married women and their husbands (Figure 2.1). A significant proportion of women (34.4%) and husbands (23%) have no formal education, reflecting educational gaps. Primary education is attained by 21.1% of women and 17.6% of husbands, while middle-level education is slightly higher for husbands (17%) compared to women (12.2%). Secondary education shows a notable gap, with 26.1% of husbands and 16.2% of women achieving this level. Interestingly, both women and husbands share equal representation (16.2%) at the higher education level, indicating parity in this category.

Figure 2.1: Percent distribution of currently married women and husband's education attainment



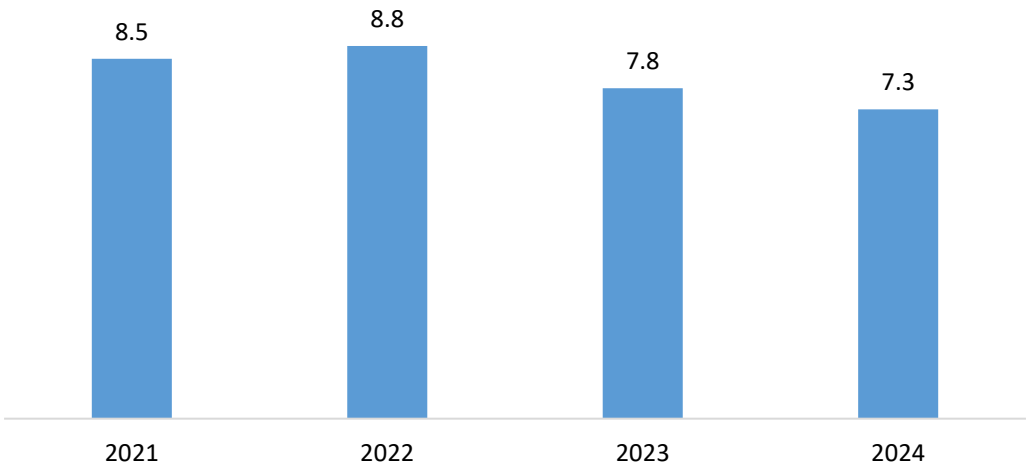
The results show the mean number of children ever born and currently living among married women aged 15-49 (Figure 2.2). Women aged 15-19 have an average of 0.7 children ever born and 0.5 living children, with the numbers progressively increasing with age. For women aged 25-29, the mean number of children ever born is 2.9, while 2.3 children are living. The highest averages are observed in the 45-49 age group, where 5.6 children have ever been born, and 4.4 are living. These figures highlight a trend of increasing childbearing and survival rates as women move through their reproductive years.

Figure 2.2: Percent distribution of women by mean number of children ever born and mean number of living children



The survey reveals a declining trend in the percentage of women reporting current pregnancies over the years. In 2021, 8.5% of women reported being pregnant, which slightly increased to 8.8% in 2022 (Figure 2.3). However, the percentage began to decline in 2023, dropping to 7.8%, and further decreased to 7.3% in 2024. This downward trend may reflect changes in family planning practices.

Figure 2.3: Trend of percentage women reporting currently pregnant

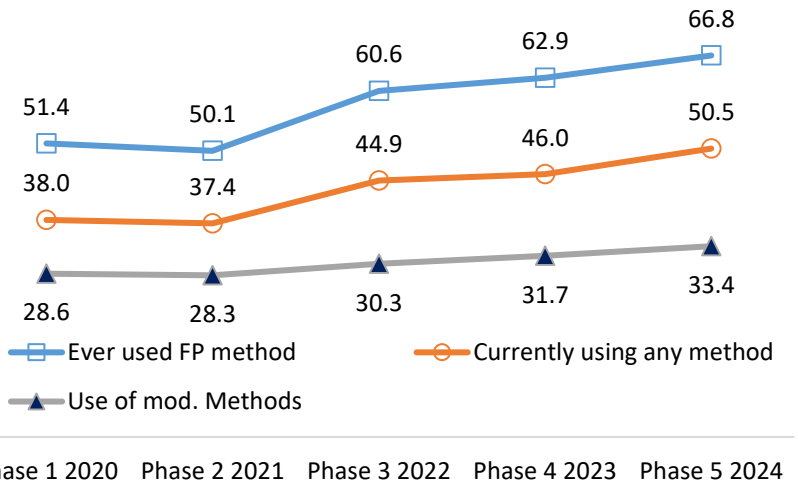


KNOWLEDGE AND CONTRACEPTIVE USE 3

3.1 Family Planning Practices and Contraceptive Prevalence

Contraceptive prevalence rate is the percentage of women who use any family planning method to space or limit births. Over various surveys, a positive trend in contraceptive use is noted across different phases in Punjab. The percentage of women who have ever used a family planning (FP) method increased steadily from 51.4% in Phase I to 66.8% in Phase V (Figure 3.1). Similarly, the proportion of women currently using any method of contraception rose from 38% in Phase I to 50.5% in Phase V. The use of modern methods also showed gradual growth, from 28.6% in Phase I to 33.4% in Phase V. These trends suggest an increasing adoption of family planning practices over time, reflecting improved awareness and accessibility to contraceptive methods.

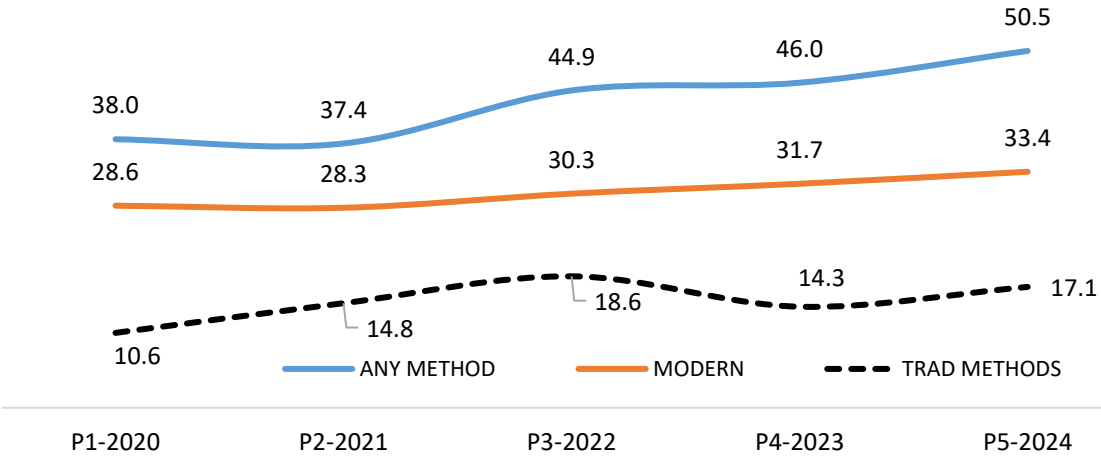
Figure 3.1: Trend of contraceptive use



3.2 Contraceptive Use and Method Choice – Trend Analysis

As per the CCI Recommendations and FP2030 Commitments, Punjab is committed to achieve a CPR of 54 percent by 2025, indicating much yet needs to be done to achieve target. Trend analysis of five surveys reveal contraceptive use among married women show a gradual rise in CPR since 2021 from 37 percent to 51 percent in 2024 (Table 3.2). The use of any contraceptive method increased consistently, rising from 38% in Phase I (2020) to 50.5% in Phase V (2024). Modern methods use also reflect a steady rise, from 28.6% in Phase I to 33.4% in Phase V. However, the use of traditional methods fluctuated, with a peak at 18.6% in Phase III before decreasing slightly to 17.1% in Phase V. The trend suggests a growing preference for modern contraceptive methods over time.

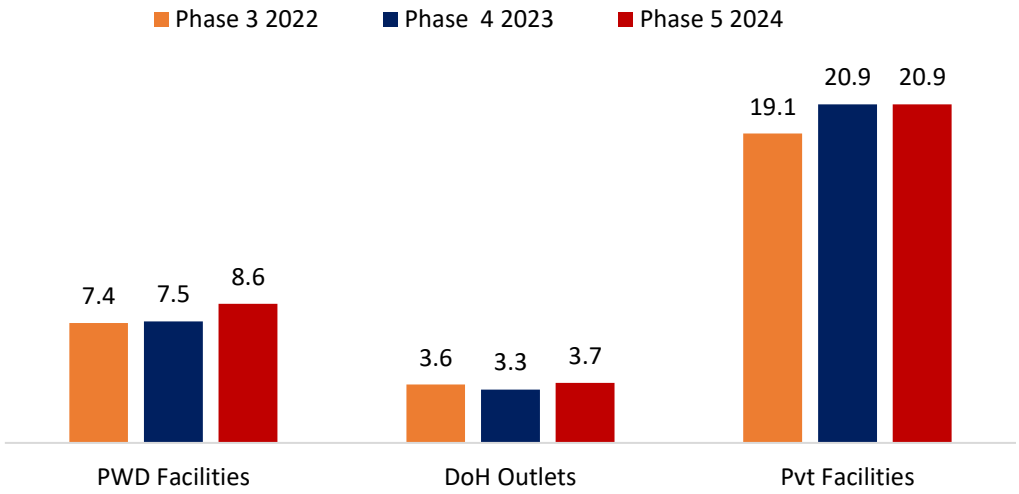
Figure 3.2: Trend of contraceptive use



3.3 Source of Contraceptive Methods

Trend data shows the sources of contraceptive methods used by women in Punjab from 2022 to 2024. The source of modern contraception is predominantly all private sector facilities together serving almost more than 63 percent of women (Figure 3.5) over the years. The use of Population Welfare Department (PWD) facilities has steadily increased, rising from 7.4% in Phase III to 8.6% in Phase V (Figure 3.3). The use of Department of Health (DOH) outlets has remained relatively stable, fluctuating slightly from 3.6% in Phase III to 3.7% in Phase V. Private facilities are consistently the most utilized source, with usage increasing from 19.1% in Phase III to 20.9% in both Phases IV and V.

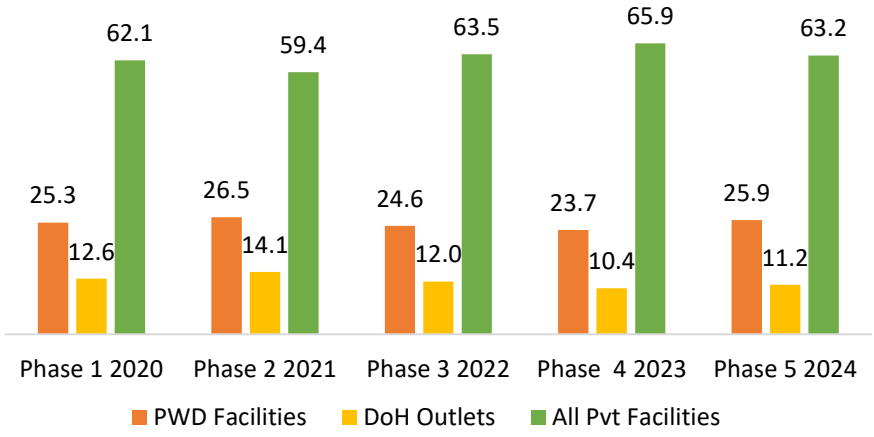
Figure 3.3: Trend of source of current method in use



Comparison of survey results uncover the distribution of sources for contraceptive methods from Phase I to Phase V. The use of Population Welfare Department (PWD) facilities has shown slight variation, starting at 25.3% in Phase I, peaking at 26.5% in Phase II, and stabilizing around 23.7%

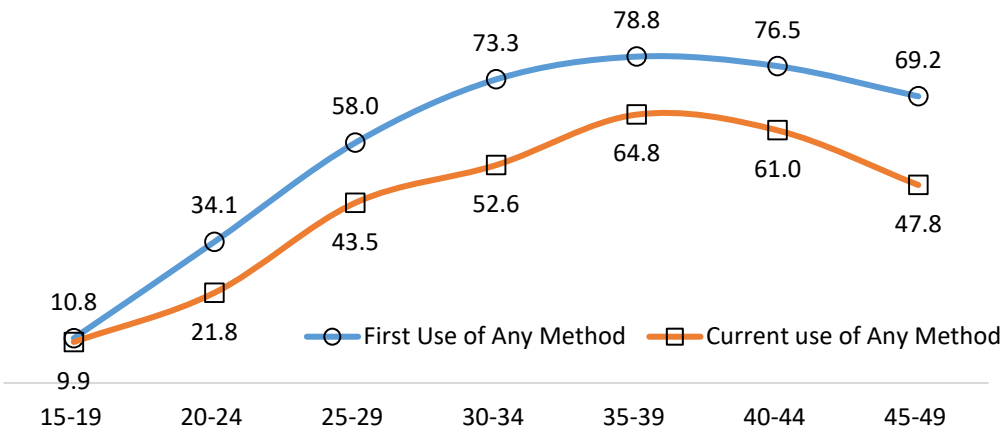
in Phase IV before rising again to 25.9% in Phase V (Figure 3.4). Department of Health (DOH) outlets have experienced a gradual decline, from 12.6% in Phase I to 11.2% in Phase V. In contrast, private facilities have consistently been the most used source, although the percentage has slightly fluctuated, dropping from 62.1% in Phase I to 59.4% in Phase II, before rising to 65.9% in Phase IV and stabilizing at 63.2% in Phase V. Trend indicates a shift towards increased reliance on private facilities over time.

Figure 3.4: Trend of percent distribution of contraceptive methods by source



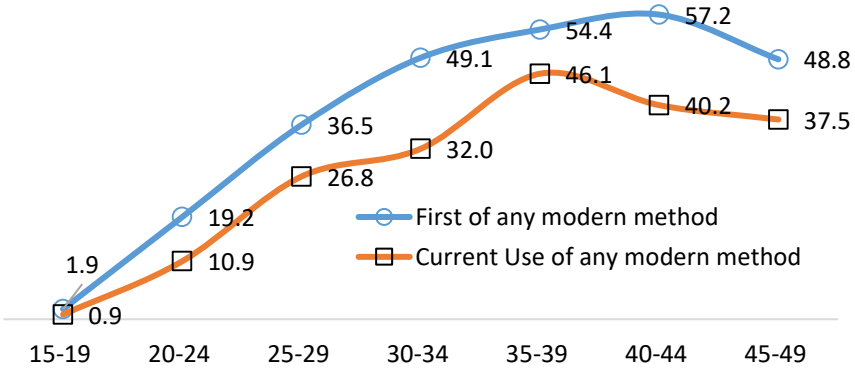
Contraceptive use increases with age, as reflected in the data. Among women aged 15-19, 10.8% have ever used a method, and 9.9% are currently using a method (Figure 3.5). In the 20-24 age group, 34.1% have tried contraception, with 21.8% still using it. By ages 25-29 and 30-34, usage increases significantly, with 58% and 73.3% reporting first use, respectively, and around 43.5% and 52.6% currently using a method. For women aged 35-39, 78.8% have used contraception, with 64.8% still using it. Usage declines slightly in older age groups, with 47.8% of women aged 45-49 currently using a method.

Figure 3.5: First and current use of any contraceptive method by age groups



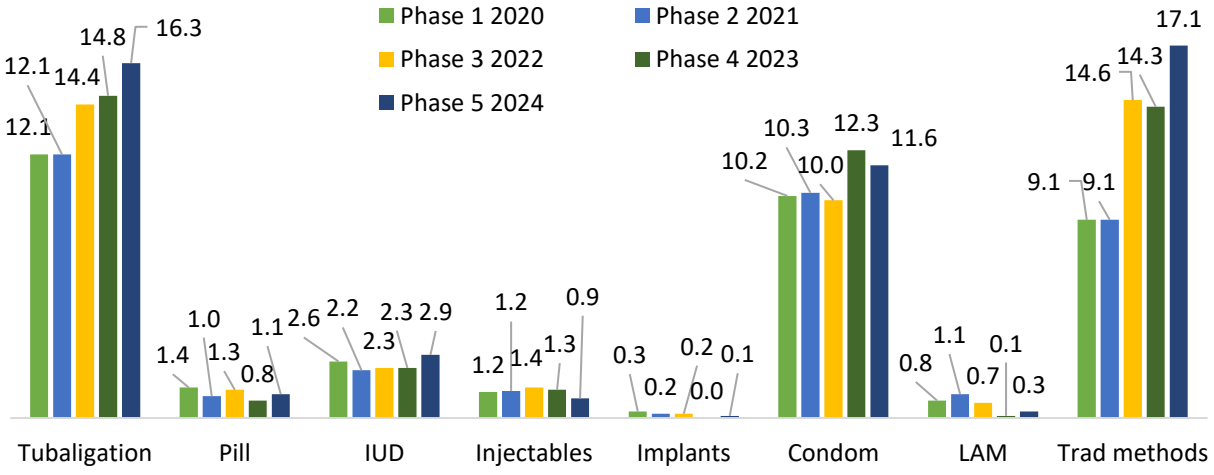
The use of modern contraceptive methods increases with age. Among women aged 15-19, only 1.9% have ever used a modern method, with 0.9% currently using one. In the 20-24 age group, 19.2% have tried modern methods, and 10.9% are currently using them (Figure 3.6). Usage continues to rise for women aged 25-29 and 30-34, with 36.5% and 49.1% reporting first use, respectively, and 26.8% and 32% currently using modern methods. By ages 35-39, 54.4% have used a modern method, and 36.1% are currently using one. In older age groups, first-time use remains high, with 57.2% in the 40-44 range and 48.8% in the 45-49 range, while current use stands at 40.2% and 37.5%, respectively.

Figure 3.6: First and current ue of any modern contraceptive method by age groups



The survey reveals changing patterns of contraceptive use over different phases. The use of Tubal-ligation has steadily increased from 12.1% in Phase I to 16.3% in Phase V (Figure 3.7). The use of pills saw a slight decrease, dropping from 1.4% in Phase I to 1.1% in Phase V, while the use of IUDs remained relatively stable, with a small increase from 2.6% in Phase I to 2.9% in Phase V. Injectables showed a slight decline from 1.2% in Phase I to 0.9% in Phase V. The use of implants has remained minimal, decreasing slightly over time, from 0.3% in Phase I to 0.1% in Phase V. Condom use fluctuated slightly, increasing from 10.2% in Phase I to 12.3% in Phase IV, then

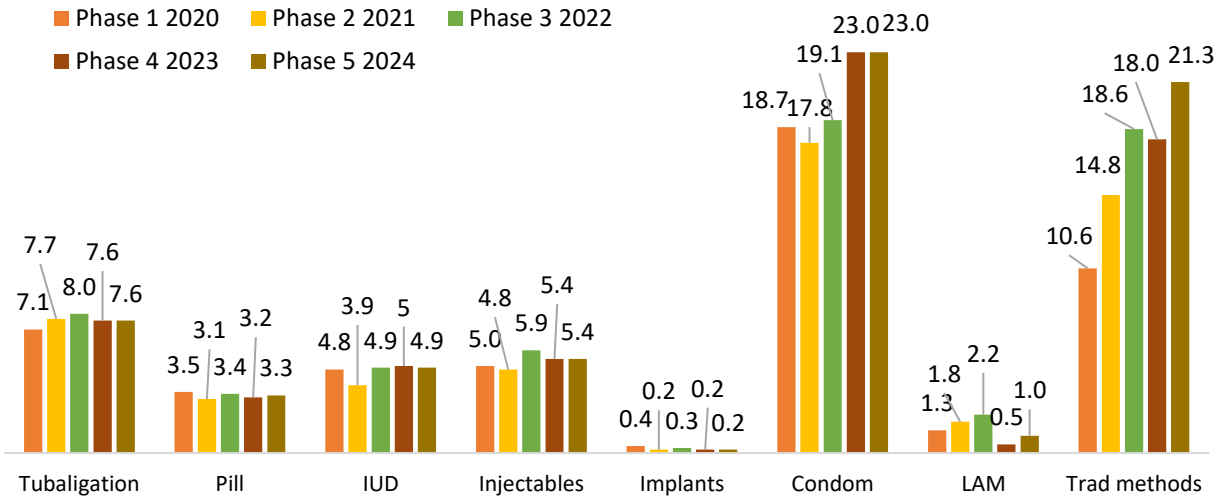
Figure 3.7: Trend of percent women reporting current use of method



slightly declining to 11.6% in Phase V. Lactational Amenorrhea Method (LAM) showed a decrease from 0.8% in Phase I to 0.3% in Phase V. Traditional methods, on the other hand, saw a rapid increase, from 9.1% in Phase I to 17.1% in Phase V, indicating a growing reliance on traditional methods at first use over time.

The results show a trend in the first use of contraceptive methods across different phases. Tubal-ligation has remained relatively stable, with a slight increase from 7.1% in Phase I to 7.7% in Phase II, but staying consistent thereafter (Figure 3.8). The pill's first use decreased slightly from 3.5% in Phase I to 3.3% in Phase V. IUD usage saw slight fluctuations, from 4.8% in Phase I to 4.9% in Phase V. Injectables increased slightly, peaking at 5.9% in Phase III, but remained steady at 5.4% in later phases. Implant use remained minimal, consistently around 0.2%. Condom use showed an upward trend, rising from 18.7% in Phase I to 23% in Phase IV and Phase V. Lactational Amenorrhea Method (LAM) usage peaked at 2.2% in Phase III but decreased to 1% by Phase V. Traditional methods experienced a steady rise, from 10.6% in Phase I to 21.3% in Phase V, indicating an overtime growing preference of non-modern methods for current users.

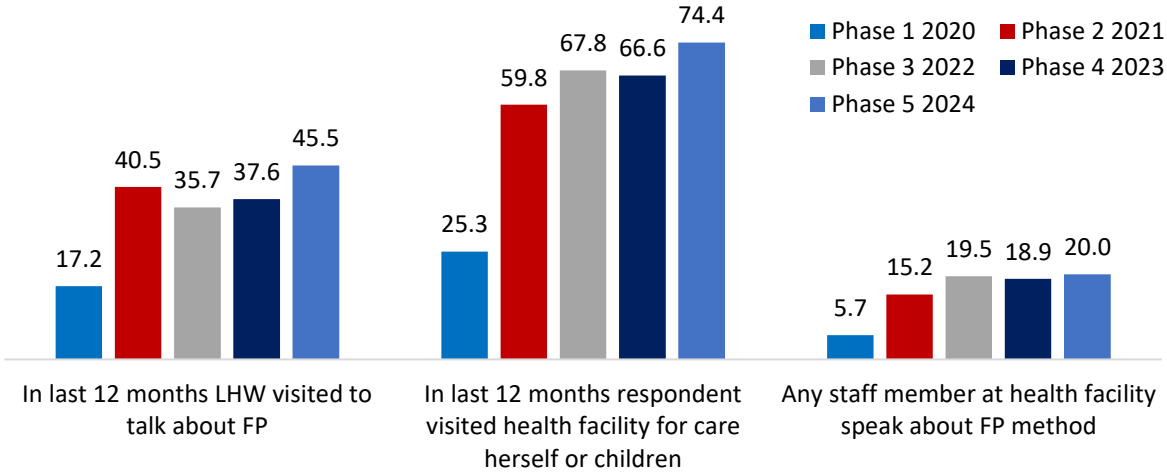
Figure 3.8: Trend of percent of women reported first use of a method - all surveys



3.4 Assessing Performance of Community Based Workers and Facility Based Staff

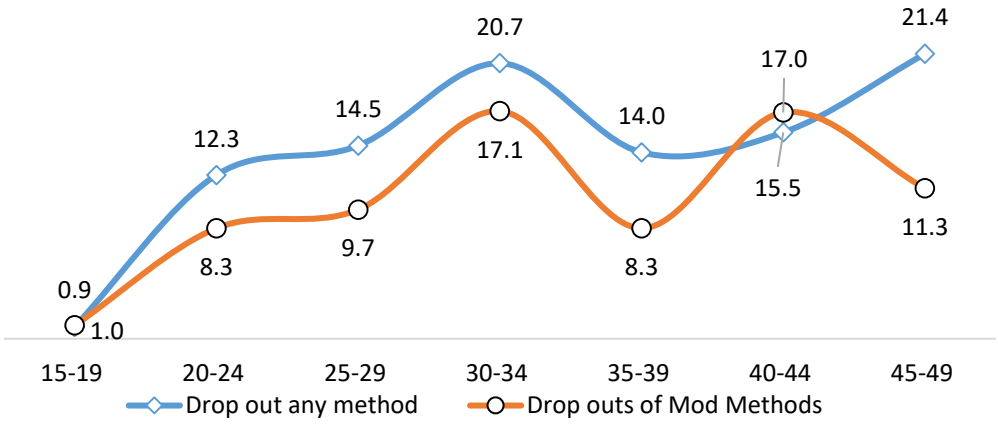
The data shows a significant increase in engagement with family planning and health services over time. The percentage of women who were visited by a Lady Health Worker (LHW) to talk about family planning rose sharply from 17.2% in Phase I to 45.5% in Phase V (Figure 3.9). The proportion of women who visited a health facility for care of themselves or their children also showed a steady increase, from 25.3% in Phase I to 74.4% in Phase V. Furthermore, the percentage of women who were spoken to by a staff member about family planning at health facilities grew from 5.7% in Phase I to 20% in Phase V. This reflect growing access to family planning information and health services over time.

Figure 3.9: Trend of percent currently married women who were visited by LHW or they visited a health facility



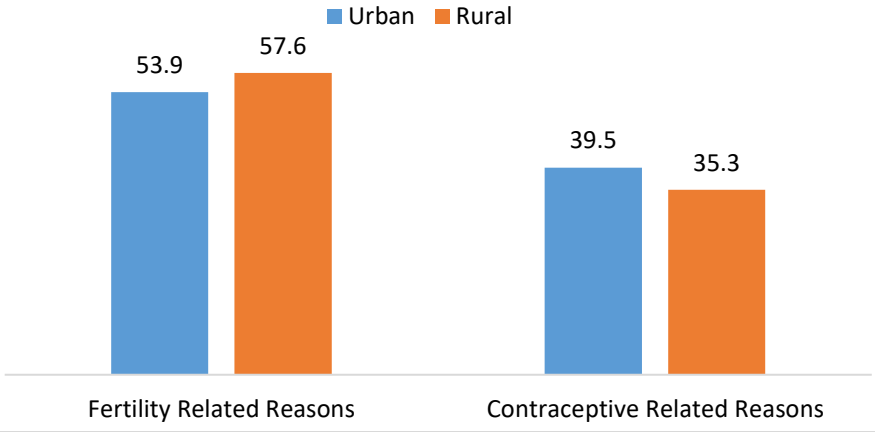
The data shows a varying rate of dropout from contraceptive use across different age groups. Among women aged 15-19, the dropout rate is very low for both any method (0.9%) and modern methods (1%). However, as women age, the dropout rate increases. In the 20-24 age group, 12.3% drop out from any method, and 8.3% from modern methods. The dropout rate continues to rise in the 25-29 and 30-34 age groups, with 14.5% and 20.7% discontinuing any method, respectively, and 9.7% and 17.1% dropping out from modern methods (Figure 3.10). The dropout rate slightly decreases in the 35-39 age group, but increases again in the 40-44 and 45-49 age groups, with 15.5% and 21.4% of women discontinuing any method, and 17% and 11.3% discontinuing modern methods. The trend suggests that contraceptive discontinuation tends to rise with age, especially for modern methods.

Figure 3.10: Percent women who dropped out from any or modern method use by age groups



The reasons for discontinuing contraceptives vary between urban and rural areas. In both areas, fertility-related reasons are the most common, with 53.9% of urban women and 57.6% of rural women citing this as their primary reason for discontinuation (Figure 3.11). Contraceptive-related reasons are the next most frequent, with 39.5% of urban women and 35.3% of rural women reporting them as the cause for stopping use. The results indicate that fertility concerns are the dominant factor for discontinuation in both areas.

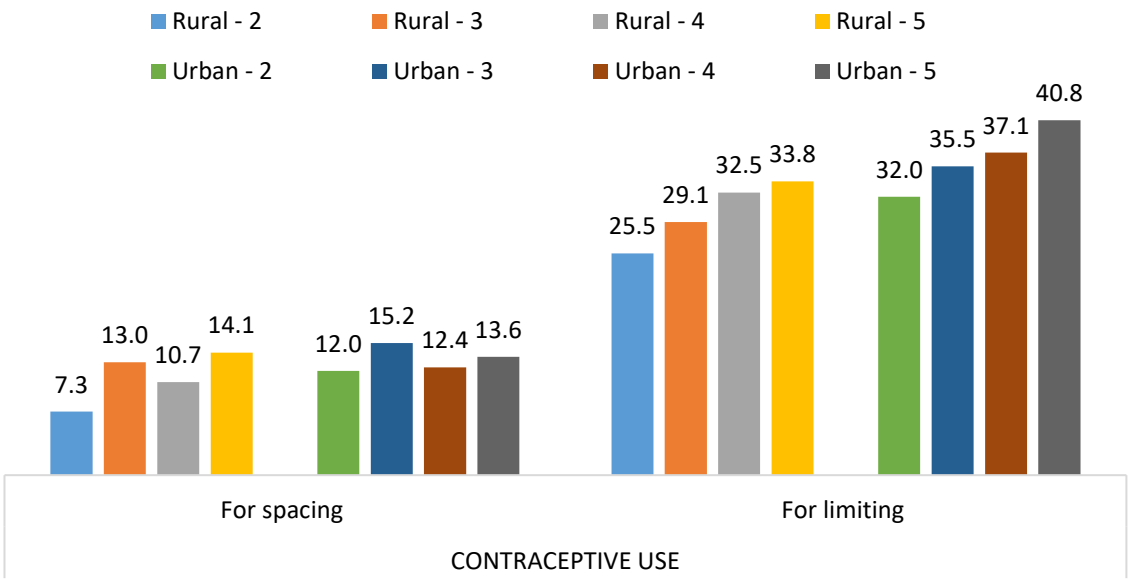
Figure 3.11: Percent distribution of women, who discontinue contraceptives by area of reasons and residence



3.5 Purpose of Contraceptive Use and Unmet Need for Family Planning

Comparison of survey data shows trends in the use of contraceptives for spacing and limiting pregnancies in both urban and rural areas. For spacing, the use of contraceptives increased over time in both areas. In rural areas, it rose from 7.3% in Phase II to 14.1% in Phase V, while urban areas saw a more modest increase from 12% in Phase II to 13.6% in Phase V (Figure 3.12). In terms of limiting pregnancies, rural areas experienced a steady increase, rising from 25.5% in

Figure 3.12: Trend of contraceptive use for spacing and limiting births by urban rural

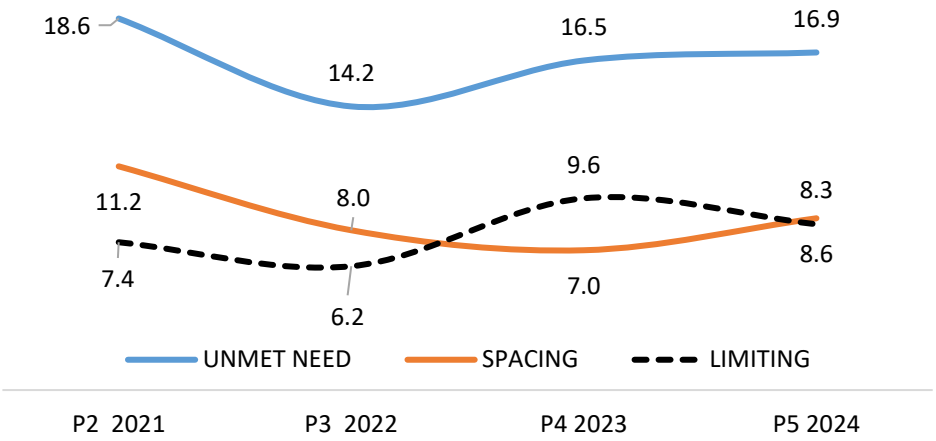


Phase II to 33.8% in Phase V. Urban areas also saw an increase from 32% in Phase II to 40.8% in Phase V. Overall, contraceptive use for limiting pregnancies is higher in urban areas.

Unmet need for family planning is defined as the proportion of women who (1) are not pregnant and not postpartum amenorrhoeic and are considered fecund and want to postpone their next birth for 2 or more years or stop childbearing altogether but are not using a contraceptive method, or (2) have a mistimed or unwanted current pregnancy, or (3) are postpartum amenorrhoeic and their last birth in the last 2 years was mistimed or unwanted/unintended.

The estimates of unmet need for contraception show fluctuations over the years. In Phase II, the overall unmet need was 18.6%, which decreased to 14.2% in Phase III but increased again to 16.5% in Phase IV and slightly further to 16.9% in Phase V (Figure 3.13). When broken down by purpose, unmet need for spacing pregnancies decreased from 11.2% in Phase II to 8.0% in Phase

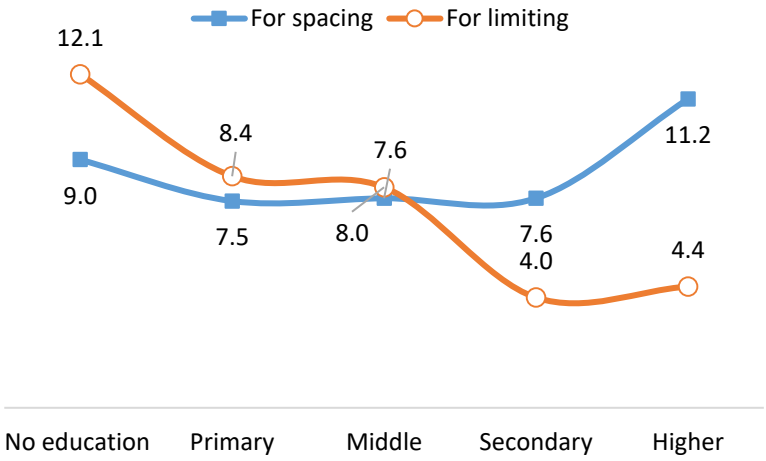
Figure 3.13: Trend of unmet need for contraception



III and 7.0% in Phase IV, but slightly increased to 8.6% in Phase V. Unmet need for limiting pregnancies followed a different trend, dropping from 7.4% in Phase II to 6.2% in Phase III, then rising to 9.6% in Phase IV before declining again to 8.3% in Phase V. Although some fluctuations persist, the trends suggest overall improvements in addressing unmet contraceptive needs particularly for limiting pregnancies.

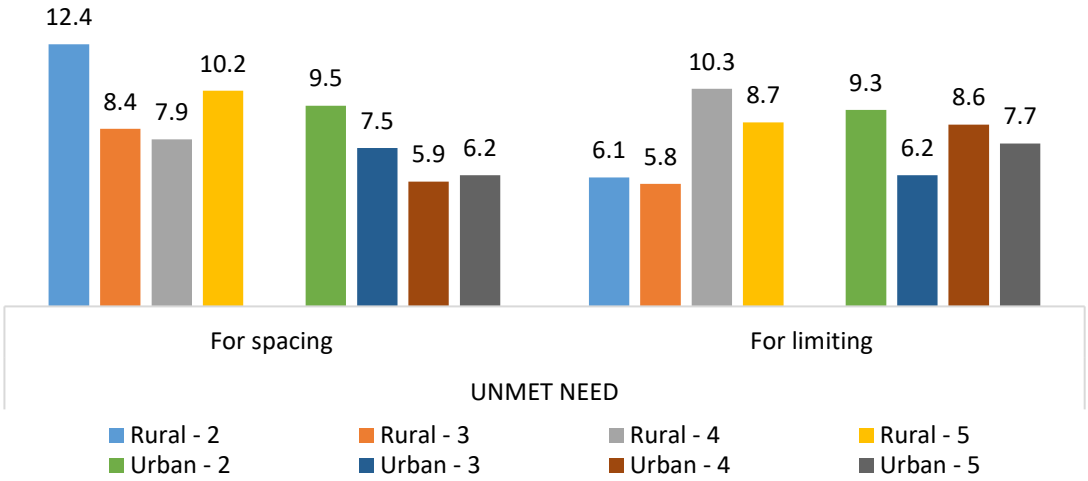
The unmet need for family planning varies with educational attainment. Women with no education have the highest unmet need, with 9% for spacing and 12.1% for limiting pregnancies (Figure 3.14). For those with primary education, the unmet need is slightly lower, at 7.5% for spacing and 8.4% for limiting. Women with secondary education show similar unmet needs, with 7.6% for spacing and 8% for limiting. The unmet need decreases further for women with middle-level education, where it is 7.6% for spacing and 4% for limiting. Interestingly, women with higher education have the highest unmet need for spacing (11.2%) but a relatively low unmet need for limiting pregnancies (4.4%). Result shows that education plays a role in reducing unmet need for contraception, particularly for limiting pregnancies.

Figure 3.14: Percentage of women with unmet need for family planning by educational attainment



The unmet need for contraception, both for spacing and limiting pregnancies, shows distinct trends across urban and rural areas. In rural areas, the unmet need for spacing decreased from 12.4% in Phase II to 7.9% in Phase IV, but increased to 10.2% in Phase V (Figure 3.15). In urban areas, unmet need for spacing steadily decreased from 9.5% in Phase II to 5.9% in Phase IV, with a slight increase to 6.2% in Phase V. For limiting pregnancies, unmet need in rural areas initially decreased from 6.1% in Phase II to 5.8% in Phase III, then increased significantly to 10.3% in Phase IV before decreasing to 8.7% in Phase V. In urban areas, the unmet need for limiting pregnancies decreased from 9.3% in Phase II to 6.2% in Phase III, but then increased to 8.6% in Phase IV and slightly decreased to 7.7% in Phase V. The result opens that, rural areas continue to face higher and more fluctuating levels of unmet need for both spacing and limiting contraception compared to urban areas.

Figure 3.15: Trend of unmet need for contraception by urban rural

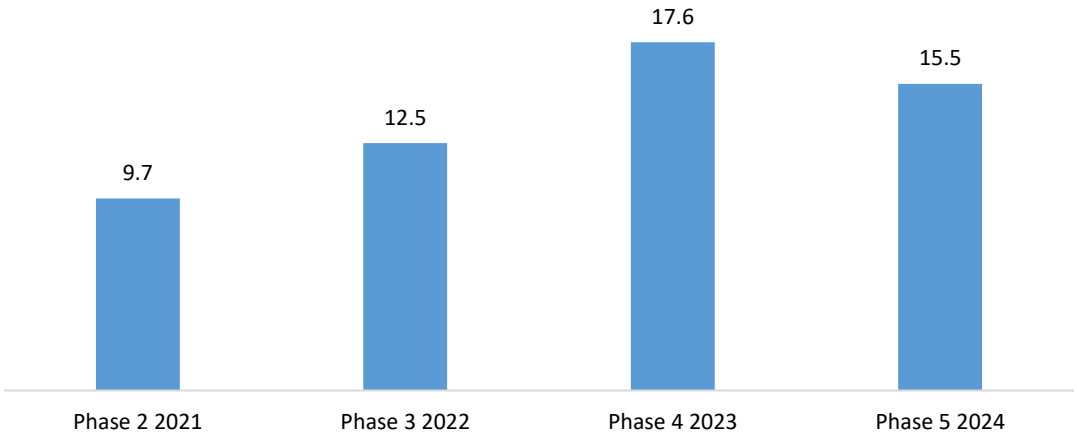


3.6 Trend of Maternal Health Indicators

3.6.1 Unintended Pregnancies

The Survey was keenly interested to seek information on unintended pregnancy and the ages of women at which they experience it. The trend data indicates an increase in the percentage of women reporting unintended pregnancies over their lifetime. In Phase II, 9.7% of women reported such pregnancies, which rose to 12.5% in Phase III (Figure 3.16). The proportion continued to climb, reaching 17.6% in Phase IV. However, in Phase V, the percentage slightly decreased to 15.5%. This suggests a peak in unintended pregnancies in Phase IV, followed by a slight decline in the most recent survey.

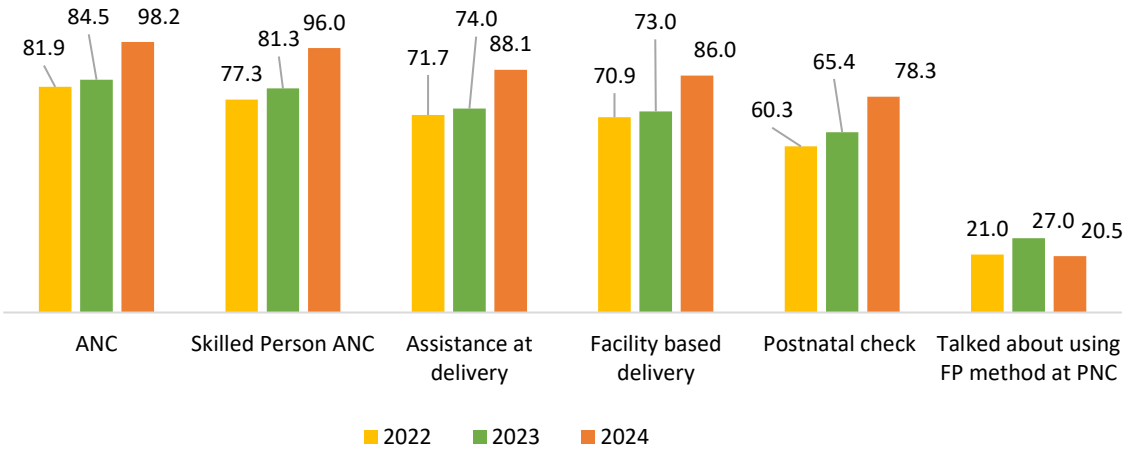
Figure 3.16: Percent women reported experienced unintended pregnancy over lifetime



Over the past three years, there have been significant improvements in key maternal health indicators. Antenatal care (ANC) from a skilled health care provider is important to monitor

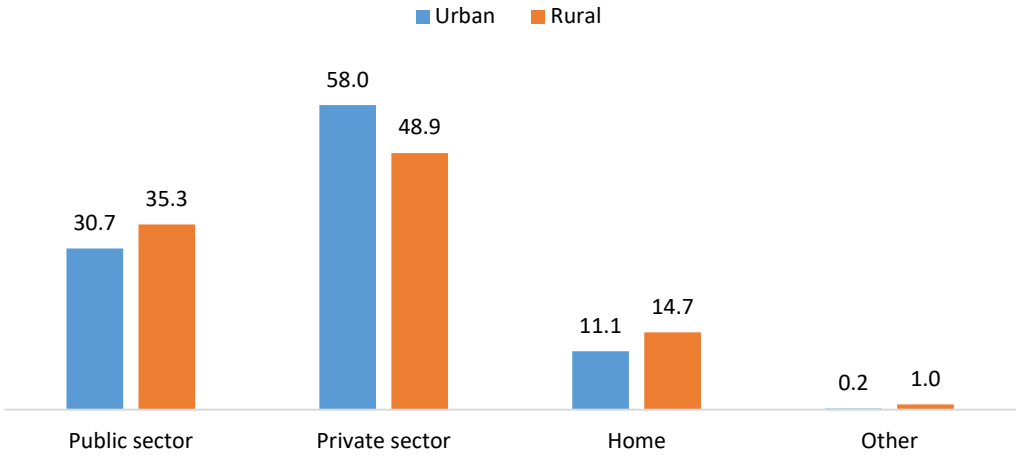
pregnancy and reduce morbidity and mortality risks for the mother and child during pregnancy, at delivery, and during the postnatal period (42 days after delivery). Surveys' findings show a positive increase over the years in all aspects of maternal health enquired. Antenatal care (ANC) coverage increased from 81.9% in 2022 to 98.2% in 2024, with skilled personnel providing ANC rising from 77.3% to 96% (Figure 3.17). Assistance at delivery also improved, from 71.7% in 2022 to 88.1% in 2024, while facility-based deliveries increased from 70.9% to 86%. Postnatal check-ups saw a steady rise from 60.3% in 2022 to 78.3% in 2024. However, the percentage of women who discussed family planning methods during postnatal checks slightly decreased from 27% in 2023 to 20.5% in 2024. Significant progress in maternal health services is observed, though attention is needed to improve family planning counseling at postnatal check-ups.

Figure 3.17: Trend of key maternal health indicators



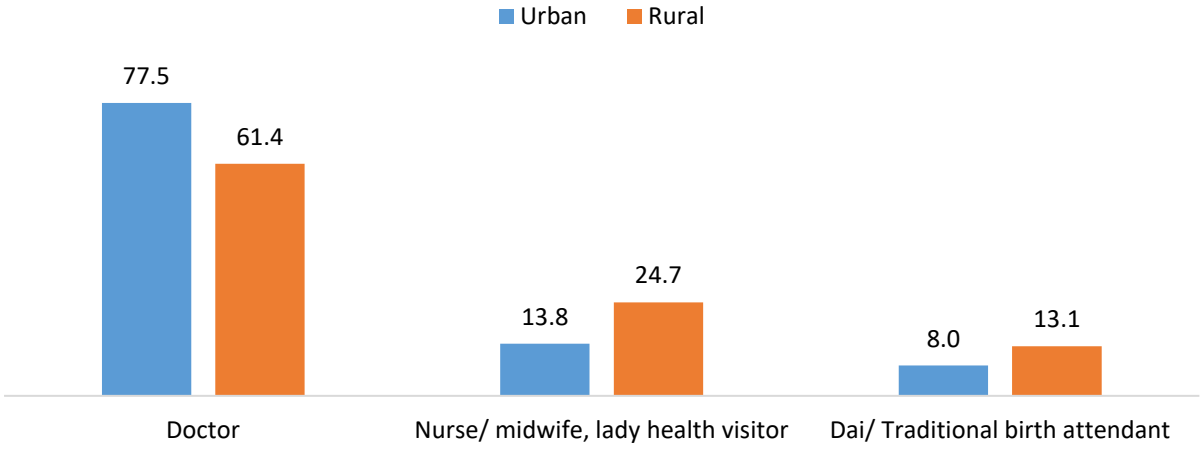
The place of delivery for most recent births varies between urban and rural areas. In urban areas, the majority of births occurred in private sector facilities (58%), followed by public sector facilities (30.7%) and home deliveries (11.1%) (Figure 3.18). In rural areas, a higher percentage of births took place in public sector facilities (35.3%), while private sector births accounted for 48.9%. Home deliveries in rural areas were more common (14.7%) compared to urban areas (11.1%).

Figure 3.18: Percent distribution of most recent births in the 5 years preceding the survey by place of delivery



The assistance during delivery shows distinct differences between urban and rural areas. In urban areas, doctors attended the majority of births (77.5%), while in rural areas, this figure was lower at 61.4 percent (Figure 3.19). Nurses, midwives, and lady health visitors played a more prominent role in rural areas (24.7%) compared to urban areas (13.8%). Traditional birth attendants (Dai) were involved in 13.1% of rural births, but only 8% in urban births.

Figure 3.19: Percent distribution of most recent births in the 5 years preceding the survey by person providing assistance during delivery



MENTAL HEALTH 4

Mental health is a critical aspect of overall well-being, and its importance cannot be overstated, especially for married women in Punjab, where cultural, social, and economic factors often aggravate mental health challenges. Mental health is integral to physical health, emotional stability, and social functioning. Poor mental health can lead to chronic physical conditions, reduced productivity, and impaired relationships. Mental health problems can lead to social isolation, stigma, and discrimination, further worsening the individual's condition. Poor maternal mental health can negatively impact children's development, leading to long-term consequences for future generations.

Married women in Punjab often face societal expectations related to marriage, childbearing, and household responsibilities, which can lead to stress, anxiety, and depression. Many women in Punjab have limited decision-making power, which can contribute to feelings of helplessness and low self-esteem. High rates of domestic violence in the region can lead to trauma, anxiety, and depression among married women. Issues like unintended pregnancies, lack of access to family planning, and postpartum depression can significantly impact mental health. Stigma surrounding mental health prevents many women from seeking help, while limited access to mental health services further compounds the problem.

To assess symptoms of anxiety, the Mental Health Module includes the Generalized Anxiety Disorder 7 scale (GAD-7), a series of seven items designed to measure the main feature of anxiety: persistent and impairing worry. The GAD-7 captures characteristics of three other common anxiety disorders: panic disorder, social anxiety disorder, and posttraumatic stress disorder. Anxiety is a feeling of worry, nervousness, or unease about something with an uncertain outcome. It becomes a mental health disorder when it is excessive, persistent, and interferes with daily functioning. Furthermore, to assess symptoms of depression, the module includes nine items from the Patient Health Questionnaire, or PHQ-9. Stress is often inferred from symptoms like trouble relaxing, feeling nervous, or worrying too much. The questions in the PHQ-9 are based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for diagnosis of depression. Both scales focus on symptoms experienced in the 2 weeks preceding the survey. Severity of symptoms for both tools is depicted using a Likert scale in which scores of 0, 1, 2, and 3 are assigned to the response categories "not at all" (never), "several days" (rarely), "more than half the days" (often), and "nearly every day" (always), respectively. A total score is generated by adding together the scores of individual items. One of the key elements in implementing the Mental Health Module was the effort to use a set of translated questionnaires for the GAD-7 and PHQ-9 in the local languages.

The distribution of responses to each individual item in the GAD-7[1] is given in Table 4.1: (a) feeling nervous, anxious, or on edge; (b) not being able to stop or control worrying; (c) worrying

[1] GAD-7 scores range from a minimum of 0 to a maximum of 21. Higher scores are associated with more severe symptoms of anxiety.

too much about different things; (d) trouble relaxing; (e) being so restless that it is hard to sit still; (f) becoming easily annoyed or irritable; and (g) feeling afraid as if something awful might happen.

Table 4.1: Symptoms of anxiety

Percent distributions of women and men age 15-49 by frequency of symptoms of anxiety in the 2 weeks preceding the survey, according to specific symptoms included in the Generalized Anxiety Disorder 7 (GAD-7) scale, Punjab Longitudinal Panel Study, 2024

Symptom of anxiety	Never	Rarely	Often	Always	Refuse	Don't Know	Total	Number of women
Feeling nervous, anxious or on edge	29.0	46.4	18.7	5.8	0.0	0.0	100.0	2,348
Not being able to stop or control worrying	46.7	34.2	15.9	3.0	0.1	0.1	100.0	2,348
Worrying too much about different things	29.7	38.7	23.6	7.8	0.1	0.1	100.0	2,348
Trouble relaxing	50.6	33.0	13.7	2.5	0.1	0.2	100.0	2,348
Being so restless that it is hard to sit still	64.8	23.6	9.7	1.5	0.2	0.2	100.0	2,348
Becoming easily annoyed or irritable	49.4	31.3	14.3	4.8	0.0	0.1	100.0	2,348
Feeling afraid as if something awful might happen	53.4	31.9	11.3	3.3	0.1	0.1	100.0	2,348

Prevalence of anxiety symptoms: A significant proportion of women reported experiencing anxiety symptoms often or always: (i) "Worrying too much about different things" (31.4% combined often/always); (ii) "Feeling nervous, anxious, or on edge" (24.5% combined often/always); and (iii) "Not being able to stop or control worrying" (18.9% combined often/always). These findings suggest that anxiety is a notable mental health concern among women in this population.

Protective factors: The relatively low prevalence of symptoms like "Being so restless that it is hard to sit still" and "Feeling afraid as if something awful might happen" suggests that some women may have coping mechanisms or social support systems in place. In conservative or patriarchal settings, women may face stressors such as limited autonomy, domestic responsibilities, or gender-based violence, contributing to anxiety. Furthermore, limited access to mental health care may prevent women from seeking help.

4.1 Severity of Symptoms of Anxiety

The percent distribution of women aged 15–49 by their Generalized Anxiety Disorder 7 (GAD-7) scores presented in Table 4.2, gives a measure the severity of anxiety symptoms and it shows the percentage of women with symptoms of anxiety (GAD-7 score ≥6) across various background characteristics.

General observation regarding Anxiety Severity which is reflected by the percentage with Symptoms of Anxiety (GAD-7 ≥6) shows that 42.6% of women interviewed in Punjab have symptoms of anxiety. Women with GAD-7 score distribution of 15–21 (severe anxiety) are 3.5 percent. Little less than half of all women (42.6%) have symptoms of anxiety (GAD-7 ≥6),

indicating a significant mental health burden. The survey data reveals that anxiety is a significant mental health concern among women in Punjab.

Table 4.2: Severity of symptoms of anxiety

Percent distribution of women age 15-49 by their Generalized Anxiety Disorder 7 (GAD-7) score and percentage with symptoms of anxiety, according to background characteristics, Punjab Longitudinal Panel Study, 2024

	GAD-7 Score					
Background characteristic	**0-5**	**6-14**	**15-21**	**Total**	**Percentage with symptoms of anxiety[5]**	**Number of women**
Respondent Age						
15-19	81.3	18.7	0.0	100.0	18.7	36
20-24	75.2	23.0	1.8	100.0	24.8	228
25-29	63.6	33.6	2.8	100.0	36.4	447
30-34	57.0	39.8	3.2	100.0	43.0	485
35-39	50.7	45.2	4.1	100.0	49.3	471
40-44	51.6	43.2	5.2	100.0	48.4	398
45-49	50.2	46.5	3.4	100.0	49.8	282
Number of living children						
0	64.2	32.7	3.1	100.0	35.8	164
1-2	64.4	33.1	2.5	100.0	35.6	670
3-4	54.8	41.9	3.3	100.0	45.2	983
5+	51.3	43.4	5.3	100.0	48.7	531
Region						
Urban	52.5	42.2	5.3	100.0	47.5	947
Rural	60.7	37.0	2.3	100.0	39.3	1,401
Respondent's Education						
No education	52.6	43.3	4.2	100.0	47.4	808
Primary[1]	61.9	35.4	2.7	100.0	38.1	494
Middle[2]	53.5	41.6	4.9	100.0	46.5	286
Secondary[3]	59.9	37.7	2.4	100.0	40.1	381
Higher[4]	62.3	34.6	3.2	100.0	37.7	380
Employment status						
Currently employed	45.1	47.3	7.6	100.0	54.9	447
Not currently employed	60.3	37.2	2.5	100.0	39.7	1,901
Any spousal violence (physical or sexual or emotional) in last 12 months						
Yes	41.1	53.1	5.8	100.0	58.9	632
No	63.2	33.9	2.9	100.0	36.8	1,293
Privacy not obtained/Women not selected	64.1	34.2	1.7	100.0	35.9	422
Any spousal violence (physical or sexual or emotional) ever						
Yes	42.1	52.0	5.9	100.0	57.9	745
No	64.7	32.7	2.6	100.0	35.3	1,181
Privacy not obtained/Women not selected	64.1	34.2	1.7	100.0	35.9	422
Wealth Index						
Lowest	54.7	40.1	5.2	100.0	45.3	448
Second	53.8	42.5	3.7	100.0	46.2	451
Middle	59.6	38.1	2.3	100.0	40.4	480
Fourth	59.6	37.9	2.5	100.0	40.4	490
Highest	58.9	37.2	3.9	100.0	41.1	479
Total	**57.4**	**39.1**	**3.5**	**100.0**	**42.6**	**2,348**

[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] Respondents with a GAD-7 score of 6 or higher

4.2 Patterns by Background Characteristics

Age-Specific pattern: Percentage of women with symptoms of anxiety the highest prevalence is in the 45-49 age group (49.9%) and the lowest prevalence was in the 15–19 age group (18.7%). Older women (35 and above) have higher percentages of mild to moderate anxiety (GAD-7 6–14) while younger women (15-19) have higher percentages of minimal or no anxiety (GAD-7 0–5). Older women (e.g., 30 and above) are more likely to experience anxiety, possibly due to increased responsibilities (e.g., childcare, financial stress).

Number of living children: Women with high parity (5+) have the highest prevalence of anxiety symptoms (55.4%) as against low parity women (with 1–2 children) who have the lowest prevalence of anxiety symptoms (35.8%). Women with three or more children show high prevalence of anxiety, likely due to the physical, emotional, and financial strain of raising a large family.

Education level: Women with no education had the highest prevalence of anxiety symptoms (47.5%) it basically reflects the protective role of education in mental health. Women with middle level education too reflect a high prevalence of anxiety (46.5%).

Employment status: Currently employed women have higher prevalence of anxiety symptoms (54.9%) relative to unemployed women (39.77%). Employed women had higher anxiety rates, possibly due to workplace stress or the dual burden of work and household responsibilities.

Anxiety and spousal violence (Last 12 months): Women who experienced any form of spousal violence in the last 12 months have significantly higher anxiety symptoms (63.9%) compared to those who did not (36.8%). The proportion of women with moderate (GAD-7: 6-14) or severe anxiety (GAD-7: 15-21) is much higher among those who faced violence (53.1% + 5.8%) than those who did not (33.9% + 2.9%. The results suggest a strong association between spousal violence and anxiety symptoms, reinforcing the mental health burden of husband's violence.

Anxiety and spousal violence (Ever experienced): The pattern is similar when considering lifetime exposure to violence. Women who ever experienced spousal violence report anxiety symptoms at a higher rate (57.9%) compared to those who never experienced it (36.3%). The severity of symptoms remains notably higher among those who faced violence, with nearly 52% falling in the moderate anxiety category. The results suggest that even past exposure to violence has long-term mental health consequences.

4.3 Symptoms of Depression

The elements covered in the Patient Health Questionnaire (PHQ-9)2 include: (a) little interest or pleasure in doing things; (b) feeling down, depressed, or hopeless; (c) trouble falling asleep or staying asleep or sleeping too much; (d) feeling tired or having little energy; (e) poor appetite or overeating; (f) feeling bad about yourself or that you are a failure or have let yourself or your family down; (g) trouble concentrating on things such as reading the newspaper or watching television; (h) moving or speaking so slowly that other people could have noticed or the opposite

[2] PHQ-9 scores range from a minimum of 0 to a maximum of 27. Higher scores are associated with more severe symptoms of depression. A PHQ-9 score of 0–4 is considered minimal symptoms or no symptoms, while a score of 5–9 is considered mild, 10–14 is considered moderate, 15–19 is considered moderately severe, and 20–27 is considered severe.

(being so fidgety or restless that you have been moving around a lot more than usual); and (i) thoughts that you would be better off dead or of hurting yourself in some way. The PHQ-9 is a reliable and valid measure of depression severity. The PHQ-9 is a widely used tool to assess depression severity, and the symptoms listed in Table 4.3 are key indicators of depressive disorders. Detailed distribution of each element of PHQ-9 can be seen in Table 4.3.

Table 4.3: Symptoms of depression

Percent distributions of women and men age 15-49 by frequency of symptoms of depression in the 2 weeks preceding the survey, according to specific symptoms included in the Patient Health Questionnaire (PHQ-9), Punjab Longitudinal Panel Study, 2024

Background characteristic	Never	Rarely	Often	Always	Refuse	Don't Know	Total	Number of women
Symptoms of depression								
Little interest or pleasure in doing things	39.6	42.9	15.0	2.5	0.0	0.0	100.0	2,348
Feeling down, depressed or hopeless	40.9	38.1	16.6	4.2	0.1	0.1	100.0	2,348
Trouble falling asleep, staying asleep, or sleeping too much	43.2	36.1	15.9	4.7	0.1	0.1	100.0	2,348
Feeling tired or having little energy	15.9	38.9	30.9	14.3	0.0	0.0	100.0	2,348
Poor appetite or overeating	45.4	38.6	13.3	2.7	0.1	0.0	100.0	2,348
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	88.6	7.7	2.5	0.8	0.3	0.0	100.0	2,348
Trouble concentrating on things, such as reading the newspaper or watching television	67.5	22.2	7.5	1.6	0.5	0.6	100.0	2,348
Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	75.0	19.1	4.2	0.8	0.4	0.4	100.0	2,348
Thoughts that you would be better off dead or of hurting yourself in some way	85.1	9.8	3.6	0.8	0.5	0.2	100.0	2,348

Overall Prevalence of Depression Symptoms: Three elements are noted as most common symptoms. (i) “Feeling tired or having little energy" (30.9% often, 14.3% always); (ii) "Feeling down, depressed, or hopeless" (16.6% often, 4.2% always); and (iii) "Trouble falling asleep, staying asleep, or sleeping too much" (15.9% often, 4.7% always).

High Prevalence of Depression Symptoms: A significant proportion of women reported experiencing depression symptoms often or always: "Feeling tired or having little energy" (45.2% combined often/ always); and "Feeling down, depressed, or hopeless" (20.8% combined often/always); and "Trouble sleeping" (20.6% combined often/always). These findings suggest that depression is a notable mental health concern among women in Punjab.

Following key symptoms are noted based on results: (i) Fatigue and Low Energy is the most commonly reported symptom, indicating that many women may be experiencing physical and emotional exhaustion; (ii) Sleep Disturbances implies trouble sleeping is a significant issue, which

can aggravate other depression symptoms; and (iii) Low Self-Esteem and Suicidal Thoughts are less common, these symptoms are critical to address due to their severe implications.

Table 4.4: Severity of symptoms of depression

Percent distribution of women age 15-49 by their Patient Health Questionnaire (PHQ-9) score and percentage with symptoms of depression, according to background characteristics, Punjab Longitudinal Panel Study, 2024

	PHQ-9 Score							
Background characteristic	**0-4**	**5-9**	**10-14**	**15-19**	**20-27**	**Total**	**Percentage with symptoms of depression[5]**	**Number of women**
Respondent Age								
15-19	60.4	35.2	4.4	0.0	0.0	100.0	4.4	36
20-24	57.6	33.0	8.1	1.3	0.0	100.0	9.4	228
25-29	50.1	37.2	10.8	1.6	0.3	100.0	12.7	447
30-34	44.6	36.3	16.8	2.0	0.4	100.0	19.2	485
35-39	37.9	43.1	14.7	2.6	1.6	100.0	19.0	471
40-44	42.8	36.5	15.2	4.6	1.0	100.0	20.8	398
45-49	37.3	40.5	18.8	2.4	1.0	100.0	22.2	282
Number of living children								
0	48.8	36.9	12.4	1.4	0.5	100.0	14.4	164
1-2	51.1	33.9	11.9	2.4	0.7	100.0	15.0	670
3-4	41.9	40.5	14.6	2.3	0.7	100.0	17.6	983
5+	40.2	39.0	16.8	3.1	1.0	100.0	20.8	531
Region								
Urban	39.6	36.9	19.3	3.3	0.9	100.0	23.5	947
Rural	48.0	38.8	10.7	1.9	0.7	100.0	13.2	1,401
Respondent's Education								
No education	39.8	42.2	15.1	2.3	0.6	100.0	18.0	808
Primary[1]	48.0	36.4	12.8	2.0	0.8	100.0	15.6	494
Middle[2]	39.2	41.0	15.3	4.2	0.2	100.0	19.7	286
Secondary[3]	52.7	30.2	14.2	2.5	0.5	100.0	17.1	381
Higher[4]	46.5	36.8	13.1	2.0	1.5	100.0	16.7	380
Any spousal violence (physical or sexual or emotional) in last 12 months								
Yes	27.0	43.1	22.8	4.9	2.1	100.0	29.9	632
No	51.6	35.3	11.5	1.4	0.2	100.0	13.1	1,293
Privacy not obtained/ Women not selected	49.5	38.8	9.3	1.9	0.5	100.0	11.7	422
Any spousal violence (physical or sexual or emotional) ever								
Yes	27.9	42.6	22.9	4.5	2.0	100.0	29.5	745
No	53.4	34.8	10.4	1.3	0.1	100.0	11.7	1,181
Privacy not obtained/ Women not selected	49.5	38.8	9.3	1.9	0.5	100.0	11.7	422
Employment status								
Currently employed	35.5	36.7	20.4	5.8	1.5	100.0	27.8	447
Not currently employed	46.8	38.3	12.7	1.6	0.6	100.0	14.9	1,901
Wealth Index								
Lowest	43.1	40.4	13.6	2.4	0.6	100.0	16.5	448
Second	43.8	37.6	15.4	2.5	0.7	100.0	18.6	451
Middle	43.1	40.0	14.5	2.2	0.3	100.0	17.0	480
Fourth	46.8	35.5	14.6	3.1	0.0	100.0	17.7	490
Highest	46.0	36.9	12.8	2.1	2.2	100.0	17.0	479
Total	**44.6**	**38.0**	**14.2**	**2.4**	**0.8**	**100.0**	**17.4**	**2,348**

[1] Respondents with a GAD-7 score of 6 or higher [2] Respondents with a PHQ-9 score of 10 or higher

4.4 Patterns by Background Characteristics

Overall depression prevalence: Seventeen percent women (17.4%) in Punjab show symptoms of depression (PHQ-9 score ≥10), while 14.2% experience moderate depression, 2.4% have moderately severe depression, and 0.8% suffer from severe depression. These results indicate that depression is an important mental health issue among women in Punjab, likely exacerbated by social, economic, and gender-based challenges (Table 4.4).

Age-specific pattern: The percentage with Symptoms of Depression show that the highest prevalence is in the age group 45–49 (22.2%) and the lowest prevalence is in the 15–19 age group (4.4%) possibly due to fewer responsibilities or stronger family support.

Number of living children: With respect to this background indicator, analysis shows that women with 5+ children have the highest prevalence of depression symptoms (20.8%) while women with 1–2 children have the lowest prevalence of depression symptoms (14.4%). Women with 5+ children have the highest prevalence of depression, likely due to the physical, emotional, and financial strain of raising a large family.

Education level: Analysis of data from Punjab shows that women with middle education have the highest prevalence of depression symptoms (19.7%) while women with primary show lower prevalence rates (15.6%).

Spousal violence and depression: Women who experienced spousal violence in the last 12 months have significantly higher rates of depression (29.9%) compared to those who did not (13.1%). A quarter of all of abused women (23 percent) have moderate depression (PHQ-9: 10-14), while 4.9% have moderately severe depression (15-19), and 2.1% experience severe depression (20-27). Interesting to note, women with no recent experience of spousal violence report much lower levels of depression, with only 11.5% in the moderate category and 1.4% in the moderately severe category.

Lifetime experience of spousal violence and depression: Around a third of all women (29.5%) who have ever experienced spousal violence show symptoms of depression, compared to only 11.7% of women who have never faced violence. Furthermore, 22.9% of survivors have moderate depression (PHQ-9: 10-14), while 4.5% have moderately severe depression (15-19), and 2.0% suffer from severe depression (20-27). The results confirm that even past experiences of spousal violence contribute to long-term mental health struggles.

The analysis reveals that depression is a significant mental health concern among married women in Punjab, particularly among older women, those with many children, and those with middle education.

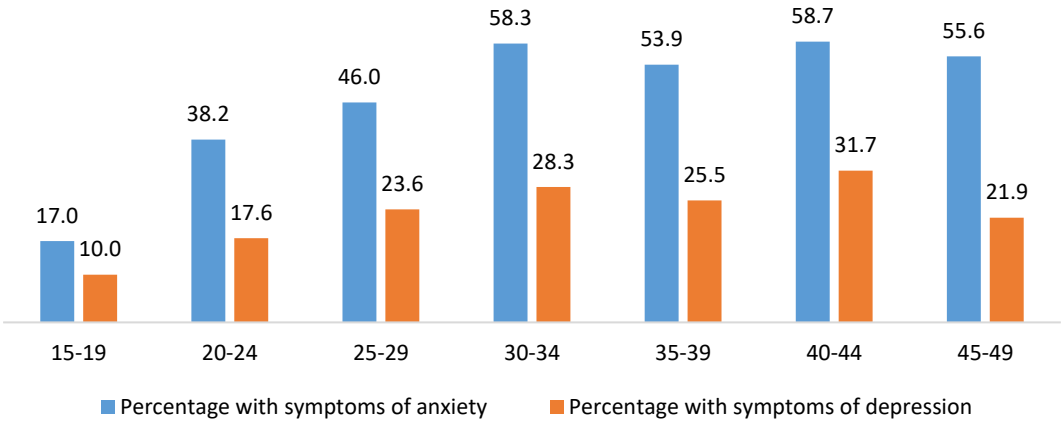
Prevalence of anxiety and depression:

- Anxiety: More than half of women (50.3%) reported symptoms of anxiety, with the highest prevalence in the 30–34 and 40–49 age groups (Figure 1).
- Depression: More than 17 percent of women reported symptoms of depression (with around a quarter or more in each age groups from 25-29 to 40-44), and the highest prevalence in the 40–44 age group.

Lower prevalence of anxiety and depression is reflected among younger women (15–19) while

higher prevalence of anxiety and depression among older Women (30–44). Younger women may benefit from stronger family support systems while some women may develop coping mechanisms over time, explaining the slight decline in depression prevalence in the 45–49 age group.

Figure 4.1: Percentages of women with symptoms of anxiety and depression, according to age groups



4.5 Treatment for Symptoms of Anxiety and Depression

Regardless of their scores on the GAD-7 or PHQ-9, all respondents were asked (a) if a health care provider had ever told them that they had anxiety or depression, (b) if they had taken medicine in the 2 weeks before the survey that was prescribed by a health care provider for anxiety or depression, or (c) if they had received counseling for their mental health condition in the 2 weeks before the survey.

Table 4.5: Treatment for symptoms of anxiety or depression

Percentage of women age 15-49 who have ever been told by a health care provider that they have anxiety or depression, percentage who took medicine prescribed by a health care provider for anxiety or depression in the 2 weeks preceding the survey, according, to background characteristics, Punjab Longitudinal Panel Study, 2024

Background characteristic	Ever told had anxiety	Ever told had depression	Ever told had anxiety or depression	Ever told had anxiety and depression	Took medicine prescribed by a health care provider for anxiety or depression in past 2 weeks	Number of women
Respondent Age						
15-19	0.0	0.0	0.0	0.0	0.0	36
20-24	4.5	3.5	5.3	2.7	3.9	228
25-29	5.7	4.8	7.3	3.2	2.1	447
30-34	6.3	5.7	7.8	4.2	3.2	485
35-39	7.5	8.5	10.1	5.9	4.8	471
40-44	9.5	11.0	12.3	8.3	8.3	398
45-49	14.5	10.9	15.7	9.7	12.3	282
Number of living children						
0	7.3	6.1	8.9	4.4	2.0	164
1-2	6.8	6.1	8.3	4.5	4.4	670
3-4	7.9	7.4	9.3	6.0	4.9	983
5+	8.5	9.2	11.5	6.2	8.1	531
Region						
Urban	9.2	9.0	11.4	6.8	6.0	947
Rural	6.7	6.2	8.2	4.6	4.8	1,401
Respondent's Education						
No education	4.4	4.4	5.5	3.4	4.6	808
Primary[1]	8.2	8.4	9.7	6.8	5.7	494
Middle[2]	11.7	10.3	13.2	8.8	9.2	286
Secondary[3]	7.8	8.7	11.1	5.4	4.0	381
Higher[4]	10.9	8.5	13.5	5.9	4.4	380
GAD-7 Score						
0-5	1.9	1.2	2.4	0.6	1.6	1,348
6+	15.5	15.6	19.1	12.1	10.2	1,000
PHQ-9 Score						
0-9	4.5	4.0	6.0	2.6	3.4	1,940
10+	22.8	23.0	26.5	19.3	14.2	408
Any spousal violence (physical or sexual or emotional) in last 12 months						
Yes	12.0	10.5	13.4	9.0	6.8	632
No	6.2	6.2	8.0	4.3	5.2	1,293
Privacy not obtained/Women not selected	5.9	6.0	8.2	3.8	3.3	422
Any spousal violence (physical or sexual or emotional) ever						
Yes	11.8	10.7	13.6	8.9	7.2	745
No	5.8	5.7	7.4	4.0	4.8	1,181
Privacy not obtained/Women not selected	5.9	6.0	8.2	3.8	3.3	422
Employment status						
Currently employed	7.4	7.4	9.3	5.4	5.3	447
Not currently employed	7.8	7.3	9.6	5.5	5.3	1,901
Wealth Index						
Lowest	2.4	2.5	2.7	2.2	3.1	448
Second	6.1	7.1	8.1	5.1	6.1	451
Middle	8.9	9.6	11.5	7.0	5.5	480
Fourth	8.3	7.2	10.2	5.3	6.4	490
Highest	12.3	9.8	14.6	7.6	5.2	479
Total	**7.7**	**7.3**	**9.5**	**5.5**	**5.3**	**2,348**

[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

4.6 Patterns by Background Characteristics

Age-specific pattern: Close to 8 percent of women age 15–49 were ever told by a health care provider that they had anxiety, while 7% of women were ever told by a health care provider that they had depression (Table 4.5). Close to 5 percent of women reported taking medicine prescribed by a health care provider for depression or anxiety in the past 2 weeks. The results indicate significant gaps in diagnosis and treatment.
Number of living children: Women with 5+ children are more likely to take prescribed medicine (8.1%) compared to those with fewer children.

Education level: Women with middle education are more likely to take prescribed medicine (9.2%) compared to those with higher education (4.4%), possibly due to greater reliance on healthcare providers.

Severity of symptoms of anxiety (GAD-7 Score): Women with higher anxiety scores (6+) were more likely to be told they had anxiety (15.5%) and to take prescribed medicine (10.2%). Regarding severity of Depression, (PHQ-9 Score), women with higher depression scores (10+) were more likely to be told they had depression (22.8%) and to take prescribed medicine (14.2%). Women with higher anxiety or depression scores are more likely to be diagnosed and treated, indicating that severe symptoms may drive healthcare utilization.

- Women with symptoms of anxiety (GAD-7 score 6+) or depression (PHQ-9 score 10+) are far more likely to be diagnosed with mental health conditions.
- 19% of those with anxiety symptoms were told they had anxiety or depression, while 12% of those with depression symptoms were told they had anxiety or depression. However, even among symptomatic women, a significant proportion remains undiagnosed.
- Medication usage is lower than diagnosis rates. Only 14% of women with anxiety symptoms and 10% of women with depression symptoms took prescribed medication in the past two weeks. This suggests treatment gaps, potential barriers to accessing medication, or discontinuation of treatment.

Spousal violence and mental health treatment - Women who have experienced spousal violence (physical, sexual, or emotional) are more likely to be diagnosed with anxiety or depression. More than 13 percent women who have experienced spousal violence were told they had anxiety or depression, compared to 8% of women who did not experience. However, only 7% of abused women took medication, despite twice as many having been diagnosed.

4.7 Care Seeking for Symptoms of Anxiety and Depression

Respondents who said that they had experienced any symptoms of anxiety or depression during the 2 weeks before the survey, regardless of frequency (i.e., respondents with a score of 1 or higher on either the GAD-7 or PHQ-9), were asked if they had ever sought help and the type of provider from whom they sought help.

Close to 22 percent of women who experienced any symptoms of anxiety or depression in the 2 weeks preceding the survey sought help (Table 4.6). Among those who sought help, almost 36 percent of women sought help from a health care provider while 63% sought help from other sources (e.g., traditional healers, religious leaders, family members). The results indicate existence of barriers to accessing mental health care.

Table 4.6: Care seeking and providers

Among women with any symptoms of anxiety or depression in the 2 weeks preceding the survey, percentage who have ever sought help, and among those who sought help, type of provider from whom the help was sought, according to, background characteristics, Punjab Longitudinal Panel Study, 2024

	Among women with any symptoms of anxiety or depression in the 2 weeks preceding the survey[5]		Among those who sought help by type of provider		
Background characteristic	**Ever sought help**	**Number of women**	**Health care provider**	**Other[6]**	**Number of women**
Respondent Age					
15-19	2.4	26	0.0	100.0	1
20-24	17.6	197	44.6	55.4	35
25-29	16.3	398	27.4	72.6	65
30-34	22.8	438	24.9	75.1	100
35-39	22.3	435	36.6	63.4	97
40-44	25.8	372	39.9	60.1	96
45-49	27.7	266	51.5	48.5	74
Number of living children					
0	18.8	143	38.2	61.8	27
1-2	20.5	599	33.0	67.0	123
3-4	23.3	887	32.7	67.3	207
5+	22.0	503	46.8	53.2	111
Region					
Urban	29.1	865	34.5	65.5	252
Rural	17.0	1,268	38.6	61.4	216
Respondent's Education					
No education	14.0	740	34.5	65.5	104
Primary[1]	20.5	464	35.2	64.8	95
Middle[2]	30.8	255	46.9	53.1	78
Secondary[3]	26.4	334	39.7	60.3	88
Higher[4]	30.0	339	28.5	71.5	102
GAD-7 Score					
0-5	12.9	1,132	30.9	69.1	145
6+	32.2	1,000	38.9	61.1	322
PHQ-9 Score					
0-9	17.1	1,725	32.3	67.7	295
10+	42.1	408	43.5	56.5	172
Any spousal violence (physical or sexual or emotional) in last 12 months					
Yes	23.4	627	35.7	64.3	147
No	22.9	1,140	34.0	66.0	261
Privacy not obtained/Women not selected	16.3	365	48.5	51.5	60
Any spousal violence (physical or sexual or emotional) ever					
Yes	23.8	737	37.4	62.6	175
No	22.6	1,030	32.5	67.5	232
Privacy not obtained/Women not selected	16.3	365	48.5	51.5	60
Employment status					
Currently employed	24.8	414	33.7	66.3	103
Not currently employed	21.2	1,718	37.2	62.8	365
Wealth Index					
Lowest	13.6	419	18.0	82.0	57
Second	19.2	411	41.3	58.7	79
Middle	20.8	440	41.5	58.5	92
Fourth	23.1	431	38.2	61.8	100
Highest	32.4	431	36.6	63.4	140
Total	**21.9**	**2,132**	**36.4**	**63.6**	**467**

[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] Includes respondents who said that they experienced any symptom of anxiety or depression during the 2 weeks before the survey, regardless of frequency (i.e., respondents with a score of 1 or higher on either the GAD-7 or PHQ-9)

[6] It includes social service organization, social worker, community health worker/fieldworker, religious leader, current/former spouse/partner, other family member, friend, neighbor, and Other

4.8 Patterns by Background Characteristics

Age-specific trends: The highest percentage of women who ever seek help are in the 45–49 age group (28%) while the lowest percentage are in the 15–19 age group (19.6%). Younger women (e.g., 20-24) are more likely to use healthcare providers, possibly due to better access to education

or healthcare services while older women (45–49) are more likely to seek help (52%), possibly due to greater awareness of mental health issues or accumulated stressors.

Type of provider: Younger and middle aged women (e.g., 20-44) are more likely to seek help from other providers (75 – 60 %) while older women (e.g., 45–49) are more likely to seek help from healthcare providers (52%).

Number of living children: Women with 3 or more children are more likely to seek help (36.2%) compared to those with fewer children.

Education level: Women with middle or those with higher education are more likely to seek help (30.8%), while those with no education are least likely (14%) to do so. Women with middle education are more likely to seek help from healthcare providers (47%) compared to those with higher education (28.5%). Women with middle education were more likely to seek help from healthcare provider, possibly due to better awareness compared to those with higher education.

Employment status and help-seeking behavior - Employed women are more likely to seek help (25%) than unemployed women (21%). Employed women are less likely to seek help from a healthcare provider (34%). Instead, 66% of employed women rely on informal sources of support.

Severity of symptoms: Women with higher anxiety GAD-7 scores (6+) are more likely to seek help (32%) compared to those with lower scores (13%). Women with higher depression PHQ-9 scores (10+) are more likely to seek help (42%) indicating that severe symptoms may drive help-seeking behavior as compared to those with lower scores (17%).

Help-seeking by anxiety and depression scores - Women with higher anxiety or depression symptoms are much more likely to seek help than those with minimal symptoms. Only 17% of women with mild anxiety sought help, compared to 42% of those with moderate to severe anxiety. Similarly, help-seeking jumps from 13% (minimal depression) to 32% (moderate to severe depression).

Among those who sought help, two-thirds consulted a non-healthcare provider. Women with severe depression (39%) sought help from a healthcare provider, while the rest relied on non-medical sources (family, religious leaders, social workers, etc.). For women with mild symptoms, reliance on informal support systems is lower (only 31% consulted a healthcare provider).

Impact of spousal violence on help-seeking - Women who have experienced spousal violence (physical, sexual, or emotional) are relatively more likely to seek help. Nearly a quarter of all women who experienced spousal violence in the last 12 months (23%) sought help, compared to only 22% of those who had not. However, 36% of women who experienced spousal violence sought help consulted a healthcare provider, meaning most still rely on informal support systems.

Women who experienced spousal violence seek help more frequently, many rely on non-medical sources such as family, religious leaders, or community support. This highlights the need for better integration of mental health services within GBV response programs to ensure that survivors receive professional psychological care.

DOMESTIC VIOLENCE 5

Gender-based violence, particularly against women, is acknowledged worldwide as a violation of basic human rights. The United Nations defines gender-based violence as any act of violence that results in physical, sexual, or psychological harm or suffering to women, girls, men, and boys, as well as threats of such acts, coercion, or the arbitrary deprivation of liberty. There is substantial research that has determined the serious health burden and demographic consequences of domestic violence (United Nations 2006)[3]. This chapter focuses on spousal violence, a widely prevalent form of gender based domestic violence.

The provincial assembly of Punjab enacted the Punjab Protection of Women against Violence Act 2016 to guarantee gender equality; this legislation included special provisions for protection of women against violence and domestic violence. It also promulgated a protection system for women victims to promote effective service delivery and create a conducive environment to encourage and facilitate women to fulfil their societal role. Similar pieces of legislation have been implemented in Sindh and Khyber Pakhtunkhwa. In total, 1926 women in Punjab, were successfully interviewed with the domestic violence module.

5.1 Measurement of Violence

In the 2024 PMA Punjab, information was obtained from currently-married women on their experience of violence committed by their current husbands. More specifically, violence committed by the current husband was measured by asking all women if their husbands ever did the following to them:

Spousal physical violence: push you, shake you, or throw something at you; slap you; twist your arm or pull your hair; punch you with his fist or with something that could hurt you; kick you, drag you, or beat you up; try to choke you or burn you on purpose; or threaten or attack you with a knife, gun, or any other weapon

Spousal sexual violence: physically force you to have sexual intercourse with him even when you did not want to, physically force you to perform any other sexual acts you did not want to, or force you with threats or in any other way to perform sexual acts you did not want to

Spousal emotional violence: say or do something to humiliate you in front of others, threaten to hurt or harm you or someone close to you, or insult you or make you feel bad about yourself

In addition, information was obtained about physical violence committed by anyone during pregnancy. Also, information was gathered on experiences of physical violence committed by women on their husbands when they were not hurting; kicking, dragging, or beating them up.

[3] United Nations. 2006. *Secretary-General's In-depth Study on All Forms of Violence against Women*. New York, USA: United Nations.

5.2 Ethical Considerations in the PMA 2024

Recognizing the challenges in collecting data on violence, the interviewers in the survey were given special training. The training focused on how to ask sensitive questions, ensure privacy, and build rapport between interviewer and respondent. Rapport with the interviewer, confidentiality, and privacy are all keys to building respondents' confidence so that they can safely share their experiences with the interviewer. Also, placement of the violence questions at the end of the questionnaire provided time for the interviewer to develop a certain degree of intimacy that should have further encouraged respondents to share their experiences of violence, if any. In addition, the following protections were built into the survey in keeping with the World Health Organization's ethical and safety recommendations for research on domestic violence (WHO, 2001)[4]:

1. Only one woman per household was administered the questions on violence to maintain confidentiality. In the selected household one female respondent was randomly selected to be administered the questions on domestic violence. The random selection of one woman was done through a simple selection procedure based on the Kish grid, which was built into the Household Questionnaire (Kish, 1965)[5].

2. As a means of obtaining additional consent beyond the initial consent provided at the start of the interview, the respondent was informed that the questions could be sensitive and was reassured regarding the confidentiality of her responses.

3. The violence module was implemented only if privacy could be obtained. The interviewers were instructed to skip the module, thank the respondent, and end the interview if they could not maintain privacy.

5.3 Spousal Physical Violence

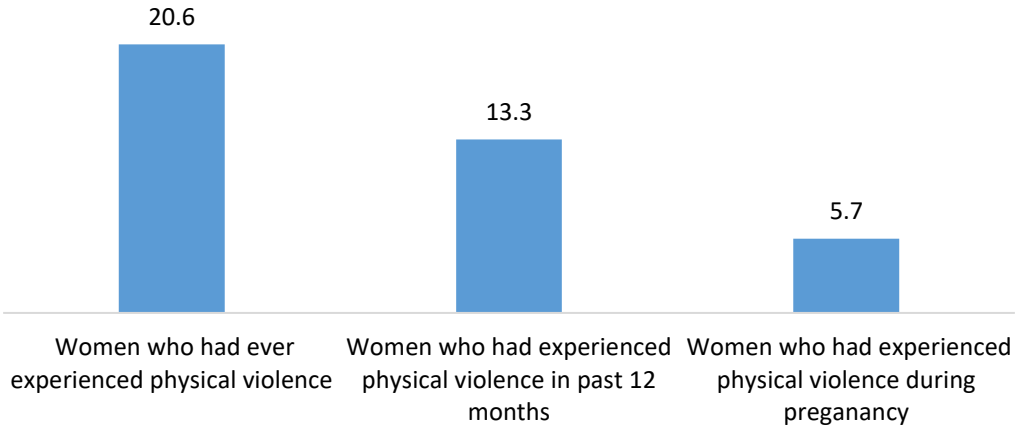
This section presents data on the experience of physical violence among currently married women of reproductive age. The percentage of women who have experienced any Spousal physical violence during their lifetime and in the 12 months preceding the survey is discussed by background characteristics of women i.e. age, number of living children, place of residence, women's and husband's education, employment and wealth status.

Spousal physical violence is experienced by 20.6 percent of women and by 13.3 percent women in the twelve months preceding the survey. Spousal physical violence during pregnancy, is reported by 5.7 percent women-Figure 5.1.

[4] World Health Organization (WHO). 2001. *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women*. Geneva, Switzerland: Department of Gender and Women's Health, Family and Community Health, WHO.

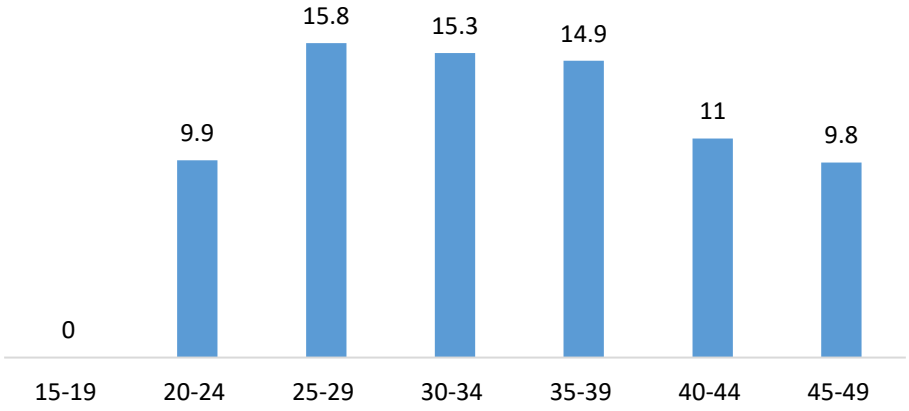
[5] Kish, L. 1965. *Survey sampling.* New York: John Wiley and Sons Inc.

Figure 5.1: Women's experience of spousal physical violence



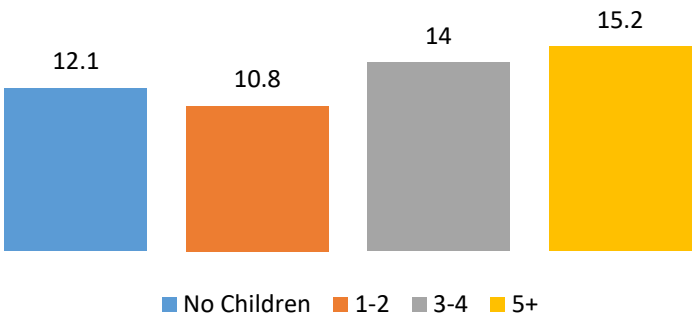
Spousal physical violence is most prevalent in women in the middle groups with women aged 25-29 years most frequently (15.8%) reporting the experience of spousal physical violence-Figure 5.2. Moreover, women in the youngest age group (i.e. 15-19 years) report no incidence of physical violence.

Figure 5.2: Percentage of women who have experienced spousal physical violence by age



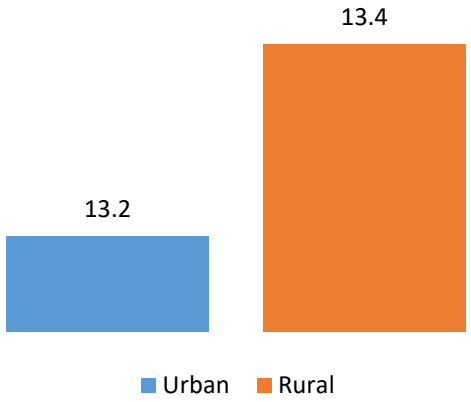
A trend is observed indicating that the experience of spousal physical violence tends to increase with the number of living children-Figure 5.3. However, there is no drastic variation in the experience of spousal violence with the number of children.

Figure 5.3: Percentage of women who have experienced spousal physical violence by number of living children



Urban and rural women both report similar percentages of Spousal physical violence, with 13.2 percent of urban women experiencing physical violence compared to 13.4 percent of rural women, in the 12 months preceding the survey-Figure 5.4.

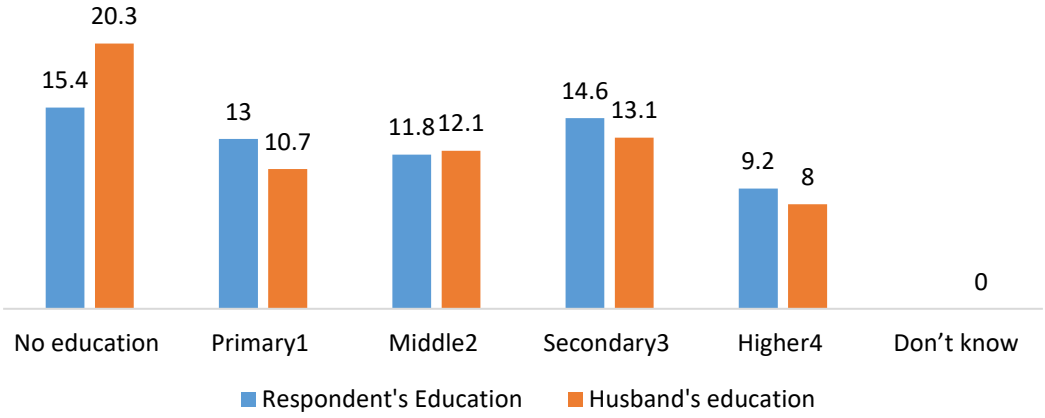
Figure 5.4: Percentage of women who have experienced spousal physical violence by residence



Women with no education (15.4%) reported the highest rates of experiencing violence, while those with higher education reported the lowest rates (9.2%), indicating that spousal physical violence decreased with the increase in educational attainment of women-Figure 5.5.

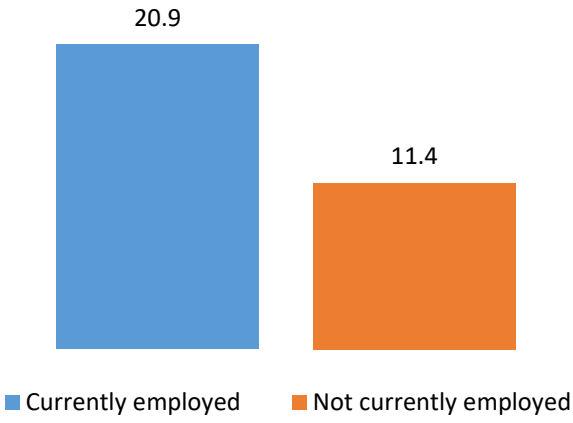
Husband's education level also influences the prevalence of physical violence. Women whose husbands have no education report the highest incidence of violence (20.3%). Whereas, women whose husbands have higher education report the lowest level of violence (8%).

Figure 5.5: Percentage of women who experienced spousal physical violence by women's and husband's educational attainment



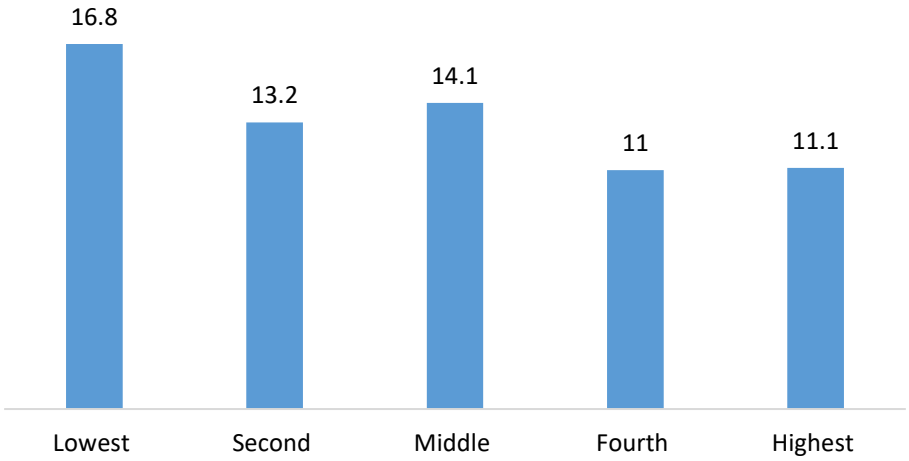
Employment status also plays a role in the experience of Spousal physical violence and being employed. Currently employed women (20.9%) experience physical violence more commonly compared to currently unemployed women (11.4%)-Figure 5.6.

Figure 5.6: Percentage of women who have experienced spousal physical violence by employment status



Women belonging to the lowest wealth quintile report the highest prevalence of physical violence, at 16.8%. In contrast, the prevalence is notably lower among women in the fourth and highest wealth quintiles, at 11.0% and 11.1% respectively-Figure 5.7. This indicates that increased household wealth may be linked to a reduced risk of experiencing physical violence,

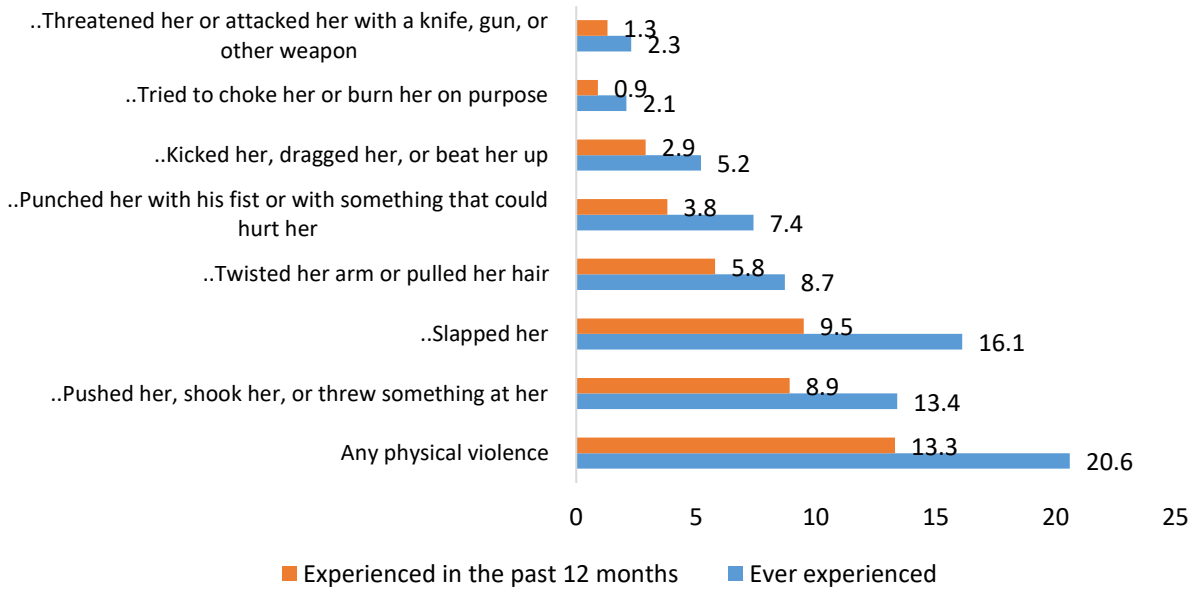
Figure 5.7: Percentage of women who have experienced spousal physical violence by Wealth Index



Women were also asked about the various forms of physical violence that they had experienced. Figure 6.8 reveals that slapping was the most common form of violence (16.1%) followed by being pushed, shook or thrown something at (13.4%) and twisting arm and pulling hair (8.7%). Threatening or attacking with a knife or a gun and trying to choke or burn on purpose were the least reported forms of violence (2.3% and 2.1%, respectively).

Women are also asked about the specific forms of spousal physical violence they have ever experienced. Slapping emerges as the most commonly reported form of violence (16.1%), followed by being pushed, shaken, or having something thrown at them (13.4%). The least commonly reported form is being choked or deliberately burned (2.1%)-Figure 5.8.

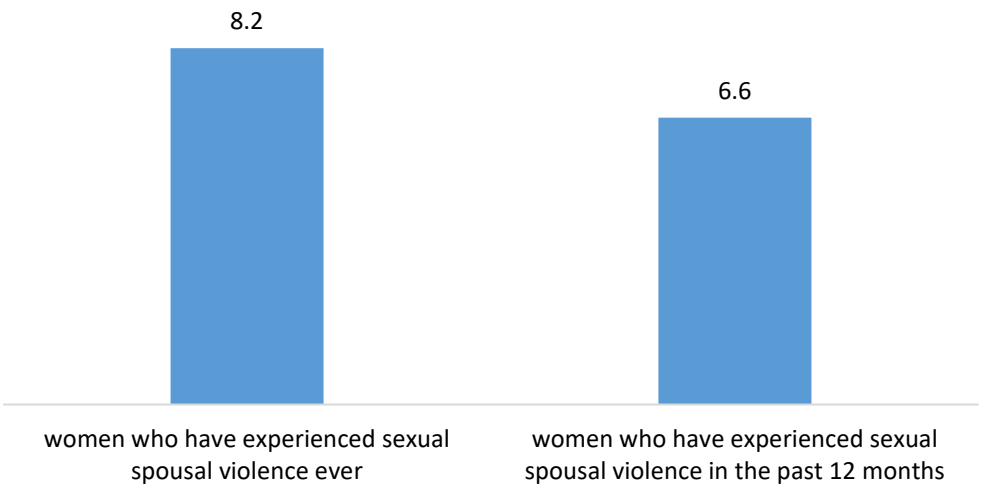
Figure 5.8: Percentage of women who have experienced various forms of violence



5.4 Spousal Sexual Violence

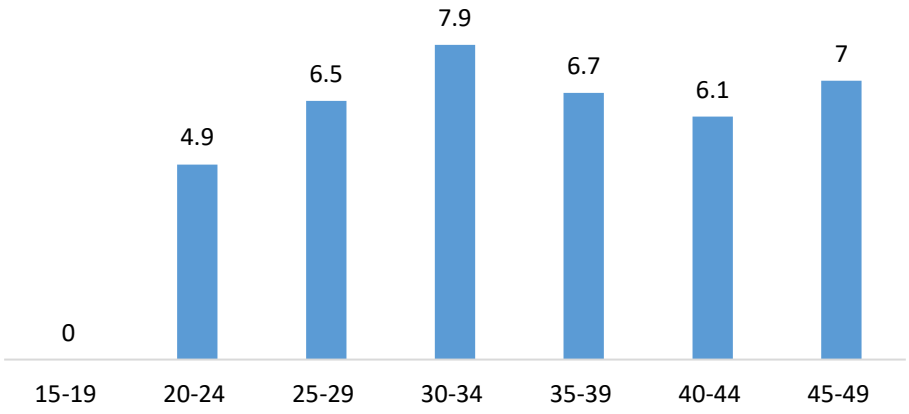
Women were asked about their experience of Spousal sexual violence; the findings of the survey are reported by background characteristics of women in this section. The results show that 8.2 percent of women respondents said that they had experienced Spousal sexual violence during their lifetime. Moreover, 6.6 percent reported the experience of Spousal sexual violence in the twelve months preceding the survey-Figure 5.9.

Figure 5.9: Women's experience of spousal sexual violence



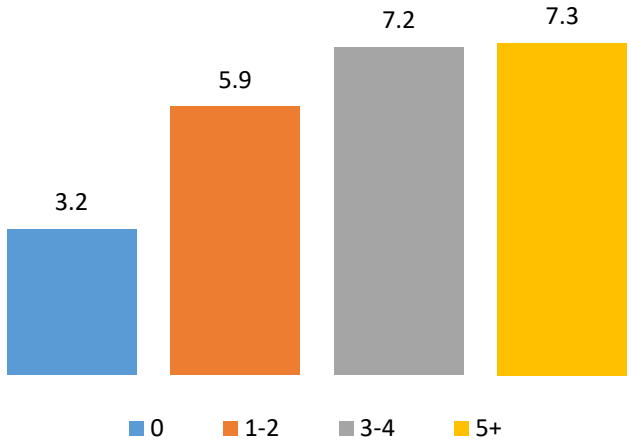
Women in the 30-34 years age group report the highest percentage of spousal sexual violence (7.9%), followed by women aged 45-49 years (7%). In contrast women in their teens (i.e. 15-19 years old) report no incidence of spousal sexual violence-Figure 5.10.

Figure 5.10: Percentage of women who have experienced spousal sexual violence by age



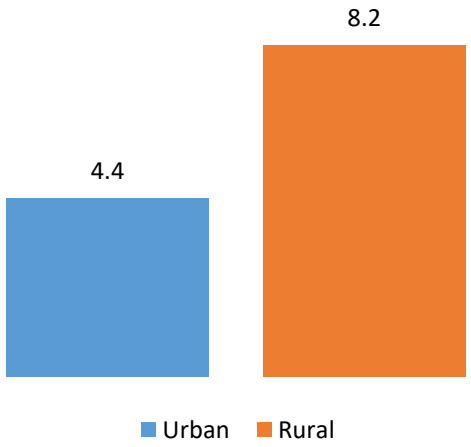
The experience of spousal sexual follows a trend similar to spousal physical violence i.e. the percentage of women who experience spousal sexual violence increases with the number of living children- Figure 5.11.

Figure 5.11: Percentage of women who have experienced spousal sexual violence by number of living children



Rural women report a significantly higher percentage (8.2%) of spousal sexual violence compared to urban women (4.4%)-Figure 5.12.

Figure 5.12: Percentage of women who have experienced spousal sexual violence by residence

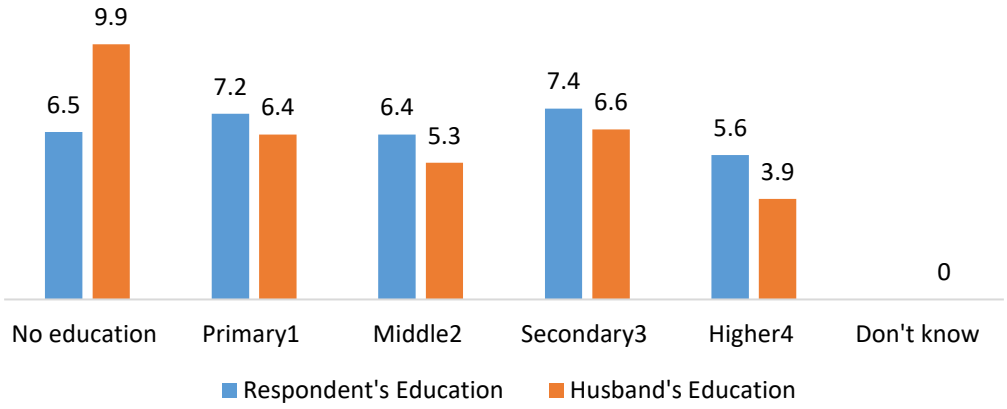


Women who have secondary education report the highest percentage of spousal sexual violence (7.4%), followed by women who have received primary education (7.2%). Women with the higher education reported lowest percentage of spousal sexual violence (5.6%)-Figure 6.13.

Women's experiences of spousal sexual violence in relation to their husbands' educational attainment reveals a clear trend. The prevalence of sexual violence is highest among women whose

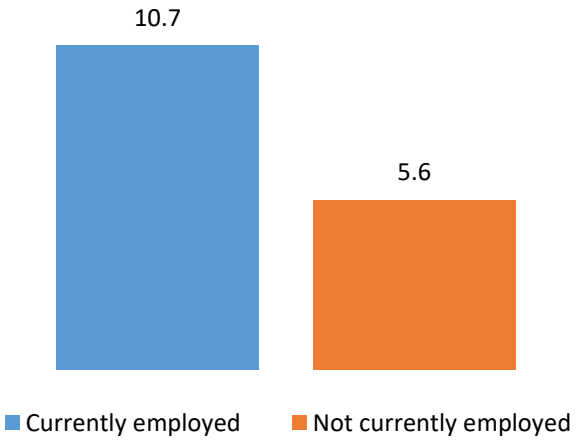
husbands have received no formal education (9.9%). In contrast, the lowest incidence of spousal sexual violence (3.9%) is reported by women whose husbands have attained higher education-Figure 5.13.

Figure 5.13: Percentage of women who experienced spousal sexual violence by women and husband's education



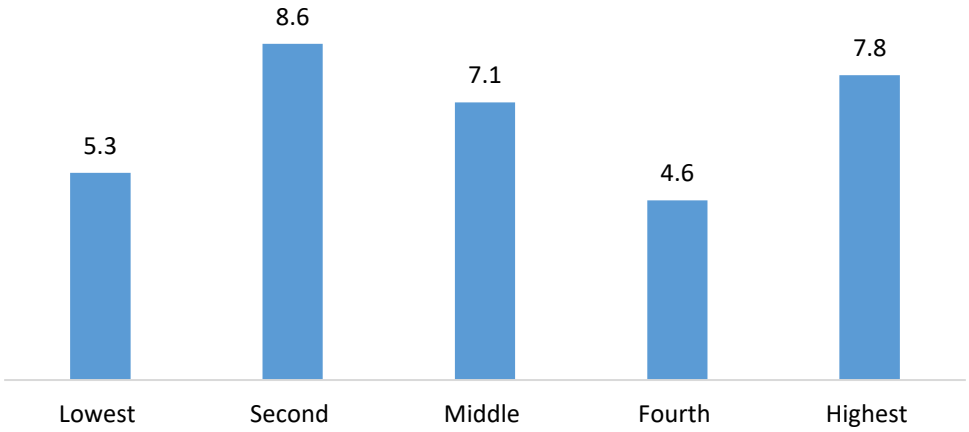
Women who are currently employed report a higher incidence of the experience of spousal sexual violence (10.7%) than those who are currently unemployed (5.6%)-Figure 5.14.

Figure 5.14: Percentage of women who have experienced spousal sexual violence by employment status



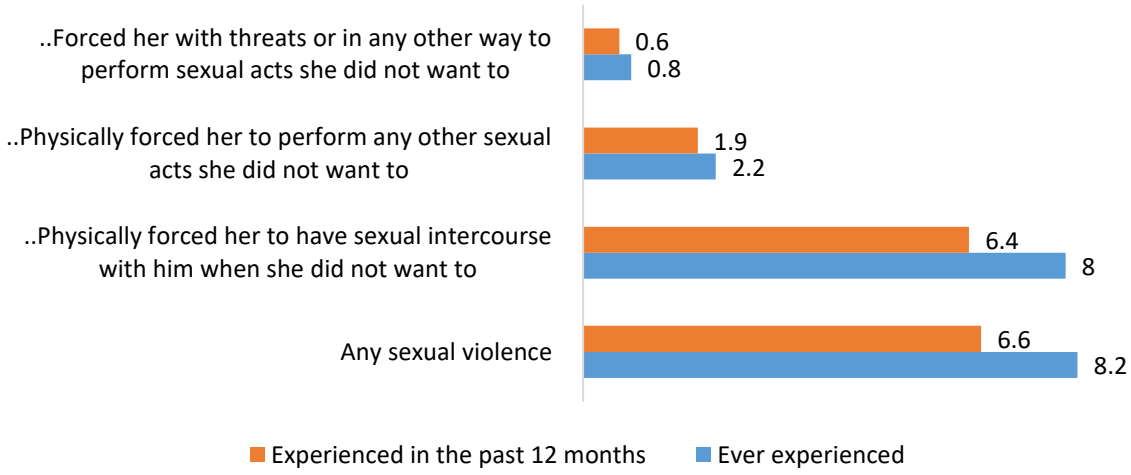
The prevalence of spousal sexual violence varies across wealth quintiles without indicating a consistent trend. Women in the second wealth quintile report the highest incidence at 8.6%, followed by those in the highest (7.8%) and middle (7.1%) quintiles. The lowest reported incidence was among women in the fourth wealth quintile (4.6%) Figure 5.15.

Figure 5.15: Percentage of women who have experienced spousal sexual violence by wealth index



The most commonly reported form of spousal sexual violence is 'physically forced her to have sexual intercourse with him when she did not want to' (8.2%), followed by 'physically forced her to perform any other sexual acts she did not want to' (8%). The least commonly reported form of spousal sexual violence is 'forced her with threats or in any other way to perform sexual acts she did not want to' i.e. (only 0.8%)-Figure 5.16.

Figure 5.16: Forms of spousal sexual violence



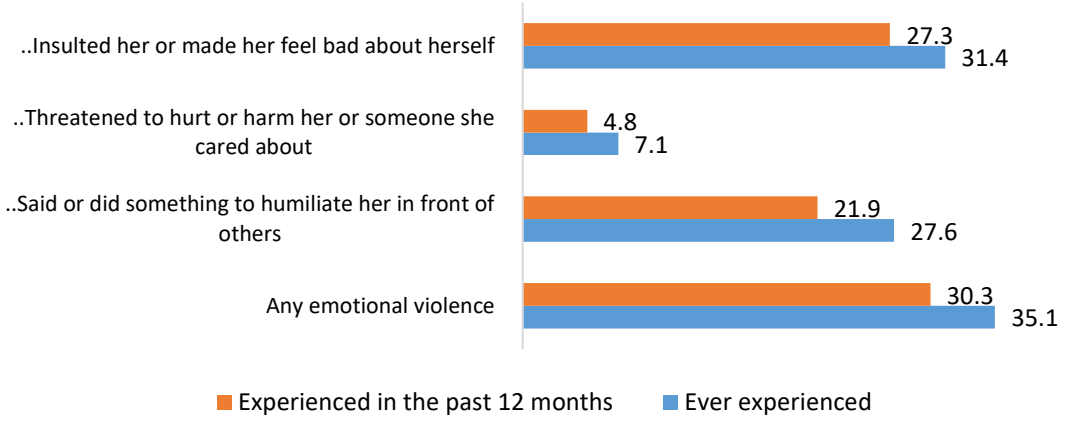
5.5 Experience of Spousal Emotional Violence

This section presents data on the experience of emotional violence among currently married women of reproductive age. The percentage of women who have experienced any Spousal emotional violence during their lifetime and in the 12 months preceding the survey are discussed here. A total of 35.1% of women report having experienced spousal emotional violence at some

point in their life, while 30.3% women report such experiences within the twelve months preceding the survey.

Among the different forms of emotional violence, the most commonly reported is being 'insulted her or made her feel bad about herself' (31.4%), followed by 'said or did something to humiliate her in front of others' (27.6%). The least frequently reported form is being 'said or did something to humiliate her in front of others', reported by 7.1% women-Figure 5.17.

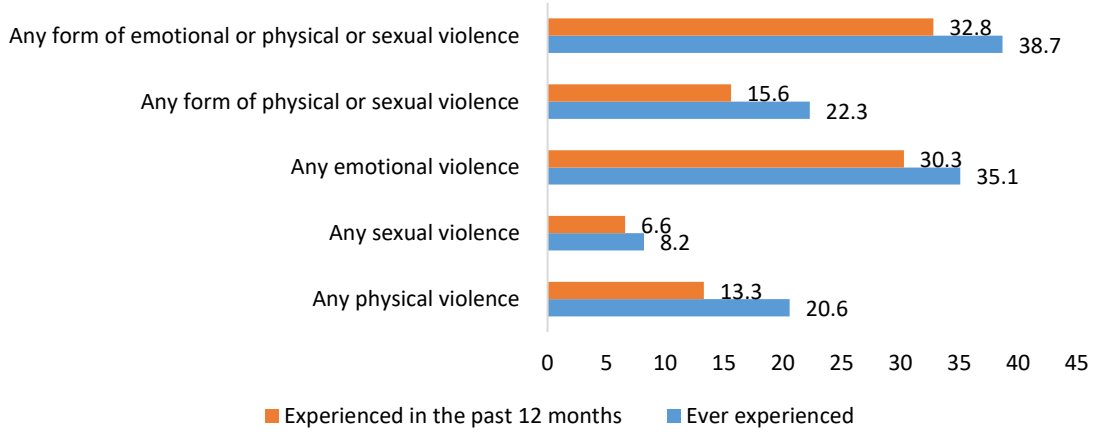
Figure 5.17: Spousal emotional violence



5.6 Experience of Spousal Violence

Emotional violence is the most common form of spousal violence, where 35.1% of all participants report experiencing it during their lifetime and 30.3% report experience of emotional violence in the 12 months preceding the survey. Spousal physical violence is reported by 20.6% women. Spousal sexual violence is the least common form of violence reported by only 8.2% women. A total of 38.7% report the experience of some kind of physical, sexual, or emotional violence and 22.3% report experiencing either physical or sexual violence.

Figure 5.18: Experience of spousal violence



SERVICE DELIVERY POINTS SURVEY AND PREPAREDNESS FOR FAMILY PLANNING SERVICES 6

Under the FP2030 commitments achieving 'universal access to safe and quality reproductive health care and family planning services with increased and widely accessible method choices' is endorsed by government of Punjab. In this regard, strengthening of Population Departments' coordination with Department of Health to expand FP services including post-pregnancy family planning services to minimize missed opportunities; and approval of Task Shifting and Task Sharing strategies and competency-based training of paramedics and doctors in implant insertion and systematic procurement. Strong ownership of Department of Health is recognized as means for universal access.

6.1 Structure of Family Planning Availability System

Family planning is provided both by the public and private sectors across province of Punjab. Outlets of PWD including Family Health Clinics (hospital based facilities) and Family Welfare Centers (facilities located at community level serving FP and basic MCH services), and facilities of Health Dept. including tertiary care hospitals, secondary healthcare and primary health care unit (District hospitals, RHCs, BHUs, and MCH Centres) are dedicated to provide family planning services and commodities to clients who visit and seek these services. Lady Health Workers (community-based health workers) are essential part of primary healthcare system provide FP counseling and services as part of MCH package served to women and children of the communities they are assigned, mostly in rural areas. Private sector and NGOs outlets also provide family planning services within their health facilities. Private sector encompasses private clinics, hospitals, maternity homes and MCH facilities and drug stores spread mostly in urban areas. Population Welfare has a limited dedicated infrastructure while Dept. of Health has a wider infrastructure across the province where family planning services are provided. A major segment of Health infrastructure is open 24 hours for seven days making FP available for a large segment of population visiting facilities. Public sector dispenses FP commodities free of cost or a nominal charges while private sector charges for commodities and services depending on commodities purchased. Private sector also charges service fee for the commodities. The analysis in this section would maintain distinction of the three entities to see their contribution and delivery of FP services.

A total of 245 public and private facilities were visited in the survey by the enumerators in 52 clusters across the province. These facilities were identified by the women respondents where they normally visit to obtain services for their family health and family planning needs. The aim of maintaining same facilities over all phase of survey is to see if any substantive changes have been made in the facilities especially in improving availability and quality of service that leads to 'choice'.

A comprehensive insight into the distribution of service delivery points, categorized into public and private facilities shows that public facilities constitute the majority, comprising 81 percent of

the total service delivery points surveyed. Among these, the most covered are Family Welfare Centers, constituting 35 percent of all public facilities, followed by Rural Health Centres and Basic Health Units (30%) and MCH Centres and Public Dispensaries (12%) - Table 6.1. On the other hand, private facilities accounted for 19 percent of the total service delivery points. Notable categories within private facilities included Big and small Hospitals (5%), Maternity Homes and midwife clinic (4% each), and doctors' Clinics (2%).

Table 6.1: Percent distribution of service delivery points

	Percent		Percent
Public Facility	**81**	**Private Facility**	**19**
Tehsil Head Quarter	4	Big hospital (4+ beds)	5
Rural Health Centre	5	Doctors Clinic (male/female)	2
Basic Health Unit	25	Nurse Clinic (male/female)	1
Public Dispensary	1	LHV Clinic	2
Maternal and Child Health Care Center	2	Midwife Clinic	4
Family Health Clinic	5	Maternity Home	4
Family Welfare Centre	35	Private Dispensary	1
LHW Health Clinic /Health House	4		
Number of Facilities 245			

Available staff at the facility who serve family planning was the key respondent for the facility survey. Table 6.2 shows the key staff who responded and facilitated the survey in public and private sector facilities. Respondents are asked questions about the general infrastructure, services available, resources, and systems at the facility including staff pattern, basic amenities, management information systems, performance monitoring by tracking records. A quick glance of respondents' show that almost all PWD facilities staff are FWWs or FWAs, while more than a quarter of Health facility staff are nurse/midwife (Table 4.2). More than two-thirds of private sector facility respondents are Nurses and LHVs.

Table 6.2: Percent distribution of respondents of service delivery points questionnaire

Designation of respondent	DOH	PWD	Private Facility
Doctor	0	0	6
Nurse/Midwife	16	3	43
LHV/FHT	65	1	26
FWW/FWC	6	78	2
FWA	2	17	0
Dispenser	0	0	0
Other	11	1	11
Gender of respondent			
Male	0	1	4
Female	100	99	96

Among the facilities from Dept of Health (99), Population Welfare (99), and Private facilities (47) family Planning services/ products are offered by all of them. More than half of all Dept. of Health facilities (53 percent) offer services for 7 days a week while remaining 47 percent offer these services six days a week (Table 6.3). On the other hand, very large proportion (94%) of Population

Welfare facilities provide services 6 days a week and a handful offer throughout the week. Amongst the Private Facilities less than a quarter (20%) offer for six days a week and more than two-thirds offer throughout the week (78%).

Table 6.3: Percent distribution of facilities offers family planning services

Characteristic	DOH	PWD	Public Facility	Private Facility
Offering family planning services/products				
Yes	100	100	100	99
Number of Facilities	**99**	**99**	**198**	**47**
Days in a week are family planning services offered	DOH	PWD	Public Facility	Private Facility
<=5	0	3	2	2
6	47	94	71	20
7	53	3	28	78
Number of facilities that offer family planning services	**99**	**99**	**198**	**46**

6.2 Availability of Family Planning Services

All facilities visited in Punjab were asked regarding availability of contraceptives. Four contraceptive methods are universally available in all facilities: condoms, injectables, oral pills, and IUCDs (Table 6.4). Availability of condoms was a problem during 2023 which has been taken care and all facilities report availability. Provision of tubal ligation and vasectomy remains limited in a handful of facilities across the province. Female sterilization is available in 36% private facilities much more than public sector facilities. Emergency contraceptive pills, though not recognized as a contraceptive method, is essentially available at large number of facilities of PWD and a reasonable proportion of private facilities. Availability of implants appears to be low across all facilities esp public and private facilities. IUDs are available in large proportion of facilities. The overall availability appears to be good and reflects availability of various methods to enhance choice and accessibility.

Table 6.4: Percentage of family planning methods provided to client

Contraceptive Methods	DOH	PWD	Private Facility
Female sterilization	8	14	36
Male sterilization	1	3	9
IUD	89	99	85
Injectables	99	99	91
Implants	19	14	9
Pills	100	100	87
Condoms	100	100	72
Emergency contraception	29	99	51
Number of Facilities	**99**	**99**	**47**

Facility readiness to serve family planning is an important area of enquiry and asked about a number of aspects. The survey findings reveal that all public and private facilities are adequately prepared with running water, equipment needed for service, examination table, visual and auditory privacy, examination table, and essential chemicals for disinfection and good quality service (Table 6.5). The survey data shows the percentage availability of various items necessary for preparedness in examination rooms and adjacent areas across different types of health facilities. Overall, information below reflects a comprehensive overview of the availability of essential items in examination rooms and adjacent areas across different types of health facilities, highlighting variations in availability among different facilities.

Table 6.5: Percentage of facilities having separate room for examination and items in examination and adjacent room

Items necessary for Preparedness	DOH	PWD	Public Facilities	Private Facilities
Separate room for examination	76	93	84	70
Yes, Separate place	20	6	13	26
Running water (piped)	93	96	94	100
Other running water (bucket with tap or pour pitcher)	79	87	83	85
Available from other sources	62	56	59	70
Hand-washing soap	90	93	91	96
Hand drying towels	80	84	82	79
Waste basket with lid	94	93	93	87
Sharps container	93	98	95	89
Disposable latex gloves	93	99	96	96
Disinfectant	95	92	93	91
Disposable needles and syringes	91	96	93	91
Auditory privacy	90	97	93	94
Visual privacy	95	99	97	96
Examination table	92	98	95	89
Client educational materials on FP	86	98	92	70
Examination lamp on stand (Proper light arrangement)	99	97	98	100
Syringe cuter	94	99	96	89
Chlorine solution	90	93	91	85
Boiler/Sterilizer	85	94	89	83
Number of Facilities	**99**	**99**	**198**	**47**

6.3 Preparedness to Service IUDs and Implants

The survey focused on evaluating the readiness of facilities to provide key contraceptives, particularly Intrauterine Devices (IUDs) and Implants. Public and private facilities offering family planning services were visited for this purpose, aiming to assess staff training and service quality preparedness. Staff members were questioned regarding their training in IUD and Implant insertion and removal. The findings, as depicted in tables below, indicate that almost all facilities have trained personnel for IUD and Implant procedures. Overall it's evident that 88 percent of DOH facilities, 99 percent of PWD facilities, and 85 percent of private facilities reported prepared to serve IUCDs (Table 6.6).

IUD insertion emerges as a prominent contraceptive method offered by many health facilities, both public and private. Facilities offering IUD services were surveyed regarding the availability and functionality of various items required for the procedure. With the exception of autoclave availability and functionality in few PWD facilities (33%) and two-thirds of private facilities, all other necessary items were reported to be available and operational in a vast majority of facilities, indicating strong preparedness and adequate equipment for IUD services across different facility types. IUCD availability in Punjab has improved over 2023 in Health and PWD facilities.

Table 6.6: Percent distribution of facilities having trained personnel and supplies to insert and remove IUDs

Facility has trained personnel able to insert or remove IUDs	DOH	PWD	Private Facility
Insert	100	100	93
Remove	100	100	93
Facility has the supplies needed to insert and/or remove IUDs:			
Sponge holding forceps	100	100	98
Vaginal speculum	100	100	98
Tenaculum	100	97	93
Uterine sound	100	100	98
Examination table/ couch	100	99	98
Examination lamp on stand	100	96	95
Adult weighing scale	99	95	93
Stethoscope	99	95	98
BP apparatus	100	95	98
Kidney tray	100	100	98
Scissors straight	100	99	98
Bowls	100	99	98
Pair of gloves	97	98	98
Disposable syringes 5cc, 3cc, 2cc	100	93	95
Sterilizer	92	97	90
Autoclave	94	33	65
Disinfection solution: (Dettol, Savlon, iodine)	100	89	98
Chlorine Solution	98	93	80
Container for chlorine solution	99	98	80
Number of facilities that provide IUDs	**88**	**98**	**40**

Facilities are also enquired concerning implant provision and their readiness with essential supplies and equipment for aseptic implant insertion/removal. The findings show that only a handful of visited facilities report having necessary items for implant provision (Table 6.7). Upon reviewing it's evident that among all facilities, only 19 percent of DOH facilities, 14 percent of PWD facilities, and 9 percent of private facilities report to be prepared to serve implants. All required items were reported to be available and functional in these selected few facilities, demonstrating low preparedness for implant services across various facility types of Punjab. In general, fewer PWD and private health facilities are prepared to offer implants to clients. Overall, Punjab (survey of 2024) reflects a slight improvement in the coverage and provision of implants over Phase-4 survey in 2023 – (from 7% to 19% of DoH facilities), (from 11 percent of PWD facilities to 14 percent) and (from 7 percent to 9 percent of private facilities).

Table 6.7: Percent distribution of facilities having trained personnel and suppliers to insert or remove the implants

Facility have trained personnel able to insert and remove implants	DOH	PWD	Private Facility
Insert	100	100	100
Remove	95	100	100
Facility has following supplies/items to handle implants			
Marking pen	89	93	100
Tape measure (Plastic ruler preferred)	84	93	100
Alcohol pads	84	79	100
5 ml syringe 2% lidocaine with Epi + 0.5 ml	89	100	100
8.4% Sodium Bicarbonate	84	71	100
18 g to draw up medication	79	64	100
25g 1-1/2 needle to attach syringe	84	86	100
Non-sterile 4 x 4's	84	79	100
A + D ointment	79	71	100
1 or 2 inch gauze roll for pressure	84	100	100
Tape	89	100	100
Bandage Scissors	95	100	100
Benzoin, Sterile-strips, Ethyl Chloride	89	79	100
Clean Gloves	89	100	100
Antiseptic	89	100	100
Sterile Gauze Pad or Cotton Wool	89	100	100
Local Anaesthetic	89	100	100
Sealed Implant Pack	79	100	100
Surgical Blade	89	100	100
Mosquito forceps (Straight or Curved)	84	100	100
Number of facilities that provides Implants method	**19**	**14**	**4**

6.4 Quality of Services

Effective communication between service providers and family planning (FP) clients plays a crucial role in ensuring continued use and satisfaction among clients. Counselling, as highlighted by previous research, is an essential aspect requiring persistence and comprehensiveness to encourage clients to adopt contraception for the long term. During the survey, facility staff were asked regarding FP counselling, specifically focusing on informing clients about the benefits and side effects of various methods. According to the facility staff, the benefits of all methods are communicated to clients, some are emphasized more than others as per the need of client. Modern methods such as IUCD, Pills, injectables, condoms, and ECP receive greater attention from the DOH and PWD facility staff compared to private sector staff. Tables 6.8 reveal that DOH and PWD health facilities exhibit a significantly higher level of emphasis on communicating benefits relative to private sector facilities. Vasectomy receives the least attention by all facilities followed by implants.

Staff across all types of facilities also provide necessary information on the side effects of various modern and traditional FP methods to clients. According to the survey results, DOH and PWD

health facilities staff place a notably greater emphasis on communicating the side effects of FP methods compared to private sector facilities (Table 6.9).

Table 6.8: Percent distribution of service providers who provide information on benefits of various methods

Contraceptive Methods	DOH	PWD	Private Facility
Female sterilization	95	98	98
Male sterilization	80	90	83
IUD	100	100	98
Injectables	100	100	98
Implant	90	95	91
Pills	100	100	100
Condoms	100	100	96
Emergency contraception	93	99	96
Standard days method	92	92	89
Lactational amenorrhea method	99	100	98
Rhythm method	98	96	94
Withdrawal	100	100	98
Number of Facilities	99	99	47

Table 6.9: Percent distribution of service providers who provide information on side-effects of methods

Contraceptive Methods	DOH	PWD	Private Facilities
Female sterilization	95	98	98
Male sterilization	80	89	85
IUD	100	100	98
Injectables	100	100	98
Implant	89	96	91
Pills	100	100	100
Condoms	100	100	96
Emergency contraception	93	99	96
Standard days method	91	89	89
Lactational amenorrhea method	98	96	98
Rhythm method	98	93	94
Withdrawal	99	96	98
Number of Facilities	**99**	**99**	**47**

6.5 Trend of Charges Made on FP Commodities and Services

A dedicated segment was incorporated in the survey to assess the pricing charged by different facilities. Service providers were requested to disclose their approach to charging for commodities. DOH and PWD facilities uniformly offer FP commodities and services either free of charge or at nominal rates. Conversely, private sector facilities indicated that a significant proportion levy charges for commodities and services to maintain their business operations. Trend of percentage

of facilities (2022 to 2024) offering contraceptives for a fee and the average charges imposed on clients by private facilities for each contraceptive method is illustrated in Table 6.10.

- The 2024 survey indicates that among the visited facilities 32 percent private health facilities provide female sterilization services (tubal ligation), with an average cost of Rs 4,113. Generally, a small proportion of private sector facilities offer tubal ligation and vasectomy, and the average charges differ. Generally, the charges for Tubal ligation have remained stable since 2022 survey.
- The 2024 survey findings indicate that 77 percent private health facilities reported provision of injectables on charges, with an average cost of Rs 284, which was Rs 220 in 2022 survey. It is noted that though charges have slightly increased but the percent of facilities charging for injectables has also increased over the years.
- Among the long-acting contraceptives, implants provided by private facilities are the most costly item, priced at Rs. 4,250 which was Rs 2,250 in 2022 survey. Only a handful of private health facilities are providing implants in Punjab.
- Furthermore, a large proportion of private facilities (79%) make IUCD available and their charges are on average are Rs. 1,372 which were less than half this price (Rs. 738 per unit) in 2022. IUCD is comparatively less expensive LARC available from private providers and proportion of facilities charging for IUCD has slightly increased.
- The survey indicates oral pills, and condoms, made available by private sector are notably low priced than other commodities. Moreover, percent of facilities charging for pills and condoms has also increased over the years.

Table 6.10: Trend of percent private facilities providing FP commodities to clients on charges

Methods and No of Facilities	Private Sector Facilities		
	2022	**2023**	**2024**
Female sterilization	30	6	32
Average Charges (Rs)	4,150	2734	4,113
Male sterilization	4	- -	9
Average Charges (Rs)	4,375		4,063
IUD	68	66	79
Average Charges (Rs)	738	952	1,372
Injectables	67	59	77
Average Charges (Rs)	220	252	284
Implants	4	7	9
Average Charges (Rs)	2,250	3125	4,250
Pills	49	48	66
Average Charges (Rs)	84	114	121
Condom	37	36	47
Average Charges (Rs)	97	93	93
Emergency contraception	40	34	45
Average Charges (Rs)	92	151	80
Number of Facilities	**57**	**56**	**47**

6.6 Availability of Contraceptive Stocks

Availability of FP commodities is the backbone of FP delivery mechanism. All facilities visited during the survey were enquired about the stocks of each contraceptive method and the duration of stock outs where these were not available. The stocks register was used to record information of various key contraceptives at the facility. Table below (Table 4.11) captures percent of facilities that reported availability of various commodities, percent facilities that experienced stock out which were asked for the period of stock outs of that commodity. Survey reveals the stocks of various key contraceptives have improved tremendously. PWD facilities consistently show stocks of five contraceptives in all facilities (Table 6.11).

As compared to 2023 survey report, Health Dept. facilities show a slight increase in percent facilities that reflect stocks-outs of condoms, oral pills, IUCDs and injectables. The number of days of stock outs of these items from Health facilities also reflect a major increase, which is a concern. Regarding oral pills, Health Dept. facilities are slightly more than previous year which reflect stock outs. Overall IUCD stock situation has improved in public sector but private sector facilities need due attention to build stock in facilities that report stock outs. Implants are available only in a few private facilities but lack of stocks in some facilities for several months need attention for improved availability to enhance accessibility and continuity of use. On the other hand, majority of PWD facilities show improved stocks availability (Table 6.11) and only a few facility reflect short term stock out.

Table 6.11: Percent facilities with stocks of contraceptives and stock outs by number of days

Condoms	DOH		PWD		Private Facility	
	Available	Not Available	Available	Not Available	Available	Not Available
Percent of Facilities	89	11	96	4	51	13
Stock out days (average)		469		10		941
Pills (Cycles)						
Percent of Facilities	94	6	98	2	64	15
Stock out days (average)		960		17		861
IUD (units)						
Percent of Facilities	87	1	99	1	68	9
Stock out days (average)		1080		-		1193
Injection (Vials)						
Percent of Facilities	87	12	98	1	74	11
Stock out days (average)		783		13		1080
Implants						
Percent of Facilities	18	1	12	1	6	0
Stock out days (average)		120		120		-
Emergency Pills						
Percent of Facilities	21	8	84	14	36	9
Stock out days (average)		310		81		39
Number of Facilities	**99**		**99**		**47**	

6.7 Human Resource Development for Family Planning

Proficient and skilled service providers are core to ensure quality of service delivery. Survey asked several questions regarding human development to staff dispensing family planning services in the facility. The idea is to assess their technical knowledge and how they use their knowledge in service delivery. Staff was asked about types of training in family planning received by them in the previous three years. Survey revealed that 83 percent of staff of DoH, 80 percent of PWD, and 45 percent staff of private sector facilities received training in the past three years (Table 6.12). Main training for PWD staff focused on FP counselling (75%) followed by IUCD related training (65%). Similarly, the Health Department staff training focused also on IUCD, and FP counselling training and distantly followed by implant training. Fewer staff received training in Minilap and infection prevention management, which needs to be enhanced to all staff. Very few PWD staff received training in implant insertion.

Table 6.12: Percentage of type of training received by the facility's staff/respondents

Type of training received on family planning/ contraceptive	DoH	PWD	Public Facility	Private Facility
Family planning (contraceptive technology)	44	52	48	48
IUCD insertion/removal	72	65	68	62
Contraceptive logistics management	41	54	48	33
Family planning counseling	61	75	68	67
Client Centered Family planning	37	53	45	29
Clients rights	39	48	43	29
Minilap/ Vasectomy	11	13	12	5
Implant insertion/ removal	59	13	36	24
PPIUCD insertion / removal	52	56	54	62
Infection prevention management	22	39	30	19
Number of respondents who attend training	**82**	**79**	**161**	**21**

6.8 Opinions Regarding Service Improvement

Provision and access to family planning services have been persistent issues over the years. All facility based service providers were asked what they felt was essential to help boost delivery of FP services. A wide variety of responses were noted across type of facilities and spelled out in the Table 4.13. Staff of DoH pointed additional staff needs followed by availability of contraceptives and distantly need for transport for counseling to community level and community mobilisation. The PWD staff also noted need for additional staff and provision of medicines as two important areas. For private sector staff provision of provision of free contraceptive (53%) and availability of contraceptive commodities (38%) as two key areas (Table 6.13). These are good field level suggestions to enhance access and availability of family planning services at the grassroots.

Table 6.13: Percentage of requirements identified by staff to promote family planning

Requirements identified by staff	DoH	PWD	Private Facility
Training to provide and serve the methods	17	17	30
Training for management for side effects	23	13	11
Availability of contraceptives commodities	36	30	38
Provide counseling to community level	18	14	23
Clarify doubts about religious aspects	11	4	9
Provide contraceptive free of cost	16	7	53
Provide general medicines	24	54	15
More staff needed	46	51	19
Free camps	27	18	28
Ultrasound machine and delivery kit should be provided	20	29	4
Clients should be supported financially	12	14	13
Transport for field visits	25	31	11
Staff for community mobilization	11	18	6
Others	14	20	28
Number of Facilities	**99**	**99**	**47**

6.9 Suggestions Regarding Service Quality Improvement

Service providers were asked to identify key areas they deemed essential to discuss with potential family planning clients. Health, PWD, and private sector providers highlighted several crucial areas, including the advantages and disadvantages of various methods, instructions on how to use the method, clarification on how the method works to address any misinformation, the duration of use, and potential side effects (Table 6.14). However, there was a notable variance in prioritization among Health staff regarding how the method works, management of side effects, and follow-up procedures. To ensure quality counseling, it is imperative that all these aspects are comprehensively covered and uniformly discussed with clients using standardized protocols. Encouragingly, there was a consensus among respondents across Health, PWD, and private sector providers on many aspects of counseling, indicating a degree of uniformity in practice. Management of side effects is an important area that has emerged in research as a cause of discontinuation of contraceptives and should be given due priority.

Table 6.14: Percentage of areas of counselling given to clients

Suggestions for Improvement	DOH	PWD	Private Facility
Advantages and disadvantages of the method	95	97	85
How the method works	57	68	62
How to use the method	74	76	62
How often to use the method	54	65	57
Duration of use	70	81	70
Effectiveness level	62	67	60
Possible side effects	71	73	62
Management of side effects	30	26	11
Return for follow up	72	75	40
Refer, if method not available	34	40	32
Number of Facilities	**99**	**99**	**47**

6.10 Assessment of Service Provider's Technical Knowledge

To evaluate the technical knowledge of service providers, facility staff providing family planning were presented with eight specific questions covering various aspects of family planning, contraceptive technology, health conditions for contraception use, and technical issues related to different contraceptive methods. Multiple-choice responses were provided, aiming to seek the correct answer from respondents. The table below details the questions and the percentage of facility-based care providers who provided the correct answer (along with the correct answer).

Overall, DoH staff demonstrate better knowledge compared to staff from other entities, correctly responding to three questions with over 60 percent accuracy (Table 6.15). On the other hand, PWD and private facility staff achieved a 60 percent accuracy rate in only two to three technical questions. For more specific inquiries concerning topics such as miscarriage, Norigest usage, oral pills, IUCD side effects, and emergency pills, the proportion of correct responses varied across staff entities, indicating the need for knowledge enhancement and refresher training among staff. The Population Department staff rating suggests their enhanced understanding due to focused contraceptive training, while Health Department staff exhibit better pre-service training in maternal health issues, particularly related to miscarriage, postpartum care, and delivery. Questions with less than a 60 percent response rate warrant immediate attention and staff refresher training. Utilizing e-learning technology could be beneficial in addressing knowledge gaps among facility staff.

Table 6.15: Trend of percentage of correct responses to technical questions about contraceptive methods and family planning/ birth spacing

Questions and Correct answers	PHASE-III			PHASE-IV			PHASE-V		
	DoH	PWD	Private Facility	DoH	PWD	Private Facility	DoH	PWD	Private Facility
Period of spacing between birth and subsequent pregnancy									
At least 24 months	49	40	44	52	39	57	67	38	74
How long should woman wait after a miscarriage before becoming pregnant again									
After 6 months	70	60	68	73	67	64	79	70	62
For how long a Norigest injection gives continuous protection against pregnancy									
8 weeks	27	48	26	21	39	27	29	41	23
Indications when oral pills can be provided									
Women aged over 35 years who smokes	71	61	72	71	60	73	31	25	23
Who cannot be provided with an IUCD									
Post abortion clients who have purulent discharge	74	81	77	78	72	75	76	79	72
What is true about emergency contraceptive (EC) Pills									
All of these answers	31	37	33	36	35	32	31	42	36
Side effects of IUCD									
All of the above	11	32	46	33	34	55	28	36	36
Replace IUCD after how long									
After 12 Years	11	32	7	16	47	4	13	38	15
Number of Facilities	**93**	**97**	**57**	**92**	**98**	**56**	**99**	**99**	**47**

6.11 Assessing Knowledge of FP Providers regarding Family Planning Methods and Services

FP service providers across all facilities were surveyed using 14 statements to assess their understanding of various aspects related to contraceptive methods and family planning/birth spacing. The table below (Table 6.16) illustrates the trend of percentage of service delivery staff who provided correct responses to various technical statements. The questions covered a range of topics, including the decision-making process for providing contraceptive methods, handling of medical equipment, and guidelines for different contraceptive methods. Responses were categorized by the type of healthcare facility, including DoH, PWD, public facilities, and private facilities. Some questions were intentionally posed in a tricky format to gauge clarity of understanding among the staff, while others focused on recent advancements in infection prevention and other preventive measures. The aim was not only to evaluate their technical knowledge but also their perceptions based on their training and experience. Overall, the questions

addressed quality-of-service aspects crucial for building confidence in contraception among clients.

Technical knowledge pertaining to disposable syringes, oral pills, IUCDs, and Depo-Provera appears to be lacking among several service providers based on the questions asked. Trend analysis (Table 6.16) reflects persistent low scores over three surveys in seven areas of enquiry which is worrisome. The low percentage of correct responses across all entities is a serious concern and highlights an urgent need for refresher training for all service providers. Enhancing competencies through refresher training for FP staff across all sectors is essential to improve the quality-of-service delivery.

Table 6.16: Trend of percentage of service delivery staff with correct understanding about contraceptive methods and family planning/birth spacing

Questions and correct response	Phase-III			Phase-IV			Phase-V		
	DoH Facilities	PWD Facilities	Private Facilities	DoH Facilities	PWD Facilities	Private Facilities	DoH Facilities	PWD Facilities	Private Facilities
The doctor should decide provision of contraceptive of method to a client as per his/ her own best judgment (False)	80	81	70	76	90	70	82	84	66
It is important to discuss misconceptions and rumors about Family Planning methods with the client (True)	100	99	96	99	99	100	99	100	98
Always bend the needle of a disposable syringe after use to make sure it cannot be reused (False)	25	11	16	21	6	14	25	21	28
Decontamination of the needle and syringe must be done before destroying it in destruclip (False)	70	52	60	66	50	64	73	60	74
The strength of chlorine solution is 0.1% for effective decontamination (False)	51	68	35	58	71	48	48	71	38
If a client is on injection depo-provera, she comes one week later than the schedule time; she can be given a second injection (True)	51	69	53	53	78	46	56	69	66
Oral pills can be given to nulliparous women (True)	16	53	30	34	49	41	54	64	47
A woman who is breastfeeding a baby can take progestin-only pills after 6 weeks of delivery (True)	62	87	68	77	88	75	65	87	68
A progestin-only pills can be used for emergency contraception after unprotected sex (True)	62	87	68	49	40	50	43	39	47
A **woman should stop using depo-provera (3 months injection) if she has no menstrual bleeding for a long time (amenorrhea) (False)**	17	27	26	26	39	36	39	31	28
Sterilization should be offered only to woman who have had a certain number of children or who have reached a certain age (False)	8	21	7	9	15	14	15	15	17
A woman who has never had a baby can use an IUCD (True)	13	19	18	16	12	11	20	22	21
A woman with diabetes can be given/insert an IUCD (True)	39	39	39	49	50	45	37	46	38
Withdrawal method is highly effective and practical among teenagers (False)	31	39	33	40	42	29	46	45	38
Number of Facilities	**93**	**97**	**57**	92	98	56	**99**	**99**	**47**

6.12 Facility Level Family Planning Performance Assessment

Survey examined and recorded two important pieces of information from facilities' based Client and Service Registers - the number of clients served and total commodities dispensed by various facilities from June to August 2024. The Table 6.11 gives an interesting distribution of clients for three months and facilities by Departments. Facilities register clients with the purpose of their visit and records commodities dispensed to them.

The three-month record of clients shows a mixed trend (some increase and others decline) in general clientele during June to August 2024 at Health and PWD facilities. The striking fact to be noted is that PWD facilities perform much better and higher (in terms of clients served and commodities dispensed) than the DoH facilities over the three months. This is consistent with the results noted in the previous surveys of 2022 and 2023. One more interesting result to note relates to the number of clients and number of commodities dispensed by PWD and DoH facilities esp. for IUCDs, implants, and injectables are very well aligned (quite similar) reflecting accuracy in recording of commodity dispensation. For oral pills and condoms are two commodities that are dispensed more than one per client for longer term usage. It appears PWD facilities are more generous in dispensation of these items while DoH facilities serve these conservatively. These are truly reflected in Table 6.17 below.

The three month trend of clients and commodities dispensed by public sector facilities is smooth with hardly any increase or sliding down. Implants dispensation is quite low across both PWD and DoH facilities that could be related to shortage of supplies, training of staff, and lack of demand by clients. Similarly, dispensation of emergency contraceptive pills (ECP) is also quite low to fewer clients and is basically dispensed by PWD facilities (Table 6.17).

Closer analysis of Table 4.17 reveals total number of IUCD clients and number of IUCD dispensed are consistent over three months for each type of facility. Injectables clients do also match with the number of injectable dispensed. What catches eyes is the difference between PWD and DoH facilities number of clients and number of commodities dispensed oral pills, and condoms. Pills dispensation is almost 1.5 times the number of clients registered by the DoH and PWD facilities. Condoms are normally dispensed 5-6 items per client on their visit.

A quick review of three month record shows that 81,830 family planning clients were served by 245 public and private facilities during 2024. Thirty percent of these FP clients are served by Dept of Health facilities. An interesting point to be noted is that there is hardly any change in overall number of FP clients served by all stakeholders – 79,660 in 2022 (by 247 facilities), 82 thousand in 2023 (by 246 facilities), and 81,830 in 2024 (by 245 facilities). The proactive pursuit of FP agenda by Health facilities is yet to seen aspect of enhancing access and availability of contraception to women in Punjab.

Table 6.17: Percent distribution of total number of family planning clients according to type of facility

June-24	Total FP Clients				July-24	Total FP Clients				Aug-24	Total FP Clients			
Contraceptive Method	DOH	PWD	Public Facility	Private Facility		DOH	PWD	Public Facility	Private Facility		DOH	PWD	Public Facility	Private Facility
Female sterilization	98	413	511	28		131	402	533	43		126	306	432	33
Male sterilization						1	0	1	0					
IUD	695	1,599	2,294	28		836	1,581	2,417	20		799	1,593	2,392	23
Injectables	1,000	1,377	2,377	56		976	1,326	2,302	49		1,137	2,157	3,294	35
Implant	34	41	75	0		19	60	79	1		48	48	96	2
Pills	2,046	4,709	6,755	86		2,179	4,230	6,409	59		2,240	4,524	6,764	71
Condoms	3,716	9,979	13,695	75		4,253	10,017	14,270	67		4,285	10,541	14,826	63
Emergency contraception	80	486	566	0		75	432	507	2		73	420	493	1
Number of Facilities	**99**	**99**	**198**	**47**		**99**	**99**	**198**	**47**		**99**	**99**	**198**	**47**

Jun-24	Total Products/Services dispensed				July-24	Total Products/Services dispensed				Aug-24	Total Products/Services dispensed			
Contraceptive Method	DOH	PWD	Public Facility	Private Facility		DOH	PWD	Public Facility	Private Facility		DOH	PWD	Public Facility	Private Facility
Female sterilization	98	413	511	28		131	402	533	43		130	306	436	33
Male sterilization						1	0	1	0					
IUD	698	1,633	2,331	28		856	1,625	2,481	20		832	1,625	2,457	23
Injectables	1,006	1,366	2,372	56		970	1,395	2,365	49		1,119	2,150	3,269	35
Implant	34	49	83	0		18	63	81	1		48	56	104	2
Pills	2,390	5,665	8,055	284		3,354	5,049	8,403	60		2,480	5,252	7,732	215
Condoms	30,843	92,050	122,893	696		34,670	87,582	122,252	915		33,785	85,920	119,705	634
Emergency contraception	80	498	578	0		77	437	514	2		78	417	495	1
Number of Facilities	**99**	**99**	**198**	**47**		**99**	**99**	**198**	**47**		**99**	**99**	**198**	**47**

6.13 Integration of Family Planning with Maternal Health Services

An important area of interest to enhance access to family planning is integration of FP in maternal health services especially by Department of Health and private sector facilities. The facility survey enquired this in particular from all outlets as to what extent integration of services is being practiced. The reason behind that is to assess the scope that FP services could be enhanced for women coming for maternal health needs.

Percentage of facilities that offer maternal health services besides FP services categorized by the Department of Health (DOH), Population Welfare Dept. (PWD), and private facilities are presented in Table 6.18. For instance, under the "Antenatal care service", 96% of DOH facilities, 93% of PWD facilities, and 98% of private facilities provided antenatal care services. Similarly, "delivery service," is provided by 82% of DOH facilities, 4% of PWD facilities, and 87% of private facilities offered delivery services. Only handful of PWD facilities offer safe delivery services. All facilities also claimed to provide FP counseling and services at each of these maternal health stages. Overall, the table provides insights into the availability of various healthcare services beyond family planning across different types of health facilities.

Table 6.18: Percentage of health facilities which provided services other than family planning

Characteristic	DOH	PWD	Private Facility
Antenatal care service	96	93	98
Delivery service	82	4	87
Postnatal care service	93	92	96
Post-abortion/Miscarriage service	85	76	94
General Ailment service	99	98	94
Number of Facilities	**99**	**99**	**47**

A large proportion of DoH and Population Welfare facilities acknowledged providing counseling to women visiting facilities for ANC/PNC and post-abortion care. The areas of counseling include healthy timings and spacing of pregnancies, exclusive breastfeeding, long-acting methods, and where to obtain their choice method. Detail is provided in the Table 6.19 and 6.20.

Table 6.19: Percentage of health facilities which discussed the services with women after delivery or during first postnatal visit

Matters discussed with Women on Postnatal Visit	DOH	PWD	Private Facility
Return to fertility Healthy timing and spacing of pregnancies services	99	100	100
Immediate and exclusive breastfeeding services	99	99	98
Family planning methods available while breastfeeding services	99	100	96
Lactational Amenorrhea Method and to use transition to other methods services	97	99	98
Long-acting method options-LAM services	96	97	100
Woman offered a method of family planning during the postnatal visit	96	93	87
Number of facilities which provide ANC/ delivery care/ postnatal care	**95**	**94**	**46**

The survey revealed that most of the public facilities and private facilities discussed the services with women after delivery or during their first postnatal visit and during the post abortion visits (Table 6.20).

Table 6.20: Percentage of health facilities which discussed the services with women during post-abortion visits

Areas discussed with post-abortion patients	DOH	PWD	Private Facility
Post-abortion/ Miscarriage maternal health	94	97	98
Return to fertility Healthy timing and spacing of pregnancies	100	100	98
Long-acting method options-LAM	100	99	95
FP methods for birth spacing	100	100	98
Women offered a method of family planning during the post-abortion visit	95	95	89
Given information on where they can obtain contraception elsewhere	100	100	100
Number of facilities which provide post abortion/ miscarriage services	**84**	**75**	**44**

Facilities staff were asked to share their MCH services records and patients attendance for the three months prior to the survey (June – Aug. 2024). The idea was to assess the functional integration of FP with various MCH services. Registers reveal a total of 137 thousand MCH visits recorded over the three months in the 245 facilities (Table 4.21). In addition, nearly 322 thousand visits are recorded for general ailment health issues during these months. Nineteen percent of all ANC maternal health visits are recorded by private facilities for ante-natal care, 16 percent for delivery and 10 percent for post-natal care. All these visits reflect tremendous potential for FP counseling and PNC patients for post-pregnancy FP. Of the total maternal health visits, 17 percent are recorded by private sector facilities. Of the total general ailment visits, 8 percent are recorded by private sector facilities. Private sector therefore plays an important role in health sector and their involvement in integrating family planning in MCH is critical and essential to move forward in the sector. Currently, private facilities do not maintain any record on integration of services. The analysis reflects a huge potential for FP integration with MCH services in DoH and private sector facilities. PWD and Health Department need to jointly gear up to meet counseling needs thousands of women coming to Health facilities for ANC every month, and thousands of women visiting monthly for delivery or post-natal care services. Patients flow towards private facilities for ANC and Delivery reflects the need to engage private facilities for greater integration with family planning services especially in urban areas. Lack of engaging private sector health facilities to integrate FP remains a major barrier in enhancing access to FP services.

How can DoH strengthen family planning service delivery using its MCH care perspective? Women coming for ANC, delivery or post-natal care at DoH facilities if given fully integrated FP services, the contraceptive use would double in a very short duration. Integrating FP services with maternal health and also using the opportunity of women visiting for general ailment to get more access to information and contraceptives can give tremendous boost to acceptance of contraception. These are critical missed opportunities that can be best utilized to enhance access to mothers needing family planning.

Table 6.21: Average number of patients recorded in the three months, according to type of facility

June 24	Average Number of Patients				July -24	Average Number of Patients				Aug -24	Average Number of Patients			
Health Services	DoH	PWD	Public Facility	Private Facility		DoH	PWD	Public Facility	Private Facility		DoH	PWD	Public Facility	Private Facility
Antenatal Care	297	12	155	359		309	12	160	400		303	12	157	424
Delivery	35	5	33	41		38	5	37	45		40	5	39	37
Postnatal Care	55	8	31	41		59	8	33	48		62	9	34	46
General Ailment	993	78	511	586		1,108	84	568	517		1,134	82	580	564
Number of Facilities	99	99	**198**	**47**		99	99	**198**	**47**		99	99	**198**	**47**

Total number of patients recorded in the month according to type of facility

June-24	Total Number of Patient Visits				July -24	Total Number of Patient Visits				Aug. -24	Total Number of Patient Visits			
	DoH	PWD	Public Facility	Private Facility		DoH	PWD	Public Facility	Private Facility		DoH	PWD	Public Facility	Private Facility
Antenatal Care	27,358	1,093	28,451	6,101		28,391	1,095	29,486	6,803		27,843	1,105	28,948	7,210
Delivery	2,680	20	2,700	572		2,939	21	2,960	623		3,116	19	3,135	517
Postnatal Care	4,808	724	5,532	613		5,167	704	5,871	721		5,352	782	6,134	691
General Ailment	86,375	7,558	93,933	9,383		96,420	8,139	104,559	8,271		98,675	7,973	106,648	9,031
Number of Facilities	99	99	**198**	**47**		99	99	**198**	**47**		99	99	**198**	**47**

USER'S VOICE: CLIENT EXIT INTERVIEWS AND SERVICE SATISFACTION 7

Interviewing women exiting health facilities adds to the uniqueness of the survey to learn directly from them their experience of service quality and what they received. This segment is the only section where respondents are not the same as were in the household/woman section and Facility interviews. The survey focuses on family planning, the tool also seeks information from them regarding family planning services and experiences of counselling, and affordability. Ten exit interviews were performed with the women in each facility to seek their feedback and level of satisfaction for FP/MCH services received/ provided at the facility to them. In Punjab, the trend over the last few years has been as follows:

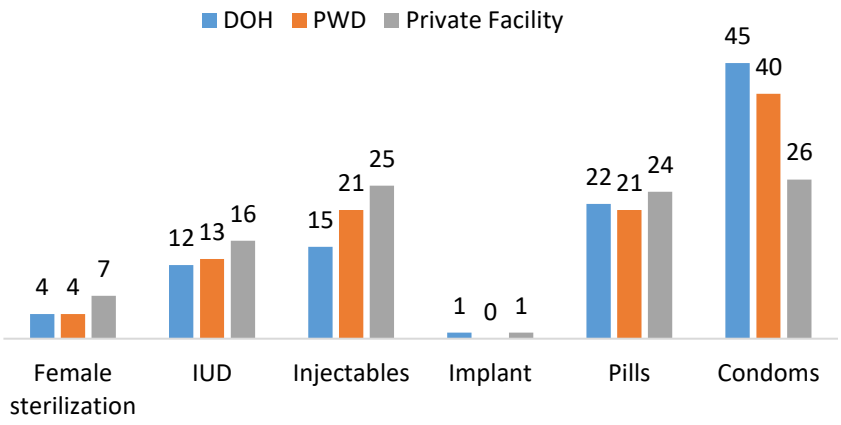
Client Exit Surveys	Phase II	Phase III	Phase IV	Phase V
Number of Health Facilities visited	240	247	246	245
Number of Exit Interviews done	2,396	2,468	2,460	2,440

A total of **2,440** women clients were interviewed in 2024, of whom 53 percent are from urban facilities. Overall almost 57 percent were family planning clients (1492 cases), 13 percent came for ANC and 26 percent visited for general health and child issues. Age-wise women were 13 percent are below age 25, a quarter are of age 25-29 and 30-34 each, 21 percent between 34 and 39, and 16 percent above age 40. More 40 percent are from DoH and PWD facilities each. All women clients were currently married, and less than a third (29%) women had no education while more than a third (36%) have Secondary and Higher education levels.

7.1 Method Prescribed or Given on the Visit

The family planning clients exiting facilities are asked about the method prescribed or given to them. The Survey reveals that though condoms remains at top the list (40%), while oral pills and injectables are also prescribed/ suggested to a reasonably high percent of clients (22% and 19%) (Figure 5.1). Condom distribution is reported highest for Dept of Health facilities followed by PWD facilities. In percentage terms, private sector facilities are reported for distributing injectables

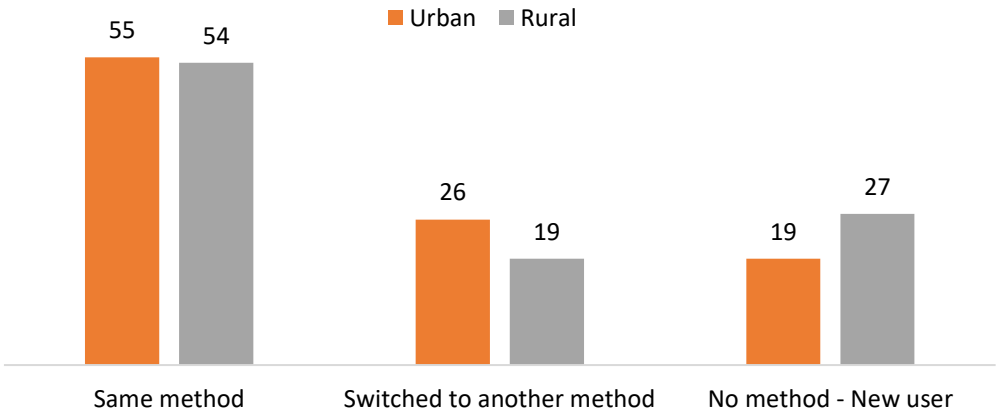
Figure 7.1: Percent distribution of family planning method prescribed to clients exiting by type of facility



and IUCDs relatively higher than public sector facilities. Implants are almost non-existent as reported by exiting facilities. There is no major difference between urban and rural exiting client's responses regarding method suggested to them. However, the most prescribed method at to young women is condoms and oral pills. Interestingly, older clients (age 35 plus) are prescribed IUCD and injectables.

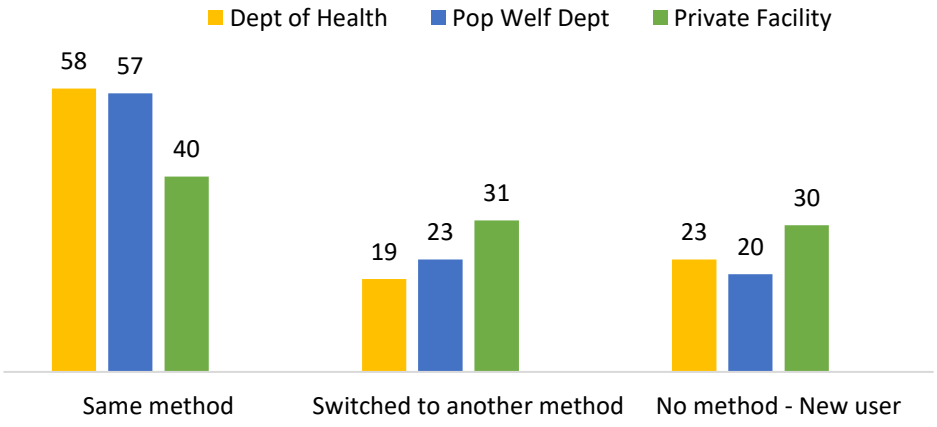
The survey reveals that almost same percent of clients from urban and rural areas are prescribed same method as they were using previously. More than a quarter (26%) of urban clients switched to another method and similar percent in rural areas are new users (Figure 7.2).

Figure 7.2: Percent distribution of family planning method prescribed to clients exiting by residence



More than half (55%) exiting clients reported using the same method as before visiting the facility while less than a quarter reported to be a new user (23%) – Figure 5.3. An interesting observation is noted that relatively higher percent of users reported to be switching method or a new user and they visit private facilities. Relatively low percent of method switching is reported by clients exiting DoH facilities (19%). Need for accurate counseling is felt at this point esp when a large segment of clients visit private sector where counseling for family planning is rather weak. Survey reveals that majority of new users fall in the younger ages (less than age 30), while users of same method are in the older age groups (30 and above) and those with parity 2 plus.

Figure 7.3: Percent distribution of family planning method prescribed or given by health facilities



7.2 Charges Paid by Clients

Accessing family planning (FP) services may face obstacles, including issue of affordability. Clients exiting facilities were asked about the costs incurred for contraceptive methods and services received. For each contraceptive method, the Table 7.1 shows the percentage of private sector facilities that charge for the commodities and service - average charges in Rupees (Rs) for both the method (actual contraceptive) and service (administration or consultation fees). Data reveals that public sector clients typically reported no charges, while private sector clients displayed varying charges for different contraceptive methods, indicating a price differential. Additionally, private sector clients bear extra service charges, potentially increasing the overall cost of receiving contraceptives. Despite these factors, women continue to utilize private sector services due to affordability. Survey (2024) reveals that only 19% of private facilities report charge for tubal ligation service, and the average charges for the method are recorded Rs. 3,840. Similarly, 65% of facilities charge for the IUCD, with an average charge of Rs. 988, and 42% charge for the service, with an average charge of Rs. 479. For the Depo-Provera injection charges are made by 65 percentages private facilities, charging Rs 261 for commodity and Rs 232 as service fee. No public sector facility clients reported charges paid and informed of free dispensation to clients. Trend as reflected in Table 7.1 reflects small changes in commodity prices and service charges over two years.

Table 7.1: Trend of average charges made by private sector facilities for FP method

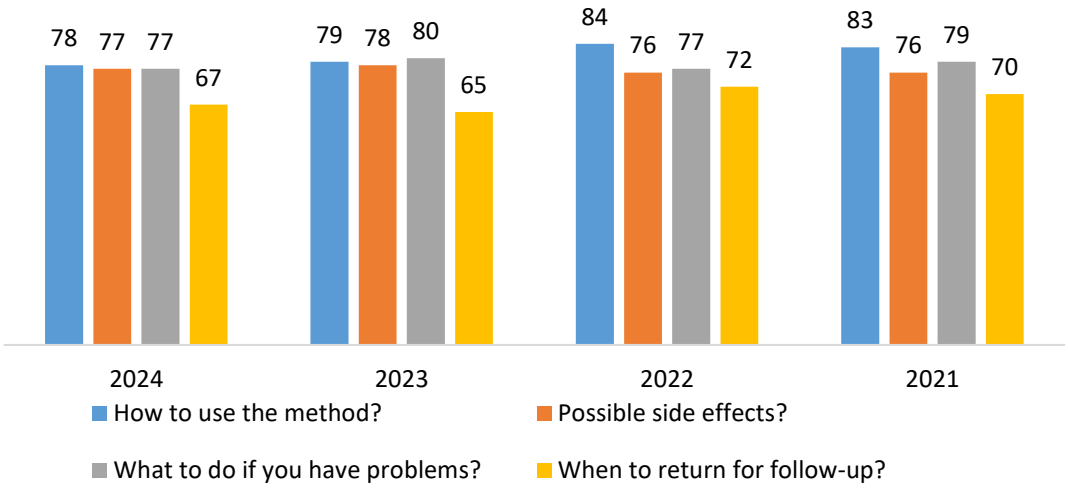
Contraceptive Methods		2024	2023
Tubal ligation - Service Charges	Percent Facilities Charged	19	6
Average Charges (Rs)		3,840	3,333
IUD - Method Price	Percent Facilities Charged	65	69
Average Charges (Rs)		988	787
IUD - Service Charges	Percent Facilities Charged	42	69
Average Charges (Rs)		479	460
Depo-Provera injection - Method Price	Percent Facilities Charged	72	67
Average Charges (Rs)		261	283
Depo-Provera injection - Service Charges	Percent Facilities Charged	39	67
Average Charges (Rs)		232	250
Implant - Method Price -	Percent Facilities Charged		0
Average Charges (Rs)		- -	0
Implant - Service Charges	Percent Facilities Charged		0
Average Charges (Rs)		- -	0
Pills - Method Price	Percent Facilities Charged	63	64
Average Charges (Rs)		114	127
Pills - Service Charges	Percent Facilities Charged	18	64
Average Charges (Rs)		194	250
Condoms - Method Price	Percent Facilities Charged	49	54
Average Charges (Rs)		200	158
Condoms - Service Charges	Percent Facilities Charged	12	54
Average Charges (Rs)		216	160

7.3 Quality of Service – Family Planning

Effective counselling is essential to ensure good understanding among women regarding contraceptive choice and selection of right method to address women's birth spacing needs. Several questions were posed to women exiting facilities to assess the comprehensiveness of counselling. The areas included: Whether they were explained how to use the method; possible side effects of various methods; what to do if they faced problems (side effects); and when to return for follow-up; contraceptive methods other than the method were given or prescribed; family planning method preference; and she could switch to a different method in the future.

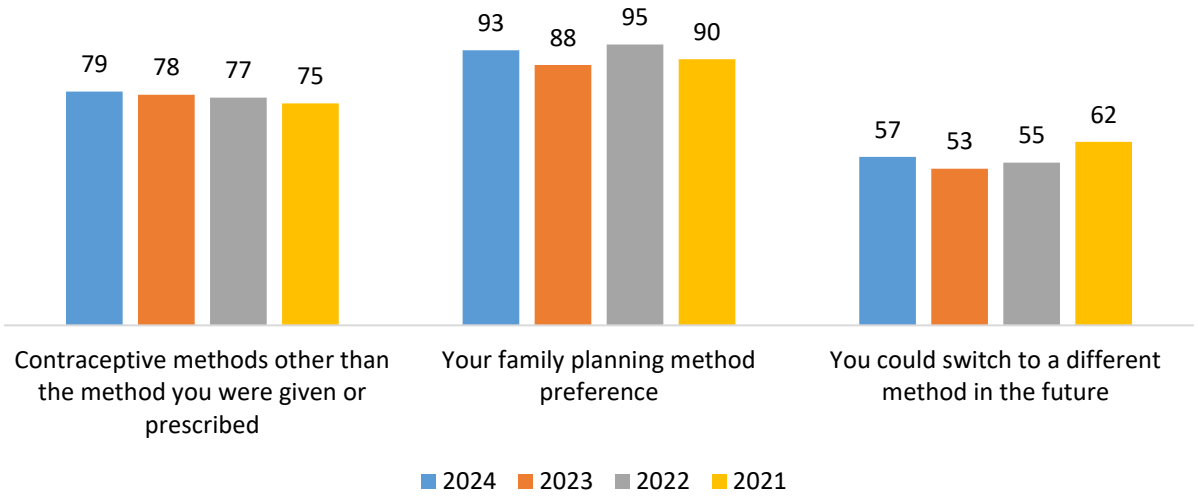
Upon analyzing clients' feedback over different years it is noted that clients report persistent counseling by facility staff over the years. Figure 5.4 shows clients reporting these four aspects persistently implying positive trend. One area 'when to return for follow-up' needs better attention. It is apparent from this analysis that a high percentage of women exiting all health facilities are informed about all four aspects of family planning focused quality of services.

Figure 7.4: Trend of percent FP clients who were advised on four aspects of FP



Three additional aspects were also asked from the clients on quality of FP services issues. Survey trend reveals that three-fourth (75%) women were informed about contraceptive methods other than the method given to them, a substantial percent of women (90% or more) were counseled about their 'preference of method', and more than half (57%) were informed that they could switch to another method too in Phase V (Figure 5.5). Switching methods appears to be discussed lowest with clients by all service providers. Though this reflects good counselling but needs to cover all aspects fully for comprehensive coverage.

Figure 5.5: Trend of percent FP clients who were advised on three additional aspects of FP



Examining the entity of facilities, private sector facilities according to feedback by clients, higher percent are found to be counseled on all seven areas, which is quite different from their expected role (Table 7.2). An issue that emerges from here is that private sector has basically urban orientation and this urban based facilities tend to reflect better percentages. Need to improve rural counseling is quite evident.

Table 7.2: Percent of exiting clients feedback on several areas of counseling by facility type

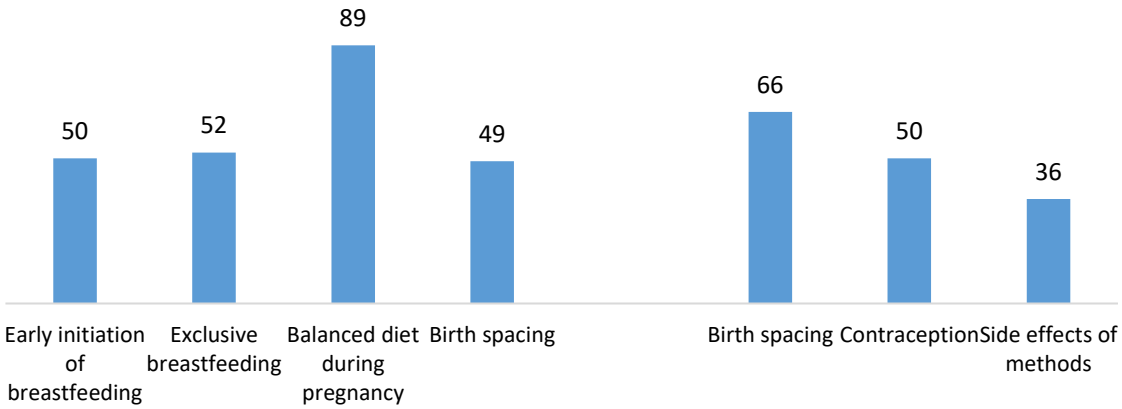
Area of Counselling	DOH	PWD	Private Facility	Urban	Rural
Explain how to use the method	75	79	82	85	73
Possible side effects	75	77	81	79	75
What to do if you have problems	69	80	85	81	73
When to return for follow-up	60	70	73	76	59
Contraceptive methods other than the method you were given or prescribed	77	80	84	83	76
Family planning method preference	92	94	94	95	91
You could switch to a different method in the future	54	58	58	56	57
Number of clients, prescribed or given family planning method	**106**	**226**	**279**	**287**	**324**

7.4 Maternal Health and Integration of Services - Quality of Counselling Services

Integration of family planning with MCH services is an important area covered in the survey. Women were asked whether counseling was done or not on important matters during ANC visit. Four important areas of counseling were enquired while seeking details on Antenatal Care (ANC) covered in the survey (329 cases): early initiation of breastfeeding; exclusive breastfeeding; maintaining a balanced diet during pregnancy; and birth spacing. Three additional areas were also

enquired from women who came for postnatal care (58 cases) and included: birth spacing, contraception and side effects of methods.

Figure 7.6: Percent distribution of quality of services during ANC (329 cases) and PNC stages (58 cases)



Balanced diet is highly reported for ANC stage (Figure 5.6) while other three areas receive lesser attention during ANC visits. For postnatal visits (18 percent of ANC visits) highest reported is counseling on birth spacing followed by contraception. Counseling on side effects, which is critical to minimize drop out / discontinuation of contraceptive, is done only to a third of women who visit for PNC.

ANC visit counseling when observed by type of facility visited, we find percent PWD staff reported for providing much higher counseling to women relative to other two entities (DoH and private facilities) especially for birth spacing and exclusive breastfeeding (Table 7.3). DoH facilities need to gear up their facility staff to be better prepared and respond to quality of service issue and convey the same to clients. Examining responses across urban and rural facilities, results reveal no major difference across both setting except urban facilities are reported better counselling on birth spacing.

Table 7.3: Percentage of women who reported counseling during ANC visit on specific matters by type of facility

Type of Health Facility	Early initiation of breastfeeding	Exclusive breastfeeding	Balanced diet during pregnancy	Birth spacing	No of Cases
DOH	50	50	86	49	**179**
PWD	62	64	85	72	**47**
Private Facility	45	49	96	40	**103**

In order to see variance across various background characteristics of exiting clients regarding three counseling aspects (presented in Table 5.4) it is noted that counseling is tilted towards older women (age 25 and above), women with primary and middle education, and proactively done by PWD

outlets. Low key counseling by Dept of Health facilities need to be geared up to meet high demand for such counseling to women during ANC visits.

Table 7.4: Percentage distribution of quality of services of postnatal care according to background characteristics

Characteristic	Birth spacing	Contraception	Side effects of methods		Number of client exit interview for postnatal care
Residence					
Urban	53	86	49		152
Rural	50	92	49		177
Respondent age					
15-19	18	76	24		17
20-24	49	88	39		93
25-29	53	90	50		109
30-34	57	94	60		65
35-39	59	85	59		39
40-44	50	100	83		6
Respondent education					
No education	46	87	43		95
Primary	66	88	52		64
Middle	57	88	54		56
Secondary	47	90	55		62
Higher	44	94	46		52
Type of Health Facility					
Private Facility	45	49	96		103
Public Facility					
DOH	50	50	86		179
PWD	62	64	85		47
Total	**50**	**52**	**89**		**329**

CONCLUSIONS AND RECOMMENDATIONS 8

8.1 Main Conclusions

1. The PMA framework-based exercise is efficient in terms of cost and time, and a tool for program decision makers with provincial level representative estimates of actionable results.
2. The exercise provides valuable information on several indicators and its use to reform and improve programme components is critical to capture desired progress.
3. Two clear messages are visible from the exercise: (i) changes in CPR are currently driven by traditional methods which needs serious programme reforms; and (ii) private sector has become a predominant source to access and provide modern contraceptives. Public sector has not shown its lead in the last few years to steer access to modern method.
4. The contraceptive method mix has remained unchanged over the years. Female sterilization and condoms use remained the two most popular methods in Punjab over two decades while traditional methods are being adopted in increasing proportions. These methods have little effect on birth spacing or limiting and on fertility decline. The use of oral pills, injectables and IUD remains low. The use of implants has been negligible, reflecting need for concerted effort in promoting choice of methods, as well as availability in its supplies.
5. Use of traditional method is quite high especially among women ages 25 to 44 (jumped to 14%). Proactive engagement by LHWs with effective planning and reaching out users of traditional methods is certainly needed to help shift to modern methods which is needed for protection against unintended pregnancies.
6. Weaknesses in FP Counseling appears to be a concern especially given to new users or first time users. Maximum number or proportion of users should be encouraged and followed to use modern methods.
7. In-depth analysis of contraceptive prevalence by programme interventions reveals ANC visits and LHVs interaction with woman substantially effects CPR positively. The effect on CPR is much higher among rural women than urban women. Visits of LHWs to women's households does not show any noticeable change in CPR even in rural areas.
8. Women interaction with LHWs influences contraceptive use for birth spacing but does not have any noticeable effect on birth limiting behaviour.
9. Women's interaction with health staff regarding FP is noted to give boost to percent women using contraception for birth spacing (in both urban and rural settings).
10. Higher percent of women who had ANC for her recent birth are users of contraception for birth spacing. ANC provides women the opportunity to learn more about contraception and improve their behaviours.
11. A high proportion of women either do not intend or don't know whether they intend to use contraception in the future. For an effective FP programme, a strong social mobilization and effective communication strategy with face-to-face meeting them is need of the time.

12. LHWs interaction with rural women do show a positive effect on their intention to use contraception as against those who did no interact with her. LHWs are the best source of information to rural women in deciding their contraceptive use.

13. Improved attention of LHWs is needed to ensure their focus on newly-wed, younger women to encourage them use effective birth spacing methods. Addressing myths and misconceptions is crucial.

14. Relatively high unintended pregnancies beyond age 25 is a serious concern reflecting unmet need for contraception and poor maternal health. Furthermore, urban women have higher unintended pregnancies that could be related to increased use of traditional methods.

15. Only a small percent facilities visited in the survey confirmed to be prepared to serve implants. This is a serious limitation and a bottleneck to 'choice' for clients. Limited contraceptive method choice, besides stock-outs and low method availability could promote conditions that ultimately discourage the use of modern methods and likely lead to increased contraceptive discontinuation.

16. A fairly large number of DoH facilities have trained staff to insert implants but facility, as a whole, are not prepared and equipped to perform. Investment and due attention are surely needed to fill the gap.

17. All DoH outlets/facilities claim to integrate FP counseling and services at all maternal health stages. This holds true for fewer facilities when results of client exit interviews are examined. Serious gaps exist in FP counselling during ANC and PNC stages especially by Department of Health staff.

18. Technical knowledge of contraceptives and family planning is critical for effective counseling and FP services. PWD service providers have better technical knowledge than staff at Health Department and private sector. Low percent of providers across all entities giving correct responses to a few critical questions is upsetting indicating urgent need for refresher training to all service providers. In particular, refresher training for DoH staff in various aspects of contraceptive technology and counseling is recommended. E-Learning technology may employed to reach out facility staff in remote areas to address staff's knowledge gaps.

19. Facility level performance was assessed based on number of clients served and commodities dispensed. Health facilities dispensed much lower average number of clients served and commodities than PWD outlets especially for IUDs, condoms, Injectables and Pills. Lower number of clients served by Health Department facilities (relative to PWD with much smaller network of facilities) point towards **underused capacity** that needs urgent attention to boost clientele. The low monthly average FP client attendance by Health facilities reflect serious under-utilization of the large network for FP purposes. The IRMNCH Program managers must take necessary measures to increase FP clientele and dispensation of contraceptives.

8.2 Key Recommendations

1. To accelerate programme performance and timely achieve the targets, all stakeholders must fully and urgently implement FP2030 commitments and CCI Recommendations. Urgently

reactivate the Punjab Provincial Population Task Force and strengthen provincial accountability fora to coordinate among government and development partners. Consider establishment of a Joint Technical Support Unit equipped with expertise to advise the task force and development partners and placed in Chief Minister's Office. Continuation of the PMA surveys and timely availability of reliable data will be important instrument to enable decision makers to track progress and make informed decisions.

2. Enhancing access, coverage, quality of service and contraceptive security are critical to fulfill FP2030 prime commitments. Making family planning counselling and services universally available at all public sector health facilities and private sector health facilities by 2025, especially where deliveries and PNC services are available is important. Promote post-pregnancy family planning services. Strong ownership by Department of Health is recognized as means for universal access.
3. Social mobilization and community level counseling are essential to accelerate family planning programme. Adequate preparation is critical to overhaul demand creation and communication strategy and components. All community-based service providers (LHWs and CMWs) and facility-based care providers (FWWs and LHVs) should give greater attention to counseling and must receive refresher training to focus on newly-wed, younger couples, low parity women and promote IUDs and implants. Furthermore, male mobilizers posted in rural communities must proactively pursue social mobilization role to educate men to make informed choices for birth spacing and use of long acting reversible methods. Myths and misinformation among men needs to be addressed.
4. Inequity in access remains a management barrier across the province. Proactively reaching out the vulnerable, poorest of the poor and marginalized population through its infrastructure should be a key priority of the public sector. Link family planning activities with Social Safety Net Program (such as providing vouchers to poor women) and introduce innovative schemes for adoption of FP service and institutionalized birth delivery. Use of mobile service unit and local health facilities with trained staff must be engaged to reach out the poor communities for better access to services. Home delivery services of contraceptives must be tested and scaled up by the private sector entities.
5. Punjab Heath Dept. has made credible progress in training facility staff in insertion and removal of implants. Survey reveals that more staff is actually trained in implant insertion than the number facilities record full preparedness. Top priority be given to fully equip health facilities in rural communities with trained staff in implant insertion with due provision of implants supplies to address unmet need and unintended pregnancies.
6. Boosting integration of family planning counseling and services: With a very large base of women visiting health facilities for their health needs (ante natal care, delivery and post-natal care) complete plan of action for functional integration of FP in all health protocols needs to be developed to ensure family planning services are delivered at ANC, delivery or postnatal stages including counseling regarding birth spacing and contraception services.

7. Proper implementation of Life Skills Education and Planned Parenthood programmes should be carried forward to boost not only demand but better understanding of contraceptive methods.
8. In order to achieve programme objectives and accelerate the FP Programme, competent and motivated human resource is of crucial importance. E-Learning technology developed and successfully tested in recent years has become very convenient to use. This technical advancement must be brought under use to meet the human development needs across all sectors especially for those working in remote facilities.
9. Long-term Joint assessment and procurement plan for all stakeholders is highly recommended to overcome the supply related problem. A dynamic logistics system must be in place to minimize chances of clients returning without a method and face increased risk of unintended pregnancies. The procurement plans for the upcoming years should specifically include the acquisition of implants. Additionally, ensuring long-term financing is crucial to guarantee contraceptive security.

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