

Punjab

Final Report

Monitoring the situation of children and women



Multiple Indicator Cluster Survey 2014



Bureau of Statistics
Planning & Development Department
Government of the Punjab



United Nations Children's Funds



Title page picture is taken by Ms. Shagufta (UNICEF) with the permission from Ms. Rukhsana with her one month daughter Mahnoor, in her house at basti nandanpura near Kacha Pakka in Kasur district, Punjab.



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Multiple Indicator Cluster Survey 2014

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December, 2015*



**Report was endorsed by MICS Steering Committee, Punjab in December, 2015 and disseminated in March, 2016*

The Multiple Indicator Cluster Survey (MICS) Punjab, 2014 [Pakistan] was carried out in 2014 by Bureau of Statistics Punjab in collaboration with United Nations Children's Fund (UNICEF). It was conducted as part of the fifth global round of MICS. Major funding was provided by Government of the Punjab through Annual Development Programme 2014-15 and the technical support was provided by the UNICEF.

The global MICS programme was developed by UNICEF in the 1990s as an international household survey programme to support countries in the collection of internationally comparable data on a wide range of indicators on the situation of children and women. MICS surveys measure key indicators that allow countries to generate data for use in policies and programmes, and to monitor progress towards the Millennium Development Goals (MDGs) and other internationally agreed upon commitments. MICS Punjab, 2014 is the fourth MICS in Punjab since 2004. Information on the global MICS may be obtained from mics.unicef.org and information about Bureau of Statistics, Punjab from bos.gop.pk and pndpunjab.gov.pk

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SUMMARY TABLE OF SURVEY IMPLEMENTATION AND THE SURVEY POPULATION, MICS PUNJAB, 2014

Survey implementation			
Sample frame	1998 census	Questionnaires	Household
- Updated	2010		Women (age 15-49)
Interviewer training	June-July, 2014	Fieldwork	Children under five
			June to September 2014
Survey sample			
Households		Children under five	
- Sampled	41,413	- Eligible	31,083
- Occupied	39,333	- Mothers/caretakers interviewed	27,495
- Interviewed	38,405	- Response rate (Percent)	88.5
- Response rate (Percent)	97.6		
Women			
- Eligible for interviews	61,286		
- Interviewed	53,668		
- Response rate (Percent)	87.6		

Survey population			
Average household size	6.4	Percentage of population living in	
Percentage of population under:		- Urban areas	33.4
- Age 5	12.7	- Rural areas	66.6
- Age 18	43.3	- Bahawalpur	10.7
Percentage of ever married women age 15-49 years with at least one live birth in the last 2 years	30.6	- D.G. Khan	8.9
		- Faisalabad	12.7
		- Gujranwala	14.5
		- Lahore	17.3
		- Multan	12.1
		- Sahiwal	6.9
		- Rawalpindi	9.4
		- Sargodha	7.5

Housing characteristics	
Percentage of households with	
- Electricity	95.4
- Finished floor	63.3
- Finished roofing	82.2
- Finished walls	86.6
Mean number of persons per room used for sleeping	3.91

Household or personal assets	
Percentage of households that own	
- A television	67.6
- A refrigerator	53.1
- Agricultural land	30.5
- Farm animals/livestock	45.5
Percentage of households where at least a member has or owns a	
- Mobile phone	92.6
- Car or Van	5.8

SUMMARY TABLE OF FINDINGS¹

Multiple Indicator Cluster Surveys (MICS) and Millennium Development Goals (MDGs) Indicators, Punjab, 2014

Indicator No.		Indicator	Description	Value ^A
MICS	MDG			
CHILD MORTALITY				
Early childhood mortality				
1.2	MDG 4.2	Infant mortality rate	Probability of dying between birth and the first birthday	75.0
1.5	MDG 4.1	Under-five mortality rate	Probability of dying between birth and the fifth birthday	93.0
^A Indicator values are per 1,000 live births and rates refer to April, 2011. The East Model was assumed to approximate the age pattern of mortality in Punjab, Pakistan and calculations are based on the Time Since First Birth (TSFB) version of the indirect children ever born/children surviving method.				
Indicator No.		Indicator	Description	Value
MICS	MDG			
NUTRITION				
Nutritional status				
2.1a	MDG 1.8	Underweight prevalence	Percentage of children under age 5 who fall below	
2.1b		(a) Moderate and severe (b) Severe	(a) minus two standard deviations (moderate and severe) (b) minus three standard deviations (severe) of the median weight for age of the WHO standard	33.7 11.3
2.2a		Stunting prevalence	Percentage of children under age 5 who fall below	
2.2b		(a) Moderate and severe (b) Severe	(a) minus two standard deviations (moderate and severe) (b) minus three standard deviations (severe) of the median height for age of the WHO standard	33.5 13.3
2.3a		Wasting prevalence	Percentage of children under age 5 who fall below	
2.3b		(a) Moderate and severe (b) Severe	(a) minus two standard deviations (moderate and severe) (b) minus three standard deviations (severe) of the median weight for height of the WHO standard	17.5 4.4
2.4		Overweight prevalence	Percentage of children under age 5 who are above two standard deviations of the median weight for height of the WHO standard	0.8
Breastfeeding and infant feeding				
2.5		Children ever breastfed	Percentage of women with a live birth in the last 2 years who breastfed their last live-born child at any time	93.7
2.6		Early initiation of breastfeeding	Percentage of women with a live birth in the last 2 years who put their last newborn to the breast within one hour of birth	10.6
2.7		Exclusive breastfeeding under 6 months	Percentage of infants under 6 months of age who are exclusively breastfed	16.8
2.8		Predominant breastfeeding under 6 months	Percentage of infants under 6 months of age who received breast milk as the predominant source of nourishment during the previous day	47.8
2.9		Continued breastfeeding at 1 year	Percentage of children age 12-15 months who received breast milk during the previous day	65.6
2.10		Continued breastfeeding at 2 years	Percentage of children age 20-23 months who received breast milk during the previous day	34.5
2.11		Median duration of breastfeeding	The age in months when 50 percent of children age 0-35 months did not receive breast milk during the previous day	17.4 months
2.12		Age-appropriate breastfeeding	Percentage of children age 0-23 months appropriately fed during the previous day	41.2

¹ See Appendix F for a detailed description of MICS indicators

Indicator No.		Indicator	Description	Value
MICS	MDG			
2.13		Introduction of solid, semi-solid or soft foods	Percentage of infants age 6-8 months who received solid, semi-solid or soft foods during the previous day	61.1
2.14		Milk feeding frequency for non-breastfed children	Percentage of non-breastfed children age 6-23 months who received at least 2 milk feedings during the previous day	90.8
2.15		Minimum meal frequency	Percentage of children age 6-23 months who received solid, semi-solid and soft foods (plus milk feeds for non-breastfed children) the minimum number of times or more during the previous day	65.3
2.16		Minimum dietary diversity	Percentage of children age 6-23 months who received foods from 4 or more food groups during the previous day	17.3
2.17a 2.17b		Minimum acceptable diet	(a) Percentage of breastfed children age 6-23 months who had at least the minimum dietary diversity and the minimum meal frequency during the previous day (b) Percentage of non-breastfed children age 6-23 months who received at least 2 milk feedings and had at least the minimum dietary diversity not including milk feeds and the minimum meal frequency during the previous day	11.2 7.3
2.18		Bottle feeding	Percentage of children age 0-23 months who were fed with a bottle during the previous day	57.7
Salt iodization				
2.19		Iodized salt consumption	Percentage of households with salt testing 15 parts per million or more of iodate	49.2
Low-birthweight				
2.20		Low-birth weight infants	Percentage of most recent live births in the last 2 years weighing below 2,500 grams at birth	29.4
2.21		Infants weighed at birth	Percentage of most recent live births in the last 2 years who were weighed at birth	25.6
Vitamin A				
2.S1		Vitamin A supplementation	Percentage of children age 6-59 months who received at least one high-dose vitamin A supplement in the 6 months preceding the survey	64.8
CHILD HEALTH				
Vaccinations				
3.1		Tuberculosis immunization coverage	Percentage of children age 12-23 months who received BCG vaccine by their first birthday	92.8
3.2		Polio immunization coverage	Percentage of children age 12-23 months who received the third dose of OPV vaccine (OPV3) by their first birthday	84.8
3.3 3.5 3.6		Diphtheria, pertussis and tetanus (DPT), hepatitis B (HepB) and haemophilus influenza type B (Hib) (PENTA) immunization coverage	Percentage of children age 12-23 months who received the third dose of PENTA vaccine (diphtheria, pertussis, tetanus, hepatitis B and haemophilus influenza B) by their first birthday	71.7
3.4	MDG 4.3	Measles immunization coverage	Percentage of children age 12-23 months who received measles vaccine by their first birthday	71.6
3.8		Full immunization coverage	Percentage of children age 12-23 months who received all vaccinations recommended in the national immunization schedule by their first birthday	56.6
Tetanus toxoid				
3.9		Neonatal tetanus protection	Percentage of women age 15-49 years with a live birth in the last 2 years who were given at least two doses of tetanus toxoid vaccine within the appropriate interval prior to the most recent birth	76.4

Indicator No.		Indicator	Description	Value
MICS	MDG			
Diarrhoea				
-		Children with diarrhoea	Percentage of children under age 5 with diarrhoea in the last 2 weeks	17.4
3.10		Care-seeking for diarrhoea	Percentage of children under age 5 with diarrhoea in the last 2 weeks for whom advice or treatment was sought from a health facility or provider	72.1
3.11		Diarrhoea treatment with oral rehydration salts (ORS) and zinc	Percentage of children under age 5 with diarrhoea in the last 2 weeks who received ORS and zinc	9.7
3.12		Diarrhoea treatment with oral rehydration therapy (ORT) and continued feeding	Percentage of children under age 5 with diarrhoea in the last 2 weeks who received ORT (ORS packet, pre-packaged ORS fluid, recommended homemade fluid or increased fluids) and continued feeding during the episode of diarrhoea	38.9
Acute Respiratory Infection (ARI) symptoms				
-		Children with ARI symptoms	Percentage of children under age 5 with ARI symptoms in the last 2 weeks	2.5
3.13		Care-seeking for children with ARI symptoms	Percentage of children under age 5 with ARI symptoms in the last 2 weeks for whom advice or treatment was sought from a health facility or provider	77.1
3.14		Antibiotic treatment for children with ARI symptoms	Percentage of children under age 5 with ARI symptoms in the last 2 weeks who received antibiotics	39.1
Solid fuel use				
3.15		Use of solid fuels for cooking	Percentage of household members in households that use solid fuels as the primary source of domestic energy to cook	61.1
Malaria / Fever				
-		Children with fever	Percentage of children under age 5 with fever in the last 2 weeks	20.8
3.20		Care-seeking for fever	Percentage of children under age 5 with fever in the last 2 weeks for whom advice or treatment was sought from a health facility or provider	79.3
3.21		Malaria diagnostics usage	Percentage of children under age 5 with fever in the last 2 weeks who had a finger or heel stick for malaria testing	4.0
3.22	MDG 6.8	Anti-malarial treatment of children under age 5	Percentage of children under age 5 with fever in the last 2 weeks who received any antimalarial treatment	1.3
3.23		Treatment with Artemisinin-based Combination Therapy (ACT) among children who received anti-malarial treatment	Percentage of children under age 5 with fever in the last 2 weeks who received ACT (or other first-line treatment according to national policy)	9.4*
3.25		Intermittent preventive treatment for malaria during pregnancy	Percentage of women age 15-49 years who received three or more doses of SP/Fansidar, at least one of which was received during an ANC visit, to prevent malaria during their last pregnancy that led to a live birth in the last 2 years	0.4
*Indicator denominator based on 25-49 unweighted cases - only shown here in summary table and not in main report chapter.				
WATER AND SANITATION				
4.1	MDG 7.8	Use of improved drinking water sources	Percentage of household members using improved sources of drinking water	94.4
4.2		Water treatment	Percentage of household members in households using unimproved drinking water who use an appropriate treatment method	2.1
4.3	MDG 7.9	Use of improved sanitation (Not shared)	Percentage of household members using improved sanitation facilities which are not shared	66.2

Indicator No.		Indicator	Description	Value
MICS	MDG			
4.S1		Use of improved sanitation	Percentage of household members using improved sanitation facilities whether shared or not shared	75.1
4.4		Safe disposal of child's faeces	Percentage of children age 0-2 years whose last stools were disposed of safely	71.4
4.5		Place for handwashing	Percentage of households with a specific place for hand washing where water and soap or other cleansing agent are present	79.6
4.6		Availability of soap or other cleansing agent	Percentage of households with soap or other cleansing agent available anywhere in the household	92.8
REPRODUCTIVE HEALTH				
Contraception and unmet need				
-		Total fertility rate	Total fertility rate ^A for women age 15-49 years	3.5
5.1	MDG 5.4	Adolescent birth rate	Age-specific fertility rate ^A for women age 15-19 years	34.0
5.2		Early childbearing	Percentage of ever married women age 20-24 years who had at least one live birth before age 18	11.8
5.3	MDG 5.3	Contraceptive prevalence rate	Percentage of women age 15-49 years currently married who are using (or whose partner is using) a (modern or traditional) contraceptive method	38.7
5.4	MDG 5.6	Unmet need	Percentage of women age 15-49 years who are currently married who are fecund and want to space their births or limit the number of children they have and who are not currently using contraception	17.5
<p>^AThe age-specific fertility rate is defined as the number of live births to women in a specific age group during a specified period, divided by the average number of women in that age group during the same period, expressed per 1,000 women. The age-specific fertility rate for women age 15-19 years is also termed as the adolescent birth rate.</p> <p>The total fertility rate (TFR) is calculated by summing the age-specific fertility rates calculated for each of the 5-year age groups of women, from age 15 through to age 49. The TFR denotes the average number of children to which a woman will have given birth by the end of her reproductive years (by age 50) if current fertility rates prevailed.</p>				
Maternal and newborn health				
5.5a	MDG 5.5	Antenatal care coverage	Percentage of women age 15-49 years with a live birth in the last 2 years who were attended during their last pregnancy that led to a live birth	
5.5b	MDG 5.5		(a) at least once by skilled health personnel	78.8
			(b) at least four times by any provider	48.0
5.6		Content of antenatal care	Percentage of women age 15-49 years with a live birth in the last 2 years who had their blood pressure measured and gave urine and blood samples during the last pregnancy that led to a live birth	45.3
5.S1		Content of antenatal care (All four)	Percentage of women age 15-49 years with a live birth in the last 2 years who had their blood pressure measured, weight measured and gave urine and blood samples during the last pregnancy that led to a live birth	36.3
5.7	MDG 5.2	Skilled attendant at delivery	Percentage of women age 15-49 years with a live birth in the last 2 years who were attended by skilled health personnel during their most recent live birth	64.7
5.8		Institutional deliveries	Percentage of women age 15-49 years with a live birth in the last 2 years whose most recent live birth was delivered in a health facility	60.8
5.9		Caesarean section	Percentage of women age 15-49 years whose most recent live birth in the last 2 years was delivered by caesarean section	23.6
Post-natal health checks				
5.10		Post-partum stay in health facility	Percentage of women age 15-49 years who stayed in the health facility for 12 hours or more after the delivery of their most recent live birth in the last 2 years	52.0

Indicator No.		Indicator	Description	Value
MICS	MDG			
5.11		Post-natal health check for the newborn	Percentage of last live births in the last 2 years who received a health check while in facility or at home following delivery, or a post-natal care visit within 2 days after delivery	88.8
5.12		Post-natal health check for the mother	Percentage of women age 15-49 years who received a health check while in facility or at home following delivery, or a post-natal care visit within 2 days after delivery of their most recent live birth in the last 2 years	86.3
CHILD DEVELOPMENT				
6.1		Attendance to early childhood education	Percentage of children age 36-59 months who are attending an early childhood education programme	25.7
6.2		Support for learning	Percentage of children age 36-59 months with whom an adult has engaged in four or more activities to promote learning and school readiness in the last 3 days	35.0
6.3		Father's support for learning	Percentage of children age 36-59 months whose biological father has engaged in four or more activities to promote learning and school readiness in the last 3 days	2.6
6.4		Mother's support for learning	Percentage of children age 36-59 months whose biological mother has engaged in four or more activities to promote learning and school readiness in the last 3 days	11.8
6.5		Availability of children's books	Percentage of children under age 5 who have three or more children's books	7.6
6.6		Availability of playthings	Percentage of children under age 5 who play with two or more types of playthings	52.5
6.7		Inadequate care	Percentage of children under age 5 left alone or in the care of another child younger than 10 years of age for more than one hour at least once in the last week	6.8
6.8		Early child development index	Percentage of children age 36-59 months who are developmentally on track in at least three of the following four domains: literacy-numeracy, physical, social-emotional, and learning	67.2
LITERACY AND EDUCATION				
7.1	MDG 2.3	Literacy rate among young women	Percentage of young women age 15-24 years who are able to read a short simple statement about everyday life or who attended secondary or higher education	72.6
7.S1		Literacy rate 10+ (<i>reported</i>)	Percentage of household members age 10 years or older where it is reported that they are able to both read & write with understanding in any language excluding quranic reading, if this was the only response	60.8
7.S2		Literacy rate 15+ (<i>reported</i>)	Percentage of household members age 15 years or older where it is reported that they are able to both read & write with understanding in any language excluding quranic reading, if this was the only response	58.0
7.S3		Literacy rate 15-24 years (<i>reported</i>)	Percentage of household members age 15-24 years where it is reported that they are able to both read & write with understanding in any language excluding quranic reading, if this was the only response	75.9
7.2		School readiness	Percentage of children in first grade of primary school who attended preschool during the previous school year	92.5
7.3		Net intake rate in primary education	Percentage of children of school-entry age who enter the first grade of primary school	23.4
7.4	MDG 2.1	Primary school net attendance ratio (adjusted)	Percentage of children of primary school age currently attending primary or secondary school	57.9
7.S4		Primary school gross attendance ratio (adjusted)	Percentage of children of all age currently attending primary or secondary school	86.1

Indicator No.		Indicator	Description	Value
MICS	MDG			
7.5		Secondary school net attendance ratio (adjusted)	Percentage of children of secondary school age currently attending secondary school or higher	42.1
7.6	MDG 2.2	Children reaching last grade of primary	Percentage of children entering the first grade of primary school who eventually reach last grade	95.8
7.7		Primary completion rate	Number of children attending the last grade of primary school (excluding repeaters) divided by number of children of primary school completion age (age appropriate to final grade of primary school)	74.9
7.8		Transition rate to secondary school	Number of children attending the last grade of primary school during the previous school year who are in the first grade of secondary school during the current school year divided by number of children attending the last grade of primary school during the previous school year	91.4
7.9	MDG 3.1	Gender parity index (primary school)	Primary school net attendance ratio (adjusted) for girls divided by primary school net attendance ratio (adjusted) for boys	0.97
7.10	MDG 3.1	Gender parity index (secondary school)	Secondary school net attendance ratio (adjusted) for girls divided by secondary school net attendance ratio (adjusted) for boys	0.98
7.S5		Government school attendance rate (primary)	Percentage of children aged 5-9 years attending Government primary schools	54.2
CHILD PROTECTION				
Birth registration				
8.1		Birth registration	Percentage of children under age 5 whose births are reported registered	72.7
Child labour				
8.2		Child labour	Percentage of children age 5-17 years who are involved in child labour ²	16.4
Child discipline				
8.3		Violent discipline	Percentage of children age 1-14 years who experienced psychological aggression or physical punishment during the last one month	80.7
Early marriage and polygyny				
8.4		Marriage before age 15	Percentage of women age 15-49 years who were first married before age 15	5.2
8.5		Marriage before age 18	Percentage of women age 20-49 years who were first married before age 18	20.8
8.6		Young women age 15-19 years currently married	Percentage of women age 15-19 years who are married	9.2
8.7		Polygyny	Percentage of women age 15-49 years who are in a polygynous marriage	2.5
8.8a		Spousal age difference	Percentage of young women who are married and whose spouse is 10 or more years older, (a) among women age 15-19 years, (b) among women age 20-24 years	18.8
8.8b				14.6
Attitudes towards domestic violence				
8.12		Attitudes towards domestic violence	Percentage of women age 15-49 years who state that a husband is justified in hitting or beating his wife in at least one of the following circumstances: (1) she goes out without telling him, (2) she neglects the children, (3) she argues with him, (4) she refuses sex with him, (5) she burns the food	39.8

² Children involved in child labour are defined as children involved in economic activities at or above the age-specific thresholds, children involved in household chores at or above the age-specific thresholds, and children involved in hazardous work

Indicator No.		Indicator	Description	Value
MICS	MDG			
Children's living arrangements				
8.13		Children's living arrangements	Percentage of children age 0-17 years living with neither biological parent	1.4
8.14		Prevalence of children with one or both parents dead	Percentage of children age 0-17 years with one or both biological parents dead	4.8
8.15		Children with at least one parent living abroad	Percentage of children 0-17 years with at least one biological parent living abroad	3.9
HIV/AIDS				
HIV/AIDS knowledge and attitudes				
-		Have heard of AIDS	Percentage of ever married ³ women age 15-49 years who have heard of AIDS	39.0
9.S1		Knowledge about HIV prevention among young women	Percentage of ever married young women age 15-24 years who correctly identify ways of preventing the sexual transmission of HIV, and who reject major misconceptions about HIV transmission	3.3
9.S2		Knowledge of mother-to-child transmission of HIV	Percentage of ever married women age 15-49 years who correctly identify all three means of mother-to-child transmission of HIV	23.6
9.S3		Accepting attitudes towards people living with HIV	Percentage of ever married women age 15-49 years expressing accepting attitudes on all four questions toward people living with HIV	19.0
HIV testing				
9.S4		Women who know where to be tested for HIV	Percentage of ever married women age 15-49 years who state knowledge of a place to be tested for HIV	8.5
9.S5		Women who have been tested for HIV and know the results	Percentage of ever married women age 15-49 years who have been tested for HIV in the last 12 months and who know their results	0.6
9.S7		HIV counselling during antenatal care	Percentage of ever married women age 15-49 years who had a live birth in the last 2 years and received antenatal care during the pregnancy of their most recent birth, reporting that they received counselling on HIV during antenatal care	1.3
9.S8		HIV testing during antenatal care	Percentage of ever married women age 15-49 years who had a live birth in the last 2 years and received antenatal care during the pregnancy of their most recent birth, reporting that they were offered and accepted an HIV test during antenatal care and received their results	1.1
9.16	MDG 6.4	Ratio of school attendance of orphans to school attendance of non-orphans	Proportion attending school among children age 10-14 years who have lost both parents divided by proportion attending school among children age 10-14 years whose parents are alive and who are living with one or both parents	(0.83)*
*Indicator denominator based on 25-49 unweighted cases - only shown here in summary table and not in main report chapter.				
ACCESS TO MASS MEDIA AND ICT				
Access to mass media				
10.1		Exposure to mass media	Percentage of women age 15-49 years who, at least once a week, read a newspaper or magazine, listen to the radio, and watch television	1.3
Use of information/communication technology				
10.2		Use of computers	Percentage of women age 15-24 years who used a computer during the last 12 months	21.4

³ The modules of "Individual questionnaire for women" i.e. "Fertility", "Desire for last birth", "Maternal and newborn health", "Post-natal health checks", "Contraception", "Unmet Need" & "HIV/AIDS" were asked to ever married women (age 15-49 years) only.

Indicator No.		Indicator	Description	Value
MICS	MDG			
10.3		Use of internet	Percentage of women age 15-24 years who used the internet during the last 12 months	12.4
SUBJECTIVE WELL-BEING				
11.1		Life satisfaction	Percentage of young women age 15-24 years who are very or somewhat satisfied with their life, overall	90.5
11.2		Happiness	Percentage of young women age 15-24 years who are very or somewhat happy	90.9
11.3		Perception of a better life	Percentage of young women age 15-24 years whose life improved during the last one year, and who expect that their life will be better after one year	59.2
TOBACCO USE				
Tobacco use				
12.1		Tobacco use	Percentage of women age 15-49 years who smoked cigarettes, or used smoked or smokeless tobacco products at any time during the last one month	4.1
12.2		Smoking before age 15	Percentage of women age 15-49 years who smoked a whole cigarette before age 15	0.2
ADULT HEALTH AND HEALTH CARE				
Adult health care				
13.S1		Care provided by Lady Health Worker (LHW)	Number of ever married women aged 15–49 years who have given birth in the previous 2 years and were visited by a Lady Health Worker (LHW) in the last month	37.6
13.S2		Prevalence of chronic cough	Number of household members with cough that lasted for the past 3 weeks	3.2
13.S3		Reported tuberculosis	Number of household members that were diagnosed with tuberculosis in the past year	0.5
13.S4		Reported hepatitis	Number of household members that were diagnosed with hepatitis in the past year	1.5
SOCIO-ECONOMIC DEVELOPMENT				
Assets				
14.S1		Ownership of assets: House, land, livestock	Percentage of household members living in a household that own a house, land or livestock	
		a) House		87.0
		b) Agriculture land		30.5
		c) Livestock		45.5
Unemployment				
14.S2		Unemployment rate (10+ years)	Percent of household members aged 10 years or older who are unemployed and are seeking jobs	7.1
Housing⁴				
14.S10		Mean household size	Average members in a household	6.4
14.S11		Currently married population	Percentage of household members of age 10 years and above currently married	51.4
14.S12		Mean number of persons per room	Average members sleeping in one room	3.91
14.S13a		Household characteristics	Main material of floor, roof and wall	
14.S13b			a) finished floor (pacca)	63.4
14.S13c			b) finished roof (pacca)	82.2
			c) finished wall (pacca)]	86.6

⁴ The information related to provincial indicator 14.S10 and 14.S12 & 14.S13 is given in chapter III “sample coverage and the characteristics of households and respondents” at Table HH.3 and HH.6 respectively.

Indicator No.		Indicator	Description	Value
MICS	MDG			
Remittances and zakat				
14.S3		Population working outside village/city/country	Percentage of family members working outside village/city/country	12.0
14.S4		Receiving remittances from within Pakistan	Percentage of household members who received remittances from within Pakistan during the year preceding the survey	3.1
14.S5		Receiving remittances from abroad	Percentage of household members living in a household that received remittances from abroad during the year preceding the survey	7.3
14.S6		Receiving cash donation	Percentage of household members living in a household that received cash donation such as zakat or other means during the year preceding the survey	1.2
Social benefits and Subsidies				
14.S7		Safety nets (getting benefits from government schemes of social protection)	Percentage of household members living in a household that got benefits from government schemes of social protection [Benefits include: zakat, dearness allowance, health subsidy, education subsidy, marriage grant, subsidized food, others]	7.2
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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BCG	Bacillus-Calmette-Guerin (Tuberculosis)
BHU	Basic Health Unit
BoS	Bureau of Statistics
CSPRO	Census and Survey Processing System
DPT	Diphtheria Pertussis Tetanus
ECDI	Early Child Development Index
EOBI	Employees Old-Age Benefits Institution
EPI	Expanded Programme on Immunization
GPI	Gender Parity Index
GAR	Gross Attendance Rate
HIV	Human Immunodeficiency Virus
IDD	Iodine Deficiency Disorders
IMR	Infant Mortality Rate
IUD	Intrauterine Device
LAM	Lactational Amenorrhea Method
LHV	Lady Health Visitor
LHW	Lady Health Worker
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MICS5	Fifth global round of Multiple Indicator Clusters Surveys programme
NAR	Net Attendance Rate
ORT	Oral Rehydration Treatment
PBS	Pakistan Bureau of Statistics
P&DD	Planning and Development Department
PENTA	Combination of 5 Vaccines (Diphtheria, Pertussis, Tetanus, Haemophilus influenzae B (HIB) and Hepatitis B)
PNC	Post-natal Care
PNHC	Post-natal Health Checks
ppm	Parts Per Million
PSUs	Primary Sampling Units
ROSA	Regional Office for South Asia – UNICEF
SDGs	Sustainable Development Goals
SPSS	Statistical Package for Social Sciences
SSUs	Secondary Sampling Units
TBAs	Traditional Birth Attendants
TFR	Total Fertility Rate
U5MR	Under 5 Mortality Rate
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children’s Fund
WFFC	World Fit for Children
WHO	World Health Organization
ASFR	Age Specific Fertility Rate

FOREWORD

Social sector has remained a priority area for the Government of Punjab. Development outlays for the sector have grown manifold over the last few years. Government of the Punjab, along with the national and international partners, is committed to achieve the Sustainable Development Goals (SDGs)/Millennium Development Goals (MDGs) vis-a-vis education, health, water supply, sanitation, poverty etc. This would require not only provision of adequate resources but also a very robust system for ascertaining the area specific needs, efficient use of resources and regular monitoring of the results and impacts. The first district based Multiple Indicator Cluster Survey (MICS) was conducted 2003-04. This survey provided benchmark for a number of indicators at district level and created a culture for using data for planning purposes. The raw data was shared with academia, research organizations and development partners for carrying out further research. Second and third round of MICS Punjab took place in 2007-08 and 2011. These surveys proved to be the most imperative tools in determining government budgetary outlays, particularly for the social sector. Besides many international papers, various students have completed their M.Phil/Ph.D theses by using the MICS data.

MICS Punjab, 2014 is a district based survey covering 125 indicators, and is the largest on this account. It is a matter of immense satisfaction that the survey has been completed within a stipulated time period. The results of MICS Punjab, 2014 will enable the government to measure progress made on key social indicators. It also provides a baseline for a number of new social indicators which were not covered earlier. Planning & Development Department, UNICEF, and other stakeholders at the provincial and district level richly deserve all the credit for coming up with an excellent report. Special credit goes to Bureau of Statistics (BoS) Punjab for their untiring efforts and hard work.

This present round of MICS, like the other three rounds, allows the provincial and district governments to monitor their respective status of human and social development with precise data on variety of key indicators. It will assist the decision-makers to move towards new avenues of human and social development.

I am confident that this report will prove to be a valuable source for planning efforts of Government of Punjab and development partners, and a reference for academia and research organizations.

MOHAMMAD JEHANZEB KHAN

Chairman

Planning and Development Board, Punjab

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The Punjab Multiple Indicator Cluster Survey (MICS) 2014 is the result of devoted efforts of different departments and organisations. Major funding for the survey was provided by Government of the Punjab through the Punjab Annual Development Programme (ADP) and a moderate contribution by UNICEF. Field work was conducted by the Bureau of Statistics (BoS), like in all previous rounds of MICS in Punjab. It is remarkable that for the first time, data processing of the current MICS Punjab which was outsourced in all previous rounds was carried out by BOS. This really was an exceptional achievement and the staff involved deserves special appreciation. The Global MICS team provided technical support throughout the survey process. Pakistan Bureau of Statistics (PBS) provided the sample design which was reviewed by an international expert on sampling engaged by UNICEF.

The Chairman, Planning & Development Board who heads the Provincial Steering Committee extended his fullest support throughout the process. Mr. Shamim Rafique, the Director General of BoS and his team worked hard for the timely completion of the survey. Keen interest and contribution made by members of the Steering Committee, Technical and Planning and Coordination groups are also acknowledged. The continuous coordination efforts of Mr. Khalid Sultan, focal person from Planning & Development Department, are commendable.

Ms. Pashmina Naz Ali (Ex-Chief Planning, Monitoring, Evaluation and Reporting, UNICEF, Islamabad), Mr. Nouman Ghani (Planning, Monitoring, Evaluation and Reporting Specialist), Rana Muhammad Sarwar (UNICEF MICS Consultant) and Mr. Faateh ud din Ahmad (Data Processing Consultant) played an active role in the process of MICS Punjab, 2014.

All district governments and administrative departments provided valuable support and facilitation in the field work. Communities, local leaders and members of the selected households devoted their precious time. They need to be applauded for their confidence in sharing personal information and enriching this survey. The information provided by respondents remains in trust and will not be used for any purposes other than for their own benefit.

IFTIKHAR ALI SAHOO

Secretary

Planning & Development Department, Punjab

EXECUTIVE SUMMARY

The Punjab Multiple Indicator Cluster Survey (MICS), 2014 is a household survey covering 38,405 households to provide estimates of around 125 indicators for the province, 9 divisions and 36 districts. The results will be used to update indicators used for monitoring the situation of children and women in Punjab.

MICS Punjab, 2014 was conducted as part of the fifth global round of MICS. The survey was planned, designed and implemented by Punjab Bureau of Statistics. The sample design was provided by Pakistan Bureau of Statistics. Technical support was provided by UNICEF through the Global MICS team. Fieldwork was carried out from June to September 2014.

The survey collected information on standard MICS topics such as housing characteristics, child and maternal health, HIV/AIDS, domestic violence, child discipline, child protection and use of Information/Communication Technology among other topics. Additional information was also collected on income and employment, remittances, safety nets, tuberculosis, hepatitis and life satisfaction.

The findings on most of the indicators presented in this summary show significant variations by some of the background characteristics.

Infant and Under-five Child Mortality

Under-five child mortality rate is estimated at 93 deaths per thousand live births and the Infant mortality rate at 75 deaths per thousand live births. Among divisions, infant mortality rates and under-5 mortality rates are lowest in Rawalpindi division (72 and 59 deaths per thousand live births respectively) and highest in DG Khan division (118 and 91 deaths per thousand live births respectively). By wealth quintile, the data show that the probability of dying before age 5 for children living in the households in the highest quintile is lower at 53 deaths per thousand live births and this rises to 137 deaths per thousand live births in the lowest quintile.

Nutritional Status

Information collected on nutrition of children shows that 34 percent of children under 5 are underweight. The same proportion of children is stunted while 18 percent are wasted. The three anthropometric indicators vary by household wealth. Nearly half of children living in the households in the lowest quintile are stunted (49%) and 48 percent are underweight compared to 17 percent for stunting and underweight in the highest quintile. Underweight, stunting and wasting is less common among children in Rawalpindi division compared to the other divisions.

Breastfeeding

Ninety-four percent of the children under 2 years have ever been breastfed. Early initiation of the breastfeeding is only 11 percent that is children that were put to breast within one hour of birth. Only 17 percent of children aged 0–5 months are exclusively breastfed as recommended by WHO guidelines while 48 percent of children age 6-23 months are predominantly breastfed. The median duration of any breastfeeding is 17.4 months and this declines to 0.6 months for exclusive breastfeeding. Sixty-one percent of the infants age 6-8 months have been introduced to solid, semi-solid and soft food. Overall, 65 percent of the children age 6-23 months are receiving solid, semi-solid and soft foods the minimum number of times. However, only 10 percent of these children are benefitting from a diet sufficient in both diversity and frequency.

The findings also show that 58 percent of the children age 0-23 months are being fed through a bottle with a nipple. By education of the mother, 72 percent of children whose mothers have higher education are bottle fed compared to 49 percent of children whose mother have pre-school or no education. The findings further show that the practice of bottle feeding with a nipple among children age under six months is not uncommon even though it is discouraged, as 45 percent of the children are fed using a bottle with a nipple.

Results from MICS Punjab, 2014 show that 49 percent of the households are found to be using adequately iodized salt. Use of iodized salt is lowest in Sargodha division (33%) and highest in Gujranwala division (63%).

Child Health

Information on child vaccination shows that 62 percent of the children are fully vaccinated and only 56 percent of children were vaccinated by their first birthday as recommended. About three in four children living in the households in the highest quintile are fully vaccinated (74%) compared to 42 percent living in the households in lowest quintile. Approximately 93 percent of children age 12-23 months received a BCG vaccination by their first birthday and the first dose of PENTA vaccine was given to 85 percent of children. The percentage declines to 81 percent for the second dose of PENTA, and to 72 percent for the third dose. Similarly, 95 percent of children received Polio 1 by first birthday and this declines to 85 percent by the third dose. For the first dose of measles vaccine, 72 percent of children received the vaccine by first birthday.

In Punjab, 65 percent of children aged 6–59 months received a high dose Vitamin A supplement in the 6 months preceding the survey.

Information collected on childhood diseases shows that 17 percent of children under 5 had diarrhoea in the 2 weeks preceding the survey. Out of these children, 47 percent were given Oral Rehydration Therapy (ORT) whereas 39 percent were treated with ORT with continued feeding. About 3 percent of the children had symptoms of ARI in the two weeks preceding the survey. Of these, 77 percent were taken to a health facility or provider, and 39 percent of the children were given antibiotics. The results also show that 21 percent of children were found to have an episode of fever, of which 79 percent were taken to a health facility or provider. Only 1 percent of children with fever were treated with anti-malarial drug; Of these, 9 percent were given Artemisinin-based Combination Therapy.

Use of solid fuel is of concern regarding health as it increases risk of diseases such as acute respiratory illness. The findings reveal that 61 percent of the households use solid fuels for cooking, most of which is wood (33%). Majority (83%) of the households in rural areas use solid fuel compared to only 17 percent in urban areas. All of the population living in the households in the lowest quintile use solid fuel for cooking compared to only 4 percent of population in the highest quintile.

Water and Sanitation

In Punjab, 94 percent of the population is using improved sources of drinking water and 81 percent have water in their premises. The main sources of improved drinking water are motorized pump (42%) and hand pump (31%).

Seventy five percent of the population is using improved sanitation facilities; higher in urban (92%) and lower in rural (67%). Most commonly used facilities are flush toilets connected to septic tanks (44%) and facilities connected to a sewerage system (21%). In Punjab, 18 percent of the population still has no access to toilet facilities and this proportion rises to 25 percent in rural areas.

One other issue of interest is disposal of children's stool. The results show that stools of 71 percent of the children under 2 years were disposed of safely. The most commonly reported method of children's stool disposal was rinsing into toilet or latrine (65%). For 17 percent of children, stool was thrown into garbage. Safe disposal of child's faeces is found to be higher in urban (89%) compared to rural areas (64%).

Information collected on handwashing shows that at the time of the survey, 80 percent of households with a place for handwashing had both water and soap (or another cleansing agent) present at the handwashing place. In 17 percent of the households, only water was available at the handwashing place. However 93 percent of households had soap or other cleansing agent available somewhere in the household.

Reproductive Health

Total Fertility Rate (TFR) as a measure of current fertility is estimated at 3.5 children per woman. Fertility is slightly higher in rural areas compared to urban areas. TFR among women having pre-school or no education is 4.2 and declines to 2.7 children per woman among women with higher education.

Current use of a contraceptive method is reported by 39 percent of currently married women. The most popular modern method is the male condom (11%) followed by female sterilization (10%). Unmet need for contraception is 17 percent.

Out of the total women with a live birth in the last two years, 79 percent received antenatal care at least once during their pregnancy from a skilled personnel whereas 17 percent received no antenatal care. Further to that, 48 percent of the women had at least four antenatal care visits. During the antenatal visits, 45 percent of the women had their blood pressure measured, urine and blood sample taken.

Sixty-five percent of deliveries were attended by skilled personnel. Sixty-one percent of the births were delivered in a health facility: mostly (43%) in private health facility compared to 18 percent in public health facility. Traditional birth attendants delivered 33 percent of the babies; 40 percent in rural and 19 percent in urban. Eighty-six percent of the mothers had a postnatal check-up and 41 percent of the first PNC visits occurred in a private facility.

MICS Punjab, 2014 also collected information on visits by Lady Health Workers. About 38 percent of women aged 15-49 years, who had given birth in two years preceding the survey, reported having been visited by a Lady Health Worker (LHW). The proportion of women visited by a LHW is higher in rural (43%) than urban areas (26%). More than half of the women visited by LHW reported that they received health education or advice.

Child Development

Among children aged 36-59 months, 26 percent were attending an early childhood education programme. Children who got support for learning from their father was 3 percent while 12 percent of children got support from the mother. Among children under 5, only 8 percent had at least three children's books and 53 percent had two or more types of playthings in their homes.

Early Child Development Index was calculated to measure the developmental status of children within four domains namely: literacy-numeracy, physical, social-emotional development and learning. Overall, 67 percent of children age 36-59 months were developmentally on track in at least three of the four domains.

Literacy and Education

In Punjab, 61 percent of the population age 10 years and above is able to read and write. Literacy rate among young women age 15-24 is 76 percent. Literacy is higher among males than females. By age, only 19 percent of population age 75 years or older is literate compared to 78 percent of population age 15-19.

School readiness, that is percentage of children attending first grade at the time of the survey who attended pre-school in previous year is 93 percent and 26 percent of children of primary school entry age have entered the first grade. The Net Attendance Rate (NAR) i.e. children age 5-9 years who attend primary or secondary school, is 58 percent. Four percent of children age 5-9 years are attending government schools and 46 percent private schools. It is interesting to note that of all children starting grade 1, the majority (96%) eventually reach the last grade of primary school.

In case of secondary school children (10–14 years), 42 percent are attending secondary school, with a lower percentage in rural areas (36%) compared to urban (54%). There is only a small difference in the attendance of girls and boys in primary and secondary schools. The Gender Parity Index (GPI), that is the ratio of girls to boys attending school is 0.97 for primary school and 0.98 for secondary school. The GPI is lower in rural areas, 0.94 for primary and 0.88 for secondary schools.

Child Protection

The findings from MICS Punjab, 2014 show that 73 percent of children under 5 years were registered at birth. Birth registration ranges from 31 percent in D.G Khan division to 90 percent in Gujranwala division. There is variation by wealth quintile; 90 percent of children living in the households in the highest quintile are registered compared to 46 percent of children living in the households in the lowest quintile.

Sixteen percent of children age 5–17 years are involved in child labour. A higher proportion of male children (20%) is involved in child labour compared to female children (12%). Similarly, child labour is more prevalent in rural (20%) than urban areas (8%).

As a form of child discipline, 81 percent of children age 1-14 experienced violent discipline in form of psychological aggression or physical punishment, during the last one month. The most severe forms of physical punishment which include hitting the child on the head, ears or face or hitting the child hard and repeatedly were given to 27 percent of children.

Information collected on early marriages shows that 5 percent of the women age 15-49 were married before age 15 while 21 percent of women age 20-49 were married before age 18. There is a decline in early marriage over the years as 31 percent of women age 45-49 reported being first married by age 18 compared to 15 percent of women age 20-24. The data further show that 19 percent of the currently married women age 15-19 are married to a man that is older by 10 years or more.

MICS Punjab, 2014 results on attitudes towards domestic violence show that 40 percent of women believe that a husband is justified in hitting or beating his wife if she goes out without telling him, neglects the children, argues with him, refuses sex with him or burns the food. Twenty seven percent of women agree and justify violence in instances when a wife neglects the children and 26 percent of women justify violence if a wife goes out without telling her husband or argues with him.

HIV/ AIDS

In Punjab, 39 percent of the ever married women have heard of AIDS and it drops to 28 percent in rural areas compared to 60 percent in urban. Only 16 percent of women know that using a condom every time during sexual intercourse and having only one faithful uninfected are the main ways of HIV prevention. Comprehensive knowledge among the women about HIV transmission is even lower (5%) and it falls to 3 percent among young women age 15-24.

About 24 percent of ever married women age 15-49 years know that the HIV can be transmitted from mother to child during pregnancy, delivery and breastfeeding. Out of the ever married women who have heard about HIV/AIDS, 19 percent express accepting attitude towards people living with HIV/AIDS.

While 9 percent of ever married women know a place where one can get tested for HIV, almost 2 percent of women have actually been tested and about the same proportion of women know the result of their most recent test.

Access to mass media and ICT

Information collected on access to mass media shows that 11 percent of the women read newspapers, 5 percent listen to the radio and 64 percent watch television at least once a week. While 66 percent of women use any of the three media types at least once a week, 34 percent do not have regular exposure to any of the three types of media.

Twenty-one percent of young women age 15-24 used a computer during the last 12 months and fewer women (14 percent) used a computer during the last month. Use of internet is lower, with 12 percent of young women reporting use of internet during the last 12 months. At division level, only 9 percent of young women in DG Khan division used a computer during the last year compared with 32 percent of women in Lahore division during that same period.

Subjective well-being

The survey included a module on life satisfaction for women age 15-24 years to understand how satisfied this group of young people is in different areas of their lives, such as their family life, friendships, school, current job, health, where they live, how they are treated by others, how they look, and their current income. The data show that 91 percent of the women age 15-24 are satisfied on overall with their lives and about the same proportion of women is happy with their life. Six out of ten young women (59%) think that their life has improved over the last one year and expect that life will get better in the coming year.

Overall, only 8 percent of young women have an income and of those with income, 67 percent are satisfied with their current income.

Tobacco Use

Four percent of women smoked cigarettes or used smoked or smokeless tobacco products at any time in the last one month. In D.G Khan division, 13 percent of women used tobacco, a proportion much higher than the other divisions. There is also notable variation by age, with a higher proportion of older women using tobacco compared to younger women; 13 percent among women age 45-49 compared to less than 1 percent among women age 15-19.

The proportion of women who smoked a cigarette before age 15 is less than 1 percent.

Adult health

Three percent of household members were reported to have had a cough for the past 3 weeks. Almost 6 percent of the population in Sahiwal division was reported to have had a cough, a proportion much higher than the other divisions. Furthermore, less than 1 percent of the household population was reported to have been diagnosed with tuberculosis and 2 percent was diagnosed with hepatitis.

Socio-economic development

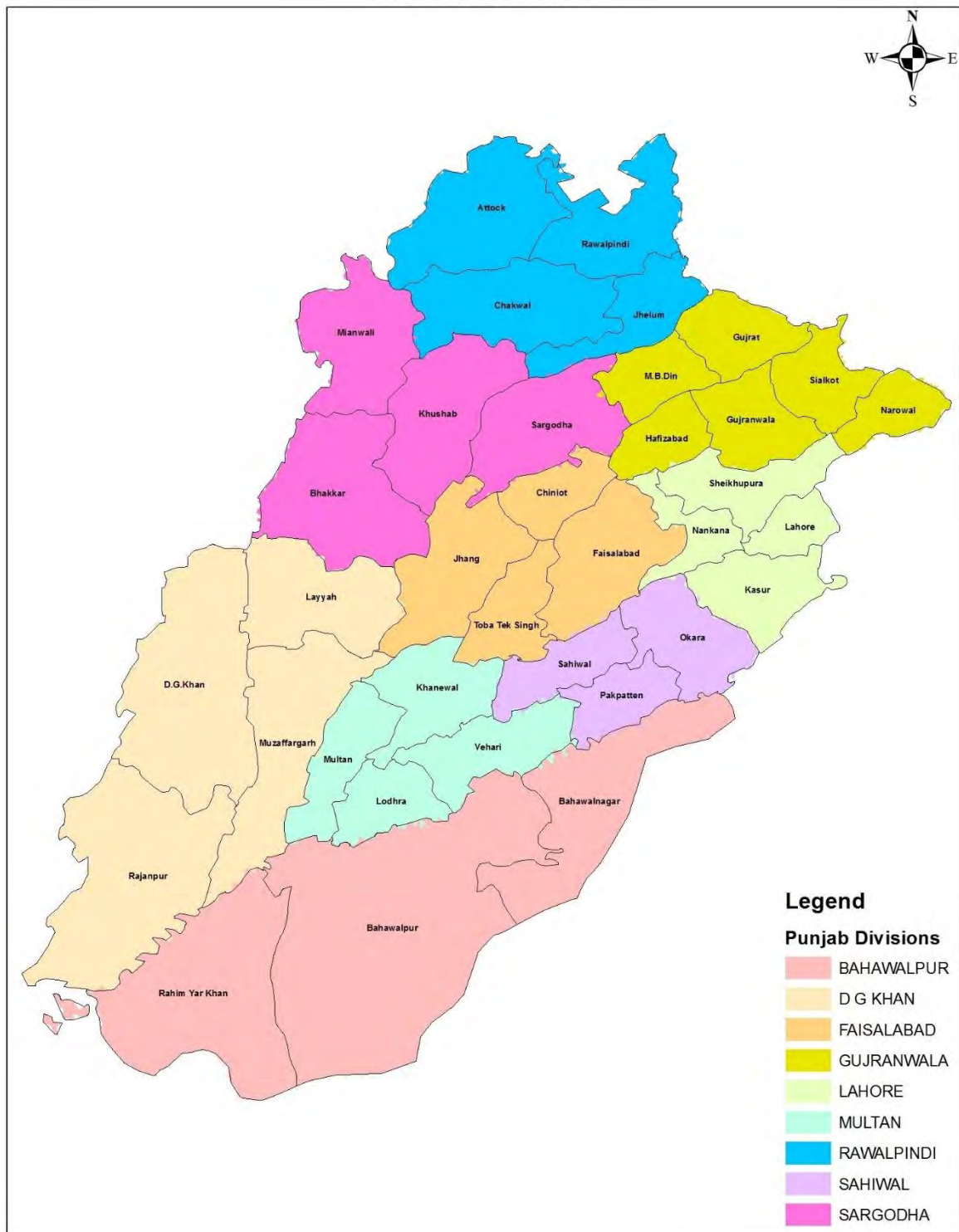
The unemployment rate among population age 10 years and over is 7 percent.

In Punjab, 87 percent of the population is living in a household that owns a house, 30 percent own agricultural land and 45 percent own livestock. Ownership of agricultural land and livestock is higher amongst the rural population.

The survey also collected information on remittances. The results reveal that 3 percent of the respondents reported having received remittances from within the country while 7 percent reported receiving remittances from outside the country. In addition, 7 percent of household members are living in a household that received benefits such as *zakat*, dearness allowance, health and education subsidy from government schemes of social protection

MAP OF THE PUNJAB

Punjab Districts And Divisions Map



I. INTRODUCTION

Background

This report is based on the Multiple Indicator Cluster Survey (MICS), conducted in 2014 by the Bureau of Statistics (BoS) Punjab, Planning and Development Department (P&DD), Government of the Punjab, in collaboration with UNICEF. It is the fourth report in the MICS series since 2004 in Punjab. These surveys provide statistically sound and internationally comparable data essential for developing evidence-based policies and programmes and for monitoring progress towards national goals and global commitments. These commitments emanate from the World Fit for Children Declaration and Plan of Action, the goals of the United Nations General Assembly Special Session on HIV/AIDS, the Education for All Declaration and the Millennium Development Goals (MDGs) (See box below).

The MICS Punjab, 2014 results will be critically important for final MDG reporting in 2015, and are expected to form part of the baseline data for the post 2015 era.

A Commitment to Action: National and International Reporting Responsibilities

The governments that signed the Millennium Declaration and the World Fit for Children Declaration and Plan of Action also committed themselves to monitoring progress towards the goals and objectives they contained:

“We will monitor regularly at the national level and, where appropriate, at the regional level and assess progress towards the goals and targets of the present Plan of Action at the national, regional and global levels. Accordingly, we will strengthen our national statistical capacity to collect, analyse and disaggregate data, including by sex, age and other relevant factors that may lead to disparities, and support a wide range of child-focused research. We will enhance international cooperation to support statistical capacity-building efforts and build community capacity for monitoring, assessment and planning.” (**A World Fit for Children**, paragraph 60)

“...We will conduct periodic reviews at the national and subnational levels of progress in order to address obstacles more effectively and accelerate actions....” (**A World Fit for Children**, paragraph 61)

The Plan of Action of the World Fit for Children (paragraph 61) also calls for the specific involvement of UNICEF in the preparation of periodic progress reports:

“... As the world’s lead agency for children, the United Nations Children’s Fund is requested to continue to prepare and disseminate, in close collaboration with Governments, relevant funds, programmes and the specialized agencies of the United Nations system, and all other relevant actors, as appropriate, information on the progress made in the implementation of the Declaration and the Plan of Action.”

Similarly, the **Millennium Declaration** (paragraph 31) calls for periodic reporting on progress:

“...We request the General Assembly to review on a regular basis the progress made in implementing the provisions of this Declaration, and ask the Secretary-General to issue periodic reports for consideration by the General Assembly and as a basis for further action.”

MICS Punjab, 2014 is expected to contribute to the evidence base of several other important initiatives, including Committing to Child Survival: [A Promise Renewed](#), a global movement to end child deaths from preventable causes, and the accountability framework proposed by the [Commission on Information and Accountability for the Global Strategy for Women's and Children's Health](#).

Survey Objectives

The MICS Punjab, 2014 has as its primary objectives:

- To provide up-to-date information for assessing the situation of children and women
- To generate data for the critical assessment of the progress made in various areas, and to put additional efforts in those areas that require more attention;
- To furnish data needed for monitoring progress towards goals established in the Millennium Declaration and other internationally agreed upon goals, as a basis for future action;
- To collect disaggregated data for the identification of disparities, to allow for evidence based policy-making aimed at social inclusion of the most vulnerable;
- To contribute to the generation of baseline data for the post 2015 agenda;

Report Structure

This final report presents the results of the indicators and topics covered in the survey. Preliminary findings of MICS Punjab, 2014 were shared with the government in May, 2015. The description for each chapter is based on tables within the text that contain provincial level results by background characteristics including divisional level results. District level tables are placed in Appendix – A of the report.

The report comprises 17 chapters, focusing on different socio-economic features of the survey. The first three chapters explain about the survey background and objective, methodology (sample design, questionnaires, training and fieldwork) and sample coverage, characteristics of the households, asset ownership, and wealth quintiles. The remaining 14 chapters present the findings on child mortality, nutrition, child health, water and sanitation, reproductive health, early child development, literacy and education, child protection, HIV/AIDS knowledge, access to mass media and use of information/communication technology, subjective wellbeing, tobacco use, adult health and health care and socio economic development.

II. SAMPLE AND SURVEY METHODOLOGY

Sample Design

The sample for the MICS Punjab, 2014 was designed by the Pakistan Bureau of Statistics (PBS) to provide estimates for a large number of indicators, on the situation of women and children including the socio-economic indicators at the provincial level, 9 divisions, 36 districts, and urban and rural areas at the provincial level. The total sample size was 41,000 households, located in 2050 sample clusters (enumeration areas). For the calculation of the sample size, the key indicator used was the underweight prevalence among children age 0-4 years. The detail of districts under each division is as follows:

Bahawalpur: *Bahawalpur, Bahawalnagar and Rahim Yar Khan*

DG Khan: *DG Khan, Layyah, Muzaffargarh and Rajanpur*

Faisalabad: *Faisalabad, Chiniot, Jhang and TT Singh*

Gujranwala: *Gujranwala, Gujrat, Hafizabad, Mandi Bahauddin, Narowal and Sialkot*

Lahore: *Lahore, Kasur, Nankana Sahib and Sheikhupura*

Multan: *Multan, Khanewal, Lodhran and Vehari*

Sahiwal: *Sahiwal, Pakpattan and Okara*

Rawalpindi: *Rawalpindi, Attock, Chakwal and Jhelum*

Sargodha: *Sargodha, Bhakkar, Khushab and Mianwali*

The urban and rural areas within each district were identified as the main sampling strata and the sample was selected in two stages. Eight large cities (Lahore, Faisalabad, Rawalpindi, Gujranwala, Multan, Sargodha, Sialkot and Bahawalpur) were also treated as separate strata within their respective districts. Within each stratum, a specified number of census enumeration areas were selected systematically with probability proportional to size. After a households listing in the selected urban and rural enumeration areas, a systematic sample of 20 households was drawn in each sample enumeration area. All sample enumeration areas were covered except for three enumeration areas which were substituted for technical reasons in consultation with PBS. Within each district the sample was proportionally allocated to urban and rural areas. The sampling rates vary by stratum and cluster, so the sample is not self-weighting. For reporting all results from the survey data, sample weights are used. The sample design including weights were reviewed for adequacy and soundness by an international consultant engaged by UNICEF Pakistan. The sample design and weighting procedures are described in more detail in Appendix B, which includes a summary of the sample size by divisions and districts.

List of Indicators

The fifth round of the Multiple Indicator Cluster Survey (MICS5), being a standard methodology, has limited space for additional indicators but is flexible enough to adapt indicators to local environment. The Punjab MICS Technical Group followed a comprehensive plan for the finalization of list of indicators for the Punjab MICS, 2014. The group held sectoral consultations with key social sector departments and development partners. Based on these consultations, the group made recommendations to finalize the list of indicators. The recommendations were approved by the Punjab MICS Steering Committee. The final list of indicators approved by the Steering Committee is presented in Appendix – F.

Questionnaires

A set of the following three questionnaires was used in the survey instead of the four available with the MICS5 methodology.

1. **Household Questionnaire** which was used to collect basic demographic information on all *de jure* household members (usual residents), the household, and the dwelling with the following modules;

- List of Household Members⁵
- Education⁶
- Child Discipline
- Child Labour
- Child Discipline
- Household Characteristics
- Water and Sanitation
- Handwashing
- Salt Iodization

Non-Global Standard MICS Modules

- Income and Employment
- Remittances
- Pension Benefits
- Safety Nets

2. **Questionnaire for Individual Women** administered in each household to all women age 15-49 years and included the following modules;

- Woman's Background
- Access to Mass Media and Use of Information/Communication Technology
- Marriage
- Fertility
- Desire for Last Birth
- Maternal and Newborn Health⁷
- Post-natal Health Checks
- Illness Symptoms
- Contraception
- Unmet Need
- Attitudes Toward Domestic Violence
- HIV/AIDS
- Tobacco Use
- Life Satisfaction

3. **Questionnaire for Children Under-Five**, administered to mothers (or caretakers) for all children under 5 years of age⁸ living in the household. Normally, the questionnaire was administered to mothers of children; in cases when the mother was not listed in the

⁵ The module also includes non-standard MICS questions on cough, TB and Hepatitis

⁶ It also includes non-MICS questions on type of schools

⁷ It also includes non-MICS questions on Lady Health Worker (LHW)

⁸ The terms "children under 5", "children age 0-4 years", and "children age 0-59 months" are used interchangeably in this report for children age less than 5 years.

household roster, a primary caretaker for the child was identified and interviewed. The questionnaire included the following modules:

- Age
- Birth Registration
- Early Childhood Development
- Breastfeeding and Dietary Intake
- Immunization
- Care of Illness
- Anthropometry

Non-Global Standard MICS Modules

- Vitamin A Supplementation

The questionnaires were based on the MICS5 model questionnaires and translated from English to Urdu language for data collection and again retranslated into English to ensure accuracy and quality of the translation.

Pretesting of Questionnaires

The Questionnaires were pretested in Southern, Central and Northern zones of the Punjab. For this purpose, one district was selected randomly in each zone and within it, one urban site and one rural site (20 households), called cluster, was enumerated as per guidelines of MICS5 methodology. Based on findings from the pretest, modifications were made to the wording and translation of the questionnaires. A copy of the MICS questionnaires is provided in Appendix – G.

In addition to the administration of questionnaires, field teams tested salt used for cooking in the households for iodine content, observed the place for handwashing, and measured the weights and heights of children under 5 years. Findings of these observations and measurements are provided in the respective sections of this report.

Appointment of Regional Supervisors

To manage huge fieldwork operation while assuring quality and proper supervision, the province was divided into 10 regions of 3–5 districts each: Bahawalpur, DG Khan, Faisalabad, Gujranwala, Lahore I, Lahore II, Multan, Rawalpindi, Sahiwal and Sargodha. Ten senior officers of BOS were designated as regional supervisors - one for each region. They were responsible for all aspects of the field work in their respective regions (See list of field staff in Appendix – C).

Training

Training of Trainers (ToT) was conducted for 10 days in Lahore including two days of field practice. A total of 35 field teams were recruited for field data collection, each team comprising one team supervisor, two field editors (one male and one female), two measurers (both female), three male interviewers, and five female interviewers. The field teams were given 18 days training in two phases. In the first phase, the trainings were held at Multan, Faisalabad and Rawalpindi for field teams belonging to Multan, Bahawalpur, DG Khan, Faisalabad, Sargodha, Rawalpindi and Gujranwala divisions. During this phase, 312 field staff including regional supervisors, team supervisors, field

editors, measurers and interviewers were trained at Multan (126), Faisalabad (99), and Rawalpindi (97). The rest of the teams were trained in second phase, wherein trainings were held at Sahiwal (51) and Lahore (104). During this phase, altogether 155 field staff were trained. During the trainings, about 9 percent additional staff were also trained to be deployed in case of dropout during the field work. Trainings included sessions on contents of the questionnaires along with the survey theoretical concepts, survey ethics, interviewing techniques, and mock interviews to practice in asking questions. The whole training took 18 days, including three days of practice in the field. All trained staff overwhelmingly participated in the hands on sessions. Moreover, measurers received three days exclusive hands on training for height and weight measurement of children at Basic Health Units (BHUs).

Field Work

The field teams who received training in the first phase started field work in their respective divisions immediately after the completion of training session in June 2014. The rest of the teams, however were deployed into the field in July 2014 after the completion of the second phase of training. A total of 33 teams were deployed into the field to collect the information on prescribed questionnaire (Household, Woman and Child). Each team was comprised of one supervisor, two field editors (male and female), two measurers, and eight interviewers (3 males and 5 females). Twenty households were interviewed from an urban or rural cluster by each team in a day. One android cellular was provided to each team supervisor for the purpose of sending key information (i.e. GPS Coordinates, Cluster Control Sheet) of the enumerated cluster. The information was compiled at BoS office headquarters and shared with Secretary, Director General/Project Director through a dash board. The field monitoring was also carried out extensively by the technical team, Deputy Project Director, Project Director and representative of UNICEF to achieve the quality milestone. During the field visits, necessary support and feedback was provided to each field team by the technical monitors. In addition, consistency tables were examined and evaluated weekly in respect of each field team and in case of any issue, the concerned team supervisor was notified immediately. The whole field work exercise was completed in about three months.

Monitoring Mechanism

The monitoring of field work for quality data included conventional as well as innovative system known as Online Monitoring Mechanism (OMM). Under the conventional method, the nominated monitors from BoS and other stakeholders visited field teams. All the monitoring activities were planned in such a way that each field team could be visited more than once.

As regards to the innovative method (OMM), a GPS device was given to each team supervisor through which they sent GPS coordinates of the cluster to BoS headquarters in Lahore twice a day, firstly when the team reached the cluster and secondly at the time of leaving the cluster. To share the latest information received from the field with the stakeholders, a dashboard was designed. The information sent by the field supervisors was used not only to observe duration of their stay in the cluster, but also to update the dashboard on daily basis. The dashboard was shared with all concerned stakeholders on a daily basis to give updates on progress on the cluster completion.

Online Monitoring Mechanism

Online Monitoring Mechanism (OMM) was especially designed and implemented for effective online monitoring of field teams. It was used to detect:

- Location of survey teams through Global Positioning System (GPS)
- Entering and leaving time in the Cluster
- Time spent in the Cluster

Open Data Kit (ODK) Aggregate server (<https://bos-punjab.appspot.com>) was set-up at google. Two ODK forms were programmed for updating data about GPS coordinates and cluster summary information. Android based smart phones with internet connectivity through U fone SIM were provided to team supervisors. By using the above facility following, two reports were generated on daily basis:

- Time spent in the field by survey team
- Dash board for easy review/monitoring of the field work

Another monitoring tool was the use of field check tables. These tables were produced on weekly basis using latest field data entered in computers. These tables were regularly shared with the regional supervisors who in turn had discussions with the team supervisors in their respective regions. In this way, a number of data collection weaknesses were addressed before it is too late.

The field check tables were also shared with operational teams who then issued instructions immediately to the concerned regional supervisors/ team supervisors through email, text messages, telephone calls and personal visits. These tables included descriptive statistics on key variables for each team. Moreover, to enhance data quality, other corrective steps were also taken including reshuffling of team(s) member(s) reporting inadequately and conducting additional trainings in the field where felt necessary.

Data Processing

Data were entered using the CSPro software version 5.0 on 22 desktop computers by 44 data entry operators under the supervision of 2 data entry (DE) supervisors. There were four assistant DE supervisors who were monitoring the data entry process and helping data entry operators (DEOs) in rectifying the problems. For quality assurance purposes, all questionnaires were double-entered and the differences thereof resolved by referring back to the questionnaires. Internal consistency checks were also performed and the secondary editors fixed those inconsistencies according to the secondary editing manual. Procedures and standard programs developed under the global MICS programme and adapted to the MICS Punjab, 2014 questionnaire were used throughout. Data processing began simultaneously with data collection at the beginning of July 2014 (after one week of data collection) and was completed in October 2014 (one week after completion of field work). Data were analysed using the Statistical Package for Social Sciences (SPSS) software, version 22. Model syntax and tabulation plans developed by UNICEF were customized and used for this purpose.

Initial analysis, for cleaning purpose, was carried out by examining frequency distribution of all variables and looking at possible errors in data entry and otherwise. Dummy tables reflecting cross-tables between dependent and independent variables were generated focusing on presenting frequencies and simple bivariate tables. After cleaning, the final data was exported from CSPro to SPSS software tabulation programme for construction of analysis files (comprising HH: Household, HL:

Household listing, WM: Women and CH: Children), production of tabulations, analysis of sampling errors/ confidence intervals; and production of datasets and tabulations for report writing.

International Review

All stages of the survey were closely monitored by the UNICEF global MICS team. Before the start of survey, UNICEF reviewed the sample design, survey tools and trainings through international consultants. The software used for data entry and analysis was adapted from the MICS5 recommended methodology which was also reviewed by the national and international consultants. The data files, syntax files and tabulations were shared with the global MICS team. The data and software review inputs received from these organizations were addressed before the finalization of the tables and report.

III. SAMPLE COVERAGE AND THE CHARACTERISTICS OF HOUSEHOLDS AND RESPONDENTS

Sample Coverage

Initially 41,000 households were selected for the sample and distributed equally in 2050 selected clusters. Following MICS5 guidelines, if a selected household was untraceable or unreachable or refused to be interviewed, there was no replacement. Further to that, if there was more than one household identified in the selected dwelling at the time of data collection and these households were not listed then all of them were to be interviewed. As a result, the final sample size was 41,413 households.

Of the 41,413 households selected for the sample, 39,333 were found to be occupied. Of these, 38,405 were successfully interviewed achieving household response rate of 98 percent. In the interviewed households, 61,286 eligible women (age 15-49 years) were identified. Of these, 53,668 were successfully interviewed, yielding a response rate of 88 percent within the interviewed households.

There were 31,083 children under age five listed in the household questionnaires. Questionnaires were completed for 27,495 of these children, which corresponds to a response rate of 89 percent within interviewed households.

Overall response rate of households i.e. 98 percent is 12 percent higher than the response rates of individual women and children under 5s (85.5 and 86.4 percent) due to the reason that the children and women were not at home at the time of interview (Table HH.1).