Report

Assessment of Civil Registration and Vital Statistics practices, resources and functioning in ICT, GB, and AJK

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Federal SDG Support Unit

Federal SDGs Support Unit
Ministry of Planning Development and Reform
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Abbreviation

AJK	Azad Jammu and Kashmir
BISP	Benazir Income Support Program
BHU	Basic Health Unit
COD	Cause of Death
CMW	Community Midwife
CNIC	Computerized National Identity Card
CRMS	Civil Registration Management System
CRVS	Civil Registration and Vital Statistics
DHIS	District Health Information System
DHQ	District Headquarters
EPI	Expended Program on Immunization
GB	Gilgit Baltistan
ICD	International Classification of Diseases
ICT	Islamabad Capital Territory
IT	Information Technology
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MoH	Ministry of Health
NADRA	National Database and Registration Authority
NSER	National Socio-Economic Registry
PBS	Pakistan Bureau of Statistics
PDHS	Pakistan Demographic Health Survey
RHC	Rural Health Centres
SDGs	Sustainable Development Goals
UC	Union Council
UN	United Nations
UNICEF	United Nations Children’s Emergency Fund
WB	World Bank
WHO	World Health Organization

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1. Introduction

Globally almost 230 million children worldwide under the age of five are not registered at birth (UNICEF, 2013), and over two-thirds (38 million) of 56 million annual deaths are not registered (WHO, 2014). Functioning vital registration systems are global public goods that help with the collection, storage, retrieval, and analysis of accurate population and demographic data to support development policy. Without strong vital registries, individuals do not have legal documentation of their own personhood, citizenship, and all associated rights; national policymakers do not have the necessary data for resource allocation and planning; and the international community does not have evidence to monitor development progress against global benchmarks such as Sustainable Development Goals (SDGs)(Setel et al., 2007).

A strong Civil Registration and Vital Statistics (CRVS) system is a fundamental requirement for, and a sign of, a strong and developed economy. Knowledge of population size, structure, and changes (e.g., births, deaths, and causes of death) becomes a necessary mean for a government to plan, implement, and monitor development programs. However, as countries race to meet their development goals, very few have efficient and population-wide CRVS systems, and thus the data needed to monitor their own development progress are missing. In this parlance, a well-functioning CRVS system gets an added significance in the instant socio-economic milieu. CRVS is the most reliable, cost-effective and sustainable source to provide accurate data on nominators and denominators at the national, provincial and district levels. Various cross-sectional surveys including the Pakistan Demographic Health Survey (PDHS) and Multiple Indicator Cluster Survey (MICS) provide stop-gap arrangements, but are costly and lack accurate data at the district levels.

Vital statistics are tabulations of birth, marriage, divorce, and death certificates typically generated by civil registration systems. Vital statistics are usually based on legal requirements regarding the registration and certification of vital events. While the importance of civil registration for the identification of individuals is well recognized, vital statistics are also critically important for informing public policies and programs (Phillips et al., 2014). Registration of births, recording deaths by age, sex and cause, and calculating mortality levels and differentials are fundamental to evidence-based policy formulation, monitoring, and evaluation (Mathers et al., 2005, Joubert et al., 2012).

1.1 Track Development Goals

Starting their quest for an equitable international development framework with the introduction of Millennium Development Goals (MDGs) at the start of the new millennium; in 2015 world leaders adopted 17 Sustainable Development Goals (SDGs) along with 167 targets to be achieved by 2030. The list of SDGs indicators was revised in 2017 by the UN General Assembly to 232 indicators (United Nations, 2017). The targets set for SDGs contain many of the indicators which may be well assessed through the CRVS systems. The literature suggests that around 67 indicators may be measured effectively through an efficient and robust CRVS system (Mills et al., 2017). A functional CRVS system is thus the main requirement to achieve "leaving no one behind," the goal of inclusive development and a cross-cutting objective of the Sustainable Development Goals (Mills et al., 2017).

However, as countries race to meet their development goals, very few have efficient and population-wide CRVS systems, and thus the data needed to monitor their own development progress are missing. CRVS systems provide the most reliable, cost-effective and continuous data source to track progress on the achievement of various targets of SDGs (Maduekwe et al., 2018). It needs to be reiterated that the UN in its commitment to meet the SDGs emphasized that nobody should be left behind (United Nations, 2015). There is, therefore, need of urgent measures to plug the loopholes in the existing CRVS system in the country, so that a well-formulated CRVS system captures the data for further policy formulation and monitoring the SGDs indicators.

Therefore, in order to monitor the progress on the SDGs targets, a renewed emphasis has been placed on the need for timely and reliable data involving counting of all births and deaths, especially around the time of birth (Moxon et al., 2015). For instance, birth registration will not only be legal identity rather it will be the first step towards social inclusion; while a compulsory recording of marriages through marriage certificate may provide the immense help in determining the age of marrying partners and hence prevent the child marriages. The cardinal importance of CRVS lies in providing population data as it the denominator for all the population-based SDGs indicators. In addition, Indicator 17.19.2 (b) includes a specific aim to achieve 100% birth registration and 80% death registration by 2030 (Mills et al., 2017).

1.2 Causes of Deaths

Death registration data, with accurate information on the cause of death and cause of death coded using International Classification of Diseases (ICD), are the preferred sources of information for monitoring mortality by cause, age, and sex. Policymakers require timely and accurate data of various diseases and injuries to properly plan and implement appropriate strategies and interventions. Data on cause-specific mortality is required to monitor the desired improvements in the health of population and that the required targets are being met. In many developing countries, birth registrations are normally higher than deaths, mostly because the perceived benefits of birth registration to families are more direct and immediate than those of death registration (AbouZahr et al., 2015). This leads to lower registration of deaths than births. In 2015, globally 27 out of 56 million (48%) deaths were registered with the cause of death. Of these, 13 million were reported to WHO with a meaningful ICD code. For monitoring SDGs indicators not only the registration of deaths with civil authorities needs to be improved, but registration with causes of deaths along with ICD codes also need to be improved.

A functional and complete civil registration and vital statistics can provide timely data on cause-specific mortality rates. However, most developing countries, including Pakistan lack a functional civil registration and vital statistics system. A recent article by Erin K. Nichols et al reported that Pakistan is among countries with no data on causes of death (Nichols et al., 2018). A functional CRVS system captures all deaths, records the age and sex of each deceased person, and the causes of death and assigned ICD code. However, challenges arise when a death occurs outside the formal healthcare system. In such circumstances, verbal autopsy is one of the methods used to ascertain the causes of deaths. A verbal autopsy is a semi-structured interview carried out with a family member of the deceased. The questions are designed to elicit signs and symptoms of the final illness, and events surrounding the death. This data is then used to assign a probable cause of death.

Evidence from the literature suggests that there is a wide variation of uncertainty in assigning the cause of death by one method over another. Approximately 40 million deaths annually are not reliably assigned the cause of death (Byass et al., 2015). This leads to arguments on using automated assigning of cause of death by the use of standard verbal autopsies (Byass, 2016).

1.3 Use of technology

In countries with weak CRVS systems, digitization may be beneficial for overall system improvement. It is important to note that digitalization should not just be the digitization of a flawed system. In flowed CRVS system, paper-based systems may be more appropriate in the early stages of development. With the age of information technologies, interventions including the use of ID management at the point of registration of births and deaths can accelerate the strengthening of CRVS.

1.4 CRVS in Emergencies

Emergencies including natural and man-made disasters greatly affect the formal process of CRVS systems. This may be because of damage to infrastructure or loss of documents. In such circumstance, the existing weakness of CRVS systems may increase many folds. Such circumstances require actions on the part of the Government to ensure the rights of the people are met and timely needed data is provided to the concerned stakeholders. The effective civil registration in emergencies warrants the need to have a clear coordination mechanism among the key stakeholders and requires appropriate measures for strengthening CRVS systems in such emergencies. Provision of accurate vital statistics has become an integral part of humanitarian assessment, emergency preparedness, response, and recovery.

1.5 Stakeholder Mapping

Stakeholder mapping is widely recognized as an important tool to facilitate the integration to achieve desired objectives. In the context of CRVS and the complexities of its process, it is important to map CRVS stakeholders that cover various aspects of registration and vital statistics. For instance, some of the stakeholders are responsible for the events notifications; while others for registrations, record maintenance and generating vital statistics. Stakeholder mapping and data sources identification will help to identify essential players and clarify their actual and potential contributions to the overall performance of the CRVS system. The current study will involve a wider range of sectors and partners to identify and map stakeholders and explore opportunities to develop their linkages for strengthening CRVS in Pakistan.

1.6 Data Sources

The civil registry deals with individual, personalized, transaction-level data, while vital statistics systems usually focus on aggregated data using multiple sources e.g. census, surveys etc. Different agencies/departments at various levels are continuously collecting the data on different socio-economic indicators, which if synthesized and combined may become invaluable for CRVS system. However, data aggregation from sources is a difficult task and requires comprehensive mapping of data sources and its flow with a detailed architecture explaining data linkages. The data exchange often requires institutional agreements across many government departments. The challenges, include coordination mechanism with clear responsibilities within the CRVS systems, ensuring that there is no duplication during the registration lifecycle and dealing with issues of interoperability of data sources.

2. Aims

Keeping the aforementioned challenges in perspective, this study aims to review the existing practices in reporting of vital events and generation of vital statistics by the national and provincial authorities. The study also examined the existing data sources including the existing health information system that can be utilized to monitor the SGDs indicators. The study analysed mechanism commonly used to generate vital statistics including growth rate, fertility rate, mortality rates etc and provided evidence for informed policymaking and programs development.

3. Objectives

The objectives of this study are described below:

a. Review the existing practices in reporting and registration of vital events (births, deaths, marriages, divorces, property damages, and roads, work, home, accidents, and environmental hazards etc.) in the selected three federal areas.
b. Analyze the generation of vital statistics using available data on vital events.
c. Analyze the contributions of the national statistics organization and the health institutions involved in active notification of vital events.
d. Identify and enlist types of vital events currently registered by various stakeholders in Federally Administered Areas.
e. Analyze the SDGs indicators that can be generated through available data sources of CRVS in Pakistan.

f. Explore the possibility to include primary health coverage information through CRVS on SDGs related indicators.

4. Methods

A desk review of published and unpublished literature including journal articles, reports, and gray literature was carried out to analyze the existing practices by different stakeholders on reporting vital events and generating vital statistics in the Federally Administered Areas. The desk review of existing reporting tools for the vital events was carried out to examine the possibilities of tracking indicators on primary healthcare coverage. Field observations were made to observe current practices of vital events recording and registration at local government offices, municipal offices, hospitals, NADRA registration centres and at the community health services.

A field review including in-depth interviews and consultative meetings with health authorities, and other key stakeholders including Pakistan Bureau of Statistics (PBS), Local Government, NADRA and Health Department was conducted to review the existing practices of generating vital statistics. The list of interview participants is attached at Annex 2. The study was conducted in the Federally Administered areas including Islamabad Capital Territory (ICT), Gilgit Baltistan (GB) and Azad Jammu and Kashmir (AJK) (Figure 1).

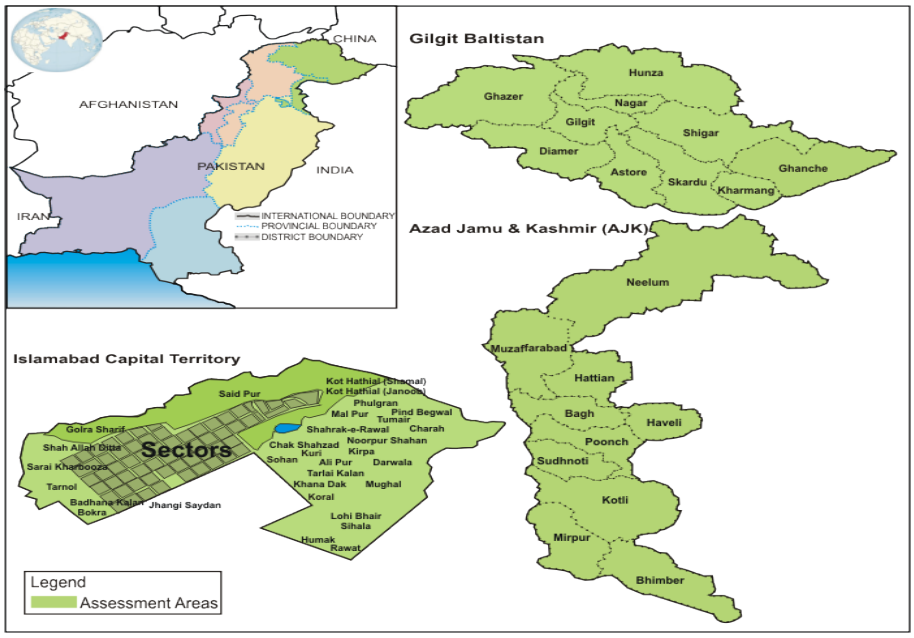


Figure 1. Map of assessment areas: Gilgit Baltistan, Azad Jammu and Kashmir, and Islamabad Capital Territory

A semi-structured questionnaire was developed for field observations to capture various aspects of vital events recording and registration (Annex 1). Another questionnaire was developed to capture information from key informants (Annex 1). Descriptive statistics were used to summarize data collected on CRVS events recording and registration at Health facilities and local government.

5. Findings

The findings presented in this report are derived from a combination of literature review, desk review, field observations, meetings with stakeholders and in-depth interviews with key informants. Almost 75% of the key informants had knowledge about CRVS system. Of those who were aware, 90% mentioned births as key vital events, 87% mentioned deaths, and around 60% mentioned marriage and divorce (Figure 2).

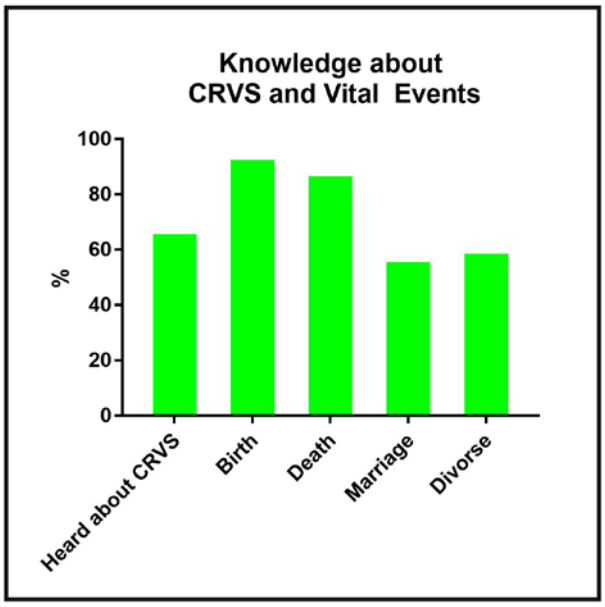


Figure 2. Knowledge about CRVS Vital Events

The report's findings are divided into sections in accordance with the study aims and objectives. These sections covered areas of reporting, registrations, vital statistics generation, the role of National Statistical Organization and other stakeholders in the recording of vital events, primary healthcare covered through CRVS and monitoring of SDGs indictors using CRVS system.

5.1 Existing practices in reporting and registration of vital events

Existing practices of reporting and registration of vital events were reviewed in all three areas of AJK, GB, and ICT. The authority responsible to register vital events in these areas was the Department of Local Government and Rural Development.

5.1.1 Registration of Vital Events by Local Government Department

The existing process of registration and certification of vital events by the Local Government and Rural Development Department in the three-study areas is presented as under:

5.1.1.1 Azad Jammu and Kashmir

Azad Jammu and Kashmir (AJK) is divided into 10 districts and 206 UCs. An Assistant Director manages and supervises the work of Local Government at the district level and Program Manager works at a Tehsil level and manages 4-11 UCs secretaries. Registration of births and deaths is performed by the Department of Local Government in rural areas and Municipal Administration in Urban areas of AJK. Records of births and deaths are maintained manually in registers at the Union Council offices of the local government in case of rural areas. Whereas, in urban areas, the records are maintained with the Municipal Administration offices. There is no mechanism to flow the data of registered births and deaths from UC level to Tehsil, District and upward to the state level. Another gap in the registration of refugees by the Local Government Department was observed in AJK area. Although their records are maintained in District Administration Offices, there is no mechanism to formally register theses refugees with the local government.

The Municipal Offices or the Local Government offices do not perform marriage registration. The registration of marriage and divorces are carried out by the Department of Auqaf and Religious affairs also known as Amoor-e-Dinya using the Registration Act of Marriage and Divorce. For 150-200 households there is a marriage registrar. Around 3000 Nikkah Khawans are registered in 206 UC of AJK with Auqaf and religious affairs department. The records are maintained at the UC, Districts and State levels. Approximately 90% of the marriages are registered in AJK. A fee of PKR 2150/- is charged if marriage is registered within one month, which is increased to twice after two months. Madaras registration is also managed by them. Zakat Dept pays PKR 1,000 to boards in Madaras and maintains their records.

5.1.1.2 Gilgit Baltistan

Gilgit Baltistan is administratively divided into 109 Union Councils. All UCs are equipped with desktop computers and the required infrastructure. A CRMS Software (provided by NADRA) is functional in all UCs of GB. A few years ago, the local government staffs in 103 UCs were provided training on CRMS by UNFPA with the support of Agha Khan Rural Support Program (an NGO). Similar to AJK, registration of births and deaths is performed by the Department of Local Government in rural areas and Municipal Administration in Urban areas. Records of vital events are maintained both manually in registers at the Union Council offices of the local government and in CRMS Software in both rural and urban areas. NADRA staff regularly visits Local Government and Municipal Offices, take the records on a USB stick and update their main databases. There is no mechanism for flow of the data of registered vital events from the UC level to Tehsil, District and upward to the provincial level. Figure 3 shows the process of vital events registration and certification in all three areas of AJK, GB, and ICT.

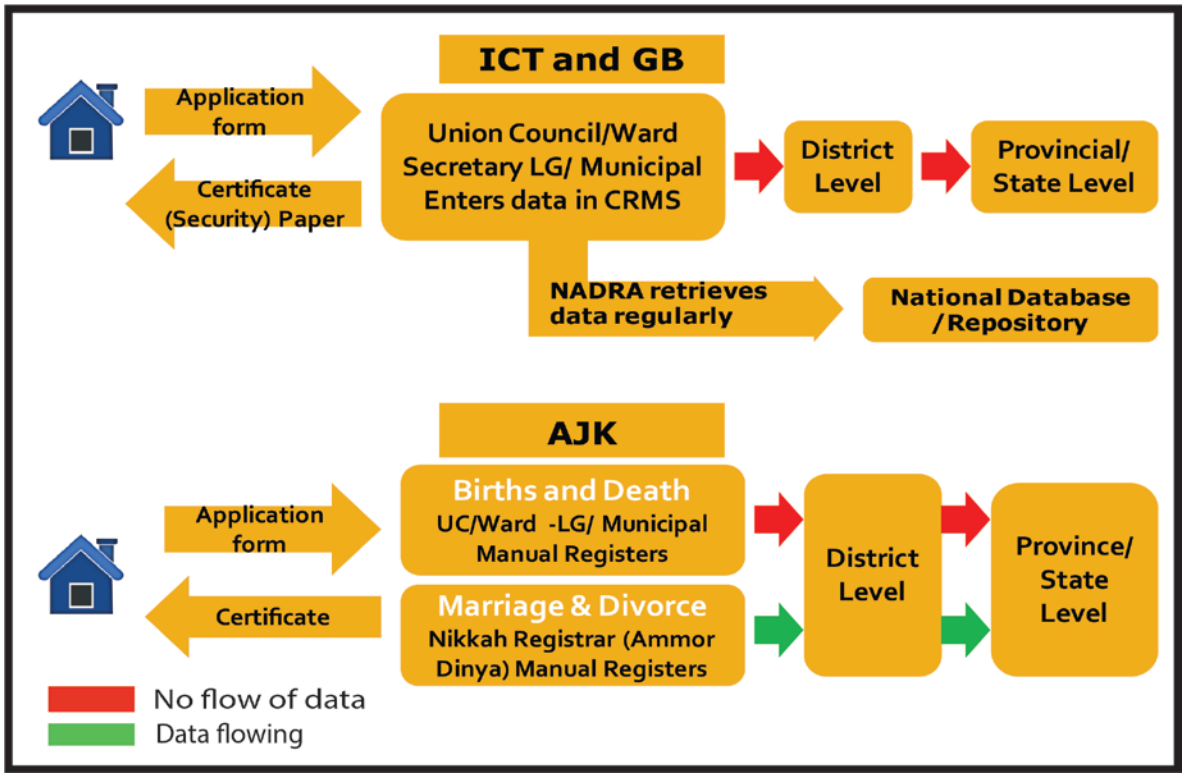


Figure 3. The process of vital events registration and certification in AJK, GB, and ICT

5.1.1.3 Islamabad Capital Territory

Islamabad Capital Territory (ICT) is administratively divided into 50 Union Councils. All sectors are divided into 38 UCs as urban areas and rural areas are divided into 12 UCs. The list of these UCs along with the health facilities in these UCs is provided at Annex 4. An elected Chairman along with 12 members constitutes the elected members of a UC in ICT. In rural areas of ICT, births and deaths are registered by the Local Government and RD department through its UC secretaries. In Urban Areas (Sectors), births and deaths are registered by the Municipal Administration. Whereas, marriages and Divorces, both in Rural and Urban areas are registered by the Local Government and RD department through marriage (nikkah) registrar at the UC level. Approximately two Nikkah registrars are present at a Ward level, whose licenses are issued by the Chairman of the concerned UC. A copy of marriage and divorce application is maintained at the UC Office. Marriage and divorce registration records are maintained at ICT Complex located at Sector G 11.

The application forms currently used by the Local Government and Rural Development Department in the study areas were also reviewed. It was observed that there is no standard format in any of the three areas and inconsistencies exist across Union Councils within the three areas. Figure 4 shows a birth and death registration application forms used in one of the UC of ICT.

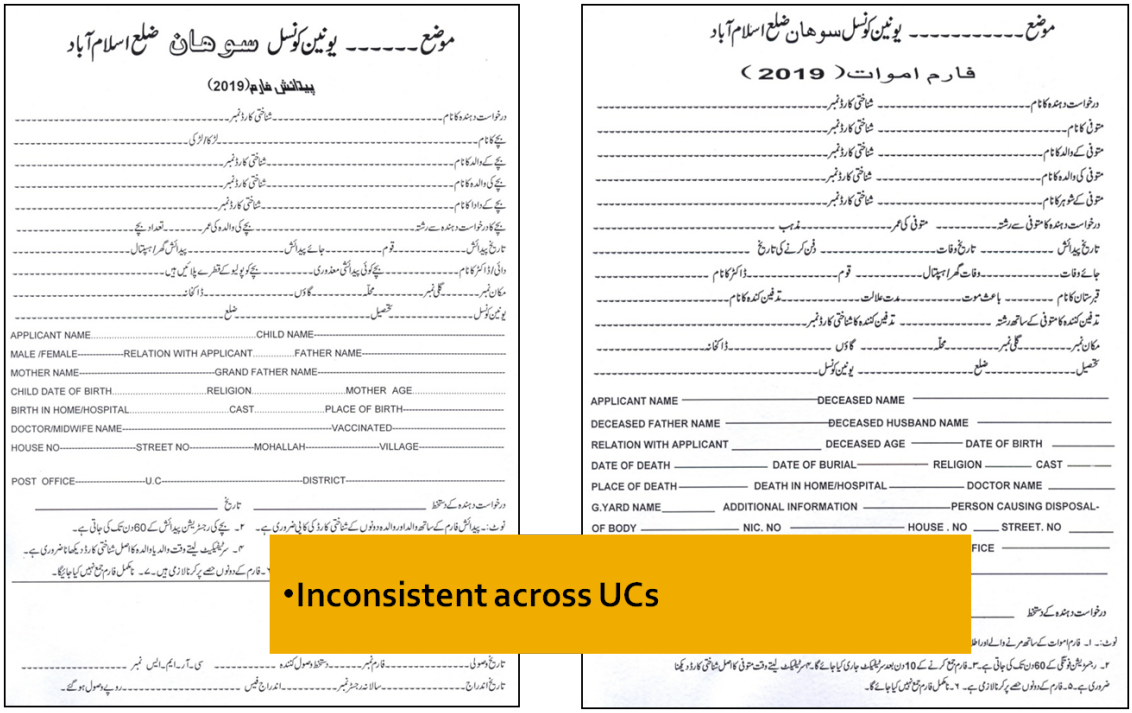


Figure 4. Birth and Death Certificate Application Form used by the Local Government in ICT Area

5.1.2 Registration of Births and Deaths at Health Facilities

Basic Health Units (BHUs), Rural Health Centres, District Headquarter Hospitals (DHQs), and Tertiary care hospitals register births and deaths and maintain their records at the Health Facilities.

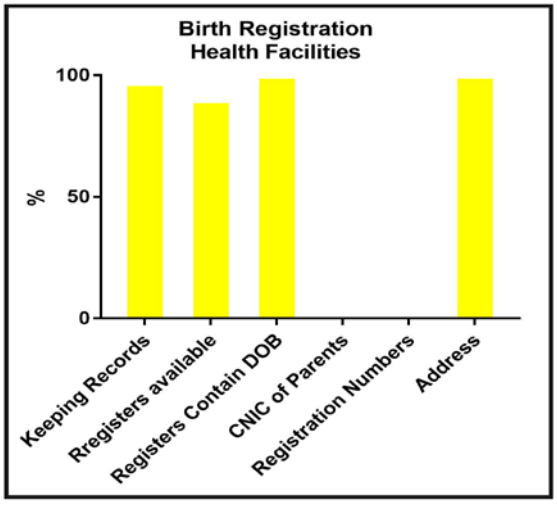


Figure 5. Birth Registration and Health Facilities

More than 90% of the health facilities observed during the study kept births records, and registers are available; date of births is mentioned along with the address of the newborn (Figure 5). No data on the CNIC of parents or any other unique ID number was available in the health facilities visited.

Health facilities records and registers were also examined to analyze the current practices of death registration at the health facilities. Around 80% of the health facilities maintain death records and registers and issue deaths certificates. More than 75% of the health facilities contain registers with causes of deaths mentioned. No register in any health facility contains data on ICD code for the cause of death. Records of death certificates were available at 37% of the health facilities. Only 12% of visited health facilities (Private sector) issue death certificates that mention both primary and secondary cause of death. Figure 6 shows information on death registration at health facilities.

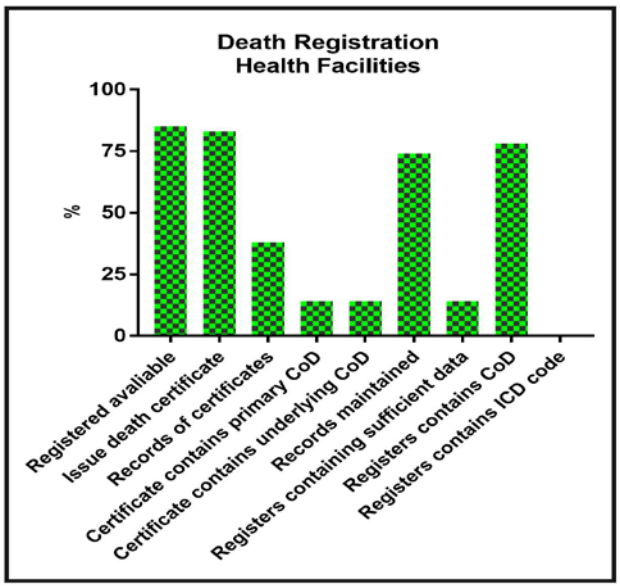


Figure 6. Death Registration at Health Facilities

Concerning reporting of births and deaths by the health facilities, more than 90% of health facilities send a monthly report to their concerned district and provincial offices. However, all of these reports only contain aggregated numbers on births and deaths. None of births or deaths records contains sufficient data to trace or link these births and deaths records to the Local Government offices or national ID management authorities. Figure 7 shows information on births and deaths reporting particles by health facilities.

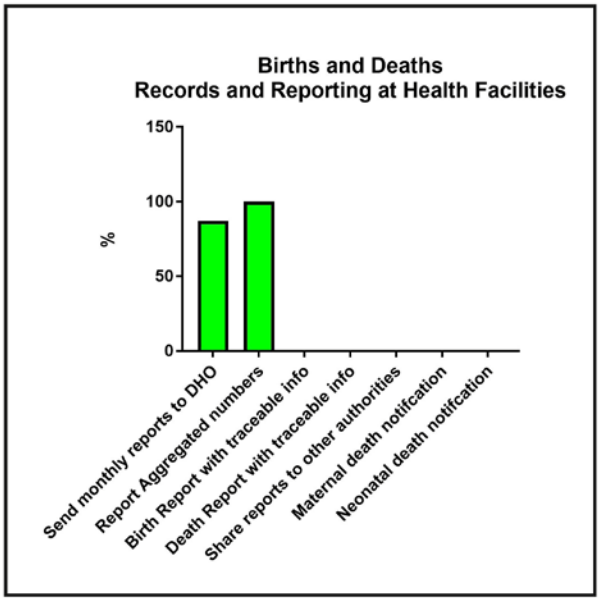


Figure 7. Births and Deaths Records and Registration Practices at Health Facilities

5.1.2.1 Primary and Secondary Care Health Facilities

At primary level healthcare facilities (BHUs and RHCs) a Lady Health Visitor registers pregnant women in the Mother Health Register (Figure 8). The pregnancy record of the individual women is updated at each visit and outcome of the delivery (live births or stillbirths) is recorded. The postnatal record is also updated including the maternal conditions, maternal deaths, and cause of maternal deaths. However, there is no mechanism to capture the CNIC of the women (Unique ID) that can be used for the registration of outcomes or pregnancy with the local government department. The data on the mother register is kept only at the Health Facility level. No mechanism exists to flow this data to higher levels including District Health Offices or Health Directorate at the Provincial level. No data sharing protocols exist for sharing information with the Local Government Department.

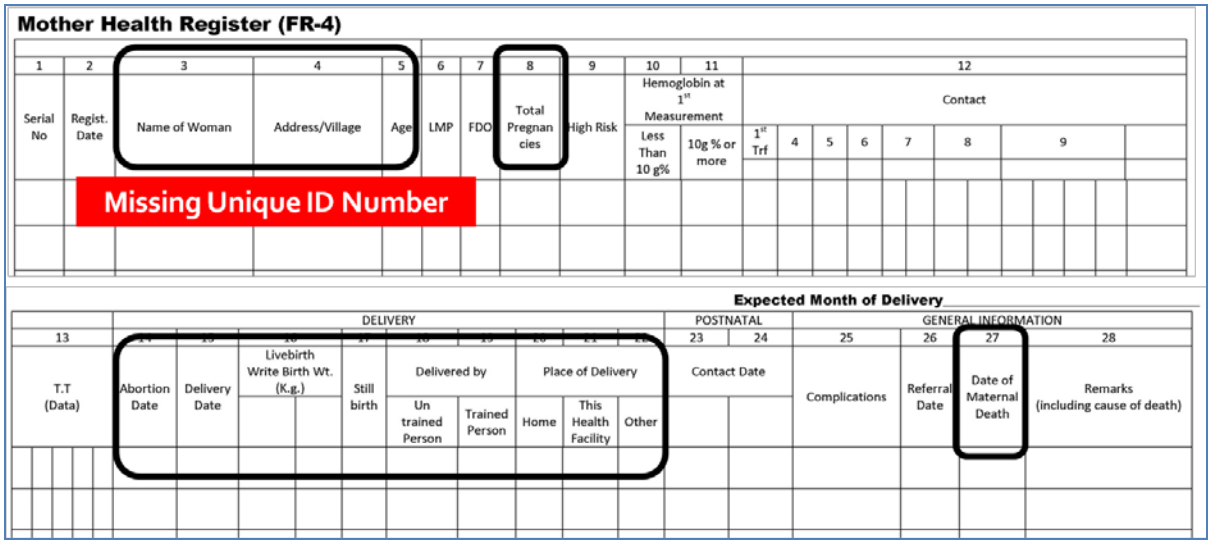


Figure 8. Mother Health Register at BHUs and RHCs

A birth register was also available in primary level health facilities. The birth register capture basic data on the birth of the newborn with capturing of data on the CNICs of the parents. Figure 9 shows a births register in practice by primary health facilities in GB, AJK, and ICT.

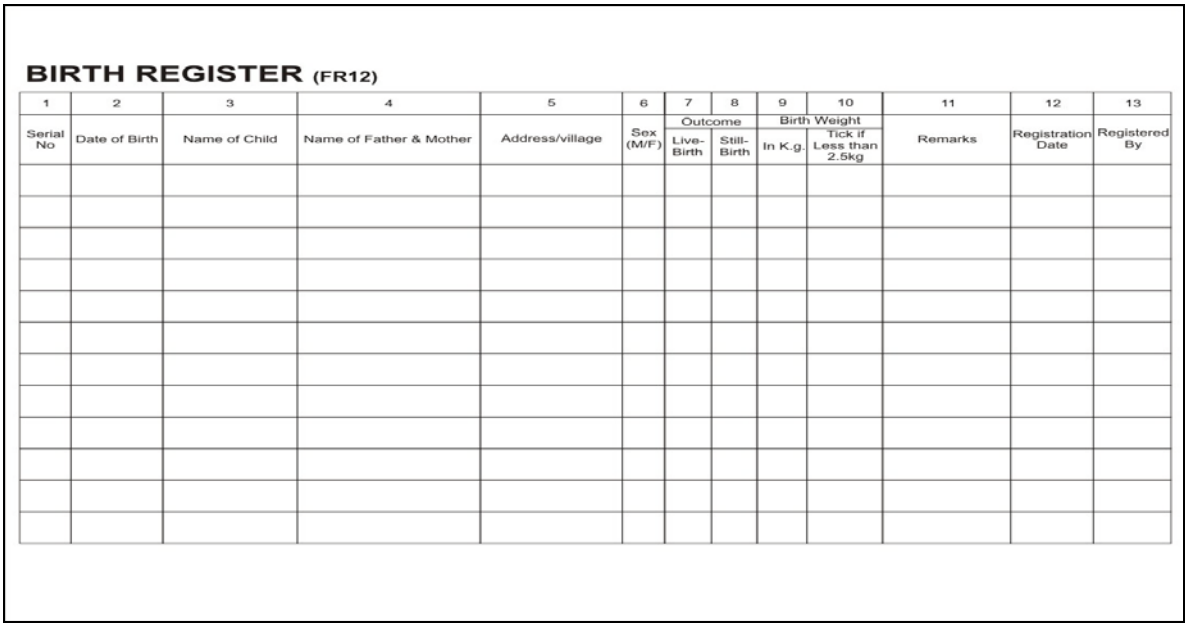


Figure 9. Birth Registers at Basic and Rural Health Facilities

5.1.2.2 Tertiary Level Healthcare Facilities

In all health facilities where delivery services are provided in the labour room and indoor health services are provided to pregnant and postnatal women, data of pregnant women and

the pregnancy outcomes are registered on the Obstetric Register (OBS Register). This register was available in all such secondary level healthcare facilities in AJK and GB only. Two tertiary care health facilities in ICT areas (Polyclinic and PIMS) are not using DHIS and have developed their own EMR Systems.

The OBS Register showed in Figure 10, does not record any data on CNICs or unique ID and thus cannot be linked with ID management System or Local Government Offices in its current form. The aggregated data of births and deaths including maternal deaths is submitted to district health office through monthly reports and its upward transmission through DHIS in GB and AJK areas only.

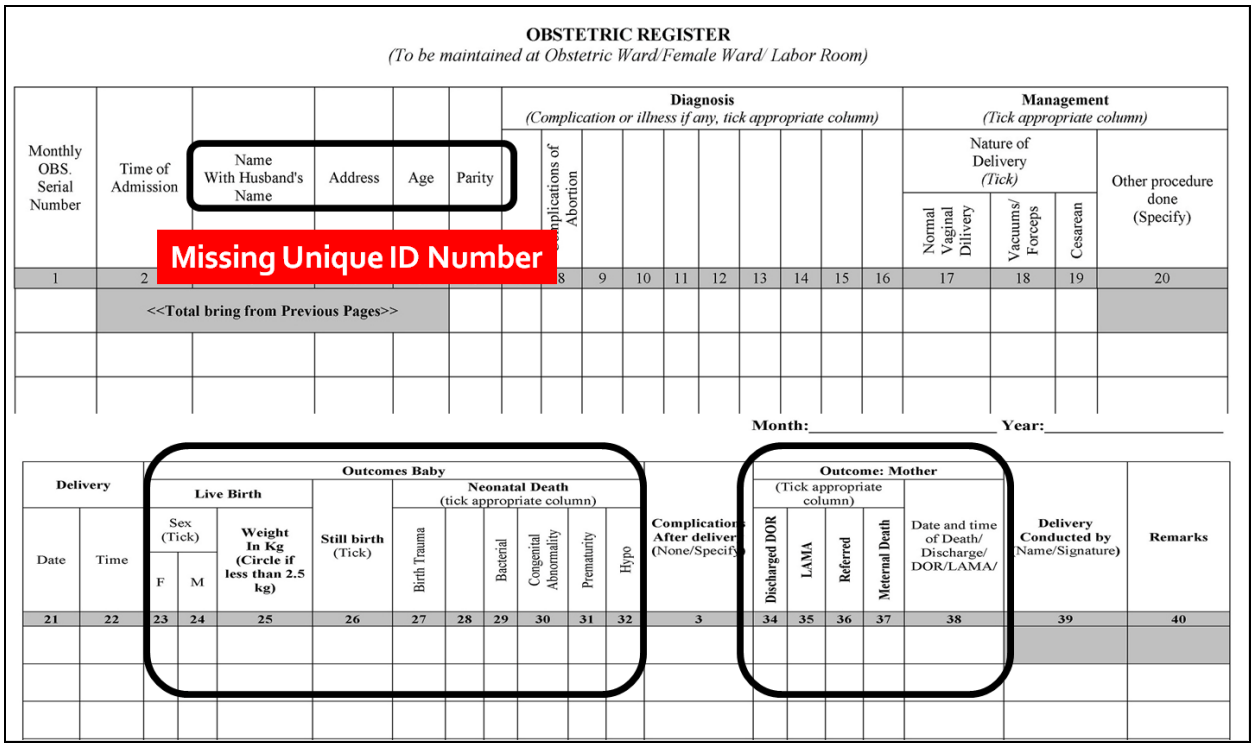


Figure 10. Obstetric Register in THQs, DHQs and Tertiary Level Health Facilities in GB and AJK

Where there are gaps and issues with recording and registration of births and deaths in health facilities, the study noticed few good particles. In Polyclinic Hospital, Islamabad, a dedicate counter was established for births certificate (Figure 11). The hospital administration also developed a Hospital Management Information System, which captures and maintains

individual records of all patients. In addition, standardized birth and death applications and certificate are also being developed.

Figure 11. Birth Certificate Counter at Poly Clinic Hospital, Islamabad

5.1.3 Expanded Program on Immunization

Vaccination centres were visited in all levels of health facilities i.e. BHU, RHCs, DHQs and Tertiary Level Hospitals in three study areas of GB, AJK, and ICT. It was observed that vaccination records were maintained on a temporary and permanent vaccination register. The aggregates of the vaccinations services were compiled and submitted to the District and provincial level on a monthly basis. However, we could not find any information pertaining to the unique identification of the child or its parents. Figure 12 shows a vaccination register currently in use by both public and private health facilities in these areas.

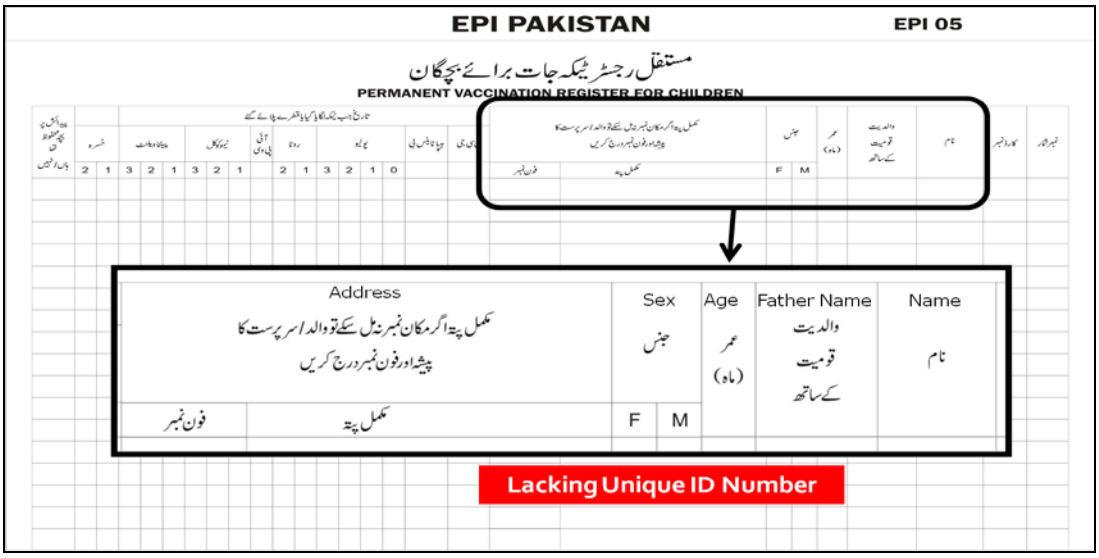


Figure 12. Permanent Vaccination Registers used by EPI Program

5.1.4 Lady Health Workers Program

Approximately 3,000 LHWs are working at the community level covering 69% of the population in AJK. Each LHW maintains a family register, and records information on each family within her catchment population. The family register is regularly maintained with births and deaths are entered in the family records. However, no data on CNIC or other unique ID is captured that can later be used to link with Local government for registration and certification purposes. Figure 13 shows a Family Register used by each LHW in the three regions of AJK, GB, and ICT.

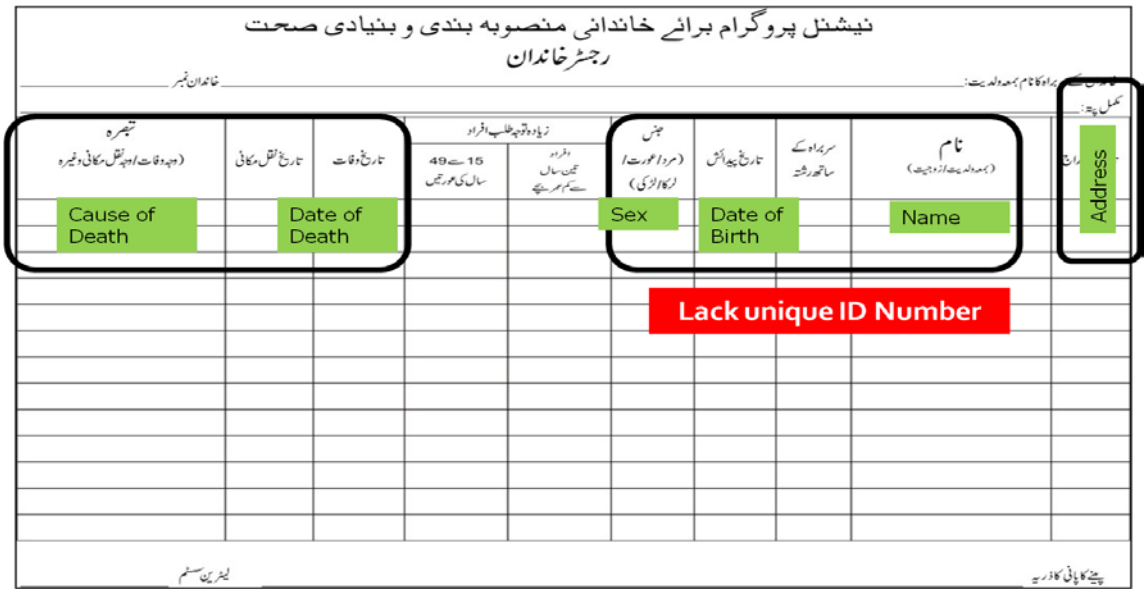


Figure 13. Family register of a Lady Health Worker

Each LHW also submits a monthly report, that contains aggregated figures of births and deaths occurred in her catchment population (Figure 14). LHW also verifies each maternal death using a death verification form.

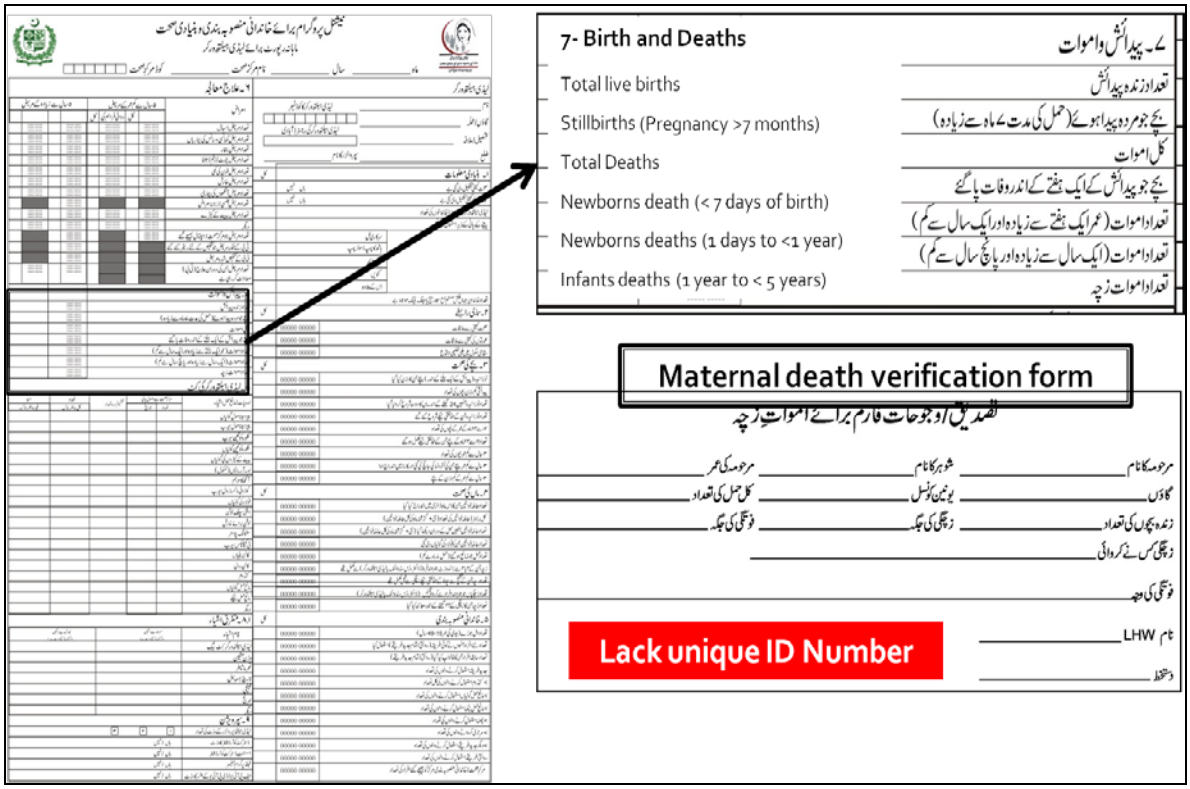


Figure 14. LHWs Monthly Report and Maternal Death Verification Form

However, these forms do not capture data on any unique number or CNIC. Further, there is no mechanism on the flow of this data and it remains at the health house level. Each maternal and neonatal death is further verified by an Assistant Deputy Coordinator of LHWs program using a non-standardized verbal autopsy form. Further, these maternal deaths were also discussed at the district level for assigning causes of deaths but there is no mechanism to record this information in the LHWs MIS. No mechanism exists for sharing of the data with Local Government for registration of births and deaths at any level.

In GB 76% of the population is covered by LHWs. Similar to the recording of births and deaths and maintenance of family registers by LHWs in AJK, LHWs in GB and ICT record births and deaths using the standard monthly reports that contain aggregated numbers of births and deaths. No mechanism exists to uniquely identify each birth and death and no protocols of data sharing with the local government and other authorities exist.

5.1.5 The National Maternal Newborn and Child Health Program

Another health program that operates at the community level is known as the National Maternal Newborn and Child Health Program. It was launched in 2007 to improve the

delivery of better health care services to women and children. It provides maternal and child healthcare services through Community Midwives (CMWs). Each CMW covers a population of 5,000 and submits a monthly report including data on number of pregnant women, antenatal care visits and mortality rates from her catchment population. The monthly reports only contain aggregated data without any information on unique IDs. Their monthly reports flow upwards to the district offices and to the provincial or the state offices. There are no protocols for sharing this data with the local government or other organizations for the purpose of registration of births and deaths. Figure 15 shows monthly reports form currently used by the CMWs in GB, AJK, and ICT.

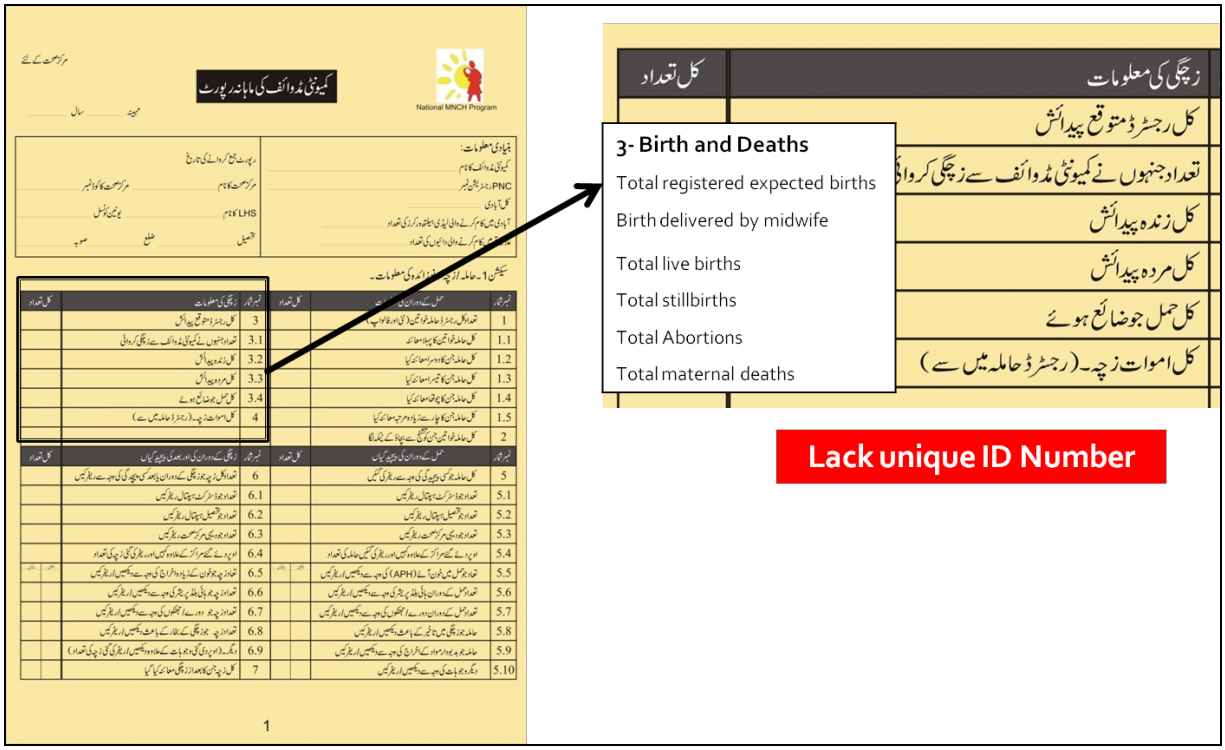


Figure 15. Community Midwife Monthly Report Form

5.2 Births and Death Certificates

Births and deaths certificate currently issued by the public sector health facilities are not standardized in all three areas of AJK, GB, and ICT. Births certificate do not capture any data on the parents CNICs of the newborn. The death certificate does not capture any data on the CNIC of the deceased or his/her parents/husband. Figure 16 shows a few examples of births and deaths certificates currently in practice by public sector health facilities.

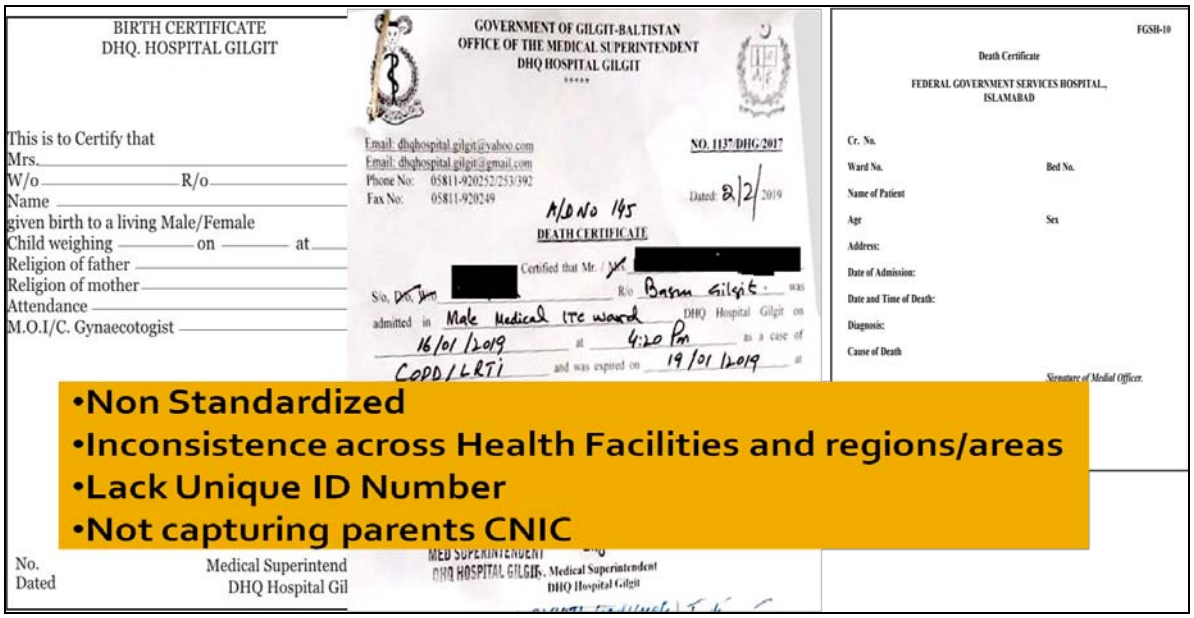


Figure 16. Birth and Death Certificate issued by Public Health Facilities

Private Sector Health Facilities

Private sector health facilities in GB and AJK maintain records of births and deaths manually on registers. They issue birth certificates using a non-standardized birth certificate. In the case of deaths, a death certificate is issued without data on causes of deaths and ICD code. However, few private sector health facilities e.g. Agha Khan Hospitals in these areas properly maintain records of births and death with unique ID and causes of deaths. No mechanism exists to share the data on births and deaths with health authorities and local government offices for the purpose of registration. Figure 17 shows inconsistence among births and deaths certificates currently used by few private health facilities in GB.

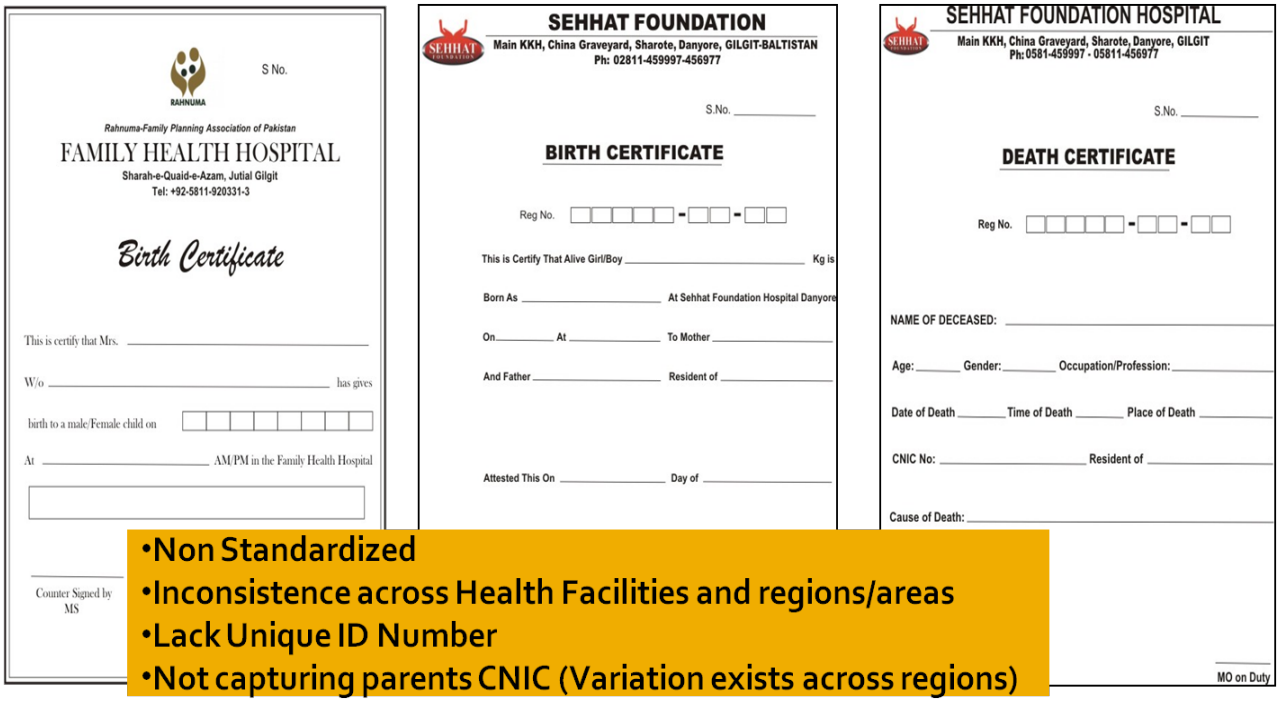


Figure 17. Birth Certificate of a Private Sector Health Facility in GB

5.3 Vital Events Registration by NADRA

National Database and Registration Authority (NADRA) was established as the National Database Organization, an attached department under the Ministry of Interior, Government of Pakistan in 1998, to facilitate the Department of the Local Government, NADRA established a civil registration system known as “Civil Registration Management System (CRMS)” for covering registration of four vital events i.e. Birth, Death, Marriage, and Divorce. The intention was to automate all the local government UCs, Municipal Committees and Cantonment Boards for the provision of computerized registration and certification of vital events with a unique ID. Figure 18 shows a screenshot of the NADRA CRMS death registration form. It is worth noticing that only two main categories of causes of deaths are provided for the issuance of a death certificate.

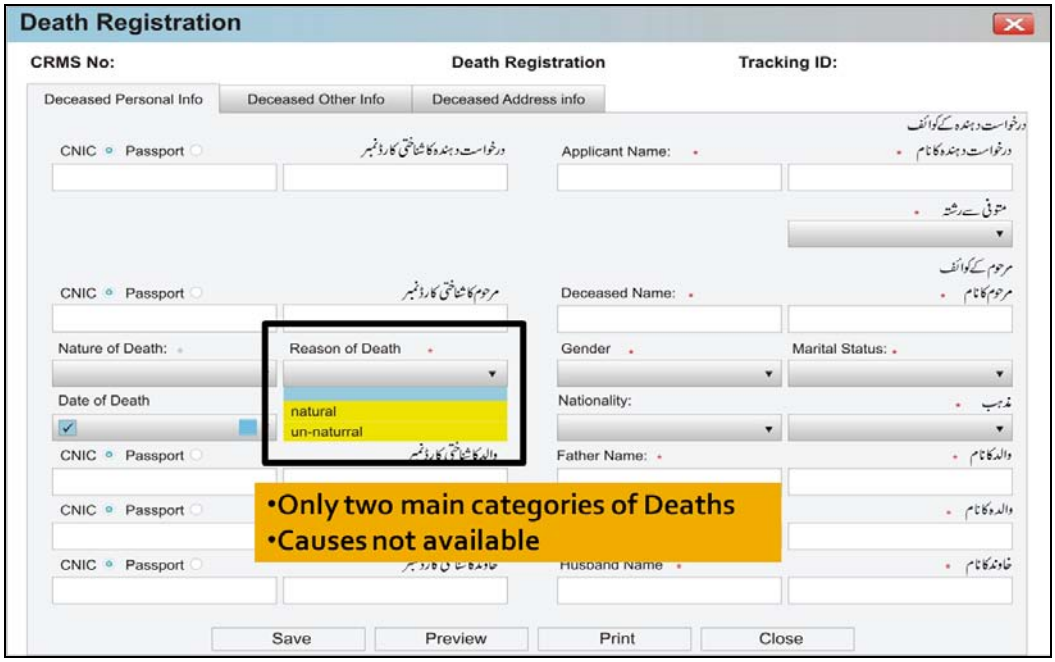


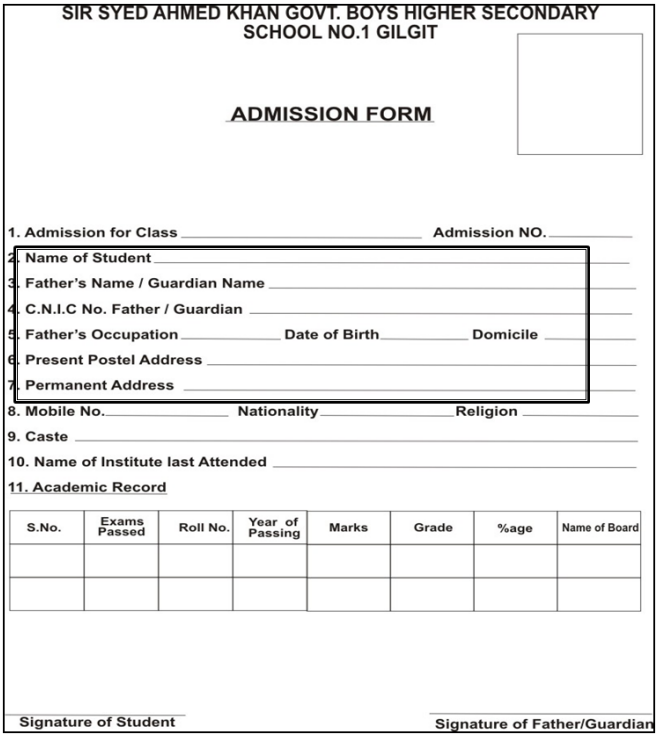
Figure 18. CRMS Death Registration Form

NADRA also issues a Child Registration Certificate that contains a unique ID of 13 digits, which becomes the CNIC Number when a person reaches the age of 18 years. NADRA also processes the cancellation of CNIC of the deceased persons. In Gilgit city (Cantt area) NADRA also issues birth and death certificates.

5.4 Vital Events Notification by Various Stakeholders

5.4.1 Education Department

The Primary and Secondary Education department is maintaining the record of children enrolled in the schools in the Education Management Information System (EMIS). However, the EMIS does not capture the CNICs of the parents and there is no mechanism to share this information for the registration of schoolchildren with the Local Government department. Moreover, there is no mechanism to register private schools in GB and AJK. Figure 19 shows the application forms currently in use by a public school in GB. It was noticed that the form contains sufficient data on the child and its parents including their CNIC. If a mechanism exist this information can be used to link with registration authorities.



SIR SYED AHMED KHAN GOVT. BOYS HIGHER SECONDARY SCHOOL NO.1 GILGIT

ADMISSION FORM

1. Admission for Class _____ Admission NO. _____
2. Name of Student _____
3. Father's Name / Guardian Name _____
4. C.N.I.C No. Father / Guardian _____
5. Father's Occupation _____ Date of Birth _____ Domicile _____
6. Present Postel Address _____
7. Permanent Address _____
8. Mobile No. _____ Nationality _____ Religion _____
9. Caste _____
10. Name of Institute last Attended _____
11. Academic Record

S.No.	Exams Passed	Roll No.	Year of Passing	Marks	Grade	%age	Name of Board

Signature of Student

Signature of Father/Guardian

Figure 19. Current School Admission Form in Gilgit Baltistan Province

The admission registers currently in use do not capture data on CNIC and variation exits across schools and regions. **Figure 20** shows a school admission register currently in use by a public school in GB.

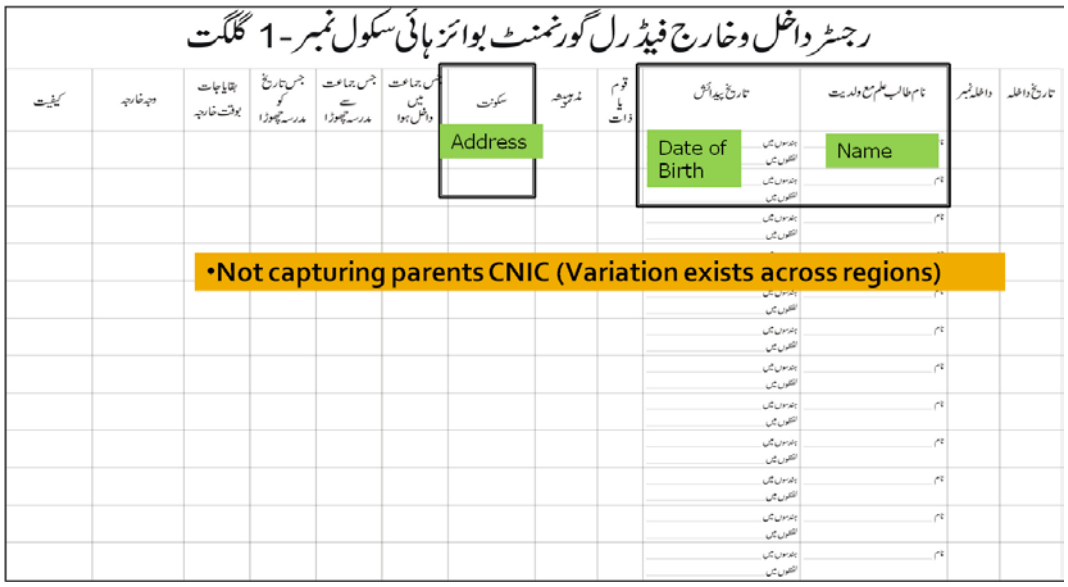


Figure 20. Admissions register in a public school of Gilgit Baltistan

5.4.2 Population Welfare Department

Population Welfare Department provides family planning and counselling services to married couples through the Population Welfare centres. One centre provides service to a population of 7,000. The community workers of the population welfare department register eligible couples using a registration form and provide family planning, and counselling services. The married couple registration form captures information on address, education, and occupation of couples including the number of children. Neither, data is captured to uniquely identify these couples, nor data on the CNIC is recorded. The information collected remains at a welfare centre level without upwards flow to the district and state/provincial level. Figure 21 shows the married couple registration form currently used by the population welfare department in GB, ICT, and AJK.

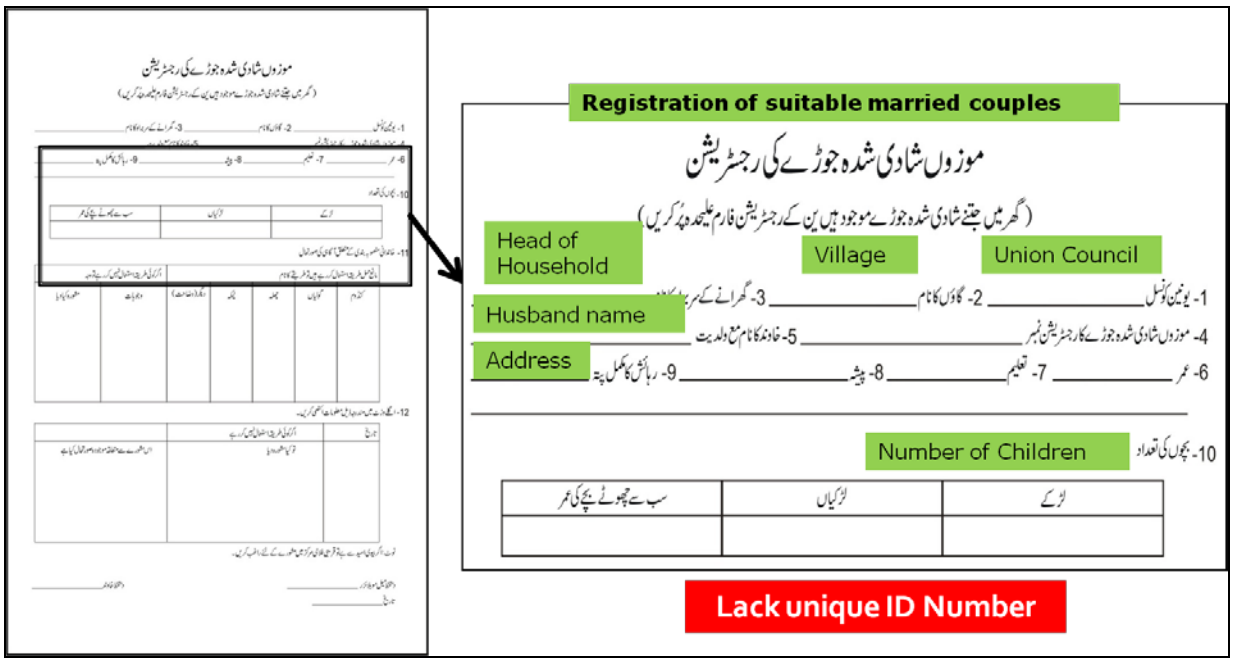


Figure 21. Married Couple Registration by the Population Welfare Department

5.5 Vital Events Notification by NGOs

Rahnuma-Family Planning Association of Pakistan manages nine health clinics and four delivery centres in GB. Similarly, there are other Non Government Organizations e.g. the Agha Khan Health Services and the Sehat Foundation that provide health care services. These organizations are currently not sharing their births and deaths information with the concerned health departments or with registration authorities.

5.6 Vital Events Registration in Disasters

Continuity of the services in case of any natural or man-made disaster is the priority for the Government and its concerned organization including Provincial and State disaster management authorities. Depending upon the magnitude of the disaster, the affected population may be displaced internally. In such an instance, the population (especially high-risk groups including children, pregnant women, disables) is vulnerable to various risks and requires special arrangements for the service provision. Although, a strong coordination mechanism of line departments is in place in all the three areas of ICT, GB, and AJK, a clear guideline to ensure the provision of registration of vital events services was not available. A manual record of deaths subsequent to disasters is maintained at the District Administration offices but is not shared with Local Government for registration purposes.

5.7 Ministry of Human Rights

Provision of a legal identity to all individuals is the primary responsibility of the state. Currently, the Ministry of Human Rights lacks a strategy to strengthen the births registration. The MIS wing at the ministry office maintains a database on various statistics and generate statistics on a need basis only.

5.8 Benazir Income Support Program

Benazir Income Support Programme (BISP), initiated by the Government of Pakistan (2008) was started with the primary objective to support poor households (Benazir Income Support Programme, 2011). In order to carry out its programs, BISP collects data through the door-to-door complete household surveys, which so far, is the largest database of poorest families of Pakistan. The indicators used by BISP reflect the socioeconomic conditions of the targeted population from multiple angles. Therefore, the data collected by the BISP, particularly pertaining to population-based statistics is of major importance in generating vital statistics. The BISP has established National Socio-Economic Registry (NSER), which is the data repository of poverty score survey conducted in 2010 and contains data of over 27 million households. Vital statistics on poverty, population structure, employment, education, disability and under 5-registration coverage can be estimated using poverty score survey data (NSER). BISP plans to conduct a household census in 2019 with intentions to cover 100% households in all provinces and regions of Pakistan.

5.9 Generation of vital statistics

The local Government in GB, AJK, and ICT generates no vital statistics. Health Department generates statistics on need basis (non-regular). Similarly, NADRA generates statistics on a need basis (non-regular). Pakistan Bureau of Statistics generates annual and monthly bulletin on vital statistics. It conducts various surveys including Pakistan Demographic Survey (PDS), Pakistan Social and Living Standards Measurement Survey, Household Integrated Income and Consumption Survey and have the mandate to conduct the household population census. These surveys are conducted to collect statistics of births and deaths in order to arrive at various measures of fertility and mortality for Pakistan and its rural and urban areas and to estimate current rate of natural increase of population at the national level. ICT areas surveys are managed by the HQ of Pakistan Bureau of Statistics. A Bureau of Statistics office was established in AJK also, while no Bureau of Statistics Office exists in GB.

5.10 CRVS and SDGs

Tracking the progress of the SDGs requires the collection, processing, analysis of a large amount of data at sub-national, national, regional and global levels. Many developing countries including Pakistan face the challenge of availability of timely and accurate data with sufficient coverage and completeness (The Sustainable Development Goals Report 2018). With 15 of the 17 SDGs (82%) require CRVS data to measure their indicators (Figure 22), two of the SDGs targets and related indicators are directly related to improving civil registration and vital statistics: The target 16.9 is about providing a legal identity for all, including birth registration, and target 17.19 is about the proportion of countries that have achieved 100 percent birth registration, and 80 percent death registration. The analysis of the existing CRVS System in GB, AJK and ICT areas suggest that currently 3 of 17 (18%) SDGs Goal be monitored using CRVS data available at the Health Facilities and UC Offices of the Local Government (Figure 22).

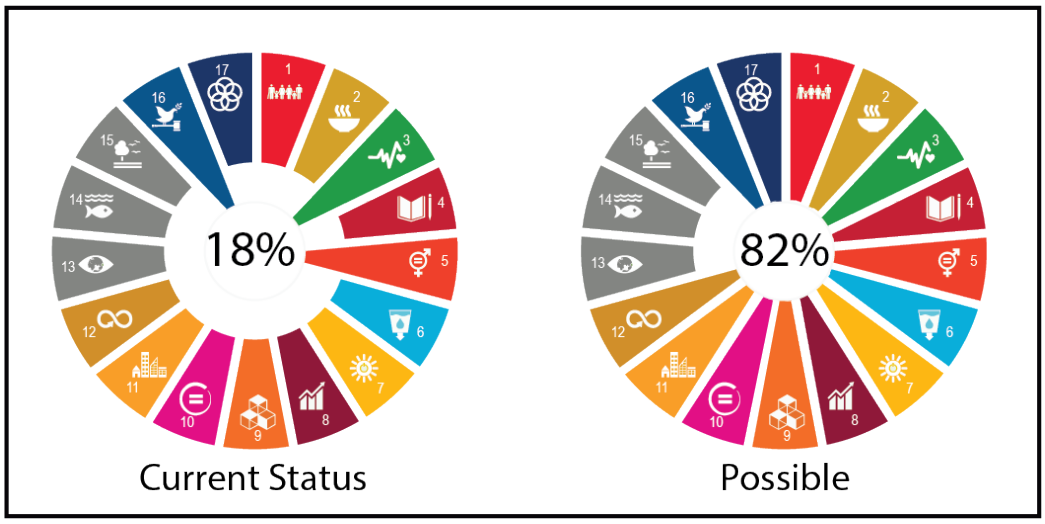


Figure 22. Sustainable Development Goals monitoring by CRVS System in AJK, GB, and ICT

All 169 targets and 232 indicators were analyzed in the context of data provision by the CRVS system for either nominators or denominators or both. A total of 48 out of 169 Targets (28%) and 91 out of 232 Indicators (39%) can be monitored using data from a fully functional CRVS system (Annex 3). The proportions of Targets and Indicators derived using CRVS data within each of the 17 Goals is presented in Figure 23.

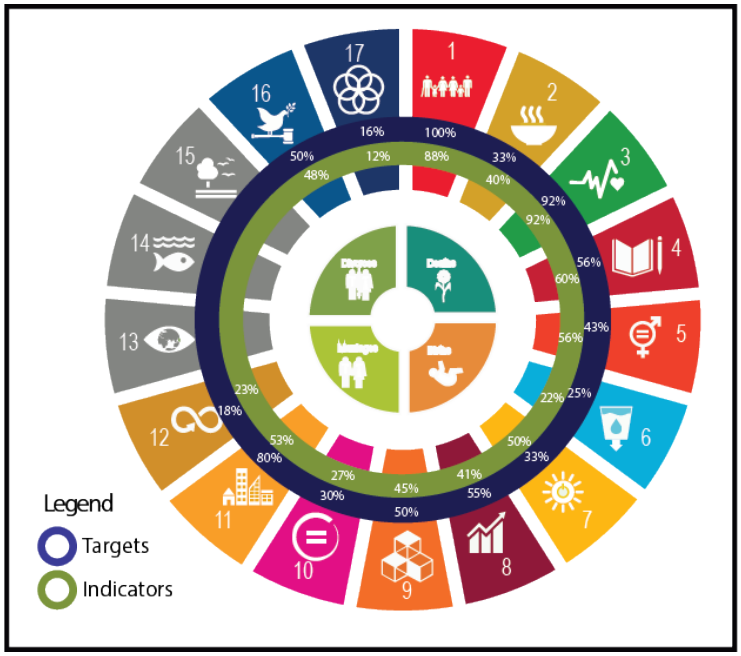


Figure 23. The Proportion of SDGs Targets and Indicators that can possibly be derived from a CRVS System

The assessment of existing CRVS in these three areas of GB, AJK and ICT showed that only 4% of the Targets and Indicators can exclusively be derived using existing data of CRVS i.e. both nominators and denominators of the SDGs indicators derived from CRVS Systems (Table 1). The proportion is higher if survey data is used for nominators and CRVS system data for denominators. In that case, 7 of 160 Targets (24%) and 81 of 232 Indicators (35%) can be derived using survey data for nominators and CRVS data for denominators (Annex 3).

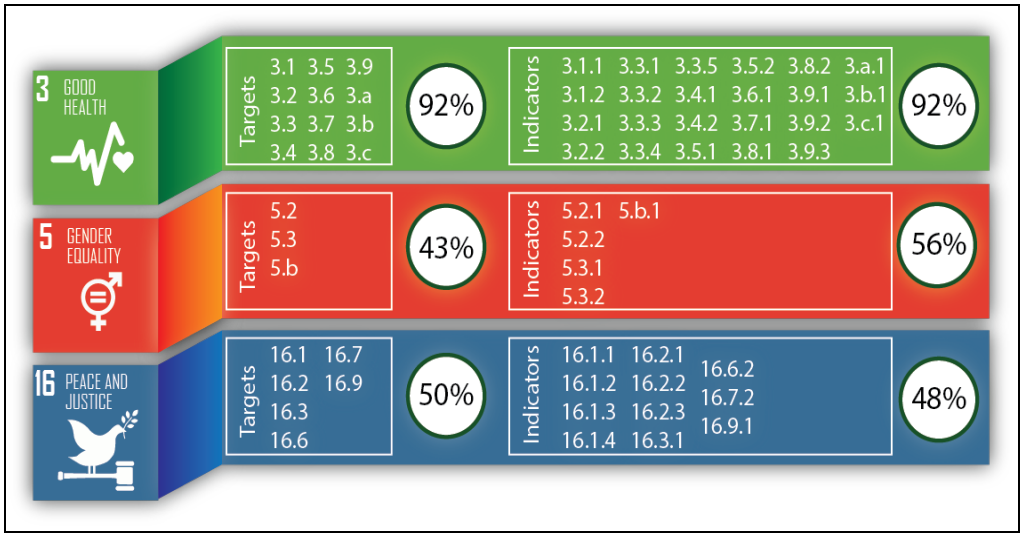


Figure 24. The proportion of Targets and Indicators that can be derived using existing CRVS data in AJK, GB, and ICT

Table 1. Current CRVS System in AJK, GB and ICT that can provide both nominators and denominators for monitoring SDGs Indicators,

Goals	Targets		Indicators		Tier*
	No.	Description	No.	Description	
Goal 3	3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1	Maternal mortality ratio	I
			3.1.2	Proportion of births attended by skilled health personnel	I
	3.2	By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	3.2.1	Under-5 mortality rate	I
			3.2.2	Neonatal mortality rate	I
	3.4	By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	3.4.1	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	I
			3.4.2	Suicide mortality rate	I
	3.6	By 2020, halve the number of global deaths and injuries from road traffic accidents	3.6.1	Death rate due to road traffic injuries	I
	3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	3.7.2	Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group	I
Goal 5	5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation	5.3.1	Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18	II
Goal 16	16.9	By 2030, provide legal identity for all, including birth registration	16.9.1	Proportion of children under 5 years of age whose births have been registered with a civil authority, by age	I

* updated tier classification, reflecting changes made by the Inter-agency and Expert Group on SDG Indicators (IAEG-SDGs) following the January 2019.

Pakistan is among 11 countries that have an under-five mortality rate higher than the SDG target of 25 per 1000 live births. To achieve this SDGs target, Pakistan needs to triple the reduction rate for under-five mortality (Wang et al., 2017). However, with infrequent surveys and lack of data at sub-national and district level, it is not possible to monitor the rate of reduction. In such an instance, a functional CRVS system can provide a reliable source of data to monitor such reduction.

5.11 CRVS and Emergencies

In disaster, whether it's a man made or natural, countries face challenges in registering life events (e.g. births, deaths, marriages, divorces). Displaced individuals may be unable to prove their legal identity, creating barriers to protection. Further, lack of a legal identity in disaster situations may increases vulnerability to various threats, including human trafficking. The study find a defined protocols in all three regions of GB, AJK and ICT that provides a frameworks and a mechanism to ensure provision of civil registration services to displaced population to register their births, deaths, marriage and divorce and obtain legal certificates. Furthermore, the study did not find any mechanism for registration of migrants and stateless persons in any of the study areas.

5.12 Measuring Primary Health Care Coverage

Coverage in the context of Primary Health Care (Universal Health Care) relies on the availability and appropriate use of services that are of sufficient quality. For example, increase in the facility based births may not have a direct impact on the reduction of maternal and neonatal mortality, unless the health facilities are provided with sufficient supplies, equipment and an efficient referral system. The Inter-agency and Expert Group (IAEG) changed one of the two indicators for SDGs target 3.8 — "to achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all" — to be defined as the "number of people covered by health insurance or public health system per 1,000 population". To measure the coverage of this indicator, the application forms used to register births and deaths need revision to capture data on Health care provision and quality.

6. Recommendations

- Standardization of Births, Deaths, Marriage and Divorce application forms is required by the Local Government with agreed minimum sets of information mandatory to be collected by all areas of GB, AJK, and ICT.
- A framework for the upward data flow of vital events, data maintenance across UC/Municipal offices, and creating a database is required by GB, AJK and ICT.
- Up-gradation of CRMS Software to include a comprehensive list of causes of deaths along with ICD code.
- Standardization of births and death reports (slips/certificates) in health facilities
    - Capture CNICs of parents in births certificate
    - The primary cause, underlying causes, and ICD code in deaths certificate
- Assigning a unique ID to each birth wherever it is registered.
- Linkages of National ID Management with Hospital Information Systems.
    - Births unique IDs are linked with parents CNIC
    - Deaths IDs are updated
- Actions for mandatory notification of maternal and neonatal deaths.
- Coordination mechanism with District Administration for registration of death due to disasters.
- Building the analytical capacities of the Local Government and Health Department in coordination with PBS for generating of vital statistics.
- Mechanism to enable the service provision of registration of vital events across Pakistan i.e. a birth in a place “A” can be registered at that place rather at the place of permanent residence.
- Mechanism to register migrants and stateless person should be defined and incorporated with the existing service provision by the Local Govt.
- The inclusion of primary healthcare coverage capturing information e.g. family planning, vaccination, access to healthcare, in standardized births, marriage, and death applications forms.

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Annexes

Annex 1

Study on

Assessment of Civil Registration and Vital Statistics
practices, resources and functioning in Federally Administrated Areas
(ICT, GB, AJK)

HF Questionnaire

	1	2	FINAL VISIT
DATE	_____	_____	DAY ☐☐
RESULT*	_____	_____	MONTH ☐☐
			YEAR ☐☐☐☐

*RESULT CODES:COMPLETED

1. POSTPONED
2. REFUSED
3. OTHER_____

HF Details	
Name of the Interviewer: _____	Date: _____
Signature of the Interviewer: _____	Respondent agrees to be interviewed…….1
Respondent does not agree to be interviewed……2 →END	

Name of interviewee: _____	Designation: _____
Type of Health Facility BHU ☐ THQ ☐ Tertiary Care ☐ RHC ☐ DHQ ☐ Other_____	Public Health Facility ☐ Private Health Facility ☐
Province:_____ District (If applicable): _____ UC/Ward/Area _____	

Assalam-o-Alaikum.

My name is _____. I am conducting a study on CRVS data sources and reporting gaps and use of CRVS data sources for SDGs indicators monitoring for the Federal SDGs Unit of Ministry of Planning Development and Reform. I will ask few questions. Interview may take around 20 minutes.

Part A: Registration and Reporting

No.	Questions	Answer
	Birth Registration	
1C01	Have you ever heard of CRVS?	Yes ☐ No ☐
1C02	What are the key events registered in Pakistan for CRVS? **Answer should cover the followings:** Birth Deaths Marriage Divorce	Births ☐ Deaths ☐ Marriage ☐ Divorce ☐
1C03	Are any birth taking place in this HF?	Yes ☐ No ☐
1C04	Are you keeping records of births taking place in this HF?	Yes ☐ No ☐
1C05	Are the births registers available at the HF?	Yes ☐ No ☐
1C06	Are the birth registers containing the following data on births records? **Check the followings if present in the register** Date of Birth Unique ID Father Name Father CNIC Mother Name Mother CNIC Complete Address	Date of Birth ☐ Unique ID ☐ Father Name ☐ Father CNIC ☐ Mother Name ☐ Mother CNIC ☐ Complete Address ☐
1C07	Do you issue a birth certificate?	Yes ☐ No ☐
1C08	Do you keep a copy of birth certificate?	Yes ☐ No ☐
1C09	Are the birth certificate containing the following data on it? **Check the followings if present in the certificate** Date of Birth Unique ID Father Name Father CNIC Mother Name Mother CNIC Complete Address	Date of Birth ☐ Unique ID ☐ Father Name ☐ Father CNIC ☐ Mother Name ☐ Mother CNIC ☐ Complete Address ☐

Death Registration		
2C10	Are any death take place at the HF?	Yes ☐ No ☐
2C11	Are the deaths registered at the HF?	Yes ☐ No ☐
2C12	Are the death records maintained at the HF?	Yes ☐ No ☐
2C13	Are the death registers containing sufficient data on death records? **Check the followings if present in the register** Date of Death Unique ID of Death Certificate Name of Deceased Name of Father/Husband of Deceased Complete Address Primary Cause of Death Underlying Cause of Death ICD Code for the Cause of Death	Date of Death ☐ Unique ID of Death Certificate C ☐ Name of Deceased ☐ Name of Father/Husband ☐ of Deceased ☐ Complete Address ☐ Primary Cause of Death ☐ Underlying Cause of Death ☐ ICD Code for the Cause of Death ☐
2C14	Do you issue a death certificate to the relatives of the deceased?	Yes ☐ No ☐
2C15	Do you keep a copy of death certificates in your records?	Yes ☐ No ☐
2C16	Are the death certificate containing sufficient data on it? **Check the followings if present in the certificate** Date of Death Unique ID of Death Certificate Name of Deceased Name of Father/Husband of Deceased Complete Address Primary Cause of Death Underlying Cause of Death ICD Code for the Cause of Death	Date of Death ☐ Unique ID of Death Certificate C ☐ Name of Deceased ☐ Name of Father/Husband ☐ of Deceased ☐ Complete Address ☐ Primary Cause of Death ☐ Underlying Cause of Death ☐ ICD Code for the Cause of Death ☐
Births and Deaths Reporting		
3C17	Do you prepare a monthly report with aggregated figures on births and deaths data?	Yes ☐ No ☐
3C18	Do you prepare a monthly report with complete details of individual births and deaths data?	Yes ☐ No ☐
3C19	Do you report births and deaths to District Health Office/Executive District Officer (Health)	Yes ☐ No ☐

3C20	Do you report births and deaths to other authorities?	Yes ☐ No ☐
3C21	Which authority do you report births and deaths?	District Administration ☐ Population Welfare ☐ Local Government ☐ Others_____ ☐
3C22	Is a maternal death a notify able event at the HF?	Yes ☐ No ☐
3C23	Is a neonatal death a notify able event at the HF?	Yes ☐ No ☐

EPI Registration

4C24	Is there vaccination center in this hospital?	Yes ☐ No ☐
4C25	Are you providing vaccination to children?	Yes ☐ No ☐
4C26	Are you providing vaccination to pregnant women?	Yes ☐ No ☐
4C27	How do you maintain records of vaccination? _____ _____ _____ _____	
4C28	Are the records of vaccination available?	Yes ☐ No ☐
4C29	Are the vaccination records containing the following data? **Check the following if present** Name of Child/Women Father's / Husband's Name Father's / Husband's CNIC Mother's Name Mother's CNIC Unique ID of vaccination record	Name of Child/Women ☐ Father's / Husband's Name ☐ Father's / Husband's CNIC ☐ Mother's Name ☐ Mother's CNIC ☐ Unique ID of vaccination record ☐
4C30	Do you submit monthly report to your immediate supervisor?	Yes ☐ No ☐
4C31	How do you submit the report to your immediate supervisor? _____ _____ _____ _____	

END

That is the end of our questionnaire. Thank you very much for taking the time to answer these questions. We appreciate your help.

Study on

Assessment of Civil Registration and Vital Statistics practices, resources and functioning in Federally Administrated Areas (ICT, GB, AJK)

Interview Questionnaire for Community level

INTERVIEWER VISITS

	1	2	FINAL VISIT
DATE	_____	_____	DAY ☐☐
RESULT*	_____	_____	MONTH ☐☐
			YEAR ☐☐☐☐

*RESULT CODES:
1. MPLETED
2. POSTPONED
3. REFUSED
4. OTHER_____

Interviewer Details	
Name of interviewer: _____	Date: _____
Signature of interviewer_____	Respondent agrees to be interviewed…….1
Respondent does not agree to be interviewed……2 →END	

Interviewee Details	
Name of interviewee: _____	Designation: _____
Department: _____	Province: _____
District (If applicable): _____ Union Council (If applicable) _____	

Assalam-o-Alaikum.

My name is _____. I am conducting a study on CRVS data sources and reporting gaps and use of CRVS data sources for SDGs indicators monitoring for the SDGs Unit of Ministry of Planning Development and Reform. I will ask few questions. Interview may take around 20 minutes.

No.	Questions	Answer
B01	Have you ever heard of CRVS?	Yes ☐ No ☐
B02	What are the key events (listed below) your program, collects data on? **Events** Births Deaths Marriages Divorces Property damages Roads accidents Environmental hazards (Earthquake, Floods, Drought, landslides) Population Displacement (Internal and External)	Births ☐ Deaths ☐ Marriages ☐ Divorces ☐ Property damages ☐ Roads accidents ☐ Environmental hazards (Earthquake, Floods, Drought, landslides) ☐ Population Displacement (Internal and External) ☐
B03	Do you keep records of births in your community?	Yes ☐ No ☐
B04	How do you keep the records of births in your community? _____ _____	
B05	Are the records of births available?	Yes ☐ No ☐
B06	Are the records contain the following data? **Check the following if present:** Date of birth Unique ID Father's Name Father's CNIC Mother's Name Mother's CNIC Complete Address (with UC)	Date of birth ☐ Unique ID ☐ Father's Name ☐ Father's CNIC ☐ Mother's Name ☐ Mother's CNIC ☐ Complete Address (with UC) ☐
B07	Do you keep records of death in your community	Yes ☐ No ☐

B08	How do you keep the records of deaths in your community? _____ _____	
B09	Are the records of deaths available?	Yes ☐ No ☐
B10	Are the records contain the following data of deaths? **Check the following if present:** Date of Death Unique ID Deceased's Name Deceased's CNIC Father's Name Father's CNIC Complete Address (with UC)	Date of Death ☐ Unique ID ☐ Deceased's Name ☐ Deceased's CNIC ☐ Father's Name ☐ Father's CNIC ☐ Complete Address (with UC) ☐
B11	Do you submit report on births and death in your community to your immediate supervisor?	Yes ☐ No ☐
B12	How do you submit the reports of births and deaths in your community? _____	
B13	Is the monthly report form containing information of births and deaths that is identifiable with a unique ID?	Yes ☐ No ☐
B14	Do you keep records of marriages?	Yes ☐ No ☐
B15	How do you keep records of marriages? _____ _____	
B16	Are the records containing the following data of deaths? **Check the following if present:** Name of Husband Husband's CNIC Name of Woman Woman's CNIC Date of marriage	Name of Husband ☐ Husband's CNIC ☐ Name of Woman ☐ Woman's CNIC ☐ Date of marriage ☐
B17	Do you keep records of divorces?	Yes ☐ No ☐
B18	How do you keep records of divorce? _____	

END

That is the end of our questionnaire. Thank you very much for taking the time to answer these questions. We appreciate your help.

Study on

Assessment of Civil Registration and Vital Statistics practices, resources and functioning in Federally Administrated Areas (ICT, GB, AJK)

Interview Questionnaire
(For department involved in registration and certification of Vital Events)

INTERVIEWER VISITS

	1	2	FINAL VISIT
DATE	_____	_____	DAY ☐☐
RESULT*	_____	_____	MONTH ☐☐
			YEAR ☐☐☐☐

*RESULT CODES
1. COMPLETED
2. POSTPONED
3. REFUSED
4. OTHER_____

Interviewer Details	
Name of interviewer: _____	Date: _____
Signature of interviewer_____	Respondent agrees to be interviewed…….1
Respondent does not agree to be interviewed……2 →END	

Interviewee Details	
Name of interviewee: _____	Designation: _____
Department: _____	Province: _____
District (If applicable): _____ Union Council (If applicable) _____	

Assalam-o-Alaikum.

My name is _____. I am conducting a study on CRVS data sources and reporting gaps and use of CRVS data sources for SDGs indicators monitoring for the SDGs Unit of Ministry of Planning Development and Reform. I will ask few questions. Interview may take around 20 minutes.

No.	Questions	Answer
D01	Are you aware of CRVS?	Yes ☐ No ☐
D02	Are you registering vital events?	Yes ☐ No ☐
D03	Which vital events do you register?	Births ☐ Deaths ☐ Marriage ☐ Divorce ☐
D04	At what level registration of vital events is performed? _____ _____ _____	
D05	What is the process of vital events registration and certification? _____ _____ _____	
D06	How do you keep the records of vital events? _____ _____ _____	
D07	Is the data on vital events flow from village/UC to the district of higher levels? _____ _____ _____	
D08	Are the application forms for vital events standardized i.e. consistent across the region/province?	Yes ☐ No ☐
D09	Are the application forms for vital events available in local languages?	Yes ☐ No ☐

D10	Is there any column/space to write the cause of death in the death certificate application form?	Yes ☐ No ☐
D11	Is it mandatory to write/mention cause of death in the application form?	Yes ☐ No ☐
D12	Is there any process to assess the quality of data from civil registration?	Yes ☐ No ☐
D13	Are you generating vital statistics from the civil registration data?	Yes ☐ No ☐

END

That is the end of our questionnaire. Thank you very much for taking the time to answer these questions. We appreciate your help.

Study on

Assessment of Civil Registration and Vital Statistics practices, resources and functioning in Federally Administrated Areas (ICT, GB, AJK)

Interview Questionnaire for Bureau of Statistics

INTERVIEWER VISITS

	1	2	FINAL VISIT
DATE	_____	_____	DAY ☐☐
RESULT*	_____	_____	MONTH ☐☐
			YEAR ☐☐☐☐

*RESULT CODES:

1. COMPLETED
2. POSTPONED
3. REFUSED
4. OTHER_____

Interviewer Details	
Name of interviewer: _____	Date: _____
Signature of interviewer_____	Respondent agrees to be interviewed…….1
Respondent does not agree to be interviewed……2 →END	

Interviewee Details	
Name of interviewee: _____	Designation: _____
Department: _____	Province:_____
District (If applicable):_____ Union Council (If applicable) _____	

Assalam-o-Alaikum.

My name is _____. I am conducting a study on CRVS data sources and reporting gaps and use of CRVS data sources for SDGs indicators monitoring for the SDGs Unit of Ministry of Planning Development and Reform. I will ask few questions. Interview may take around 20 minutes.

No.	Questions	Answer
A01	Have you ever heard of CRVS?	Yes ☐ No ☐
A02	Which data sources are used for the production of annual statistical information on births?	_____ _____ _____ _____
A03	Which data sources are used for the production of annual statistical information on deaths?	_____ _____ _____ _____
A04	Is there a strategy for promoting wider use of vital statistics? If so is the strategy being implemented?	_____ _____ _____ _____
A05	Who are the main users of vital statistics data at different levels?	_____ _____ _____ _____
A06	Are vital statistics from civil registration used to check accuracy of data from other sources, such as population censuses?	_____ _____ _____ _____

END

That is the end of our questionnaire. Thank you very much for taking the time to answer these questions. We appreciate your help.

Annex 2

List of Participants

In-depth Interviews and Field Observations

Islamabad Capital Territory		
1.	Dr. Syed Mursalin	National Advisor, TSU-CRVS, Ministry of Planning, Development, and Reform
2.	Dr. Nasser Mohiuddin	Director General (Technical), National Ministry of Health Services Regulation and Coordination
3.	Mrs. Rizwana Siddique	Director, Pakistan Bureau of Statistics
4.	Maj (Retd) Aftab Khan	Director CRMS National Database and Registration Authority
5.	Mr. Owais Farooq	Deputy Director Operation, Benazir Income Support Program
6.	Dr. Sabeen Afzal	Assistant Executive Director, Poly Clinic Hospital, Islamabad
7.	Brig Fiaz Hussain Shah (Retd)	Director General National Institute of Disaster Management
8.	Mr. Arshad	Director General (Ops), Ministry of Human Rights
9.	Mr. Nishat Bashir	Senior Program Office, Ministry of Human Rights
10.	Syed Shafaqat Hussian Shah	Assistant Director LG and RD ICT
11.	Dr Najeeb Durrani	District Health Officer ICT
12.	Mr. Faiz	Superintendent LG and RD, ICT
13.	Mr. Ghulam Hussain	UC Secretary, UC Sohan, ICT
14.	Dr. Inam Ullah	Incharge, RHC Bara Kahu, ICT
15.	Mr. Iqbal	Medical Assistant, BHU Sohan, ICT
16.	Ms. Adeeba Taj	LHW Nai Abadi, UC Sohan, ICT
Azad Jammu and Kashmir		
17.	Mr. M Ijaz Khan	Secretary Local Govt AJK
18.	Mr. Shamoon Hasmi	Chief Economist, Ministry of Planning and Development
19.	Mr. M. Shabir Abbasi	Chief Municipal Officer, District Govt, Muzafarabad

20.	Mr. Malik Noaman	Program Manager LG and RD, Rural Development Center Muzafarabad
21.	Mr. M. Rafique Chughtai	UC Secretary, LG and RD, Rural Development Center Muzafarabad
22.	Mr. Haniz Nazir Ahmed	Director Auqaf and Religious Affairs (Amoor-e-Dinya)
23.	Mufti Syed Nazakat	Mufti HQ, Auqaf and Religious Affairs (Amoor-e-Dinya)
24.	Dr. M Saeed Awan	Joint Executive Director Ammore Teaching Hospital
25.	Mrs. Gulshan Bibi	LHV BHU Langarpura
26.	Mr.s Rukhsana Kazmi	CMW Birth Station, Langarpura
27.	Dr. Farhat	Coordinator LHWs Program AJK
28.	Mr. Sajjad Gillani	P/o D&DD
29.	Syed Ali Hussain Gilani	SDGs Coordinator P&DD/UNDP
30.	Mr. Abdul Wahid Khan	Director SWD
31.	Dr. Masood Bukhari	DHS/DOH
32.	Mr. Bilal Siraj Shah	DRM Officer
33.	Mr. Faheem Shah	AJ&K Police
34.	Mr. Anees-ur-Rehman	AD Population
35.	Mr. Gul Zaman Khan	Director General
36.	Dr. Qudsia Batool	Director Women Development
37.	Mr. M Nabeel Gorsi	PO P&DD
38.	Mr. Abdul Ghafoor	Planning Officer (P&DD)
39.	Mr. M. Ejaz-Ul haq	PO (P&DD)
40.	Mr. Nauman Ahmed	PO (PPEH Section P&DD)
41.	Mr. Asim Bashir Awan	Research Officer (HE)
42.	Mr. Raja Shahab Saleem	Assistant Director (E&S)
43.	Mr. Ahmad Hussain	AC-F.AID

44.	Mr. Ahmed Waseem Qureshi	AC LG&RD
45.	Mr. Seema Amin	CSO AJK BOS P&DD
46.	Ms. Mahnaz	Chief R&D/P&DD
47.	Mr. Muhammad Aslam	Chief P&DD
48.	Mr. Raja Zulqarnain	Dy. Director LG&RDD
49.	Mr. Adnan Nasim	A.D/P&DD
Gilgit Baltistan		
50.	Mr. Ali Jabbar	FP, CRVS P&DD, GB
51.	Mr. Anisa Yousaf	RO P&DD, GB
52.	Mr. Syed Nazir Ahmad Shah	RED Coordinator EPI - GB
53.	Mr. M. Afzal Khan	Deputy Director EMIS Education Dept.
54.	Mr. Zubair Ahmad Khan	AD, GBDMA
55.	Mr. Amin Khan	DD, Population Welfare, GB
56.	Mr. Manzoor Karim	M/S Coordinator NP LHWS Program
57.	Mr. M. Abbas	Program Coordinator Nutrition GB
58.	Ms. Najma Farman	SDGs Coordinator, GB
59.	Mr. Sardar Hussain	Admn Officer, Municipal Corporation Gilgit City
60.	Dr. Farman Ullah	MS DHQ Gilgit
61.	Ms. Nafeesa Rani	LHWs Sakwar Gilgit
62.	Mr. Tahir Hussain	BHU Jalalabad, Tehsil Danol, Nagar
63.	Mr. Zulfiqar Ali	Administrator, Sehat Foundation, Danyore, Gilgit
64.	Mr. Abdul Kareem	Project Manager, Rehnuma Foundation (IPPF)
65.	Mr. Matloob Hussain	AD LG, UC Chalt, District Nagar
66.	Dr. Asad	MO, Agha Khan Hospital Gilgit

67.	Mr. Ishfaq Ahmed	AD NADRA Gilgit
68.	Ms. Yasmeen Kareem	Project Manager AKRSP Gilgit

Annex 3

SDGs Indicators that can be monitored with denominators derived from CRVS data

Goal 1	1.1	By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than $1.25 a day	1.1.1	Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)	**Tier I**
	1.2	By 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions	1.2.1	Proportion of population living below the national poverty line, by sex and age	**Tier I**
			1.2.2	Proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions	**Tier II**
	1.3	Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable	1.3.1	Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable	**Tier II**
	1.4	By 2030, ensure that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance	1.4.1	Proportion of population living in households with access to basic services	**Tier II**
			1.4.2	Proportion of total adult population with secure tenure rights to land, (a) with legally recognized documentation, and (b) who perceive their rights to land as secure, by sex and type of tenure	**Tier II**
	1.5	By 2030, build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters	1.5.1	Number of deaths, missing persons and directly affected persons attributed to disasters per 100,000 population	**Tier II**
Goal 2	2.1	By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round	2.1.1	Prevalence of undernourishment	**Tier I**
			2.1.2	Prevalence of moderate or severe food insecurity in the population, based on the Food Insecurity Experience Scale	**Tier II**
	2.2	2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and	2.2.1	Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age	**Tier I**

		wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons	2.2.2	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)	**Tier I**
Goal 3	3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	3.3.1	Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations	**Tier I**
			3.3.2	Tuberculosis incidence per 100,000 population	**Tier I**
			3.3.3	Malaria incidence per 1,000 population	**Tier I**
			3.3.4	Hepatitis B incidence per 100,000 population	**Tier I**
			3.3.5	Number of people requiring interventions against neglected tropical diseases	**Tier I**
	3.5	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1	Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders	**Tier III**
			3.5.2	Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol	**Tier I**
	3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	3.7.1	Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods	**Tier I**
	3.8	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	3.8.1	Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)	**Tier I**
			3.8.2	Proportion of population with large household expenditures on health as a share of total household expenditure or income	**Tier I**
	3.9	By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.9.1	Mortality rate attributed to household and ambient air pollution	**Tier I**
			3.9.2	Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water,	**Tier I**

				Sanitation and Hygiene for All (WASH) services)	
			3.9.3	Mortality rate attributed to unintentional poisoning	**Tier I**
	3.a	Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	3.a.1	Age-standardized prevalence of current tobacco use among persons aged 15 years and older	**Tier I**
	3.b	Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all	3.b.1	Proportion of the target population covered by all vaccines included in their national programme	**Tier I**
	3.c	Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	3.c.1	Health worker density and distribution	**Tier I**
Goal 4	4.1	By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes	4.1.1	Proportion of children and young people (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex	**Tier II**
	4.2	By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education	4.2.1	Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex	**Tier III**
			4.2.2	Participation rate in organized learning (one year before the official primary entry age), by sex	**Tier I**

	4.3	By 2030, ensure equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university	4.3.1	Participation rate of youth and adults in formal and non-formal education and training in the previous 12 months, by sex	**Tier II**
	4.4	By 2030, substantially increase the number of youth and adults who have relevant skills, including technical and vocational skills, for employment, decent jobs and entrepreneurship	4.4.1	Proportion of youth and adults with information and communications technology (ICT) skills, by type of skill	**Tier II**
	4.6	By 2030, ensure that all youth and a substantial proportion of adults, both men and women, achieve literacy and numeracy	4.6.1	Proportion of population in a given age group achieving at least a fixed level of proficiency in functional (a) literacy and (b) numeracy skills, by sex	**Tier II**
Goal 5	5.2	Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation	5.2.1	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	**Tier II**
			5.2.2	Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence	**Tier II**
	5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation	5.3.2	Proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting, by age	**Tier II**
	5.b	Enhance the use of enabling technology, in particular information and communications technology, to promote the empowerment of women	5.b.1	Proportion of individuals who own a mobile telephone, by sex	**Tier II**
Goal 6	6.1	By 2030, achieve universal and equitable access to safe and affordable drinking water for all	6.1.1	Proportion of population using safely managed drinking water services	**Tier II**
	6.2	By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations	6.2.1	Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water	**Tier II**
Goal 7	7.1	By 2030, ensure universal access to affordable, reliable and modern energy services	7.1.1	Proportion of population with access to electricity	**Tier I**

			7.1.2	Proportion of population with primary reliance on clean fuels and technology	**Tier I**
Goal 8	8.1	Sustain per capita economic growth in accordance with national circumstances and, in particular, at least 7 per cent gross domestic product growth per annum in the least developed countries	8.1.1	Annual growth rate of real GDP per capita	**Tier I**
	8.4	Improve progressively, through 2030, global resource efficiency in consumption and production and endeavour to decouple economic growth from environmental degradation, in accordance with the 10 Year Framework of Programmes on Sustainable Consumption and Production, with developed countries taking the lead	8.4.1	Material footprint, material footprint per capita, and material footprint per GDP	**Tier III**
			8.4.2	Domestic material consumption, domestic material consumption per capita, and domestic material consumption per GDP	**Tier I**
	8.6	By 2020, substantially reduce the proportion of youth not in employment, education or training	8.6.1	Proportion of youth (aged 15–24 years) not in education, employment or training	**Tier I**
	8.7	Take immediate and effective measures to eradicate forced labour, end modern slavery and human trafficking and secure the prohibition and elimination of the worst forms of child labour, including recruitment and use of child soldiers, and by 2025 end child labour in all its forms	8.7.1	Proportion and number of children aged 5–17 years engaged in child labour, by sex and age	**Tier II**
	8.8	Protect labour rights and promote safe and secure working environments for all workers, including migrant workers, in particular women migrants, and those in precarious employment	8.8.1	Frequency rates of fatal and non-fatal occupational injuries, by sex and migrant status	**Tier II**
	8.10	Strengthen the capacity of domestic financial institutions to encourage and expand access to banking, insurance and financial services for all	8.10.1	(a) Number of commercial bank branches per 100,000 adults and (b) number of automated teller machines (ATMs) per 100,000 adults	**Tier I**
			8.10.2	Proportion of adults (15 years and older) with an account at a bank or other financial institution or with a mobile-money-service provider	**Tier I**
Goal 9	9.1	9.1 Develop quality, reliable, sustainable and resilient infrastructure, including regional and trans-border infrastructure, to support economic development	9.1.1	Proportion of the rural population who live within 2 km of an all-season road	**Tier II**

		and human well-being, with a focus on affordable and equitable access for all			
	9.2	9.2 Promote inclusive and sustainable industrialization and, by 2030, significantly raise industry's share of employment and gross domestic product, in line with national circumstances, and double its share in least developed countries	9.2.1	Manufacturing value added as a proportion of GDP and per capita	**Tier I**
			9.2.2	Manufacturing employment as a proportion of total employment	**Tier I**
	9.5	Enhance scientific research, upgrade the technological capabilities of industrial sectors in all countries, in particular developing countries, including, by 2030, encouraging innovation and substantially increasing the number of research and development workers per 1 million people and public and private research and development spending	9.5.2	Researchers (in full-time equivalent) per million inhabitants	**Tier I**
	9.c	Significantly increase access to information and communications technology and strive to provide universal and affordable access to the Internet in least developed countries by 2020	9.c.1	Proportion of population covered by a mobile network, by technology	**Tier I**
Goal 10	10.1	By 2030, progressively achieve and sustain income growth of the bottom 40 per cent of the population at a rate higher than the national average	10.1.1	Growth rates of household expenditure or income per capita among the bottom 40 per cent of the population and the total population	**Tier II**
	10.2	By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status	10.3.2	Proportion of people living below 50 per cent of median income, by sex, age and persons with disabilities	**Tier II**
	10.3	Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard	10.3.1	Proportion of population reporting having personally felt discriminated against or harassed in the previous 12 months on the basis of a ground of discrimination prohibited under international human rights law	**Tier III**
Goal 11	11.1	By 2030, ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums	11.1.1	Proportion of urban population living in slums, informal settlements or inadequate housing	**Tier I**

	11.2	By 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons	11.2.1	Proportion of population that has convenient access to public transport, by sex, age and persons with disabilities	**Tier II**
	11.3	By 2030, enhance inclusive and sustainable urbanization and capacity for participatory, integrated and sustainable human settlement planning and management in all countries	11.3.1	Ratio of land consumption rate to population growth rate	**Tier II**
	11.4	Strengthen efforts to protect and safeguard the world's cultural and natural heritage	11.4.1	Total expenditure (public and private) per capita spent on the preservation, protection and conservation of all cultural and natural heritage, by type of heritage (cultural, natural, mixed and World Heritage Centre designation), level of government (national, regional and local/municipal), type of expenditure (operating expenditure/investment) and type of private funding (donations in kind, private non-profit sector and sponsorship)	**Tier III**
	11.5	By 2030, significantly reduce the number of deaths and the number of people affected and substantially decrease the direct economic losses relative to global gross domestic product caused by disasters, including water-related disasters, with a focus on protecting the poor and people in vulnerable situations	11.5.1	Number of deaths, missing persons and directly affected persons attributed to disasters per 100,000 population	**Tier II**
	11.6	By 2030, reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality and municipal and other waste management	11.6.2	Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted)	**Tier I**
	11.7	By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, in particular for women and children, older persons and persons with disabilities	11.7.2	Proportion of persons victim of physical or sexual harassment, by sex, age, disability status and place of occurrence, in the previous 12 months	**Tier III**

	11.a	Support positive economic, social and environmental links between urban, peri-urban and rural areas by strengthening national and regional development planning	11.a.1	Proportion of population living in cities that implement urban and regional development plans integrating population projections and resource needs, by size of city	**Tier III**
Goal 12	12.2	By 2030, achieve the sustainable management and efficient use of natural resources	12.2.1	Material footprint, material footprint per capita, and material footprint per GDP	**Tier III**
			12.2.2	Domestic material consumption, domestic material consumption per capita, and domestic material consumption per GDP	**Tier I**
	12.4	By 2020, achieve the environmentally sound management of chemicals and all wastes throughout their life cycle, in accordance with agreed international frameworks, and significantly reduce their release to air, water and soil in order to minimize their adverse impacts on human health and the environment	12.4.2	Hazardous waste generated per capita and proportion of hazardous waste treated, by type of treatment	**Tier III**
Goal 16	16.1	Significantly reduce all forms of violence and related death rates everywhere	16.1.1	Number of victims of intentional homicide per 100,000 population, by sex and age	**Tier I**
			16.1.2	Conflict-related deaths per 100,000 population, by sex, age and cause	**Tier III**
			16.1.3	Proportion of population subjected to (a) physical violence, (b) psychological violence and (c) sexual violence in the previous 12 months	**Tier II**
			16.1.4	Proportion of population that feel safe walking alone around the area they live	**Tier II**
	16.2	16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children	16.2.1	Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month	**Tier II**
			16.2.2	Number of victims of human trafficking per 100,000 population, by sex, age and form of exploitation	**Tier II**
			16.2.3	Proportion of young women and men aged 18–29 years who experienced sexual violence by age 18	**Tier II**
	16.3	Promote the rule of law at the national and international levels and ensure equal access to justice for all	16.3.1	Proportion of victims of violence in the previous 12 months who reported their victimization to competent authorities or other officially recognized conflict resolution mechanisms	**Tier II**

	16.6	Develop effective, accountable and transparent institutions at all levels	16.6.2	Proportion of population satisfied with their last experience of public services	**Tier III**
	16.7	Ensure responsive, inclusive, participatory and representative decision making at all levels	16.7.2	Proportion of population who believe decision-making is inclusive and responsive, by sex, age, disability and population group	**Tier III**
Goal 17	17.6	Enhance North-South, South-South and triangular regional and international cooperation on and access to science, technology and innovation and enhance knowledge-sharing on mutually agreed terms, including through improved coordination among existing mechanisms, in particular at the United Nations level, and through a global technology facilitation mechanism	17.6.2	Fixed Internet broadband subscriptions per 100 inhabitants, by speed	**Tier I**
	17.8	Fully operationalize the technology bank and science, technology and innovation capacity-building mechanism for least developed countries by 2017 and enhance the use of enabling technology, in particular information and communications technology	17.8.1	Proportion of individuals using the Internet	**Tier I**
	17.19	By 2030, build on existing initiatives to develop measurements of progress on sustainable development that complement gross domestic product, and support statistical capacity-building in developing countries	17.19.2	Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100 per cent birth registration and 80 per cent death registration	**Tier I**

Annex 4: List of Health Facilities in ICT

S. No	Name of RHC/BHU	Union Council	Population
1	RHC, Tralai	Tarlai	195,657
2	BHU, Kirpa	Kirp	79,286
3	BHU, Jhang Syeddan	Kirpa	79,286
4	BHU, Chirrah	Chirrah	23,943
5	BHU, Tumair	Tumair	15,400
6	BHU, Jagiot	Kurri	32,914
7	BHU, Sohan	Sohan	109,286
8	RHC, Sihala	Sihala	29,743
9	GHU, Gagri		
10	BHU, Bhimber Tarar	Koral	86,857
11	BHU, Bhukkar		
12	BHU, Rawat	Rawat	72,343
13	Model Town Hummak		
14	RHC Barakau	Bara kau	113,800
15	BHU Shahdara		
16	BHU, Phulgran	Phulgran	39,629
17	BHU, Pind Begwal		
18	BhU, Shah Allah Ditta	Shah Allah Ditta	12,057
19	BHU Gokina Talhar		
20	BHU Tarnol	Tarnol	

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Federal SDG Support Unit

Assessment of Civil Registration and Vital Statistics practices, resources and functioning in ICT, GB, AJK

Federal SDGs Support Unit
Ministry of Planning Development and Reform
Islamabad Pakistan
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