Foundation for Ageing and Inclusive Development

AGEING WITH DIGNITY: A REVIEW OF SOCIAL PROTECTION PROGRAMS FROM OLDER PEOPLES PERSPECTIVES IN PAKISTAN.

This research study was conducted under the project **"Strengthening Legal Framework and Civil Society for an Inclusive Pakistan"** implemented by Foundation for Ageing and Inclusive Development (FAID). The project generously funded by the Germen Federal Ministry for Economic Cooperation and Development (BMZ), HelpAge International, and HelpAge Deutschland.

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****DISCLAIMER****
The findings, interpretations, and conclusions presented in this report are based solely on the subjective perspectives of the authors/ consultant and do not necessarily reflect the official views of the Foundation for Ageing and Inclusive Development.

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Table of Contents

List of Tables and Figures

Acronym	Description
BISP	Benazir Income Support Programme
BP	Blood Pressure
CNIC	Computerized National Identity Card
COVID-19	Corona Virus Disease-2019
C-Section	Caesarean
FGD	Focus Group Discussions
HIV	Human Immunodeficiency Virus
HR	Human Resources
INGOs	International non-governmental organization
KIIs	Key Informant Interviews
MHPSS	Mental Health and Psycho-social Support
MoHR	Ministry of Human Rights
MoNHSRC	Ministry of National Health Services Regulation and Coordination
NADRA	National Database & Registration Authority
NRSP	National Rural Support Programme
OPD	Outpatient Department
PKR	Pakistani Rupees
PSPA	Punjab Social Protection Authority
PWDs	Person With Disabilities
SOPs	Standard operating procedure (SOP)
SSP	Sehat Sahulat Program

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This research study, which assessed three government social protection programmes in Islamabad (Capital Territory) and Lahore (Punjab Province), was commissioned by the Foundation for Ageing and Inclusive Development (FAID) and executed by DevCon Development Consultants (Pvt) Ltd.

We express our sincere gratitude to the Foundation for Ageing and Inclusive Development team Mr. Syed Moeez ud Din Kakakhel (CEO), Ms. Dilshad Bano (Monitoring & Evaluation Officer), Ms. Sylvia Szabo (Global Income Security Advisor, HelpAge International) for their invaluable technical feedback, guidance, and support in achieving the study's objectives. We also appreciate the cooperation of the government social protection program officials Mr. Muhammad Arshad Kaimkhani (CEO) Sehat Sahulat Program, Mr. Muhammad Arif (Asst: Director NSER-1) Benazir Income Support Program, and Mr. Ali Shehzad (CEO) Ba Himmat Buzurg program, who provided essential support.

Our thanks extend to the Ministry of Human Rights (MoHR) for their ongoing support and coordination throughout the research process, including facilitating communications and liaising with the social protection programs. Finally, we acknowledge the entire DevCon team for their dedicated efforts in coordinating with the FAID team and ensuring the smooth execution of the research work.

EXECUTIVE SUMMARY

Pakistan is undergoing a profound demographic shift. With life expectancy rising and family structures transforming, the proportion of older people in our society is increasing at a pace that demands urgent attention. This transition presents both opportunities and challenges: older people continue to contribute to our families, communities, and nation, yet too often they remain excluded from systems designed to protect vulnerable citizens.

Social protection programs are a cornerstone of dignity and resilience. For older people, they can mean the difference between security and deprivation, inclusion and isolation. This research study provides timely evidence on how three major government initiatives—the Sehat Sahulat Program, the Ba Himmat Buzurg Program, and the Benazir Income Support Programme (BISP)—are serving older citizens.

The findings reveal both progress and gaps. The Sehat Sahulat Program has expanded healthcare access, but many older people struggle with information barriers, mobility challenges, and limited coverage for outpatient care. The Ba Himmat Buzurg Program offers crucial financial support, yet its stipend is modest and inconsistent in delivery. The BISP has improved the lives of millions, especially women, but older people—particularly older women and persons with disabilities—face hurdles in accessing its benefits due to digital and physical barriers. Together, these insights remind us that while Pakistan has made commendable strides, social protection systems must become more inclusive and responsive to the needs of an ageing population.

I wish to acknowledge with gratitude the efforts of DevCon Development Consultants (Pvt.) Ltd. for conducting this study with professionalism and dedication. I am equally appreciative of the hard work of the FAID team, especially Mr Shahzado, Ms. Dilshad, Syed Sajjad, and Ms. Tanzila, whose coordination and support were invaluable throughout the research process.
We are deeply thankful to our partners and donors—the German Federal Ministry for Economic Cooperation and Development (BMZ) and HelpAge International—for their generous support, and to HelpAge Deutschland (HAD) for their tireless coordination. Without their commitment, this research would not have been possible.

This study forms an important part of the project ***"Strengthening the Legal Framework and Civil Society for an Inclusive Pakistan."*** It provides policymakers, practitioners, and civil society with the evidence needed to strengthen social protection systems so that older people are not left behind. Our collective responsibility is to ensure that ageing in Pakistan is met with dignity, respect, and fairness.

Syed Moeez Uddin Kakakhel
Chief Executive Officer
Foundation for Ageing and Inclusive Development (FAID)

EXECUTIVE SUMMARY

Introduction and Background

This report outlines the work conducted in the research study on government social protection programs. It includes a review of existing literature and presents the key findings and recommendations identified during the research. The research study of three Government Social Protection Programs i.e. Sehat Sahulat Program, Benazir Income Support Program and Ba Himmat Buzurg Program was conducted in August 2024 - January 2025. The study was commissioned by Foundation for Ageing and Inclusive Development to DevCon Development Consultants (Pvt.) Limited. The objectives of the study were to (a) assess the effectiveness, inclusiveness and sustainability of government-implemented social security programs, identify potential access barriers that older people (above 60) or and Persons with Disabilities (PWDs) face in benefiting from these programs. (b) make recommendations for required reforms to ensure healthy and dignified lives.

A mixed method research approach was used where; quantitative data was collected from the 1052 beneficiaries and 48 non-beneficiaries of the three programs. Qualitative data was collected with by conducting 7 focused group discussions (FGDs) with older men and women and KIIs conducted with service providers, program staff and community leaders. The domain of the study was Lahore, Punjab Province and Islamabad, Capital of Pakistan. The quantitative data was gathered manually and entered into Kobo toolbox software and analysed in Excel. The quantitative data was triangulated and cross validated with the qualitative data collected from the program beneficiaries and stakeholders. Percentages, frequencies and cross-tabs were applied to narrate the data and to reach to conclusions.

Before starting the research study, Devcon, in coordination with the Social Protection Departments (Sehat Sahulat, BISP, and Bahimat Buzurg) and the FAID team, successfully obtained ethical clearance from the Health Services Academy. The clearance, granted by the Institutional Ethical Review Committee (IERC), certifies that the research protocol has been thoroughly reviewed and meets all required ethical standards for conducting the study in Islamabad and Lahore. To ensure compliance with all legal and regulatory requirements, the ethical clearance letter has been submitted to the Ministry of Health for their records and further processing.

Furthermore, No Objection Certificate (NOC) has been received from the Home Department, Government of Punjab, confirming that there are no objections to conducting the research study. This NOC further ensured that the study can proceed smoothly, adhering to all necessary approvals and protocols.

Key Findings

Sehat Sahulat Program (SSP)

Inclusiveness and Access: The SSP has been largely successful in addressing the urgent health needs of beneficiaries, with 89% of respondents reporting immediate need for support. Transparency was noted by 90% of beneficiaries, although 10% recommended further streamlining of eligibility criteria.

Health Package and Services: Most respondents found the cash limit of the health package to be adequate, though some exceeded this limit and incurred out-of-pocket expenses. Beneficiaries received multiple treatments covering conditions such as heart disease, kidney issues, and various surgical needs.

Challenges: Barriers included limited access to social media for timely information, long travel distances to facilities, extended waiting times, and cultural constraints particularly affecting female beneficiaries. Feedback mechanisms were not well known, raising concerns about future continuity if the programme were discontinued.

Impact: The programme has significantly improved the quality of life for older people by providing timely and quality healthcare, though there is a pressing need for enhanced outpatient coverage and inclusion of additional health conditions, including mental health and psychosocial support.

Benazir Income Support Program-BISP

Inclusiveness and Impact: BISP has effectively reached the poorest and most vulnerable segments of society, ensuring equitable access across rural and urban areas. The programme has notably improved beneficiaries' overall well-being by providing direct financial support that has alleviated immediate economic pressures.

Empowerment: Women have particularly benefited from BISP, which has enhanced their financial stability and empowered them to participate in household decision-making.
Communication and Information: While dissemination of information has been effective through multiple channels, some beneficiaries experienced delays due to limited access to digital platforms.

Challenges: Despite the revised cash limit from PKR 12,000 to PKR 35,000 as of January 2025 beneficiaries continue to face issues such as long queues, inadequate infrastructure at cash distribution centres, and difficulties in accessing support due to mobility constraints.

Ba Himmat Buzurg Program

Financial Support and Reach: Providing a monthly stipend of PKR 2,000, the programme has had a significant impact in reducing vulnerabilities among older people, particularly those facing income and health challenges. Nearly all beneficiaries confirmed that the programme reduced their dependency on family support, improved participation in community activities, and enhanced their emotional well-being.

Payment Patterns and Satisfaction: Although 29% of respondents received the full 12 payments in the last year, 71% received fewer than 12, with many citing early programmes closure as a major concern. Overall, 83% expressed satisfaction with the programme, and a substantial majority urged its continuation.

Barriers: Key challenges included insufficient cash limits, inaccessible mobile shops, and inadequate outreach, as well as logistical and cultural barriers that hinder consistent access to benefits.

Key Recommendations:

Based on the study's findings and an in-depth analysis of data from multiple sources, the following recommendations are proposed for the consideration of the programme's management and relevant decision-makers:

Sehat Sahulat Program (SSP)

1. Establish additional counters to reduce waiting times and ensure the timely availability of medical staff, necessary paperwork, and essential supplies, thereby minimising treatment delays.
2. Broaden the pool of qualified surgical providers and improve surgical services to meet growing demand.
3. Incorporate Mental Health and Psychosocial Support (MHPSS) into the programme, including care for conditions such as diabetes, hypertension, ophthalmology issues, and respiratory infections among older people.
4. Consider providing Outpatient Department (OPD) services for older people, addressing their urgent need for regular medical attention.
5. Continue offering transportation subsidies for the most vulnerable older populations to facilitate access to healthcare facilities.
6. Embed geriatric care into all social protection programmes to ensure ongoing, needs-based care for older people.
7. Ensure hospitals are equipped with ramps for seamless wheelchair access and, where possible, install patient-friendly lifts accessible to older people and persons with disabilities.
8. Facilitate connections for older people with other social protection programmes, such as Bait-ul-Mal, which provides cash grants to eligible individuals.
9. Implement robust monitoring mechanisms through monthly visits to health facilities and hold debriefing sessions with senior management to promptly address issues.
10. Inform beneficiaries about the dedicated Complaint Redressal and Feedback Mechanism, including a helpline, and ensure strong accountability through both online and in-person oversight.

Benazir Income Support Programme (BISP)

1. Address current delays by improving planning and expediting cash distribution, which disproportionately affects beneficiaries with health or mobility challenges.
2. Introduce secure, user-friendly digital payment platforms to ensure prompt financial assistance for older and vulnerable populations, prioritising rapid deployment for enhanced accessibility.
3. Consider reinstating the transport allowance to alleviate travel difficulties, particularly for vulnerable beneficiaries.
4. Invest in targeted awareness campaigns to ensure that current and potential beneficiaries fully understand the registration and cash withdrawal processes, thereby maximising programme benefits.
5. Introduce specialised provisions at cash distribution centres such as dedicated counters, comfortable seating, well-maintained sanitation facilities, and options for online cash transfers to reduce waiting times and create a more inclusive service environment.

Benazir Income Support Programme (BISP)

Investigate alternative, tax-exempt cash disbursement methods to facilitate easier access to funds without incurring deductions

1. Address administrative and financial delays to ensure the uninterrupted continuation of the programme, as beneficiaries have consistently called for sustained support.
2. Broaden the programme's coverage across all districts of Punjab, and introduce specific interventions to guarantee that persons with disabilities can access benefits and participate fully.
3. Establish a fully operational complaint and feedback mechanism and ensure that beneficiaries are well-informed about its use to promote transparency and accountability.

01
Introduction

In partnership with the German Federal Ministry of Economic Cooperation and Development (BMZ) and the Ministry of Human Rights, Foundation for Ageing and Inclusive Development (FAID) a network member of HelpAge International has launched a three-year project entitled Strengthening Legal Framework and Civil Society for an Inclusive Pakistan. Implementing in the Punjab Province and Islamabad Capital Territory, this initiative seeks to advance the rights and inclusion of older people and persons with disabilities.

Under this project, multiple research studies have been designed to assess the effectiveness of government-led social security programmes namely the Benazir Income Support Programme (BISP), the Sehat Sahulat Programme, and the Ba Himmat Buzurg Programme which aim to support vulnerable groups in Pakistan. Employing a mixed-methods approach that integrates both quantitative and qualitative methods, these studies evaluate each programme's inclusiveness, sustainability, and overall impact on older people (aged 60 and above) and persons with disabilities.

Findings and recommendations arising from the research have been presented in a workshop organised in Islamabad, attended by relevant government bodies and policymakers. This step underscores the project's commitment to effecting policy change and safeguarding the rights, dignity, and quality life of Pakistan's diverse older population. This consultative process is expected to inform further technical support, ensuring the sustainability of these programmes and laying groundwork for potential expansion into other provinces.

1.1 Research Approach and Process

This research involves a comprehensive literature and data review to deepen understanding of the Benazir Income Support Programme, Sehat Sahulat, and Ba Himmat Buzurg, particularly with regard to their impact on older people and persons with disabilities. Building on these insights, the study team conducts both quantitative and qualitative data collection in Punjab, utilising surveys, focus group discussions, interviews, and key informant consultations.

These studies aim to assess the effectiveness of government social security programmes designed for Pakistan's vulnerable populations. In doing so, they focus on the programmes' inclusiveness and sustainability, while identifying any barriers that may prevent older people (aged 60 and above) and persons with disabilities from fully accessing their benefits. The resulting recommendations will be presented to the Health and Social Protection Departments to inform policy enhancements and strengthen programme inclusivity.

Subsequent analysis employs statistical tools (e.g., Kobo, SPSS, STATA) to evaluate the effectiveness, inclusiveness, and sustainability of each programme. The findings inform evidence-based policy recommendations designed to address identified barriers and enhance access for vulnerable populations. These recommendations are presented in a comprehensive national status report and an accompanying policy brief, which concisely outline core challenges and propose targeted solutions.

1.2 Structure of the Report

This report is organised into seven sections to provide a clear, logical flow of information:

Section 1 introduces the core research objectives, explaining the motivation behind the study and outlining its overall scope.

Section 2 details the research methodology, including sampling strategies, the structure of the research team, data collection tools, analytical methods, and other pertinent considerations.

Section 3 offers a literature-based overview of ageing and demographic trends in Pakistan, establishing the wider context necessary for interpreting the study findings.

Section 4 describes the national ageing policies under review, setting the stage for assessing their effectiveness.

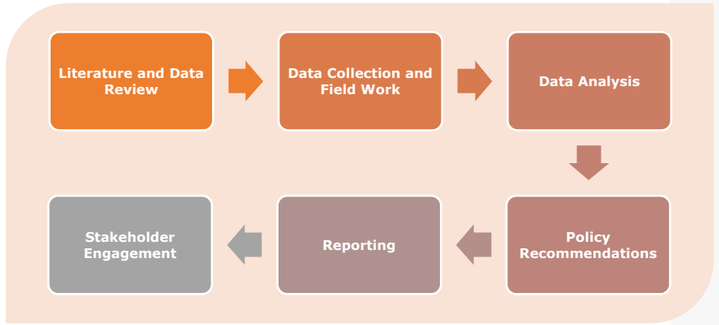
Section 5 presents the study's key findings for each programme, supported by statistical insights relevant to various factors and performance indicators.

Section 6 proposes evidence-based recommendations derived from the research, aimed at improving inclusivity and effectiveness within each programme.

Section 7 provides a concise conclusion, summarising the study's central points and suggesting potential avenues for further policy development or research.

02
Research Methodology

This research adopts a mixed-methods approach, integrating both quantitative and qualitative techniques. Data collection takes place at health facilities as well as at the household and community levels. Quantitative information is gathered through survey questionnaires, while qualitative insights are obtained via focus group discussions (FGDs) and key informant interviews (KIIs).



Literature & Data Review: Comprehensive exploration of existing studies, reports, and datasets on BISP, Sehat Sahulat, and Ba Himmat Buzurg to understand their impact on older people and persons with disabilities.

Data Collection & Fieldwork: Use quantitative (surveys) and qualitative methods (focus group discussions, interviews) to gather information from the field, particularly within Punjab.

Data Analysis: Employ statistical software (e.g., Kobo, SPSS, STATA) to interpret collected data and evaluate the effectiveness of social security programmes.

Policy Recommendations: Develop actionable strategies to address identified barriers, thereby improving accessibility and inclusiveness for older people and persons with disabilities.

Reporting: Compile findings into a comprehensive national status report, complemented by a concise policy brief that highlights core issues and suggested solutions.

Stakeholder Engagement: Present the research outcomes and recommendations in a workshop to facilitate dialogue with government officials, civil society, and other key players for policy refinement and practical implementation.

2.1 Sample Size

Name of Program	Men beneficiaries	Women beneficiaries	Non-beneficiaries	Total
Sehat Sahulat Program	317	145	38	500
Benazir Income Support Program/BISP	18	471		489
Ba Himmat Buzurg Program	0	101	10	111
			Total	**1100**

Table 1 Quantitative Sample Size

Name of Program	FGDs with men	FGDs with women	KII with Provider/ Staff	KIIs with Focal Persons	Total
Sehat Sahulat Program	02	02	01	03	08
Benazir Income Support Program/ BISP	0	02	0	02	04
Ba Himmat Buzurg Program	0	01	0	01	02
Total					**14**

Table 2 Quantitative Sample Size

2.2 Study Area

The study focused on programmes implemented in Islamabad (Federal) and Lahore (Punjab). Specifically, Sehat Sahulat Programme and Benazir Income Support Programme (BISP) were examined in both Islamabad and Lahore. In contrast, the Ba Himmat Buzurg Programme was only reviewed in Lahore, as it is not operational in Federal Areas.

2.3 Primary Data Source

Primary data were collected directly from beneficiaries at both health facilities (hospitals) and within their communities/households. Access to programme participants was facilitated through focal persons who maintained direct links with beneficiaries. For the purpose of analysis, households served as the primary unit of examination.

2.4 Secondary Source /Desk Review

To contextualise the research, a desk review of both internal and external documents was conducted. This review aimed to deepen understanding of existing social protection schemes and clarify the project's focus and scope. Key resources included:

- Government publications and official literature
- Materials available on government websites
- Programme data and information from private publications

Among the specific documents reviewed were:

1. Punjab Social Protection Authority Annual Reports (2017 and 2017-2020)
2. 7th Digital Population and Housing Census 2023 – Pakistan Bureau of Statistics
3. Evaluating Emergency Benazir Income Support Program Success, Oversights and Possibilities (Democracy Reporting International, December 2020)
4. Webinar of Pakistan Institute of Development Economics on Sehat Sahulat Program (Muhammad Khalid, Sara Rizvi Jafri, Sahabnam Sarfaraz, 2021)
5. The Notion of Access to Health Care in a Large-Scale Social Health Protection Initiative: A Case Study of 'Sehat Sahulat Programme' at Khyber Pakhtunkhwa, Pakistan (Journal of Global Health Reports, March 2023)

2.5 Recruitment and Training of Team

A team of 21 researchers, all possessing relevant expertise, was recruited to conduct the study. They received training aligned with the study's objectives, approach, and methodology. To refine the data collection tools, a pre-test was carried out at the Pakistan Institute of Medical Sciences (PIMS) in Islamabad with selected beneficiaries. Insights from this pilot led to adjustments that enhanced clarity and relevance for both researchers and respondents.

2.6 Data Collection

Data collection took place during August and September 2024. For the Sehat Sahulat Programme, information was gathered from 33 hospitals in Islamabad and 37 in Lahore. In addition, teams visited 57 localities in Islamabad and 98 in Lahore to interview beneficiaries at the community level.

- Quantitative Data: Captured using Kobo software, which facilitated subsequent tabulation and analysis.
- Qualitative Data: Gathered through FGDs, KIIs, and case studies, then organised and analysed using Excel.

2.7 Quality Assurance

Quality control was maintained through the continuous involvement of the Lead Consultant, who supervised field activities and engaged directly with focal persons. All completed questionnaires were reviewed daily to ensure accuracy and completeness. A dedicated WhatsApp group was created to share real-time updates and location information, including photographs, with the FAID and DevCon management teams. The Lead Consultant's on-site presence throughout the data collection phase further reinforced data quality and reliability.

2.8 Data Analysis

Quantitative Data: Exported from Kobo into Excel for initial checks, then imported into SPSS for more extensive statistical analysis. Key insights were derived by generating frequencies, percentages, and cross-tabulations.
Qualitative Data: Organised in Excel, where core themes and sub-themes were extracted. These themes were then analysed and synthesised to derive meaningful conclusions.

2.9 Ethical Considerations

Due to the inclusion of human participants, ethical clearance was necessary and obtained from the Health Services Academy's Ethics Review Board (ERB) for the Sehat Sahulat Programme, while No Objection Certificates (NOCs) were secured for BISP and the Ba Himmat Buzurg Programme from the Punjab Home Department. These measures ensured adherence to ethical standards and respect for participants' rights throughout the study.

03
Insights From Literature Review

Pakistan, situated in South Asia, currently ranks 164th on the United Nations Human Development Index (HDI) out of 193 countries.[1] In 2020, it was the world's fifth most populous nation, with over 241.5 million inhabitants and a population growth rate of 2.10%.[2] At present, approximately 6% of the population is aged 60 or above, and around 40% of households include at least one older person. Demographic projections indicate that by 2050, this proportion will rise to 12.4% of the total population,[3] while average life expectancy currently 67 years is expected to reach 76.[4]

Despite the sizeable demographic share of older adults, national policies in Pakistan largely concentrate on younger populations. A 2022 survey by HelpAge found that most older people struggle to afford vital necessities such as clean water, food, shelter, and healthcare.[5] Moreover, the transition from extended to nuclear family structures means many older adults no longer live with their relatives; this shift, coupled with limited resources, reduces their influence in decisions about their emotional and physical well-being.

Across Pakistan's four principal linguistic and ethnic groups, old age traditionally signifies piety, wisdom, and respect, rooted in the strong joint family system maintained by religious values. Consequently, older people have historically enjoyed a position of dignity in society, a pattern commonly observed in many Asian contexts. However, under Pakistan's patriarchal norms, older women often depend more heavily on younger male relatives. As modernisation erodes the extended family framework, older family members may be viewed less as integral contributors and more as a burden, leaving them increasingly vulnerable to neglect by their offspring. This dynamic frequently leads to social isolation, vulnerability, and a profound sense of hopelessness among older adults.[6]

3.1 Challenges of Ageing Population in Pakistan

Pakistan's predominantly agrarian economy poses particular difficulties for older people, many of whom are unable to sustain physical work in the agricultural sector or secure pensions sufficient for their later years. Consequently, they often rely on family members for both financial and emotional support. In many households, older people assume a guardian-like role for younger generations, fostering social bonds that help preserve the extended family structure. However, this arrangement has weakened over time due to factors such as international migration and rapid urbanisation, as increasing numbers of adult children relocate for education, employment, marriage, or lifestyle reasons. [7]

Older people's vulnerability can be further exacerbated by financial constraints, divorce or widowhood, and various disabilities. Currently, there are few government-led benefit or retirement programmes specific to this demographic, compelling most older citizens either to rely on pensions from earlier formal employment or to seek alternative income-generating opportunities in the informal sector. Still, some gradual improvements are emerging, such as the establishment of geriatric wards to provide age-appropriate care.

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1 United Nations Development Programme. (2024.). Country insights: Ranks. Available at: https://hdr.undp.org/data-center/country-insights#/ranks

2. Butt, N. (2024, July 19). Pakistan 5th most populous country with population of 241.49m: Report. Business Recorder. https://www.brecorder.com/news/40313328

3. Usmani, B. A., Lakhdir, M. P. A., Sameen, S., Batool, S., Odland, M. L., Goodman-Palmer, D., Agyapong-Badu, S., Hirschhorn, L. R., Greig, C., & Davies, J. (2024). Exploring the priorities of ageing populations in Pakistan, comparing views of older people in Karachi City and Thatta. PLoS ONE, 19(7), e0304474. https://doi.org/10.1371/journal.pone.0304474

4. ibid

5. Trends in Ageing and Health, Pakistan by HelpAge International.

6. Abdullah, S. (2021). Ageing in Pakistan: A curse or blessing? Pakistan Institute of Development Economics. Retrieved February 20, 2025, from https://pide.org.pk/blog/ageing-in-pakistan-a-curse-or-blessing/

7. HelpAge Asia [Internet]. [cited 2024 Mar 27]. Ageing population in Pakistan. Available from: https://ageingasia.org/ageing-population-pakistan/

Despite these positive developments, Pakistan's older population continues to face multiple challenges. A central issue is the limited availability of public transport and inconsistent private-sector solutions, which constrain mobility and lead to greater dependency, particularly for those with physical or mental health conditions. The resulting restricted access to care facilities and community services heightens social isolation and diminishes older adults' capacity to engage in economic or social activities. Furthermore, inadequate transportation infrastructure can hinder efforts to seek employment, forge social connections, and maintain a meaningful societal role. In response, many older people turn to informal or home-based self-employment to retain a degree of financial autonomy and sustain their positions within the family.[8]

3.2 Consequences of Ageing

An ageing population brings diverse healthcare, social, and economic implications. The Global Age Watch Index (GAWI) measures the socioeconomic well-being of older adults worldwide by assessing factors such as health status, financial security, education, employment, and enabling environments. In 2015, Pakistan ranked 92nd out of 96 countries, reflecting the precarious situation of its older population and underscoring a pressing need for government action.[10]

Globally, older people often face the need for care, health insecurity, and financial dependence. Pensions play a pivotal role in safeguarding their dignity, rights, and stable incomes. In Pakistan, however, nearly half of the population does not receive any form of pension, placing the country 95th out of 96 for income security. As a result, many older people rely on their children or peers for financial support, particularly when health concerns or scarce employment opportunities limit their capacity to earn. Between 2020 and 2021, the labour force participation rate among older adults dropped from 36.98% to 20.72%, likely increasing this dependency and highlighting the urgent need for targeted policy interventions.[11]

[8] Rizvi Jafree S, Mahmood QK, Burhan SK, Khawar A. Protective Factors for Life Satisfaction in Ageing Populations Residing in Public Sector Old Age Homes of Pakistan: Implications for Social Policy. J Aging Environ. 2022. Apr 3;36(2):136–55

[9] World Health Organization (2016). The Global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life.

[10] Global Age Watch Index. (2024). Available at: ttps://www.helpage.org/global-agewatch/population-ageing-data/country-ageing-data/?country=Pakistan#collapseFour

04

Review Of Social Protection Programs In Pakistan

4.1 Sehat Sahulat Program

The Ministry of National Health Services, Regulations and Coordination (NHSRC), in collaboration with provincial governments, introduced the Sehat Sahulat Programme as a significant step towards achieving Universal Health Coverage (UHC) in Pakistan. A key objective is to offer free, easily accessible healthcare services to the country's most vulnerable populations. To date, the programme has enrolled nine million families, extending eligibility to persons with disabilities and transgender individuals holding special Computerised National Identity Cards (CNICs) issued by NADRA.[11]

Originally, Sehat Sahulat provided cashless health services exclusively for underprivileged beneficiaries particularly those registered under the Benazir Income Support Programme (BISP) with a Poverty Means Test (PMT) score below 32.5through a phased rollout. Eligibility is determined via the NADRA CNIC database, and beneficiaries can avail in-patient services without incurring any financial obligations by presenting only their CNIC.[12]

Initially, the scheme covered up to PKR 60,000 per year for primary-level diseases and PKR 400,000 for priority-level conditions. More recently, it has been expanded to include all citizens,irrespective of their socio-economic status.

Challenges and Solutions

Access and Acceptability: Geographical barriers and service acceptability remain significant hurdles, particularly in remote regions.

Demand vs. Supply: While the programme addresses the demand side of healthcare (insurance coverage), it has highlighted the need to strengthen healthcare infrastructure on the supply side to achieve genuine universal coverage. Ensuring an adequate network of health facilities is essential for comprehensive, equitable access.

These experiences underscore the importance of robust coordination between insurance mechanisms and healthcare service delivery, ensuring that improvements are made both in financing and the physical availability of quality healthcare services.[13]

4.2 Benazir Income Support Program/BISP

The COVID-19 pandemic, one of the most challenging crises in modern history, disrupted lives, overwhelmed health systems, and severely impacted economies worldwide. It impacted millions of individuals and disproportionately affected the poor (IMF 2020). The lockdown impacted the livelihoods of nearly 25 million workers (11.37 million daily/piece rate workers in the formal and informal sectors and 13.52 million self-employed workers in the informal economy),[14] affecting approximately 160 million people, or roughly two-thirds of the population, given the average family size of 6.45.[15]

[11] PIDE, available at https://pide.org.pk/webinar/sehat-sahulat-program/
[12] Nadra Pakistan, avaialbel at https://www.nadra.gov.pk/sehat-sahulat-program/
[13] Sheraz A Khan et all, Journal of Global Health Reports, title of publication the notion of access to health care in a large-scale social health protection initiative: a case study of 'Sehat Sahulat Programme' at Khyber Pakhtunkhwa, Pakistan, available at https://www.joghr.org/article/75411-the-notion-of-acess-to-health-care-in-a-large-scale-social-health-protection-initiative-a-case-study-of-sehat-sahulat-programme-at-khyber-pakhtunk
[14] Pakistan Bureau of Statistics. (2018). Pakistan Social and Living Standards Measurement Survey 2018. Islamabad, Pakistan: Pakistan Bureau of Statistics.
[14] Ibid

In response, the Pakistani government implemented the Benazir Income Support Programme (BISP) under the Poverty Alleviation and Social Safety Division. Leveraging the existing digital payment system of the original BISP cash transfer programme, this initiative was rapidly deployed to meet urgent needs. Just prior to the pandemic in 2020, Pakistan had been updating its cash transfer approach for women; the Kafaalat programme had replaced BISP and utilised in-person surveys to identify recipients. However, with the onset of COVID-19, further enrolments were halted, allowing the government to rely on pre-existing mechanisms when launching the enhanced BISP initiative. Beneficiaries already registered under BISP were automatically notified, facilitating a seamless transition and ensuring continuous support for women.[16]

Under the revised scheme, beneficiaries in the first category received a top-up of US $6 per month in addition to the regular US $12 monthly transfer for the existing 4.5 million BISP beneficiary families.[17] Additionally, a further 7 million non-BISP beneficiary families in Categories 2 and 3 received a one-time transfer of US $71, while an extra 1.2 million beneficiaries were enrolled under Category 4 designed specifically for those who self-reported job losses via the federal government's central assistance web portal.[18]

Challenges and Solutions

A notable gap in the programme is the inclusion of older people. Research conducted by FAID on the impact of COVID-19 revealed that many older people were inadvertently excluded from receiving benefits. Technological barriers hindered access for many in this demographic, particularly older women who often lack independent mobile phone ownership. Additionally, difficulties in accessing cash disbursement centres—stemming from disabilities or reduced mobility were not adequately considered during the programme's design. Some of these issues were addressed for beneficiaries in Categories 3 and 4, but further efforts, including initiatives to improve digital literacy, remain essential to ensure that older citizens can fully benefit from the programme.

4.3 Ba Himmat Buzurg Program

The Punjab Social Protection Authority, functioning as an autonomous body, has introduced the Ba Himmat Buzurg Programme to support citizens aged 65 and above who are in immediate need of financial assistance.[18] This social reform initiative seeks to reduce poverty and safeguard the most vulnerable segments of society by providing a monthly stipend of PKR 2,000 to eligible individuals, thereby helping them meet their basic needs.[19]

Targeted primarily women (in their absence older men) living in poverty who often lack access to quality healthcare and experience social isolation the programme responds to demographic trends highlighted by Census 2023, which indicate that the proportion of older citizens is rising. As many older people are unable to earn a living and are dependent on their children, they constitute one of the most disadvantaged groups in society, especially in the absence of specialised skills that could facilitate employment.[20]

[16] PIDEAND POSSIBILITIES) retrieved on 19-11-2024.
[17] World Bank. (2020). World Bank G2P x COVID-19 Pakistan Brief [PDF]. Retrieved February 20, 2025, from https://thedocs.worldbank.org/en/doc/760541593464535534-0090022020/original/WorldBankG2PxCOVID19PakistanBrief.pdf
[18] Ibid
[19] Ehsaas Web Portal. (n.d.). Ba-Himmat Bazurg Program. Retrieved February 20, 2025, from https://ehsaaswebportal.pk/ba-himmat-bazurg-program/
[20] Ibid
[21] Ibid

The social pension aims to empower this demographic, ensuring access to essential resources such as food and healthcare while promoting their social inclusion and dignity. This initiative reflects a growing global recognition of the importance of comprehensive social protection policies that address the unique challenges faced by older populations. It represents a vision for a society where the ageing process is met with respect and adequate support, ensuring that older citizens do not fall behind in the national development agenda.[21]

Challenges and Solutions

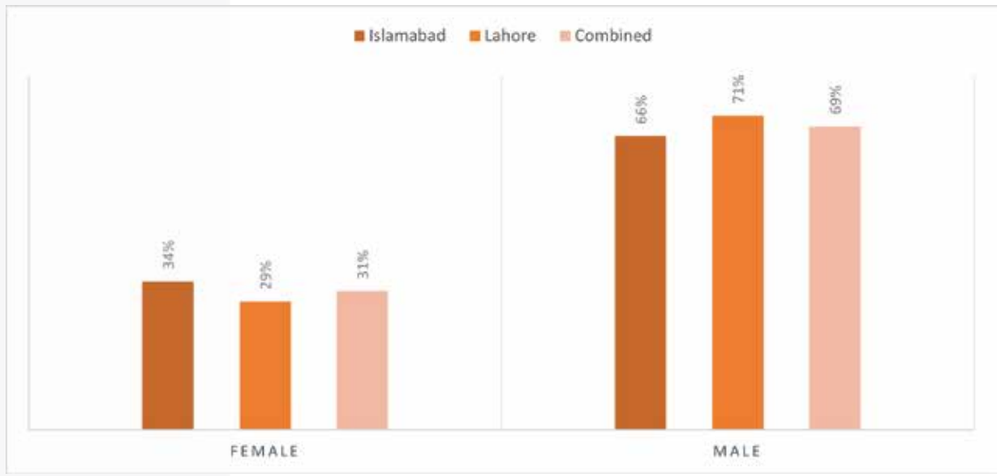
Despite its notable successes, the programme faces challenges in reaching remote areas and ensuring broad inclusivity. However, through innovative strategies and enhanced collaboration among stakeholders, these challenges can be overcome, thereby further strengthening the programme's overall effectiveness.

05
Findings From Quantitative And Qualitative Research

4.1 Sehat Sahulat Program

4.4.1 Demographic Characteristics of Respondents

The analysis reveals that the respondents of Sehat Sahulat Program had diversified socio-economic backgrounds. Majority of the respondents (63%) were interviewed from rural areas as compared to 37% respondents who were interviewed from urban areas. With regards to gender, 69% respondents were men, whereas 31% respondents were women.



Graph 1 Findings from quantitive and qualitative research - Sehat Sahulat Program

Marital status data reveal that 81% of respondents were married, 17.7% were widowed, 1% were divorced, and 0.2% were unmarried. Age distribution shows that the majority (63%) were between 60 and 65 years old, followed by 24% aged 66–70, 10% aged 71–75, and a small fraction (0.3%) aged 76 or above.

Regarding residential status, 82% of respondents were permanent residents of their areas, while 8% were internally displaced persons (IDPs) and another 8% were seasonal migrants. An additional 2% were returnees. In terms of household dynamics, 97% of the visited households were male-headed, with the remainder being female-headed. Nuclear families accounted for 71% of respondents, while 29% belonged to joint family systems. The average family size was most commonly between 6 and 10 members (52%), followed by 38% with 1–5 members, 8% with 11–15 members, and 2% with 16–20 members. Additionally, school enrolment patterns indicated that 52% of female children were attending school compared to 48% of male children.

Educationally, a significant majority (67%) of respondents were either illiterate or had education below the primary level. Occupationally, 29% of respondents engaged in unskilled labour, 19% in skilled labour, 6% held private jobs, and 2% were employed in government positions. Furthermore, 12% were unemployed and 2% operated small-scale businesses. Among the female respondents, 95% identified as housewives. Finally, 56.9% of respondents contributed to their household income.

In response, the Pakistani government implemented the Benazir Income Support Programme (BISP) under the Poverty Alleviation and Social Safety Division. Leveraging the existing digital payment system of the original BISP cash transfer programme, this initiative was rapidly deployed to meet urgent needs. Just prior to the pandemic in 2020, Pakistan had been updating its cash transfer approach for women; the Kafaalat programme had replaced BISP and utilised in-person surveys to identify recipients. However, with the onset of COVID-19, further enrolments were halted, allowing the government to rely on pre-existing mechanisms when launching the enhanced BISP initiative. Beneficiaries already registered under BISP were automatically notified, facilitating a seamless transition and ensuring continuous support for women.

Under the revised scheme, beneficiaries in the first category received a top-up of US $6 per month in addition to the regular US $12 monthly transfer for the existing 4.5 million BISP beneficiary families.[16] Additionally, a further 7 million non-BISP beneficiary families in Categories 2 and 3 received a one-time transfer of US $71, while an extra 1.2 million beneficiaries were enrolled under Category 4 designed specifically for those who self-reported job losses via the federal government's central assistance web portal.[17]

Average Monthly Income	#	%	#	%	#	%
	Islamabad		Lahore		Combined	
0 to 5000	14	5.9%	49	21.9%	63	13.6%
5001 to 10000	17	7.1%	1	0.4%	18	3.9%
10001 to 20000	36	15.1%	20	8.9%	56	12.1%
20001 to 30000	35	14.7%	49	21.9%	84	18.2%
30001 to 40000	52	21.8%	49	21.9%	101	21.9%
40001 to 50000	46	19.3%	32	14.3%	78	16.9%
50001 to above	38	16.0%	24	10.7%	62	13.4%
Total	**238**	**100.0%**	**224**	**100.0%**	**462.0**	**100.0%**

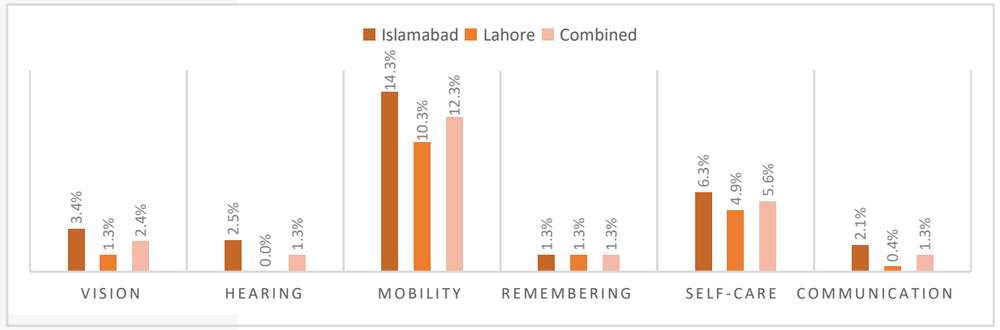
Table 3 Monthly Household Income of the respondents

The analysis of respondents' average monthly income shows that the majority of individuals fall within the income brackets of PKR 30,000 to 40,000 and PKR 20,000 to 30,000. Specifically, 21.9% of respondents earn between PKR 30,000 and 40,000, which represents the highest proportion, while 18.2% earn between PKR 20,001 and 30,000, making it the second most common income range. These two categories collectively account for a significant portion of the respondents' earnings, highlighting that a large number of individuals in the sample have relatively moderate monthly incomes, which likely reflect the economic conditions.

4.4.2 Status of Impairment

The analysis indicates varying levels of impairment among respondents. In terms of vision, 6% reported some difficulty seeing even with glasses, while 2% experienced significant difficulty. Regarding hearing, 10% encountered some difficulty even when using a hearing aid, with 1% facing considerable challenges. Mobility issues were reported by 9% of respondents as some difficulty and by 12% as a great difficulty.

For cognitive functions, 5% of respondents experienced some difficulty in remembering, with 1% facing significant challenges. In terms of self-care, 7% reported some difficulty, while 6% had considerable difficulty. Communication difficulties were reported by 7% to some extent, with 1% facing substantial challenges.



Graph 2: Status of impairment among respondents of the research.

4.4.3 Access to information

Family and friends emerged as the primary source of information for older respondents regarding the Sehat Sahulat Program (SSP) and its registration process. Overall, 61% of respondents relied on these personal networks, with 65% of women and 59% of men reporting family and friends as their main source of information. This trend was consistent across regions: in Islamabad, 63% of women and 58% of men obtained Program details from family and friends, while in Lahore, the figures were 68% for women and 59% for men. Additionally, all 24 respondents in the focus group discussions confirmed that they had received information about the SSP through these channels. In contrast, the use of social media platforms, such as cell phones and WhatsApp, was notably low for obtaining Program-related information.

4.4.4 Relevance and Inclusivity

The Sehat Sahulat Program has made significant strides in improving the health outcomes of vulnerable communities by providing essential inpatient healthcare services. A substantial 89% of respondents indicated that they were in dire need of the Program, while 82% affirmed that it reached all socio-economic groups equitably. 78% of respondents in Islamabad and 85% in Lahore shared this view. However, 18.4% of respondents suggested that the eligibility criteria could benefit from further streamlining.

Qualitative insights corroborated these findings. In focus group discussions, all 24 participants confirmed that the Program successfully ensures inclusiveness by reaching older people, persons with disabilities, and those in remote or marginalised areas. Furthermore, 90% of survey respondents noted that healthcare under the Sehat Sahulat Program is provided without discrimination, a sentiment unanimously echoed by focus group participants. Specifically, 67% of respondents stated that older men, women, and persons with disabilities receive healthcare services on an equitable basis, with 59% observing targeted inclusion efforts and 12% noting the establishment of fixed quotas for these groups.

Approximately 67% of respondents reported that the Program was launched in both rural and urban areas without any observed discrimination. Yet, 51% observed that at least one eligible individual did not benefit from the Program due to a lack of awareness, a concern also raised by all 38 non-beneficiaries who participated in the study. This highlights a pressing need for enhanced awareness campaigns regarding Program facilities.

In terms of engaging the poorest of the poor, 37% of respondents rated engagement as reasonable and 55% as good, though 8% felt that engagement was low. Overall, both quantitative and qualitative data indicate that the Sehat Sahulat Program is highly inclusive, ensuring that all eligible individuals—regardless of age, gender, or socio-economic status are given access to critical healthcare services.

4.4.5 Enrollment Status

Approximately one-third of respondents don't have knowledge about their enrolment status in the program. The predominant challenge was a lack of access to information, reported by 47% of respondents, while 10% cited no access to social media platforms (e.g., smartphones, WhatsApp). Additionally, 15% of respondents indicated that they lacked the skills necessary to operate smartphones effectively. Conversely, 28% of respondents reported no registration issues.

A geographical analysis revealed that the lack of access to information was more pronounced in Lahore (58%), whereas in Islamabad, challenges related to smartphone access (13%) and inadequate digital skills (20%) were more prevalent. Furthermore, 56% of respondents overall lacked sufficient knowledge about their enrolment status, highlighting an urgent need for improved awareness campaigns. This gap in understanding was especially significant in Islamabad, where 79% of respondents were uninformed compared to 30% in Lahore. Knowledge of recent developments specifically, that the Sehat Sahulat Program is now open to all segments of society regardless of income was limited to only 14% of respondents.

All 19 beneficiaries in the control group confirmed that they were unable to get more details due to a lack of awareness regarding their enrolled status. For persons with disabilities, mobility constraints emerged as the most common obstacle, reported by 12% overall (with 14% in Islamabad and 10% in Lahore).

What problems did you face while checking for enrolled status?	Islamabad		Lahore		Combined	
	Male	Female	Male	Female	Male	Female
Had no access to information	40.5%	21.3%	58.5%	56.9%	49.5%	42.8%
Had no access to digital media/cell phone	13.9%	11.3%	6.9%	9.2%	10.4%	10.3%
Was not skilled enough to use digital media/cell phone	20.9%	17.5%	7.5%	13.8%	14.2%	15.9%
Did not face any problem	24.1%	37.5%	26.4%	20.0%	25.2%	29.7%
Don't Know	0.6%	2.5%	0.6%	0.0%	0.6%	1.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table 4 Gender-wise analysis of problems faced in registration

Gender analysis indicated that 41% of men in Islamabad, compared to 31% of women, and 58.5% of men in Lahore, compared to 57% of women, lacked access to information. Although similar proportions of men (10%) and women (10%) reported no access to smartphones, a digital literacy gap was evident: 16% of women who had access were not sufficiently skilled to use smartphones, compared to 14% of men. These findings underscore that while access remains a challenge for both genders, addressing the digital literacy gap is crucial for improving registration outcomes.

4.4.6 Coherence

A substantial 81% of respondents indicated that the Sehat Sahulat Program is comparable to other social protection initiatives such as the AAGHOSH and Hamqadam Programs operating in their areas. Conversely, 19% felt that other Programs differ from Sehat Sahulat, noting that alternatives often focus on specific forms of support: 28% mentioned hospital-based services, 50% highlighted livelihood assistance, and 5.2% referenced old home assistance.

When asked about their preferences for future initiatives, 64% of respondents expressed a desire for enhanced healthcare assistance. Additionally, 21% advocated for the inclusion of mental health and psychosocial support, while 15% emphasized the need for Programs that foster self-reliance and independence.

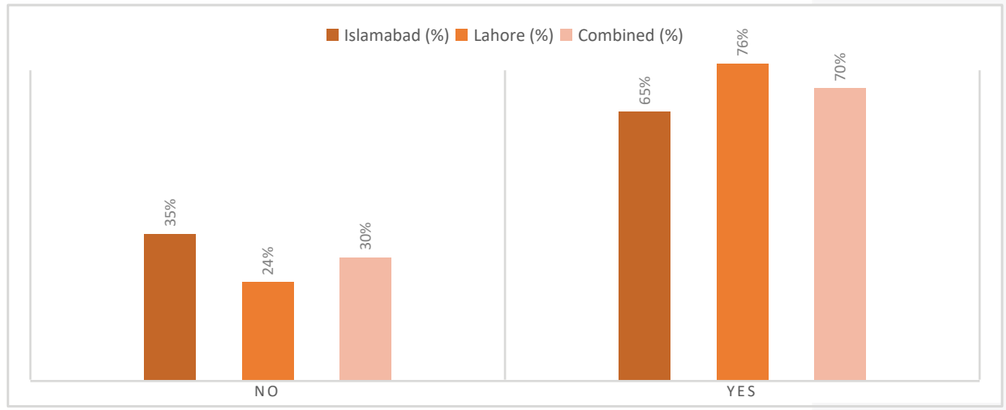
4.4.7 Knowledge about Benefit Package/ Limit of Benefit Package

The findings reveal that a significant majority of respondents (82%) had limited knowledge regarding the annual limit of the Sehat Sahulat Program. In particular, 71% of respondents in Islamabad and a striking 94% in Lahore were unaware of this limit, underscoring the need for enhanced awareness and advocacy to support informed decision-making and increase satisfaction with the Program.

When examining gender differences, 83% of women and 81% of men were not aware of the annual limit. In Islamabad, 73% of women and 70% of men lacked this knowledge, while in Lahore, the figures were even higher with 95% of women and 93% of men unaware indicating that although the gap is slight, women generally had marginally lower levels of awareness.

Moreover, only 21% of respondents knew that additional financial limits could be allocated in life-threatening conditions or during maternity. Awareness of this provision was higher in Islamabad (28%) compared to Lahore (14%), with 25% of women and 30% of men in Islamabad, and 15% of women and 13% of men in Lahore, being informed of this benefit.

Regarding the impact of exceeding the limit, 40% of respondents reported that they would discontinue treatment if the limit was reached, while 38% indicated they would incur out-of-pocket expenses. Only 9% believed that the limit might be extended, highlighting a critical need for sensitisation on this issue.



Graph 3: Knowledge of the respondents regarding benefits and limit of the packages

In terms of the adequacy of the limit provided by the Program, 70% of respondents felt that it was sufficient to cover healthcare expenditures. However, this perception varied by location: 35% of respondents in Islamabad found the limit inadequate, whereas 76% of respondents in Lahore considered it sufficient.

Furthermore, findings indicate that 15% of respondents had incurred out-of-pocket expenses, primarily for tests and medications. Moreover, 28% of respondents noted that while the Program covers in-patient costs, there is a significant need for out-patient care particularly among older people.12% reported that routine medical tests were not covered, another 12% mentioned that medications for dental and eye care were excluded, and 2% observed that certain diseases and corresponding treatments were not covered. Focus group discussions reinforced these findings, with participants advocating for an extension of coverage to include more common age-related conditions such as diabetes, hypertension, ophthalmological issues, and routine nephrology treatments and related diagnostic tests.

The SSP focal persons reported that special cases submitted for approval under the Sehat Sahulat Program (SSP) seldom experience procedural delays, which adversely affect patient health outcomes. During focus group discussions (FGDs), several respondents noted that the benefit package limit was insufficient to meet their healthcare needs. Notably, all 38 non-beneficiaries indicated that they had no information regarding this issue.

Knowledge about Diseases Covered

A majority of respondents (69%) were unaware of the specific diseases covered under the Program, with 54% of respondents in Islamabad and 85% in Lahore lacking such knowledge. Conversely, only 31% of respondents demonstrated any awareness of the conditions included. Among those with some knowledge, 16% were aware of coverage for heart diseases, 14% for kidney diseases and dialysis, and 11% for conditions such as hernia, appendix issues, fractures, gall bladder stones, kidney stones, typhoid, and pneumonia. Awareness regarding diabetes mellitus, burns and accidents, hepatitis/HIV, and organ failure (liver, kidney, heart) was reported at around 10% or slightly higher for each category. Awareness of maternity care (delivery/C-section) and cancer care was notably low, at 9% and 8% respectively. Overall, there was no indication of adequate awareness concerning any single disease.

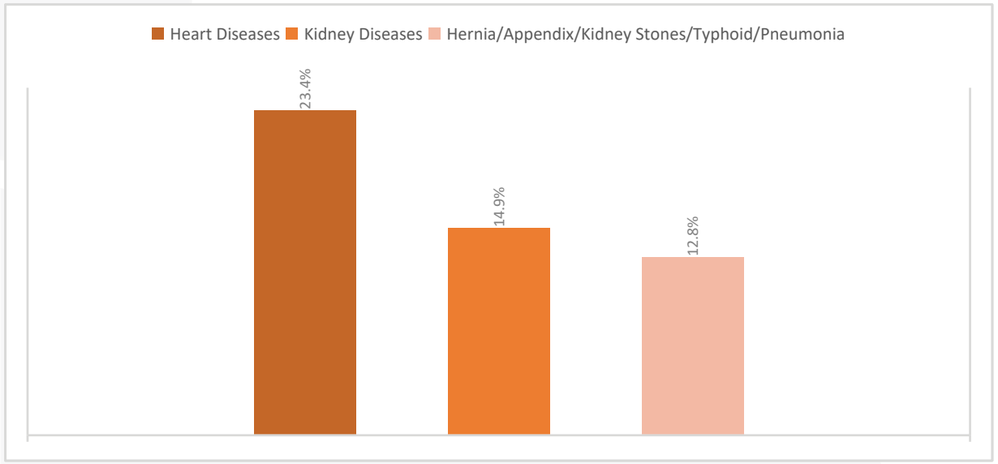
A comparative analysis by gender reveals that 29% of men and 37% of women were aware of the diseases covered under the SSP. In Islamabad, 44% of men compared to 51% of women demonstrated awareness, whereas in Lahore, these figures were 14% for men and 19% for women. Although awareness was slightly higher among women, the overall levels remained low across both genders.

During FGDs, when respondents were queried about the selection criteria and their overall understanding of the Program, all 24 participants admitted to having no awareness of the benefit package and its limits. Furthermore, eight of these respondents reported that they discovered, upon arrival, that the hospital or health facility was no longer empanel under the Program.

Similarly, nearly all of the 38 non-beneficiaries were unaware that the SSP had recently expanded eligibility to include all citizens, nor did they know how to register. Despite being deserving of support, these individuals remained deprived of services due to inadequate access to information, underscoring the critical need for comprehensive community awareness initiatives.

4.4.8 Effectiveness

All respondents reported having received treatment under the Sehat Sahulat Program. Of these, 50% had availed in-patient care on one occasion, 17% on two occasions, 7% on three occasions, and 19% received in-patient care until the allocated limit was fully utilised, while 7% could not recall the exact number of times they were treated. Regarding disease profiles, the majority received care for heart-related conditions (23%), followed by kidney diseases and dialysis (15%), and a range of other conditions including hernia, appendix issues, fractures, gall bladder stones, kidney stones, typhoid, and pneumonia accounting for 13%. Notably, treatment for heart diseases was sought equally by both men and women (23% each).



Graph 4: Disease profiles receiving treatment

Additionally, 33% of respondents were reimbursed for transportation expenses, which ranged from PKR 300 to over PKR 1,000, incurred when visiting health facilities. While 78% of respondents received treatment within the benefit package's limit, 22.5% exceeded this limit and had to make out-of-pocket payments, indicating a need to review and potentially enhance the package limits for older beneficiaries.

Furthermore, 55% of respondents benefited from free consultations and follow-up medications after discharge. However, 9% were refused treatment due to inadequacies in staffing, medications, or equipment. A further 32% experienced delays or did not receive treatment at all, prompting 24% to seek services at other public facilities and 27% to turn to private hospitals, while 17% took no alternative action. These findings highlight the necessity for improved human resources and consistent supply chains in hospitals and health facilities.

Among non-beneficiaries, 45% reported suffering from heart-related conditions yet did not seek treatment from empanel hospitals due to a lack of awareness; 10% resorted to private, non-empanel facilities, while the remainder remained undecided. The research team subsequently provided guidance regarding the registration process and the locations of empanel hospitals.

Equity and Inclusion in Treatment

Equitable service delivery remains a core objective. 73% percent of respondents observed that treatment and services were provided equally to both beneficiaries and non-beneficiaries (those paying out-of-pocket). In contrast, 16% noted instances of discrimination, and 10% were unsure. This suggests room for improvement in ensuring universal equity and inclusion.

Safeguarding

Safeguarding protocols appear largely effective, with 95% of respondents affirming that hospital staff and providers ensured protection from harmful practices during treatment. Specifically, 26% noted that special safeguarding measures were in place for older people, while 25% reported that safeguarding and no-harm policies were uniformly applied. Additionally, 17% indicated that both adults and youth were protected, 14% observed protection for children, and 5.7% acknowledged adherence to COVID-19 standard operating procedures. Persons with disabilities (5%) and transgender individuals (3%) were also reportedly safeguarded. Nonetheless, there remains a need for enhanced safeguarding measures specifically tailored for older people.

Right to Respect and Dignity

Respect and dignity in service provision were widely reported. A total of 87% of respondents stated that they were treated with dignity and respect by healthcare teams when they declared their intention to receive services under the Program, ensuring non-discriminatory and equal care. Conversely, 13% expressed dissatisfaction with the manner in which they were treated. Among those admitted for in-patient care, 84.4% felt they were treated respectfully, and 87% reported that their independence and self-esteem were upheld. While all 24-focus group discussion (FGD) participants confirmed respectful treatment, striving for 100% compliance in dignified care remains essential.

Overall Impact

The intervention had no adverse effects for 94% of respondents. However, 6% reported negative impacts, citing out-of-pocket expenditures, inadequate communication by staff, lack of travel cost compensation, extended waiting times, and embarrassment due to delays. During FGDs, 19 out of 24 participants reported no adverse impacts, while the remainder highlighted issues similar to those mentioned above. These findings underscore the importance of refining communication strategies, reducing waiting times, and ensuring that cost barriers do not hinder access to timely care.

4.4.9 Special Care

Approximately one-quarter of respondents reported that they received special care tailored to their individual needs. In contrast, while 76% of respondents noted that Program staff and providers effectively addressed their concerns throughout travel, admission, discharge, and follow-up, 25% indicated that their specific needs were not met. This gap underscores the urgent need for enhanced, specialised geriatric care.

4.4.8 Gaps and Challenges of Respondents above 60 Years of Age

Majority of the respondents (63%) had faced difficulties in accessing health care i.e. hospital/health facility being far away (22%), long queues (20%), delays in receiving treatment (16%) and security issues (5%). Further analysis shows that 57% respondents had faced issues due to lack of knowledge about empanel hospitals, benefit package and how to avail services. Similarly, 52% respondents had faced issues regarding lack of proper sitting arrangements and prolonged standing. 9% respondents had faced problems due to lack of WASH facilities whereas 2% respondents had experienced shortage of medicine.

At household level, 404 respondents had faced cultural constraints/low mobility due to non-accompaniment of household members. A number of 14% respondents had no money for travel, 10% respondents had low decision-making power to seek health care whereas 5% respondents had not heard and walking aids available.

With regards to gaps and challenges being faced by women respondents above 60 years of age, the analysis shows that majority of the older women (49%) respondents lacked knowledge about empanel hospitals, benefit package and how to avail services. 17% women respondents had experienced non-availability of medicines, equipment, surgical services and/or providers. Similarly, 15% respondents had also faced lack of proper sitting arrangements and prolonged standing.
The other barriers faced by the older women respondents were inadequate package limit (11%), non-availability of women-specific health care or non-existent privacy (11%), less adaptive behaviour of hospital/ health facility management (10%), less adaptive communication method of providers (10%) and delay in treatment (3%).

At household level, women respondents had faced cultural constraints/low mobility due to non-accompaniment of family members (59%), low decision-making power to seek health care (17%) and sexual harassment during travel (4%).

This shows that majority of the women had faced problems related to mobility, low decision-making power and lack of knowledge. When asked about gaps and challenges being faced by PWDs, the findings show that all PWD respondents had lack of knowledge about empanel hospitals, benefit package and how to avail services. 30% PWD respondents had experienced inadequate package limits whereas 15% of these respondents had faced issues due to shortage of medicine.

At household level, 20% PWD respondents had faced issues due to low decision-making power to seek treatment. Similarly, 14% respondents had no money for travel whereas 5% PWD respondents had no hearing and walking aids available.

The analysis of different geographical location shows that main barriers reported in Islamabad were low mobility (14%), long queues (17%) and lack of knowledge on diseases covered under Sehat Sahulat Program (9%. On the other hand, barriers reported in Lahore emerge as lack of knowledge on how to avail health care under the program (15%), long queues (15%) and lack of knowledge on diseases covered under Sehat Sahulat Program (14%). This shows that the respondents of both locations had experienced almost similar barriers. All these results have been obtained through a multiple response analysis.

The respondents had overcome the identified difficulties mainly by waiting patiently in long queues (23%), arranging money to pay out-of-pocket cost for tests and medicines (10%), undergoing difficulties in transportation (9%) and receiving treatment by using personal references (6%).

4.4.11 Feedback Mechanism

A promising 17% of respondents were already aware of a Feedback or Complaint Redressal Mechanism in their areas, indicating a strong foundation to build upon. Among this informed group, 2% had taken proactive steps to lodge complaints primarily concerning treatment rejections (86%) and delays in follow-up (14%). Of the complaints submitted, only 14% were resolved satisfactorily, while the majority (86%) remained inadequately addressed. These findings clearly indicate the need to improve the operationalisation of the feedback mechanism through enhanced awareness initiatives and stronger accountability measures.

4.4.12 Respondents' Satisfactiont

Overall, 62% of respondents expressed satisfaction with the Sehat Sahulat Program,4% reporting high satisfaction. In contrast, 35% of respondents were not fully satisfied, and 2% were not satisfied at all. A geographical comparison revealed that 67% of respondents in Lahore were more satisfied with the Program compared to 51% in Islamabad. Among those who were less or not satisfied, 31% cited the unavailability of providers during treatment, 38% noted insufficient time and attention from providers, another 31% felt they were not treated well, and 31% experienced delays in medicine availability. Additionally, 19% mentioned that limited space for admission and prolonged waiting times adversely affected their experience. These challenges underscore the need for improvements in hospital management and the monitoring of both public and private healthcare facilities to optimise service delivery. Notably, all 24 focus group discussion participants reported satisfaction with the Program.

When asked what aspects of the Program worked best for older people, 38% highlighted the benefits of regular check-ups, timely treatment, quality surgical care, and consistent follow-ups. Moreover, 16% appreciated the counselling services provided, and 14% valued the provision of free medicines and tests as well as the financial independence it afforded older people. Other successes noted included the provision of equal treatment and dedicated counters for beneficiaries (9%), the respectful and cooperative nature of the providers and staff (8%), and the ease of access and registration processes (5%).

4.4.13 Efficiency

A majority of respondents (61%) felt that the benefits of the Sehat Sahulat Program exceeded their expectations, while 29% believed the Program did not fully meet their expectations and 10% remained neutral. Notably, 75% of respondents indicated that the support provided by the Program was delivered in a timely manner. Both survey respondents and focus group participants expressed high levels of satisfaction with the Program's efficiency, with many appreciating the effective delivery mechanisms that ensured prompt support when needed.

4.4.14 Impact

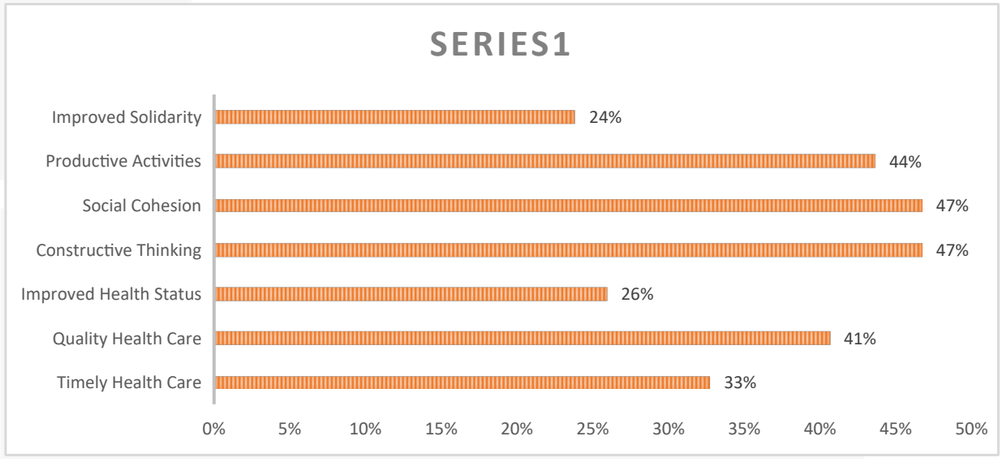
The Sehat Sahulat Program has had a profoundly positive impact on nearly all respondents (99%). Specifically, 33% reported that they now seek healthcare more promptly, 41% have access to higher quality care, and 26% experienced improvements in their overall health status. Prior to the Program, many respondents were unable to access timely healthcare due to financial constraints and often resorted to low-quality treatment options.

The Program has also enhanced healthcare accessibility through various means: for 9% of respondents, healthcare became more easily accessible; 6% benefited from the provision of two-sided travel cost support, which improved their access to hospitals and health facilities; and 7% experienced increased access to health information, resulting in greater awareness of diseases and the locations of empanel hospitals. Additionally, 6% of respondents noted a reduction in healthcare expenditure, 5% received effective follow-up care, and 4% felt empowered to make their own health-related decisions. Furthermore, 4% reported an increase in confidence, which enabled them to choose their preferred empanel hospital.

The Program's benefits extended beyond direct healthcare outcomes. For 3% of respondents, decreased healthcare expenses allowed for reallocation of funds toward their children's education, while 3% experienced enhanced well-being and happiness due to improved health. Social protection, peace, and harmony improved for 5% of respondents, who now felt more secure and less discriminated against in healthcare settings. Enhanced relationships with healthcare providers and improved rapport among community members further contributed to these positive outcomes.

Moreover, the Program has addressed social isolation and fostered constructive engagement: 47% of respondents reported that they now spend their time in productive activities and social gatherings due to improved health, 47% observed better social cohesion and relationships, 44% remained engaged in productive social activities, and 39% no longer felt isolated, enjoying more interaction without the stigma of illness. Additionally, 24% experienced improved social networking, demonstrating a positive shift in community solidarity and interpersonal support.

Collectively, these findings illustrate that the Sehat Sahulat Program not only enhances healthcare access and quality but also contributes significantly to the social and economic well-being of its beneficiaries.



Graph 5: Perception of respondents on impact of health outcomes.

During focus group discussions, Program beneficiaries reported positive impacts on their health, increased empowerment, and enhanced confidence leading to a more optimistic outlook. In contrast, data from non-beneficiaries revealed poorer health outcomes, as many delayed seeking treatments due to unaffordability and insufficient information about the Program and empanel hospitals.

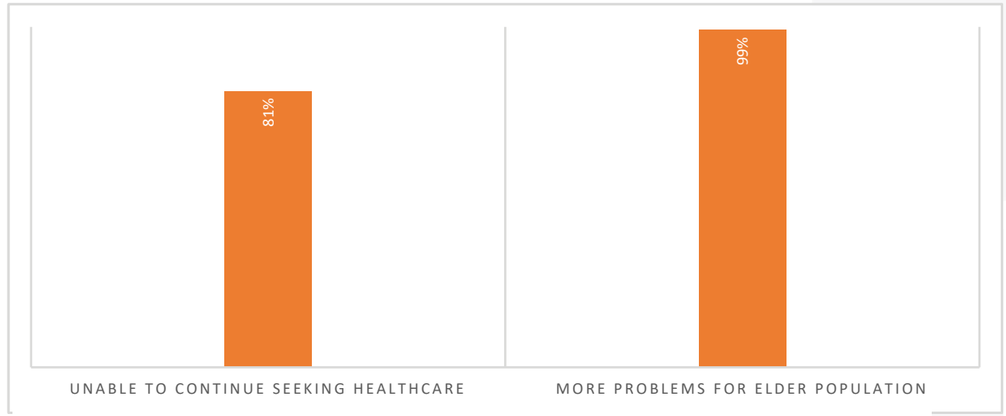
4.4.15 Sustainability

The analysis indicates that the sustainability of the Program is uncertain without ongoing economic stability for respondents. A significant majority (81%) reported that they would be unable to continue accessing quality, timely healthcare if the Program ends, citing their financial constraints. Only 18.8% believed they could maintain quality healthcare on a self-help basis.

Older people are not vulnerable but valuable.
Their contribution in nation-building stands prominent irrespective of age. Provider Zobia Hospital Islamabad

Community Self-Help Groups (CSHGs) represent a promising mechanism for fostering community engagement and sustainability. For example, the Community Organizations of the National Rural Support Program (NRSP) in Pakistan effectively promote village-level welfare and development. However, when respondents were asked about the presence of such groups in their areas, 51% indicated that no self-help groups had been formed.

Nearly all respondents (99%) expressed concerns that older people would face significant challenges in obtaining healthcare if the Sehat Sahulat Program were discontinued. This sentiment underscores the critical importance of sustaining the Program to ensure that the poorest and most vulnerable segments of society, including the older population, continue to benefit. All focus group participants agreed that the termination of the Program would create substantial problems for them.

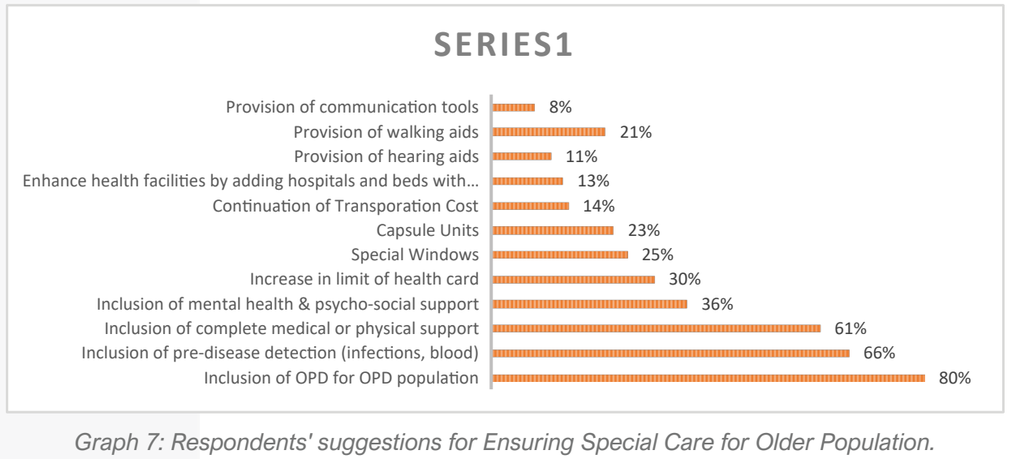


Graph 6: Perception of respondents regarding the sustainability of the program.

4.4.16 Ensuring Special Care for Older populations

Ensuring special care for older populations requires a tailored approach that addresses their unique healthcare needs. A significant majority (80%) emphasized the need for outpatient coverage, noting that older people often require regular outpatient care for multiple general ailments that affect both physical and mental health. In addition, 66% of respondents advocated for the inclusion of a broader spectrum of diseases such as diabetes, hypertension, and respiratory infections to better address the evolving health challenges faced by the older people.

Furthermore, 61% of respondents called for the provision of comprehensive, prompt, and free treatment that includes quality medicines and facilitates access to outdoor diagnostic tests and follow-ups. Many respondents expressed a strong desire for the continuity of Program, with 55% underscoring its importance and 36% recommending the integration of Mental Health and Psychosocial Support (MHPSS). There were also suggestions to increase the Benefit package limit, along with calls for enhanced awareness regarding the limit, the designation of special counters in healthcare facilities, and the installation of patient-friendly lifts equipped with proper ventilation, lift attendants, and emergency bells.



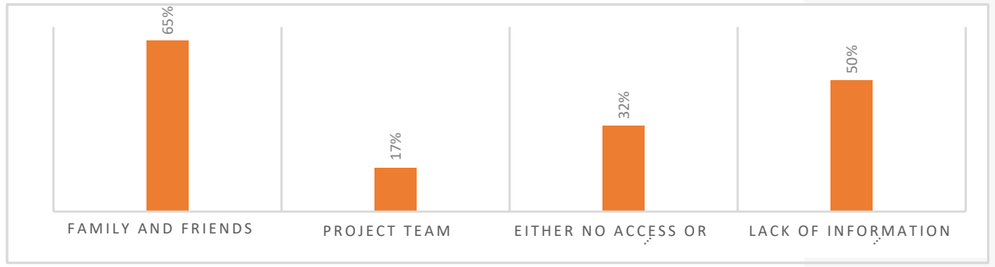
Graph 7: Respondents' suggestions for Ensuring Special Care for Older Population.

Additional recommendations included maintaining transportation cost subsidies to facilitate travel, expanding the network of hospitals and healthcare facilities and inclusion in service provision. Some respondents also highlighted the need for qualified staff with improved communication skills, proper seating arrangements, and easier access to healthcare facilities. Finally, there were calls for the provision of assistive devices, such as hearing aids, walking aids, and communication assistance.

Multiple response analysis

During focus group discussions, all 24 respondents acknowledged that although the Sehat Sahulat Program is intended for everyone and offers considerable benefits, there is a pressing need to focus more specifically on older populations. They highlighted that older people would greatly benefit from having glucometers and blood pressure monitors available in their homes, along with caregiver training to ensure these devices are used effectively. Furthermore, they stressed the importance of patient-friendly lifts equipped with proper ventilation, lift attendants, and emergency bells, as well as the establishment of special counters and the provision of travel cost subsidies. The respondents also advocated for regular supplies of essential medicines, a broader inclusion of diseases, and outpatient care coverage. Additionally, they called for an increased number of health facilities, a higher limit under the Benefit package, and the inclusion of more emergency procedures within the Program.

In parallel, the 38 non-beneficiaries suggested that information about the Program should be disseminated more effectively at the community level through targeted awareness-raising initiatives, ensuring that those in need are better informed and can access the benefits provided by the Sehat Sahulat Program.

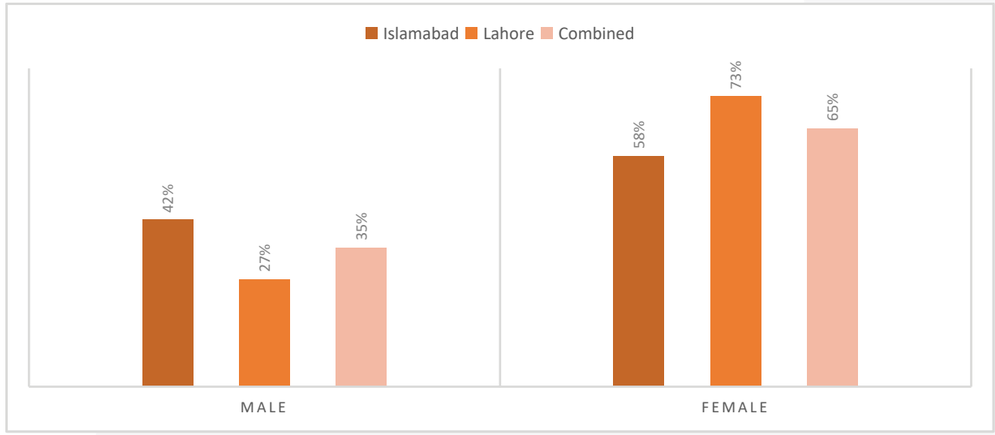


Graph 8: Information regarding registration process and Program

4.5 Benazir Income Support Program

4.5.1 Demographic Characteristics

The respondents in this study represented a diverse range of socioeconomic backgrounds. A majority (62%) resided in rural areas, while approximately 36% lived in urban settings. As the programme was specifically designed for women, a substantial 96% of the respondents were female. In the context of the Benazir Income Support Programme (BISP), the gender distribution varied by region: in Islamabad, 42% of respondents were men, whereas in Lahore, women constituted 73% of the sample.



Graph 9: Demographic Characteristics - BISP Program- Respondents

Regarding marital status, 64% of respondents were married, while 32% were widowed or widowers, and 3% were divorced. In terms of age, 73% of respondents were between 60 and 65 years old, 17% were aged 66 to 70, and 2% were above 76 years. The residential status further indicated that 75% of respondents were permanent residents, 13% were internally displaced, 10% were seasonal migrants, and 2% were returnees.

Household composition varied, with 77% of households being male-headed and 23% female-headed. The majority of respondents reported an average family size of between 6 and 10 members; 28% had 1–5 members, while 15% had 11–15 members. The nuclear family structure was predominant, with 68.9% of respondents living in nucleus families compared to 32% residing in joint family systems. Educationally, there was a notable imbalance: 88% of respondents had no formal education, 10% had attained primary or middle-level education, and a mere 0.2% had graduated. In terms of school attendance, nearly equal percentages of girls (51%) and boys (49%) were reported to be in school.

Table below represents average monthly income; Employment data revealed that 59% of respondents were housewives, 29% were engaged in unskilled labour, 2% in skilled labour, and 1% were employed in the private sector to meet basic needs. Only a small fraction (2%) held government jobs or ran their own businesses. With respect to monthly income, 29% of respondents earned between PKR 30,000 and 40,000, 26% earned between PKR 20,000 and 30,000, 20% earned less than PKR 5,000, and 16% earned between PKR 10,000 and 20,000. Additionally, 9.7% of respondents reported earning between PKR 40,000 and 50,000, while only 2% earned above PKR 50,000 per month.

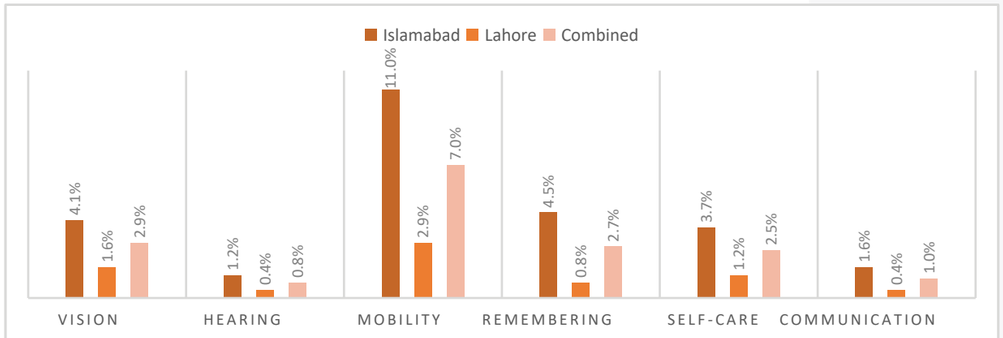
Average Monthly Income	#	%	#	%	#	%
0 to 5000	6	2.4%	85	34.8%	91	19.7%
5001 to 10000	8	3.3%	8	3.3%	16	3.5%
10001 to 20000	30	12.2%	45	18.4%	75	16.2%
20001 to 30000	57	23.3%	63	25.8%	120	26.0%
30001 to 40000	100	40.8%	33	13.5%	133	28.8%
40001 to 50000	36	14.7%	9	3.7%	45	9.7%
50001 to above	8	3.3%	1	0.4%	9	1.9%
Total	**245**	**100.0%**	**244**	**100.0%**	**489**	**105.8%**

Table 5: Average Monthly Income of the Household – BISP – Respondents.

Financial insecurity was widespread, as evidenced by 93% of respondents lacking a bank account and 99% living from hand to mouth with no savings; only 1% had any savings from the previous month

4.5.2 Status of Impairment

Among respondents, 8% reported some difficulty with vision even when wearing glasses, while 3% experienced significant visual challenges. Similarly, 12% encountered some hearing difficulties despite using a hearing aid, with 1% facing considerable issues. Regarding mobility, 12% experienced some challenges, and 7% reported substantial difficulty moving. In terms of cognitive function, 9% had some difficulty remembering, whereas 3% faced notable memory issues. Additionally, 10% of respondents reported some difficulty with self-care, with 3% indicating significant challenges, and 12% experienced some difficulty in communication, with 1% facing major communication barriers.



Graph 10: Status of Impairment of the BISP respondents.

4.5.3 Access to information

Family and friends emerged as the primary source of information regarding the Benazir Income Support Programme (BISP) and its registration process, with 65% of older respondents relying on these channels. However, there was notable geographical variation: in Islamabad, only 51% of respondents received information from family and friends, compared to 79% in Lahore. In contrast, non-beneficiaries of the BISP Programme were either not entitled to cash assistance or remained unaware of the programme and its selection criteria.

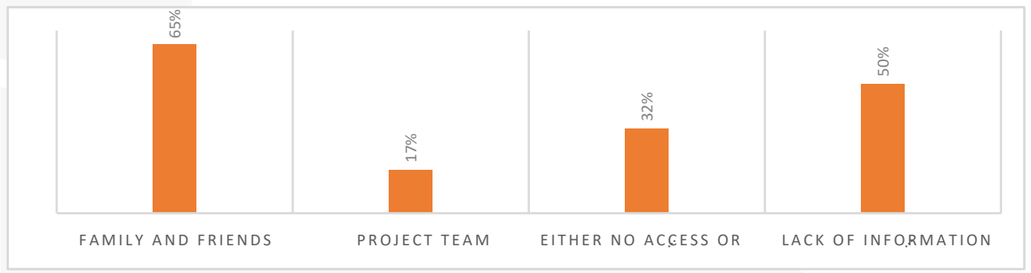
4.5.3 Relevance to cater specific needs of older population (Inclusivity)

Approximately 49% of beneficiary respondents—and all non-beneficiary respondents—lacked awareness of the programme's selection criteria. Nonetheless, an overwhelming majority (86%) agreed that there is an urgent need to launch such a programme, particularly to support poor older populations, with 85% in Islamabad and 89% in Lahore expressing this view. Additionally, a significant proportion of respondents felt that the programme effectively caters to the needs of older populations and people living with disabilities, with 74% of respondents in Islamabad and 94% in Lahore endorsing its success—making up 84% of the total responses.

Graph 11: Perspective on program's effectiveness to cater specific needs of older population – BISP Respondents.

Accessibility to program:
Most respondents (68%) were satisfied with the programme's accessibility across all socioeconomic classes, and overall, 87% including 84% in Lahore and 53% in Islamabad believed that the Benazir Income Support Programme was implemented on an equitable basis. This sentiment was echoed by all 15 focus group discussion participants, who affirmed that the programme's benefits were intended for all deserving individuals on an equal basis. The programme's equitable implementation extended to both rural and urban areas (80%), and respondents reported no instances of discrimination.

Furthermore, the programme has empowered women, with 78% of respondents noting that it has boosted their confidence to participate in household decision-making, manage basic expenses, and express their opinions freely. Among non-beneficiaries, many were not selected simply because they did not seek out information or because programme details did not reach them; some were also not eligible for support.



Graph 12: Information regarding registration Process -BISP

4.5.5 Problems in Registration
Approximately 50% of respondents encountered difficulties during the registration process, primarily due to a lack of access to information. Additionally, 16% of respondents reported issues stemming from the unavailability of smartphones, while another 16% indicated that they lacked the necessary training or skills to use smartphones effectively. Non-beneficiaries faced similar challenges, often lacking both the devices and the awareness required to utilise them. These findings highlight the urgent need for awareness-raising campaigns that not only disseminate programme information but also impart essential technology adaptation skills to beneficiaries.

4.5.6 Coherence
The Benazir Income Support Programme was perceived as similar in nature to other social protection initiatives such as the Hamqadam Programme and the Himmat Card Programme by 77% of respondents. A majority also noted that the government appeared to focus more on the capital, Islamabad, compared to Lahore 71% of respondents from Islamabad versus 51% from Lahore indicated this disparity. Additionally, 32% of respondents expressed a preference for receiving cash support for livelihood in similar programmes.

4.5.7 Effectiveness
The Benazir Income Support Programme (BISP) primarily delivered cash support on a quarterly basis, with 52% of respondents indicating that they received assistance every quarter. An additional 20% reported receiving cash support on a biannual basis, while 17% received payments monthly. Another 12% of respondents noted that they received assistance at other intervals throughout the year. Tailored packages were provided for women who were pregnant or had school-going children, with support delivered at different times to address their specific needs. Cash distribution centres facilitated the disbursement process, and overall, this mechanism was largely effective in fulfilling the basic needs of respondents.

In contrast, all non-beneficiaries experienced financial insecurity, primarily because they were excluded from the programme due to its limited scope.

4.5.8 Barriers and Challenges
A significant proportion of respondents (57%) reported difficulties in accessing cash or assistance at the distribution centres, highlighting the need for improvements in the cash disbursement system and the online platforms used to facilitate easier, more effective transactions.

A smaller number of respondents faced additional issues: 6% experienced delays in cash transfers, 2% encountered difficulties due to the absence of ramps at centres, and 1% noted that no special counter was designated for disabled persons. One of the most pressing challenges was the presence of long queues and prolonged waiting hours, as reported by approximately 36% of respondents. Moreover, 23% of beneficiaries indicated that they were not paid due to diminished fingerprints, while 28% reported that staff deducted between PKR 200 and 500 before releasing their cash. In many cases, respondents (28%) encountered multiple challenges, including the lack of special counters for disabled people and slow processing systems. All 15 participants in the focus group discussions complained about slow systems, extended queues, lengthy waiting times, and inadequate seating arrangements.

At the household level, 2% of respondents faced difficulties due to the non-availability of wheelchairs, and 23% reported challenges reaching the centres because of long distances. Geographical differences in barriers were notable: respondents from Islamabad primarily cited issues related to cash deductions (38%), lack of seating arrangements (24%), and delays in payments due to diminished fingerprints (11%). In contrast, those in Lahore most frequently reported a lack of seating arrangements (26%), insufficient knowledge on how to withdraw cash (17%), and inaccessible cash distribution centres (16%).

Past beneficiaries also expressed financial challenges following the discontinuation of programme support, with many noting a decline in their wealth and equity index as household members were compelled to seek income-generating activities; some even had their names removed from the entitlement list by NADRA.

In terms of overall satisfaction with the programme, 66% of respondents expressed satisfaction, with 38% in Islamabad and 52% in Lahore reporting a positive experience. Conversely, 44% were not satisfied, primarily due to distant distribution centres and delays in receiving cash assistance. Additionally, 62% opined that the cash assistance amount was inadequate, while 38% felt it was sufficient to meet their basic needs. Notably, 55% suggested that the minimum cash assistance under BISP should be raised to PKR 15,000 or more per month, despite the Deputy Director of BISP noting that the cash assistance had been increased from PKR 12,000 to PKR 13,500 in January 2025.

Respondents detailed how they allocated the cash assistance: the highest proportions spent it on food (28%) and healthcare (25%), followed by expenditures on clothing and shoes (11%) and payment of consumer bills (12%). Smaller proportions allocated funds towards education (6%), livelihoods such as small businesses (8%), and other activities including health insurance, leisure, and improved housing (10%). The programme's benefits were evident, with 31% of respondents reporting that their healthcare needs were now met, 26% experiencing improved health status, and 29% stating that they were able to purchase sufficient food items as a result of the intervention.

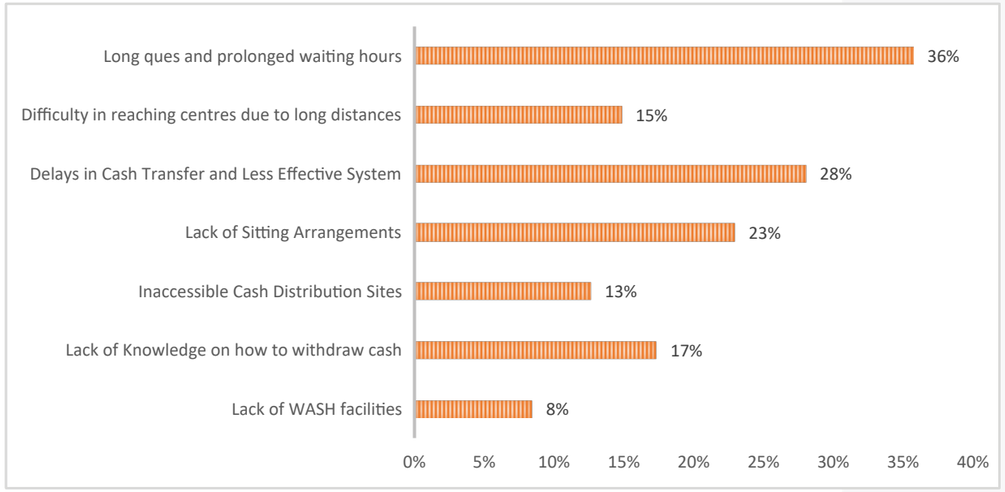
4.5.9 Right to Respect and Dignity

A strong majority of respondents in both Islamabad and Lahore (84%) reported being treated with dignity and respect during the selection process, with their rights acknowledged and their needs carefully addressed. Specifically, 80% of respondents in Islamabad and 85% in Lahore expressed satisfaction with the programme team's responsiveness to their needs and concerns. However, concerns were raised by approximately 25% of respondents in Islamabad and 7% in Lahore regarding the programme team's less adaptive communication methods. Furthermore, when receiving cash assistance, 70% of respondents in Islamabad and 90% in Lahore felt that they were served with respect and dignity, indicating a need for improved communication skills among the Islamabad team compared to their counterparts in Lahore.

Overall, 75% of respondents reported that the BISP intervention had no adverse impact on them, while 25% were affected by multiple factors, with long queues at cash disbursement centres being one of the most commonly cited issues. Focus group discussions further confirmed that beneficiaries were generally treated respectfully during cash assistance provision.

4.5.10 Gaps and Challenges of Respondents

Several challenges emerged in relation to the overall experience of the programme. Key issues included inadequate sitting arrangements (23%), inaccessible cash distribution sites or mobile shops (13%), and a lack of knowledge on how to withdraw cash (11%). In addition, 8% of respondents reported insufficient WASH facilities, and another 8% noted less adaptive behaviour from security guards. For persons with disabilities, the absence of proper seating arrangements was particularly problematic (22%), along with additional challenges such as inaccessible cash withdrawal sites (15%) and limited understanding of the cash withdrawal process (13%). At the household level, issues related to low mobility among women (18%), cultural constraints (11%), and limited decision-making power (19%) were prominent. Geographical analysis revealed that respondents in Islamabad most frequently encountered barriers such as cash deductions (38%), lack of adequate seating (24%), and delays in payments due to diminished fingerprints (11%). In Lahore, the main challenges were identified as insufficient seating (26%), a lack of awareness on how to withdraw cash (17%), and inaccessible cash distribution centres (16%). Additionally, six out of 15 focus group participants mentioned difficulties related to the absence of smartphones, inadequate skills to use available technology, and transportation issues.



Graph 13: Challenges in Accessing Services (BISP)

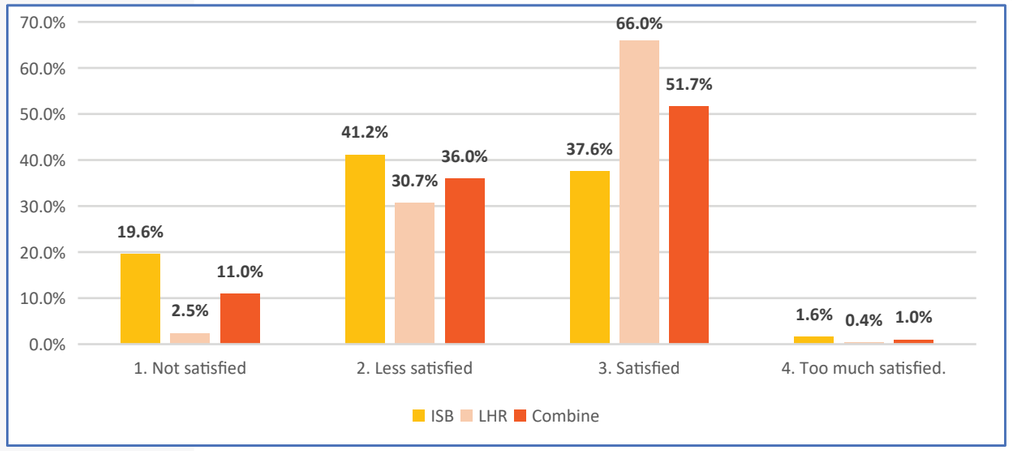
4.5.11 Feedback Mechanism

A significant majority of respondents 89% overall, with 83% in Islamabad and 95% in Lahore noted that they were unaware of any feedback or complaint redressal mechanism operational under the Benazir Income Support Programme (BISP). Only 4% of respondents had registered complaints, which primarily related to delays in cash disbursement, management issues, and the communication methods of staff. Moreover, most respondents expressed dissatisfaction with the way their complaints were handled.

4.5.12 Respondents' Satisfaction

The graph below depicts the satisfaction level of the respondents with the program. On a spectrum from least satisfied to very much satisfied, below are the responses. Across both locations, 51.7% of respondents indicated they were "Satisfied" with the programme, while 1.0% reported being Too much satisfied. In comparison, 36.0% described themselves as "Less satisfied," and 11.0% stated they were "Not satisfied. The primary reasons for dissatisfaction were distant distribution canters and delays in receiving cash due to overcrowded facilities. However, all participants in the focus group discussions reported overall satisfaction with the project

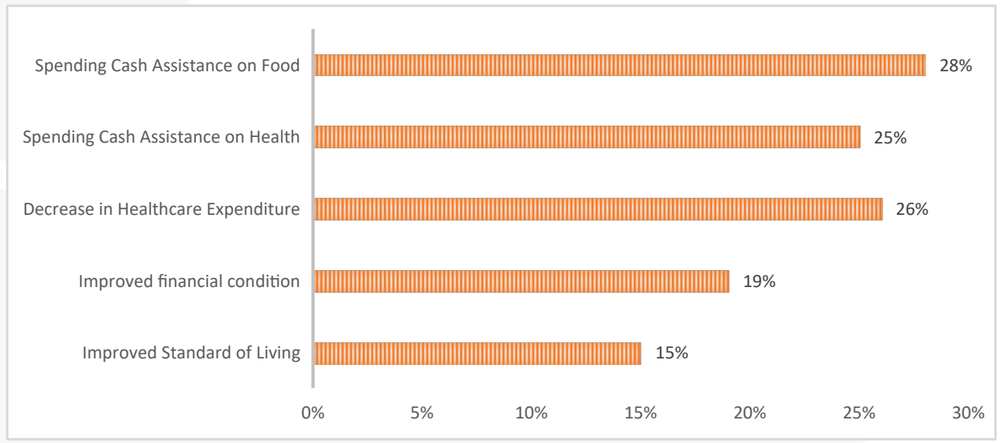
Regarding efficiency, 47% of respondents felt that the benefits of the BISP exceeded their expectations. Additionally, 48% reported that support was delivered in a timely manner, though 44% experienced delays in disbursement. Focus group participants similarly indicated that the benefits of the programme were greater than anticipated.



Graph 14: Satisfaction level of the respondents with the program

4.5.13 Impact of the program

The programme has made a substantial difference in the lives of vulnerable beneficiaries by significantly reducing poverty and hunger, as financial stress has notably diminished due to its interventions. The Benazir Income Support Programme has proven crucial in assisting underprivileged segments of society, especially those who lost their jobs during the COVID-19 pandemic. Respondents from both Islamabad and Lahore reported improvements in their financial conditions (20%) and overall well-being (15%).



Graph 15: Perspective on program addressing the basic need of BISP respondents

Beneficiaries indicated that the programme helped reduce their dependency on other family members and effectively addressed their basic needs. Additional benefits cited included increased empowerment (14%), an enhanced sense of social protection and safety in their surroundings (12%), improved confidence (11%), and elevated personal and social dignity resulting from this increased confidence (11%). Other positive outcomes were reflected in more participatory decision-making within households (8%) and improved peace and harmony due to better financial circumstances.

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Many beneficiaries also noted that the financial support enabled them to become more resilient in the face of natural or man-made disasters. Respondents in Islamabad reported a greater improvement in their overall well-being (28%) compared to those in Lahore (9%), while beneficiaries in Lahore experienced more pronounced improvements in personal dignity and empowerment (14% and 15%, respectively) relative to their counterparts in Islamabad.

There was strong emphasis on the need for the continuation of the programme. Older respondents highlighted that sustained support is essential for enhancing self-resilience and improving their quality of life. However, the analysis suggests that the continuity of these benefits remains uncertain in the absence of ongoing financial stability. A significant 91% of respondents in Lahore and 78% in Islamabad indicated that they would struggle to maintain the same level of healthcare, education, and livelihood after the programme ends, due to limited financial resources.

Some respondents, particularly in Islamabad (22% compared to 9% in Lahore), expressed optimism that they might continue to meet their educational, health, and livelihood needs on a self-help basis or through their savings. Nevertheless, all 16 focus group participants agreed that once the project concludes, they would be unable to sustain their current living standards because of financial constraints.

Community self-help groups were identified as an important mechanism for ensuring the sustainability of such initiatives. Drawing on the example of the National Rural Support Programme (NRSP), which has successfully formed village-level community organisations, respondents in the Ba Himmat Buzurg Programme were asked about the existence of similar groups in their area. Fifty-two per cent confirmed that no such community self-help groups were in place to assist them, while 37% were unsure whether such groups had been established or properly capacitated locally.

Moreover, all 15 focus group participants reported that they currently allocate funds for food, education, health, transportation, and consumer bills, and that their increased confidence has encouraged them to participate in social gatherings. In contrast, non-beneficiaries of BISP noted that their children had not been able to access education, whereas among beneficiaries, 52% of female children attended school compared to 48% of male children, as previously indicated in the demographic section.

4.6 Ba Himmat Buzurg Program

4.6.1 Demographic Characteristics

The demographic profile of households participating in the Ba Himmat Buzurg Program reveals that a majority of these households were male-headed (73%), while the respondents interviewed were predominantly women (69%), indicating the programme's focus on vulnerable older women. Most of the respondent women were illiterate, and 88% were not contributing to household income as they were primarily housewives. Only 12% were engaged in any form of employment, with 3% employed in skilled jobs and the remaining 9% working as unskilled laborers. In terms of household income, 89% of respondents reported an average monthly income below PKR 25,000. The nuclear family structure was prevalent in 65% of households, with the remaining 35% adhering to a joint family system. Additionally, 64% of households had between 6 and 10 family members, 25% had 1–5 members, and 11% had between 11 and 15 members. Financially, none of the respondents maintained a bank account, and 98% had no savings from the previous month.

Graph 16: Ba Himmat Bazurg Program-Respondents

Access to Information:

Access to information was largely driven by interpersonal networks; family and friends served as the most popular channel for disseminating information about the programme, with 77% of respondents relying on these sources. All participants in the focus group discussions reported receiving programme information primarily through family and friends. Knowledge of the selection criteria, however, was nearly non-existent among respondents (only 1%), and non-beneficiaries remained financially insecure, largely because they were not covered by the programme due to its limited scope.

4.6.2 Relevance and Inclusivity

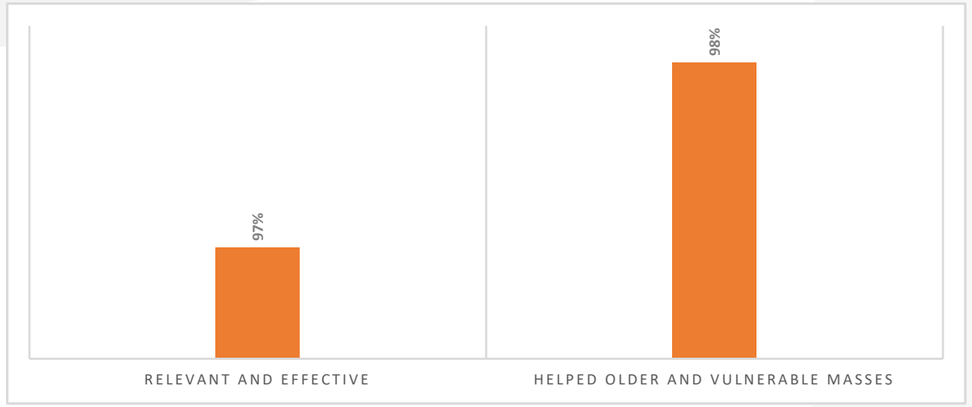
The programme was considered highly relevant to the needs of older populations, with 99% of respondents affirming its importance.

Inclusivity was also well regarded, as 97% believed that the programme ensured broad inclusion, with 98% noting that all eligible individuals were included this extended to people living with disabilities, for whom inclusion was reported at 99%.

All respondents indicated that in future similar projects, cash assistance should continue to be provided to the most deserving older populations. In the focus group discussions, all five participants confirmed that equity and inclusion were fully realised within the programme.

Right to Dignity and Respect:

Respect and dignity formed a cornerstone of the programme's approach. Every respondent reported being treated with dignity and respect throughout the process, with their safety and security assured at all times. Focus group participants reiterated that they received support with honour and respect, reinforcing the programme's commitment to upholding the rights and self-worth of its beneficiaries.



Graph 17: Relevance and Inclusivity in the Program meeting the needs of older population

4.6.3 Effectiveness

The effectiveness of the financial support provided by the programme was evident. Beneficiaries received a fixed amount of PKR 2,000 per month via a mobile agent, which significantly helped to alleviate financial stress related to food and healthcare expenditures. This support not only improved financial security but also enhanced self-confidence and self-reliance, enabling beneficiaries to live more independently. Although 71% of respondents received fewer than 12 payments in the past year and 29% received all 12 payments, some challenges persisted. For instance, 36% of interviewed women faced mobility and cultural constraints that hindered their ability to access cash, while 17% reported long queues at cash distribution centres, and 23% noted that the mobile agent or shop was situated too far away. In addition, 4% experienced delays in cash transfer, and 8% had difficulty accessing the cash assistance.

Beneficiaries utilised the financial support in various productive ways: 24% spent it on food, another 24% on healthcare expenses, 18% on improved housing, 15% on clothing and shoes, and 14% on consumer bills. These expenditures reflect the programme's role in addressing basic needs. The overall impact of the programme on the lives of poor and vulnerable older populations was significant. Thirty-one percent of respondents reported that the programme enabled them to cover healthcare costs, another 31% stated that it ensured sufficient food availability, and 28% experienced an improvement in their overall health status. Protection for people living with disabilities was maintained in 27% of cases, while 24% reported that safeguarding and no-harm policies were followed. Moreover, 39% felt that the safety of older populations above 65 was ensured, with beneficiaries experiencing a sense of security and freedom from stigma.

In summary, the Ba Himmat Buzurg Program has made a meaningful impact by addressing critical financial, social, and health-related needs among vulnerable older populations. While significant strides have been made in promoting inclusivity, respect, and dignity, ongoing challenges such as financial insecurity and limited access to employment and banking services highlight areas for further intervention to ensure sustained impact and improved quality of life for beneficiaries.

4.6.4 Equity and inclusion and women empowerment

The programme ensured inclusivity by specifically incorporating persons with disabilities, widows, and other vulnerable populations. The programme team applied rigorous selection criteria to target the neediest, with analysis indicating that the Ba-Himmat Buzurg Programme engaged the poorest of the poor to a reasonable extent (78%) and to a good extent (20%).

4.6.5 Barriers and Challenges

Respondents identified several key barriers. Inaccessible cash withdrawal sites were reported by 28% of respondents, while 26% lacked awareness of how to withdraw cash. Cultural factors also played a role; 21% indicated that it was not deemed appropriate for them to leave their homes, particularly affecting women with low mobility. Additionally, 5% noted limited decision-making power regarding the use of cash. Persons with disabilities encountered further difficulties: 23% experienced discriminatory behaviour, 22% found withdrawal sites inaccessible, 9% faced cultural constraints, and 8% were not aware of the cash withdrawal process. All five focus group discussion participants mentioned challenges such as low programme coverage, distant mobile shops, low cash limits, tax deductions, travel expenses, and the inability to be accompanied by family members, while the ten non-beneficiaries called for enhanced coverage.

4.6.6 Beneficiaries Satisfaction

A vast majority (96%) of respondents were unaware of any complaint redressal mechanism/hotline in their communities, a shortfall attributed to the programme team's insufficient efforts in raising awareness.

4.6.7 Complaint Redressal Mechanism

Overall satisfaction with the financial assistance was reported by 76% of respondents, with 7% expressing high satisfaction. However, 17% were less satisfied, primarily due to the programme's early closure and inadequate cash limits. Notably, all five focus group discussion participants expressed satisfaction with the programme.

Graph 18: Satisfaction of Beneficiaries on Financial Assistance received through the program.

4.6.8 Efficiency

Timely support from the programme enabled older populations to meet their financial needs without significant delays, as affirmed by 84% of respondents. All focus group participants remarked that the benefits of the programme exceeded their expectations.

4.6.9 Sustainability

The sustainability of the programme remains a major concern. A majority of respondents (95%) indicated that they would be unable to continue accessing healthcare, children's education, and livelihood support at the same level once the programme ends. Furthermore, 99% reported that older people would encounter significant difficulties in seeking healthcare after the programme's cessation. Sixty-five per cent of respondents strongly recommended that the programme continue, and all focus group participants emphasised the need for longer-term benefits to ensure continued support.

Graph 19: Perspectives on Sustainability of the Program – Ba Himath Buzrug respondents

4.6.10 Impact

The programme has had a notable impact on its beneficiaries by helping them better meet their dietary and healthcare needs. Specifically, 16% of respondents reported improved healthcare, 13% experienced an enhancement in their financial condition, and another 13% noted an increase in their confidence. In addition, 12% observed improvements in their living standards, 10% felt a boost in social protection and a greater sense of security, and 9% enjoyed improved emotional balance. Moreover, 8% experienced enhanced social and personal dignity owing to increased confidence.

The programme also significantly reduced feelings of loneliness and financially empowered older people to participate more actively in family and communal activities. Primary data showed that social solidarity and cohesion improved for 39% of respondents, 10% engaged in more constructive activities due to enhanced mental health, and 4% became busier with productive pursuits as a result of improved overall health.

Nonetheless, 54% of respondents were adversely affected by the programme's early closure, while 16% felt that the cash limit was too low to meet their basic needs and 5% reported difficulties in accessing mobile withdrawal sites. Nearly all beneficiaries advocated for the programme's continuation to help them meet their essential needs, and non-beneficiaries emphasised the need to expand the programme's scope so that the neediest and most vulnerable older populations are included. All focus group participants recommended the allocation of more cash withdrawal sites, and the majority of non-beneficiaries continued to struggle with dietary and routine healthcare needs.

06
Recommendations

Based on a detailed analysis of the three government social protection programmes, a comprehensive set of recommendations has been formulated to address the identified gaps and enhance the overall impact and sustainability of these initiatives. These recommendations, drawn from both quantitative data and qualitative insights, target key areas such as service accessibility, beneficiary engagement, and infrastructural improvements. By implementing these measures, it is anticipated that the programmes will not only better serve the vulnerable and older populations but also promote equitable access, financial stability, and improved health outcomes. The following recommendations outline specific steps for the Sehat Sahulat Programme, the Benazir Income Support Programme (BISP), and the Ba Himmat Buzurg Programme, and are intended to inform policy reforms and drive meaningful change in social protection delivery.

Sehat Sahulat Program (SSP)

1. Establish additional counters to reduce waiting times and ensure the timely availability of medical staff, necessary paperwork, and essential supplies, thereby minimising treatment delays.
2. Broaden the pool of qualified surgical providers and improve surgical services to meet growing demand.
3. Incorporate Mental Health and Psychosocial Support (MHPSS) into the Program, including care for conditions such as diabetes, hypertension, ophthalmology issues, and respiratory infections among older people.
4. Consider providing Outpatient Department (OPD) services for older people, addressing their urgent need for regular medical attention.
5. Continue offering transportation subsidies for the most vulnerable older populations to facilitate access to healthcare facilities.
6. Embed geriatric care into all social protection Programs to ensure ongoing, needs-based care for older people.
7. Ensure hospitals are equipped with ramps for seamless wheelchair access and, where possible, install patient-friendly lifts accessible to older people and persons with disabilities.
8. Facilitate connections for older people with other social protection Programs, such as Bait-ul-Mal, which provides cash grants to eligible individuals.
9. Awareness campaigns for Information on Sehat Sahulat Program should be prioritised.

Benazir Income Support Program/BISP

1. Beneficiaries expressed significant concerns about delays in the cash distribution process, which create frustration among older people—especially those with health issues and mobility constraints. Improved planning and faster implementation of cash distribution processes are needed.
2. People living with disabilities should receive enhanced support, including better information about the locations of cash distribution centres, to ensure an inclusive and accessible environment for all older people and persons with disabilities.
3. Many beneficiaries reported travelling difficulties following the discontinuation of the transport allowance; therefore, authorities should consider reinstating or continuing this allowance.
4. The introduction of digital payment methods is recommended to ensure timely financial assistance that meets the needs of older populations.
5. The government should conduct periodic reviews of prevailing inflation rates and adjust the cash limits accordingly to maintain adequate support.
6. Awareness-raising initiatives should be intensified to help current and potential beneficiaries fully understand the registration and cash withdrawal processes, thus maximising programme benefits.
7. Multiple channels of communication should be used to ensure that the most vulnerable people are informed about the programme's eligibility criteria and procedures.
8. The government should provide additional facilities for older populations, such as dedicated desks or counters to reduce waiting times, improved seating arrangements, functional WASH facilities, enhanced safeguarding, and facilitated online cash transfers.

Ba Himmat Buzurg Program

1. Alternative methods of cash disbursement should be explored and implemented to enable beneficiaries to receive cash smoothly.
2. Conduct comprehensive awareness-raising initiatives about the Ba Himmat Program, its selection criteria, cash withdrawal sites, and related processes by leveraging existing local government structures such as Union Council Chairmen, District, and Tehsil Nazims, who are directly engaged with their communities.
3. Initiate targeted awareness programmes for women to empower them to make informed decisions regarding the use and allocation of the cash received.
4. Address the continuity issues of the programme, as beneficiaries are demanding ongoing support due to current interruptions caused by administrative or financial challenges.
5. Enhance collaboration between the government and INGOs working on similar programmes to create a more effective support system for the most vulnerable older populations.
6. Develop sustainable strategies to ensure that the programme provides long-term financial assistance, enabling older populations to live with dignity in safe and secure environments.
7. Launch targeted interventions to include people with disabilities, ensuring they have equitable opportunities for inclusion and equal access to programme benefits.

07
Conclusions

This study provided comprehensive insights into three government social protection programmes by engaging both beneficiaries and non-beneficiaries in the Federal area (Islamabad) and the province of Punjab (Lahore). The research, which combined quantitative and qualitative methods, reveals that all three programmes have achieved considerable success in protecting and supporting their beneficiaries. They have significantly alleviated financial challenges, promoted health and well-being, and contributed to social inclusion. In particular, the combined benefits of financial security and enhanced healthcare have improved the quality of life for older people, empowering them to live with dignity and greater financial independence.

In contrast, non-beneficiaries continue to face more acute financial and health challenges. These individuals, who were excluded from programme benefits due to limited awareness or restrictive eligibility criteria, also exhibit lower rates of educational attainment among children and poorer health outcomes. The study documents success stories and detailed case studies based on direct interactions with beneficiaries, while also incorporating the perspectives of non-beneficiaries. It highlights specific areas for improvement and offers valuable suggestions from beneficiaries, drawn from their firsthand experiences with the services provided.

This report distils lessons learnt and offers recommendations aimed at ensuring healthy ageing. It underscores the importance of incorporating the voices of older people into policy-making processes to drive the necessary reforms in both policy and practice. Finally, it advocates for robust advocacy and consultation meetings as the most effective means of translating these recommendations into tangible actions.

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Annexes

Annex 1: Study tools and Selected Locations in Islamabad for the Impact Assessment of SSP and BISP

Key Informant Interview-KIIs with Project Staff

BISP, Sehat Sahulat Program and Ba-h Himmat Buzurf Program

Geo-identification

Region		Province		District/City	
Name of Directorate/Department		Name of Interviewee		Designation	
Date of Interview		Names of Moderator and Note-taker		Signatures	

Respondent's Consent – YES |___| **/ NO** |___| (If no, end the interview and move to the next respondent).

S. #	Relevance
1.	To what extent were target communities (older people and people with disabilities) and stakeholders (including government) involved in the needs assessment, design, and implementation of the program?
2.	Do you know what efforts were made to ensure that all eligible individuals have access to related information about the program and they apply for registration?
3.	What measures were undertaken to ensure the inclusivity of the registration process to ensure that older men and women and people with disability in the target communities are engaged in the program
	Coherence
4.	Was the program in context with/relevant to the social protection required in your community/area?
5.	Regarding coherence between various social protection programs, how aligned is this program with other related social protection initiatives and policies? Please explain/provide examples.
6.	What are any potential synergies or conflicts between this program and other social protection schemes?
7.	How can conflicts/differences between this program and other social protection schemes be resolved?
	Effectiveness
8.	Who were the direct and indirect/wider beneficiaries of the program supported? (Please provide Age, disability, and gender-disaggregated data).
9.	How did you ensure the equity and inclusion of all socio-economic segments of society in the program?
10.	How satisfied are you with regards to the coverage of the program and what else needs to be done?
11.	How effective were the following? Please explain. • Administrative processes • Enrollment • Benefit distribution • Fraud prevention • Customer service
12.	If the program is closed, what are the reasons behind the closure? Are there plans to restart it?
13.	Keeping in mind the difference (inflation) before five years and now, will you reconsider a person to be included in the program now who was denied five years before due to not being eligibly poor?
14.	What specific considerations do you ensure for the following: -? • Women and girls • Transgenders • People living with disabilities • The elderly (above 60 years of age).
15.	How is the program addressing the needs and priorities of those who are the poor and vulnerable?
16.	What is the implementation status of related acts? If these are under_implemented, what are the challenges and how can this be overcome?
17.	How was the monitoring system used to capture the correct information at the appropriate times throughout the program?
18.	Were any areas left behind due to resource constraints? If yes, which areas and what are your plans for their inclusion?
	Bottlenecks
19.	What challenges did you face/are you facing in HR, financial resources, technology, and capacity gaps and how did you resolve/are you resolving these?
20.	In your opinion, what are the main barriers that older people encounter in accessing and benefiting from social protection programs, particularly in terms of economic, and social inclusion?
	Enabling Environment
21.	To what extent has the program improved governance?
22.	What progress has been done for policy reform/ policy formulation and with what result?
	Sustainability
23.	In your views are the benefits of this program likely to continue once the program concludes or if any challenges may undermine its sustainability or continuity.
24.	How can the sustainability of the program be ensured further?
	Impact
25.	What is the contribution of this Program in improving the socio_economic status of the elderly people of ICT and Punjab? Please tell in detail about PWDs, older people, the ailing and transgenders.
26.	What is the overall income security, well_being, and health impact of these social protection programs on the target beneficiaries and their households? Do you have data that shows this impact? (if so, could you share?)
27.	To what extent has the Program improved the subsistence of poor older people and persons with disabilities p?
28.	To what extent has the Program reduced the dependency of poor elderly people on their social network? Kindly explain (using statistics or/or examples)
29.	How has the Program ensured social cohesion and solidarity?
30.	What are the intended and unintended consequences of the program and were there any positive or negative externalities? Please tell in detail
	Suggestions
31.	How can this program be improved further to accommodate the needs of an added number of beneficiaries through enhanced coverage and adequate resources?

32.	In your experience, what specific measures could be implemented to enhance the coverage and resource allocation of existing programs to better meet the needs of older people and persons with disabilities?
33.	How can these programs be optimized to accommodate an increased number of beneficiaries within these demographics?
34.	Was there a feedback mechanism in place for beneficiaries to provide input on improving the program? If so, how effective was this mechanism in incorporating the needs and suggestions of older people and persons with disabilities to enhance the program?

Annex 2: Focus Group Discussions with Communities members Men, women & Persons with Disabilities-(PWDs)

(BISP, Sehat Sahulat Program and Ba-Himmat Buzurg Program)

Geo-identification

Region		**Province**		**District/City**	
Name of town/ village/hamlet		Name of Interviewees	Fill attendance sheet at the end	Type of respondents	• Older Men • Older Women • Transgenders • PWDs
Number of respondents		Name of Program	• Ehsaas Cash Transfer Program merged with BISP • Sehat Sahulat Program • Ba-Himmat Buzurg Program		
Date of Interview		Names of Moderator and Note-taker		Signatures	

Respondent's Consent – YES |___| **/ NO** |___| (If no, end the interview and move to the next respondent).

Registration Process	
1.	How did you know about the program and apply for registration? Who helped you in both receiving information and getting registered?
2.	How were you registered to benefit from this social protection Program?
3.	If new beneficiary is to be selected under the Program, what is the criteria?
Relevance	
4.	Did you take part in any survey/need assessment conducted before the start of the program? If so, please tell details.
5.	Did you take part in the implementation of the project? If yes, please share details.
6.	Were older men and women and PWDs in the target communities engaged in the process and program? If yes, how? If not, why?
7.	From your experience, how inclusive do you find the programs in reaching out to older people with PWDs, particularly those living in remote or marginalized areas?
8.	What measures were undertaken to ensure the inclusivity of the selection process? For example, how was the inclusion of all socio-economic segments of society in the program ensured?
Coherence	
9.	If any similar projects are being implemented in your area, please tell us in detail.
10.	Which success of the project would you like to see in other similar projects in the future? What could make this program better/more effective?

Right to dignity and respect	
11.	How was dignity and respect ensured or not ensured by the Program team when you were selected and practically served? In your experience with the social protection Program, how did they demonstrate to uphold dignity and respect throughout the selection process and during your time of service? Could you share some examples? (can be positive and/or negative)
12.	How did or did not you feel that the project team is deciding everything themselves without taking care of your opinions and their behaviour is not good?
13.	Which interventions, if any, negatively affect you?
14.	How has the Program team taken care of your needs and concerns being an older or person with disabilities? (probing: registration process, mode of delivery, complain system)
Effectiveness	
Ask questions 16-17 only from Ehsas Cash Transfer and Ba-Himmat Buzurg program beneficiaries:	
15.	What type of support are/were you receiving from the Program?
16.	With which interval, are you receiving the program support, and how is the cash distributed? Are you satisfied with the mode of delivery (yes/no, why?)
17.	How many payments did you receive from the Program during the last year i.e. 2023? Were these regular? If not, what were the reasons? In what ways do you think programs have helped reduce the dependency of older people on their social networks? This question is for all the
Ask questions 18-19 only from Sehat Sahulat program beneficiaries:	
18.	Against which diseases had you received treatment with a Sehat Sahulat Card? How was your experience?
19.	Was the cash limit of your card enough? If not, how did you manage the expenses?
Ask the next questions from all	
20.	What difficulties did you face in accessing support/services and how did you resolve these problems?
21.	How did you spend the cash assistance and is/was the amount enough to meet your needs?
22.	What was the benefit of this program for you?
23.	How did the Program ensure your safety and security during the implementation of the Program?
Equity and inclusion and women empowerment	
24.	In your views, how were all socio_economic classes covered under the program on an equitable basis? Are the programme eligibility criteria fair? Please explain.
25.	How do you think or don't you think that the program was launched for all rural and urban areas in need and there was no discrimination observed?
26.	Have you ever observed any person who was deserving but who was not included in the program/who was not provided cash assistance? What did you do then? Why was the person(s) not included?
Barriers and challenges	
27.	Which barriers were faced to access the cash support b older men and women and those living with disabilities? Please tell for all separately.
28.	Were there any barriers related to technology? Please explain.
29.	What were the barriers for transgenders and people living with disability? What are the main barriers or challenges that older people have faced in accessing and benefiting from the program?

Complaint Redressal Mechanism	
30.	What complaint redressal (management) mechanism made and operationalized in your respective communities? How was it functioning? Please narrate any personal experience of making the complaint.
Beneficiaries Satisfaction	
31.	How will you rate your satisfaction with the program? If 10 is the highest and 1 the lowest, how would you rate your satisfaction? What has worked best and what did not work well?
Efficiency	
32.	In your views, were the benefits of the Program greater than you expected? If yes, how, if no why?
33.	How was the timeliness of providing the support of the Program ensured?
Sustainability	
34.	How will you or will you not be able to continue to have enough healthcare, food, and livelihood at the same pace after the Program comes to an end?
35.	What type of forum at the community level has been formed and capacitated to help elderly people receive support from other relevant Departments after the program comes to an end?
36.	How will this forum generate resources on a self-help basis for distribution to deserving elderly people, after the project?
Impact	
37.	What was the impact of the program on your life? Please tell in detail. How has the program contributed to improving the subsistence of older people in your community? Could you share any specific examples or experiences that highlight the effectiveness or impact of the program in improving the lives of older people in your community?
	Did the program have positive effects of the well-being of your family/other HH members? How?
Suggestions	
38.	What would you like to add for improving the services of this Program? What improvements or adjustments do you think could be made to enhance the inclusivity and sustainability of the social protection programs?

Annex 3: Focus Group Discussions with Control Group (Non-Beneficiaries)

Geo-identification

Region		**Province**		**District/City**	
Name of town/ village		Name of Interviewees	Fill attendance sheet at the end	Type of respondents	• Older Men • Older Women • Transgenders • PWDs
Number of respondents					
Date of Interview		Names of Moderator and Note-taker		Signatures	

Ask this questionnaire from older men and women who are not registered in the program but are eligible (poor and not benefitting from any other related program).

Knowledge about social protection programs	
1.	Do you know about any of the following programs? If yes, how are these working: • Sehat Sahulat Program • Ehsas Cash Transfer Program • Ba Himmat Buzurg Program
Relevance	
2.	What do you think why were you not registered to benefit from this social protection Program?
3.	How were you approached or not approached for registration?
4.	What efforts did you make to get registered?
5.	How did the program team respond to your efforts?
Right to dignity and respect	
6.	How was dignity and respect ensured or not ensured by the Program team when you were selected and practically served? In your experience with the social protection Program, how did they demonstrate to uphold dignity and respect throughout the selection process and during your time of service? Could you share some examples? (can be positive and/or negative)
7.	How did or did not you feel that the project team is deciding everything themselves without taking care of your opinions and their behaviour is not good?
8.	Which interventions, if any, negatively affect you?
9.	How has the Program team taken care of your needs and concerns being an elderly or disabled person? (probing: registration process, mode of delivery, complain system)
Effectiveness	
10.	In what ways, do you think programs have helped reduce the dependency of older people on their social networks who are registered?
Equity and inclusion and women empowerment	
11.	In your view, were the programme eligibility criteria fair? Please explain.
12.	Have you ever observed any person who was deserving but who was not included in the program/who was not provided cash assistance? What did you do then? Why was the person(s) not included?
Barriers and challenges	
13.	Which barriers did you face to get registered in the program and how did or did not you resolve these? Please explain.
Complaint Redressal Mechanism	
14.	Did you ever register a complaint for not getting registered? If yes, what was its outcome,
Impact	
15.	What is the impact of not getting registered on you and your Families health and well-being?
Suggestions	
16.	What would you like to add to improve the services of this Program? What improvements or adjustments do you think could be made to make sure that all eligible people are registered in the programs?

Household survey (Benazir Income Support Program-BISP)

Demographic Information

Name of the Respondent		Sex	• Male • Female • TG	Marital status	• Married • Unmarried • Divorcee • Widow/widower • Separated
Age in years					
Status of Residence	1) Permanent Residents 2) Seasonal Migrants 3) IDPs 4) Returnees Other (Please specify)	Type of household		• Man-headed household • Woman headed household.	
Education	1) Illiterate/below primary 2) Primary -Middle Matriculate-Intermediate 3) Bachelors/ 4) Master or higher education 5) Madrasah education	Occupation of the respondent	• Unskilled labor (cleanliness, fishery, domestic work, livestock, sales, etc.) • Skilled labor (sanitation, construction, factory, agriculture, stitching/ handicraft) • Govt. job • Private job • Domestic assistance • Business • Unemployed • Student • Non-school going child • Housewife • Other (Pl. specify)		
Average family income per month		Occupation of husband (ask only from married women/girls)	• Unskilled labor (cleanliness, fishery, domestic work, livestock, sales, etc.) • Skilled labor (sanitation, construction, factory, agriculture, stitching/ handicraft) • Govt. job • Private job • Domestic assistance • Business • Unemployed • Other (Pl. specify)		
Type of family	1) Nuclear 2) Joint 3) Other (Pl. specify)	Family Size (family members)		No. of school going children	• Male • Female
		No. of elderly people in the household (above 60 years of age)			
		Sex of Elderly People	• Male • Female		
Category of household	1) Men-headed household 2) Women –headed household	Head of Household	• Myself • Husband • Father/father-in-law • Mother/mother-in-law • Son/daughter • Other (Pl. specify)		
Contribution to household income	1) Yes 2) No	The bank account of the respondent	• Yes • No	Last month's saving	• Yes • No

(Disability), If any.

Vision	
Do you have difficulty seeing, even if wearing glasses? [Read response categories]	• No difficulty • Some difficulty • A lot of difficulty • Cannot do at all
Hearing	
Do you have difficulty hearing, even if using a hearing aid(s)? [Read response categories	• No difficulty • Some difficulty • A lot of difficulty • Cannot do at all
Mobility	
Do you have difficulty walking or climbing steps? [Read response categories]	• No difficulty • Some difficulty • A lot of difficulty • Cannot do at all
Cognition (Remembering)	
Do you have difficulty remembering or concentrating? [Read response categories]	• No difficulty • Some difficulty • A lot of difficulty • Cannot do at all

Instructions: Only the year 2023 is to be evaluated

S. #	Questions	Options	Skip Pattern
Registration Process			
1.	How did you access the related information about the program and apply for registration?	• Family and friends had informed us • Project staff had informed us • We came to know through a Lady Health Worker/outreach worker • We came to know through social media • Other (Please specify….)	
2.	How were you registered to benefit from the Ehsaas Cash Transfer Program (now merged into the Benazir Income Support Program)? (multi-select)	• Poverty scorecard (some list) was used • Need assessment (research) was conducted • The program team visited us to identify the neediest persons • Online NADRA database/ID Card number was used • Do not know • Any Any other (Please specify……)	
3.	What problems did you face in registration?	• Had no access to information • Had no access to digital media/cell phone • Was not skilled enough to use digital media/cell phone • Did not face any problem • Any other (Please specify……)	
4.	Who helped you to get registered?	• I got registered myself • Family and friends • Project team • Lady health worker/outreach worker • Any other (Please Specify)	
5.	Do you know if a new beneficiary is registered, what are the criteria?		
Relevance			
6.	Who told you about the start of the Ehsaas Cash Transfer Program in your area? (multi-select)	• Lady health worker • CMW • Other outreach worker/social mobilizer • Program staff	
		• Family and friends • Came to know through advertisement • Others (Pl. specify….)	
7.	Did you take part in any survey/need assessment conducted before the start of the project?	• Yes • No	**If no, skip to Q. 9**
8.	If so, please tell details.		
9.	Did you take part in the activities/implementation of the project?	• Yes • No	**If no, skip to Q. 11**
10.	If so, please tell details.		
11.	In your opinion, was this the support provided under the Program needed for the poor people in your area?		
12.	Do you think that all the eligible (who were poor and who needed financial support) were selected for the program?	• Yes • No	**If yes, skip to Q.14**
13.	If not, what were the reasons?		
14.	Were older men and women and people with disability in the target communities involved in the process?	• Yes • No	
15.	How was it ensured that all deserving older people above 60 years of age who are poor and who have no access to any other program of cash assistance, are registered in the Ehsas Cash Transfer program	• The results of poverty score card/need assessment were followed • Lady health workers and community midwives had helped in this regard • Community leaders had identified such older people • Others (Pl. specify….)	
Coherence			
16.	Was the program similar to other social protection programs being implemented in your area?	• Yes • No	**If no, skip to Q. 18**
17.	If yes, how is this program similar to the other programs being implemented in your area?	• There is some other Government program which is also providing support to older people • Some NGO/INGO is working for this in our area • Others (Pl. specify….)	
18.	If no, how is this program different to the other programs being implemented in your area?	• Other programs are only offering medical support • Other programs are only offering livelihood support • Other programs are only offering old home assistance • Others (Pl. specify….)	
19.	Which success of the project would you like to see in other similar projects?	• Unconditional cash transfer • Livelihood support • Health care assistance • Mental health and psycho-social support • Peace and harmony • self-reliance/independence • Others (Pl. specify….)	

Right to dignity and respect			
20.	Were you dealt with dignity and respect by the Program team when you were selected?	• Yes • No	
21.	Were you dealt with dignity and respect by the Program team when you were practically served?	• Yes • No	
22. 23.	Was your right to independence and self-esteem respected?	• Yes • No	
24.	Did any intervention negatively affect you?	• Yes • No	**If no, skip to Q. 26**
25.	If yes, how did it affect you?		
26.	Has the Program team taken care of your needs and concerns?	• Yes • No	
Effectiveness			
27.	With which interval, are you receiving the program support?	• Monthly • Quarterly • By-annual (six monthly) • Other (please specify)	
28.	How much cash support in PKR are you receiving from the program for a one-month period?		
29.	How is/was the cash distributed?	• It is/was distributed through vouchers • It is/was distributed in the form of cash in hand • It is/was distributed through a bank account • Other (please specify)	
30.	How many payments did you receive from the Program during the last year 2023?	• One • Two • Three • More	
31.	Is/was your access easy to cash distribution sites/banks?	• Yes • No	
32.	What difficulties did you face in accessing cash? (multi-select)–read out options and take responses for all.	• The site was far away • There were long queues • It was not culturally appropriate to visit the sites • Women mobility is low and women cannot go outside homes • Elderly men and women faced problem in traveling and standing in long queues • There were security threats • The security guards of banks charged us money for supporting in cash withdrawals. • I was unaware of the process/I am unable to use ATM? • There were delays in cash transfer • Lack of ramps • Lack of wheel chair • No specific window for disabled persons • Did not face any difficulty • Other (please specify)	

33.	How did you resolve these problems?		
34.	Is/was the amount enough to meet your needs?	• Yes • No	
35.	If no then what should be the minimum cash?		
36.	How did you spend the cash assistance? (multi-select)	• Education • Healthcare • Food • Livelihood (shop/ small business/ trade/sale purchase) • Clothes and shoes • Improved housing • Regular payment of consumer bills • Health and accident insurance • Leisure time/entertainment • Other (please specify)	
37.	What was the benefit of this cash assistance for you and your household/family? (multi-select)	• Variety of food was available to eat • Our healthcare needs were fulfilled • Our health status has improved • We have started the education of our children • We have started a small-scale work • Other (please specify)	
38.	How did the Program ensure your safety and security during the implementation of the Program? (multi-select)	• By compliance with COVID-19 SOPs • By complying safeguarding and no harm policy • By protecting and safeguarding children • By safeguarding adults and youth • By safeguarding adults above 60 years of age • By safeguarding transgenders • By safeguarding PWDs • It did not ensure safety and security • Other (please specify)	
Equity and inclusion and women empowerment			
39.	Do you feel that the cash support had reached to all socio-economic classes on equitable basis?		
40.	In your view, to what extent had the Program engaged the poorest of the poor in the program?	• To a reasonable extent • To a good extent • To a low extent	
41.	Do you think that the program was launched for all rural and urban areas in need and there was no discrimination observed?	• Yes • No	
42.	Have you ever observed any person who was deserving but who was not included in the program/who was not provided cash assistance?	• Yes • No	
43.	Do you think that the project has empower women and now they are confident enough to take a decision or participate in household decision-making?	• Yes • No • Don't know	
Barriers and challenges			
44.	Which barriers did you face in accessing cash support? (multi-select)	• Cultural constraints • Low women mobility • Lack of sitting arrangement	

		• Lack of WASH facilities • Low decision-making power • Inaccessible cash withdrawal sites • Sexual harassment • Lack of knowledge on how to withdraw cash • Exploitation by security guards/ receiving of cash for helping in money withdrawal • No barriers were faced as we had received cash in bank accounts/through digital accounts of mobile companies. • Others (Please specify)	
45.	What were the barriers for men and women about 60 years of age? (multi-select)	• Cultural constraints • Low mobility • Lack of sitting arrangement • Lack of WASH facilities • Low decision-making power • Inaccessible cash withdrawal sites • Sexual harassment • Lack of knowledge on how to withdraw cash • Exploitation by security guards/ receiving of cash for helping in money withdrawal • No barriers were faced as we had received cash, I bank account/through digital accounts of mobile companies. • Others (Please specify)	
46.	What were the barriers for transgenders and people living with disability? (multi-select)	• Cultural constraints • Low mobility • Lack of sitting arrangement • Lack of WASH facilities • Low decision-making power • Inaccessible cash withdrawal sites • Sexual harassment • Lack of knowledge on how to withdraw cash • Exploitation by security guards/ receiving of cash for helping in money withdrawal • No barriers were faced as we had received cash, I bank account/through digital accounts of mobile companies. Others (Please specify)	
Complaint Redressal Mechanism			
47.	Was the complaint redressal (management) mechanism made and operationalized (implemented) in your respective communities?	• Yes • No • Don't Know	
48.	Have you ever made a complaint?	• Yes • No	**If no, skip tot next section *Beneficiaries Satisfaction***
49.	If yes, can you tell me what was it about?		

50.	How was your complaint handled?	• It was handled in a fair way • It was not handled in a fair way • Other (pl. specify)	
Beneficiaries Satisfaction			
51.	How much satisfied are you with the program? (research/enumerator should read out all the three levels and tick whichever is told by the respondent).	• Not satisfied • Less satisfied • Satisfied • Too much satisfied.	
52.	What has worked best and what did not work well?		
Efficiency			
53.	In your views, were the benefits of the Program greater than you expected?	• Yes • No • Do not know	
54.	Was the support of the Program delivered in time?	• Yes • No • Do not know	
Sustainability			
55.	Will you be able to continue the healthcare, education, and livelihood at the same pace after the Program comes to an end?	• Yes • No	**If no, skip to Q. 55**
56.	If so, please tell me how will you do that.	• We will do it on self-help basis • We have saved enough money to ensure this Others (Please specify….)	
57.	If not, why will you not be able to do that?	• We will face problem as we will not have financial support • Others (Please specify….)	
58.	Have any community self-help groups formed and capacitated to help you receive support from other relevant Programs after the program comes to an end?	• Yes • No • Do not know	
59.	Have any community self-help groups formed and capacitated to generate resources on a self-help basis for distribution to the deserving people, after the project?	• Yes • No • Do not know	
Impact			
60.	What was the impact of cash distribution on your or your family's life? Multiple Response	• Improved well-being/living standard • Increased empowerment • Participatory decision-making at household level • Personal and social dignity • Enhanced social protection • Reduced poverty • Enhanced confidence • Peace and harmony • Other (pl. specify)	
61.	Could you share any specific examples or experiences/stories in this regard?		
Suggestions			
62.	If the Program is extended, what would you like to add to improve services?		

Annex 4: In-depth Interviews with Households (Sehat Sahulat Program-SSP)

Ask only from those card holders, who have used the card in 2023. Those who have not used a card should not be interviewed.

Sr. #	Questions	Options	Skip Pattern
Registration Process			
1.	How did you access the related information about the program and apply for registration?	• Family and friends had informed us • Project staff had informed us • We came to know through a Lady Health Worker/outreach worker • We came to know through social media • Other (Please specify….)	
2.	How were you registered to benefit from the Sehat Sahulat Program? (multi-select)	• Poverty scorecard (some list) was used • Need assessment (research) was conducted • The program team visited us to identify the neediest persons • Online NADRA database/ID Card number was used • Do not know • Other (Please specify….)	
3.	What problems did you face in registration?	• Had no access to information • Had no access to digital media/cell phone • Was not skilled enough to use digital media/cell phone • Did not face any problem • Any other (Please specify……)	
4.	Who helped you to get registered?	• I got registered myself • Family and friends • Project team • Lady health worker/outreach worker • Any other (Please specify……)	
5.	Do you know if a new beneficiary is registered, what are the criteria?		
Relevance			
6.	Who do you think is eligible for the Sehat Card? (multi-select)	• The poor • Only women • Only sick people • The elderly • PWDs (People Living with Disabilities) • Everyone is eligible • Don't know • Other (Pl specify)	
7.	Who told you about the start of the Sehat Sahulat Program in your area? (multi-select)	• Lady health worker • CMW • Other outreach worker/social mobilizer • Program staff • Family and friends • Came to know through advertisement • Others (Pl. specify….)	
8.	Did you take part in any survey/need assessment conducted before the start of the project?	• Yes • No	**If no, skip to Q. 10**
9.	If so, please tell details.		
10.	How do you believe that the cash limit allocated by the Sehat Card is or is not sufficient to cover healthcare expenditures?	• Our healthcare needs are fulfilled without charging extra money from us • All diseases are sufficiently covered in the program • We never made out-of-pocket expenses • Others (Please specify….	**If no, skip to Q. 12**
11.	If not sufficient, please tell details.	• We are charged money as the diseases are not fully covered. • The package is limited to in-patient treatment only • Some of the tests are not covered in the program • Some medication is not covered in the program • All diseases are not covered in the program • Others (Please specify….)	
12.	In your opinion, was the Sehat Sahulat card provided under the Program needed for the poor people in your area?	• Yes • No	
13.	Do you think that all the eligible (who were poor and having medical issues who needed financial support) were selected for the provision of Sehat Card? What additional steps do you think are necessary in this area?	• Yes • No	**If yes, skip to Q.15**
14.	If not, what were the reasons?	• The results of poverty score card/need assessment were not followed • Lady health workers and community midwives were not taken on board to identify the neediest persons • Community leaders were not taken on board to identify such older people • Selection criteria were not followed in letter and spirit. • Others (Please specify….)	
15.	Were older men and women and people with disability in the target communities provided with Sehat Card?	• Yes • No	**If no, skip to Q.17**
16.	If yes, how?	• They were specifically included in the poverty score card exercise/need assessment • Their quota was fixed • Others (Pl. specify….)	
17.	How was it ensured that all deserving older people above 60 years of age who are poor and who have no access to any other program of cash assistance, are registered in the Ehsas Cash Transfer program>	• The results of poverty score card/need assessment were followed • Lady health workers and community midwives had helped in this regard • Community leaders had identified such older people • Others (Pl. specify….)	

Coherence			
18.	Was the program similar to other social protection programs being implemented in your area?	• Yes • No	**If no, skip to Q.20**
19.	If yes, how is this program similar to the other programs being implemented in your area?	• There is some other Government program which is also providing support to older people • NGO/INGO is working for this in our area • Others (Pl. specify….)	
20.	If not, how this program is different from the other programs being implemented in your area?	• Other programs are only offering medical support • Other programs are only offering livelihood support • Other programs are only offering old home assistance • Others (Pl. specify….)	
21.	Which success of the project would you like to see in other similar projects?	• Health care assistance • Mental health and psycho-social support • Self-reliance/independence • Others (Pl. specify….)	
Right to dignity and respect			
22.	Were you dealt with dignity and respect by the healthcare team and providers when you informed them that you will avail services by Sehat Card?	• Yes • No	
23.	Were your dealt with dignity and respect by the healthcare team and providers when you were practically served/when you were admitted to receive inpatient services?	• Yes • No	
24.	Was your right to independence and self-esteem respected?	• Yes • No	
25.	Did any intervention negatively affect you?	• Yes • No	**If no, skip to Q. 27**
26.	If yes, how did it affect you?		
27.	Has the Program team taken care of your needs and concerns during travel, admission, discharge, and follow-ups?	• Yes • No	
Effectiveness			
28.	What is the annual credit limit on Sehat Card?	• 400,000 PKR for priority health care services • 60,000 PKR for secondary health care services • Do not know	
29.	According to your knowledge are additional financial limits allocated to families in life-threatening conditions and in case of maternity?	• Yes • No • Do not know	
30.	According to your knowledge, what happens if the card limit ends?	• We spend from our own pocket • We do not take treatment in that case • If we make a request, the limit of the card is extended • Don't know	
31.	Do you know which diseases are covered in this benefit package?	• Yes • No • Do not know	**If no, skip to Q. 33**

32.	If yes, what are these? (multi-select)	• Heart diseases • Diabetes Mellitus • Burns and Accident • Kidney diseases/ Dialysis • Hepatitis/HIV • Organ failure (Liver, Kidney, Heart) • Cancer • Hernia/Appendix/Fractures/Gall bladder stones/Kidney stones/Typhoid/Pneumonia • Maternity care (Delivery/C-Section) • Others (Pl. specify)	
33.	How many times did you seek inpatient care by using the card during the last year 2023?	• Once • Twice • Three times • Until the credit limit is consumed • Don't know	
34.	From which hospital/health facility had to you received the very last services?		
35.	What disease(s) were you suffering from when you used the card for the last time? (if the respondents do not want to answer, do not probe and tick option number 10)	• Heart diseases • Diabetes Mellitus • Burns and Accident • Kidney diseases/ Dialysis • Hepatitis/HIV • Organ failure (Liver, Kidney, Heart) • Cancer • Hernia/Appendix/Fractures/Gall bladder stones/Kidney stones/Typhoid/Pneumonia • Maternity (Delivery/C-Section) • Don't want to answer the Question • Others (Pl. specify)	
36.	What benefits did you receive for free, by using this card in the year 2023? (multi-select)	• In-Patient Services (All services including consultation, accommodation, tests, medicines, etc.)	
37.	How much transportation charges were your paid for a single hospital/health facility visit in 2023? Enter the amount in PKR		
38.	Was the treatment according to the limits of the card?	• Yes • No • Don't know	
39.	Have you also paid out of your own pocket for the treatment?	• Yes • No	
40.	If yes, what did you pay, and for what purpose?		
41.	Did you get free consultations and medicines on follow-up visits after you were discharged from the hospital/health facility?	• Yes • No • I did not receive follow-up services • Don't know	
42.	Had hospital/health facility ever refused to treat you on account of inadequate staff, medicines or equipment?	• Yes • No	**If no, skip to Q. 44**
43.	If yes, what did you do then?	• Did not receive treatment • Received treatment from some other public hospital/health facility • Received treatment from some other private hospital/health facility/clinic • Others (Please. specify)	
44.	Do you think that the treatment and services were provided equally to cardholders and non-cardholders who paid cash?	• Yes • No • Don't know	

45.	What difficulties did you face in accessing health care? Multiple Response –read out options and take responses for all.	• The hospital/health facility was far away • There were long queues • There were security threats • There were delays in receiving treatment • Did not face any difficulty • Other (please specify)	
46.	How did you resolve these problems?		
47.	Is the cash limit enough to meet your healthcare needs?	• Yes • No	
48.	How did the hospital/health facility staff and the respective provider ensure your safety and security while providing inpatient care? (multi-select)	• By compliance with COVID-19 SOPs • By complying with safeguarding and no harm policy • By protecting and safeguarding children • By safeguarding adults and youth • By safeguarding adults above 60 years of age • By safeguarding transgenders • By safeguarding PWDs • It did not ensure safety and security • Other (Pl. specify)	
49.	What was the benefit of the Sehat Sahulat Card for you and your household/family? (multi-select)	• We seek timely healthcare • We receive quality healthcare services • Our health status has improved • Other (please specify)	
Equity and inclusion and women empowerment			
50.	Do you feel that the Sehat Card had reached to all socio-economic classes on equitable basis?	• Yes • No	
51.	In your view, to what extent had the Program engaged the poorest of the poor in the Sehat Sahulat Program?	• To a reasonable extent • To a good extent • To a low extent	
52.	Do you think that the Sehat Sahulat card was launched for all rural and urban areas in need and there was no discrimination observed?	• Yes • No	
53.	Had you every observed any person who was deserving but who was not included in the Sehat Sahulat Program/who was not provided with a Sehat Sahulat Card?	• Yes • No	
Barriers and challenges			
54.	What were the barriers for women and girls to access the program? (multi-select)	• It was not culturally appropriate to visit the hospital/health facility • Low women's mobility • Implementation of sitting arrangements in hospital/health facility • Low decision-making power to seek medical healthcare for underprivileged citizens/older people in your region? • Inadequate cash limit that challenges have been encountered in card • Sexual harassment • Lack of knowledge on which diseases the card cover • Lack of knowledge on how to use the card • Lack of knowledge about impanelled hospital/health facility • Exploitation by hospital/health facility management due to not paying cash. • Women-specific health care was not covered • Privacy was not ensured in the hospital/health facility • It was hard to reach hospital/health facility	

		• The ensuring dignified access to entitled healthcare staff was rude • The behaviour of provider was not good • Medicines were not available • Equipment was not available • Provider was not available • Surgical services were not available • No barriers were faced as we had received cash in bank account/through digital accounts of mobile companies the SSP program, and how have they been addressed? • Others (Pl. specify)	
55.	What were the barriers for men and women about 60 years of age? (multi-select)	• Low mobility • No one was at home to accompany to the hospital/health facility • Elderly men and women faced problems in standing in long queues • Lack of sitting arrangement in hospital/health facility • Lack of WASH facilities • Non-availability of money for travel • Low decision-making power to seek healthcare • Lack of knowledge on which diseases the card cover • Lack of knowledge on how to use the card • Lack of knowledge about impanelled hospital/health facility • Hearing and walking aids were not available • No barriers were faced • Others (Pl. specify)	
56.	What were the barriers for transgenders and people living with disability? (multi-select)	• Non-availability of money for travel • Low decision-making power to seek healthcare • Lack of knowledge on which diseases the card cover • Lack of knowledge on how to use the card • Lack of knowledge about impanelled hospital/health facility • Sexual harassment • Stigma • Discrimination by other patients • Discrimination by the healthcare provider • Sexual harassment • No barriers were faced • Others (Pl. specify)	
Complaint Redressal Mechanism			
57.	Was the complaint redressal (management) mechanism made and operationalized (implemented) in your respective communities?	• Yes • No • Don't know	
58.	Have you ever made a complaint?	• Yes • No	If no, skip
59.	If yes, can you tell me what was it about?		
60.	If yes, can you tell me what was it about?	• It was handled in a fair way • It was not handled in a fair way • Other (pl. specify)	
Beneficiaries Satisfaction			

61.	How satisfied are you with the services received through the card? (The research/enumerator should read out all three levels and tick whichever is told by the respondent).	• Not satisfied • Less satisfied • Satisfied • Too much satisfied.	
62.	If no, why are you not satisfied? Multi-select	• Doctors were not available • Doctors did not give considerable time/attention • Attendants were not treated well • Medicines were not made available in time • Space was not available for admission • It took too long to get admitted • Others (Pl. specify)	
63.	In your opinion, what has worked best in the program?		
Efficiency			
64.	In your view, were the benefits of the Sehat Sahulat Program greater than you expected?	• Yes • No • Do not know	
65.	Was the support of the Program delivered on time?	• Yes • No • Do not know	
Sustainability			
66.	Will you be able to continue seeking quality and timely healthcare after the Program comes to an end?	• Yes • No	If no, skip
67.	If so, please tell me how will you do that?	• We will seek health care on self-help basis • We have saved enough health care expenditure to receive healh care • Others (Pl. specify….)	
68.	If not, why will you not be able to do that?	• We will face problem as we will not have financial support to seek health care • Others (Pl. specify….)	
69.	Have any community self-help groups formed and capacitated to help you receive support from other relevant Programs after the program comes to an end?	• Yes • No • Do not know	
70.	Have any community self-help groups formed and capacitated to generate resources on a self-help basis for distribution to the deserving people to seek quality health care after the Program?	• Yes • No • Do not know	
71.	What will happen, if the program comes to an end?	• Older people will face problems in health care • Others (Pl. specify….)	
Impact			
72.	What was the impact of Sehat Sahulat Program on your and your family's life? Multiple Response	• Timely healthcare seeking • Improved health by providing quality health care • Reduced diseases • Quality health care • Healthcare in easy access • Easy access to health care information	

		• Easy access to healthcare sites/health facilities • Good follow-up • Healthcare expenditure has decreased • Due to decreased healthcare expenditure, now we spend on the education of our children. • Improved well-being due to good health • Enhanced social protection • Enhanced confidence • Feel empowered • Peace and harmony • Other (pl. specify)	
73.	Could you share any specific examples or experiences/stories in this regard?		
74.	How did the program address your loneliness? Multi-select	• We remain busy in productive activities now • We pass time in constructive thinking • We do not feel alone as the Program is a source of activity for us • Social cohesion has improved • Solidarity has improved • Other (Pl. specify…)	
Suggestions			
75.	What would you like to add more to the Program for improving services?		
76.	Which specific health issues you have which are not covered by Sehat Sahulat program?		
77.	How much it cost you monthly?		
78.	How can the Govt. of Punjab improve the program further?		

Annex 5: Households Survey (Ba-Himmat Buzurg Program)

Instructions:

Only the year 2023 is to be evaluated.

S. #	Questions	Options	Skip Pattern
Registration Process			
1.	How did you access the related information about the program and apply for registration?	• Family and friends had informed us. • Project staff had informed us. • We came to know through a Lady Health Worker/outreach worker. • We came to know through social media. • Other (Please specify….)	
2.	How were you selected to benefit from the Ba-Himmat Buzurg Program of the Govt. of Punjab? (multi-select)	• A poverty scorecard (some list) was used. • Need assessment (research) was conducted. • The program team visited us to identify the neediest people. • Online NADRA database/ID Card number was used. • Do not know. • Other (Please specify)	

3.	If new beneficiary is to be selected under the Himmat Buzurg Program, what is the criteria?		
Relevance			
4.	Who told you about the start of the Himmat Buzurg Program in your area? (multi-select)	• Lady health worker • CMW • Other outreach worker/social mobilizer • Program staff. • Family and friends • Came to know through advertisement. • Others (Pl. specify….)	
5.	Did you take part in any survey/need assessment conducted before the start of the project?	• Yes • No	**If no, skip to Q. 7**
6.	If so, please tell details.	• I took part in the survey • I took part in the selection process/identification • I took part in project staff meeting to identify the neediest persons • Others (Pl. specify….)	**If no, skip to Q. 9**
7.	Did you take part in the activities/implementation of the project?	• Yes • No	
8.	If so, please tell details.		
9.	In your opinion, was this the support provided under the Program needed for the poor people in your area?	• Yes • No	
10.	Do you think that all the eligible (who were poor elderly and who needed financial support) were selected for the program?	• Yes • No	**If yes, skip to Q.12**
11.	If not, what were the reasons?	• The results of poverty score card/need assessment were not followed • Lady health workers and community midwives were not taken on board to identify the neediest persons • Community leaders were not taken on board to identify such older people • A selection criterion was not followed in letter and spirit. • Others (Pl. specify….)	
12.	Were older men and women in the target communities included in the program?	• Yes • No	**If no, skip to Q.14**
13.	If yes, how?	• They were specifically included in the poverty score card exercise/need assessment	

		• Their quota was fixed • Others (Pl. specify….)	
14.	Were people with disability in the target communities involved in the process?	• Yes • No	**If yes, skip to Q.15**
15.	If yes, how?	• They were specifically included in the poverty score card exercise/need assessment • Their quota was fixed • Others (Pl. specify….)	
16.	What measures were undertaken to ensure the inclusivity of the selection process? For example, how was the inclusion of all socio-economic segments of society in the program ensured?	• The results of poverty score card/need assessment were followed • Lady health workers and community midwives had helped in identifying and including all deserving people into the program • Community leaders had identified such older people • Others (Pl. specify….)	
Coherence			
17.	Was the program similar to other social protection programs being implemented in your area?	• Yes • No	**If no, skip to Q. 19**
18.	If yes, how this program is like the other programs being implemented in your area?	• There is some other Government program which is also providing support to older people • Some NGO/INGO is working for the cash assistance of older people in our area • Others (Pl. specify….)	
19.	If no, how is this program different to the other programs being implemented in your area?	• Other programs are only offering medical support • Other programs are only offering livelihood support • Other programs are only offering old home assistance • Others (Pl. specify….)	
20.	Which success of the project would you like to see in other similar projects?	• Cash assistance • Mental health and psycho-social support • Self-reliance/independence • Others (Pl. specify….)	
Right to dignity and respect			
21.	Were you deal with dignity and respect by the Program team when you were selected?	• Yes • No	
22.	Were you dealt with dignity and respect by the Program team when you were practically served?	• Yes • No	
23.	Was your right to independence and self-esteem respected?	• Yes • No	
24.	Did any intervention negatively affect you?	• Yes • No	**If no, skip to Q. 27**

25.	If yes, how did it affect you?		
26.	Has the Program team taken care of your needs and concerns being an elderly person?	• Yes • No	**If no, skip to the next section *Effectiveness***
27.	If yes, how did the Program ensure these?	• We were registered with and ease of access to the process • We were provided cash assistance at an ease of access • We are linked to health care and psycho-social support • We are supported in livelihood • Others (Pl. specify….)	
Effectiveness			
28.	What type of support are you receiving from the Ba-Himmat Buzurg Program?	• PKR 2000/- per month • Other (please specify)	
29.	With which interval, are you receiving the program support?	• Monthly • Quarterly • By-annual (six monthly) • Other (please specify)	
30.	How is the cash distributed?	• It is distributed through vouchers. • It is distributed in the form of cash in hand • It is distributed through a bank account. • Other (please specify)	
31.	How many payments did you receive from the Program during the last year i.e. 2023?	• 12 payments • Less than 12 payments	**If option 1 is selected, skip to Q. 33**
32.	If you received less than 12 payments, how many payments were short?		
33.	Was your access easy to cash distribution sites/banks?	• Yes • No	
34.	What difficulties did you face in accessing cash? Multiple Response –read out options and take responses for all.	• The site/bank was far away. • There were long queues. • It was not culturally appropriate for women to visit the sites. • Women's mobility is low, and women cannot go outside their homes. • Elderly men and women faced problems in traveling and standing in the absence of proper seating arrangements. • There were security threats. • The security guards of banks charged us money for support in cash withdrawals. • There were delays in the cash transfer. • Did not face any difficulty. • Other (please specify)	
35.	How did you resolve these problems?		
36.	Is/was the amount enough to meet your needs?	• Yes • No	

37.	How did you spend the cash assistance? (multi-select)	• Healthcare • Food • Livelihood (shop/ small business/trade/sale purchase) • Clothes and shoes • Improved housing • Regular payment of consumer bills • Health and accident insurance • Sports • Leisure time/entertainment • Hobbies • Other (please specify)	
38.	What was the benefit of this cash assistance for you? (multi-select)	• Enough food was available to eat. • Our healthcare needs were fulfilled. • Our health status has improved. • We have started the education of our children. • We have started a small-scale work. • We live a peaceful life now. • Other (please specify)	
39.	How did the Program ensure your safety and security during the implementation of the Program? (multi-select)	• By compliance with COVID-19 SOPs • By complying with safeguarding and no harm policy • By safeguarding adults 65 years of age and above • By safeguarding transgenders • By safeguarding PWDs • It did not ensure safety and security. • Other (Pl. specify)	
Equity and inclusion and women empowerment			
40.	Do you feel that the cash support had reached to all socio-economic classes on equitable basis?	• Yes • No	
41.	In your view, to what extent had the Ba-Himmat Buzurg Program engaged the poorest of the poor in the program?	• To a reasonable extent • To a good extent • To a low extent	
42.	Do you think that the program was launched for all rural and urban areas in need and there was no discrimination observed?	• Yes • No	
43.	Have you every observed any person who was deserving but who was not included in the program/who was not provided cash assistance?	• Yes • No	
Barriers and challenges			
44.	Which barriers were faced to accessing the cash support? (multi-select)	• It was not culturally appropriate to go outside houses/low women mobility. • Lack of sitting arrangements in banks • Lack of WASH facilities • Low decision-making power with women to spend money. • Inaccessible cash withdrawal sites • Sexual harassment • Lack of knowledge on how to withdraw cash. • Exploitation by security guards/ receiving of cash for helping in money withdrawal. • No barriers were faced as we had received cash in bank accounts/through digital accounts of mobile companies. • Others (Pl. specify)	

45.	What were the barriers for transgenders and people living with disability? (multi-select)	• Cultural constraints • Low mobility • Lack of sitting arrangement • Lack of WASH facilities • Low decision-making power to spend money. • Inaccessible cash withdrawal sites • Sexual harassment • Discrimination • stigma • Lack of knowledge on how to withdraw cash. • Exploitation by security guards/ receiving of cash for helping in money withdrawal. • No barriers were faced as the cash was received cash in bank accounts/through digital accounts of mobile companies. • Others (Pl. specify)	
Complaint Redressal Mechanism			
46.	Was the complaint redressal (management) mechanism made and operationalized in your respective communities?	• Yes • No • Do not know	
47.	Have you ever made a complaint?	• Yes • No	**If no, *skip***
48.	If yes, can you tell me what it was about?		
49.	How was your complaint handled?	• It was handled in a fair way. • It was not handled in a fair way. • Other (please. specify)	
Beneficiaries Satisfaction			
50.	How satisfied are you with the Ba-Himmat Buzurg program? (research/enumerator should read out all the three levels and tick whichever is told by the respondent).	• Not satisfied • Less satisfied • Satisfied • Too much satisfaction.	
51.	What has worked best and what did not work well?		
Efficiency			
52.	In your views, were the benefits of the Program greater than you expected?	• Yes • No • Do not know	
53.	Was the support of the Program delivered in time?	• Yes • No • Do not know	
Sustainability			
54.	Will you be able to continue to have enough healthcare, food, and livelihood at the same pace after the Program comes to an end?	• Yes • No	**If no, skip to Q. 57**
55.	If so, please tell me how you will do that.	• We will seek care on self-help basis • We have saved enough money receive care • Others (Pl. specify….)	
56.	If not, why will you not be able to do that?	• We will face problem as we will not have financial support to seek care • Others (Pl. specify….)	
57.	Have any community self-help groups formed and capacitated to help elderly people receive support from other relevant Departments after the program comes to an end?	• Yes • No • Do not know	
58.	Have any community self-help groups formed and capacitated to generate resources on a self-help basis for distribution to the deserving elderly people, after the project?	• Yes • No • Do not know	
59.	Can your spouse receive the amount after you?	• Yes • No • Do not know	
60.	What will happen if the Program comes to an end?		
61.	Can your spouse receive the amount after you?	• Yes • No • Do not know	
62.	What will happen if the program comes to an end?	• Older people will face problems in health care • Others (Pl. specify….)	
Impact			
63.	What was the impact of cash distribution in your life? Multiple Response	• Improved well-being/living standard. • Improved healthcare • Psychological well-being • Emotional balance • We pass time in constructive thinking. • Increased empowerment • Participatory decision-making at household level • Personal and social dignity • Enhanced social protection. • Reduced poverty • Enhanced confidence • Peace and harmony as social cohesion has improved • We remain busy with productive activities now. • We do not feel alone as the Program is a source of activity for us. • Other (pl. specify)	
64.	Could you share any specific examples or experiences/stories in this regard?		
65.	How did the program address your loneliness? Multi-select	• We remain busy with productive activities now. • We pass time in constructive thinking. • We do not feel alone as the Program is a source of activity for us. • Social cohesion has improved. • Solidarity has improved. • Other (Pl. specify…)	
Suggestions			
66.	What would you like to add to improve services in the Ba-Himmat Buzurg Program?		
67.	How can the Govt. of Punjab improve the program further?		

Annex 6: Hospitals / Health Facilities visited in Islamabad

Islamabad Hospital/ Health Facilities		
1. Akbar Niazi Teaching Hospital	12. Fauji Foundation	23. PAF Complex
2. Al-Latif Hospital	13. General Hospital	24. Ghazi Hospital
3. Al Nafees Hospital	14. Ghazi Hospital	25. HBS Hospital
4. Al Shifa Hospital	15. HBS Hospital	26. PHQs ISB
5. Al Farooq Hospital	16. RIC	27. PIMS
6. Al Noor Medical Centre	17. Holy Family Hospital	28. Poly Clinic
7. Benazir Bhutto Hospital	18. Islamabad International Hospital	29. Rafa Hospital Sihala
8. Begum Jan Hospital	19. Kidney Centre	30. Railway General Hospital
9. Capital Hospital	20. Life Care Hospital	31. Rawal Hospital
10. Cardiology Rawat	21. Max Health	32. KLR
11. CMH	22. NORI Hospital	33. Shakeela Hospital

Annex 7: List of visited UCs, towns, and villages of Islamabad

Union Council	Town/Village
1. Kirpa	Nai Abadi Kirpa
2. Kuri	Village
3. G7	Sitara Market BISP Islamabad
4. Rawat	Village
5. Dhok shahzad isb	Village
6. F.6	Town
7. Tarlai	Village
8. Hamsa colony	Hamsa colony g-8
9. Jodh	Shamsabad Market, Jodh
10. E11	Islamabad International Hospital
11. Non sectorial area	Village
12. Nai abadi	Village
13. Tarlai	Village
14. E/11	Town
15. Sihala	Village
16. Bhara kahu	Village
17. Muslim kachi abadi i-9	Muslim kachi abadi i-9
18. Eissa nagri i-9	Eissa nagri i-9
19. France colony	France colony
20. 100 quarter	100 quarter
21. Kachi abadi g-7	Kachi abadi g-7
22. Bisp office	Bisp office
23. G-9/1	Zobia Hospital
24. Jaffar colony	Jaffar colony, Mehr Abadi
25. Cristian Colony	Cristian Colony
26. Saidpur village	Saidpur village
27. Noor Por Shahan	Noor Por Shahan
28. Jafar Colony	Jafar Colony
29. Nain Sukh	Nain Sukh
30. Khadda market g-7	Khadda market g-7
31. Golra shareef	Golra shareef
32. Mehran abadi f-12	Mehran abadi f-12
33. Karlot	Karlot
34. Kachi abadi g-6	Kachi abadi g-6
35. Lehtrar	Lehtrar
36. Christian colony	Christian colony F6
37. Christian colony i9	Christian colony i9
38. Muslim colony i9	Muslim colony i9
39. Shah Allah Dita	Shah Allah Dita
40. E-11	E-11
41. I9	Muslim colony
42. Taramri	Taramri
43. Khana pul	Khana pul
44. Alipur	Alipur
45. Mohrian	Mohrian
46. Sain mircho	Sain mircho
47. Jhangi syedan	Jhangi syedan
48. Chal shahzad	Chal shahzad
49. Kachi abadi	Kachi abadi f7
50. Frash town	Frash town
51. Golra	Golra
52. Naka	Dhok mian juma
53. Jaffar Colony	Jaffar Colony
54. Mehra F12	Mehra F12
55. Dhoke paracha	Dhoke oaracha
56. Tarnol	Tarnol
57. Bari Imam	Bari Imam

Annex 8: Selected Locations in Lahore for the Impact Assessment of SSP and BISP

Hospitals

Lahore Hospital/Health Facilities		
1. Ali Fatima Hospital	15. Gulab Devi Hospital	29. Noor Hospital Kachi Kothi
2. Govt. Hospital, Amamia Colony	16. Hamad Hospital Ijaz Hospital	30. Punjab Institute of Cardiology
3. Anmol Hospital	17. Imran Idrees Hospital	31. PKLI
4. Govt. Hospital, Baba Fareed Colony	18. Ayaz Hospital	32. Saira Meraaj Hospital
5. Cardiology	19. Jinnah Hospital	33. Sardar Bibi Hospital
6. Centre Park Hospital	20. Lahore Care Hospital	34. Services Hospital Lahore
7. Civil Hospital	21. Manawa Hospital	35. Shalimar Hospital
8. Doctors Hospital	22. Manawan Hospital	36. Sheikh Zaid Hospital
9. Ever Care Hospital	23. Manshi Hospital	37. Social Security Hospital
10. General Hospital	24. Mao Hospital	
11. Govt. Hospital Ghulam Bhatti Road	25. Meo Hospital	
12. Ghurki Hospital	26. Multan Road Hospital	
13. Gondal Hospital	27. Mustafa Colony Ammer Sadho	
14. National Hospital Fezpour	28. Namaz Shareef Hospital	

Annex 9: List of visited UCs, towns, and villages in Lahore

Union Council	Town/Village
1. Jail Road	Jail Road
2. UC 70	Khans
3. UC 6	Shahdra town
4. UC 118	Shadbagh
5. UC 74	Sandha band road
6. UC 2	Taaj colony shahdra
7. Raiwind	Sundar state
8. UC 70	Islampura
9. Chungi	Rignal head quarter
10. UC 97	Sadhokey
11. JAIL ROAD	PIC Hospital
12. UC 50	Gaoshala
13. Morkhunda	Nathaa
14. Malfifyana	710GB
15. UC 2	Kot barkat
16. Gulberg	PMC
17. UC 2	Ithad park
18. 109	Fateh singh
19. Darogawala	Shalimar
20. Yateem khana	Yateem khana
21. Thokar	Farooq hospital
22. Kahna	Kahna
23. Shahpur	Kanjra
24. Ammaia Colony Hussain chok Shahra Lahore	Ammaia Colony Hussain chok Shahra Lahore
25. Bhatta Chok Badiya road	Bhatta chok phatya lahore
26. Bank stop chongi Ammar sadho	Bank stop chongi Ammar sadho
27. Barki road Lahore	Barki road Lahore
28. Taj colony	Taj colony
29. Ali town	66B
30. Rehan wala	Mandi faiz abad
31. Nayi kachehri	Muzafar colony
32. Wahgha	Wahgha
33. Kahna	Muhalaa Eid ghah
34. Bhubatian	Sher shah colony
35. Chunian	Rasoolpur
36. Tibba	Tibba kacha
37. UC 96	Gulberg
38. Street 9	Rasool park
39. Township	Machli bazar
40. Madhulaal	Madhulaal Hussain

Union Council	Town/Village
41. Bagriyan	Bagriyan
42. Shakr ghar	Shan e milat street
43. Theem mor	Chunian
44. Shahdra	Hussnain chock
45. Chak 27	Chak 27
46. Chak 42	Chak 42
47. Darogawala	Darogawala
48. Town ship	Town ship
49. Bhag	Bhag
50. Multan chungi	Multan chungi
51. Faisal Town	Faisal Town
52. Jail Road	Village
53. Ameer pour	Ameer pour
54. Miya wali	Miya wali pheli
55. Cotli peara Abdul Rahman Lahore	Cotli peara Abdul Rahman Lahore
56. Ghulam bhatti chandray road	Ghulam bhatti chandray road
57. Bahawal Nagher	Bahawal Nagher
58. Darham pora sadder cannt	Darham pora sadder cannt
59. Mall road	Mall road
60. Darogha Wala	Darogha Wala
61. Kazafi stadium	Kazafi stadium
62. Baba Fareed Colony Chongi Ammer Sadho Lahore	Baba Fareed Colony Chongi Ammer Sadho Lahore
63. Butt Chok Chongi Ammer Sadho Lahore	Baba Fareed Colony Chongi Ammer Sadho Lahore
64. Mustafa Colony Chongi Ammer Sadho Lahore	Baba Fareed Colony Chongi Ammer Sadho Lahore
65. Mustafa Colony Chongi Ammer Sadho Lahore	Mustafa Colony Chongi Ammer Sadho Lahore
66. Hejjarr wala	Hejjarr wala
67. Khot Radho	Khot Radho
68. Awan chok Lahore	Awan chok Lahore
69. Green town Lahore	Green town Lahore
70. Baba Fareed Colony Ammer Sadho Lahore	Nawaz Shareef Hospital Multan Chongi Lahore
71. Phool Nagar Lahore	Phool Nagar Lahore
72. Baba Fareed Colony Ammer Chongi Sadho Lahore	Baba Fareed Colony Ammer Chongi Sadho Lahore
73. Alia Park Shahidra Lahore	Alia Park Shahidra Lahore
74. Amima Colony Hussain Chok shahidra Lahore	Amima Colony Hussain Chok shahidra Lahore
75. Amima Colony Hussain Chok Shahidra Lahore	Amima Colony Hussain Chok Shahidra Lahore
76. Batt Chok Chongi Ammer Sadho Lahore	Batt Chok Chongi Ammer Sadho Lahore
77. Umamia colony	Umamia colony
78. Kakkar chowk mohalla lahore	Kakkar chowk mohalla
79. Ali park	Ali park

Union Council	Town/Village
80. Kakkar chowk mohalla	Kakkar chowk mohalla
81. Nashtar colony	Nashtar colony
82. Multan chungi	Multan chungi
83. Gulab dewi	Town
84. Shadbagh	Shadbagh
85. Shadbagh	Shadbagh
86. Chongi Amar Sadu	Chongi Amar Sadu
87. Pattoki chak but treated in Lahore	Pattoki chak but treated in Lahore
88. Gulberg	PMC
89. Gulberg	PMC
90. Gulberg	PMC
91. Ghazi road	General Hospital
92. Ghazal road	General hospital
93. Ghazi road	General hospital
94. Ghazi Road	General hospital
95. Shadbagh	Shadbagh
96. Johar town	Johar town
97. Shadbagh	Shadbagh
98. Shahdra	Shahdra

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