Exploring the Role of Education and Health in Promoting Sustainable Development in ICT, Punjab & KPK: A Case Study of Human Development Foundation Pakistan

RESEARCHER

Muhammad Saud

182-FSS/MSSOC/F14

SUPERVISOR

Prof. Dr. Saif Abbasi

DEPARTMENT OF SOCIOLOGY

FACULTY OF SOCIAL SCIENCES

INTERNATIONAL ISLAMIC UNIVERSITY

ISLAMABAD

2017

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Researcher

Muhammad Saud

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Submitted in partial fulfillment of the requirements for the award of MS degree in Sociology in the Department of Sociology, Faculty of Social Sciences, International Islamic University Islamabad.

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2017

In the Name of Allah The Most Gracious &

The Most Merciful

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FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF SOCIOLOGY

It is certified that thesis submitted by Mr. Muhammad Saud Registration No. 182-FSS/MSSOC/F14 **titled** ***"Exploring the Role of Education and Health in Promoting Sustainable Development in ICT, Punjab and KPK: A Case Study of Human Development Foundation Pakistan"*** ***has*** been evaluated by the following viva voce committee and found that thesis has sufficient material and meets the prescribed standard for the award of **M.S** degree in the discipline of Sociology.

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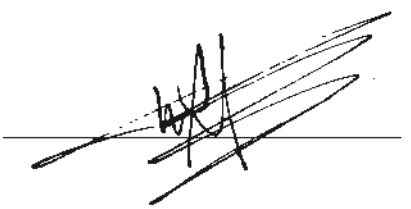
Prof Dr. Saif Abbasi



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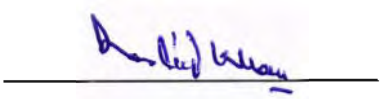

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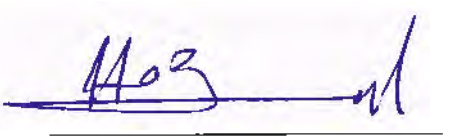

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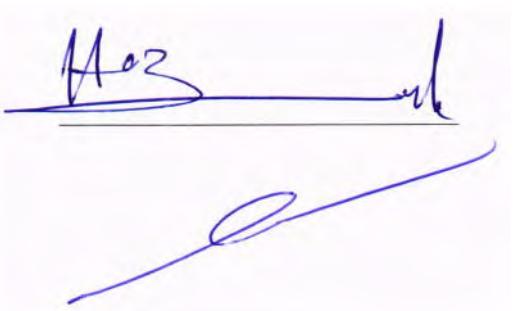

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Dedication

This piece of work is dedicated to

My beloved parents

Mureed Hussain

&

Farzana Parveen

Thank you for your Love, the Freedom you gave me and teaching me to believe in Allah Almighty, in myself and in my dreams

Muhammad Saud

Table of Contents **Page No.**

Acknowledgements

I am thankful to Allah Almighty for providing me enough strength to complete useful piece of writing. All the respect is for Holy Prophet Muhammad (PBUH) for enlightening our lives with the precious and incredible belief in Allah.

I am grateful to my supervisor Prof. Dr. Saif Abbasi who guided and encouraged me through every corner of difficulty that I faced during my research and throughout my university education. He motivated me in studies as well as guided me in my personal matters. I am also indebted to all the faculty members of Department of Sociology IIUI for their support. This research would not have been possible without the co-operation of all those who helped me. I would like to thank them all who facilitated me. I would like to record a debt of gratitude to my Mother for her continued dedication throughout the period of my postgraduate studies. I am grateful to my family and friends who supported & encouraged me to accomplish this research.

Last but not the least; I feel pleasure to express my gratitude to the Human Development Foundation, its regional heads and supporting staff for their help in data collection from fields of respective regions. To my friends, Mr. Zaheer Abbas (PhD Scholar & Visiting Lecturer, International Islamic University Islamabad) and Mr. Asim Muneeb Khan, Cluster head (Sociology & Anthropology) Bahria University Islamabad. I owe a very special thanks to person who made this road of success easy for me through her intense love care and encouragement. I wish to extend my heartfelt thanks to all of you for your unending support throughout this academic pursuit and your belief in my abilities.

Muhammad Saud

Abstract

Sustainable Development is one of the key areas for the researchers in modern age. The present study was aligned with the contemporary debate on sustainable development goals set by the United Nations in 2015. This study was conducted to explore the role of education and health programs in promoting sustainable development particularly in Human Development Foundation (HDF) communities. The purpose of the present study was to know the point of views of the families benefiting from educational institutes established by HDF and to explore the availability and use of HDF Pakistan health care services by the respondents in the study area. Quantitative design was opted for the research and simple random sampling technique was used to draw the sample from population. In order to conduct the study, those parents whose children are getting educational (enrolled in HDF formal schools) and health services provided by HDF were selected as the respondents. A sample of 398 respondents was taken from three regions namely; Islamabad, Lahore & Mardan. The study found that HDF is playing a vital role in providing both health and education facilities in its related communities that benefit and enrich the Pakistani health and education sector in general and the communities' health and education in particular. The schools and the community health centers of HDF are utilized by the people of those communities at a larger level. HDF health centers are helping to reduce infant mortality by providing adequate maternal child health care services. HDF has strengthened the communities in different regards through its awareness raising campaigns. The study also showed that the parents of school going children and patients showed a higher level of satisfaction from HDF programs and agreed that HDF was promoting sustainable development in those areas. The study also gives some recommendations.

LIST OF TABLES

PAGE

CHAPTER ONE

INTRODUCTION

Background of the Study

Development has taken a significant place in today's globalized world. Every nation is focusing on it and it has divided some states into developed while others are developing. The developing nations have imperative need of devising different strategies to reach at the stage of development. Sustainable development is one of the strategies through which developing and underdeveloped nations are fulfilling their needs.

> Sustainable development is a development that meets the needs of the present without compromising the ability of future generations to meet their own needs.
>
> (Brundtland Commission of the United Nations 1987)

Sustainable development or sustainability is not a new idea. It is deeply rooted in the cultures of the Asia Pacific region under different forms and names. It means caring for not one's own self only, but for our children and their children as well. The world in which we live in must be a better place while leaving it for our children. So, in brief, sustainable development means living well within the provided means (Bhandari and Abe, 2003).

Sustainability of any community depends on the creation and promotion of its economic &environmental health protection which fosters social justice as well as promotes greater citizen participation in planning and implementation. Communities which involve their citizens and institutions to develop the principles of sustainability and

a common future vision and application of an integrated approach to environmental, economic and social objectives are more successful in the rule (Basiago, 1998).

Thus, sustainable communities are the communities basically planned to promote, built or modify sustainable existence. Sustainable communities are inclined to bring attention towards economic and environmental sustainability, social justice, health care facilities, educational services, urban infrastructure and municipal administration. It is shown that a number of factors are being mulled over for developing sustainable communities in which health and education are provided with the greater importance (Basiago, 1998).

For over half a century education has been recognized as fundamental right by the international community of nations. In 2000, Millennium Development Goals (MDGs) also recognized education as the necessary means for people to realize their potential and priorities for completion of the primary school cycle (Aslam, 2013).

Education is considered humanity's best hope and most effective in the pursuit of sustainable development. Everyone has a desire to lead a happy and safe life in the future. Sustainability is related to education, or to have necessary tools to sustained life. Education for Sustainable Development (ESD) in the early years is significantly under-implemented, with limited resources and under interrogation even young children are going to suffer the consequences of our actions and inactions associated to sustainable development (Davis, 2008).

Education for Sustainable Development (ESD) is a vibrant notion which basically aims to enable the people of all ages and all walks of life to pursue and benefit from a

sustainable future. Education is the key to the formation of values and behavior in order to lend a hand and ensure sustainable development through the acquisition of knowledge, skills and capabilities. Moreover, quality education meets the needs of individuals, giving them their own voice and the ability to use their potential to the fullest (Aslam, 2013).

A favorable relationship between sustainable development and education as one of the important indicators of sustainable development is clearly demonstrated in Agenda 21, which was adopted by 178 countries at the United Nations Conference on Environment and Development (Grubb & Grubb, 1993). In the Agenda 21, great importance is given to education where chapter 36, one of the most important parts of Agenda 21, stated education as decisive for achieving sustainable development.

ESD requires that all must work together for achieving the sustainable development by providing education which is a lifelong learning process and takes place in a formal, informal and non-formal setting, as well as in the society at large. Through ESD we can make real progress towards a more sustainable world. Most of the world's poor, often living in rural areas are among those who are most in need of information to help improve their lives. While education can help improve their agriculture and living conditions, people in rural areas have far less access to education than in urban dwellings (UNESCO, 2010).

Sustainability is a process of continuous improvement for the community to constantly evolve and change in order to achieve their goals. Initiatives and resources that are taken in this process are selected so as to make healthier, safer, greener, more livable and more prosperous community (Dixon, and Fallon, 1989)

Children are at the heart of sustainable development, as they are the future of any nation. Well-behaved, safer and healthy children are the foundation for a prosperous and just society, appropriate management of its natural resources and its sustainable growth. A society can be developed on sustainable basis only if the basic needs and rights of children, especially the poorest and most vulnerable segments of the population are met. A sustainable society is the one in which every child both the current generation and the future, and from an early age has better access to safe environment, clean water, healthy nutrition and medical care where he can better participate and learn without violence, pollution and disaster risks (UNICEF, 2013).

By its very nature, health is also basic human right, but it is also critical to achieve in this mainstay of sustainable development. The national aspirations for economic growth cannot be achieved without a healthy and productive population. Thus for economic benefits, the health and its value in the resulting goals is an important catalyst for development, and known as the heart of the MDG. Infant and maternal mortality has become a measure of the overall development of the nation along with the eradication of poverty, empowerment of women and environmental sustainability. At the same time, it was recognized that the fight against HIV/AIDS and reduced burden of TB and malaria is essential to human progress because these diseases disproportionately affect the development potential of dozens of countries (Assembly, 2013).

Basiago (1998) stated that in sustainable community development where the communities get the chance of being empowered. Community empowerment refers to the process of creating the conditions for communities to increase control over their lives. "Communities" are groups of people who may or may not be spatially connected but who

share common interests, concerns or identities while the success of sustainable communities depends on the commitment and participation of their members by:

i. An active, organized, and informed citizenship.

ii. Empowered, efficient and responsive management.

iii. Responsible, care and healthy public institutions, services and companies.

Therefore, in order to achieve sustainable development, everyone must be active and be provided with the resources to meet their needs. The social sustainability enables the people to maintain the quality of life. Social sustainability involves the protection of the mental and physical health of all stakeholders, fostering communities, corresponding to all stakeholders fairly, and the provision of basic services. It is also important that essential services must be delivered effectively to all who need them (Basiago, 1998).

Sustainable Development in Global Context

Sustainable development is a holistic approach to improving the quality of life. The study suggested that there are internal connections between the economic, social and environmental wellbeing. Changes in any of the approaches will ultimately have an effect on the other two dimensions (Mushtaq & Azeem, 2012). Thus, particularly from a social point of view, human wellbeing cannot be sustained without a healthy environment and are equally unlikely in the absence of a dynamic economy. Pearce and Warford (1997) noted that sustainable development requires an increase in capital goods, i.e. industrial capital, human capital, education and care for people and environmental capital.

Hanley (2000) has defined sustainable development in different ways, but the general consensus which is understood is that sustainable development requires a non-decreasing echelon of prosperity for future generations. Sustainable development is a pattern of growth in the use of resources aimed at meeting human needs while preserving the environment so that these needs can be met not only for the present but also for future generations.

According to UNESCO (2011), sustainable development means the right to development and it basically implies the right to improve the social, economic, political conditions and cultural traits. To improve the overall quality of life is the introduction of changes, which guarantees everyone a decent way of living or the way of living in a society which gives respect and helps all in realizing human rights. These changes should include eradicating and combating pervasive poverty, unjust social condition, unemployment, illiteracy, poor health and poor sanitation.

Sustainable development ensures a better way of living to human beings in the way by integrating social development, environmental protection as well as economic advances. It further implies that the basic needs of people can only be met through the better realization and proper implementation of human rights. Basic needs of individuals of any community include food, proper housing, better education, good healthcare, right to employment and fair share in the income. Moreover, social development also promotes democracy in order to engage the public in the formulation of policies, as well as to create conditions for good governance and accountability. This makes capacity building specifically for sustainable communities (Blaas & Nijkamp, 1994).

Social development works to empower the poor by expanding the use of available resources in order to meet their own needs and to change their lives. Particular attention is paid for ensuring equitable treatment to women, children, and people of the local culture, persons with disabilities, and all members of the population who consider themselves most vulnerable towards poverty (Blaas & Nijkamp, 1994).

The World Summit for Social Development (2005) identified three major areas for sustainable development; economic development, social development and environmental protection as contributing to the philosophy of social sciences and sustainable development. These "pillars" in many of the national standards and certification systems form the basis of the solution of the main areascurrently facing the world. We must think about the future and then make our decisions about the present.

The economic development of people is about what they want, without compromising the quality of life especially in developing countries and reduces the financial burden and "red tape" of doing the right thing (Holmberg & Sandbrook, 1992).

There are many facets of the second component; which is social development, the focus of this study. The most important thing is the awareness, legislation and the protection of human health from the pollution and other harmful activities of companies and other organizations. In North America, Europe and the rest of the developed world, there is a strong management and law programs for ensuring the health and welfare of people. It is also about maintaining access to basic resources without compromising the quality of life (Holmberg & Sandbrook, 1992).

The final element is education to encourage people to participate in social and environmental sustainability and teach them about achieving objectives (Holmberg & Sandbrook, 1992). During the last decade, the experts of development field have made efforts to help rural schools in order to better meet the growth and survival needs of their communities (Miller, 1991; Israel, Coleman & Ilvento, 1993; Nachtigal, Haas, Parker & Brown, 1989; Spears, 1990).

We all know what need to do to protect the environment such as recycling, reducing energy consumption by switching off electronic devices rather using standby, walking short distances instead of taking the bus etc. Protecting the environment is the third pillar, and the major concern of the future of mankind. It defines how we should study and protect ecosystems, air quality, integrity and sustainability of our resources and focuses on elements that emphasize the environment (Holmberg & Sandbrook, 1992). It also refers to how the technology will stimulate our green future. EPA acknowledged that the development of technology is the key to sustainability and environmental protection in the future for any damage that technological advances could potentially bring.

In addition to the understanding the relationship between economic, social and environmental spheres, the question whether certain social activities are more in line with the concept of sustainable development than others arises. Although there is no definitive answer it seems there are some key areas that arise in the studies and interpretation of the concept. These include poverty reduction, social investment and the construction of safe and supportive communities.Education is the main form of social investment; it is also the main way to reduce poverty around the world. Actual data on population growth indicates that education level and fertility rates are inversely related; the highest levels of

education, generally correlated with fewer children (Pearce, Barbier & Markandya, 2013).

Education and training are essential for the economic health of individuals and peoples. In order to compete in a rapidly evolving knowledge based economy, both developed and developing countries have to invest heavily in education, training and skills (Thurow, 1999; Betcherman, McMullen & Davidman, 1998). A higher level of education is associated with an increase in labor productivity and the ability to generate higher incomes. This is the basis for the reasonably informed civilian population, which comprises the foundation of democracy.

Canada has made significant investments in health care, supporting the Medicare system with public funds. Despite this support the system faces serious problems and requires both structural and financial reform. But health is only partially achieved through the provision of medical services, which are essentially a form of recovery. Promotion of health is equally important especially in prenatal and postnatal care as both are based on the assumption, a healthy environment clean water and air, healthy food and adequate shelter. In addition to investments in health benefit of the entire population, there are important social investments which should be made at certain stages of the life cycle, especially in early childhood. There is ample evidence that early childhood investment is reaping important benefits in general health and wellbeing in old age (McCain and Mustard, 1999).

Sustainable Development in Pakistan

Sustainable development in Pakistan is defined as a model of development that allows future generations of Pakistan to live at least as well as the current generation. In the early stages of the Pakistani economy and ultimately with the passage of time, there was improvement in the various assets and also were the steps of successive governments in relation to the stability of Pakistan's economy.

In particular, since 1990, the National Strategy for the Conservation and over the past ten years, the total consideration of capital depreciation, particularly environmental accounting is considered in the development process that is damage to terrestrial ecosystems, the depletion of natural resources, destruction of forests, which is a serious threat to the wider range of plant and animal species, as well as environmental pollution. This environmental pollution ultimately harms the health of general masses. In addition, since 1990, Pakistan has focused four additional priorities to some extent in promoting sustainable economic development especially in recent years and current planning of the government strategy for the sustainable development of Pakistan is to address this issue at the national level (Khan, Awan & Khan, 2012).

Many countries have realized the need for education for sustainable development, but it is unfortunately very limited in Pakistan because of the false concept of sustainable development and also the lack of progress, for example lack of vision or understanding or lack of policy or funding. Pakistan is the sixth most populous country in the world, and in accordance with the State Bank of Pakistan in its annual report 2009, poverty and illiteracy are obstacles to sustainable development. There is an urgent need to work on that. In order to bring the awareness among masses education can also play an important

role. Government and various development agencies are doing their best for the welfare of the population and to make the economy of Pakistan strong. Even more efforts are needed to provide better living conditions for the population to provide clean drinking water and to provide a higher level of education (Mushtaq & Azeem, 2012).

Pakistan's economy has shown positive signs of growth and development since 1947. The country's economy has been facing multidimensional problems over sixty-nine years of age. To overcome these various problems a number of areas in the field of sustainable development are one of these programs on which state functionaries work (Khan and Sasaki, 2001).

Sustainable development in Pakistan is conceptualized as only to monitor the general state of fixed assets after independence since 1947, when the British government has divided the region into two successor states i.e. India and Pakistan. Pakistan had backward economy including major sectors of economy as agriculture, industry and services (Aslam, 2013).

Institutions in Pakistan have become the custodian of environmental protection and civil society and the media has assumed the supervisory role. Government agencies, non-governmental organizations and the media have made considerable efforts to raise awareness among all sectors of society. The most significant achievement of 2001 and 2002 was the inclusion of environmental issues in public policies and initiations of EIA in development plans (Rex and Singh, 2003).

As development agents, non-governmental organizations (NGOs) have become the main service providers in countries where the government is unable to fulfill its

traditional role. In the education sector, many NGOs have gone beyond "addressing gaps" into the activities of capacity-building initiatives. NGOs are increasingly involved in capacity building. As development discourse builds on the development of skills and tools to strengthen society NGOs reacted accordingly (Ulleberg, 2009).

Development NGOs intend to work on economic, social and political development in developing countries. Norwegian bilateral aid to the Norwegian Agency for Development Cooperation (NORAD) (2004) defines development oriented NGOs as organizations that "attempt to improve socio-economic and operational conditions, both in the form of small community based organizations at the village and district level, as well as large professional development agencies at the state or national level" (UNESCO, 2004).

Sustainability can be grey and boring but this achievement is the biggest challenge for all of us today. Provision of education and better health is one way to get rid of developmental differences to help alleviate poverty, and is a prerequisite for the creation of a sustainable society as well (Ratcliffe, 1978).

From the above evidence it can be stated with certainty that the aspect of social investment is largely ignored in Pakistan which is the key to sustainable development. Taking into account the importance of health and education in Pakistan's current scenario, where the proportion of child drop out is being neglected as well as human health remains alarming. Thus, this study has put an effort in this regard to show how NGOs which are considered as key players in today's world have contributed in developing the sustainability of people in particular communities (Aslam, 2013).

Statement of Problem

Different non-governmental organizations are working for the purpose of development, so this study was an attempt to see the real picture whether these organizations are contributing in the process of community development or not. The present study tried to analyze the role of education and health in the sustainable development among HDF communities. It further found out the provision of different educational and healthcare facilities with regard to sustainable development.

Research Objectives

- To find out the socio-economic and demographic profile of the respondents
- To study the family benefiting from educational institutes established by Human development foundation (HDF) Pakistan.
- To explore the availability and use of Human development foundation (HDF) Pakistan's health services by the respondents in the study area.
- To explore the role of Human Development Foundation in promoting sustainable development among their communities.
- To suggest appropriate policy measures for strengthening sustainable development among communities in Pakistan.

Hypotheses

- There is an association between educational facilities and sustainable development.
- There is an association between health care facilities and sustainable development.

Research Questions

i. What are the socio-economic and demographic characteristics of the respondents?
ii. How families are being benefited from educational institutes established by Human development foundation (HDF) Pakistan?
iii. How families are being benefited by the use of Human development foundation (HDF) Pakistan health services in the study area?
iv. How HDF is playing its role in propping up sustainable development among communities?

Significance of the Study

Sustainable development is a broader discipline which provides insights into diverse facets of the human world from business to technology to environment and the social sciences. It has long-term potential and is the only way forward for a growing world economy. Over enough time, it will no longer be an option for people who want to have good life rather will be the need.

Therefore, this research attempted to highlight those aspects of sustainable development, on which different organizations are putting their efforts. It tried to fill the gap between theory and practice as theoretically, a lot of work has been done but this research has seen whether the communities are getting facilities in reality or not. This research is a valuable contribution for prospective researchers, academician, policy makers, HDF senior management and most significantly the stakeholders of this issue; the communities.

Conceptualization and Operationalization

Indicators of independent variable:

i) Education:

Education is defined as:

a) The action or process of educating or of being educated; also a stage of such a process.

b) The knowledge and development resulting from an educational process.

c) The field of study that deals mainly with methods of teaching and learning in schools.

In present study, the effect of education on sustainable development has been measured through primary enrollment, quality of education, availability of books material, schools and teachers, monthly follow ups (students and teachers), capacity building and training programs for teachers, co-curricular activities, civic sense awareness, fee structure and facilities.

ii) Health:

Health is defined as:

a) The condition of being sound in body, mind, or spirit; especially : freedom from physical disease or pain

b) The general condition of the body.

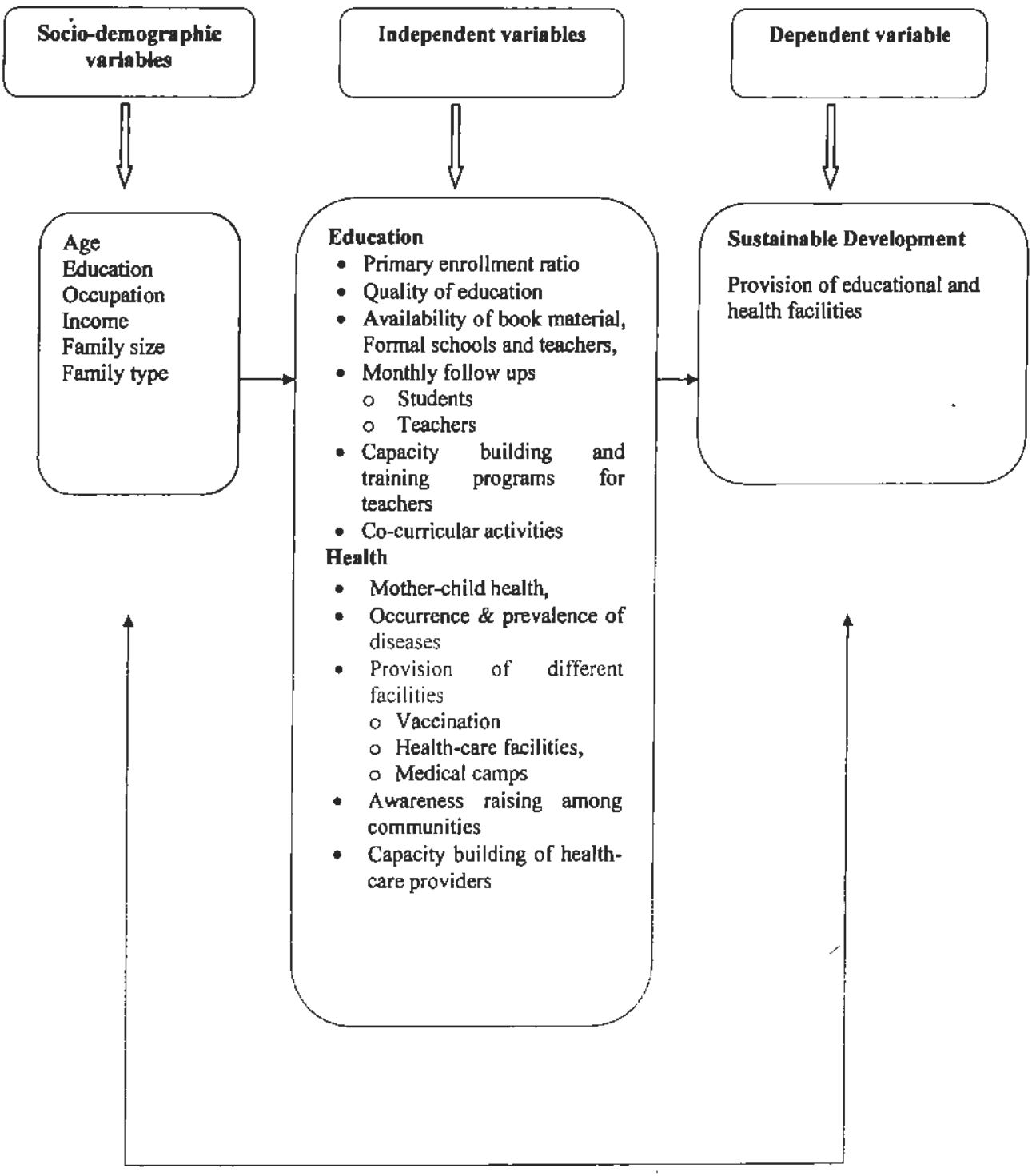
c) Flourishing condition: well-being or general condition/ state.

In present study, the effect of education on sustainable development has been measured through different indicators as mother-child health, occurrence & prevalence of diseases,

provision of vaccination and health-care facilities, medical camps unit, awareness raising among communities, capacity building of health-care providers.

Dependent variable: Sustainable Community Development (Provision of educational and health facilities)

CONCEPTUAL FRAMEWORK



CHAPTER TWO

LITERATURE REVIEW

Sustainable development is an all-encompassing way to deal with the ways which enhances the personal satisfaction. It hypothesizes that there are natural connections among financial, social and ecological prosperity. Changes in any one space will have an effect upon the other two measurements. From a social point of view specifically, human prosperity can not be maintained without a solid situation and is similarly far-fetched without a dynamic economy (Torjman, 2000).

Destitution decrease is an essential goal of practical development. This objective emerges from notices by the United Nations which distinguished destitution as the "best danger to political security, social attachment and the ecological soundness of the planet" (United Nations Development Program, 1992). Destitution is both brought on and exacerbated by the unequal circulation of land and different assets and resources (World Commission 1987).

Poverty can decrease destitution in a few ways (Torjman, 1998). Communities can address fundamental issues by guaranteeing that their individuals are satisfactorily supported, housed and shielded from viciousness. Communities can expel hindrances that counteract support in preparing programs, the work showcase and more extensive capacities, for example, recreational and social occasions. They can handle destitution by building dialect, instructive and work abilities. Social venture is essential to financial development; a lively economy requires a solid and taught workforce. Canada has been positioned close to the highest point in the world with regard to development. In any case, the World Bank observes that the future accomplishment of nations depends upon

how much they place assets into HR (World Bank 1998/99). Two critical districts for social wander are prosperity and guideline.

Canada has made generous interests in wellbeing by supporting a freely financed Medicare framework. In spite of this support, the framework faces genuine difficulties and requires both basic and financing change. Be that as it may, wellbeing is achieved just halfway through the arrangement of social insurance administration which basically is a type of remediation. The advancement of wellbeing is similarly imperative especially in the territories of pre-birth and postnatal care. Furthermore, neither social insurance administrations nor wellbeing advancement can meet their separate targets alone. They are both introduced upon a solid domain clean air and water, a protected sustenance supply and satisfactory lodging (Canada Royal Commission on Health Services, 1964).

In addition to investments in health that benefit the entire population, there are crucial social investments to be made at certain stages of the life cycle, notably during early childhood. There is ample evidence that investment in early childhood reaps substantial returns in overall health and wellbeing later in life (McCain & Mustard, 1999).

Over the span of development, few procedures are as interlaced with financial development as human capital gathering. Tutoring makes specialists more profitable, rates the advancement of new innovations, and better prepares guardians to bring up talented youngsters, all of which advance financial development (Björklund & Salvanes, 2011; Lindahl & Krueger, 2001).

Human capital is a major concern of development. The immovable part of human capital is not constrained to total pay development. Education shows complex element

associations with a few segments of prosperity, including health. For instance, education influences health in adulthood; future influences educational interest in youth; and the health and education of guardians especially mother influences both results in their youngsters. Similarly, as with salary, these connections are probably going to be particularly vital in creating nations, where levels of both tutoring and health are low however, have risen quickly over the past half-century (Becker; Philipson & Soares 2005; Barro & Lee, 2011).

Education

Education is fundamental to development and growth. The human personality makes conceivable all improvement accomplishments, from health progress and agrarian advancements to proficient open organization and private part development. For nations to receive these rewards completely they have to unleash the capability of the human personality. And there is no preferable apparatus for doing as such over education (McDowell, Wakelin, Montgomery & King, 2011).

Education, or the transmission, acquisition, creation and adaptation of information, knowledge, skills and values, is a key lever of sustainable development. This is based on a vision of inclusive societies in which all citizens have equitable opportunities to access effective and relevant learning throughout life delivered through multiple formal, non-formal and informal settings. As such, education is essential to individuals' development as it is to the development of their families of the local and national communities to which they belong and to the world at large. As a fundamental

human right enshrined in a number of international normative frameworks[1], and built into most national legislation[2], the right to education is to be seen as an enabling right for the realization of other economic, social and cultural rights, as well as a catalyst for positive societal change, social justice and peace[3].

It has been archived that there is sure effect of fundamental education on different features of social and financial advancement (UNESCO, 2005). It is entrenched that education is a critical impetus for accomplishing all advancement objectives. It has been perceived that, inside the MDG structure, there is "an interconnectedness of all advancement objectives with key linkages among education, health, destitution decrease, and sexual orientation uniformity, where change in one territory positively affects the others" (Quisumbing, 2010).

Surely, similarly that education impacts health, need diminishment and end of appetite, and on sexual orientation balance each thus, positively affects education. More elevated amounts of more applicable learning results are in this way both a condition for, and in addition an aftereffect of advance in other social parts (Quisumbing, 2010).

The author developed his argument on the relevance of early childhood education for a sustainable society. The starting point is the importance of the first years of a human being in constructing the basis of the personality, the qualities and demeanors that will direct musings, sentiments and conduct of individuals for whatever is left of their life. At

[1]Foremost among these international normative frameworks are the Universal Declaration of Human Rights (art. 26), the International Covenant on Economic, Social and Cultural Rights (art. 13), as well as the Convention on the Rights of the Child (art. 28).

[2] An estimated 90 percent of all countries have legally-binding regulations requiring children to attend school (UNESCO Institute for Statistics, 2009).

[3]Drèze and Sen (1995), India, Economic Development and Social Opportunity, Delhi: Oxford University Press.

that point, he contends that youth are extremely delicate, intrigued and inquisitive about the components of nature, and attests that early adolescence education, from its initial start ought to incorporate into the program inventive encounters and exploratory exercises with components, for example, plants, blooms, seeds, water, fire and wind. As of late, educators and youngsters in education and care focuses have been examining and watching ecological issues. The article finishes up calling the consideration of political and educational powers to the significance of taking choices that consider kids as natives fit for contributing essentially towards a maintainable society and environment (Didonet et al., 2014).

Kagaland Abelson (2010) contended that one compelling approach to build an equitable and economical world is to focus on early adolescence to guarantee satisfactory look after of all kids and to show them the sorts of learning, aptitudes and values, for example, compassion, sharing, regard for others, adore for nature that advance supportability from an early age. Recommending a few components of early youth education that adds to building a reasonable society the review likewise called attention to the significance of establishing the related endeavors in the nearby substances utilizing diverse formal, casual and non-formal settings; reorienting the program content towards maintainability; guaranteeing strong health, social, monetary and work approaches for youngsters and their families; fashioning organizations; and putting resources into all zones of education comprehensively, including early adolescence, essential, auxiliary, grown up and proficiency education.

Sustainable development with respect to people is both an essential for empowering individuals to live amicably together on the planet and a sacred right. Early

adolescence training ought to have a critical influence in building a feasible society since it can be viewed as a first stage in encouraging a practical way of life, regarding others and building up a non-ethnocentric observation. It is especially essential to teach youngsters who are from underdeveloped spots. In this way the grant sketched out some methodologies, for example, making vote based environment and regard for individual contrast to youngsters' reasonable instruction and the difficulties including low kids enlistment proportion, in-successful technique for educating, conventional model of educating and learning in underdeveloped locales (Qemuge, 2008).

Kwon, Kam and Park (2000) portrayed the biological and social parts of early adolescence instruction for supportable development in the Republic of Korea. Most kindergarten instructors still utilize formal, data situated strategies to educate about the earth. Interestingly, a case of an eco-focused early youth training preschool is given and its connections with conventional thought and life believed are called attention to. The review proposed that an ease back pace way to deal with learning in close contact with nature and living things is the correct approach to make youngsters mindful of their duty to cooperate for maintainable development.

The World BankEducation Strategy emphasized several core ideas: Invest early. Invest smartly. Invest in learning for all (King, 2011).

In the first place, foundational abilities procured ahead of schedule in adolescence make conceivable a lifetime of learning. The conventional perspective of training as beginning in elementary school responds to the call past the point of no return. The study of mental health demonstrates that adapting should be empowered early and regularly, both inside and outside of the formal tutoring framework. Pre-birth wellbeing and early

youth development programs that incorporate training and wellbeing are subsequently essential to understand this potential. In the essential years, quality instructing is fundamental to give understudies the foundational education and numeracy on which long lasting learning depends. Youthfulness is additionally a time of high potential for adapting, yet numerous young people leave school now, attracted by the possibility of an occupation, the need to help their families, or dismissed by the cost of tutoring. For the individuals who drop out too soon, additional opportunity and non-formal learning openings are fundamental to guarantee that all adolescent can get aptitudes for the work advertise (Jones, 2007; Fuller 1986).

Second, getting results requires smart investmentsthat is, investments that prioritize and monitor learning, beyond traditional metrics, such as the number of teachers trained or number of students enrolled. Quality should be the concentration of training speculations, with learning picks up as the key metric of value. Assets are excessively restricted and the difficulties are too huge to plan strategies and projects oblivious. We require prove on what actually works so as to contribute intelligently (Jones, 2007; Fuller 1986).

Third, learning for all means ensuring that all students and not just the most privileged or gifted, acquire the knowledge and skills that they need. Major challenges of access remain for disadvantaged populations at the primary, secondary and tertiary levels. We must lower the barriers that keep girls, children with disabilities, and ethno-linguistic minorities from attaining as much education as other population groups. "Learning for All" promotes the equity goals that underlie Education for All and the MDGs. Without

confronting equity issues, it will be impossible to achieve the objective of learning for all (Jones, 2007).

There has been quick advance made in extending access to formal essential training around the world, noteworthy imbalances between nations hold on, and national midpoints in numerous nations keep on masking striking disparities in levels of instructive achievement and results. Conventional components of underestimation in training, for example, sex and urban/rustic living arrangement keep on combining with pay, dialect, minority status, HIV and AIDS, age (especially on account of youthful pre-adult young ladies), and inability, to make "commonly fortifying drawbacks", especially so in low salary and strife influenced nations (UNESCO, 2011).

With the developing salutation of the difficulties of "coming to the unreached", there is a need to better adventure more disaggregated information, (for example, family unit, wellbeing and work review information) keeping in mind the end goal to better recognize purposes behind prohibition or withdrawal from formal and non-formal learning openings, in perspective of setting up more focused on procedures for the most helpless kids, youth and grownups. This has led some countries, in order to reach the hard to reach children, to include education as an integral part of social protection programs.

The expansion in access to basic formal education has also resulted in a shift from a quantitative focus on access and participation in formal education to a concern with qualitative aspects and the results of learning and their social distribution.The expansion of access to essential (primary) training has additionally brought about the acknowledgment of a developing interest for optional and tertiary instruction and expanding sympathy toward professional abilities development, especially in a setting of

developing youth unemployment. To be sure an excessive number of youngsters and grownups are right now not able to build up the abilities, learning and states of mind. They require for now quick changing advances and universe of work (Cowen, Cowen & Shenton, 1996).

This lacking access to more elevated amounts of learning is bringing about an information gap that incorporates the 'e-proficiency' crevice. The 'e-proficiency' hole is further declared between sexes, where young ladies for the most part have a lower education rate. These patterns have critical results in today's innovation driven world, where absence of ICT learning limits work openings. Notwithstanding deficient nature of learning at essential instruction, we additionally have seen little advance on other EFA objectives like early child care and education, life aptitudes and literacy. In the point of view of deep rooted learning, it is apparent that rejection from the learning procedure begins early. There is solid confirmation that nourishment and intellectual incitement in the early years of a youngster's life is basic in shaping the capacity to learn sometime down the road. This is specifically applicable concerning aptitudes like inventiveness, adaptability and issues fathoming, abilities that are coming more sought after in the information economy. In numerous nations an excessive number of kids are learning pretty much nothing, and youngsters leave school without having gotten basic learning aptitudes. Along these lines numerous kids and youth are avoided in light of the fact that they don't secure essential abilities like proficiency and numeracy which are basic for further learning. This has prompted to a more grounded concentrate on the nature of early instruction as an establishment for learning (UN, 2012).

Despite the centrality of instruction in settlements, pledges and understandings, the universal group has yet to perceive the maximum capacity of training as an impetus for development. While numerous national governments have expanded their dedication to and bolster for training since 2000, its accentuation among benefactors and in numerous nations stays powerless against moving conditions, budgetary and something else (EFAGMR, 2008).

Education and skills development are essential to the economic health of individuals and of nations. In order to compete in a rapidly changing knowledge-based economy, both developed and developing nations must invest heavily in education, training and skills formation (Thurow, 1999; Betcherman; McMullen and Davidman, 1998). Higher levels of education are associated with enhanced worker productivity and the ability to generate higher incomes.

Changing financial and social conditions have given information and abilities to human capital, an undeniably focal part in the monetary achievement of countries and people. Data and correspondences innovation, globalization of monetary action and the pattern towards more prominent moral duty and self-sufficiency have all changed the interest for learning. The key part of skill and information in invigorating financial development has been generally perceived by market analysts and others while the social effect of learning is similarly as critical as the monetary one. The nonmonetary comes back to learning as improved individual prosperity and more prominent social attachment, are seen by many as being as critical as the effect on work advertise income and financial development. These individual and social objectives of learning are not

really conflicting with the objective of advancing monetary execution, not minimum also adjusted, adaptable and versatile people prepared to keep learning all through life are vital for understanding the financial objectives of training (Healy & Cote, 2001).

The idea of practical development suggests that all people and areas have a duty to advance human prosperity. They are the overseers of each-others welfare much as people and all areas are viewed as stewards of the earth. Protected and minding groups begin with the resident as the base. The dynamic engagement of nationals in building sheltered and minding groups includes much more than surveying their conclusions on choice issues or welcoming them to display their perspectives at an open counsel. One way that natives connect with groups is through direct association in their organizations and exercises, for example, schools and recreational, social and ecological gatherings. Another approach to empower significant engagement is through group critical thinking (Torjman, 2000).

People's realization of sustainability development (SD) through education can improve implementation of national policies of sustainability development (SD) and society then is in a position to be reoriented to help achieve sustainability (Mushtaq & Azeem, 2012).

FNAEC (1993) coordinated their examination on rustic groups. They utilize the expression entrepreneurial social infrastructure (ESI) to depict their perspective of social capital, which includes three interrelated components. In the first place, "typical differences" alludes to a feeling of comprehensiveness, where the assorted components of the group are seen as important and important to effective groupprosperity. Second,

"asset activation" mirrors a readiness to contribute all in all and to utilize private capital locally. At long last, "nature of linkages" alludes to the systems inside and between groups that encourage data stream and quality basic leadership.

Joining these three components FNAEC (1993) gave an establishment to building applied comprehension of the vital parts that schools and youth can play in group development. Obviously, the school speaks to an essential component in the group's social capital. Again and again in any case, nearby schools see themselves just as an instructive asset for the group's childhood. Humorously, the group has for the most part been seen exclusively as an income asset for managing operation of the schools.

Health

Health is inherently important as a human right but is also critical to achieving these four pillars. National aspirations for economic growth cannot be achieved without a healthy and productive population while health benefits from economic growth its value as a critical catalyst for development led to health related goals being centrally positioned in the MDGs.

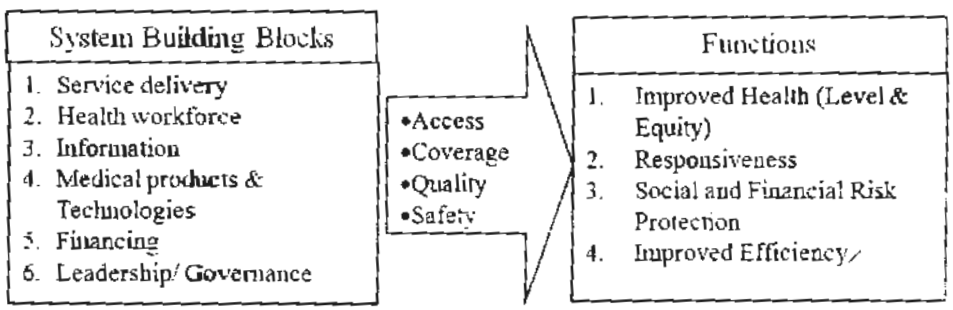


Figure: The building blocks of the health systems, aims and attributes. World Health Organization 2007

The World Health Organization (WHO) defined health systems as "all the organizations, institutions, and resources that are devoted to producing health actions" in its World Health Report of the year 2000. This definition incorporates a full scope of

players occupied with the arrangement and financing of wellbeing administrations including open, not for profit, and revenue driven private divisions, and in addition the worldwide and reciprocal givers, establishments, and the deliberate associations required in the subsidizing or actualizing wellbeing exercises (WHO, 2000).

Health frameworks are relied upon to serve the populace needs in a successful, effective and impartial way. Hence, the World Health Organization later joined the endeavors to impact determinants of wellbeing which made the wellbeing frameworks more than simply the pyramid of openly possessed offices that convey individual wellbeing administrations (WHO, 2007). In this manner, the Health frameworks are grinding away at local, provincial, region, group, and family levels, and consequently every one of these substances should be considered at all levels of talk on wellbeing frameworks fortifying. The elements of wellbeing frameworks have been portrayed most thoroughly in the World Health Report 2000 by WHO, and later explained in 2007 as appeared in Figure above.

Health System Strengthening (HSS) is defined as any array of initiatives and strategies that improve one or more functions of the health system, leading to better health through improvements in the access, coverage, quality and safety (Mills, Rasheed &Tollman, 2007). Importance of strengthening of the public, private and community health systems has been emphasized in a variety of documents by various international, regional and national bodies concerned with the health care such as WHO, USAID, Global Fund etc. Weaknesses and gaps in the health systems limit the achievement of desired outcomes from the interventions at various levels and therefore impede the attainment of the broader national and international health care goals.

Developing countries and their international partners are increasingly adopting methods of financing health care activities in developing countries that link the availability of funding to concrete, measurable results on the ground. This has been evident now over a period of many years that the public sector in Pakistan is lacking in capacity in the context of delivery and management of health services (Shaikh &Rabbani, 2004; Nishtar, 2006). Moreover, there are issues in the quality, efficiency and coverage of these services (Rizvi &Nishtar, 2008). The dynamics of health planning in the history of Pakistan have been predominantly influenced by either the strong political agendas /manifestos or by the successive military regimens, marked by corruption and poor governance (Khan &, Van den Heuvel, 2007).

The healthcare system of Pakistan has always been inadequate and inept in meeting the needs of the ever growing populace (Spears, 1990). Difficult or no access to health care services, extreme poverty, least awareness regarding maintenance of the health among the population, inadequate emphasis on addressing of the social determinants of health by the policy makers are some of the factors that worsen the situation of public health sector even more in the country. Some of the issues tend to exist for more than two decades now. One example pertains to the insufficient resources and their inefficient and ineffective use leading to an inequitable provision of quality health care services. Another one relates to the discriminatory distribution of resources to government facilities in various provinces and regions of the country (Mubarak, 1990).

Due to the multitude of reasons, the primary health care is underutilized and least productive in terms of its functions and achievement of its objectives (Ahmed & Shaikh, 2008). Maintenance of the existing infrastructure and other resources within the public

sector is another issue that has been influencing its functioning. Moreover, the public health sector has reflected the inability to cater the emerging needs for health care due to the population growth and the rising expectation on the quality of care (Rizvi & Nishtar, 2008).

An independent report recorded that the recurrence of the casual installments to the general social insurance suppliers (which ought to be free of cost) among the clients of administrations is 96% in Pakistan; a large portion of these are requests from the suppliers at the human services offices (Transparency International, 2002). Political shakiness, absence of responsibility for projects by each next government and successive exchanges of the medicinal services suppliers are further compounding the working of general society area on the loose. The exchanges of the social insurance suppliers are not need or legitimacy based; rather these happen by temperance of the political impact and 'under the table installments' in the majority of the cases (Husain, 1999).

Nonetheless, private sector has been a major contributor of the health care services in Pakistan. For financing, it is found that out of the total health expenditures in Pakistan, 33.6% is by the general government. The private expenditures constitute 64.5% of the total health expenditures in Pakistan, out of which 99.6% are the household's out of pocket health expenditures; most of which is spent on the purchase of drugs and payment of fee (Nishtar et al., 2013).

Rizvi and Nishtar (2008) stated that National Health Policy intends to shield individuals from transferable and non-transmittable infections and advance general wellbeing and better preventive and remedial wellbeing administrations. The arrangement

record distinguishes ten key ranges for accomplishing through advance in the wellbeing area:

- To decrease across the board pervasiveness of transferable sickness, Expanded Program of Immunizations (EPI), TB, intestinal sickness, Hepatitis B, and HIV/AIDS.
- To address the deficiencies in essential and auxiliary medicinal services administrations
- To expel proficient and administrative lacks in the region wellbeing framework
- To advance more prominent sex value in the wellbeing segment
- To extend the essential nourishment crevice in the objective populace, kids, ladies and defenseless gatherings
- To see urban predisposition in the wellbeing division urban modalities.
- To present required control in the private therapeutic area with a view to guarantee legitimate principles of gear and administrations in doctor's facilities, centers and research facilities and also private restorative universities and tibb homeopathic educating organizations.
- To make mass mindfulness in general wellbeing matters.
- To impact changes in the medication area with a view to guarantee the accessibility, reasonableness, and nature of medications in the nation.

Theoretical Framework

In the 1960's. social scientists became interested in studies related to the economic value of investment in education. This interest was generated by the human capital theorists' notion that the most productive course to national development of any

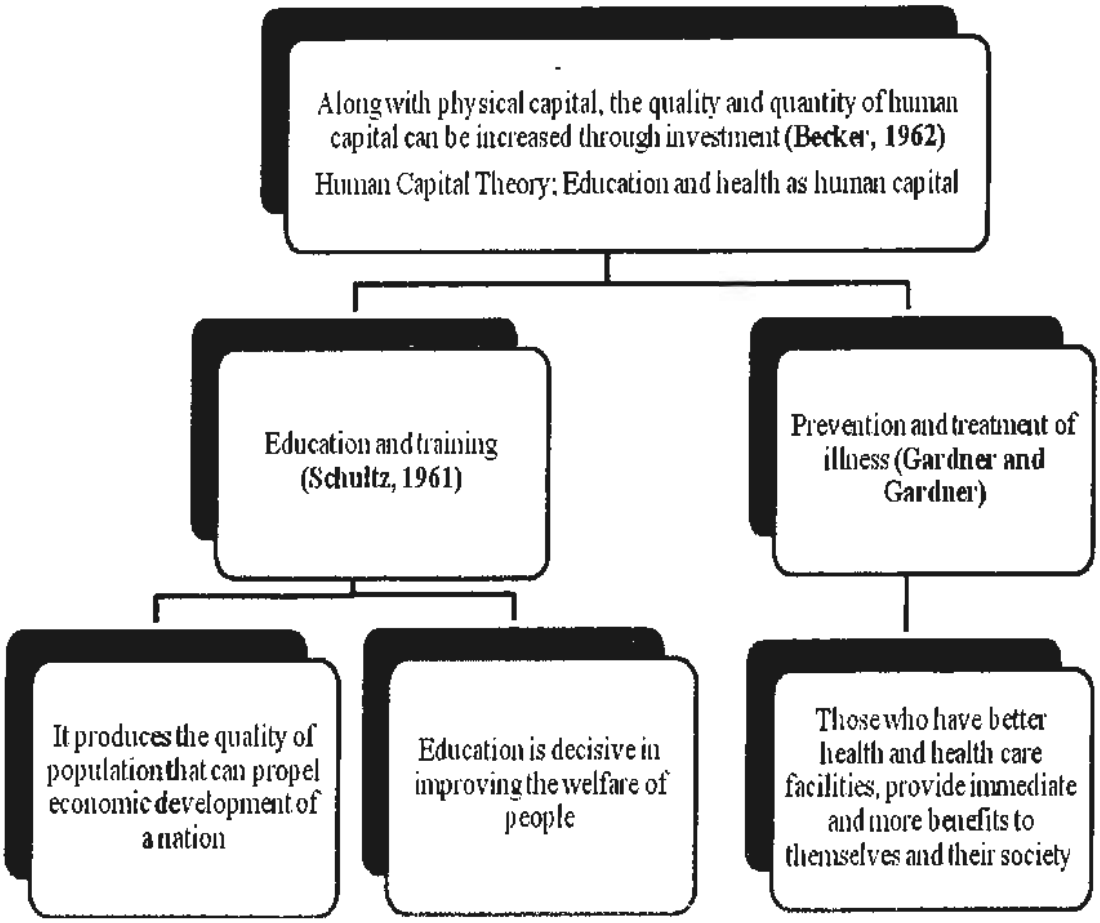
society lies in the advancement of its population that is its human capital (Schultz, 1961; Denison, 1962; Becker, 1964).

In other words, human capital theory contends that because an educated population is a productive population, education contributes directly to the growth of the national income of societies by enhancing the skills and productive abilities of employees. Human capital theorists argue that economic growth and development should only take place when technology becomes more efficient and when societies utilize human resources in the use of technology.

Human capital theorists assume that improved technology leads to greater production and that employees acquire the skills for the use of technology through formal education. Thus, when societies invest in education, they invest to increase the productivity of the population.

In his address to the American Economic Association in 1960, Theodore Schultz declared that education was a productive investment and was not merely a form of consumption (Schultz, 1961). He maintained that apart from improving individual choices available to people, education provides the category of labor force required for industrial development and economic growth.

In his book, 'Investing in people' the economics of population quality, Schultz (1981) identifies the acquired abilities of people as the most important economic resource available to societies. He maintains that human capital is decisive in improving the welfare of poor people throughout the world. Schultz maintains that education is an investment that produces the quality of the population that can propel economic development and welfare of a nation.


Along with physical capital, the quality and quantity of human capital can be increased through investment (Becker, 1962)
Human Capital Theory: Education and health as human capital
Education and training (Schultz, 1961)
Prevention and treatment of illness (Gardner and Gardner)
It produces the quality of population that can propel economic development of a nation
Education is decisive in improving the welfare of people
Those who have better health and health care facilities, provide immediate and more benefits to themselves and their society

CHAPTER THREE

Research Methodology

Nachmias and Nachmias (1987) defined methodology as a system of explicit rules and procedures upon which research is based and against which research claims for knowledge are evaluated. The purpose of methodology is to describe and explain research design and techniques of research as Merton (1957) referred methodology as the logic of scientific procedure. Social sciences use various methods of empirical investigation and critical analysis to develop and refine a body of knowledge about human social activity. Sociology is methodologically a very broad discipline and applies both qualitative and quantitative research methods for the understanding of human phenomenon.

This chapter describes in detail the various steps that were undertaken to conduct the research work, while keeping in mind the objectives of the research. This study is based on quantitative research methodology to get deep insight of the phenomenon. The researcher used this because of maintaining both objectivity as well as subjectivity of the present study.

3.1 Universe

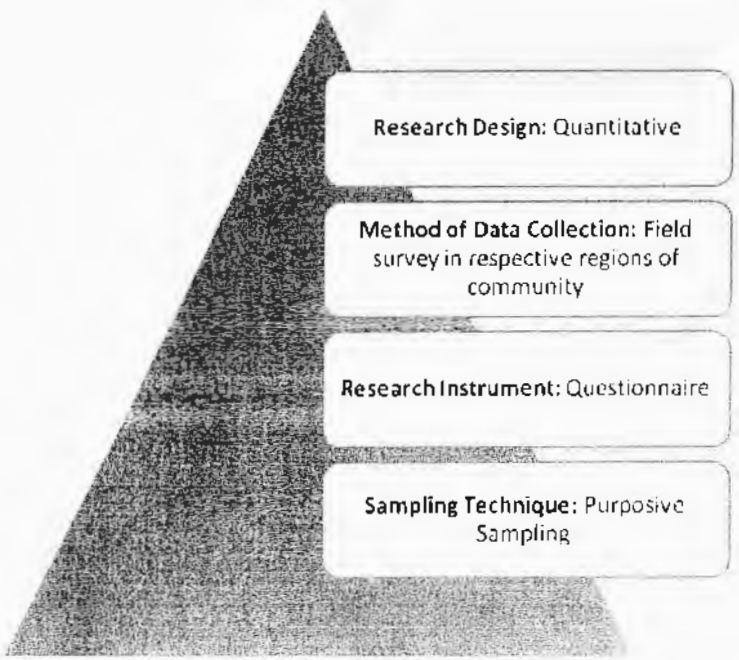
Another technique for focusing a research question to which the answer of the question can be generalized is universe. It is defined as the area or region from where population is taken for the study.

The universe of my study was limited to Islamabad, Lahore and Mardan of HDF intervention rural areas. Respondents of the study are all those parents whose children are getting benefits from school and are availing health services.

3.2 Research design

The research design is the plan of research that is used to answer the research objectives. It is a framework to solve a specific problem. According to Luck and Rubin (2009), "A research design is the determination and statement of the general research approach or strategy adopted in the particular project. The researcher used cross sectional research design which focuses the temporal period of time. In order to have systematic and wider understanding of the research topic, quantitative research design has been employed in this study.

3.3 Research Methodology (Research Design and Data Sources)

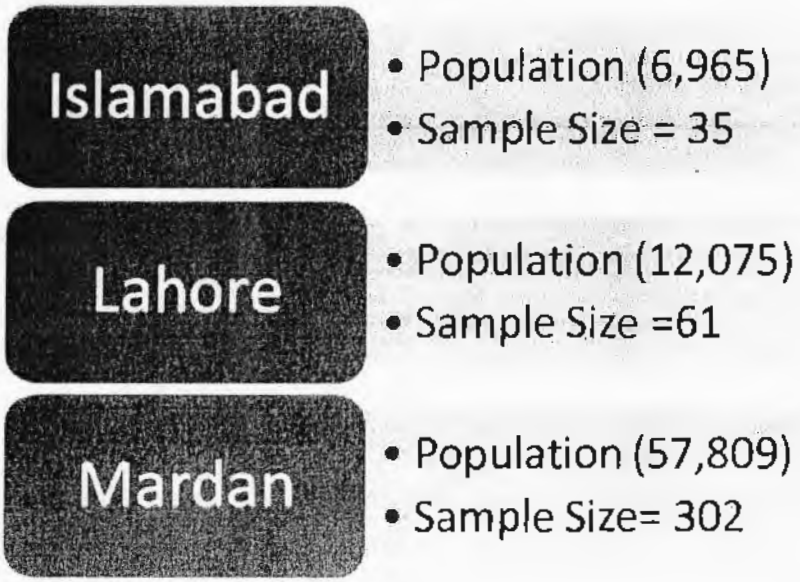


3.4. Research Methodology (Universe and Population)

Taro Yamane's formula for the sample size calculation

$$n = \frac{N}{1 + Ne2}$$

Where (Population Size) N=76,849 (sampling error) e= .05 and (sample size) n= 398



Sr. #	City	District	Tehsil	UCs	Villages	HHs	Population
1	Mardan	1	1	6	81	7,476	57,809
2	Lahore	1	1	1	5	2,000	12,075
3	Islamabad	1	1	2	8	1,078	6,965
Total		**3**	**3**	**9**	**94**	**10,554**	**76,849**

3.5 Sample

A sample refers to small representation of the whole population. It is a part or subject population which represents the characteristics of the whole population. Time and cost are usually limiting factors in research.In this study a sample size of 398 respondents was

selected through simple random sampling technique from all the parents living in specified areas whose families are benefiting from health and educational facilities established by HDF in their regions.

3.6 Sampling and Technique

Studying and covering the entire study universe is not permitted by resources and time constraints. Therefore, the researchers in majority cases employ sampling technique. According to Neuman (1989) sampling is a process of systematically selecting cases for inclusion in a research project. Researcher used simple random sampling technique as a technique of data collection.

3.7 Population

Walter (2010) defined population as a set of individuals or objects having some common observable characteristics and includes the collection of all the units that we want to study. It is the abstract idea from which a researcher draws a sample and to which results from a sample are generalized. The population of the study includes student parents who were currently living in these areas.

3.7 Data Collection Tools

In social sciences data means group of information that represent the qualitative and quantitative attributes of a variable. The success of research depends upon how carefully data was collected.

Moreover, the reliability and validity of data mostly depends on the tools of data collection used in the research. In the present study, researcher administered

questionnaire was used as research instrument for collecting quantitative data respectively.

3.8 Pre-testing

It is always useful to make a test of research instrument before giving it final shape. It not only provides the way to modify the questions but also explores a new understanding of research problem. This involves cognitive interviewing in which researcher examines how respondents answer the questions, retrieves relevant information, evaluates information and selects the response categories.

In present research, for the purpose of pre-testing, researcher randomly selected ten respondents from Islamabad region. On the basis of pretesting few questions were added and few were modified to elicit the correct information and finalized the questionnaire.

3.9 Unit of analysis

The unit of analysis of the present research was the parents of HDFformal school students, those who are living in the jurisdiction of HDF intervention areas of Islamabad, Mardan & Lahore of Pakistan.

3.10 Data Collection

Quantitative research method was used to conduct this study. To obtain relevant information from the respondents, questionnaire was developed. Questionnaire comprised brief outline of the topics covering the personal information of the respondents, their family background and their working conditions. It facilitates probing, provides opportunity for clarification if needed, facilitates motivation of the subjects to respond

and helps to ensure that the subject has responded to all the items. It also gives the interviewer an opportunity to observe nonverbal cues and reaction to specific questions.

3.11 Data Analysis

In the present research the data was analyzed with the help of Statistical Package for Social Sciences (SPSS). The following statistical tools were applied.

3.12 Percentage

Simple frequency tables were made to interpret the data. Percentage of different categories was obtained by the below mentioned formula.

$$P = \frac{F}{N} \times 100$$

Where: N = Population, P= Percentage, F= Frequency

3.13 Correlation

Correlation was used to measure the relationship between dependent and independent variables. It is a statistical technique that can show whether and how strongly pairs of variables are related.

$$r = \frac{n(\Sigma xy) - (\Sigma x)(\Sigma y)}{\sqrt{[\, n\Sigma x^2 - (\Sigma x)^2 \,][\, n\Sigma y^2 - (\Sigma y)^2 \,]}}$$

3.14 Field experiences

Approaching respondents is useful and practical way of learning, polishing the skills in the research. Meeting different respondents unearthed the way to get required answers from them. Many respondents were hesitant to tell about their personal information. Most of the parents were happy to share their views about HDF intervention on health and education.

Moreover, researcher had to maintain the ethical concerns of the study. The respondents were parents and they were usually busy in their working. Furthermore, the respondents were reluctant to share their problems as they have strong cohesion with their family. Researcher moved in the field with the HDF team members that made the interviews possible. Hence, the time spent in field was quite delicate for obtaining the true and valid information.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION

In this chapter the research focuses on the analysis and presentation of relevant data collected from the study locale. Since the study is quantitative in nature, therefore SPSS was used for analysis of primary data. The data then has been presented in tabular form with explanation, description and interpretation. Keeping in view the objectivity of the study, the research has tried to present data without incorporating the likes and dislikes. However, at the end of each explanation below the table, the researcher has deconstructed the statistics which depicts the researcher's personal opinion or more or less subjective approach. This chapter consists of different items where each table represents statistical and descriptive information.

Table 4.1 Frequency distribution of the respondents regarding their area of residence, age, gender, marital status, family type and family size

Demographic Characters			
S. No	Categories	Frequency	Percentage (%)
Residential area of the respondents			
i.	Islamabad	35	8.8
ii.	Lahore	61	15.3
iii.	Mardan	302	75.9
	Total	398	100
Age of the respondents in years			
i.	Up to 25	36	9.0
ii.	26-30	170	42.8
iii.	31-35	131	32.9
iv.	36-40	26	6.5
v.	Above 40	35	8.8
	Total	398	100
Gender of the respondents			
i.	Male	77	19.3
ii.	Female	321	80.7
	Total	398	100
Marital status of the respondents			
i.	Married	398	100
	Total	398	100
Type of family respondents are living in			
i.	Nuclear	96	24.1
ii.	Joint	302	75.9
	Total	398	100
Family size of the respondents			
i.	3-8	284	71.4
Ii	9-13	114	28.6
	Total	398	100

Table 4.1 reveals the results about socio-economic background of the respondents such as their area of residence, age, gender, marital status, family type and size of family.Three districts of Pakistan were taken as the universe of the present study namely; Lahore (Punjab), Mardan (Khyber Pakhtunkhwa) and Islamabad Capital territory (Islamabad) as HDF is working for two decades in these communities. The study was conducted by

taking a sample of 398 respondents from these areas. Among the respondents, 61 respondents were from Lahore, 35 belonged to Islamabad and 302 from Mardan.

The results of the data given in the above table portrays the age of the respondents. Less than half (42.8%) of the respondents belonged to the age category 26-30 years, 32.9% of the respondents were in 31-35 years age group. A fewer number (9%, 8.8% & 6.5%) of the respondents fall in less than 25 years of age, above 40 years of age group and 36-40 years respectively.

Table further shows the information regarding gender of the respondents. A significant majority (80.7%) of the respondents were female while 19.3% were male and all (male &female) respondents were married because the selected respondents were parents of those children who are getting education in HDF schools.Furthermore, respondents were asked about the type of family structure they are living in, in response to which 75.9% were living in Joint family system while 24.1% had Nuclear family system.

The data reveals the results about family size of the respondents. A good majority (71.4%) of the respondents were having 3-8 family members while 28.6% of them having 9-13 members in their family.

Table 4.2 Frequency distribution of the respondents regarding their Educational qualification, Occupation, Personal &Monthly family income and spouse occupation

Educational Qualification of the respondents			
S. No	**Categories**	**Frequency**	**Percentage (%)**
i.	Illiterate	4	1.0
ii.	Primary	49	12.3
iii.	Middle	69	17.4
iv.	Matriculation	174	43.7
v.	Intermediate	56	14.0
vi.	Graduate	46	11.6
	Total	398	100
Occupation of the respondents			
I	Govt. Employee	38	9.5
Ii	Private job	32	8.1
Iii	Business	59	14.8
Iv	Skilled labor	74	18.6
V	House wife	195	49.0
	Total	398	100
Occupation of the respondents' spouse			
i	Govt. Employee	90	22.6
ii	Private job	157	39.4
iii	Business	49	12.3
iv	Skilled labor	44	11.1
v	Unskilled labor	08	2.0
vi	House wife	50	12.6
	Total	398	100
Personal income of the respondents			
i.	Up to 10000	120	30.1
ii	10001-20000	55	13.8
iii	20001-30000	19	4.8
iv	30001-40000	6	1.5
v	40001-50000	3	0.8
vi.	None	195	49.0
	Total	398	100
Monthly family income of the respondents			
i.	Up to 20000	78	19.6
ii.	20001-30000	116	29.1
iii	30001-40000	73	18.4
iv	40001-50000	113	28.4
v	50001-60000	18	4.5
	Total	398	100

Table 4.2 reports the educational level of the respondents. Education plays a vital role and is considered to be very important indicator in understanding and defining respondents' behavior. Education can be measured and described under the category of illiterate, primary, middle, matriculation, inter and graduation. The data reports that 4.7% of the respondents got matriculation education while nearly 17.4% has middle level of education, 14% of the respondents had passed the intermediate level, 12.3% were having primary level education, whereas 11.6% of the respondents got graduate level and one percent were illiterate. Respondents are living in rural areas of these districts and having the few graduates and maximum matriculation level of education.

Data shows results about the occupational status of the respondents which has been measured through different indicators such as occupation of the respondent and spouse occupation of the respondents. Forty nine percent of the respondents were female and they were housewives while 18.6% of the respondents were working in the farmer fields and also were working at other homes in urban areas. While 14.8% of the respondents were having their own business and females were working of local handicrafts/ caring goat or cows while male were doing business at their shop. About 9.5% of the respondents were working in government departments in education and health institutes whereas 8.1% of the respondents were associated with private jobs in urban areas of district.

Additionally the spouse's occupation data shows that forty percent of the respondents were working in the private sector while 22.6% of the respondents were associated with government departments. While 12.6% of the respondents were housewives, 12.3% were doing their own business in different categories where as 11.1%

of the respondents were skilled labour as they were involved in construction and only two percent of the respondents were doing labour work.

Table also depicts the personal income of the respondents. Income shows the economic status of the respondents including their living standards. Less than half (44.5%) of the respondents were having no any individual source of income as they were females and were housewives, 30.1% of the respondents were earning less than 10000 monthly while 15.8% of the respondents were getting 10001-20000 rupees from their works, 7.3% of the respondents were earning 20001-30000 rupees per month, whereas 1.5% of the respondents were under the personal income category of 30001-40000 and 0.8% of the respondents were earning 40001-50000 rupees monthly.

Moreover, data also provides the result about monthly family income of the respondents. More than one forth (29.1%) of the respondents were earning 20001-30000 rupees monthly from all other sources while 28.5% of the respondents were earning 40001-50000 rupees monthly as male were working, 19.6% of the respondents were having less than 20000 rupees from all sources, mostly because were housewives or working as a labour or private jobs, while 18.4% of the respondents were under the category (30001-40000 rupees) from all sources while 4.5% of the respondents were earning 50001-60000 rupees monthly.

Table 4.3 Frequency distribution of the respondents regarding their children's (Boys & Girls) enrollment at HDF schools, school location region and educational levels

Enrollment of children at HDF School			
S. No	**Categories**	**Boys**	**Girls**
i.	Enrolled	68.3% (272)	60.6% (241)
ii.	Not enrolled	31.7% (126)	39.4% (157)
	Total	398	100
Regional enrollment of children at HDF Schools			
S. No	**Categories**	**Respondents**	**Percentage**
i.	Islamabad	35	8.8
ii.	Lahore	61	15.3
iii.	Mardan	302	75.9
	Total	398	100
Educational level of the respondents children			
S. No	**Categories**	**Boys**	**Girls**
i.	Primary	50.7% (202)	50.5% (201)
ii.	Middle	15.1% (60)	8.1% (32)
iii.	Both (Primary & Middle)	2.5% (10)	2.0% (8)
iv.	None	31.7% (126)	39.4% (157)
	Total	100% (398)	100% (398)

Table 4.3 depicts the enrollment of children at HDF Schools in Mardan, Lahore and Islamabad. Majority (66.6%) of the respondent's children were boys at different levels of education in schools while 63.1% of the respondent's children were girls.

Moreover, Human development foundation is working in the 8 different regions and majority (78%) of the respondents belonged to Mardan region as Mardan region has 7476 households where HDF is providing services and 15.3% of the respondents were from Lahore region while 8.8% of the respondents were from Islamabad region.

Furthermore, educational level of the respondent's children (gender-wise)shows thatmajority (51.7%)were boys and (50.5%) girls of the respondents were studying in the primary level of HDF schools, 15.1% boys and 8.1% girls were studying in the middle

level while 2.5% boys and two percent girls were studying in primary and middle levels of education respectively.

Table 4.4 Frequency distribution of the respondents about the duration of services availing from HDF, Availability of health facilities, sources of water access and sanitation structure

Duration of availingservices from HDF			
S. No	**Categories**	**Frequency**	**Percentage (%)**
i.	Less than 5 years	169	42.4
ii.	5 to 10 years	213	53.5
iii.	Above 10	16	4.1
	Total	398	100
Availing health facilities			
i.	HDF Community Health Center	398	100.0
	Total	398	100
Sources of water			
i.	Filtered water	173	43.5
ii.	Hand pump	206	51.8
iii.	Water supply	17	4.2
iv.	Open well	02	0.5
	Total	398	100
Sanitation structure			
i.	Paved streets	268	67.3
ii.	Unpaved Streets	126	31.7
iii.	Any other	04	1.0
	Total	398	100

Table 4.4 reveals the results for the duration of HDF services availed, health facilities and clean water access to community and sanitation structure from human development foundation to communities. Little more than half (53.6%) of the respondents were availing services of health and education for 5 to 10 years duration, Less than half (42.4%) of the respondents were availing for less than five years while 4.1% of the respondents were availing services for more than 10 years.

It also shows the results of services availed from health centers. Data shows that 100 percent of the respondents were availing services from Community health center of

each region. Community health center is a basic health unit, a step into mother and child care. There are eight community health centers (CHC) throughout Pakistan and AJK in different union councils and that was constructed and operated by HDFPAK.

The results of data taken for the present study reveals about the sources of water that were availed by the respondents or community members. Majority (51.8%) of the respondents were using hand pumps, 43.5% of the respondents were using filter water through the HDF access to clean water initiatives. 4.3% of the respondents were using the water supply scheme that was constructed under HDF special programs and 0.5% of the respondents were using open well water sources.

The table also show the sanitation structure of the community as HDF has a Community Infrastructure Projects (CIP) to improve the quality of streets. Majority (67.3%) of the respondents had paved and underground sanitation structure, while less than half (31.7%) of the respondents had unpaved streets whereas, 1.0% of the respondents were living in open areas.

Table 4.5 Respondents' opinion regarding availability of staff at community health center, such as availability of Doctor

Availability of Staff						
S. No	**Categories**	**Always**	**Sometimes**	**Rarely**	**Never**	**Total**
i.	Doctor	93.4% (373)	6.6% (25)	-	-	100% (398)
ii.	Lady health visitor	84.4% (336)	15.6% (62)	-	-	100% (398)
iii.	Dispenser	80.4% (320)	19.6% (78)	-	-	100% (398)
iv.	Community health workers	80.2% (319)	19.8% (79)	-	-	100% (398)
v.	Nurse	81.9% (326)	10.8% (43)	7.3% (29)	-	100% (398)

Table 4.5 states the results about availability of staff at health centers such as Doctor, Lady Health visitor, medical assistant, community health workers and nurse. HDF community health center has these staff at CHC in 8 regions. A greater majority (93.4%) of the respondents responded that Doctor is always available while 6.6% responded that doctor is sometimes available at CHC, 84.4% of the respondents responded that lady health visitors are always available and 15.6% shared LHV were sometimes available.

Furthermore, the results also shows that majority (80.4%) of the respondents reported that dispensers were always available while 19.6% of the respondents said sometimes dispenser were available, 80.2% of the respondents shared that community health workers were always available whereas 19.8% reported that CHWs were sometimes available at CHC. Moreover, 81.9% of the respondents reported that when they visited CHC/Nurse were available while 10.8% of the respondents shared that Nurseswere sometimes available while 7.3% of the respondents said nurses were rarely available at CHC. Usually CHWs and Nurses are in the fields to visit Households for pregnant women and child health care.

Table 4.6 Respondents' opinion regarding availability of rooms at community healtb center such as Patient examination

Availability of facility Rooms						
S. No	**Categories**	**Always**	**Sometimes**	**Rarely**	**Never**	**Total**
i.	Patient Examination	91.7% (365)	8.3% (33)	-	-	100% (398)
ii.	Dispenser	76.4% (304)	23.1% (92)	0.5% (2)	-	100% (398)
iii.	Patient Ward	79.9% (318)	20.1% (80)	-	-	100% (398)
iv.	Examination Lab	75.6% (301)	24.4% (97)	-	-	100% (398)
v.	Doctor	81.7% (325)	18.3% (73)	-	-	100% (398)

Table 4.6 depictsresults about the availability of facility rooms such as patient's examination room, dispenser room, patients ward room, examination lab and doctor. Majority (91.7%) of the respondents reported that the patient examination room was always available and 8.3% of the respondents said room was sometimes available. More than half (76.4%) of the respondents shared that dispenser room were always available, while 23.1% responded it was available sometimes while 0.5% of the respondents shared that it was rarelyavailable.

Furthermore, the table shows results about patient's ward room availability, in response to which 79.9 percent of the respondentsreported that room was always available for patient normal casualties while 20.1% of the respondents said it was sometimes available. More than half (75.6%) of the respondents said examination lab was physically available and 24.4% of the respondents responded that room was sometimes available. Majority (81.7%) of the respondents reported that the doctor's room was

available and 18.3% of the respondents shared that sometimes the doctor's room was available for sitting and patient's examination, as HDF has unique policy of patient examination room. The theme of this room is that the doctor and other health staff should check the patient in the patient examination room either lab tests, health education etc.

Table 4.7 Frequency distribution of the respondents regarding primary health facilities, such as availability of Medicines, ambulance services

Availability of primary health facilities						
S. No	**Categories**	**Always**	**Sometimes**	**Rarely**	**Never**	**Total**
i.	Medicines	80.4% (320)	19.6% (78)	-	-	100% (398)
ii.	24/7 Ambulance service	83.9% (334)	11.8% (47)	4.3% (17)	-	100% (398)
iii.	Medical equipment's for Lab tests	86.4% (344)	13.6% (54)	-	-	100% (398)
iv.	Referral system to recommend Patients	78.9% (314)	16.6% (66)	2.8% (11)	1.8% (07)	100% (398)
v.	Establishment of health points	65.8% (262)	31.2% (124)	-	3.0% (12)	100% (398)

Table 4.7 portrays the primary health care facilities such as availability of Medicines, 24-hours ambulance services, Medical equipment for lab tests, referral systems to recommend patients to others hospitals and establishment of health points where health facilities are not available. In response to these categories, majority (80.4%) of the respondents reported that medicines are always available in community health center while 19.6% of the respondents shared that sometimes all type of medicines are available. Majority (83.9%) of the respondents responded that ambulance is always available 24/7 to the community while 11.8% of the respondents said sometimes ambulance is available whereas 4.3 percent said ambulance service is rarely available.

Moreover, most (86.4%) of the respondents reported that medical equipment for Lab tests at community health center is always available while 13.6% of the respondent said it is sometimes available, 78.9% of the respondents responded that community health center has strong referral system and they always refer or recommend patients to other hospitals or clinics while 16.6% of the respondents shared that sometimes they advise patients to other hospitals, where as 2.8% of the respondents said they rarely recommend patients while 1.8% of the respondents reported that they never recommend patients.

Furthermore, 65.8% of the respondents shared that HDF has always established health points in the out areas where there is no other facility where as 31.2% of the respondents said they sometimes establish health points while 3.0% of the respondents responded that they never established health points in other areas of HDF programs.

Table 4.8 Respondents' opinion regarding mother health care where as Antenatal, Post antenatal within 2 days and first and second visit.

Mother health care						
S. No	**Categories**	**Always**	**Sometimes**	**Rarely**	**Never**	**Total**
i.	Antenatal care (visits by HDF health staff)	90.2% (359)	9.8% (39)	-	-	100% (398)
ii.	Post antenatal (1st visit; within 2 days)	64.1% (255)	34.9% (139)	1.0% (4)	-	100% (398)
iii.	Post antenatal (2weeks after 1st visit)	64.1% (255)	34.2% (136)	1.8% (7)	-	100% (398)
iv.	TT Vaccination for mother	74.6% (297)	24.4% (97)	1.0% (4)	-	100% (398)
v.	Support in delivery preparation	86.4% (344)	12.6% (50)	1.0% (4)	-	100% (398)
vii.	Institutional delivery	83.4% (332)	15.6% (62)	1.0% (4)	-	100% (398)
viii.	Eligible couples using contraceptive methods (family planning)	80.4% (320)	19.6% (78)	-	-	100% (398)

Table 4.8 shows results about the mother health care facilities provided by the Human Development Foundation at their community health center. As per the WHO standards, mother health care during the pregnancy is essential part of child and mother health while HDF is responsible to reduce the mother and child mortality in their respective regions. Respondents were asked about the facility of antenatal care by human development foundation, majority (90.2%) of the mothers of the students at HDF Schools shared that they are always facilitated from HDF staff visits during their pregnancy while 9.8% of the respondents sometimes availed services.

Table shows results about post antenatal care which is after one week of delivery. Majority (64.1%) of the respondents always supported, 34.9% of the respondent sometimes get benefited while 1.0% of the respondents rarely visited during the first week. Furthermore, Post antenatal mother care after two weeks show results that 64.1%

of the respondents always availed services, 34.2% of the respondents sometimes get facilitated while 1.8% of the respondents rarely visited.

This table also reveals that the mother health care in term of vaccination particularly the *Tetanus* (TT) is compulsory during the cases of normal or C-section delivery. Majority (74.6%) of the respondents were always vaccinated TT at CHC after the delivery, 24.4% of the respondents were sometimes vaccinated while one percent usually refused and rejected to get vaccinated.

It is also found that support in delivery preparation at local level is a mandatory task for health program in HDF. In response to delivery preparation cases, majority (86.4%) of the respondents were always assisted, 12.6% of the respondents were sometimes supported in delivery preparation while one percent of the respondents were rarely visited for support in delivery preparation. Institutional delivery is a delivery care at well-organized medical hospitals. In response to this, majority (83.4%) of the respondents always preferred at organized and registered clinics, 15.6% of the respondents sometimes give priority to home deliveries while one percent of the respondents rarely serviced for institutional deliveries.

In response to the use of contraceptive methods (family planning), majority (80.4%) of the respondents said that they always use family planning methods as per the government instructions and also take medicine provided by the government health departments while 19.6% of the eligible couples sometimes use contraceptive methods.

Table 4.9 Respondents' opinion regarding child health care, Growth monitoring under 5 years, completely immunization, and EPI vaccination

Child health care						
S. No	**Categories**	**Always**	**Sometimes**	**Rarely**	**Never**	**Total**
i.	Growth Monitoring Under 5 years	94.7% (377)	5.0% (20)	0.3% (1)	-	100% (398)
ii.	Completely immunization (24-59 months)	70.1% (279)	29.4% (117)	0.5% (2)	-	100% (398)
iii.	EPI Vaccination (Zero-23 months)	76.4% (304)	22.1% (88)	1.5% (6)	-	100% (398)
iv.	Identification & treatment of malnourished Under 5	82.2% (327)	15.3% (61)	2.5% (10)	-	100% (398)

Table 4.9 depicts the child health care regarding their growth, immunization, vaccination and complete identification of malnourished under 5 years. Growth monitoring is a physical checkup of infants or under 5 years' children about the weight and height measurements. Majority (94.7%) of the respondents were always provided services of growth monitoring, five percent of the respondents sometimes get opportunity of child growth monitoring while 0.3% were rarely benefited. This table also shows the complete or full immunization while immunization is the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine.

The Expanded Program on Immunization (EPI) was established in 1976 to ensure that infants/children and mothers have access to routinely recommended infants/children vaccines. Six vaccine-preventable diseases were initially included in the EPI: tuberculosis, polio, diphtheria, tetanus and measles. Majority (70.1%) of the respondents were always complete immunized, 29.4% of the respondents were sometimes get completely immunized while 0.5% were rarely completely immunized. Majority (76.4%)

of the respondents shared they always get their children vaccinated timely, 22.1% sometimes vaccinated while 1.5% of the respondent rarely vaccinated their children through EPI program.

Malnourishment is due to improper health or improper functioning of immune system. Majority (82.2%) of the respondents were completely nourished, 15.3% of the respondents were sometimes identified and treated while 2.5% of the respondents were rarely assisted due to the permanent stage of malnourishment.

Table 4.10 Respondents' opinion about the provision of community health caresuch as Community screening camps, schools screening camps

Community health care						
S. No	**Categories**	**Always**	**Sometimes**	**Rarely**	**Never**	**Total**
i.	Community Screening Camps	87.2% (347)	12.1% (48)	0.8% (3)	-	100% (398)
ii.	Schools Screening Camps	73.1% (291)	24.1% (96)	2.8% (11)	-	100% (398)
iii.	Mobile Health Unit for outreach village	75.9% (302)	21.6% (86)	2.5% (10)	-	100% (398)
iv.	Community health workers Visit	74.4% (296)	23.9% (95)	1.8% (7)	-	100% (398)

Table 4.10 reveals about the results of community health care including the community screening camps, school screening camps, mobile health unit for villages and community health workers' visits to households. Majority (87.2%) of the respondents always get benefited from community screening camps, 12.1% of the respondents were sometimes availed services while 0.8% of the respondents rarely facilitated get by screening camps. School health program is started by HDF in their schools which is totally for the students of HDF.Majority (73.1%) of the respondents were always get benefited from school

health camps, 24.1% of the respondents were sometimes availed services while 2.8% of the respondents were rarely assisted in school screening camps.

In addition, a village wise health program was started in those respective villages which do not have access to basic health unit, community health center or any other private dispensary. Majority (75.9%) of the respondents always get facilitated in mobile health units, 21.6% of the respondents sometimes get assisted in mobile health unit while 2.5% of the respondents rarely get assisted in mobile health camps.

Furthermore, HDF community health workers visited households for the mother and child health care and awareness of health protection. Usually regularly CHWs visited the designed households. Majority (74.4%) of the respondents shared that CHWs visited their home, 23.9% of the respondents shared sometimes they visited while 1.8% of the respondent were rarely stopover us for health education.

Table 4.11 Respondents' views regarding awareness raising programssuch as Health sessions and International health day celebrations

Awareness raising						
S. No	**Categories**	**Always**	**Sometimes**	**Rarely**	**Never**	**Total**
i.	Health Sessions through VDOs	90.2% (359)	9.8% (39)	-	-	100% (398)
ii.	School celebration of international health days	66.6% (265)	33.4% (133)	-	-	100% (398)
iii.	Role plays for health education	71.6%(285)	27.9% (111)	0.5% (2)	-	100% (398)
iv.	Health awareness walk	77.9% (310)	20.9% (83)	1.3% (5)	-	100% (398)
v.	Newsletter (sehat- nama) by field staff for CHWs and support groups	76.1% (303)	21.4% (85)	1.3% (5)	1.3%(5)	100% (398)
vi.	Wall charts of health messages	33.7% (134)	33.7% (134)	16.8% (67)	15.8% (63)	100% (398)
vii.	Audio messages through mobile ICT	50% (199)	22.6% (90)	11.6% (46)	15.8% (63)	100% (398)

Table 4.11 depicts the opinion regarding awareness raising programs on Health sessions. The first indicator of the table Health Sessions through Village Development Organizations shows that majority (90.2%) of the respondents always get awareness through VDOs , while less than ten percent (9.8%) of the respondents sometimes get awareness through VDOs.

The second indicator of the table about the awareness of 'School celebration of international health days' shows that more than half (66.6%) of the respondents always have awareness about the School national or international day celebration of international health days. Furthermore 33.4% of the respondents sometimes get aware about the School celebration of international health days.

The third item of the table about the awareness for health education shows that majority (71.6%) of the respondents always support this notion that awareness plays a

vital role for health education. Furthermore, 27.9% of the respondents were of the opinion that awareness plays role for health education to some extent.

The fourth part of the table about the importance of 'health awareness walk', shows results that majority (77.9%) of the respondents were always in favor of health awareness walk, while 20.9% of the respondents were sometimes in favor of health awareness walk campaigns.

The fifth indicator of the table about the role of 'newsletter (sehat-nama) by field staff for CHWs to promote the health awareness' among the respondentsshows that majority (76.1%) of the respondents were always satisfied with the role of newsletter (sehat-nama) by field staff for CHWs to promote the health awareness. Furthermore 21.4% of the respondents sometimes agreed with the said notion.

The second last item of the table about the awareness through 'wall charts of health messages' shows that one third (33.7%) of the respondents always like wall charts of health messages activity, while 16.8% of the respondents rarely agreed that wall charts of health messages is a good activity.

The last indicator of the table about the awareness through mobile ICT depicts that fifty percentof the respondents always like the awareness campaign through audio messages mobile ICT, while 22.6% of the respondents sometimes agreed on this notion.

Table 4.12 Respondents' opinion about capacity building of core members of communities, health committees and general health education

Capacity building						
S. No	Categories	Always	Sometimes	Rarely	Never	Total
i.	Trainings of core members of the community on health responsibility & refusal cases	88.7% (353)	6.5% (26)	4.8% (19)	-	100% (398)
ii.	Trainings of health committees on health role/support groups	76.9% (306)	23.1% (92)	-	-	100% (398)
iii.	Trainings of general community on health education	63.1% (251)	35.7% (142)	0.3% (1)	1.0% (4)	100% (398)

Table 4.12 reports the results of capacity building of core members, health committees and health education in community. Majority (88.7%) of the respondents always attended the trainings on health education and how to handle refusal cases, 6.5% of the respondents sometimes participated while 4.8% of the respondents rarely participated in core member community sustainable trainings.

HDF has trained many individuals in the community for the capacity buildings and sustainability of the community. Therefore, majority (76.9%) of the respondents attended the role of health committees and development of support groups, 23.1% of the respondents sometimes participated in the health roles and responsibilities at community level.

In addition, most (63.1%) of the respondents always attended the trainings on health education and public awareness on chronic diseases while 35.7% of the respondents sometimes availed trainings on health education.

Table 4.13 Frequency distribution of the respondents regarding educational facilities and availability of Educational staff at HDF formal schools

Availability of Staff at HDF Schools						
S. No	**Categories**	**Always**	**Sometimes**	**Rarely**	**Never**	**Total**
i.	Principal/Education Coordinator	90.5% (360)	9.5% (38)	-	-	100% (398)
ii.	Teachers	37.9% (151)	59.0% (235)	3.0% (12)	-	100% (398)
iii.	Computer teacher	70.9% (282)	24.9% (99)	4.3% (17)	-	100% (398)
iv.	Support staff	76.9% (306)	23.1% (92)	-	-	100% (398)
v.	Security guard	65.1% (259)	30.2% (120)	4.8% (19)	-	100% (398)

Table 4.13 states the results about availability of school staff such as Principal/Education Coordinator, Teachers, Computer teacher, Support staff and Security guard. A greater majority (90.5%) of the respondents responded that principal was always available while 9.5% respondedsometimes. Other educational staff like for subject specialist more than half (59%) responded sometimes while37.9% shared that teacher were always available during their visit to school.

Every HDF schools has complete computer lab and these labs were designed with the digital dish project of UKAID. The result of third indicator of this table shows majority (70.9%) of the respondents reported that computer teacher were always available while 24.9% of the respondents said sometimes computer teacher were available.

Majority (76.9%) of the respondents responded the availability of support staff for the maintenance of school buildings and class rooms while 23.1% of the respondents

reported that support staff was available sometimes. Due to security concerns of education institutions HDF has maintained their school security with proper trained security guards from private companies. Majority (65.1%) of the respondents reported that security guard was always available at gate of school while 30.2% shared that they were sometimes available.

Table 4.14 Frequency distribution of the respondents regarding availability of staff room such as computer lab, library, digital study hall, sports ground

Availability of Rooms at HDF School						
S. No	**Categories**	**Always**	**Sometimes**	**Rarely**	**Never**	**Total**
i.	Staff room	66.1% (263)	23.1% (92)	10.8% (43)	-	100% (398)
ii.	Computer lab	59.3% (236)	34.7% (138)	6.0% (24)	-	100% (398)
iii.	Library	54.3% (216)	41.7% (166)	4.0% (16)	-	100% (398)
iv.	Digital study hall	71.4% (284)	25.6% (102)	3.0% (12)	-	100% (398)
v.	Sports ground	64.8% (258)	30.4% (121)	4.8% (19)	-	100% (398)

Table 4.14 depicts the availability of facility rooms such as Staff room, Computer lab, Library, Digital study hall and sports ground for playing games. More than half (66.1%) of the respondents reported that the Staff room was always available while 23.1of the respondents said staff room was sometimesavailable. More than half (59.3%) of the respondents shared that Computer lab was always available, while 34.7% responded it was sometimesavailable for children digital activities and stories class.

Additionally, the table shows Library room availability, in response to which 54.3% percent of the respondents reported that library room was always available for

students, for reading and listening capacitates while 41.7% of the respondents said it was sometimes available. More than half (71.4%) of the respondents said Digital study hall wasalways available for nursery and class one classes and one forth (25.6%) of the respondents responded that room was sometimes available.

Moreover, most (64.8%) of the respondents reported that the sports ground was available and 30.4% of the respondents shared that sometimes sports ground was available for playing basketball, cricket and table tennis.

Table 4.15 Frequency distribution of the respondents regarding availability of services to HDF schools for students availing

Availability of services at HDF School						
S. No	**Categories**	**Always**	**Sometimes**	**Rarely**	**Never**	**Total**
i.	Ambulance service for students	64.1% (255)	32.7% (130)	3.3% (13)	-	100% (398)
ii.	CCTV for security reasons	66.6% (265)	30.4% (121)	3.0% (12)	-	100% (398)
iii.	Availability of books	77.9% (310)	19.1% (76)	3.0% (12)	-	100% (398)

Table 4.15 reports the availability of ambulance service for students in emergency, CCTV camera system for digital security purpose and availability of books. Majority (64.1%) of the respondents' children always availed ambulance service free of cost from HDF Schools while 32.7% of the respondents were sometimes availed ambulance service from HDF community health center.

Moreover, due to the threats to national security in Pakistan especially the academic institutes are facing attacks. The government of Pakistan has implemented the security policyto secure schools with security cameras. HDF all over Pakistan has

implemented the security parameters and safe their students and staff. More than half (66.6%) of the respondents has always seen security cameras are working, 30.4% of the respondents reported that sometimes cameras are working while 3.0% of the respondents rarely seen the security cameras working.

Furthermore, HDF in Pakistan is providing books to the studentsin free of cost. Usually, the books are provided to the students in the start of the academic session. Majority (77.9%) of the respondents always availed books of complete class, 19.1% of the respondents were sometimes availed books in new classes, usually books publications companies takes time for publications while three percent of the respondents rarely availed books.

Table 4.16 Frequency distribution of the respondents regarding educational activities such as Urdu reading and quiz competition

Educational Activities at HDF Schools						
S. No	**Categories**	**Always**	**Sometimes**	**Rarely**	**Never**	**Total**
i.	Urdu Reading Competition	91.2 (363)	5.8% (23)	3.0% (12)	-	100% (398)
ii.	Monthly follow-ups of students	52.8% (210)	42.7% (170)	4.5% (18)	-	100% (398)
iii.	Student exposure visits	60.3% (240)	30.9% (123)	7.8% (31)	1.0% (4)	100% (398)
iv.	Quiz competition	71.6% (285)	25.4% (101)	3.0% (12)	-	100% (398)
v.	Awareness walk on social issues	74.1% (295)	23.1% (92)	2.8% (11)	-	100% (398)
vi.	Enrollment campaigns	78.4% (312)	14.8 (59)	6.8% (27)	-	100% (398)
vii.	Scholarships to brilliant students on annual bases	82.2% (327)	12.3% (49)	5.3% (21)	0.3% (1)	100% (398)
viii.	PTA, Education Committee Training & meetings	31.4% (125)	58.5% (233)	6.0% (24)	4.0% (16)	100% (398)

Table 4.16 shows the results of educational activities such as Urdu reading and quiz competition, student follow-ups, exposure visits, walk on social cause, enrollment campaign, scholarships for needy students and parents teacher association meetings and trainings on role and responsibilities. High majority (91.2%) of the respondents were always participated in Urdu reading competition for learning of Urdu language and reading techniques while 5.8% of the respondents were sometimes participated in these reading competition activities.In response to monthly follow-ups record keeping and sharing results of students with parents,more than half (52.8%) of the respondents said they always contacted by the school administration for student progress while 42.7% of the respondents were sometimes contacted for student progress.

This table also shows results for the exposure visits of students for extra activities. Most (60.3%) of the respondents participated in exposure visits. These visits are organized for those students who get high marks in their monthly or annual papers while 30.9% of the respondents sometimes participated in these exposure visits. Quiz competition from general knowledge is a healthy activity among students of HDF, more than half (71.6%) of the respondents' children participated in quiz competitions are these competition is usually from syllabus and general knowledge while one forth (25.4%) of the respondents shared that their children sometimes participated in quiz competition activities.

The table further shows results of walk on social issues. Majority (74.1%) of the respondents' children participated in walks organized for the social issues awareness while 23.1% of the respondents sometimes participated in walks. Enrollment campaigns were organized with the coordination of education committees and majority (78.4%) of the respondents has always been a part of these campaigns to reduce dropout ratio while 14.8% of the respondents were sometimes participated.

Scholarships to brilliant students on annual basis are the special assistance to student of HDF. Majority (82.2%) of the respondents benefited from scholarships and get financial assistance while 12.3% of the respondents sometimes availed scholarships. PTA and Education Committee Training & meetings results show more than half (58.5%) of the respondents sometimes participated in PTA meetings and trainings while less than half (31.4%) of the respondents were always participated.

Table 4.17 Frequency distribution of the respondents regarding educational alerts such as study environment and civic activities

Educational Alerts at HDF Schools						
S. No	**Categories**	**Always**	**Sometimes**	**Rarely**	**Never**	**Total**
i.	Providing conducive environment at School for study	88.2% (351)	11.8% (47)	-	-	100% (398)
ii.	Teachers capacity building programs	87.2% (347)	12.8% (51)	-	-	100% (398)
iii.	Best Teacher Award on progress	87.2% (347)	16.8% (67)	-	-	100% (398)
iv.	Monthly teachers' meetings	83.7% (333)	16.3% (65)	-	-	100% (398)
v.	Awareness Raising Programs and Orientation Sessions for students	80.9% (322)	18.1% (72)	1.0% (4)	-	100% (398)
vi.	Awareness Raising Programs and Orientation Sessions for teachers	74.9% (298)	25.1% (100)	-	-	100% (398)
vii.	Awareness Raising Programs and Orientation Sessions PTA Members	61.6% (245)	37.9% (151)	-	0.5% (2)	100% (398)
viii.	Co-curricular activities/events	68.3% (272)	29.9% (119)	1.8% (7)	-	100% (398)

Table 4.17 shows results regarding educational alerts such as study environment, civic activities, teacher awards, meetings and trainings, awareness raising programs for students, teachers and PTA members. In response to providing conducive environment at school for study, majority (88.2%) of the respondentswere of the opinion that their children have always been provided with conducive environment at school while 11.8% said sometimes conducive environment is provided at school. In response to teacher capacity building program, majority (87.2%) of the respondents were always interested to have teacher training programsfor progress in pedagogy while (12.8%) of the respondents sometimes agreed to have teacher trainings.

It is also found that when asked about Best Teacher Award on progress of class majority (87.2%) of the respondents said best teacher awards for motivation and appreciation is always given while (16.8%) said sometimes awards are given. In response to monthly teachers' meetings, majority (83.7%) of the respondentssaid that the monthly meetings are always conducted while (16.3%) of the respondents sometimes appreciated the monthly meetings of teachers. For extra co-curricular activities, more than half (68.3%) of the respondents' children always participated co-curricular activities/events while one third (29.9%) of the respondents sometimes participated in these activities.

Moreover, about Awareness Raising Programs and Orientation Sessions for students, majority (80.9%) of the respondents were of the opinion that their children always get chance to participate in awareness sessions and orientation in different programs while (18.1%) of the respondents sometimes get information to participation. Inquiring about awareness raising programs and orientation sessions for teachers, majority (74.9%) of the respondents shared that HDF always conducted many orientation sessions for teachers and community committees for their new initiatives while one forth (25.1%) of the respondents sometimes heard about these orientation sessions for teachers. Asking about awareness raising programs and orientation sessions for parent teacher association members, more than half (61.6%) of the respondents always participated in PTA meetings and orientations to new session of classes while 37.9% sometimes participated in these meetings.

Table 4.18 Describes the list of variables which are used in the statistical analysis (correlation), list of bivariate Analysis variables and codes are given below:

Code	Variable name
1	Administration And Availability of staff (Health Facilities)
2	Availability of Rooms
3	Mother Health Care
4	Child Health Care
5	Community Health Care
6	Awareness Raising
7	Capacity Building
8	Administrative and Availability of staff (Educational Facilities)
9	Availability of Rooms
10	Educational Activities
11	Educational Alerts

Hypothesis: There is an association between health care facilities and sustainable development.

Hypothesis: There is an association between educational facilities and sustainable development.

Correlation Statistical Test of Variables

Code	1	2	3	4	5	6	7	8	9	10	11
1	1	.283**	.054	.045	-.056	.268**	.162**	.088	-.051	.363**	.071
2		1	.182**	.284**	.026	.376**	.274**	.400**	.027	.410**	.056
3			1	.314**	.169**	.305**	.111*	.378**	.335**	.256**	.334**
4				1	.347**	.346**	.141**	.165**	.165**	.227**	.054
5					1	.113*	.534**	.356**	.352**	.303**	.061
6						1	.157**	.458**	.328**	.373**	.311**
7							1	.565**	.349**	.571**	.030
8								1	.323**	.577**	.150**
9									1	-.410**	.045
10										1	.174**
11											1

Table 4.18 depicts the correlational statistical test of the variables. Data shows that there is a moderate positive correlation (r=.363) between educational activities and educational alerts with administration and availability of staff and only child health care can have work positive correlation (r=.045) with administration and availability of staff. Here, negative correlation is found between education facilities and community health care with administration and availability of staff. It shows that variable is correlated with each other.

Table reveals the correlational statistical test of the variables. Data shows that there is a moderate positive correlation (r=.410) between educational activities and educational alerts with community health care can have work positive correlation (r=.026) with administration and availability of staff.

Table depicts the correlational statistical test of the variables. Data shows that there is a moderate positive correlation (r=.378) between Administrative and Availability of staff (Educational Facilities) and Mother Health Care and only Capacity Building can have work positive correlation (r=.111) with Mother Health Care.

Table shows the correlational statistical test of the variables. Data shows that there is a moderate positive correlation (r=.347) between Community Health Care and Child Health Care and only Educational Alerts had work positive correlation (r=.054) with Child Health Care.

Table analyzes the correlational statistical test of the variables. Data shows that there is a moderate positive correlation (r=.534) between Capacity Building and Community Health Care and only Educational Alerts had work positive correlation (r=.061) with Community Health Care.

Table shows the correlational statistical test of the variables. Data shows that there is a moderate positive correlation (r=.458) between Administrative and Availability of staff (Educational Facilities) and Awareness Raising and only Capacity Building had work positive correlation (r=.157) with Awareness Raising.

Table analyzes the correlational statistical test of the variables. Data shows that there is a moderate positive correlation (r=.571) between Educational Activities and Capacity Building and only Educational Alerts had work positive correlation (r=.030) with Capacity Building.

Table portrays the correlational statistical test of the variables. Data shows that there is a moderate positive correlation (r=.577) between Educational Activities and Administrative and Availability of staff (Educational Facilities) and only Educational Alerts had work positive correlation (r=.150) with Administrative and Availability of staff (Educational Facilities).

Table depicts the correlational statistical test of the variables. Data shows that there is a moderate positive correlation (r=.410) between Educational Activities and Availability of Rooms and only Educational Alerts had work positive correlation (r=.045) with Availability of Rooms.

Table results show the correlational statistical test of the variables. Data shows that there is a weak correlation (r=.174) with Educational Alerts and Educational Activities.

CHAPTER FIVE

FINDING, CONCLUSION, AND SUGGESTIONS

5.1 Major Findings

- Majority of the respondents (81%) were female.
- All (100%) of the respondents availed health services from Community health center of each region.
- A high majority (93.4%) of the respondents responded that doctors are always available at community health center.
- Majority of the respondents (80.4%) reported that dispensersare always available at community health center.
- Majority of the respondents (80.2%) shared that community health workers are always available in community health center.
- Majority of the respondents (81.9%) reported that nurses are always available at community health center.
- Majority (81.7%) of the respondents reported that the doctor rooms are always available at community health center.
- Majority of the respondents (80.4%) reported that medicines are always available in community health center.
- Almost (83.9%) of the respondents responded that ambulance service to the community is always available 24/7.
- Majority of the respondents (86.4%) were always assisted for delivery preparation cases.

- Majority of the respondents (83.4%) always preferred delivery at organized and registered clinics.
- Majority of the respondents (80.4%) always use family planning methods as per the government instructions and medicines are also provided by the government health departments.
- A high majorityof the respondents (90.2%) always get awareness through village development organizations of each region.
- Majority (88.7%) of the respondents always attend the trainings on health education and how to handle refusal cases.
- A high majority (90.5%) of the respondents responded that principal is always available of education coordination.
- A high majority (91.2%) of the respondents always participated in Urdu reading competition for learning Urdu language and reading techniques.
- Majority (82.2%) of the respondents were always benefited from scholarships and get financial assistance.

5.2 Conclusion

The present research confirmed that HDF is playing a quite positive role in the development of communities where it is working. The study was an effort to understand the overall role of HDF particularly in the field of education and provision of health care services in its communities. The study will be very helpful for the initiation of the macro level program on the format of HDF Pakistan. The study showed that there were certain hurdles for the HDF to perform effectively in the communities. One of the main factors was, for sure, the financial constraints that become the hurdle for doing such kind of activities on a larger scale.

While the researcher was getting data from the respondents, it was felt that these programs need to be expanded throughout Pakistan to promote the sustainable development of communities in the far-flung areas. The establishment of non-formal and formal schools system by the HDF helped in raising the literacy rate in those communities as the data showed that there was up to 70% increase in the primary education and enrollment ratio in the schools. This ultimately reduced and even almost ended the primary school dropout ratio in those communities.

Another significant contribution of the HDF as reported by the respondents was the establishment of the community health centers that improved the overall health of the people living in those communities particularly it reduced the infant mortality rate and maternal health care services. Furthermore the research shows that various campaigns regarding certain health issues such as Anti Measles campaigns, Anti Polio campaigns, Dengue awareness campaigns and many other awareness campaigns improved the general health and nutrition conditions for the people living in those areas.

Consequently, it has been researched that the remote communities of Pakistan are in dire need of such initiatives to improve the health and education sectors as usually majority of the developmental programs from the Government side focus on the urban areas and the rural communities remain continuously marginalized.

5.3 Suggestions

Pakistan receives a lot of financial assistance from the International community for helping the marginalized groups yet the fruits of such assistance do not reach till the bottom because of various issues. Following are some of the recommendations based on this research work for better helping the marginalized areas of Pakistan.

- The International assistance should be carefully and honestly transferred till the bottom (Poor).
- Government should be in strong liaison with Non-Governmental organizations for helping the marginalized communities.
- Various programs for helping the deprived on self-help basis should be started.
- Different technical skills related education should be provided to the people in rural areas so that they can earn their livelihoods.
- Awareness campaigns should be run in local communities to aware people to combat various infectious and chronic diseases.
- The NGOs sectors should be strengthened with the support of Government and implementation agencies.
- Inter-governmental and nongovernmental coordination should be assured for the smooth implementation of the developmental projects in the communities.

References

Acker, D., Gasperini, L., Ite, U. E., Leihner, D. E., Cock, J. H., Schilde-Rentschler, L., & Bhat, R. B. (2009). *Education for Rural People. The role of educâtion, training and capacity development in poverty reduction and food security* (No. E50-1140). CIAT, Cali (Colombia). CIP, Lima (Perú). IITA, Ibadán (Nigeria). UNDP, New York, NY (EUA)..

Ahmed, J., & Shaikh, B. T. (2008). An all-time low budget for healthcare in Pakistan. *Journal of the College of Physicians and Surgeons Pakistan, 18*(6), 388.

Aslam, M. (2013). Empowering women: education and the pathways of change. *Background paper for EFA Global Monitoring Report, 4*.

Assembly, U. G. (2013). A Life of Dignity For All: Accelerating Progress Towards the Millennium Development Goals and Advancing the United Nations Development Agenda Beyond 2015. A Report of the Secretary-General. *A Report of the Secretary-General. New York, NY: United Nations*.

Barro, R. J., & Lee, J. W. (2010). A New Data Set of Educational Attainment in the World, 1950-2010. NBER Working Paper No. 15902. *National Bureau of Economic Research*.

Basiago, A. D. (1998). Economic, social, and environmental sustainability in development theory and urban planning practice. *Environmentalist, 19*(2), 145-161.

Becker, G. S., Philipson, T. J., &Soares, R. R. (2005). The quantity and quality of life and the evolution of world inequality. *The American Economic Review, 95*(1), 277-291.

Betcherman, G., McMullen, K., &Davidman, K. (1998). Training for the new economy. *Ottawa: Canadian Policy Research Networks*.

Bhandari, B. B., & Abe, O. (2003). Education for sustainable development: An emerging paradigm. *Education for sustainable development in Nepal: Views and visions*, 13-28.

Björklund, A., &Salvanes, K. G. (2011). Chapter 3-Education and Family Background: Mechanisms and Policies. volume 3 of Handbook of the Economics of Education, 201–247.

Blaas, E., &Nijkamp, P. (1994). New technology and regional development in the European snowbelt towards a new emerging network?. In *Patterns of a network economy* (pp. 275-291). Springer Berlin Heidelberg.

Cowen, M., Cowen, M. P., &Shenton, R. W. (1996). *Doctrines of development*. Taylor & Francis.

Davis, J. M. (2008). What might education for sustainability look like in early childhood? A case for participatory, whole-of-settings approaches.

Deber, R. B. (2003). Health care reform: Lessons from Canada. *American Journal of Public Health*, *93*(1), 20-24.

Didonet, J. J., Cavalcante, J. C., Souza, L. D. S., Costa, M. S., André, E., Soares-Rachetti, V. D. P., ... &Gavioli, E. C. (2014). Neuropeptide S counteracts 6-OHDA-induced motor deficits in mice. *Behavioural brain research*, *266*, 29-36.

Dixon, J. A., & Fallon, L. A. (1989). The concept of sustainability: origins, extensions, and usefulness for policy. *Society & Natural Resources*, *2*(1), 73-84.

Dreze, J., &Sen, A. (1999). India: Economic development and social opportunity. *OUP Catalogue*.

Ensor, T., & Duran-Moreno, A. (2002). Corruption as a challenge to effective regulation in the health sector. *Regulating entrepreneurial behaviour in European health care systems*, *106*.

Flora of North America Editorial Committee (FNAEC). (1993). *Flora of North America: Volume 23: Magnoliophyta: Commelinidae (in Part): Cyperaceae* (Vol. 23). Oxford University Press on Demand.

Fuller, B. (1986). *Raising School Quality in Developing Countries: What Investments Boost Learning? World Bank Discussion Papers 2*.

Grubb, M., & Grubb, M. (1993). The Earth Summit agreements: a guide and assessment: an analysis of the Rio'92 UN Conference on Environment and Development. In *United Nations Conference on Environment and Development (1992: Rio de Janeiro, Brazil)*. (No. HC 79. E5. U54 1992). The Royal Institute of International Affairs (London)..

Hanley, N. (2000). Macroeconomic measures of 'sustainability'. *Journal of Economic Surveys*, *14*(1), 1-30.

Healy, T., &Côté, S. (2001). *The Well-Being of Nations: The Role of Human and Social Capital. Education and Skills*. Organisation for Economic Cooperation and Development, 2 rue Andre Pascal, F-75775 Paris Cedex 16, France.

Holmberg, J., & Sandbrook, R. (1992). Sustainable development: What is to be done? In J. Holmberg (Ed.), Policies for a small planet (pp. 19-38). London: Earthscan.

Husain, I. (1999). The Economy of an Elitist State.

Huselid, M. A., Becker, B. E., & Beatty, R. W. (2005). *The workforce scorecard: Managing human capital to execute strategy*. Harvard Business Review Press.

Israel, G. D., Coleman, D. L., &Ilvento, T. W. (1993). Student involvement in community needs assessment. *Community Development, 24*(2), 249-269.

Jamison, D. T., Breman, J. G., Measham, A. R., Alleyne, G., Claeson, M., Evans, D. B., & Musgrove, P. (Eds.). (2006). *Disease control priorities in developing countries*. World Bank Publications.

Jones, P. W. (2007). *World Bank financing of education: Lending, learning and development*. Routledge.

Kagal, L., & Abelson, H. (2010, June). Access control is an inadequate framework for privacy protection. In *W3C Privacy Workshop* (pp. 1-6).

Khan, M. M., & Van den Heuvel, W. (2007). The impact of political context upon the health policy process in Pakistan. *Public Health, 121*(4), 278-286.

Khan, S. J. I., Awan, A., & Khan, M. M. (2012). The concept of sustainable development in Pakistan.

Khan, Y., Tariq, M., & Sasaki, K. (2001). Roles of public capital in Pakistan's economy: productivity, investment and growth analysis. *Review of Urban & Regional Development Studies, 13*(2), 143-162.

Khowaja, K. (2009). Healthcare systems and care delivery in Pakistan. *Journal of Nursing Administration, 39*(6), 263-265.

King, E. M. (2011, January). Education is fundamental to development and growth. In *Keynote address at World Education Forum, The World Bank, QE2 Conference Center, London* (pp. 10-12).

Kwon, K. W., Kam, S., & Park, K. S. (2000). Factors affecting health practice of primary school students: based on health promotion model. *Korean Journal of Preventive Medicine*, *33*(2), 137-149.

Lindahl, M., & Krueger, A. B. (2001). Education for Growth: Why and for Whom?. *Journal of Economic Literature*, *39*(4), 1101-1136.

McCain, M., & Mustard, J. F. (1999). *Early Years Study: reversing the real brain drain: final report*. Children's Secretariat.

McDowell, L., Wakelin, D., Montgomery, C., & King, S. (2011). Does assessment for learning make a difference? The development of a questionnaire to explore the student response. *Assessment & Evaluation in Higher Education*, *36*(7), 749-765.

Miller, B. A. (1991). Distress and Survival: Rural Schools, Education, and the Importance of Community.

Mills, A., Rasheed, F., &Tollman, S. (2006). Strengthening Health Systems.

Mubarak, M. M. (1990). *Health Coverage in Pakistan: An Evaluation for Future Strategy," Health for All"*. Army Press.

Mustaq, N & Azeem, M. (2012). Conceptual understanding of sustainable development. Academic Research International, 2(2), pp. 627-640.

Nachtigal, P., Haas, T., Parker, S., & Brown, N. (1989). Noteworthy. *Aurora, CO: Mid-continent Regional Educational Laboratory*.

Nishtar, S. (2006). Heartfile's contribution to health systems strengthening in Pakistan. *Eastern Mediterranean Health Journal*, *12*, S38.

Nishtar, S., Boerma, T., Amjad, S., Alam, A. Y., Khalid, F., ul Haq, I., & Mirza, Y. A. (2013). Pakistan's health system: performance and prospects after the 18th Constitutional Amendment. *The Lancet*, *381*(9884), 2193-2206.

Pearce, D. W., & Warford, J. J. (1993). *World without end: economics, environment, and sustainable development*. Oxford University Press.

Pearce, D., Barbier, E., & Markandya, A. (2013). *Sustainable development: ecanomics and environment in the Third World*. Routledge.

Qemuge, S. (2008). The role of early childhood education establishing a sustainable society. *The contribution of early childhood education to a sustainable society*, 81-87.

Quisumbing, A. R. (2010). Implementing the internationally agreed goals and commitments in regard to gender equality and empowerment of women. Gender equality and poverty eradication: good practices and lessons learned. Commission on the Status of Women, Fifty-fourth session, United Nations: New York, 1–12 March 2010.

Ratcliffe, J. (1978). Social justice and the demographic transition: lessons from India's Kerala State. *International Journal of Health Services*, *8*(1), 123-144.

Rex, J., & Singh, G. (2003). Pluralism and multiculturalism in colonial and post-colonial society-Thematic introduction. *International Journal on Multicultural Societies (IJMS)*, *5*(2), 106-118.

Rizvi, N., &Nishtar, S. (2008). Pakistan's health policy: appropriateness and relevance to women's health needs. *Health Policy*, *88*(2), 269-281.

Schuller, T. (2001). The complementary roles of human and social capital. *Canadian Journal of Policy Research, 2*(1), 18-24.

Shaikh, B. T., & Rabbani, F. (2004). The district health system: a challenge that remains. *Eastern Mediterranean Health Journal, 10*(1/2), 208-214.

Spears, J. D. (1990). Accommodating Change and Diversity: Linking Rural Schools to Communities. A Report of the Ford Western Taskforce.

Thurow, L. (1999). Building Wealth: The New Rules for Individuals, Companies and Nations in a Knowledge Based Economy. New York: Harper Business

Torjman, S. (1998). *Community-based poverty reduction.* Caledon Institute of Social Policy.

Torjman, S. (2000). *The social dimension of sustainable development* (pp. 1-11). Toronto: Caledon Institute of Social Policy.

Transparency International: Corruption in public services; informal payments among users of health services. Berlin; 2002.

Ulleberg, I. (2009). The role and impact of NGOs in capacity development from replacing the state to reinvigorating education. *International Institute for Educational Planning© UNESCO.*

UNESCO Institute for Statistics, (2009): An estimated 90 percent of all countries have legally-binding regulations requiring children to attend school.

UNESCO, E. (2007). EFAGMR 2008: Education for All by 2015. Will We Make It. United Nations Education, Science and Cultural Organization, Paris.

UNESCO, E. F. (2004). Global Monitoring Report 2003/4. table, 2, 50.

UNESCO, E. F. (2011). Global Monitoring Report 2011.

UNESCO. (2005). Decade of Education for Sustainable Development 2005-2014. Draft International Implementation Scheme. Paris: UNESCO.

UNESCO. (2010). BUILDING A MORE SUSTAINABLE WORLD THROUGH EDUCATION.

UNICEF. (2013). Sustainable development starts and ends with safe, healthy and well-educated children.

United Nations Decade of Education for Sustainable Development (DESD, 2005-2014) and The Inter- Agency Committee for the DESD.

United Nations Development Program. (1992). African Development Indicators. The World Bank, Washington, DC.

United Nations. (2012). The Millennium Development Goals Report 2012. New York: United Nations

Vogl, T. S. (2012). *Education and health in developing economies* (No. 1453).

World Bank. (1998/99). Knowledge for Development. London: Oxford University Press.

World Commission on Environment and Development. (1987). Our Common Future. Oxford: Oxford University Press (Brundtland Commission).

World Commission on Environment. (1987). El desarrollosostenible, unaguíasobrenuestrofuturocomún: El informe de la Comisión Mundial sobre el MedioAmbiente y el Desarrollo. Peterson's.

World Health Organization: Everybody's business: strengthening health systems to improve health outcomes: WHO framework for action. Geneva: 2007.

World Health Organization: World Health Report 2000. Health systems: Improving performances Geneva; 2000.

APPENDIX

QUESTIONNAIRE

Exploring the role of Education and Health in Promoting Sustainable Development in ICT, Punjab & KPK: A Case Study of Human Development Foundation Pakistan

Q.1 What is your age? (In completed years) _____

Q.2 What is your gender?

i). Male ii). Female

Q.3 What is your area of residence?

i) Islamabad ii) Lahore iii) Mardan

Q.4 What is your marital status?

i). Single ii) Married iii) Widowed iv). Separated v) Divorced

Q.5 What is your educational level? (Completed years)

0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	16+

Q.6 What is the type of family you are living in? i) Nuclear ii) Joint iii) Extended

Q.7 What is your family size? (In numbers) _____

Q.8 What is your occupation? i) Govt. Employer ii) Business iii) Private job iv) Skilled labor v) Unskilled labor vi) House wife viii) Any other (Please Specify)_____

Q.9 What is the occupation of your spouse? i) Govt. Employer ii) Business iii) Private jobiv) Skilled labor v) Unskilled labor vi) Any other (Please Specify)_____

Q.10 What is your personal income? (Rs/ Month) _____

Q.11 What is your monthly family income from all sources? (Rs/ Month) _____

Q.12 How many your children are enrolled at HDF School? **Boy(s):** ____, **Girl(s):** ___

Q.13 In which HDF school they are enrolled? i). Islamabad ii). Lahore iii). Mardan

Q.14 What are the education levels (below middle) of your children?

S. No	Level of Education	
	Boys	Girls
1	(__Class)	(__Class)
2	(__Class)	(__Class)
3	(__Class)	(__Class)
4	(__Class)	(__Class)

Q.15 From how long you are availing services from HDF?_____ Years.

Q.16 Which type of health facilities do you have? i). BHU ii). RHC iii). DHQ iv). HDF CHC v). Private Clinic vi). Homeopathic vii). Quack viii). Any other (Please Specify)_____

Q.17 Which type of sources of water do you have? i). Filtered water ii). Hand pump iii). Water supply iv). Tanker v). Open well vi). Any other (Please Specify)_____

Q.18 Do you have any proper sanitation structure? i). Paved streets ii). Unpaved streets iii). Any other (Please Specify)_____

Q.19 I would like to know how often you availed HDF health facilities in your region.

Sr.#	Statements	Never (1)	Rarely (2)	Sometimes (3)	Always (4)
19.1	Administrationand Availability of staff				
19.1.1	Doctor				
19.1.2	LHV				
19.1.3	Dispenser				
19.1.4	CHWs				
19.1.5	Nurse				
19.2	**Availability of rooms**				
19.2.1	Patient Examination Room				
19.2.2	Dispenser				
19.2.3	Patient wards				

19.6.5	Newsletter (sehat- nama) by field staff for CHWs and support groups				
19.6.6	Wall charts of health messages				
19.6.7	Audio messages (mobile ICT)				
19.7	**Capacity building**	**Never (1)**	**Rarely (2)**	**Sometimes (3)**	**Always (4)**
19.7.1	Trainings of core members of the community on health responsibility & refusal cases				
19.7.2	Trainings of health committees on health role/support group				
19.7.1	Trainings of general community on health education				

Q.20. I would also intend to know how frequent you use HDF Educational Facilities for your children's?

Sr.#	**Educational Facilities**	**Never (1)**	**Rarely (2)**	**Sometimes (3)**	**Always (4)**
20.1	**Availability of staff**				
20.1.1	Principal/EC				
20.1.2	Teachers				
20.1.3	IT teacher				
20.1.4	Support staff				
20.1.5	Security guard				
20.2	**Availability of rooms**				
20.2.1	Computer lab				
20.2.2	Library				
20.2.3	Digital study hall				
20.2.4	Sports ground				
20.2.5	Staff room				
20.2.6	School time Ambulance service for students& staff				
20.2.7	CCTV for security reasons				
20.2.8	Availability of free books& literature				
20.2.9	Availability of transportation services from HDF				

Q.21. Up to what extent following activities are being conducted by HDF for learning of your children in HDF School?

Sr.#	Statements	Never (1)	Rarely (2)	Sometimes (3)	Always (4)
21.1	**Educational Activities**				
21.1.1	**Urdu Reading Competition**				
21.1.2	Monthly follow-ups of students				
21.1.3	Student exposure visits				
21.1.4	Quiz competition				
21.1.5	Awareness walk on social issues				
21.1.6	Enrollment campaigns				
21.1.7	Scholarships to brilliant students on annual bases				
21.1.8	PTA and Education Committee Training & meetings				
21.2	**Educational Alerts**	**Never (1)**	**Rarely (2)**	**Sometimes (3)**	**Always (4)**
21.2.1	Providing conducive environment at School for study				
21.2.2	Teachers capacity building programs				
21.2.3	Best Teacher Awards on results				
21.2.4	Linkages Development with Line Department / Corporate Sector				
21.2.5	Establish Referral and Network Mechanism for Education				
21.2.6	Monthly teachers' meetings				
21.2.7	Awareness Raising Programs and Orientation Sessions for students				
21.2.8	Awareness Raising Programs and Orientation Sessions for teachers				
21.2.9	Awareness Raising Programs and Orientation Sessions PTAs				
21.2.10	Co-curricular activities/events				

Q.22 Can you Identified any four major Strengths of Health & Education programs run by HDF in your areas?

1. _____ 3. _____

2. _____ 4-_____

Q. 23 Would you like to share any four major Weaknesses in Health & Education programs run by HDF in your areas?

1. _____ 3. _____

2. _____ 4. _____

Q. 24 Please suggest four major steps HDF will improve the Health & Education program in your areas.

1. Education	**2. Health**
i) _____	i) _____
ii) _____	ii) _____
iii) _____	iii) _____
iv) _____	iv) _____

Thank you very Much!!