Gender Differentials in Governance of Health Care System in Pakistan: Effect on Women's Access and Utilization of Health Services

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Gender Differentials in Governance of Health Care System in Pakistan: Effect on Women's Access and Utilization of Health Services

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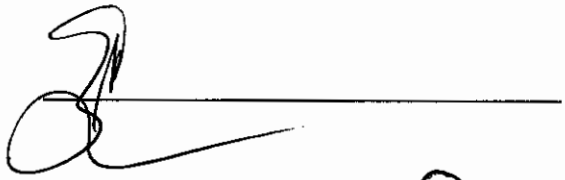

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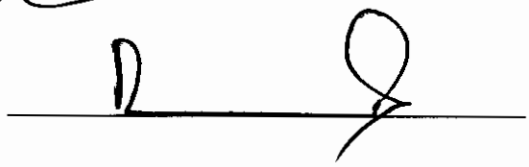

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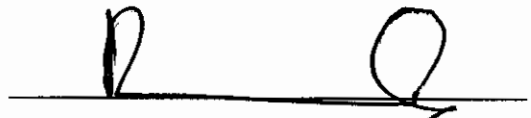

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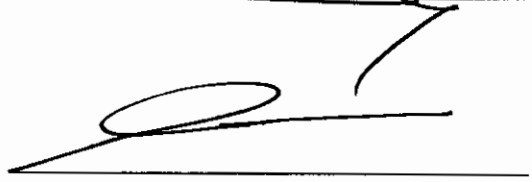

DEDICATION

This prosperous and victorious effort is dedicated to

"My Affectionate Parents

Without whom prayers and encouragement it would not have been possible for me to complete this thesis

&

My Loving Nephews"

Aon, Ahsen & Abdullah

Abstract

The study aim was to find out gender disparities in governance of health care system and its effects on women access and utilization of health services. Both quantitative and qualitative research paradigm was used for the study. In quantitative part, the data was collected from hospital administration, patients and doctors by filling the questionnaire, whereas in qualitative part, content analysis of health policies 2001 and 2009 as well as in-depth interviews were conducted to collect required information. The whole study was conducted in three phases: Phase I comprises on the content analysis of Health Policies of 2001 and 2009 by using Gender planning framework developed which was developed by Oxfam to analyze the gender issues highlighted in policies. For in-depth analysis of identifying gender issues in health policies as well as the governance of health system, interviews were also conducted with health policy makers. In phase II, public hospitals were visited to explore the resources' utilization according to the need of particular gender and also to study its governance structure. In-depth information was taken from the Medical Superintendent of the concerned hospitals by using self-semi structured questionnaire. The phase three focused on the availability of health resources and their access and utilization by patients and doctors of the district headquarter hospitals included in the study. The findings of the content analysis of policies indicated that both policies are focusing the women's health needs as its priorities areas in terms of expanding health services to women in both urban and rural areas. Although the health policies focuses on gender equity in health sector, but the resources which are given to this area are very low due to which still the utilization of health services to women are not up to mark. The results of the interviews conducted from policy makers indicated that the formulation of health policies is a complex process in which other departments like, finance, education and federal ministries are included. The health ministers and politician of parliaments have the responsibility to set the agenda and have authority to take final decisions about the health policy. Regarding the ratio of male and female policy makers, the numbers of females are very low because of lack of women at the executive post, but with the passage of time the number is increasing now. The findings of the study indicated that the infrastructure facilities of the public hospital were not enough as per their requirements of patients visited. The number of the wards, rooms and beds were not sufficient according to the number of patients visiting the public hospitals. The human resources including doctors, nurses and attendants were not sufficient to meet the number of female patients. Lastly the allocation of budget and other physical resources was not equitably distributed to all hospitals and their departments. While allocation of infrastructure to particular department, the number of patients visited to that department was not undertaken into consideration. Due to week structure of governance women still have to face many difficulties in utilization of health services when they visited to public hospitals. It is concluded that there is need to develop strategic governance plan to improve women's health care services at all level.

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In the name of Allah, the most merciful and beneficent.

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ADEELA REHMAN

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Convention on the Elimination of Discrimination against Women
DHO	District Health Officer
DHQ	District Headquarter
EmOC	Emergency Obstetric Care
FGS	Federal Government Service
FY	Fiscal Year
FP	Family Planning
GAM	Gender Analysis Matrix
GDP	Gross Domestics product
GNP	Gross National Product
GoP	Government of Pakistan
HIV	Human Immunodeficiency Virus
ICPD	International Conference of Planning and Development
LHWs	Lady Health Workers
EPI	Expanded programme on immunization
MCH	Maternal and Child Health
MCP	Malaria control programme
MDGs	Millennium Development Goals

MMR	Maternal Mortality Rate
MoH	Ministry of Health
MTBF	Medium Term Budgetary Framework
MTDF	Medium Term Development Framwork
NGOs	Non Governmental Organizations
NHP	National Health Policy
NWFP	North Western Frontier Province
PHC	Primary Health Care
PSDP	Public Sector Development Program
RH	Rural Health
TB	Tuberculosis
UN	United Nation
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for international Development
WEP	Women's Empowerment Framework
WHO	World Health Organization

Chapter 1

Gender Differentials in Governance of Health Care System in Pakistan: Effect on Women's Access and Utilization of Health Services

1.1 Introduction

Health care is defined as the treatment and management of illness through medical services provided by the health professionals. Health care system promotes and designs these medical services to recover the health of the individual. The Health Care System comprises of the body of policy makers, executives and government officials who reform health policies and program as well as govern the services of health sector (Ghaffar et al. 2009).

1.2 Health Care Delivery System:

The evolution of health care delivery system is associated with the history of mankind as it is built upon due to growing interests of individuals for protecting their health and to curing diseases. The progress of health care system is based on the structure of political, social, economic and cultural values of any society. The focus of health care system is to improve individual's status of health, reduce health inequalities on the basis of gender, race and class and promote accountable

and fair financial system. Other complementary functions of health system are stewardship, financing, service delivery and resource development which provides guidelines to formulate health care norms, standards and finally the effective implementation (Khan, 2008).

The health care delivery system also consists of the interaction of many interest groups such as patients, physicians and health policy makers etc, all competing for limited resources (Gilson, 1998). In spite of availability of improved medical technology and increasing public expenditures, during the last few decades the increasing level of illness, inequalities in health care and low access of the needy designate that equity issues in health care are still need to be addressed properly.

According to World health organizations, health system reflects the society that creates them; therefore the health system and health care services must be responsive towards the specific health needs of men and women. One of the central focus of primary health care is "to put people first", that requires special attention to the needs of the people, especially women, due to their specific and critical health needs. Evidence indicated that women are the main users of health services, but insufficient allocation of resources adversely influence on provision of maternal health care services. Some social barriers such as lack of decision

making power or low status and social values imposed on women's health are the major obstacles for them to access to health services (WHO, 2009).

Since the declaration of Alma Ata[1] in 1978, the health care systems are struggling towards the achievement of more better and equitable health services for all, and the evidence can be shown by the increasing level of life expectancy, decreasing mortality rates and promotion of health programmes. Community participation, as very important stakeholder in developing health policy and programs, leads towards the betterment of individual's own health and to restrict them to choose unhealthy situations. This shows the way to bureaucracy in health care systems that confine choice and allocate resources on the basis of risk assessment rather than health promotion (Tlou, 2002).

Access and attainment of quality health is the fundamental right of every human being. Pakistan has made progress in health services but still is much behind in addressing the health needs of the population. Inadequate public health services, socio-economic and cultural barriers, inappropriate measures to utilize the resources and weak governance are the major constraints on the affective utilization of health services. It is estimated that at the moment 55% population of

[1] The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to the attainment of the goal of Health for All.

Pakistan can avail the health care delivery services, and with comparison to gender the percentage decreases to 30% of women only (UN, 2003)

The utilization of health services in an effective way is the reflection of efficiency of health policies and its effective implementation. Health policies shape the health services for both men and women and its practices reflect the gender based differentials in accessing and utilizing health services (WHO, 2009). For efficient gender sensitive health policy, the issues of equity in health care, coverage by health services, prevention of diseases and promotion of good health, decentralization and strengthening of health infrastructure must be the focus aspects of health policy. Health policies in Pakistan are targeting to achieve the goal of "Health for All" with the collaboration of other institutions like education, industry and environment (Hammad & Smith, 1992).

1.3 Governance of Health care system:

In order to develop better and consistent health care facilities it is necessary to build structure of quick delivery of health services, equitable and professional services, transparency and accountability of the health sector (Rabbani & Shaikh, 2004). It is the state responsibility to regulate the governance of health system for the provision of efficient and equitable health services to its nation. Health

system governance consists of the strategies and practices accomplish by the government to organize and regulate the health services. The governance mechanism of health sector consists of the interdependence of local, regional and national frameworks of health system. The mechanism works as a bridge to establish interconnection between central and local governments and also the providers of health services (Ali *et al* 2008).

The present study is intended to explore the structure of governance of health system in Pakistan and to explore its effects on access and utilization of health services by women. The study also aims to identify the process and autonomy of health system governance in Pakistan and its effects on the gender based access and utilization of health services.

The health system governance can be understood as equitable delivery of health care services designed by the government. As the governance structure of health system in Pakistan is decentralized and responsibilities of its provision of services are devolved to the local level, other social institutions such as legislative and regulatory bodies also help the government for the assurance of adequate provision of health services (Lewis, 2006). According to the Devolution Plan (2000) of Government of Pakistan, districts are responsible to administer the health care activities at district level. They are responsible to develop programs,

strategies and interventions to cater the health need at local level (Hatcher & Shaikh, 2004).

To fulfill the health needs of the population, the hospital is a major social institution which provides health care services to the society. Hospital is a place where the illness and diseases are cured by providing the medical treatment to rehabilitate the health and well being of needy people. A large number of health professionals provide their medical expertise to regulate the process of provision of health services to the people who visited the hospitals (Goel, 1984). The services provided by the hospitals are defined as:

> "*Hospital Services are oriented toward a supportive notion of patient welfare, hospital rules and regulations are generally designed for the benefit of hospital personnel, so that the work of treating large number of patients can be more efficient and easier to perform*" (Cockerham, 1982: pg. 45).

The target of health care delivery system is not just to improve the structure of governance but also to deal with the patient's satisfaction with the health services (Donabedian, 1988). Patient's opinion regarding health services is one of the indicators to check the quality of services provided by medical care system as well as by medical practitioners. Patient's satisfaction can be measured by the

judgment of patient's satisfaction with the treatment and level of cooperation provided by the health providers (Durieux *et al,* 2004).

The satisfaction of health services users is based on the efficient working of health system which is based on the effective formulation of health policy. Health policy classifies the procedures and guideline to achieve the goals and targets of health sector. The process of formulating health policies is based on the establishment of working bodies form different departments such as Ministry of Health, Planning and Finance Division, Chief and Director General of Health as well as directors of specific health programs like, Family Planning, Malaria Control, AIDs etc. Although the policy formulation is the key concern of federal government but the responsibility of implementing health policy lies on provinces (Hakim, 1997)

Policy formulation is basically easing the process of the adoption of best approaches and appropriate resources for provision of health services (Sutton, 1999). Health policy reflects the role of government to improve health services as well as prevention of health problems. To access the role of government, policy analysis has been conducted to measure its effective implementation. For analyzing health policy usually two approaches have been used: rationalist and behaviorist approach. The rationalists adopt the linear model to study the content of policy that determines the aspects of how policy should be formulated (Van, *et*

al, 2000). While on the other hand, the Behaviorist deliberate to study the process and the context under which policy has been formulated and implemented (Walt, 1994 & Sutton 1999). According to Sabatier (1998), these approaches help to analyze the loopholes in the efficient implementation of health policies and how to reduce the gaps.

Effective formulation of health policy and its effective implementation reflects the governance of health care system and vice versa. Governance represents the competence of governments to formulate and implement policies, resources management and provision of good quality services to its citizen. Good governance allows its citizen to elect, monitor and replace the government to hold the accountability of social institutions. Good governance can be measured by accountability, political stability, effectiveness of government, rule of law and hold on the element of corruption (Mamdani, 2006).

1.4 Gender Differences in Health system:

Gender inequalities in health can be defined as gender disparities in health status and differences in power structure. As 50% of the population in Pakistan is female, their access to and utilization of health services is very important concern for the development of the country. The female relationship with health care

system is different from male because of maternal health needs of women. Within women groups, there is also a huge difference in access and utilization of health services such as socioeconomic differences and other demographic factors (Owens, 2008). A low status of women's health is also the result of lack of access to health services. The major factors behind this are lack of financial stability, restriction on the choice of physician, doctors-patient relationship, lack of time due to family and work responsibilities and restricted mobility outside home (Abbasi, 2006).

The economic instability and lack of social forces increase the vulnerability of poor people in terms of affordability of health services. Due to poverty, poor people are not only denied of access to health care system but also not have any say in decision making process regarding their health inequalities. Institutional policies and conditions may increase this vulnerability particularly with reference to gender and health. Health and education receives little attention of setting government in poor economies, especially where defense and debt serving engrave a larger portion of annual financial outlay. The strategies designed have a great impact on the way men and women interact with health conditions and have unique risk factors based on their sex. A disease may have different affect on women and men that may provide direction to build the hospital services according to gender needs (WHO, 2007).

In hospital, Gender based analysis is defined as a tool to investigate the men and women health experiences differently. The nature of health services provided at hospitals, accessibility and affordability of these services may also reflect the feasibility of men and women availing services differently. Within Pakistani society it is crucial to understand the gender sensitivity for the access and utilization of health services (Sajid 2000). However, health care financing is the major issue. Along with the policy decisions for the provision of social services, the allocation of appropriate budget for health sector is also needed to be focused. The budgetary allocation must be taken according to the demands of health services needed at hospitals for both men and women (Ahmed, 2008)

The sensitivity and contemplation of gender perspectives in health is the result of feminist struggles in 70's and 80's that highlighted the gender differences based on the outlook of social and cultural practices which defines the power and status of males and females. To attain gender balance structure in health sector, it is necessary to minimize gender based biasness in norms, rights, resources, service provision and policies formulation. Feminist use the concept of gender mainstreaming to entail the gender sensitivity and equity in health related issues at the level of policy formulation, institutional structures and resource allocations (SIDA, 1996). Gender analysis of health system also identifies the gender based

inequalities and issues in the process of health policy formulation, its implementation, and practices in health care services (Ucsnik, 2006).

Gender analysis of the health system is mainly focused in the situation of women in terms of their access and utilization of health resources. By conducting gender analysis the differences between women and men regarding their health needs can be identified. Similarly, gender analysis of the health policy is done to understand to the extent to which policy makers priorities the gender based health needs while forming health policy. Gender analysis in health sector highlights how inequalities affect the health of women and turn out to be disadvantageous to women and are damaging their progress and growth in the society. Such analysis will help to understand whether policy makers are aware of gender sensitive issues regarding health.

1.5. Significance of the study

The structure of governance reflects the socio-economic development of any country. The governance of health system also shows different aspects of health care delivery services and its progress to achieve development by targeting to achieve Millennium Development Goals. Pakistan has very versatile health care delivery system with very limited resources, due to which its a challenge for

government and other social coalition institutions to work together to accomplish the health demands. To understand its structure to work, it is important to study the governance of its system.

Regarding gender and health, as women are more vulnerable part of the society with respect to having responsibility of rearing and bearing new generation. They need appropriate health care facilities to cater their special health needs. But lack of concentration on women's access and use of health services has made the health status of women more vulnerable. Apart from the provision of health services either by public or private health delivery system, gender based socio-cultural determinants, low level of female education as well as economic dependency also increase the inequalities in health care system.

Women's health is an important factor of sustainable development in any society. In Pakistan, being a developing nation, women have to suffer with poor health services. The availability of health care services and governance are the key indicators to explore the women's excess to health services. Therefore, the present study has been designed to explore the governance structure of health care system with respect to gender specific health needs. The study comprises of different phases. In phase one of the study gender analyses of health policies of year 2001 and 2009 were undertaken as well as interviews were conducted from the health

policy makers to access the focus of gender needs in forming health policies. In phase two of the study, a survey was conducted from the administration, doctors and patients at Districts headquarter hospitals of selected district in Punjab.

The survey was conducted in order to find out the implementation of health policies and its outcome on access and utilization of health services by women. The information collected form both phases was interpreted under the five principle of governance designed by UNDP to measure the structure of governance in health care system. Without taking into consideration the role of governance in health sector, it might be difficult to analyze the health situation of women in regards of their access and utilization of health services.

1.6. Approaches of Gender and Health

Currently two main approaches are in focus to conduct research on gender and health:

1. Gender Equity Approach
2. Women's Health Needs Approach

Gender equity means that fulfilling desires according to their requirements. In gender equality all resources are equally divided between both sexes while in

gender equity resources are divided according to the needs of men and women as both have their specific needs and encounter different types of barriers to access their needs. Gender equality approach is useful to address the issues of gender relation with each other. The approach highlights the circumstances which promotes inequality between men and women in relation to access and utilization of health care services. Women always depend upon their male family members as well as face social barriers to use the health services (Hedderich, 2004).

Women health need's approach indicates stresses due to women's reproductive role as their health needs are specific and different from men. They are at disadvantage in society for their reproductive circle. According to the researches, this includes control of women's fertility as well as provision of resource necessary to ensure healthy pregnancy and child birth. Therefore, reproductive health care is a means to offer a compensation of women's helplessness in order to undertake equity among men and women (Hedderich, 2004).

In view of the importance of this health issue, the study has been planned with the following specific objectives:

1.7 Objective:

- To find out gender disparities in governance of health care system
- To explore the women access and utilization of health services
- To identify barriers to access and utilization of health services by female
- To suggest policy implication for the improvement of health governance and enhancement of women access to health services.

1.8. Hypotheses:

Broadly following conceptual hypotheses were tested.

- Structural disparity and negligence in health care system is the reflection of poor governance.
- Relationship between health provider and seeker is the important indicator to measure the fairness and satisfaction with health services.
- Differences between the document of health policy and its practical implementation articulate the state of governance

Chapter 2

Literature Review

This chapter comprises the review of literature based on different researches conducted on the issues related to present study.

"Health and well-being is a concept related to the facilities, and to issues of fundamental safety and integrity of person regarding the health services".

(World economics forum, 2004)

2.1 Health and Governance

Governance in health system is based on the concerns of equitable, healthier and proper health care at time which can be intended by social and legislative measures (Fikree & Omrana, 2004). The role of government asserted by the structure of governance to give power to local citizen and civil society, and the private sector to play a part in health sector and create links between government and other sectors of the society. The primary responsibility to hold the governance of health system is on local governments to plan and manage the health resources with the facilitation of ministry of health. Due to mismanagement of consumption of financial resources, corruption and low quality health services, the users of these health services feel reluctant to use it (USAID, 2007).

United Nations Development Programme (UNDP) also indicated that beside the government responsibility to govern the state issues, political, administrative and economic forces also play their active role in the process of governance (Kaufman, *et al,* 2005). Due to this body, the governance of health system also consults with different other institutions to plan and regulate the functions of health system (North, 1990). Health policy is one of the important indicators to assess the governance in health system. It is necessary to understand the relative underline factors such as political, socio-economic and demographic of country which influence the process and formulation of health policies (Phillips, *et al* 1998).

2.2. Health Policies in Pakistan

Many health polices have been formulated with the change of various Governments of Pakistan since its independence and attempted to improve policies within specific objectives and actions to cater the demand of the time (Pakistan, 2001). There have been three health policies formulated in Pakistan until now. The first health policy was announced in 1990, second in 1997 and third health policy in 2001 and the draft of fourth health policy 2009 have been formulated.

The first National Health Policy was formulated in 1990 with the goal of improving health conditions for all. The policy aimed to overcome the diseases and improve the health conditions of people by creating awareness of health education and hygiene. The policy also planned to increase the health budget to upgrade the health care system as well as health education (Pakistan, 1990). In 1997, on the basis of loopholes identified in health policy 1990, second National Health Policy was formulated. This policy focused on the promotion of Primary Health Care (PHC) services to all and adopted the approach to enlarge its health services particularly reproductive health services to all areas of Pakistan irrespective of urban or rural division. The reproductive health services also targeted the family planning services as well. It also highlighted that the critical health problems must be addresses and must meet the current needs; it includes HIV/AIDS, cancer, diabetes, road accidents, violence, crime and mental health (Pakistan, 1997).

In 2001 government of Pakistan has formulated the draft of its third national health policy. This policy is more focused on equitable access and utilization of health services. It promotes the health care services by establishing new centers in both rural and urban areas as well as professional development is the core principle of this policy (NHP, 2001).

The formulation of health policy is consisted of a certain procedure by which the regulatory bodies lay down specific goals, activities and distribute resources for the functions of health services. The process of forming health policy process is based on the careful consideration and is center of attention as it helps to be aware of the extent to which health policies and programs accomplish for the benefits of population (Barker, 1996). The process is based on the planned activities and accomplishment to struggle against the problems of health care system and to build up strategies for the continuation of better health conditions. The process of formulating health policy based on the stages of policy building, formulating, planning, implementation, and monitoring & evaluation respectively (Walt, 1994). This process also helps to identify those health problems which are unsolved, the reasons of the failure of non-efficient implementation of policy as well as the barriers in achieving the targeted goals (Brewer & Leon, 1983).

The policies are formulated and designed very systematically for their efficient implementation but sometime these are unable to achieve their targets. The foremost shortcomings of the malfunction of the health policy identified are lack of skill to recognize the real dilemma, problems and concerns neither fully addressed nor proficiently reached to the level of policy formulation (Tehobald *et al,* 2005). Due to massive gap between the set goals and their practices, the problem of poor health conditions is very common in practice in many developing

countries (Siddiqi et al, 2004). Another research finding also indicated that some other determinants such as socio-cultural, economic, political conditions and lack of resources also increase the problem of poor utilization of health resources which reflects the deprived implementation of health policies (Lush, 2003).

A research conducted by Brugha *et al (*2008) on the content of policy analysis identified that the policy process is not constant in both developed and developing countries as it changes according to the situation and condition of any country. In the beginning, policy analysis focused on the state, politicians, bureaucrats and interest groups. According to another research conducted by Gilson & Raphaely (2007), civil society all over the world also influences on policy. Apart from these major changes, other abstract confrontations also have a greater influence on the contextual changes in policy process, such as values, beliefs, the impression of power etc.

2.3 Health Care System in Pakistan: Gender Differences

The government of Pakistan is working hard towards the improvement of health care services to improve the quality of care for all people. To improve maternal health status is one of the major concerns of government and it is making its efforts to provide health services at the doorsteps of women. For this many programmes including Lady Health Workers, Maternal health centers, and family

planning services have been introduced for catering the needs of women's health. The specification of better health services can be achieved by efficient allocation of resources and budget which is unfortunately not enough to meet the current demands of health sector (Pakistan economic survey 2005-2006).

Due to insufficient budget allocation and lack of services, the status of mother and child health in Pakistan stills an immense challenge for the government. It is estimated that an average woman gives birth to four children in her reproductive life span in which every fifth birth is in the mother's age group of 15-19 years. It's also indicated that in rural areas specially, three out of every four mothers do not feed their child after delivery because of less education, and unrealistic socio-cultural superstitions (MoPW, 2005). Many social & cultural obstacles prevent the access to health care services by women such as girl's status is considered inferior and do not pay much attention to improve her health as the boy received (MDG's 2006).

Therefore it is the need of the time to pay attention to identify the gender based discrimination in health system as well as the practices exiting in our society regarding the women's health status. The Convention of the Elimination of Discrimination Against Women (CEDAW) highlights the way of attention to health status of women as:

"All health statistics are disaggregated by sex and that a comprehensive women's health profile be constructed. Such a health profile might include eliminating negative cultural practices, reducing violence against women, promoting access to comprehensive health services and education (including girls and elderly women), meeting women's non reproductive health needs"

(CEDAW, 1998).

In Pakistan, the circumstances of low health budget, enormous population, poor health care system, rapidly increasing poor quality medical schools and fragile training structure are the major hindrances for poor governance structure in health system. Due to lack and mismanagement of resources, government is not able to provide the quality basic healthy living conditions to the population (Shiwani, 2006).

The health care service is determined by both the availability and accessibility of health services. The ease of use of health services is usually indentified as the distance from the availability of health services as well as the financial stability to bear the expenditure of those services. The physical accessibility of health services is determined as access to health services within 2 to 5 km or 20 to 60 minutes walking distance. In case of women social acceptability is also very

important to access health services which include religious, tribal, and cultural barriers (Pappas et al, 2009).

Unfortunately, due to poor governance, mismanagement, inefficiencies and corruption in health system of Pakistan, the women's health status is still at low grade as compared to other Asian countries (Danida, 2008). Because of complications in pregnancy, it is estimated that about thirty thousand women lose their life in a year in Pakistan. Due to malnutrition and common infections, premature deaths and disabilities among women also reduce the status of women's health. Another major aspect of decline of women's health condition is high rate of fertility which also increases the population growth rate (Fikree & Omrana, 2004).

Many social-cultural gender discriminatory practices also play a complementary role to establish gender disparities in health system. Due to certain gender segregated roles assigned to men and women, pattern of diseases and access to health services create hindrance for women to take steps for the betterment of their own health. Women usually are not allowed visiting health services alone and sometimes she also may not easily go for the treatment due to disturbance in her daily routine activities of household chores (ADBG, 2009).

Gender difference in access and utilization of health resources is also due to patriarchal structure of Pakistan which has assigned different roles to both men and women. In health sector women always depend upon male members of family and face social and cultural barriers while accessing the service delivery that results to increase maternity issues which leads to the death of both mother and children during the time of pregnancy. In rural areas particularly the main cause of women's death are negligence, ignorance regarding health issues and diseases, social barriers, lack of awareness about health issues, lack of education, lack of hospitals, lady doctors, female staff, nurses, LHWs and lack of proper medical infrastructure.

Aside the social cultural practice which create impediments to improve women's health status, the gender inequalities and gender differences are also prevailing in health care services functioning in Pakistan. Women's health is to some extent ignored because of specific gender stereotypical roles and duties assigned to men and women. The socioeconomic structure also often limits women's mobility to accessing the health care services. By considering the different and special health needs of men and women , attention ought to be given to the health of girls and women not for today but also for future generations as women's health matters are not only related with the women themselves but it is also linked to the health of the children they will bear (UNESCAP, 2010).

In spite of giving far reaching concentration to women health needs all over the world, the maternal mortality ratio has been a very critical issue. One major reason identified behind that is lack of provision of adequate medical services during pregnancy and at the time of birth in most of developing countries. A research on utilization and expenditure of health care services to women in India conducted by Balaji *et al,* (2003) indicated that the major problem of growing ratio of maternal mortality is lack of women's access to basic and adequate health care services that is governed by their age, education, economic status as well the role and position in the family. The study also found the positive relationship between economic conditions of women with the access to health care services.

Health statistics in Pakistan shows that due to maternal mortalities the death rate of women is more than men. Women's health need is given priority at the state level and the issues related to women's health are discussed as fourth out of ten key areas highlighted in National Health Policy of Pakistan 2001. To achieve this target every year health budget may try to improve to meet the critical needs of women's health (Shehzad, 2006).

Despite the efforts going on to overcome the hindrances faced improving women's health status in Pakistan, the progress graph is not upgrading to a great

extent. Regarding the women's health needs and concerns, the analysis of health policy of Pakistan highlighted that women's health is given priority in health policy and emphasized on the more equitable promotion of health. But this also is not fulfilling the needs of women's health due to fewer resources including lack of female health care providers as well as women's lack of authority to take decision about their own well being (Nishtar & Rizvi, 2008).

A research by Butt, (2004) identified that government of Pakistan has established many maternal health centers to provide free of cost health services to women but still some women are hesitant to utilize these services due to impolite behavior of doctors, presence of male doctors while examining the patient or the fear of crowds of medical students present at the time of examination.

2.4 Governance of Health System:

Governance of health system is very important to be considered for the equitable distribution of health care services to the population. Governance of health system is based on equitable provision of resources, design appropriate strategies to improve the health conditions and well being of people, assured proper and adequate rules and procedural guidelines for measuring its actions. The application of governance to health system is obliged to measure within the particular framework of country. To regulate the structure of governance, it is the

government who is responsible to assure proper prerequisite of health services both in the public and private sector (Abdual, *et al* 2009).

The governance of health system based on the complex process in which other marker forces play a very pivotal role as it is influenced by the multiple public and private funding sources for health, and external forces that force to address health needs while framing the policy. For enabling universal coverage to all, directions for service delivery arrangements have to be articulated which is acceptable for both public private partners of health system. Besides that, the mechanisms and means of health financing need to be clearly affirmed. Other considerations of governance are decentralization of health system, mechanisms of social protection, and interventions of market forces as well as assessment of health services. Another major concern of governance is to formulate effective health policies keeping in the mind the effects of globalization, disease security and health risks existing within country.

There is an obvious dichotomy of public-private health care system in Pakistan. The finance of public sector is borne by the state and private sector is working independently for profit. Government of Pakistan spends on health care to improve the poor health indicators by establishing new programs such as immunization, knowledge of family planning and awareness about the health problems as well as where to access for health seeking. However, the low level of

basic health facilities with no accessibility to people makes its difficult to achieve the targets. The problems may flourish due to lack of availability of trained health professional especially females (Sheik, 2007).

Maternal and child health issues are moderately prevalent and most of them are unaddressed due to mismanagement and poor administration of health system. Shortage of competent female health providers increases the women's health problems to seek proper care. It is indicated that more than 80% of deliveries in Pakistan are still performed by untrained traditional birth attendants (Hatcher & Sheikh, 2008).

The efficient delivery of health care services is based on the effective and sound policies which also reflect the governance of health system. In developing countries women are using lesser health services than men because they are economically weak and they can not afford health services. A research conducted by Denton & Walters (1999) measured the health status which indicated that gender based health inequalities are also the outcome of social support, physical activities, different health needs of women and men and structure of social economic condition. Health varies at different levels of socio-economic status. Hunt, (1997) argued gender differences in health is also influenced by employment, psychological demands and social support. Less attention is paid on public sector in which women are engaged. Women's unpaid work and isolation

within the home is associated with poorer health status though it is a full time work at home.

Resources allocation and utilization is very important in efficient use of health service deliveries. In most countries, the government's spending on health promotion is low per its needs (McGinnis, *et al* 2002). Even in the developed countries like USA, there are imbalance practices between the allocation of resources to the medical care services and its effective utilization (Centers for Medicare and Medicaid Services, 2000). In Canada too, the budget allocation does not meet the needs of health promotional activities.

A research conducted by Chaudhry *et al* (2006) indicated that health care management is the crucial factor to continue the good governance structure in health system. Lack of or poor health care management cannot produce the needed and potential outcomes particularly in government sector. The study defined that the comprehensive health care system is based upon the complex issues like finance, performance and specific standards to measure its outcomes. It is necessary to build code of ethics and standards to exchange information with national and international health care organizations to achieve better results in health care promotion. Another research also indicated that the factors influencing health information system must be evaluated in particular context in which it has

been implemented, it reflects the success or failure of health care system. The evaluation methods addressed the functional, organizational, behavioral, cultural, management, technical and strategic factors to evaluate the health information system. These factors help to successfully measure the performance and characteristics of health information system for planning, development and implementation (Brender, 2008).

The Common Wealth Association has formulated a model for obtaining effective health care system which is based on the following five strategies:

1. **Extend Health Insurance to All:**

   The focus of expending health insurance is to ensure the products must be based on the income level of average people of any state.

2. **Excellence in Provision of Safe and efficient care:**

   It aims to enhance the performance of health system by establishing effective and effective legal, medical care management, promoting patient's safety and ensure efficient health care.

3. **Organizing Health care system to ensure the accessibility of services:**

   It emphasizes on the research perspective to explore the health differences in health care systems as well as it is needed to promote professional medical training programs for medical students and doctors.

4. **Developing workforce**

   The strategy of developing the workforce which foster patient centered care, it is necessary to establish reward and benefits for the medical professionals by providing them good salaries, bonuses and appreciation.

5. **Expanding the Use of Information Technology:**

   It is the need of time to incorporate health information technology to develop the health structure by incorporating rapidly changes occurring in the world. It includes computer based health records; patients and doctors support services, and health information system (Common wealth Fund, 2010).

2.5 Governance Framework:

Structural functionalist perspective defines the indictors which help to understand the structure of health system. Following model describes how governance is measured:

The World Health Organization (2007) has established a framework to access the governance of health care system which is based on the principles of strategic vision, participation, rule of law, transparency, responsiveness, equity, efficiency, accountability ethics and information. Many countries including Pakistan, Iran, Egypt etc have adopted this framework to study their health system. The World

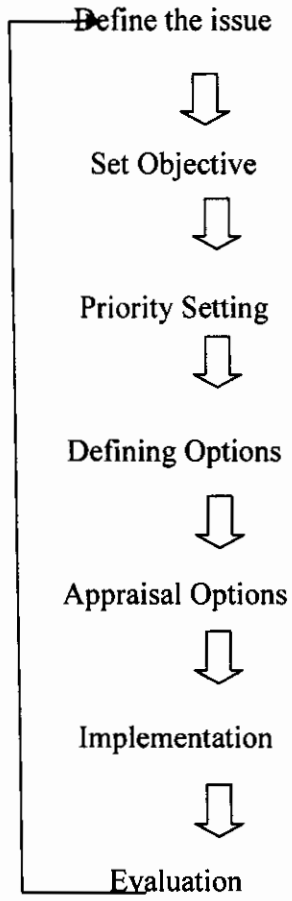
Bank also formulated six basic concepts of health governance which are presented in three clusters. First, the process by which state authorities established the accountability and political system second is the ability of government to formulate and implement the sound health policies and third cluster focuses on the rule of law and control of corruption. The United Nation Development Programmes (UNDP) has also formulated five principles of good governance that are:

- Legitimacy and voice
- Participation & consensus
- Direction
- Strategic vision & performance
- Responsiveness and effectiveness

Health system governance is imperative to furnish with special significance in national development. There are many models and frameworks to access health care system developed by different organizations, but it is necessary that the model adopted must represent the national and local concerns of any country.

As the policy making is a complex and dynamic process, there are numerous models which provide the conceptual and analytical frameworks to analyze the health policy. Walt, (1996) described four stages for policymaking process which are problem identification, policy formulation, policy implementation and policy

evaluation. Barker, (1996) also related these stages to planning process and explained its hierarchy of work through following figure. The following steps presented in following figure are involved in the policy process:



Source: Figure 1. Stages in Policy Making Process. (Barker, 1996 pg28).

2.6. Gender Analysis Frameworks

To assess the gender disparities and the policy analysis based upon gender needs, different models and formworks were reviewed for the study. Gender analysis can be defined as a strategy to examine the relationship between the problems and its practices based on gender needs. It helps to understand the gender differences and unequal as well as discriminatory practices existed in any society which treat men and women differently (Miller & Razavi, 1998). Here is the description of some of the important gender analysis frameworks in which one has been chosen for the analyses of the present study.

2.6.1 Harvard Analytical Framework

This is developed at Harvard Institute of International Development (HIID) in collaboration with USAID. It is also known as Gender Roles Framework or Gender Analysis Framework. It focuses on the concerns of distribution of resources to both men and women and identified the differences by analyzing the activities assigned to both men and women at household level either their productive or reproductive responsibilities (Catherine, 1991).

2.6.2. Moser Gender Planning Framework

It is developed by Caroline Moser, discussing the three roles of women which are; production, Reproduction and community management. These roles highlight the issues of access and control over resources by men and women as well as their participation in development programs and process.

The Moser gender planning framework was developed by Caroline Moser, identify the role of women in development process. It analyses the three roles (Production, Reproduction and Community management) of women which reflect the participation into development programs. These roles are also examines by the access and control of resources by both men and women (Moser, 1993).

2.6.3. Gender Analysis Matrix (GAM)

It was constructed by A. Rani Parker to emphasize and to study the impact of development on men and women. It works by obtaining the knowledge from the four levels of society including men, women, household and community to explore the effects of development on both men and women as well as consider the socio-cultural factors that may influence gender based participation in development process (Parker, 1993).

2.6.4. Women's Empowerment Framework

Women's Empowerment Framework was developed by Sara Longwe. She argued that women empowerment is the basis to reduce poverty. The framework discusses five levels of equality to achieve empowerment which are control, participation, conscientization, access and welfare. It helps the planners to explore to what extent development intervention follows these principles for women's empowerment.

2.6.5. Social Relations Approach

Naila Kabeer has developed the sociol relation framework to explore how institutional structure produced gender inequalities. The key institutions are family, community, marker and state which develop the policies and plan which may discriminate the gender roles. The framework helps to design such policies which consider these inequalities while establishing plans (Kabeer, 1994).

2.6.6. Oxfam Gender Analysis Framework

The Oxfam Gender Analysis Framework was developed by the combined efforts of Candida March, Ines Smyth and Maitrayee Mukhopadhyay in 1999. The

framework is based on guidelines for gender analysis and evaluate the polices and programs through gender lens.

2.7. Sociological Perspective on Governance of health care System

Medical sociologists also have contributed to articulate the understanding of health care system. Health services, defined by the field of sociology discuss three major aspects of inequalities health structure which are inequalities in distribution of resources, inequalities by social institutions, unequal organizations of health care services design by health care organizations (Burns, 2000).

To highlight gender disparities in health system, sociologists have stated that by research based evidences, it is identified that gender differences exist in health seeking behaviors. It has been indicated that although women seek more health services than men but the quality of services do not fulfill their health demands (Courtenay, 2000). The health inequalities explored by medical sociologist highlight the role of government for the provision of health care delivery services (Quadagno, 2004). Sociological research is important to understand the in-depth factors of inequalities and services provided by the health system such as who has the responsibility to develop policies and implement program etc (Peryy & Wright, 2010).

Chapter Three

Methodology

This chapter is based on the procedure to conduct the research by highlighting the different aspects of research methods. It comprises of study design which includes selection of area, sample size, development of research instruments, pre-testing, procedure to conduct research and proposed analysis of data. The filed experiences and ethical consideration of the study is also included in the chapter.

3.1 Study Design

The study comprised of both qualitative and quantitative research design. In qualitative part of the study, the content analysis of Health Policies 2001 and 2009 as well as in-depth interviews were conducted from the health policy makers. In quantitative part, survey was conducted to collect data from the hospital administration, patients and doctors. The whole study was conducted in following three phases:

3.1.1. Phase I:

Phase I comprises of the content analysis of Health Policy 2001 and 2009 through gender lens by using Gender planning framework by Oxfam as well as in depth

interview with health policy maker were also conducted for in-depth analysis of policy and the governance of health structure in the perspective of gender health needs. Phase I comprised of the Qualitative part of the study.

3.1.2. Phase II:

In phase II which is qualitative part of the study, public hospitals were visited to explore the resource utilization according to the needs of particular gender and also to checkout its governance structure explained in health policy. In-depth information was taken from the Medical Superintendent of the hospitals by using semi structured questionnaire.

3.1.3. Phase III:

In phase three of the study, information regarding the availability of health resources and its access and utilization, was taken from the patients and doctors of the particular district hospitals. This phase also comprised of qualitative part of the research design.

3.2 Universe of the Study:

The universe of the study comprises on policy makers, district hospitals of Punjab province, patient and doctors (List of DHQs in Punjab may be seen at Annexure).

3.3. Area:

The research was conducted in six districts of Punjab province and federal capital of Pakistan.

3.4 Sample:

The sample of the study is consisted of triangulation technique to verify the data collected from three different sources which are as follows:

3.4.1. **Health policy:** Health policy of 2001 and 2009 of Government of Pakistan were selected to analyze the allocation of health resources through gender lens.

3.4.2. **Hospitals:** District Headquarters Hospitals were targeted to explore the gender wise utilization of resources and women's access to health services.

3.4.3. **Human Resource:** Doctors as well as patients were selected to explore their experiences regarding access to and utilization of health services.

3.5. Sample Size:

The sample size of the hospitals and human resources for the present study was:

- Five Health Policy Makers who were the executive personnel of the Ministry of Health, Government of Pakistan, were selected for the study.
- Six Districts and one Capital Public Hospital were chosen as the sample of study
- A sample of 70 female Doctors and 210 female patients from the sampled hospitals were selected to collect data.

3.6. Sampling Technique:

Both probability and non probability sampling techniques were used to select the appropriate desired sample. To select the hospital, simple random sampling technique was used to choose the prepared list of Punjab districts. On the other hand doctors and patients from different departments on the DHQs were selected on the basis of their availability in hospital at the time of study conducted.

3.7. Sampling procedure:

For selecting hospitals as sample, Punjab province was divided into three geographical circles: Southern Punjab, Central Punjab and Northern Punjab. The districts included in each circle in the following table are arranged alphabetically to reduce the biasness for selection of any district.

Districts in Central Punjab Circle	Districts in Northern Punjab Circle	Districts in Southern Punjab Circle
1. Chiniot	1. Attock	1. Bahawalnagar
2. Faisalabad	2. Bhakkar	2. Bahawalpur
3. Gujranwala	3. Chakwal	3. Dera Ghazi Khan
4. Gujrat	4. Jehlum	4. Khanewal
5. Hafizabad	5. Mianwali	5. Layyah
6. Jhang	6. Rawalpindi	6. Lodhran
7. Kasur		7. Multan
8. Khushab		8. Muzaffargarh
9. Lahore		9. Pakpattan
10. MandiBahauddin		10. Rahimyar Khan
11. Nankana Sahib		11. Rajanpur
12. Narowal		12. Sahiwal
13. Okara		13. Vehari
14. Sargodha		
15. Sheikhpura		
16. Sialkot		
17. Toba Tek Singh		

By using random table (10-14, start from 15707) from the book Educational Research (5th edition by L.R.Gay, 1996, following districts have been selected. On the basis of propionate sampling following districts were chosen:

Central Punjab	**Northern Punjab**	**Southern Punjab**
Khushab	Rawalpindi	Bhawalpur
Lahore		Multan
Sailkot		

With comparison to DHQs, Federal Government Services Hospital, Islamabad was also selected from capital.

3.8. Variables:

The study comprised of following dependent and independent variables:

3.8.1. Dependent variable:

Gender disparities in Governance of Health system was dependent variable of the study.

3.8.2. Independent variable:

Women's access and utilization of health services, effective utilization of resources according to the needs of patients and separate facilities for women were the independent variable of the present study.

3.9. Operational Definitions:

The variables of the study are operationally defined on the basis of understanding developed by reviewing pervious researches and what this study is going to explore.

3.9.1. Governance of Health Care System

Governance of health care system is defined as the work out of political, economic and governmental authority to administer the health matters of a country. It is based on the complex strategy and procedure to manipulate the interests and priorities of governments, citizens and other institutions to use their legal rights and responsibilities. The governance of health care system can be measured through the performance of health ministry and its attached departments, formulation of health policy as well as stewardship and leadership supremacy to govern the public health system (Siddiqui, 2007).

3.9.2. Women's access to health care

Gender difference is health care system can be accesses by measuring the different health needs and challenges faced by men and women differently. The focus of gender specific health needs is necessary to address while planning and implementing health policies, programs and services. Women's access and utilization of health services reflects the effectiveness of that polices and programs (WHO, 2009).

3.10. Construction of the Instrument:-

In Phase I of the study Interview guide line was designed to explore the information from the policy makers and then Gender Analysis Framework was applied as a tool to analyze the health policy of 2001 & 2009 and themes under the same framework were developed to explain the information gathered for the policy makers. In 2nd and 3rd phase of the study, semi-structured questionnaires were designed for hospital administration, doctors and patients.

3.11. Expert's Opinion:

The interview guideline and questionnaires were referred to health policy makers and health professionals working at Health Service Academy under Ministry of Health, Government of Pakistan and doctors working at public hospitals respectively. Firstly interview guideline and questionnaires were designed under the guidance of research supervisor and then the draft of interview guideline and questionnaires along with study objectives were given to health professionals for their valuable and expert opinion regarding the improvement of instrument based on the study objectives. The researcher had five meetings with the experts for their valuable suggestion regarding inclusion of gender specific items in questionnaire of hospital administration. Their valuable suggestion and comments were incorporated in the final questionnaires after discussion with supervisor.

3.12. Pre-testing:-

The questionnaires of Hospital administration, doctors and patients were pre-tested in one public hospital to check the workability of the instrument. The sample for the pre-testing of instrument was one person from hospital administration, five doctors and ten patients. The pre-testing was conducted in Rawalpindi General Hospital.

3.12.1. Major issues encountered during field-testing:

Many important issues were highlighted during field-testing of the instrument. The issues were related to the sequence and importance of questions and interviewing technique. After field testing, the required changes were made based on the information received.

3.13. Training of research team

A research team comprised of three members was selected for field work. The training regarding the data collection was given to the members the instrument was described to them. The team was hired for 2 months for the field survey and financial stipend was given to them.

3.14. Field Experience

The field experience was very informative and thought provoking. The respondents were very cooperative and gave ample time to complete the survey. At starting, it took time to get approval from the hospitals administration to conduct research in their hospital. The process was too lengthy and no one wanted to give independent approval, therefore many visits were made to different administrative personals of the hospitals to take final approval. The medical superintendents of the hospitals were very keen to know about the findings as it

would help them to improve the facilities at the hospitals. During conducting the interviews, their refusal to answer the particular question was noted and any misconceptions about the questions were cleared with the explanation. No instructions were given and they were not directed towards any specific point in order to receive their natural responses.

3.15. Data Analysis

The policy analysis was done by using Gender Planning Analysis Framework developed by OXFAM which is based on following eight points.

1) Does policy consider the social status and role of men and women?
2) Is the health policy aware of and sympathetic towards women's need?
3) What are the likely constraints and opportunities arising from national health policy for both men and women?
4) Is policy made in accordance to the practical and strategic needs of women?
5) Does it talk about budget allocations to the needs of both men and women?
6) Does the health policy talk about monitoring systems
7) How the health policy does fulfill the requirements of MDG's?
8) Has the health policy been designed with the effective participation of its proposed beneficiaries for both men and women?

Content and thematic analysis was used to analyze documents and interview's data respectively.

3.16. Ethical considerations

Study was conducted after getting approval from the administration of hospitals. Informed consent was taken from administrative authority before conducting interviews. All information was considered confidential. Informed consent was also obtained from administrative authority as well as from the respondents before conducting their interviews. Confidentiality of the information was also ensured. The purpose of study was explained to the respondents and they were informed that their identity would not be disclosed. General ethical principles were undertaken i.e. respect for patients and doctors regarding their time.

Chapter Four

Results and Discussion

This chapter deals with the results of study in three parts. Part I deals with Gender analysis of health policies and thematic analysis of interviews conducted from the policy makers. Part II deals with survey conducted in hospitals from the hospitals administration and part III is based on the doctors and patients survey.

Part 1

4.1. Analysis of Health Polices 2001 & 2009

Part 1 of the study consisted of two section:

4.1. 1. Section 1: Content Analysis of National Health Policies 2001 & 2009

This section deals with the analysis of the National Health Policies 2001 and 2009 by applying the Oxfam Gender Analysis Frame Work.

Theme of the National Health Policy 2001 was "the Way Forward" with a goal to improve health status of the people of Pakistan. This goal was again strengthened in Health policy 2009 developed under the theme of "Stepping towards Better

Health" with the motivation to start an effort towards the progress to make Pakistan having healthy population who has the access to better health care delivery system particularly the poor.

The Policy has a vision to amend the health system by defining:

"A health system that: is efficient, equitable & effective to ensure acceptable, accessible & provides affordable health services. It will support people and communities to improve their health status while it will focus on addressing social inequities and inequities in health and is fair, responsive and pro-poor, thereby contributing to poverty reduction".

(Health policy, 2001)

4.1.2 Need to develop New Health Policy 2009

The purpose to formulate the new health policy is to overcome the strategic loopholes of pervious health policies that were:

- Slow progress in improving health outcomes
- Inadequate performance in improving easy and equitable access to health care services to all people

- Lack of organization between policy documents and target goals

The analysis of Health Policy 2001 indicated that although it was working toward the betterment of health delivery system but due to some structural constraints the progress rate was low. The issues related to unequal distribution of health resources for both men and women and poor utilization of health resources were still needed to address in a proper way.

Lack of proper monitoring and evaluation system as well as gender biased allocation of health resources were also the ambiguous of the policy.

4.1.3. Gender Analysis of National Health Polices 2001 & 2009

To analyze the national policies through gender lens, OXFAM has developed gender analysis planning framework which has been used in this study to analyze how and to what extent national health polices of Pakistan meeting the health needs and priorities of particular gender. Oxfam Gender Analysis framework addresses the following eight critical issues:

1 Social status and role of men and women

2 Awareness of women's need

3 Constraints and opportunities arising for both men and women

4 Is policy made in accordance to the practical and strategic needs of women?

5 Budget allocations according to the needs of both men and women

6 Monitoring systems that measure policy affects on women

7 Relationship between policy and MDG's

8 Beneficiaries of Policy

4.1.3.1 Social Status and Roles of Women and Men:

The sixth key area of National Health Policy 2001 discusses little bit about the opportunities given to men and women to have access to health care services. Despite the government of Pakistan's efforts to promote health services for both men and women in rural areas, women still face social barriers to seek the medical services. Because of lack of female doctors at rural areas, women can not access to health services. The female medical professionals do not prefer to work at rural areas because of inadequate services provided to them such as transportation, long distance and geographic conditions. On the other hand women in rural areas also do not want to share their health problems with male doctors and feel uncomfortable to discuss reproductive health issues with male doctors.

To overcome the problems identified, the National Health policy 2009 focuses to improve the access to primary health care services to poor and vulnerable group including women and children from rural areas. The point 3 of 1.A in policy action emphasizes the availability of female staff in rural area for primary health care service delivery and easy access for women to seek these health facilities.

To improve the health status of women, the health policy 2001 also emphasized on the establishment of Women's Friendly Hospital in twenty major districts of Pakistan. But the policy does not focus types of services to be established for improving women's health and in which district and either these twenty hospitals will fulfill the requirements of women's population. In some districts including Federal area Islamabad Maternal Health Center has been developed to cater the women's health needs. To overcome this issue, National Health policy 2009 (point 6 of 1:A) indicated that each district hospital will have separate Gynecology health care services as separate department to fulfill the women's health needs and easy access to health facilities.

4.1.3. 2. Health Policy Caring Towards Women's Need:

The fourth key area of National Health policy 2001 was to "promote greater gender equity in the health sector". It focused on improving the reproductive

health services for women as well as easy access to primary health services. The critical aspect which was analyzed through this was for reproductive health only women have been targeted but on the other hand the decision making regarding the reproduction is not in the hand of women. In patriarchal Pakistani society, the decision regarding family planning and child rearing & bearing is taken by the men. So it is necessary to address these issues in the policy as well to improve the overall situation of reproductive health of women. To promote this, health policy also emphasizes on the improvement of Lady Health Worker's services by providing them training courses and more job opportunities.

The National Health Policy 2009 also emphasizes the promotion of women's health services and highlights different programs related to women as the key areas of health policy. The programmes were:

i) Promotion of Lady Health Workers (LHWs) Programme and Maternal and New Born Child Health programme

ii) Provision of Family Planning Services at the door steps of population

iii) Focuses on the training and development of community midwives through MNCH program.

iv) Improve the nutritional status of women in child bearing age.

v) Safe Motherhood practices will be promoted through MNCH and LHW programs.

It is indicated that these interventions may help to improve the health status of women and children and will also speed up the progress of targets indicated by National Health Policy 2001.

4.1.3.3. Constraints and opportunities for both Men and Women:

The National Health policy targets the poor people as these are the worst affected by poverty. To reduce the gap between poor and access as well as utilization of health services, the third objective of NHP 2009 is "to protect the poor and under privileged population subgroups against catastrophic health expenditures and risks". Poverty is one of the major constraints the women have to face while accessing health services. By taking into consideration this aspect, the health policy actions focus following steps:

a) The government will ensure the poorest people to access health services by developing National Health Services for all. The health care services will be provided to treat patients irrespective of socio-economic class.
b) Government will help the women to have their own financial resources to spend for access and utilization of health care. For this Government started Benazir Income Support program which will help the poor women to register themselves and take the financial stipend monthly.

c) It will be assured at all primary level public health services that the services centers and treatment will be provided free of cost. The patients only have to bear the charges of hospitals if they visited tertiary level hospitals but if they will be referred from primary health care service provider, the charges will be exempted. Other social protection initiatives such as Baat-ul-mal, Zakat etc will also be available for the poor patients.

These initiatives will provide the better opportunities to both men and women of poor socio-economic class to have access to health care services.

4.1.3.1. Practical and Strategic Needs of Women:

Practical and strategic needs are the very important criterion of measuring development of any country. The NHP 2001 discusses the practical and strategic needs of women regarding their health. By focusing the practical needs of women's health, the policy emphasizes to establish new hospitals in all provinces of Pakistan to improve the easy and better health services for women. To fulfill the strategic needs second key area of policy addresses the provision of trained Lady Health Workers under the supervision of Ministry of Health and Village-based family planning workers under the supervision of Ministry of Population Welfare.

The fifth and eighth key area of policy also address the practical needs of women's health and focus on the provision of nutritional package to women, children and vulnerable groups of population. Rising awareness among women about different aspects of health is also the major concern of the policy.

But just to increase the numbers of hospitals will not be enough to meet the needs of health unless and until the work force resources are not expanded. The National Health policy 2009 addresses the gaps of NHP 2001 in this regard. The NHP 2009 (objective 4) focuses on "strengthening health system by taking into consideration the resources". It was highlighted that the stewardship of health system on human resources and other finical, medical resources will be strictly monitored.

The NHP 2009 policy indicated that for efficient planning and management of human resources, the government will have responsibility to formulate effective law and policy regarding the services of health professional. These include the job structure, salaries, promotions, recruitments and skills enhancements of health professional. To overcome the shortages of particular human resources such as nurses, LHWs, specialized technicians, doctors and hospitals managers etc. the policy emphasize that staff vacancies at hospitals will be filled on priority basis

and the issue of the scarcity of female staff especially in rural areas will be addressed.

4.1.3.5. Separate Budget Allocations for Men and Women

Both National Health policies 2001 & 2009 did not focus on the separate budget allocation to fulfill the specific health needs of men and women. The budget in health system is allocated for overall health needs of entire population without the segregation of men, women, children or any other group of society. In Pakistan, health budget is allocated for two purposes i.e. "development" and "recurrent budget".

The fourth key area of NHP talks about the greater gender equity in health sector, but to achieve this, resources have not been specified and the allocated resources are very low, therefore women have to face subordination in health system too. To improve the women's health status, many programs were introduced in both NHP 2001 & 2009, but the overall allocation of budget for health system cannot fulfill these particular initiatives for improving women's health. This indicated that government lacks efficiency regarding the allocation of budgets for health sector specially to fulfill the women's health needs.

The gender based analysis of budgeting in health sector indicated that health policies did not addressed the issues of separate budgets for men and women's health needs. Government needs to pay attention on gender sensitive budgeting in health sector and for effective utilization of health policies. The gender based budget allocation in health policies is necessary to highlight women's health issues and problems which are different and more than men such as reproductive health, child rearing and bearing concerns etc. So, for good health system and better achievement in health sectors, gender budgeting and sex disaggregated data is very important. And mostly Pakistan policies failed because of the lack of health expenditures. Government of Pakistan may focus its attention to increase the health expenditures on the basis of gender health needs.

4.1.3.6. Monitoring System:

Monitoring is very important to implement health policies efficiently. The tenth key area of NHP, 2001 addresses the issues of monitoring system to check the utilization of health policies. The policy lacks the adequate specialized monitoring system to measure the efficient working of health services for women. The projects and programs, which are highlighted in policy to improve the women's health needs, have not discussed proper mechanism for their monitoring. As women's health needs are more sensitive and specialized as compared to men's

health needs, therefore it is necessary to have proper monitoring system to check the sensitive utilization and working of programs. There must be proper team for monitoring the effectiveness of health programs on women's status.

The NHP 2009 (Objective 5) also addresses the issue of effective monitoring and implementation of health policies. It emphasizes "Strengthening stewardship functions in the sector to ensure service provision, equitable financing and promoting accountability". To strengthen the health system, three vital functions have been addressed in policy which is service provision, financing ad promoting accountability. Ministry of health will work to explore the ways for establishing health services mechanism as well as to ensure implementation and monitoring of health services delivery and if required build partnership to measure patient's safety.

The NHP 2009 also indicated that for effective utilization of monitoring and implementation of policies, public sector health services may devolve to the local level through the process of decentralization. The health service delivery will be monitored by federal and provincial governments by focusing on stewardship functions of policy making, planning, monitoring, evaluation, regulation and financing. It was also highlighted that instead of increasing tertiary level health system, already existing hospitals will be develop in a way to improve the quality

of health services. For gender based monitoring of health services, the ministry of health will work with provincial departments of health as well as Federal Bureau of Statistics (FBS) to ensure the collection of gender segregated data to promote gender inequalities in health system.

4.1.3.7. Millennium Development Goals and National Health Policies:

National Health policies have a vision to meet the goals of UN Millennium Development Goals (MDGs). Three goals of MDGs address the goals related to health sector which are: reduce child mortality, improve maternal health and combating HIV/AIDS, Malaria & other diseases.

The health policy 2001 discusses the issue "to promote greater gender equity in health sector" which focus the third goal of MDGs. It talks about the women reproductive health issues and assured to eliminate gender disparity in health sector. To work on that government should take such initiative which may promote women's decision making regarding their own health issues. To address these, policy should also highlights the barriers women have to face while access to health services.

The implementation of health policies indicated that progress to meet the MDGs goals is slow in developing countries like Pakistan because of lack of utilization a proper way as well as lack of public health expenditure. There is still a gap to achieve the efficient performances in reduction of child and maternal mortality.

4.1.3.8. Participate of its propose Beneficiaries:

The participation of proposed beneficiaries are the stakeholders including official, donor agencies, line ministry, and all citizens of the particular society who are affected by the policy and program. The National Health Policy 2001 and 2009 formulated with the vision of the provision of services to all population. But in-depth analysis of policies indicated that policies are not effectively utilizing for the older people as they are facing different types of health issues such as not have an easy access t health services.

Although policies discuss the issues to promote gender equity in health sector but their focus was women's reproductive roles and other related issues regarding women's health such as safe motherhood and health issues of unmarried women were not addressed. The policy ignored the issues related to violence women have to face due to which their health is affected.

4.2. Section: 2 (Thematic Analysis of Interviews of Policy makers)

This sector deals with the results of the interviews taken from those personals who are involved in the process of the formulation of health policies.

4.2.1 Planning of health Policy:

Most of the respondents responded that overall governance of health care system in terms of policy planning and control of the resources is the responsibility of federal ministry of health. They, as policy makers, take part in the formulation of policies according to their areas of expertise. At the level of provinces, there is a provincial ministry of health having an exclusive directorate of health care services which monitors and governs the efficient allocation and distribution of health care services. The directors deal with the administration, preventive health and curative care in the particular province. The number of directors and deputy directors in the provincial health ministries vary due to different size of population and number of health facilities in every province. The provincial health ministries exert direct control over these teaching hospitals. Below the provincial level the district (local) level is responsible for the implementation of plans, policies and recommendations of the federal and provincial government.

One of the respondents said that although the mechanism is based on the decentralization, but all provincial directors of health are accountable to the federal ministry of health to regulate and transparent use of resources. Another executive personnel of ministry of health pointed out that to maintain the good governance of health sector, there are two wings to function the health system, that are; technical and administrative wing. The director health of technical wing at all level deals with the technocracy, whereas the administrative wing deals with the issues of bureaucracy. These wings are responsible for the efficient implementation of health policy. Through this process, the governance of health system has sustained.

4.2.2. Consultation of Other Departments

Beside these wings and federal ministry of health, many other departments are also consulted and take part in drafting health policies. These departments include ministry of finance, ministry of population welfare, and ministry of law, donor agencies, World Health Organization, pharmaceutical companies and private sector. All departments put their agendas, interests and available resources for the formulation of the health policy.

Further, the results indicated that the civil society, medical councils, national and international organizations, international donors and private sector play their role as stakeholders in developing health policy. Regarding the importance of the involvement of stakeholders in policy formulation process, most of the respondents mentioned that without stakeholders, policy cannot be implemented. One executive personnel responded that if you want policy for just documentation that needs no donors and other agencies, but if you want to implement it effectively, stakeholders from different areas must be a part of policy making. Another respondent said that due to many stakeholders participation the conflict may raise due to different needs and interests, this is the biggest obstacles towards the acceptance of policies.

4.2.3. Policy Makers

The health ministers and politicians of parliament have the responsibility to set the agenda and have authority to take final decisions about the health policy. Regarding the ratio of male and female policy makers, some of the respondents said that 70 percent of males and 30 percent of female take part in policy making. These women belong to diverse spheres of life including civil society, finance ministry or international donors. One of the respondents said that possibly 40 percent women are involved in policy making procedure, and one of the

respondent was unable to give exact data about the percentage of women involved in policy making process because in policy making process different groups are involved and mostly female parliamentarians are involved. But overall women percentage is less as compared to men. Most of the respondents said that although women are a part of policy making process but they have less control of holding many decisions.

4.2.4. Gender sensitive health policy

Majority of the respondents replied that special gender needs are addressed in health policies of 2001 and 2009. There are a number of programmes like family planning, lady health workers, maternal and child health centers are working under the policy 2001 and there is a plan to upgrade these in 2009 health policy. Some of the respondent also demonstrated that gender needs are addressed in health policy, as health policy focuses maternal and child health needs as priority issues.

On the other hand some of the respondent also argued that policy makers are not aware of poor people's needs; they don't know main problems faced by the population. Regarding access to health services, women needs and mobility problems are not kept in focus while developing any plan to build health services.

All the respondents agreed that gender disaggregated data must be utilized for policy making to oversee the extent of men and women suffering in common and specific diseases and health concerns.

4.2.5. Budget Allocation

All of the respondents pointed out that in health sector due to the misconception of equal health needs of both men and women, no specific budget has been allocated separately.

Some other respondents argued that Pakistan government does not give separate budget for women health. But many international organizations like WHO, USAID, UNICEF and UNAID are working to fulfill the women and child's health needs by running different projects.

4.2.6. Constraints in efficient gender sensitive policy:

Many of the respondents highlighted that due to weak monitoring mechanism and no strong body to maintain check on health system, health policy not efficiently achieve its implementation targets. Mismanagement of resources and wastage of budget are also very critical and biggest problems to create obstacles in the

efficient implementation of health policy. Some of the resources are wasted due to poor management and extra utilization, some are under utilized. One of the respondents critically argued that about 50% of the budget allocated in a year to health sector was returned back at the end of year. The reason behind this is lack of knowledge about how and where to utilize it. There are no such human resources who have these skills and expertise to utilize the resources according to the needs and priorities.

Other findings also indicated that according to most of the respondents, financial problem that lies in health sector, is also one of constrains in good health care system. As the budget allocation is not sufficient for allocating human resources, equipments, medicines and other health care delivery services and facilities at hospitals.

4.3. Part II
(Hospital Survey)

Part II of the results deals with survey conducted in District hospitals from the hospital administrations. Six District Headquarter Hospitals (DHQs) were selected from the Punjab and one Federal Government Hospital was selected from Federal Area of Pakistan. From each hospital three departments; Medicines, Surgery and Obstetric & Gynecology were selected to conduct survey. This survey consisted of the information related to number of patients visited to selected departments, health services and facilities provided by the hospital to patients and doctors, the monitoring system, budget allocation and access to health services by women. The information obtained has been described and analyzed as follows.

For the selection of districts, Punjab has been divided in three circles on the basis of its geographical and climate division. The three circles are Central Punjab, Southern Punjab and Northern Punjab. The area of Southern Punjab consists of semi agriculture with 300-600 mm rainfall on average per anum. The dry subtropical tract of central and north Punjab and Salt Range with annual rainfall ranging from 600 - 1200 mm.

4.3.1. District Health System (DHS)

District health system comprised of the interrelated components such as health services, educational institutions, communities and physical as well as social environment. It focuses the primary health care services works under the national heath system. It includes the provision of health care facilities, appropriate support services such as laboratory, diagnostic and logistic support services. the administrative and functional structure of district health system is based on Executive District Officer Health which works with the support of other organizations and community (USAID, 2005). The district health system covers an area of having population of one to three million with the capacity of 125 to 259 beds on average (Bile *et al,* 2010).

Table 4.3.1.1 History of District Headquarter Hospitals of Punjab (DHQ)

DHQs	Year of Construction	Area in Acres	Population Served (in million)
Bhawalpur	1906	10	0.2
Khushab	1953	7.5	0.3
Sialkot	1967	13.75	0.4
Rawalpindi	1850	8	0.5
Multan	1887	20	0.6
Lahore	1886	12.5	1 million
Islamabad	1966	35	2 Million

Table 4.3.1.1 indicates historical information about District Headquarter of Punjab province. The second largest province of Pakistan, Punjab is spread over 205,344 km (79,284 sq mi) having 56% of the country's total population. The estimated population in 2010 is approximately 81, 330,531. Out of its 36 districts, six districts were selected for the study (Population Census Organization, 2011).

The districts listed in above tables are according to the population served (from lowest to highest) by particular districts headquarter and federal hospital. Most of the major districts of Punjab province are included in the study. Table shows that Bhawalpur district headquarter hospital served 0.2 million population which is the least population served among the other districts included in the study. The hospital was constructed in year 1906 before the independence of Pakistan and spread over 10 acres of land. District headquarter hospital Khushab was constructed in year 1900 under the British rule over the subcontinent, the hospital is spread over 7.5 acres of the area and currently served 0.3 million of population of district Khushab and its surroundings. District Headquarter Hospital Sailkot was constructed on 1967 spread over 13.75 acres of land and served 0.4 million of population. District Headquarter Hospital Rawalpindi was established on 1850 which is the oldest one of the DHQ's. It spread over 8 acres and served 0.5 million of population. Although it is situated on very small area as compared to other districts but serves more population than most of the other district hospitals.

District Headquarter Hospital Multan was established in 1887 based on 20 acres of land and served 0.6 million populations of district Multan and other areas. District Headquarter Hospital Lahore was established on 1884 based on 12.5 acres of land and provides health facilities to 1 million populations. In Sailkot, the DHQ Hospital was constructed on 1967 placed on 13.75 cares of land and served 0.4 million populations of the respective district and it are nearby areas. Federal Government Services Hospital Islamabad was constructed on 1966 that is the latest established hospital as compared to other districts but served larger number of population which is 2 million and it is constructed on an area of 35 acres. The served population of this hospital not only lives in Islamabad and its surroundings but the patients from all over Pakistan use the services of this hospital on referral basis, availability of basic health services and qualified doctors. In all DHQ the patients who visited the particular hospitals not only belonged to that districts but patients also came from the surroundings areas as well as from other cities. The patients who came from other cities were mostly those who were referred to these hospitals due to availability of experienced doctors and health services.

A Report by SDSSP, (2010) highlighted that DHQs are located at the hub of the district with having all types of basic health care services. It also indicated the standard for providing minimum services at district hospitals that is, DHQ should cover the population of one to two million approximately. The DHQs also serves

the patient who referred from Tehsil Headquarters (THQs), Rural Health Centers (RHCs), Basic Health enters (BHUs) and maternal and child health care centers.

Table 4.3.1.2. Average number of female patients visited in Medicine, Surgery and MCH departments of District Headquarter Hospitals of Punjab and Federal Area

Name of DHQs	Female patients visited various Department of DHQ			
	MCH	Medicine	Surgery	
	Percentage	Percentage	Percentage	Total
Bhawalpur	63	15.32	21.50	100
Khushab	60	20.15	19.85	100
Sialkot	42.79	34.69	22.52	100
Rawalpindi	34.43	32.71	32.86	100
Multan	53.90	25.15	20.96	100
Lahore	45.45	18.18	36.36	100
Islamabad	67.16	16.86	15.98	100

The table 4.3.1.2 shows the percentage of female patients who visited the department of MCH, medicine and surgery. It is indicated that in DHQ hospital Bhawalpur 63% of patients visited MCH department, 15% visited medicine and almost 22% visited surgery department. Further table indicated that 60% of the female patients visited to MCH in DHQ hospital Khushab as compared to 20% each in medicine and surgery departments. In DHQ hospital Sailkot 43% of the patient visited MCH, 35% medicine and 23% surgery department. In DHQ hospital Rawalpindi 34% of the patients visited MCH as compared to 33% each to medicine and surgery department. In DHQ hospital Multan 54% of the female patients visited to MCH department, 25% to medicine and 21% to surgery

department. In DHQ hospital Lahore 45% of the patients visited MCH department as compared to 19% to medicine and 36% to surgery department. In Islamabad at Federal government service hospital 67% of the female patients visited MCH department, 17% medicine and 16% surgery department.

The data of this table revealed that as per the highest health need of women which is maternal health, the percentage of female patients visited MCH department is higher at all public hospitals as compared to other departments studied. As pregnancy is very critical period in the life of women, which must be treat with special care, reproductive health care in Pakistan are given priories in health system. In most of the hospitals, there is separate department or Gynae and Obstetrics that offers a range of services to the women who visited the hospitals as inpatient and outpatient. These services includes routine checkup, obstetrical care, labour, caesarean section, infertility and other treatment related to gynecological disorders (Stone, 1980).

Table 4.3.1.3. Procedure and Facilities for the patients at District Headquarter Hospitals of Punjab and Federal Area

Procedure and Facilities		Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	Total
		Number	*Number*	*Number*	*Number*	*Number*	*Number*	*Number*	
Proper procedure for enrolling Patients	Yes	1	1	1	1	1	1	1	7
Fill enrollment forms	Yes	1	1	1	1	1	1	1	7
Separate waiting rooms for both men and women	Yes	1	1	0	1	1	1	1	6
	No	0	0	1	0	0	0	0	1
Separate Consultation hours	Yes	0	0	0	1	1	1	0	3
	No	1	1	1	0	0	0	1	4
Separate Wards	Yes	1	1	1	1	1	1	1	7
Separate Examination rooms	Yes	1	1	1	1	1	1	1	7
Availability of female doctors for women patients	Yes	1	1	1	1	1	1	1	7
Separate toilets	Yes	1	1	1	1	1	1	1	7

The above table 4.3.1.3 indicated the procedure for the enrollment of patients and the facilities provided to the patients at DHQs. The data shows that in all selected DHQs there were proper procedure of enrolling patients who visited the hospital as in-patient and out-patient. The patients have to fill enrollment form provided by the hospital to get registered which helps the administration of the hospital to maintain the records of number of patients visited to the hospital in each department. The enrollment form or slip bears number which helps the patients to wait for their turn to be examined by the doctors.

Further tables indicated the specific facilities provided to both men and women separately. Regarding the separate waiting facilities for men and women, the data revealed that out of seven, six DHQs have separate waiting facilities as in our cultural norms and values it is preferable to have separate facilities for both men and women. The waiting area or place is for the patients who wait for their turn to be examined by doctors as well as for the attendants who accompany the patients either the patients visited as in or out-Patient. The separate waiting area becomes more critical and important for those attendants who have to stay with the patients at hospital. Only in DHQ Sailkot separate waiting room facility for both men and women was not available, and the reason was lack of adequate space for the departments to have separate waiting facility for men and women. Therefore, at that hospital both male and female patients have to share same waiting area.

Regarding the concern of separate consultation hour for men and women, the table indicted that three DHQs have this facility, while four lacked it. The separate consultation hours for male and female patients indicated that hospital has specific time allocation for examining or treating them separately, except for emergency situation. Further table shows that all DHQs have separate facilities of wards, examination rooms, and female doctors for female patients as well as separate toilets for men and women. This revealed the respect and privacy of the patients. The availability of female doctors in each department makes women feel

comfortable to seek treatment, as socially and psychologically it is a matter of fact that one feels at ease with the same gender. In case of getting health treatment and examining for the diagnosis of diseases, female feels comfortable and easily discuss her health matters with female doctors. Moreover the availability of female doctors increases women access to health care especially in the case of Obstetric and Gynecological services. Therefore the availability of female doctors is essentially required at each hospital.

4.3.2 Hospital Services

Hospital services is defined as the health services provided to the patients seek treatment for their health illness related to medical, surgery and diagnostic procedure. Hospital services comprises of delivery of health care procedures and services as well as financial and human resources (Brikmeyer, *et al,* 2001).

The basic health care services that hospitals offer include short-term hospitalization, emergency room services, general and speciality surgical services, x- ray/radiology services, laboratory services, blood bank etc. Present study also explored the basic health services provided by the DHQs which are described in following table:

Table 4.3.2.1. Availability of Health Services at District Headquarter Hospitals of Punjab and Federal Area

Nature of Health Services available		Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	*Total*
		Number	Number	Number	Number	Number	Number	Number	
Short-term hospitalization	Yes	1	1	1	1	1	1	1	7
Burn Care	Yes	1	0	1	0	0	1	1	3
	No	0	1	0	0	0	0	0	1
	Partial	0	0	0	1	1	0	0	2
Emergency	Yes	1	1	1	1	1	1	1	7
Laboratory services	Yes	1	1	1	1	1	1	1	7
Blood bank	Yes	1	0	1	1	1	1	1	6
	No	0	1	0	0	0	0	0	1
x-Ray / Radiation	Yes	1	1	1	1	1	1	1	7
Radiation Therapy	Yes	1	0	1	0	1	0	1	4
	No	0	1	0	1	0	1	0	3
Physical Rehabilitation	Yes	1	0	1	1	0	1	1	5
	No	0	1	0	0	1	0	0	2
Pediatric specialty care	Yes	1	0	1	0	0	0	1	3
	No	0	1	0	0	1	1	0	3
	Partial	0	0	0	1	0	0	0	1
Home nursing services	Yes	1	0	0	0	0	0	1	2
	No	0	1	1	1	1	1	0	5
Nutritional counseling	Yes	1	0	0	0	1	0	1	3
	No	0	1	1	0	0	1	0	3
	Partial	0	0	0	1	0	0	0	1
Mental health care	Yes	1	1	1	0	1	1	1	6
	No	0	0	0	1	0	0	0	1
Financial services	Yes	1	0	1	1	1	1	1	6

	No	0	1	0	0	0	0	0	1
Social work	Yes	1	0	1	1	0	0	1	4
	No	0	1	0	0	1	0	0	2
	Partial	0	0	0	0	0	1	0	1

Table 4.3.2.1 indicates that all DHQs have short term hospitalization services for the patients. Short term hospitalization is defined as the provision of short-term medical treatment in hospital for the patients having acute illness, injury or recovering from surgery. The hospitals provide basic and necessary treatment of a disease or severe illness for only a short period of time and discharge the patient as soon as the patient is considered healthy with suitable discharge instructions. Burn care is another important health service provided by those hospitals that have expertise and resources. The data show that in among the studied DHQs hospitals, only DHQ hospital Sailkot, Lahore and federal hospital, Islamabad have proper burn care services for patients while DHQ hospital Khushab has no burn care services. The DHQ hospital Rawalpindi and Multan have partial availability of such services. Burn care service is very critical to mange as it needs expertise of health care professionals for proper care and protection of patients.

Further, the table shows that in all selected hospitals, the emergency medical service was available for the patients. Emergency is defined as any serious situation or occurrence that happens all of a sudden and requires abrupt action. Emergency services considered as those services mostly provided outside the

hospital in terms of transportation to patients with acute illness or injury and initial or pre hospital aspects of care. The laboratory services also have an important consideration in health services at any public hospital. All the studied DHQs hospitals and federal government hospital have the facility of laboratory services for the patients.

Laboratory services can be understood as clinical study for diagnosing the actual cause of disease by testing materials, tissues or fluids obtained from the patient. So it is good that all hospitals have this service to give proper treatment to patients by diagnosing the actual cause. Regarding the services of blood blank, apart from DHQ Khushab, all other DHQ hospitals and federal government hospital has the blood bank services available for the patients. District Khushab is considered as the rural area of Punjab, and lacks some basic facilities and limited resources resulting non-existence of blood bank services at this hospital.

Table 4.3.2.2. Availability of Beds at District Headquarter Hospitals of Punjab and Federal Area

Availability of beds		Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad
		Number	Number	Number	Number	Number	Number	Number
Medicine Department								
Beds in Wards	Male	70	20	45	20	60	80	90
	Female	70	20	45	20	60	80	90
Beds in Private Rooms	Male	15	8	12	4	4	8	16
	Female	15	8	12	4	4	6	16
Surgery Department								
Wards	Male	50	20	45	20	48	55	60
	Female	50	20	45	20	48	50	60
Private Rooms	Male	12	06	10	4	06	14	16
	Female	12	06	10	4	06	14	16
MCH Department								
Wards		80	45	60	40	72	80	150
Private Rooms		8	8	12	2	8	10	20

The table 4.3.2.2 shows the availability of number of beds in wards and private rooms in medicine, surgery and MCH department for male and female. The data indicated that in each hospital almost equal numbers of beds were allocated to both male and female. Regarding the medicine department, the table shows that there were seventy beds in DHQ hospital Bahawalpur for both male and female, twenty beds in wards for each male and female in DHQ hospital Khushab, 45 each in Sialkot, 20 each for male and female in DHQ hospital Rawalpindi, 60 in Multan, 80 in Lahore and 90 each for male and female in FGS hospital Islamabad. The number of beds in private rooms in medicine department was 15 each for

male and female in DHQ hospital Bahawalpur, eight in Khushab, 12in Sialkot, 4 in Rawalpindi and Multan, eight beds in DHQ hospital Lahore for male and six for female, and 16 each for male and female in FGS hospital Islamabad.

In department of surgery the number of beds in wards for male and female was 50 for each in DHQ Hospital Bahawalpur, 20 in Khushab, 45 in Sialkot, 20 in Rawalpindi, 48 in Multan, 55 in Lahore and 60 beds each for male and female in FGS hospital Islamabad. The number of beds in private rooms in surgery department was 12 beds for both male and female in DHQ hospital Bahawalpur, six in Khushab, ten in Sialkot, four in Rawalpindi, six in Multan, 14 in Lahore and 16 beds for both and female in FGS hospital Islamabad.

The number of beds in the wards of MCH department was eighty in DHQ hospital Bahawalpur, 45 in Khushab, 60 in Sialkot, 40 in Rawalpindi, 72 in Multan, 80 in Lahore and 150 beds in wards of MCH department at FGS hospital Islamabad.

A research conducted by Hassan & Rehman (2007) indicated that as per the limited resources in public hospital and more number of patient visited, the number of beds in wards and rooms in the gynecology department were not sufficient. In public hospital the number of the beds in wards and rooms were not sufficient according to the number of patients visiting the public hospitals.

Another study also supported the results by highlighting the facts that public health systems do not have sufficient resources and infrastructure to meet the requirements of the patients visited to public health care services (UNICEF, 1998).

4.3.3. Training for Doctors and Staff

Table 4.3.3.1. Orientation and on-job Trainings of Human resources at District Headquarter Hospitals of Punjab and Federal Area

Trainings of Human resources		Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	*Total*
		Number	*Number*	*Number*	*Number*	*Number*	*Number*	*Number*	
Orientation of new staff	Yes	1	0	0	1	1	1	1	5
	No	0	1	1	0	0	0	0	2
Type of orientation system									
Brief Introduction	Yes	1	0	0	0	1	1	0	3
	No	0	1	1	1	0	0	1	4
Training, Visit to hospital and brief introduction	Yes	0	0	0	1	0	0	1	2
	No	1	1	1	0	1	1	1	5
Training for Administration staff	Yes	1	0	1	1	1	1	1	6
	No	0	1	0	0	0	0	0	1
Training for paramedic staff	Yes	0	0	1	1	0	0	1	3
	No	1	1	0	0	1	1	0	4
Training for medical officers	Yes	0	0	1	1	0	0	1	3
	No	1	1	0	0	1	1	0	4
Training for specialist doctors	Yes	0	0	1	1	0	0	0	2
	No	1	1	0	0	1	1	1	5
Training for laboratory staff	Yes	1	0	1	1	1	1	1	6
	No	0	1	0	0	0	0	0	1
Training for Nurses	Yes	1	0	1	1	1	1	1	6
	No	0	1	0	0	0	0	0	1

Training for helpers	Yes	0	0	1	1	0	1	1	4
	No	1	1	0	0	1	0	0	3
Financial arrangements of the trainings									
Financial Budget	No	0	0	0	0	0	0	1	1
Ministry of Health		0	1	1	1	1	1	0	5

The table 4.3.3.1 indicates that, apart from the DHQ hospitals Khushab and Sailkot, other district hospitals provide orientation to the new staff and doctors inducted in hospital. It is better to have proper orientation system for new staff to give them insight of hospital rules and procedure. Out of those five hospitals which provide orientation to new staff, three hospitals give the brief introduction about the hospital rules, procedures and about the responsibilities. On the other hand DHQ hospital Rawalpindi and federal government hospital provide some basic trainings regarding working at hospital, arrange visits to the relevant departments of the hospital to introduce them with other staff, doctors and hospital administration and places as well as give them introduction about all the procedural requirements of their duties.

Besides the trainings for new inducted staff, it is also crucial to upgrade the skills and knowledge of the already working staff and doctors. The table also shows that six studied hospitals excluding Khushab provide some types of trainings to their administration staff to upgrade their skills to manage the administrative task.

Trainings for paramedical staff and medical officers are provided at DHQ hospitals Rawalpindi, Sailkot and Federal Government Hospital Islamabad, while other DHQ hospitals do not have any training for paramedical staff. It is also indicated that only two hospitals; DHQ hospital Sailkot and Rawalpindi provide trainings to specialist doctors to enhance their knowledge and expertise in their field. Further the table also shows the information about the trainings provided to laboratory staff and nurses which revealed that apart from DHQ hospital Khushab, all other studied hospitals provide some kinds of training to their laboratory staff and nurses as well. Nurses are considered the vital component of the health care service delivery to the patients; therefore it is necessary to equip them with latest and advance technique and treatment procedures. Helpers, who are commonly known as attendants of the hospitals also require some training to provide their assistance to patients with proper care. The data indicated that in DHQ hospital Rawalpindi, Sailkot, Lahore and federal hospital training has been provided to helpers as well.

To conduct and mange the training, financial arrangements is one of the vital concerns. At public hospitals mostly training has been conducted by the Ministry of Health Government of Pakistan with collaboration of other organizations. The data shows that in federal government hospital, almost all trainings have been financially supported by the annual financial budget provided to the hospital,

while in district hospitals Ministry of Health directly manages the financial resources for trainings. The government and ministry of health must provide and give financial support to the hospitals to conduct trainings for different types of staff on regular basis as it is necessary to improve the skills and knowledge of the staff and doctors. It will increase the interest and expertise of human resources in their particular field that in return will help to improve the provision of quality of health services at hospitals.

Table 4.3.3.2. Salaries of Staff and doctors at District Headquarter Hospitals of Punjab and Federal Area (n=7)

Salaries	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	*Total*
	Number	*Number*	*Number*	*Number*	*Number*	*Number*	*Number*	
Receiving Salaries Regularly								
Always	0	1	1	1	0	1	1	5
Often	1	0	0	0	1	0	0	2
Reasons of not to pay the staff on time								
Lack of Funds	1	0	0	0	1	0	0	2
How many Months salaries becomes late								
3-4 Months	1	0	0	0	1	0	0	2
Bonus for staff								
Some times	0	1	1	1	0	1	1	5
Never	1	0	0	0	1	0	0	2
Reasons for Giving Bonus								
Extra Duty Hours	0	1	1	0	0	1	1	4
Good Performance	0	0	0	1	0	1	1	3

This table 4.3.3.2 shows the information related to the salaries given by the staff and doctors at DHQ hospitals. It is indicated that the doctors at DHQ hospitals Khushab, Sailkot, Rawalpindi, Lahore and federal government hospital have always received their salaries on time. This shows that hospitals have good

financial management system. While in DHQ hospital Bhawalpur and Multan, doctors often may not receive their salaries on time. Lack of proper utilization or mismanagement of resources may also lead to delay in salaries of doctors. This is also due to the lack of interests and non-availability of doctors at hospitals. The hospitals, which are unable to give salaries to doctors or staff on time, usually get late for three to four months and when the funds are available, the combine salaries of the missing months, are given to the staff and doctors.

Further more, the data also indicated that those hospitals which provide salaries to the doctors and staff on time, also sometime award bonus to their staff and the hospitals which already delay salaries due to lack of funds, also do not give any bonus. The bonus is the special incentives apart from their salaries which may be given to the doctors and staff on the basis of their good performances in terms of reward and for extra duty hours. The incentive may encourage the doctors to take keen interest in their profession.

4.3.4. Performance Monitoring System

The performance of hospitals can be measured through the clinically and administrative achievements of specified goals. These can be the hospital's functions, diagnosis, treatment, care, rehabilitation as well as performance of

health professionals. Performance monitoring is defined as the steps taken to identify the provision of quality services delivering at hospital. It overseen the actual working standard and condition of hospital and compare it with other hospitals with respect to health services provided to the patients (Shaw, 2003). To monitor the selected targets and goals, it is crucial to have proper performance monitoring system and plan which helps to identify the targets; the outcomes may for planning and developing health programs (USAID, 1996).

Table 4.3.4.1. Performance Monitoring at District Headquarter Hospitals of Punjab and Federal Area

Monitoring of Staff Performances	**Bhawal-pur**	**Khush-ab**	**Sial-kot**	**Rawal-pindi**	**Multan**	**Lahore**	**Islam-abad**	***Total***
	Number	***Number***	***Number***	***Number***	***Number***	***Number***	***Number***	
Any monitoring system								
Yes	1	1	1	1	1	1	1	7
Which measure taken if staff performance is not satisfactory								
Give Chance	1	1	1	1	1	1	1	7
Steps taken on wrong treatment by staff								
Expel	0	1	0	0	0	0	1	2
Punishment	1	1	1	1	1	1	1	7
Mechanism use to upgrade the skill and knowledge								
Seminars	1	0	0	1	1	1	1	5
Training Workshops	1	1	1	1	1	1	1	7
Researches	1	0	0	0	0	0	0	1
Monitoring to check the proper utilization of Medicines								
Annual Audit	1	0	0	1	0	1	1	4
Record checking	0	1	1	0	1	0	0	3

The table 4.3.4.1 indicates that all the studied hospitals had monitoring system to check out the performance and utilization of hospital services which shows that management of these hospitals recognized the importance of monitoring and Evaluation. Regarding the performance, the input of human resources is very critical as all the health service deliveries are held by the staff and doctors. The table shows that in case of non satisfactory performances of doctors and staff, hospital administration gives a chance to them instead of immediate replacement and guiding or providing any training to improve their skills. In case of wrong treatment given to the patients, which is a very bad practice in most of the public hospital of Pakistan due to lack of knowledge and experience, in two studied hospitals such as DHQ Khushab and federal government hospital doctors or staff who commit any mistake during treatment may get expelled form the duties. While, in other DHQ hospitals some kind of punishment is given to the staff, the punishments are related to deduction of their salaries or stop them to perform the specific task given to them. To reduce such cases in hospitals, it is necessary to upgrade the skills and knowledge of the staff by providing them practical trainings. At all studied DHQ hospitals, training workshops to the staff were provided to enhance the knowledge and information of the staff on particular issues. Besides providing the opportunity of training workshop and seminar, the DHQ hospital Bhawalpur also provides the research opportunity to staff and

doctors to explore the new advances in health sector to upgrade their skills and knowledge.

Table 4.3.4.2. General Facility at District Headquarter Hospitals of Punjab and Federal Area

Facilities	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	*Total*
	Number	*Number*	*Number*	*Number*	*Number*	*Number*	*Number*	
Central Library								
Yes	1	0	0	0	0	0	1	2
No	0	1	1	1	1	1	0	5
Complaint Centre								
Yes	1	1	1	1	1	1	1	7
No	0	0	0	0	0	0	0	0
Hospital Waste Management								
Yes	1	1	1	1	1	1	1	7
No	0	0	0	0	0	0	0	0

Regarding the general facility at hospital, the table 4.3.4.2 shows that only two hospitals such as DHQ Bhawalpur and Federal Government Service Hospital Islamabad has the facility of central library at hospital. The facility of library may be necessary to those hospitals that are teaching hospitals and the new medical practitioners are working as well as studying, but unfortunately due to lack of resources and physical space most of the tabling hospitals do not have this facility. It is also indicated that all hospitals selected for this study provide the facility of complaining against anyone by using complaint boxes. It is important to take an action against the complaints to remove the gaps existed in performance of hospital delivery services.

Hospital waste managements is another important component while discussing the structure of hospitals. Hospital waste management is defined as the efficient management of waste produced by hospital activities. It is a major issue all over the world and problems faced by this are very important to take into consideration. It is estimated that in Pakistan 250,000 approx tones of medical waste is annually produced from all sorts of health care services (WWF, 2010).

The table shows that in all public hospital, there is the hospital waste management department, but the question arises about the proper function and utilization of it in more efficient and proper way which sometime lack in our health system. Ministry of health, government of Pakistan with the help of environmental health unit has prepared certain guidelines for hospital waste management in 1998. The guidelines consisted of the detailed information of all aspects of safe hospital waste management which includes; the risk associated with the waste, formation of a waste management team in hospitals, their responsibilities, plan, collection, segregation, transportation, storage, disposal methods, containers, and their color coding, waste minimization techniques, etc. Poor management of health care waste potentially exposes health care workers, waste handlers, patients and the community at large to infection, toxic effects and injuries besides risk of polluting the environment. It is essential that all medical waste materials are separated at the point of generation, appropriately treated and disposed off safely.

4.3.5. Hospital Administration

Hospital administration is very important part of any hospital. It is consisted of those professionals who are a part of hospital management at different administrative posts to organize and run the hospital activities. They need effective leadership and management skills for the efficient functioning of hospital as they have multiple responsibilities such as planning and monitoring of health services provision at hospitals, developing rules and guideline to use the services as well as overall coordination with all department of hospital (Bridshall, 2005).

Table 4.3.5.1. Availability of Administrative staff at District Headquarter hospitals of Punjab and Federal Area

Administrative Staff	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad
	Number	Number	Number	Number	Number	Number	Number
Medical Superintendent							
Sanctioned	1	1	1	1	1	1	1
Filled	1	1	1	1	1	1	1
Male	1	1	1	1	1	1	1
Nursing Superintendent							
Sanctioned	1	1	1	1	2	1	2
Filled	1	1	1	1	2	1	2
Female	1	1	1	1	2	1	2
Account Officer							
Sanctioned	2	1	1	1	1	1	1
Filled	2	1	1	1	1	1	1
Male	2	1	1	1	1	1	1
Head Clerk							
Sanctioned	1	1	1	1	1	1	1
Filled	1	1	1	1	1	1	1
Male	1	1	1	1	1	1	1
Assistants							
Sanctioned	10	3	0	1	6	2	30

Filled	10	3	0	1	6	2	30
Male	8	3	0	1	4	2	20
Female	2	0	0	0	2	0	10
Clerks							
Sanctioned	5	2	2	7	2	4	20
Filled	5	2	2	7	2	4	20
Male	5	2	2	7	2	4	20
Social Welfare Officer							
Sanctioned	1	0	1	1	0	0	3
Filled	1	0	1	1	0	0	3
Male	1	0	0	1	0	0	2
Female	1	0	1	0	0	0	1

The table 4.3.5.1 discusses the information about the number of administrative staff sanctioned, filled and gender wise recruitment on different administrative posts of the hospitals. It has been indicated that in all studied hospitals, there was one sanctioned post for Medical Superintendent (MS) and that was filled in all hospitals. It was also explored that in all hospitals MS was male. It is not because that female were not allowed or cannot be hired on this post, but due to its demanded nature of work load and managerial issues, female may not want to be there. Further, the data also explores that all sanctioned posts of nursing superintendent were filled by females. As nursing is the female dominated profession and most of the nurses are female that's why the nursing superintendents were female in all studied hospitals. The demand of the nursing superintendents was according to the needs of hospitals to mange efficiently the nurses' duties and all other activities. As the table shows that in DHQ hospital Multan and federal government hospital Islamabad, there were two nursing

superintendents due to large number of nurses which will ease them to mange their work efficiently.

Regarding the information related to another important post, the table shows that in DHQ hospital Bhawalpur, there were two sanctioned post of account officers which were filled by male accountants only. In other studied hospitals, there was one sanctioned post of account officer which was also filled by male in each hospital. The post of one head clerk was sanctioned in each hospital and filled by male head clerks. Assistants are the major component of administrative staff who provides their assistance to doctors, management staff and any other administrative departments. But the data has shown that in DHQ hospital Sailkot there was no sanctioned post of assistant. This may be due to the lack of funds or no need of assistants. On sanctioned post of assistant in DHQ hospital Bhawalpur, eight was filled by male and two by females. Three posts were sanctioned in DHQ hospital Khushab and all were occupied by males. In DHQ hospital Rawalpindi one post and in DHQ hospital Lahore two posts of assistants were sanctioned, all of which were filled by male assistant in both hospital. In DHQ hospital Multan out of six sanctioned posts of assistant, four were filled by male and two by females. In Federal Government services hospital as per its needs, thirty post of assistant for various departments of hospitals were sanctioned in which twenty were filled by male and ten by females.

The post of clerks was also sanctioned in all studied hospital it was indicated that five post were sanctioned in DHQ hospital Bhawalpur, two each in DHQ hospitals Khushab, Sailkot and Multan, seven in DHQ hospital Rawalpindi, four in Lahore and twenty posts of clerks were sanctioned in federal government service hospital Islamabad. All the sanctioned pots in each hospital were filled by males. One post of social welfare officer was sanctioned in DHQ hospital Bhawalpur, Sailkot and Rawalpindi which was filled by both male and female. In FGS hospital Islamabad three posts of social welfare officer were sanction in which two were filled by male and one by female.

4.3.6. Paramedical Staff

Paramedical staff is consisted on health professional that are trained in emergency medical treatment and qualified in technical and laboratory procedures of health service. Paramedics provide assistance to physicians in the process of diagnosis and treatment of ailments. They are professionally trained in medical field and serve in all departments of hospitals including nursing, midwifery, dental hygiene, pharmacy, laboratory, surgery and medicine etc (IAHPC, 2009).

Table 4.3.6.1. Availability of Paramedical staff at District Headquarter Hospitals of Punjab and Federal Area

Paramedical Staff	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad
	Number	Number	Number	Number	Number	Number	Number
Nurses							
Sanctioned	200	35	73	129	100	450	400
Filled	200	35	73	108	80	420	400
Female	200	35	73	108	80	420	400
Medical Assistant							
Sanctioned	2	1	0	0	5	1	20
Filled	2	1	0	0	4	1	20
Male	2	1	0	0	2	1	10
Female	0	0	0	0	2	0	10
Laboratory Technician							
Sanctioned	2	1	2	4	2	4	12
Filled	2	1	2	3	2	4	11
Male	2	1	2	3	2	4	8
Female	0	0	0	0	0	0	3
Laboratory Assistant							
Sanctioned	4	0	3	8	2	4	15
Filled	4	0	3	7	2	4	15
Male	4	0	3	7	2	4	10
Female	0	0	0	0	0	0	5
Vaccinator							
Sanctioned	0	0	1	0	0	0	3
Filled	0	0	1	0	0	0	3
Male	0	0	1	0	0	0	3
Midwives							
Sanctioned	3	3	2	6	4	8	10
Filled	3	3	2	4	4	6	10
Female	3	3	2	4	4	6	10
X-Ray Technician							
Sanctioned	4	1	3	10	1	8	5
Filled	4	1	3	10	1	8	5
Male	4	1	3	10	1	8	5

Nurse is one of the very important paramedical staff at any hospital. Nurses are responsible for the safety, care, recovery and providing the health treatment services to the patients. Among paramedical staff, the ratio of nurses is more as compare to other staff. The table 4.3.6.1 shows that in DHQ hospital Bhawalpur

200 posts of nurses was sanctioned, 35 in DHQ hospital Khushab and 73 in Sailkot of which all were filled by female. The reason is that nurse is a female dominated profession. In DHQ hospital Rawalpindi one hundred and twenty nine posts of nurses were sanctioned but only one hundred and eight were filled, leaving twenty one posts as vacant which definitely increase nurse to patient ratio adversely affecting patient care.

Table 4.3.6.2. Availability of Clinical staff at District Headquarter Hospitals of Punjab and Federal Area

Clinical		Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad
		Number	Number	Number	Number	Number	Number	Number
Availability of Clinic Staff in Medicine								
Specialist Doctors	Male	2	1	4	3	2	2	2
	Female	2	1	4	3	2	2	2
Medical Officers	Male	10	10	20	10	8	15	10
	Female	10	10	15	10	8	15	10
House job Officers	Male	10	10	10	10	10	10	10
	Female	10	10	10	10	10	10	10
Availability of Clinic Staff in Surgery								
Specialist Doctors	Male	3	2	4	6	3	2	4
	Female	0	0	2	3	0	0	3
Medical Officers	Male	15	8	20	10	15	10	8
	Female	10	6	15	8	10	6	6
House job Officers	Male	10	10	10	5	10	5	5
	Female	10	10	10	5	10	5	5
Availability of Clinic Staff in MCH								
Specialist Doctors	Female	4	2	4	5	5	3	5
Medical Officers	Female	15	10	20	10	15	10	30
House job Officers	Female	15	5	10	15	10	15	30

The table 4.3.6.2 indicated number of available clinical staff at the hospital. The number of specialist doctors in the department of medicine was two male and two females in DHQ hospital Bahawalpur, one male and female in Khushab, four males and four females in Sialkot, three male and three females in Rawalpindi, two male and two females in each Multan, Lahore and FGS Hospital Islamabad. The medical officers in medicine department was ten male and female in DHQ hospitals Bahawalpur, Khushab and Rawalpindi, twenty males and fifteen females in DHQ Hospital Sialkot, eight males and eight females in Multan, and fifteen males and females in FGS hospital Islamabad. In medicine department, the number of male and female house job officers was ten males and ten females in each of the studied seven hospitals.

In the department of surgery, the specialist doctors were three male specialist doctors in DHQ hospital Bahawalpur, two in Khushab and Lahore, four in Sialkot and Islamabad, and six male specialist doctors were at DHQ hospital Rawalpindi. The female specialist doctors in the department of surgery were two in DHQ hospital Sialkot, and three in Rawalpindi and FGS hospital Islamabad. There was no specialist female doctor at DHQ hospital Bahawalpur, Khushab, Lahore and Multan. The number of Medical officers was fifteen male and ten female in DHQ hospital Bahawalpur, eight males and six females in DHQ hospital Khushab, twenty males and fifteen females in Sialkot, ten males and eight females in

Rawalpindi, fifteen males and ten females in Multan, and ten males and six females in FGS hospital Islamabad. The number of house job officers was ten males and ten females in each DHQ hospital Bahawalpur, Khushab, Sialkot and Multan, five males and five females in DHQ hospital Rawalpindi, Lahore and Islamabad.

The table indicated the number of clinical staff at the department of MCH, as in DHQ hospital Bahawalpur, there were four females specialist doctors, fifteen medical officer and fifteen house job officers. In DHQ hospital Khushab, the number of female specialist doctors was two; ten medical officers and five house job officers were present there. There were four specialist doctors, twenty medical officers and ten house job officers in DHQ hospital Sialkot. In DHQ hospital Rawalpindi, the number of specialist doctors was five, ten medical officers and fifteen house job officers. In DHQ hospital Multan, the specialist doctors were five, medical officer were fifteen and house job officers were ten in number. In DHQ hospital Lahore, there were five specialist doctors, ten medical officers and fifteen house job officers. In FGS hospital Islamabad, the specialist doctors in the department of MCH were five, and thirty medical and house job officers.

4.3.7. Budget Demanded and Allocation

The appropriate allocation of budget to health sector reflects the better health status of any country. By keeping in view the importance of health care budget, the ministry of health must provide the demanded budget by the health care delivery system (Bile, 2010).

Table 4.3.7.1. Budget demanded and allocated to District Headquarter Hospitals of Punjab and Federal Area

Financing		**Bhawal-pur**	**Khush-ab**	**Sial-kot**	**Rawal-pindi**	**Multan**	**Lahore**	**Islam-bad**	**Total**
		Number	Number	Number	Number	Number	Number	Number	
Budget Information		Million/ Rs	Million/ Rs	Million/ Rs	Million/ Rs	Million/ Rs	Million/ Rs	Million/ Rs	
Budget Demanded in 2009-10		13	80	710	550	50	800	1120	3323
Budget Allocation		10.15	40	436	219	30	600	734	2069
Specific Budget Allocation for Women		0	0	0	0	0	0	0	0
Separate Budget for Department									
Medicines	No	1	1	1	1	1	1	1	7
Surgery	No	1	1	1	1	1	1	1	7
	No	1	1	1	1	1	1	1	7
Financial Support System									
Zakat		1	1	1	1	1	1	1	7
Charity		1	1	1	1	1	1	1	7
Patient's Fee		1	1	1	1	1	1	1	7
Surgery		1	1	1	1	1	1	1	7
Room Charges		1	1	1	1	1	1	1	7

The table 4.3.7.1 shows that budget demanded and allocated to the DHQ and federal government hospital for year 2009-10. The DHQ Bhawalpur had

demanded 13 million of budget but only 10 million was given to hospital which is the 76% of the demanded budget. On the demand of 80 million for DHQ Khushab, 40 million (50%) was allocated by ministry of health. DHQ Sailkot's demanded budget was 700 million but was allocated only 436 million which shows that 62% of the demand was fulfilled. The DHQ Rawalpindi demanded 550 million and received just 219 million (39%) which is almost half of the demanded budget. On the demand of 50 million of budget in DHQ Multan only 30 million (60%) was allocated. In DHQ Lahore the demanded budget was 800 million but allocated only 600 million (75%). In federal government service hospital Islamabad, about Rs 1120 million was demanded but only Rs 734 million was allocated which is the 65% of the total demanded budget. The higher demand of Federal Government Hospital was due to the more number of patients visiting the hospital and growing prices of goods and services.

Further table also indicates that no separate budget has been allocated for the women's health needs as well as all other departments do not have any specific budget. All the budget of the hospital is being utilized as per need of various departments. To manage the allocated budget provided by the government, some other sources of financing also help to fulfill the financial needs of the hospital. These include zakat, charity, fee charged from those who avail hospital service as in-patients and in case of any minor or major surgery. As due to limited financial

resources of the government, it is quiet difficult to fulfill the entire health requirement by government only, so from these sources the demand of hospital's services has been fulfilled. A study by Bile (2010) also supported that the hospital do not get the demanded health budget because of lack of financial resources government have.

4.3.8. Women's access to Hospital

The accessibility of health services in terms of both the cost and time specifically for women is usually determined by the geographical distance and service hours of health care facilities. The common social practices regarding women's health such as inability to travel alone, feel uncomfortable to be examined by male doctors and lack of economic independence may increase the vulnerability of women's access to health services (Ali, 2008).

A study by Deogaonkar (2004) conducted in India indicated that as women are assigned passive and subordinate roles by the society, socially, economically and culturally women always dependent on men for their survival. As many women do not have authority to take decisions and lack of access to resources, they have less access to health services as well. They do not have access to reach the public

health services which are very far from their home as well as not bale to bear the expensive of health care services.

Table 4.3.8.1. Problems faced by women to access District Headquarter Hospitals of Punjab and Federal Area

Districts	Problems faced by women to access to hospital		
	Facility far way from home	Women cannot come to hospital independently	Lack of female staff
	Number	Number	Number
Bhawalpur	0	0	1
Khushab	0	0	1
Sailkot	1	0	0
Rawalpindi	0	1	0
Multan	1	0	0
Lahore	0	1	0
Federal Area			
Islamabad	0	1	0

The table 4.3.8.1 shows the perception of the health service providers regarding the problems faced by women to access hospital. The same information was also taken from the female patients as well to explore the actual problems existing. Although women were availing the public hospital's health services but to access these services, they have to face many socio-cultural problems as well. The data indicated that the most common problem faced by majority of women to access the hospital in Districts Bhawalpur and Khushab was lack of availability of female staff for treating specific health needs of women. In district Sailkot and Multan, the public health facility was far away for women to access hospital. Due

to our social-cultural practices there are certain restrictions for women e.g. to go alone outside the home due to which women can not come alone to the hospital. This aspect was highlighted by the district hospital Rawalpindi, Lahore and Islamabad.

4.3.9. Transparency of decision

Table 4.3.9.1. Consultation and incorporation of problem highlighted District Headquarter Hospitals of Punjab and Federal Area in forming policies

Problems highlighted	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	Total
Incorporated in policies	Number	Number	Number	Number	Number	Number	Number	
To great extent	0	0	0	1	0	0	1	2
To some extent	1	1	1	0	1	1	0	5
MS of hospital consulted in policy making								
To some extent	0	0	0	1	0	1	1	3
Not at all	1	1	1	0	1	0	0	4
Visits of executives personnel of ministry of health to hospital								
Frequently	0	0	0	0	0	0	1	1
Quarterly	1	0	0	1	0	0	0	2
Twice a year	0	0	1	0	0	1	0	2
Yearly	0	1	0	0	1	0	0	2

The table 4.3.9.1 indicated that, as responded by the administration of DHQ hospital Rawalpindi and federal government hospital Islamabad, the problems highlighted by the hospital administration will be given due consideration while making health policy in future. While the administration of other studied hospitals responded that to some extent the suggested problems have been given consideration in policy formulation. This indicates that while formulating policy

the problems of specific hospital has been reviewed and other was underestimated. Further it is also indicated that majority of the Medical superintendent of the hospitals have not been consulted in policy formulation and planning.

The visits of the executive personals of the ministry of health and other health departments who monitor and manage the health delivery services may indicate that the service provision at hospitals has been checked out and the issues and problems existed have been given importance to overcome them. The information regarding visits of executives of health ministry to hospital, the table shows that only federal government hospital indicated the frequent visits of executives to hospital, in district Rawalpindi and Bhawalpur quarterly visits, in district Sailkot and Lahore twice a year visits and in district Khushab and Multan yearly visit has been made by the executives of health departments, government of Pakistan.

4.4. Part III

Part III of the results consisted of survey conducted from doctors working in Districts Headquarters Hospitals of Six sampled districts of Punjab and in a Federal Government Service Hospital Islamabad. In District hospitals, the doctors from three departments including Medicines, Surgery and Obstetric & Gynecology were selected to conduct survey. The questionnaires based on open and closed ended items were designed to collect the information from the doctors. The questionnaire was based on the information related to the provision of facilities to the doctors, their satisfaction with services and relationship with the patients. The information obtained has been described and analyzed as following.

4.4.1. Information of Doctors

Table 4.4.1.1 Information related to female doctors at District Headquarter Hospital of Punjab and Federal Hospital.

Administrative Staff	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	
	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	Total
Departments of Doctors								
i) Medicine	20.8(5)	16.6(4)	16.6(4)	8.3(2)	8.3(2)	16.6(4)	12 .5(3)	34.2(24)
ii) Surgery	9.1(2)	9.1(2)	13.6(3)	18.2(4)	13.6(3)	18.2(4)	18.2(4)	31.4(22)
iii) Obstetric & Gynecology	12.5(3)	16.7(4)	12.5(3)	16.7(4)	20.83(5)	8.33(2)	12.5(3)	34.2(24)
Total	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	100(70)
Designation of Doctors								
i) House Job Officer	26.1(6)	21.7 (5)	4.35(1)	8.7(2)	17.39(4)	8.7(2)	13.0(3)	32.86(23)
ii) Medical Officer	6.5(2)	16.1(5)	16.1(5)	19.4(6)	9.68(3)	19.4(6)	12.9(4)	44.29(31)
iii) Specialized Doctors	12.5(2)	0	25.0(4)	12.5(2)	18.8(3)	12.5(2)	18.8(3)	22.86(16)
Total	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	100(70)
Qualification								
i) MBBS	14.8(8)	18.5(10)	11.1(6)	14.8(8)	13.0(7)	14.8(8)	13.0(7)	77.14(54)

ii) FCPSC	13.3(2)	0(0)	20.0(3)	13.3(2)	20.0(3)	13.3(2)	20.0(3)	21.4(15)
iii) MD	0(0)	0(0)	100.0(1)	0(0)	0(0)	0(0)	0(0)	1.4(1)
Total	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	100(70)
Monthly Income								
i) Up to 20000	41.2(7)	0(0)	23.5(4)	17.6(3)	5.9(1)	0(0)	11.8(2)	24.2(17)
ii) 20001-40000	8.1(3)	21.6(8)	0(0)	13.5(5)	16.2(6)	21.6(8)	18.9(7)	52.8(37)
iii) Above 40000	0(0)	12.5(2)	37.5(6)	12.5(2)	18.8(3)	12.5(2)	6.2(1)	22.8(16)
Total	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	100 (70)

Table 4.4.1.1 shows that among three departments, 35% of the doctors belonged to Medicines and Obstetric & Gynecology department and 31% belonged to Surgery department. The highest percentage of female doctors in medicine and gynecology was due to the availability of the female doctors during the study time period. In the department of surgery female doctors were less in number and as the surgery have been done in the day time and takes much time, therefore the availability of female doctors was not frequent as compared to other departments. The District wise data indicates that out of total 35% of the respondents in medicine, 21% from DHQ Bahawalpur, 17% in DHQ Khushab and Sialkot, 12% in each DHQ Lahore and FGS (Federal Government Services) hospital Islamabad and 8% of the respondents in DHQ hospital Multan and Rawalpindi belonged to medicine department. In the department of surgery, the district wise data indicates that 18% of the respondents in DHQ hospital Rawalpindi, Lahore and FGS hospital Islamabad, 14% in DHQ hospital Sialkot and Multan, and 9% in DHQ hospital Bahawalpur and Khushab belonged to surgery department. As for the

department of Obstetric & Gynecology, the table shows that out of total 35% of the respondents of the study belongs to this department, 21% belongs to DHQ hospital Multan, 17% in DHQ hospital Khushab and Rawalpindi, 12% in DHQ hospital Bahawalpur, Sialkot and FGS hospital Islamabad, and 8% of the respondents in DHQ hospital Lahore belonged to Gynecology department.

The designation of doctors indicated that overall 44% of the respondents were medical officer followed by 33% House job officers and 23% specialized doctors. It is also indicated that 26% of the respondents in DHQ hospital Bahawalpur, 22% in Khushab, 17% in Multan, 13% in Islamabad, 9% in Rawalpindi and Lahore and 4% of the respondents in DHQ hospital Sialkot were house job officers. Further, table also indicates that out of the total 44% of the medical officers, 19% belonged to DHQ hospital Rawalpindi and Lahore, 16% to Khushab and Sialkot, 13% to FGS hospital Islamabad, 7% to DHQ hospital Multan and 6% in DHQ hospital Bahawalpur were medical officer doctors. Among 23% of the specialized doctors, 12% were in DHQ hospital Bahawalpur, Rawalpindi and Lahore, 25% in DHQ hospital Sialkot and 19% of the respondents were in FGS hospital Islamabad.

Regarding the qualification of doctors, the data shows that 77% of the respondents were having the qualification of MBBS, followed by 21% FCPS

(Fellow of College of Physicians and Surgeons) and only 1% of the respondents were MD (Doctor of medicine) qualified. Among 77% of MBBS doctors, 15% belonged to DHQ hospital Bahawalpur, Rawalpindi and Multan, 18% belonged to DHQ hospital Khushab, 11% to Sialkot and 13% belonged to FGS hospital Islamabad. The 22% of the respondents who were FCPSC qualified, 13% were in DHQ hospital Bahawalpur, Rawalpindi and Lahore, 20% in Sialkot, Multan and FGS hospital Islamabad. Only 1% of the respondents in DHQ hospital Sialkot were MD qualified

Regarding the monthly income of the doctors, the table shows that 41% of the respondents in DHQ hospital Bahawalpur, 23% in Sialkot, 17% in Rawalpindi, 6% in Multan and 12% in FGS hospital Islamabad were having monthly income upto Rs. 20000. The second group of monthly income ranges 20001 to 40000, the district wise data indicates that 8%of the respondents in DHQ hospital Bahawalpur, 21% in Khushab, 13% in Rawalpindi, 16% in Multan, 21% in Lahore and 19% of the respondents belonged to FGS hospital Islamabad who had monthly income of 20001 - 40000. The data also indicated that 12% of the respondents in DHQ hospital Khushab, 37% in DHQ hospital Sialkot, 12% in Rawalpindi and Lahore, 18% in Multan and 6% of the respondents in FGS hospital Islamabad had monthly income more than Rs. 40000.

Regarding the designation of the doctors, the doctors working as house job officers, medical officers and specialized doctors were included in the study. House job officers are those medical practitioners who were employed at a hospital for short term duration as they are continuing their additional training after graduation from medical college. Medical officers are those doctors who have completed their basic medical education and employed at hospital with having experience of medical practice. After the completion of graduation in medical and having good hand practical experience, the doctors who qualified the FCPSC or MD which is considered as the advance study in medical profession in specific field were called specialized doctors. The table shows that most of the respondents were medical officers, followed by house job officers and specialized doctors.

Table 4.4.1.2 Socio-economic background of female doctors at District Headquarter Hospitals of Punjab and Federal Hospital.

Socio-Demographics	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	
	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	Total
Age of Doctors (in years)								
20-30	22.2(6)	7.4(2)	14.8(4)	11.1(3)	11.1(3)	14.8(4)	18.5(5)	38.5(27)
31-40	12.9(4)	22.6(7)	6.5(2)	19.4(6)	13(4)	13.4(4)	13(4)	44.2(31)
Above 40	0(0)	8.4(1)	33.3(4)	8.4(1)	25.0(3)	16.7(2)	8.4(1)	17.1(12)
Total	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	100 (70)
Marital Status								
Single	22.2(6)	18.5(5)	7.4(2)	11.1(3)	18.5(5)	7.4%(2)	18.5 (4)	38.5(27)
Married	9.3(4)	11.6(5)	18.6(8)	16.3(7)	11.6(5)	18.6(8)	14.0(6)	61.4(43)
Total	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	100 (70)
Experience (Years)								
1-5 years	18.4(7)	18.4(7)	10.5(4)	15.8(6)	13.2(5)	13.2(5)	10.5(4)	54.2(38)
6-10 years	10.0(2)	15.0(3)	18.2(4)	20.0(2)	10.0(2)	15.0(3)	20.0(2)	28.5(20)
11-15 years	8.3(1)	0(0)	16.6(2)	16.6(2)	25.0(3)	16.6(2)	16.6(2)	17.14(12
Total	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	100 (70)

This table 4.4.1.2 shows the age, marital status and experience of the respondents. Regarding the age of the doctors it has been indicated that among sampled percentage of the respondents, 38% of the respondents were in age group of 20-30 years, 44% in 31-40 years of age group and only 17% were in age group of 41 to 50 years. The in depth district wise analysis show that 22% of the respondents in DHQ hospital Bahawalpur, 7% in Khushab, 15% in Sialkot and Lahore, 11% in Rawalpindi and Multan and 19% in FGS hospital Islamabad were in lower age group of 20 to 30 years. Further it is indicated that 13% of the respondents in DHQ hospital Bahawalpur, 23% in Khushab, 6% in Sialkot, 19% in Rawalpindi

and 13% in Multan, Lahore and FGS hospital Islamabad were in the middle age group of 31-40 years of age. The higher group which comprised of 41-50 years of age, 8% of the respondents in DHQ hospital Khushab, Rawalpindi and FGS hospital Islamabad, 33% in Sialkot, 25% in DHQ hospital Multan and 17% in DHQ hospital Lahore fall in the age category of age group 41-50.

The statistics about marital status shows that 39% of the total respondents were single, remaining 61% of the respondents were married. Among single 39% of the respondents, 22% were in DHQ hospital Bahawalpur, almost 19% in Khushab, Multan and FGS hospital Islamabad, 11% in DHQ hospital Rawalpindi and 7% in DHQ hospital Sialkot and Lahore. Among 61% of the married respondents, 9% were in DHQ hospital Bahawalpur, almost 12% in Khushab and Multan, 18% in Sialkot and Lahore, and 14% in FGS hospital Islamabad were married.

Further table also discuss the work experience of doctors that indicate majority of the respondents, i.e. 54% of the total had 1-5 years of work experience followed by 28% had 6-10 years and 17% had 11-15 years of working experience. The district wise analysis depicted that 18% of the respondents in DHQ hospital Bahawalpur and Khushab, 10% in Sialkot and Islamabad, 16% in Rawalpindi, and 13% in Multan and Lahore had one to five years of working experience. In 2nd category, having 6-10 years of working experience, 10% of the respondents

belonged to DHQ hospital Bahawalpur and Multan, 15% to Khushab and Lahore, 18% to Sialkot, and 20% of the respondents having six to ten years of working experience belonged to DHQ hospital Rawalpindi and FGS hospital Islamabad. Further it is also indicated that 8% of the respondents in DHQ hospital Bahawalpur, almost 17% in DHQ hospital Sialkot, Rawalpindi, Lahore and FGS hospital Islamabad and 25% of the respondents in DHQ hospital Multan were having 11 to 15 years of working experience.

Table 4.4.1.3 Work status of female doctors at District Headquarter Hospital of Punjab and Federal Hospital.

Work load	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	
	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	Total
Duty hours/day								
3-4	0(0)	0(0)	66.6(2)	0(0)	0(0)	33.3(1)	0(0)	4.2(3)
5-6	16.7(2)	0(0)	0(0)	16.7(2)	8.3(1)	25.0(3)	33.3(4)	17.1(12)
7-8	5.8(1)	23.5(4)	11.7(2)	23.5(4)	11.7(2)	17.6(3)	5.8(1)	24.2(17)
9-10	0(0)	33.3(6)	11.1(2)	22.2(4)	11.1(2)	5.6(1)	16.7(3)	25.7(18)
More than 10 hours	35.0(7)	0(0)	20.0(4)	0(0)	25.0(5)	10.0(2)	10.0(2)	28.5(20)
Total	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	100 (70)
Patients received consultation (Number)								
10-15	75.0(6)	0(0)	0(0)	0(0)	12.5(1)	0(0)	12.5(1)	11.4(8)
16-30	9.0(2)	9.0(2)	18.8(4)	27.2(6)	13.6(3)	22.7(5)	0(0)	31.4(22)
31-45	11.1(2)	44.4(8)	16.6(3)	11.1(2)	0(0)	5,5(1)	11.1(2)	25.7(18)
More than 45	0	0	13.6(3)	9.0(2)	27.2(6)	18.8(4)	31.8(7)	31.4(22)
Total	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	100 (70)
Time given to patients (Minutes)								
10-20	16.1(5)	0(0)	25.8(8)	9.7(3)	22.6(7)	19.4(6)	6.5(2)	44.2(31)
21-30	0(0)	31.8(7)	4.5(1)	18.2(4)	4.5(1)	13.6(3)	27.3(6)	31.4(22)
31-40	29.4(5)	17.6(3)	5.9(1)	17.6(3)	11.8(2)	5.9(1)	11.8(2)	24.2(17)
Total	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	100 (70)
Rounds Per Day								

One	0(0)	16.7(2)	8.3(1)	33.3(4)	8.3(1)	25.0(3)	8.3(1)	17.1(12)
Two	21.6(8)	16.2(6)	10.8(4)	10.8(4)	8.1(3)	10.8(4)	21.6(8)	52.8(37)
Three	15.4(2)	15.4(2)	15.4(2)	0(0)	30.8(4)	15.4(2)	7.7(1)	18.5(13)
More than three	0(0)	0(0)	37.5(3)	25.0(2)	25.0(2)	12.5(1)	0(0)	11.4(8)
Total	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	100 (70)

The table 4.4.1.3 indicated that 29% of the respondents had more than 10 hours of duty followed by 26% had 9-10 hours, 24% had 7-8 hours of duty, 17% had 5-6 and remaining 4% of the respondents reported 3-4 hours of duty per day at hospital. Among 4% of the respondents who performed their duties for 3-4 hours, 66% were in DHQ hospital Sialkot, and 33% were in DHQ hospital Lahore. The doctors having less working hour are those who were specialized doctors and may visited the hospital for short period of time for consultation facilities. Among 17% of them having 5-6 hours of duty, 17% were in DHQ hospital Bahawalpur and Rawalpindi, 8% were in DHQ hospital Multan, 25% in Lahore and 33% of the respondents were is FGS hospital Islamabad. Among 24% of the them worked 7-8 hours, 6% in DHQ hospital Bahawalpur and FGS hospital Islamabad, 23% in Khushab and Rawalpindi, 12% in DHQ hospital Sialkot and Multan, and 17% were in DHQ hospital Lahore. Among 26% the respondents working for 9-10 hours, 33% were in DHQ hospital Khushab, 11% to Sialkot and Multan, 22% were in DHQ hospital Rawalpindi, 6% in Lahore and 17% of the respondents were belong to FGS hospital Islamabad. Among 29% of the respondent who had more than ten hours of duty, 33% were in DHQ hospital Khushab, 11% in Sialkot

and Multan, 23% in Rawalpindi, 18% in Lahore and 6% were in FGS hospital Islamabad.

The number of patients received consultation from one doctor varied from hospital to hospital as well as the designation. The table shows that 31% of the overall respondents provided consultation to 16-30 and more than 45 patients per day. Among total sampled 26% provided consultation to 31-45 patient daily followed by 11% provided consultation to 10-15 patients. The in depth district wise data indicated that among 11% of the respondents who treated 10-15 patients in a day, 75% belonged to DHQ hospital Bahawalpur, almost 13% to DHQ hospital Multan and FGS hospital Islamabad. Among 31% of the respondents who provide consultation to 16-30 patients in day, 9% belonged to DHQ hospital Bahawalpur and Khushab, 18% to Sialkot, 27% to Rawalpindi, 14% to Multan, and 23% belonged to DHQ hospital Lahore. 26% of the respondents who were providing consultation to 31-45 patients daily, 11% were in DHQ hospital Bahawalpur, Rawalpindi and FGS hospital Islamabad, 44% in DHQ hospital Khushab, 17% in Sialkot, and 5% were in DHQ hospital Lahore. Among 31% of the respondents providing consultation to more than 45 patients in a day, 14% belongs to DHQ hospital Sialkot, 9% to Rawalpindi, 27% to Multan, 19% to Lahore and 32% belonged to FGS hospital Islamabad

Regarding the time given to patient by doctors, it was revealed that 44% of the respondents spent 10-20 minutes on one patient, in which 16% of the respondents were in DHQ hospital Bahawalpur, 26% in Sialkot, 10% in Rawalpindi, 23% in Multan, 19% in Lahore and 6% of the respondents were in FGS hospital Islamabad. Among 31% of the overall respondent spent time 21-30 minutes on a patient, 32% were in DHQ hospital Khushab, 5% in Sialkot and Multan, 185 in Rawalpindi, 13% in Lahore and 27% of the respondents were in FGS hospital Islamabad. Further the table under discussion also shows that 24% of the respondents spend 31-40 minutes on a patient, in which 29% belongs to DHQ hospital Bahawalpur, almost 18% to DHQ hospital Khushab and Rawalpindi, 6% to Sialkot and Lahore, 12% belonged to DHQ hospital Multan and FGS hospital Islamabad. The time spent on one patient varies due to the nature of treatment required as well as the condition of patient and also the total number of patients visited the hospital.

Apart from providing the treatment and checkup facility to the out door patients; doctors also have to consult with the indoor patients. The data shows that overall 53% of the respondents take two rounds of respected wards and rooms to provide consultation to indoor patients while by almost 19% take three rounds, 17% take one round and 11% took more than three rounds. Among 17% of the respondents take one round in a day, 17% belonged to DHQ hospital Khushab, 8% to Sialkot,

Multan and FGS hospital Islamabad, 33% belonged to DHQ hospital Rawalpindi and 25% to DHQ hospital Lahore. The table under discussion also indicted that 53% of the respondents who took two rounds in a day, 22% were in DHQ hospital Bahawalpur and FGS hospital Islamabad, 16% were in Khushab, 11% were in DHQ hospital Sialkot, Rawalpindi and Lahore and 8% of the respondents were in DHQ hospital Multan. Among 19% of the respondents took three rounds, 15% belonged to DHQ hospital Bahawalpur, Khushab, Sialkot and Lahore, 31% belonged to DHQ hospital; Multan and 8% belongs to FGS hospital Islamabad. Among 11% of the respondents take more than three rounds in a day, 38% belonged to DHQ hospital Sialkot, 25% belonged to Rawalpindi and Multan and almost 13% belonged to DHQ hospital Lahore. The workload of taking rounds and provide short term consultation to the patients by the doctor was due to large number of out-door patients visiting and less number of on-board doctors.

Table 4.4.1.4 Work status of female doctors at District Headquarter Hospital of Punjab and Federal Hospital.

Salaries	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	
	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	Total
Receive Salary (Time)								
Always	17.5(7)	20.0(8)	5.0(2)	17.5(7)	10.0(4)	5.0(2)	25.0(10)	57.1(40)
Often	12.5(3)	8.3(2)	33.3(8)	4.2(1)	8.3(2)	33.3(8)	0(0)	34.2(24)
Sometimes not on time	0(0)	0(0)	0(0)	33.3(2)	66.7(4)	0(0)	0(0)	8.57(6)
Total	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	100 (70)
Satisfaction with Salary								
Satisfy	25.0(4)	0(0)	12.5(2)	37.5(6)	6.2(1)	12.5(2)	6.2(1)	22.8(16)
Moderate	13.3(2)	20.0(3)	26.7(4)	0(0)	20.0(3)	13.3(2)	6.7(1)	21.4(15)
Not Satisfy	9.7(3)	22.6(7)	6.5(2)	9.7(3)	6.5(2)	19.4(6)	25.8(8)	44.2(31)
Highly Not Satisfy	12.5(1)	0(0)	25.0(2)	12.5(1)	50.0(4)	0(0)	0(0)	11.4(8)
Total	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	14.3(10)	100 (70)

The table 4.4.1.4 shows that among 57% of the overall sampled respondents were getting their salary always on time followed by 34% getting often late and 9% got their salaries some time late. Among the respondents who always got their salaries on time, 17% belonged to DHQ hospital Bahawalpur and Rawalpindi, 20% to Khushab, 5% to Sialkot and Lahore, 10% belonged to DHQ hospital Multan and FGS hospital Islamabad. The 34% of the respondents who received their salaries often on time, 12% were in DHQ hospital Bahawalpur, 8% in Khushab and Multan, 33% in Sialkot and Lahore and 4% of the respondents were from DHQ hospital Rawalpindi. It is also indicated that 33% of the respondents in DHQ hospital Rawalpindi and 67% in Multan got their salaries sometimes not on time and was delayed. The delay in the provision of salaries to doctors is due to

the internal mismanagement of finance department of the hospital or delay in the process by the government due to lack of funds.

The satisfaction of doctors with their salaries is very important in measuring the doctor's performances and relationship with patients. The data shows that 44% of the respondents were not satisfied in all seven studied hospitals followed by 23% of the respondent who were satisfied, 21% were on moderate level of satisfaction and 11% of the respondents were highly dissatisfied. Among the 23% of the respondents who were satisfied with their salaries, 25% belonged to DHQ hospital Bahawalpur, 12% to Sialkot and Lahore, 37% belonged to DHQ hospital Rawalpindi and 6% belonged to DHQ hospital Multan and FGS hospital Islamabad.

Among the 21% of the respondents who had moderate level of satisfaction with their salaries, 13% belonged to DHQ hospital Bahawalpur and Lahore, 20% to Khushab and Multan, 27% to Sialkot and 7% of the respondents belongs to FGS hospital Islamabad. Among 44% of the respondents who were not satisfied with their salaries, 10% belonged to DHQ hospital Bahawalpur and Rawalpindi, 23% belong to DHQ hospital Khushab, 6% to Sialkot and Multan, 19% to Lahore and 26% of the respondents belonged to FGS hospital Islamabad. Among 11% of the respondents who stated high not satisfactory response towards their salaries, 12%

belong to DHQ hospital Bahawalpur and Rawalpindi, 25% to Sialkot and 50% belong to DHQ hospital Multan. But currently as Government of Pakistan has increased the salaries of doctors, this may reduce doctor's dissatisfaction with their salaries.

4.5. Part IV
(Patient's Survey)

Part IV of the results consists of the result and discussion of the data obtained from the patients from six DHQ hospitals of Punjab and one federal government hospital. Patients from three departments including Medicines, Surgery and Obstetric & Gynecology were selected to conduct survey. A questionnaire based on open and close ended items was designed to collect the information from the patients related to the provision of facilities to the patient, their satisfaction with services and relationship with the doctors. The information obtained has been described and analyzed as following.

4.5.1. Socio-Demographics of the Patients

Table 4.5.1.1 Age, Martial Status, income and Education of the respondents (female patients) at District Headquarter Hospital of Punjab and Federal Hospital.

Socio-Demographics	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	
	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	Total
Age of patients (Year)								
Up to 20	0(0)	20(5)	24.0(6)	36.0(9)	0(0)	16.0(4)	4(1)	11.9(25)
21-30	11.3(14)	13.7(17)	11.3(14)	13.7(17)	12.4(16)	15.3(19)	21.8(27)	59.0 (124)
31-40	28.3(13)	13(6)	15.2(7)	8.7(4)	21.7(10)	13.0(6)	0(0)	21.9 (46)
Above 40	20.0(3)	13.3(2)	20.0(3)	0(0)	26.7(4)	7.0(1)	13.5(2)	7.1(15)
Total	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	100 (210)
Mean = 2.24				St. Deviation = 1.0				
Minimum = 1				Maximum = 4				
Marital Status								
Single	21.9(7)	12.5(4)	21.9(7)	9.4(3)	3.12(1)	21.9(7)	9.4(3)	15.2(32)
Married	12.9(23)	14.6(26)	12.9(23)	15.2(27)	16.3(29)	12.9(23)	15.2(27)	84.7(178)
Total	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	100 (210)

Monthly Family Income (Rupees)								
Upto 5000	4.5(2)	25.0(11)	(4.5)2	29.5(13)	14.6(7)	13.3(6)	9.1(4)	20.9(45)
50001-25000	13.1(16)	12.3(15)	16.4(20)	11.5(14)	15.8(19)	12.3(15)	17.5(21)	57.1(120)
25001-40000	37.5(9)	12.0(3)	16.0(4)	4.2(1)	4.2(2)	25.0(6)	4.2(1)	11.9(25)
Above 40000	15.0(3)	5.0(1)	20.0(4)	10.0(2)	15.0(3)	15.0(3)	20.0(4)	9.5(20)
Total	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	100 (210)
Mean = 2.09				St. Deviation = 1.0				
Minimum = 1				Maximum = 4				
Education								
Illiterate	7.9(3)	13.2(5)	15.8(6)	18.4(7)	18.4(7)	13.2(5)	13.2(5)	18.0(38)
Upto Middle	10.1(9)	12.4(11)	19.1(17)	7.9(7)	19.1(17)	14.6(13)	16.9(15)	42.3(89)
Upto Metric	19.5(8)	19.5(8)	12.2(5)	12.2(5)	14.6(6)	14.6(6)	7.3(3)	19.5(41)
Above Metric	23.8(10)	14.3(6)	4.8(2)	26.2(11)	0(0)	14.3(6)	16.7(7)	20.0(42)
Total	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	100 (210)
Mean = 2.41				St. Deviation = 1.00				
Minimum = 1				Maximum = 4				

The table 4.5.1.1 shows that majority of the respondents belong to the 21 to 30 years of age group which is 59% followed by 22% of respondents, who fall in age group of 31-40 years and 12% of them were below than 20 years of age. The detail district wise analysis of the age groups indicted that 20% of the respondents in DHQ hospital Khushab, 24% in Sailkot, 36% in Rawalpindi 16% in Lahore and 4% of the respondents from FGS services hospital were in lower age category i.e. upto 20 years of age group. Eleven percent of the respondents in DHQ hospital Bahawalpur, almost 14% in Khushab, 11% in Sialkot, 14% in Rawalpindi, 12% in Multan, 15% in Lahore and 22% in federal government service hospital, Islamabad were members of the second category of age group (21-30 years). Further it is also indicated that 20% of the respondents in DHQ hospital

Bhawalpur, 13% in Khushab, 26% in Multan, 7% in Lahore and 13% of the respondents in FGS hospital Islamabad were above than 40 years old. The mean (2.24) indicated that average number of patients were in the age group of 21 to 30 years.

The information related to the martial status of patients, indicated that 85% of the respondents were married and rest of 15% were unmarried. The district wise distribution of the data shows that among 15% of unmarried respondents, 22% belonged to DHQ, hospital Bahawalpur, 12% to Khushab, 22% to DHQ hospital Sialkot and Lahore, 9% to Rawalpindi, 3% to Multan and 9% of the respondents in FGS hospital Islamabad were unmarried. Among 85% of married respondents, 13% in DHQ hospital Bahawalpur, Sialkot and Lahore, 15% in DHQ hospital Khushab, 15% in DHQ hospital Rawalpindi and FGS Hospital Islamabad and 16% of the respondents in DHQ hospital Multan were married.

Further table indicated the monthly income of the respondents, The under discussion table indicted that 21% of the respondents were in the income category of upto 5000, 57% having income of 5001-25000 Rs, 12% belonged to third category (25001-400000) and 9% of the respondents had more that 40000 monthly income. Among the respondents having upto 5000 of monthly income, 4% of the respondents in DHQ hospital Bahawalpur and Sialkot, 25% in

Khushab, 29% in Rawalpindi, 15% in Multan, 13% in Lahore and 9% in FGS hospital. Among 57% of the respondents having income between 5000 to 25000, 13% of the respondent belong to DHQ Hospital Bahawalpur, 12% in Khushab and Lahore, 16% in Sialkot, 15% in Multan, 11% in Rawalpindi, and 17% of the respondents belonged to FGS hospital Islamabad. Among 12% of the respondents having monthly income of Rs/-25000 to 40000, 37% of the respondents were in DHQ hospital Bahawalpur, 12% in DHQ hospital Khushab, 16% in Sialkot, 4% in Rawalpindi Multan and FGS hospital and 25% of the respondents were in DHQ hospital Lahore. Among 9% of the respondents having monthly income of more than 40000, 15% of the respondents belonged to DHQ hospital Bahawalpur and Multan, 5% in DHQ hospital Khushab, 20% in Sialkot, 10% in Rawalpindi, 15% in Lahore and 20% of the respondents were in FGS service hospital Islamabad.

Regarding the education of the respondents, the table indicated that 42% of the respondents had education up to middle, followed by 20% who were above metric, 19% were having education up to metric level and 18% of the respondents were illiterate. The district wise analysis of the respondent's education revealed that among 18% of the illiterate respondents, 8% were in DHQ hospital Bahawalpur, 13% in DHQ hospital Khushab, Lahore and FGS hospital Islamabad, 16% were in DHQ hospital Sialkot and 18% of the respondents were in DHQ hospital Rawalpindi and Multan. Among 42% of the respondent having education

up to middle, 10% belonged to DHQ hospital Bahawalpur, 12% to Khushab, 19% belongs to DHQ hospital Sialkot and Multan, 7% to DHQ hospital Rawalpindi, 15% to Lahore and 17% of the respondents belongs to FGS hospital Islamabad. Among 19% of the respondents who were having education up to Metric level, 19% were in DHQ hospital Bahawalpur and Khushab, 12% in DHQ hospital Sialkot and Rawalpindi, almost 15% in Multan and Lahore, and 7% of the respondents were in FGS hospital Islamabad. 20% of the respondents who were having education up to metric, 24% were in DHQ hospital Bahawalpur, 14% in Khushab and Lahore, 5% in Sialkot, 26% in Rawalpindi, and 17% of the respondents in FGS hospital were having education up to metric.

4.5.2. Access to Hospital

Table 4.5.2.1 Information related to visits of female patients at District Headquarter Hospitals of Punjab and Federal Hospital.

Access to Hospital	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	
	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	Total
Preference to Hospital								
Easy accessible	12.0(10)	13.3(11)	21.7(18)	14.5(12)	12.0(10)	16.9(14)	9.6(8)	39.5(83)
Availability of Qualifies doctors &Staff	33.3(8)	16.7(4)	0(0)	4.2(1)	12.5(3)	8.3(2)	25.2(6)	11.4(24)
Availability of good health services	18.2(2)	9.1(1)	27.3(3)	9.1(1)	9.1(1)	27.3(3)	0(0)	5.2 (11)
Family Hospital	17.9(7)	7.7(3)	23.1(9)	0(0)	20.5(8)	17.9(7)	12.8(5)	18.5(39)
Refer to this Hospital	6.7(3)	20.0(9)	0(0)	26.7(12)	15.6(7)	8.9(4)	22.2(10)	21.4(45)
Free on panel	0(0)	25.0(2)	0(0)	50.0(4)	12.5(1)	0(0)	12.5(1)	3.8 (8)
Total	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	100 (210)
Distance of Hospital in time								
Less than half hour	22.0(13)	20.3(12)	8.5(5)	6.8(4)	15.2(9)	8.5(5)	18.6(11)	28.0(59)

More than half to one hour	17.9(17)	7.4(7)	18.9(18)	9.5(9)	15.8(15)	18.9(18)	11.6(11)	45.2(95)
1 to 2 hours	0(0)	24.3(9)	16.2(6)	35.2(13)	8.1(3)	13.5(5)	2.7(1)	17.6(37)
More than 2 hour	0(0)	10.5(2)	5.3(1)	21.1(4)	15.8(3)	10.5(2)	36.8(7)	9.0(19)
Total	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	100 (210)

The table 4.5.2.1 shows that regarding the patient's preference to visit a particular hospital 39% of the respondents visited the particular hospital because of it being easily accessible, 11% visited due to availability of Qualified doctors and staff, 5% of the respondents visited due to availability of good health services, 18% of the respondents visited the particular hospital considering it as family hospital, 21% of the respondents were referred to that hospital, and 4% of the respondents visited as free on panel. Among 39% of the respondents who visited the particular hospital due to easy access, 12% of the respondents were in DHQ hospital Bahawalpur and Multan, 13% in Khushab, 22% in Sialkot, 14% in Rawalpindi, 17% in Lahore and 7% were in FGS hospital Islamabad. Out of 11% of the respondents who visited the hospital due to availability of qualified and experienced doctors, 33% belong to DHQ hospital Bahawalpur, 17% to Khushab, 4% to Rawalpindi, 12% to Multan, 8% to Lahore and 25% of the respondents belonged to FGS Service hospital Islamabad. Among 5% of the respondents who indicated their preference to visit particular hospital because of the availability of good health services, including medicines and other laboratory facilities, 18% of the respondents belonged to DHQ Hospital Bahawalpur, 9% to DHQ hospital Khushab, Rawalpindi and Multan, and 27% were in DHQ hospital Sialkot and

Lahore. Further table also indicated that 18% of the respondents visited the hospital because of their family hospital because they always visited the same hospital for every type of treatment. Among these, 17% of the respondents were from DHQ Bahawalpur, 7% of the respondents were in DHQ hospital Khushab, 23% in DHQ hospital Sialkot, 20% in Multan, almost 18% in Lahore and 13% of the respondents were in FGS hospital Islamabad.

Among 21% of the respondents who visited the hospital because they were being referred to that hospital due to availability of qualified doctors and better health services, almost 7% of the respondents were in DHQ hospital Bahawalpur, 20% in Khushab, 27% in Rawalpindi, 15% in Multan, 9% in DHQ Hospital Lahore, and 22% of the respondents were in FGS hospital Islamabad. Almost 4% of the respondents who visited hospitals due to free of cost health services on panel of their husbands, as the organization where they do job bear the financial cost of availing health services. Among these, 25% of the respondents belonged to DHQ Hospital Bahawalpur, 50% were in DHQ hospital Rawalpindi and 12% were in DHQ hospital Multan and FGS hospital Islamabad.

In public hospitals patients do not have to pay for specific treatment such as normal checkup and delivery of child is also free of cost as well as to some extent free medicines. Some medicines were provided by the hospital and some had to

be borne by the patients themselves. In case of the patients who visited on husband's panel, the company paid the charges if they exceed form the free cost (Hassan & Rehman 2007). Another research by Kadir *et al* (2000) also indicated that at public hospitals the delivery of women is free of costs and they only have to pay if there is any surgery or for expensive medicines.

Further table also indicated the distance the patients' covered to visit to the hospital in terms of time taken in hours. The data revealed that for 28% of the respondents it took less than half an hour, 45% of the respondents indicated that it took more than half an hour to an hour to reach to the hospital, that is followed by 17% who took one to two hours and 9% of the respondents covered the distance in more than two hours. Among 28% of the respondents who covered the distance in less than half an hour, 22% belonged DHQ hospital Bahawalpur, 20% to Khushab, 8% to Sialkot and Lahore, 7% to Rawalpindi and 18% of the respondents belonged to FGS hospital Islamabad. Among 45% of the respondents who covered the distance in more than half to one hour of time, 18% of the respondents were in DHQ hospital Bahawalpur, 7% in Khushab, 19% were in DHQ hospital Sialkot and Lahore, 9% were in DHQ hospital Rawalpindi, 16% in Multan, and 11% of the respondents were in FGS hospital Islamabad. Among 17% of the respondents who traveled the distance in one to two hours, 24% belonged to DHQ hospital Khushab, 16% to Sialkot, 35% to Rawalpindi, 8% to

Multan, 13% to Lahore and almost 3% of the respondents belonged to FGS hospital Islamabad. Nine percent of the respondents covered the distance in more than two hours to reach the hospital, among them 10% of the respondents were in DHQ hospital Khushab, 5% in Sialkot, 21% in Rawalpindi, 15% in Multan, 10% in Lahore and almost 37% of the respondents were in FGS hospital Islamabad. The analysis indicated that majority of the respondents who visited FGS service hospital covered the distance of more than two hours to reach to the hospital, the reason behind it was the availability of better health services and qualified doctors, most of the patients were referred to Islamabad from other cities such as Chakwal, Sargodha, Murre, Abbotabad etc.

Table 4.5.2.2. Information related to visits of female patients at District Headquarter Hospitals of Punjab and Federal Hospital.

Access to Hospital	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	
	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	Total
Number of Visits by patients								
Once	21.8(19)	13.8(12)	21.8(19)	4.6(4)	10.5(10)	20.1(18)	5.6(5)5	41.4(87)
Twice	11.5(6)	15.4(8)	15.5(8)	19.2(10)	21.2(11)	13.5(7)	2.2(1)	24.2(51)
More than Two Times	18.2(4)	17.2(3)	9.1(2)	27.2(6)	13.6(3)	9.1(2)	5.4(2)	10.4(22)
Frequently	2.1(1)	14.0(7)	2.1(1)	20.4(10)	12.2(6)	6.0(3)	44.0(22)	23.3(50)
Total	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	100 (210)
Accompany to Visit								
Husband	9.9(8)	9.9(8)	17.3(14)	9.9(8)	18.5(15)	11.1(9)	23.5(19)	38.5(81)
Mother in Law	20.0(8)	12.5(5)	7.5(3)	17.5(7)	17.5(7)	12.5(5)	12.5(5)	19.0(40)
Mother	14.5(10)	17.4(12)	15.9(11)	17.4(12)	10.1(7)	17.4(12)	7.2(5)	32.8(69)
Father	33.3(3)	22.2(2)	11.1(1)	0(0)	0(0)	22.2(2)	11.1(1)	4.2(9)
Alone	9.2(1)	27.2(3)	9.1(1)	27.2(3)	9.1(1)	18.2(2)	0(0)	5.2(11)
Total	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	100 (210)

The table 4.5.2.1 indicated the number of visits by the patients to the particular hospital and the persons who accompanied her during visits. Regarding the number of visits among 41% of the respondents once visited hospital, 22% were in DHQ Hospital Bahawalpur, almost 14% were in Khushab, 21% in Sialkot, 4% in Rawalpindi, 10% in Multan, 20% in Lahore and 5% of the respondents were in FGS hospital Islamabad. Among 24% of the respondents who visited the hospital twice, 11% of them belonged to DHQ hospital Bahawalpur, 15% to DHQ hospital Khushab and Sialkot, 19% to Rawalpindi, 21% to Multan, 13% to Lahore and 2% of the respondent belonged to FGS Hospital Islamabad. Among 10% of the respondents who visited more than two times, 18% were in DHQ hospital Bahawalpur, 17% were in DHQ hospital Khushab, 9% in Sialkot and Lahore, 27% were in DHQ hospital Rawalpindi, 13% in Multan and almost 5% of the respondents were in FGS hospital Islamabad. Twenty three percent of the respondents who frequently visited to hospital, 2% were in DHQ hospital Bahawalpur and Sialkot, 12% in Khushab and Multan, 2% in DHQ Hospital Sialkot, 20% in Rawalpindi, 4% in Lahore and 46% of the respondents were in FGS hospital Islamabad.

Further table indicated the findings of female patients accompanied with any family member or come alone to visit the hospital. Among 38% of the respondents visited hospital accompanying their husband, 19% with mother in

Law, 32% with mothers, 4% with fathers and only 5% of the respondents reported to visit alone. Among thirty eight percent who visited with their husbands, almost 10% of them belonged to DHQ hospital Bahawalpur, Khushab and Rawalpindi, 17% belonged to DHQ hospital Sialkot, 18% to Multan, 11% to Lahore and 23% of the respondents belonged to FGS hospital Islamabad. Among 19% of the respondents who were accompanied by their mothers in law to visit the hospital, 20% were in DHQ hospital Bahawalpur, 12% in Khushab, Lahore and FGS hospital Islamabad, 7% of the respondents were in DHQ hospital Sialkot, and 17% were in DHQ hospital Rawalpindi and Multan. Among 33% of the respondents who were accompanied by their mothers to visit the hospital, 14% were in DHQ hospital Bahawalpur, 17% in Khushab, Rawalpindi, and Lahore, 16% were in DHQ hospital Sialkot, 10% in Multan, and 7% of the respondents were in FGS hospital Islamabad. 4% of the respondents who visited hospital accompany with father, among those 33% belonged to DHQ Hospital Bahawalpur, 22% to Khushab and Lahore, and 11% of the respondents belongs to DHQ Hospital Sialkot and FGS hospital Islamabad. Among 5% of the respondents who visited alone to hospitals, 9% belonged to DHQ Hospital Bahawalpur, Sialkot and Multan 27% to Khushab and Rawalpindi, and 18% of the respondents in DHQ hospital Lahore visited hospital alone.

The data indicated the very important findings that only 5% of the respondent visited hospital alone to seek health care services while remaining 95% needed any of the family members to accompany them. The reason behind anyone to be with patient is due to our social-cultural norms and setup which may not allow female to go outside the home alone especially for health seeking.

Due to patriarchal society of Pakistan, gender differences in roles and access to resources are obvious. Because of social and cultural barriers and stereotypes women always depend on others to have access to health services.[2] This is one of the major reasons that in Pakistan maternity issues are major cause for the death of both mother and children during the time of pregnancy.

4.5.3. Satisfaction of patients with services provided by doctors and staff at hospital

The satisfaction of patients with the health services provided at hospitals is one the important aspect to be measured for the performance of health care services as well as to measure the doctor-patient relationship (Hjortdahl, 1992 & Khan, 1999). Patients satisfaction with the services provided by doctors can be measured

[2] Report on the state of women in urban local Government in Pakistan. Retrieved from the web 20th May, 2010. http://www.unescap.org/huset/women/reports/pakistan.pdf

by the perception of patients regarding the treatment provide by doctors, availability of health services on easy access (Howard *et al,* 2007*)*.

To measure the satisfaction of patients with services provided by the doctors and staffs at DHQ hospitals matrix question based on13 items related to check the level of satisfaction of patients with services was developed by using five points of likert scale.

Table. 4.5.3.1. Reliability of instrument used for patient's satisfaction

Alpha reliability of instrument used for patients (n = 210)

N	N of Items	Alpha Reliability
210	13	0.843

The table 4.5.3.1. shows the alpha reliability of the questionnaire used for patients indicate that the reliability of questionnaire is satisfied and it can be used for the final research study.

Table 4.5.3.2. Level of satisfaction about the services provided by doctors among female patients at District Headquarter Hospitals of Punjab and Federal Hospital.

Satisfaction with services provided to patients	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	
	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	Total
low	10.3(6)	8.6(5)	6.9(4)	15.5(9)	27.6(16)	13.8(8)	17.2(10)	27.6(58)
Medium	19.4(21)	20.4(22)	12.0(13)	19.4(21)	11.1(12)	11.1(12)	6.5 (7)	51.4(108)
High	6.8(3)	6.8(3)	29.5(13)	0(0)	4.5(2)	22.7(10)	29.5(13)	20.9(44)
Total	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	100 (210)

The table 4.5.3.2 indicates the level of patient's satisfaction with the services provided by the doctor's and other staff of the hospital. The results show that 51% of the respondents had medium level of satisfaction with the services provided by the doctors and staff followed by 27% had low and 20% who had medium level of satisfaction. The district wise analysis indicated that among 27% of the respondents with low level of satisfaction, 10% were in DHQ hospital Bahawalpur, 8% in Khushab, almost 7% in Sialkot, 15% in Rawalpindi, 27% in Multan, alomost14% in Lahore and the remaining 17% of the respondents in FGS hospital Islamabad. Among 51% of the respondent who had medium level of satisfaction, 19% belonged to DHQ hospital Bahawalpur and Rawalpindi, 20% to Khushab, 12% to Sialkot, 11% to Multan and Lahore, and 6% of them were from FGS hospital Islamabad. Among twenty one percent of the respondents who had high level of satisfaction with the services, almost 7% were in DHQ hospital Bahawalpur and Khushab, 29% to Sialkot, 4% to Multan, 22% to Lahore and 29% of the respondents belonged to FGS hospital Islamabad.

4.5.4. Satisfaction with the availability of health services

To measure the satisfaction of patients with the availability of health services provided to the patients by the hospital, a matrix questions comprised of 12 items was developed using five points likert scale to check the level of satisfaction of patients with the availability of health services.

Table. 4.5.4.1. Reliability of instrument used for patient's satisfaction with services

N	N of Items	Alpha Reliability
210	12	0.844

The table 4.5.4.1 shows the alpha reliability .844 indicated that scale is good to measure the level of patient's satisfactions regarding the availability of health services provided at hospital. After checking the reliability by the application of Cornbach Alpha, an index variable was developed.

Table 4.5.4.2 Level of satisfaction about the services available among female patients at District Headquarter Hospitals of Punjab and Federal Hospital.

Satisfaction with availability of services	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	Total
	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)
Low	23.3(14)	10.0(6)	0(0)	18.3(11)	13.3(8)	11.7(7)	23.3(14)	28.5(60)
Medium	14.2(16)	17.7(20)	13.3(15)	13.3(15)	15.0(17)	12.4(14)	14.2(16)	53.8(113)
High	0(0)	10.8(4)	40.5(15)	10.8(4)	13.5(5)	24.3(9)	0(0)	17.6(37)
Total	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	100 (210)

The table 4.5.4.2 indicated that 54% of the respondents were at medium level of satisfaction with the health services followed by the 28% of low and almost 18% of high level of satisfaction. The district wise analysis revealed that among 28% of respondents having low level of satisfaction, 23% were in DHQ Hospital Bahawalpur and FGS service Hospital Islamabad, 10% in Khushab, 18% in Rawalpindi,13% in Multan and almost 12% in DHQ hospital Lahore. Among 54% of the respondent having medium level of satisfaction with the health services, 14% belongs to DHQ hospital Bahawalpur and FGS hospital Islamabad,

almost 18% to DHQ hospital Khushab, 13% to DHQ Hospital Sialkot and Rawalpindi, 15% to Multan and 12% of the respondent belongs to DHQ hospital Lahore. Among 17% of the respondents having high level of satisfaction with the health services, almost 11% were in DHQ hospital Khushab and Rawalpindi, 40% in Sialkot, 13% in Multan, and 24% of the respondents were in DHQ hospital Lahore.

A study conducted by Fournier & Haddad (1995) supported the findings by indicated that quality of health services in public sector has often been over sighted. There is no strict policy and plan to monitor the delivery of services to check and maintain the quality of services.

4.5.5. Problems faced by patients

To measure the problems faced by patients at hospital regarding the provision and utilization of health services, a matrix questions based on seven items (See annexure) was developed to measure the level of the problems faced by patients.

Table. 4.5.5.1. Reliability of instrument used to measure problems faced by patients.

N	N of Items	Alpha Reliability
210	07	0.863

The table 4.5.5.1. shows alpha reliability 0.863 indicated that scale is good to measure the problems faced by patients at hospital. After checking the reliability by the application of Cornbach Alpha, an index variable was developed.

Table 4.5.5.2. Level of problems faced by female patients at District Headquarter Hospitals of Punjab and Federal Hospital.

Problems faced by patients	Bhawal-pur	Khush-ab	Sial-kot	Rawal-pindi	Multan	Lahore	Islam-abad	Total
	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)
High	5.7(5)	20.7(18)	2.3(2)	28.7(25)	14.9(13)	8.0(7)	19.5(17)	41.4(87)
Medium	21.5(20)	9.7(9)	19.4(18)	5.4(5)	15.1(14)	16.2(15)	12.9(12)	44.2(93)
Low	16.7(5)	10.0(3)	33.3(10)	0(0)	10.0(3)	26.7(8)	3.3(1)	14.2(30)
Total	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	14.3(30)	100 (210)

The table 4.5.5.2 indicated that 41% of the respondents faced high level of problems at hospital followed by 44% faced medium level and 14% faced low level of problems at hospitals during the access and utilization of health services. The district wise analysis indicated that among 41% of the respondents facing high level of problems, almost 6% belonged to DHQ hospital Bahawalpur, 21% to Khushab, 2% to Sialkot, 28% to Rawalpindi, 15% to Multan, 8% to Lahore and 19% of the respondents belonged to FGS Hospital Islamabad. Among 44% of the respondents who were facing medium level of problems, 21% of the respondents were in DHQ Hospital Bahawalpur, almost 10% in Khushab, 19% in Sialkot, 5% in Rawalpindi, 15% in Multan, 16% in Lahore and almost 13% of the respondents were in FGS hospital Islamabad. Among 14% of the respondents facing low level

of problems, almost 17% belonged to DHQ hospital Bahawalpur, 10% to Khushab and Multan, 33% to Sialkot, 26% to Lahore and 3% of the respondents belonged to FGS hospital Islamabad.

In most of the studies of hospitals, the major problem which has been indicated by the patients was lack of beds and seating facility for themselves and their attendants. It was noted that in MCH department, there were three women lying on one bed along with their newborn children and no seating was available for their attendants. The other problem highlighted by the patient was non-providence of food and water by the hospital, due to which they had to bring it from home no matter how far their home, was or else they had to purchase it from the cafeteria of hospital or from market. The findings of this study has been supported by another research study conducted by Hassan & Rehman (2007) which indicated that in public hospitals patients often compliant about the lack of seating as well as the quality of these seating also increased their problems especially for patients who have to stay long in the hospital with their attendants. In public hospitals, the seating available to patients and their attendants were mostly the plastic chairs and wooden benches. The study also finds out the problems of lack of food and water faced by the patients in public hospitals.

4.6. Bi-variate Analysis

This section deals with the bi-variate of the findings of the study undertaken in which hypothesis are tested.

Testing of Hypothesis:

Broadly following conceptual hypothesis has been tested for bi-varitae analysis of the results of study.

Hypothesis 1: Structural disparity and negligence in health care system is the reflection of poor governance.

The provision and its effective utilization of health facilities to the patients as well as the doctors can be analyzed by the satisfaction of the users of those facilities which have been used as another indicator to measure the structure and function of governance in health system. To measure this phenomenon following hypothesis has been tested.

Table. 4.6.1. Availability of separate examination rooms and patient's confident to discuss the problems with doctor

Availability of Separate Examination Room	Patient discuss the problem with doctors		Total
	Confidently	Feel Hesitation	
	Percentage(Number)		
Yes	89.0(70)	7.6(10)	38.0(80)
No	11.0(9)	92.4(121)	62.0(130)
	100.0(79)	100.0(131)	100.0(210)
Chi-square: 30.471 DF: 6 Significance level (SL): 0.000 Lambda: 0.70 Standard Error: 0.19 Approx. T: 3.907 SL: .001			

The able 4.6.1 mentioned the provision of separate health care delivery services to both men and women indicated the infrastructure of health system. It is very important to provide safe, secure and private place to the patients for consultation with the doctors. This may result in giving confident to the patients to discuss their health matters with the health professional in detail. The above table also indicated that as doctors maintain the privacy of patients to treat them, patients feel more confident to have a detail discussion with doctors about their health problems. It was also indicted that where the patients do not provide such facility by the hospital and doctors, patient feel hesitation to discuss their health problems in detail. To find out the difference between the provision of private space by the doctors and patient's level of discussion with doctors, Chi-square test was applied that indicated the significant difference between the selected variables. The

patients who feel hesitation to discuss their problems were because of lack of separate consultation rooms available at hospitals that indicated the lack of infrastructure facility which do not fulfill the needs of the patients. A research by Hassan & Rehman, (2007) conducted on public health services also supported the argument as indicated that consultation facilities at public hospitals are not satisfactory because of lack of physical space and other resources.

Table 4.6.2. Availability of treatment services by numbers of visits made by patients

Availability of Treatment services	Number of visits made by patients			Total
	Less (1-5)	Moderate (6-10)	More (Above 10)	
	Percentage(Number)			
Low	39.2(29)	9.5(4)	13.8(13)	22.0(46)
Medium	55.4(41)	33.3(14)	12.8(12)	32.0(67)
High	5.4(4)	57.2(24)	73.4(69)	46.0(97)
	100.0(74)	100.0(42)	100.0(94)	100(210)
Chi-square:12.90	DF: 4		Significance level (SL): 0.012	
Gamma: -1.05	Standard Error: .113		Approx. T: -.929 SL: ..359	

The table 4.6.2 indicated that as there is much better availability of treatment services there are more number of visits made by patients. The dependents variable was measured at three level of less, moderate and more against the

independent variable of three levels which was low, medium and high level of availability of treatment services. The treatment services included laboratory services, medicines etc were measured at three level; low, medium and high. The number of patient's visited was measured under three categories of; less (1-5 visits), moderate (6-10) and more (above 10 visits).

It is indicated that 73% of the patients visited more than ten times to the hospital due to high availability of treatment services. The Chi-square value (12.90) at 1% of significance level also indicated that there is a strong relation with the availability of treatment services and number of visits made by patients.

Table. 4.6.3. Distance covered by number of visits to hospital

Distance (KM)	Number of visits made by patients.			Total
	Less (1-2)	Moderate (3-4)	More (>4)	
	Percentage(Number)			
<5	6.2(6)	16.7(10)	65.0(35)	24.3(51)
6-10	20.3(11)	43.3(26)	29.2(28)	31.0(65)
>10	64.6(62)	40.0(24)	14.7(8)	44.7(94)
	25.7(54)	28.6(60)	45.7(96)	100(210)
Chi-square:29.17	DF: 14		Significance level (SL): 0.01	
Gamma: .594	Standard Error: .128		Approx. T: 3.96 SL: .002	

The table 4.6.3 indicated that distance of health care services affects the number of visits made by the patients. The distance in km was measured as independent

variable with the dependent variable the number of visits made by patients. The distance was measure in three categories of: less than five km, six to ten km and more than ten km. The dependents variable was measured at three level of less, moderate and more against the independent variable of three levels which was low, medium and high level of availability of treatment services. The patients who visited the hospital for one to five times were taken in the category of less visits, those who visited six to then times were taken as moderate visits and the patients visited more than ten times to the hospital were taken under the category of more visits made by patients.

The table indicated that 65% of the patients visited more than ten times on average because of less distance of hospital from their home which was approximately 5 km. As the distance increased, the number of visits made by patients became less. The patients who had to travel more than ten km to reach the hospital, the number of visits reduced. The Chi-square value at one percent level of significance also indicated a significant difference but positive relation between distance and number of visits by patients.

Hypothesis 2: Relationship between health provider and seeker is the important indicator to measure the fairness and satisfaction with health services.

Table. 4.6.4. Proper check up by doctors and patient's satisfaction with health services provided by doctors.

Doctors Checked Properly	Patient's satisfaction with Health services provided by doctors		Total
	Highly satisfied	Satisfied	
	Percentage(Number)		
To great Extent	86.0(116)	73.3(55)	81.4(171)
To some Extent	9.6(13)	16.0(12)	11.9(25)
Not at all	4.4(6)	10.6(8)	6.7(14)
	100.0(135)	100.0(75)	100.0(210)
Chi-square: 14.817	DF: 8	Significance level	(SL): 0.03
Lambda: 0.15	Standard Error: 0.35	Approx. T: .427	SL: .000
Gamma: -.254	Standard Error: .131	Approx. T: -1.817	SL: .069

The behavior and treatment given to patients at hospitals by the doctors is one of the very important determinants to measure the patient's satisfaction with the provision of health care services (Sinclair, 2007). The table 4.6.4 indicated that variable of proper check up by doctors was measure at three levels; to great extent, to some extent and not at all and patient's satisfaction was measure in two categories; highly satisfied and satisfied. The results indicated that 86% of the patients respondent that doctor checked them properly and due to that they were

highly satisfied with the health services provided by the doctors at hospital. It is indicated that based on the proper treatment and time given by the doctors to check the patient, the patient became highly satisfied with the health services. The Chi-square value (14.817 at 0.03clevel of significance revealed that there is a significant and positive relation with the variable proper checked by doctors and patient's satisfaction with health services. to doctors.

Table. 4.6.5. Time devotion by doctors and patent's improvement in health condition.

Time devotion by the doctors (Minutes)	**Patient's opinion about improvement in health condition**		**Total**
	Rapidly Improved	**Slowly improved**	
	Percentage(Number)		
Less Time (10-20)	5.2(7)	47.5(38)	21.4(45)
Moderate Time (21-30)	26.9(35)	30.0(24)	28.1(59)
More Time (>30)	67.7(88)	22.5(18)	50.5(106)
	61.9(130)	38.1(80)	100(210)
Chi-square: 15.71	DF: 2	Significance level (SL): 0.000	
Gamma: -.421	Standard Error: .109	Approx. T: -3.04 SL: .001	

The above table 4.6.5 shows the association between the time devotion by the doctors and patient's opinion about improvement in health condition. The time devotion by the doctors was measured in three level; less time (10-20 minutes), moderate time (21-30 minutes) and more time (>30 minutes). The patient's

opinion about improvement in their health condition was taken at two levels: rapidly improved and slowly improved. The date indicated that 67% of the respondents felt rapid improvement in their as more time provide by the doctors to treat them. The patients who responded about less time devotion by the doctors feel slow improvement in their health condition. The chi-squre value (15.71) at .000 level of significance indicted highly significant difference but positive association between these two variables.

Table. 4.6.6. Patient's waiting time for doctor's Visit and their satisfaction about consultation

Time to wait for Doctor's Visit	**Patient's satisfaction about consultation**			**Total**
	Not Satisfied	**Satisfied**	**Highly Satisfied**	
	Percentage(Number)			
Less than one hour	10.0(6)	20.9(14)	84.3(70)	42.9(90)
One to two hour	16.7(10)	68.7(46)	9.6(8)	30.4(64)
More than two hour	73.3(44)	10.4(7)	6.1(5)	26.7(56)
	28.6(60)	32.0(67)	39.4(83)	100(210)
Chi-square:32.85	DF: 4		Significance level (SL): 0.000	
Gamma: .594	Standard Error: .128		Approx. T: 3.96 SL: .000	

The above table 4.6.6 indicated the difference between patients' waiting time for doctor's visit and their satisfaction about consultation. The waiting time by the patients for doctor's visit was measured in three level of; less than one hour, one

to two hour and more than two hour. The patient's satisfaction about the consultation was also measured in three categories: Not satisfied, satisfied and highly satisfied. The results indicated that 84% of the respondents who had to wait less than one hour for the doctor visit to treat them were highly satisfied with the consultation provided by doctor. On the other hand 73% of the respondents who had to wit more than two hour for doctor's visit were not satisfied with the consultation provided. The Chi-square value (32.85) at .000 level of significance indicted that as the waiting time increased patient's satisfaction level with consultation became less. There is highly significance relation between these variables.

Table. 4.6.7. Workload of doctors by the satisfaction with salary.

Work load (Number of Patients Checked)	**Salary satisfaction**		**Total**
	Satisfied	**Not Satisfied**	
	Percentage(Number)		
Less **Less than 20**	61.5(80)	12.5(10)	42.8(90)
Moderate **20 to 40**	27.6(36)	25.0(20)	26.6(56)
High **More than 40**	10.8(14)	62.5 (50)	30.4(64)
	100.0(130)	100.0(80)	100(210)
Chi-square: 5.47 DF: 2 Significance level (SL): 0.05 Gamma: .449 Standard Error: 0.160 Approx. T: 2.460 SL: .014			

Human resource at the hospital is very important component for the provision of health care services to the patients. It is the responsibility of the authorities to provide adequate services and facilities to health care providers along with the provision of services to the patients. If the doctors are satisfied with their work load and salary or reward given to them for their performance and work, doctors take their profession honestly and with devotion. To explore this aspect the table 4.6.7 indicated that independent variable workload in terms of number of patients checked by doctors was cross tab with their salary satisfaction. The workload was measured in three categories; Less (less than 20), Moderate (20-40) and High (more than 40). And salary satisfaction was measured in two level of; satisfied and not satisfied. The Chi-square value (5.47) at .05 level of significance indicated that there is an association between the doctor's workload and their level of satisfaction with salary. The data indicated that 61% of the respondents who has less work load were more satisfied with their salary as compares to 62% of the respondents who had more workload and not satisfied with their salary.

Table 4.6.8. Relationship between doctor's behaviors with the patients.

Sr.no	Independent Variables	Dependent Variable	
		Attitude towards Patients	
		r	p
1	Satisfaction with facilities provided by the hospital	.498**	.000
2	Provision of trainings	.357**	.002
3	Satisfaction with salaries	.342**	.004

The table 4.6.8 find out the relationship between health provider and seekers, some variable are correlated to explore the relationship of doctor's satisfaction with the services provided at hospital with their attitude and behaviors towards the patients. The correlation of variables satisfaction with the facilities and attitude towards the patients indicated the highly significant correlation between these two variables at 1% of level of significance. This indicated that as the better facilities provided to doctors at hospital, like doctor's rooms, separate toilet facility, good working environment etc, the doctors will perform their duties well which reflects through the attitude and behavior they show to the patients during giving treatment to them .

On-job trainings are very important to enhance the skills of the doctors and update their professional knowledge for the better and expert performances. Regarding

the doctor's attitude towards the patient, some sort of trainings must be given to doctors on the enhancements of their professional and personal traits to behave with the patients. The correlation was applied to measure the argument, the correlation at 1% level of significance between the variable of provision of training to doctors and their attitude with the patients. It indicated that as much as the trainings have been provided on different ethical and professional conducts to the doctors, their skills and their attitude with the patients became more positive and friendly. Therefore, it can be said that trainings are very essential component for the friendly and cooperative relationship of doctors with the patients.

The doctor's satisfaction with their salaries also effects their attitude and behaviors towards the patients. The correlation between the salaries satisfaction of doctors and their attitude with patients indicated the highly significant relationship with doctor's satisfaction with salaries and patient's attitude at 1% level of significance. This indicated that as much as the doctor's are satisfied with their salaries, they may take keen interests to perform their duties which are reflected through their friendly and cooperative behavior towards the patients. The financial needs are important for every one to be fulfilled, if doctors are economically well off, they will not have any financial burden to run and fulfill the family needs, as a result instead of worrying all the time about the financial instability, the doctors pay attention on work performances.

4.7. Summary Table:

The following table comprised of the overall summary of the variables on which chi-square test has been applied to check the hypothesis of the study.

s.no	Variables	Chi-square	Lambda	Gamma	p
1	Availability of separate examination room for female patients by patient's discussion about the problem with doctors	30.47	0.70	-	0.000
2	Availability of treatment services by number of visits made by patients	12.90	-	1.05	0.001
3	Distance covered in km by number of time patient's visited.	29.17	-	.594	0.01
4	Proper checked by the doctors by patient's satisfaction with health services provided by doctors	14.81	-	.254	0.003
5	Time devotion by the doctors by patient's opinion about improvement in health condition	15.71	-	.421	0.000
6	Waiting time for doctor's visit by patient's satisfaction about consultation	32.85	-	.594	0.000
7	Doctor's workload by Satisfaction with salaries	5.47	-	.499	0.05

The table 4.7 shows that independent variable availability of separate examination room for female patients was cross tab with dependent variable patent's discussion about their health problems with the doctors. The value of chi-square (30.47) at 0.000 level of significance with 0.70 value of lambda indicated the positive and significant difference between the two variables. It has been analyzed

that the patients who visited those hospitals which do not have the facility of separate examination room feel hesitation to discus their health problems with the doctors as compare to those patients who avail these facilities in some hospital.

Another variable; availability of treatment services was cross tab with dependent variable; number of visits made by patients and chi-square was applied to test it significance level of difference. The chi-square value (12.90) at 0.001 level of significance with 1.05 value of Gamma indicated the significant and positive relation with these two variables. The test results indicated that if the services are at low level the number of visits made by patient also became less and in those hospitals where the treatment services was available at high level, a patients visited more times . It has been analyzed that because of availability of treatment services for basic health, patients prefer to visits more to the hospitals to avail the services.

The distance of health care services affects the number of visits made by the patients. The distance in km was measured as independent variable with the dependent variable the number of visits made by patients. The distance was measure in three categories of: less than five km, six to ten km and more than ten km. The dependents variable was measured at three level of less, moderate and more against the independent variable of three levels which was low, medium and

high level of availability of treatment services. As the distance increased, the number of visits made by patients became less. The patients who had to travel more than ten km to reach the hospital, the number of visits reduced. The Chi-square value at one percent level of significance also indicated a significant difference but positive relation between distance and number of visits by patients. The chi-square value (29.17) at 0.001 level of significance with .594 value of Gamma indicated the significant and positive relation with these two variables.

Another chi-square test was applied on the independent variable proper checkup by the doctors and patient's satisfaction about provision of health services. The chi-square value (14.84) at 0.003 level of significance with .254 value of Gamma indicated the significant and positive relation with these two variables. It is indicated that on the basis of proper checkup by the doctors, patient feel satisfaction about the health services provided to them by the doctors at hospitals. The results revealed that as the good health facilities has been provided to the health users, the higher the satisfaction of patients with the services and patients feel improvement in their health. Therefore it can be stated that the improvement in patients' health also lies on the provision of good health care facilities to the patients.

Another chi-square test was applied on the independent variable time devotion by doctors and patient's opinion about improvement in their health condition. The chi-square value (15.71) at 0.000 level of significance with .241 value of Gamma indicated the significant and positive relation with these two variables. As doctors pay much attention and time to give consultation and treatment to the patients, the patients feel rapid and positive improvement in their health condition.

The independent variable waiting time by patients for doctor's visits was cross tab with dependent variable patient's satisfaction with the consultation provided by doctors. The chi-square value (32.85) at 0.000 level of significance with .594 value of Gamma indicated the significant and positive difference with these two variables. As the doctor came late for the duty, they provide less time to the patients for consultation and due to long waiting hours patients feel less satisfaction on this short consultation time given by the doctors. It is indicated that patient's less satisfaction with the consultation provided by the doctors increased because they had to wait long for doctors' visits but they may not give them proper time and consultation.

Another independents variable work load of doctors was cross tab with doctor's satisfaction with salary. The chi-square value (5.47) at 0.05 level of significance with .499 value of Gamma indicated the significant and positive difference with

these two variables. As doctors had more workload their satisfaction with their salaries became low because it do not meet the level of performance and services they were provided. It is indicated that the doctor's level of satisfaction with the salary provided to them depends on the work load they had at hospital.

Chapter Five

Summary, Conclusion and Recommendations

The aim of the study was to find out gender disparities in governance of health care system and its effects on women access and utilization of health services. The purpose of the study was to identify barriers to accessing and utilization of health services by female

Both quantitative and qualitative research paradigm was used for the study. In quantitative part, surveys have been conducted from the hospital administration, patients and doctors and in qualitative part, content analysis of health policies 2001 and 2009 as well as in-depth interviews were conducted to collect the data. The whole study was conducted in three phases: Phase I comprises of the content analysis of Health Policy 2001 and 2009 through gender lens by using Gender planning framework developed by Oxfam as well as interviews with health policy makers were also conducted for in-depth analysis of policy and the governance of health structure in the perspective of gender health needs. In phase II, public hospitals were visited to explore the resources utilization according to the needs of particular gender and also to checkout the governance structure explained in health policy. In-depth information was taken from the Medical superintendents of the hospitals by using questionnaire comprised of open and close ended items.

In phase three of the study, information regarding the availability of health resources and its access and utilization, were taken from the patients and doctors of the particular district hospitals.

The collected data was analyzed by using appropriate statistical techniques. The uni-variate analysis was carried out to find out the emerging trends while bi-variate analysis explores the association between the interacting variable. Content and thematic analysis was used to analyze documents and interview's data respectively. The findings have been presented in the forthcoming section.

5.1: Major Findings

The phase I of the study wherein health policy was analyzed revealed the following major facts:

5.1.1. Gender Analysis of health Policies:

The review of health policy 2001 & 2009 through gender lens indicated that policies focus on gender based challenges and constraints in the health sector of Pakistan. By focusing on the National health policy 2001 and 2009 regarding the utilization of health services by women the study indicated that attention was

given to improve the social and economic status of health care providers for providing better facilities for women.

In National Health Policy 2001, the focus was on the promotion of gender equity in health sector highlighted in its fourth key area. In this key point they focused on improving the reproductive health services to child bearing women, access to primary health services for women, more training courses and job opportunities for the LHWs.

The health policies of 2001 and 2009 also discussed the practical needs of women, such as accessibility of basic health nutrition package to women; promote the basic health care of children and vulnerable population through family health workers, especially to childbearing women. Although the health policies focus on the promotion of greater gender equity in health sector, but the resources given to this area are very low due to which women are not benefited according to their needs. There is no separate budget allocation to meet the women's need in health sector due to weak structure of gender based governance in health sector and less resource.

The findings of the data collected from health policy makers regarding the efficient and equitable process for the formulation of policies, most of the health

policy makers responded that overall governance of health care system in terms of policy planning and control of the resources is the responsibility of Federal Ministry of Health. Beside these wings and federal ministry of health, many other departments are also consulted and take part in drafting health policies. These departments included are Ministry of Finance, Ministry of Population Welfare, and Ministry of Law, donor agencies, World Health Organization, pharmaceutical companies and private sector.

Majority of the respondents (Health Policy makers) responded that special genders needs are addressed in health policies of 2001 and 2009. There are number of programmes like family planning, lady health workers, maternal and child health centers are working under the policy 2001 and there is a plan to upgrade these in 2009 health policy. The women's participation in the process of formulating policies as policy makers as well as any member of the policy making body is less as compared to men. Most of the respondent said that although women are the part of policy making process but they have lesser control over any decisions. All of the respondents responded that the gender based health needs are identifies in health sector but no specific budget has been allocated separately.

The health policy makers also highlighted that due to weak monitoring mechanism in health system, health policy was not able to achieve its targets. It

was also mentioned that the yearly budget allocated to health sector is not utilized properly.

5.1.2. Women's Access and Utilization of Health Services in DHQs:

Phase II of the study based on the survey conduced at selected DHQs of Punjab and Federal Government Services Hospital. The findings of the study regarding the procedure followed by patients to visit the DHQ indicated that in all selected DHQs there were proper procedure of enrolling patients who visited to hospital as in-patient and out-patient. The enrollment form or slip had given number which also helped the patients for their turn to be examined by the doctors. This is good practice to avoid any discrimination the patient avail for their diagnosis of their health problems as well as it promotes the practices of first come first serve basis.

Regarding the separate waiting facilities for men and women, the data revealed that 86% of the District headquarter hospitals had separate waiting facilities as in our cultural norms and values it is preferable to have separate facilities for both men and women. Only in DHQ Sailkot separate waiting facilities for both men and women was not available, the main reason behind that was lack of adequate

space for the departments to establish separate waiting facilities for men and women.

All DHQs have separate facilities of wards, examination rooms, and female doctors for female patients as well as separate toilets for men and women. The basic services that hospitals offer include short-term hospitalization, emergency room services, general and speciality surgical services, x-ray/radiology services, laboratory services, blood services etc.

5.1.3. Orientation and Training to Doctors and Staff

Out of those five hospitals which provide orientation to new staff, three hospitals give the brief introduction about the hospital rules, procedures and about the responsibilities. Trainings for paramedical staff and medical officers are provided at DHQ hospitals Rawalpindi, Sailkot and federal government hospital Islamabad, while other DHQ hospitals do not have any training for paramedical staff. The data indicated that in DHQ hospital Rawalpindi, Sailkot, Lahore and Federal hospital trainings has been provided to helpers as well.

The data shows that in federal government hospital, almost all trainings have been financially supported by the annual financial budget provided to the hospital,

while in district hospital it was revealed that ministry of health manages the financial resources for trainings.

5.1.4. Payment of Salaries:

It is indicated that the doctors at DHQ hospitals Khushab, Sailkot, Rawalpindi, Lahore and federal government hospital have always receive their salaries on time. This exposes that hospitals have good financial management system. While in DHQ hospital Bhawalpur and Multan, doctors often do not receive their salaries on time; this is because of lack of funding available at hospital provided by the government.

Further the data also indicated that those hospitals which provide salaries to the doctors and staff on time also sometimes provided the bonus to staff and the hospitals, while the hospital already not paying doctors and staff salaries on time due to lack of funds were not providing any bonus. The data indicated that accepting the importance of monitoring system, all the studied hospitals had monitoring system to check out the performance and utilization of hospital services.

The other finding of the study also indicated that in case of non satisfactory performances of doctors and staff, hospital administration gives a chance to them instead of immediate replacement and guides or provides training to improve their skills. In all studied public hospital, there is the hospital waste management system, but the question arises of the proper function and utilization of it in more efficient and proper way which sometimes lack in our health system.

5.1.5. Problems faced by women in access and utilization of Health Services:

Although women are availing the public hospital's health services but to access to these services, they have to face many socio-cultural problems as well such as they cannot come to hospital alone, and due to lack of financial resources as well they are dependent on other members of family especially husband. The data indicated that the most common problem faced by majority of women to access to hospital in Districts Bahawalpur and Khushab was the lack of female staff for treating specific health needs of women.

The problems highlighted by the hospital administration should be given due consideration while making health policy in future. The visits of the executive personals of the ministry of health and other health departments who monitor and manage the health delivery services may indicates that the service provision at

hospitals has been checked out and the issues and problems exited have been given importance to be overcome.

5.1.6. Health Services provided by the doctors

Phase III of the study consisted of two parts: part one dealt with the findings of data collected from the doctors and part two dealt with the findings of data collected from the patients visited to the selected studied hospitals.

Regarding the age of the doctors, it has been indicated that total 38% of the respondents were in age group of 20-30 years, 44% in 31-40 years of age group and only 17% were in age group of 41 to 50 years. Among three departments 35% of the doctors belonged to Medicines and Obstetric & Gynecology department and 31% to Surgery department. The designation of doctors indicated that overall 44% of the respondents were medical officer followed by 33% House job officers and 23% specialized doctors.

Regarding the qualification of doctors, the data shows that 77% of the respondents were MBBS, followed by 21% FCPSC and only 1% of the respondents were MD qualified. The years of workings experience of doctors that indicated that majority of the respondents' i.e 54% of the total had 1to 5 years of

work experience followed by 28% had 6-10 years and 17% had 11-15 years of working experience.

The data of the study indicted that majority of the respondents had more than 10 hours of duty which is almost 29% followed by 26% who had nine to ten hours, 24% had seven to eight hours of duty, 17% had five to six and only 4% of the respondents had 3 to four hours of duty at hospital. Thirty one of the overall respondents provided consultation to 16 to 30 and more than 45 patients per day in different hospitals, while 26% provided consultation to 31-45 patients daily followed by 11% who provided consultation to 10 to 15 patients.

Regarding the salaries received by the doctors, fifty seven percent of the doctors who responded always got their salaries on time followed by 34% who got often late and 9% got their salaries some times late. The data shows that 44% of the respondents were not satisfied with their salaries in all seven studied hospitals followed by 23% of the respondent who were satisfied, 21% were on moderate level of satisfaction and 11% of the respondents were highly dissatisfied. The delay in the provision of salaries to doctors is due to the internal mismanagement of finance department of the hospital or delay in the process by the government due to lack of funds.

5.1.7. Women's access and utilization of Health Services (Patients' Survey)

Majority of the patients respondents belonged to the 21 to 30 years of age group which is 59% followed by 22% of respondents falling in age group of 31-40 years and 12% of the respondents were less than 20 years of age. The data indicated that 85% of the patients were married and rest of 15% was unmarried. Majority of the respondents' i.e 58% were having monthly income of Rs/- 5000 to 25000.

Regarding the education of the respondents, the table indicated that majority (42%) of the respondents had education up to middle, followed by 20% were above metric, 19% were having education up to metric and 18% of the respondents were illiterate.

The results indicated that almost 40% of the respondents indicated that they visited the particular hospital due to easy access for them, 11% visited the specific hospital due to availability of qualified and experience doctors. There were just 5 % of the respondents who indicated their preference to visit particular hospital was due to the availability of good health services, including medicines and other laboratory facilities, 21% of the respondents visited the hospital because of considering it as their family hospital. Twenty one percent of the respondents

visited the hospital because they were referred to that hospital due to availability of qualified doctors and better health services.

The data revealed that 45% of the respondents took more than half to one hour to reach to the hospital, that is followed by 28% of the respondent who took less than half an hour, 17% took one to two hours and 9% of the respondents covered the distance in more than two hours. Majority (95%) of the respondents could not come alone to the hospital, in which 38% of the respondents visited hospital accompanying with their husbands, 19% with mothers in Law, 32% with mothers, 4% with father and only 5% of the respondents reported to visit alone.

Regarding the level of satisfaction with the health services provided to the female patients 51% of the respondents had medium level of satisfaction with the services provided by the doctors and staff followed by 27% who had low and 20% had medium level of satisfaction. Fifty four percent of the respondents were at medium level of satisfaction with the health services followed by the 28% of low and almost 18% of high level of satisfaction. The level of satisfaction with services was low because of some problems faced by the patients at hospital, such as poor sanitation, lack of seating, cafeteria, and beds etc. Fourty one percent of the respondents faced high level of problems at hospitals followed by 44% who

faced medium level and 14% faced low level of problems at hospital during the access and utilization of health services.

5.2. Gender based Analysis of Governance of health care system by using Governance Framework

5.2.1. National level:

The expenditures spending on heath especially for women are not appropriate according to the maternal health needs. As it is also proven by the research studies that the allocated budget is not fulfilling the demand of the health and no specific budget has been allocated for women's health. There is lack of gender balanced participation of decision makers at national level for taking decisions regarding the health policies.

Most health researches in the past have been conducted for men, by men. The results may then were applied for women, leading to inappropriate or ineffective interventions, as Ucsnik notes:

> *Historically, the discipline of women's health tended to focus on health problems specific to women because of their*

biological/sexual make up, such as maternity related problems, and those, which relate to their child care role, such as maternal and child health. Gender analysis seeks to recognize the ways in which gender roles; resources and perceptions impact upon women and men's health (Ucsnik, 2006, p.12).

In past, the issue of health governance was the responsibility of national government only but with the increasing demands and overlapping system, it has been distributed to regional or district levels as well.

5.2.2. Policy Formulation Level:

Although the policies focus the women's health needs in its top priority areas, but no detail guidelines have been described to achieve these goals and targets. The resource allocation for particular health needs was not mentioned in the policy due to which no specific human and financial resources have been separately utilizied for women's health.

5.2.3. Policy Implementation Level:

There is gap between the formulation and implantation of health policies with respect to women's health. The monitoring and evaluation of utilization of resources and the performance of staff is not used effectively. Programs exist but are under funded for most priorities identified in national health policy due to lack of health system reforms programs to address workforce, management and financing issues.

Although health is the issue of both men and women but due to reproductive function of women's health it needs more attention by the health care providers and policy makers. Health care services must analyze by the needs of men and women and policies ay designed in a way to improve the status of women. For efficient provision of health services, there must be developing some guidelines for the health care providers to meet the standard of quality of health services. Health professionals must be accountable for their actions and decisions (Shiwani, 2006).

5.3. Principles of Health system governance

For in-depth study of governance of health care system and provision for women's health, a framework on governance of health system designed by UNDP has also been used to elaborate the study. The framework is based on following five principles:

5.3.1. Participation and Consensus Orientation

Stakeholders' participation is very crucial in formulating any policy, plan or program. According to Alma Ata Deceleration (1976), stakeholder's participations are an important dimension to analyze the governance of health care system. The WHO Harare Declaration (1987) also emphasized that consumers of health care system both men and women must be involved in developing health care system programs and plans. But the findings of this study indicated that there was no participation of civil society or health professionals in the decision making process of formulation and implementation of health policies. The health ministry have lack of expertise to engage different stakeholders such as civil society, health professional etc, in decision making process

5.3.2. Strategic Vision:

Both National health policies 2001 and 2009 of Pakistan focus on the strategic vision of health care system. The policies emphasize on developing deliberate health system which meets the health needs of all human beings as health is their basic right which has to execute by the government. But the challenge remains to meet this vision as there is still a gap between the documentation of health policy and its implications.

5.3.3. Performance (Responsiveness, Effectiveness and Efficiency):

The strategies designed in the policy level are not working properly because of weak implementation and monitoring strategies. There is no proper mechanism to measure the performances of health care providers and to maintain the check and balance of the utilization of resources. The skills of health professional are not upgraded rapidly by providing trainings due to which their performance may not as much efficient as required.

5.3.4. Accountability:

The structure of governance reflects well if there is accountability of its system. Unfortunately the process of planning and financing of health care services lacks accountability in health system of Pakistan. The matters of developing programs and its implementation always remain very confidential to the higher level only and the actions taken are not transparent to other stakeholders. The allocation of resources also lacks proper utilization with respects to gender needs of health care as well. The inefficient utilization of budgets by the hospitals was also noticed while conducting this study.

5.3.5. Fairness (Rule of Law)

The health care system of Pakistan has efficient policies and laws but lack implantation due to lack of legal expertise. The legal procedure of access and utilization of health services by the masses are not defined to them properly. And if there is procedure, the consumers of survives do not want to follow the rules and ethics and violated. Most of the times if the patients wanted to avail this right, no action took place by the authorities.

5.4. Conclusion:

The study indicated that issues related to women's health addressed and the strategies are adopted in the health policies for improving the health of women in Pakistan but have not been implemented in a proper way, therefore the gap existed between the policy documents and the actual practice of these strategies. It is reveled that if the patients are satisfied with the services provided to them by the doctors, the attitude and behavior of doctors and other staff of the hospital, they will be satisfied with the overall facilities provided at the hospital.

Although the progress has been going on to improve the health status of women in Pakistan, but there is still a long way to go to deliver gender sensitive health care practices. To promote gender equality in health care system, other sectors should work with the government for making effective and sound health policies and programs. The public sector's capacity of managing and utilizing the available resources may improve by providing the better facilities to health care provides as they are key stakeholders who works to promote the standard of health system.

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The functions of hospitals must be evaluated in a proper way to ensure its quality provision of health services. And funds only are allocated to particular hospital on the basis of its efficient utilization of resources to provide better and equitable

health care services to the patients. Health care services can also be improved through awareness raising programmes for the users and professional training programmes for health care providers to meet the demands of health care system.

For the gender balanced structure of governance in health system of Pakistan, there is a need for integrating gender perspective at all levels of health system from the policy level to its implementation. The health care providers also need to aware about the gender specific health needs and its impact on health system. It can be achieved by providing gender sensitive trainings to medical students and professionals to deal with gender sensitive issues of health in a proper way.

5.5. Limitations of the study

The processes of taking inform consent by the administration of the hospitals was very lengthy, took one to two weeks. Some time the researcher had to wait long for conducting interview from the doctors, because of their busy schedule. The researcher had to face denial from some doctors as well as patients for giving interview due to their busy schedule at hospital.

5.6. Recommendations

The following recommendations have been proposed for the planning efficient health care system:

- Public sector management capacity may be strengthened by making better use of available resources.
- It might be worthwhile to offer some financial incentives to attract the doctors for taking keen interests in their profession.
- Most of the patients in public hospitals complained of a communication gap between the doctors and the patients. This gap between the doctors and the patients must be bridged through personal attention given by the doctors to the patients.
- To encourage polite and courteous behavior of the staff towards the patients, orientation and on- job training opportunities can be provided to the staff.
- Patients may properly guided by the doctor's issuing prescriptions regarding the procedure to be followed for proper cure.
- Hospital beds may be given to patients according to the severity of the disease rather than other trifle considerations like obliging the VIPs.

- The functioning of the hospital should be organized and re organized to serve the patients most efficiently.

- Hospitals may try to establish cordial, equitable and therefore, mutually profitable relations between the hospitals and their beneficiaries.

- Health ministries need to redefine their roles as stewards of the health system, with input from citizens, civil society, and the private sector; and to establish oversight and accountability mechanisms.

- Funds may not be allocated to hospitals without regard to the efficiency or appropriateness of use of resource; instead, progress in achieving outcomes should be the criteria for resource allocation.

- Health care services can be improved through awareness raising programmes including professional training programmes to meet the demands of the new health care system about gender problems with in the hospital.

- It is observed that female staff's (doctors/administrators) recruitment in the hospital is necessary because most of the time women do not want to go to male doctors and suffer more. Therefore by the recruitment of more female doctors, women's health condition by access to health services can improve.

- There is a need for integrating gender perspective at all level of hospital management and planning from policy to implementation level.

- There is a need to educate medical professionals about the gender needs in health system and its impact. It can be done bysensitizing them through gender awareness raising workshops and training programmes.

- Gender considerations should be an integral component of each step. It is important to integrate gender considerations in all strategies and programs may aim to achieve the MDGs, and analyze the related expenditure frameworks and budgets from a gender perspective.

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S. no: _____ Date:_____

Interview Guideline For Policy maker personal of Ministry of Health

Gender Differentials in Governance of Health Care System in Pakistan: Effect on Women's Access to and Utilization of Health Services

Name: _____ **Designation:**_____

Working experience: _____ **Institute:** _____

Health Policy planning

1. What approaches or mechanism, Pakistan has adopted for governance of health sector?

_____

_____

2. As health policy is the responsibility of the Federal Ministry of Health, which of the other department has been consulted for making policy/laws/ regulations about health?

_____

_____

3. The government plays a central role in establishing the institutional framework and policy direction for the health sector. Who support the government as stakeholders?

_____

_____

4. Why the stockholder's participation is necessary in the formulation of health policy?

_____

_____

5. Who set the agenda of policy and who take the final decisions?

_____

_____

6. How many male and female policy makers are involved in it.

_____

_____

7. In your opinion what are the most critical issues with the process of developing gender sensitive health policies in Pakistan?

_____

_____

10. How and at what stage the gender specific health needs are given importance in the formulation of health policy?

_____

_____

8. Do you think that health policy 2001 and 2009 is gender sensitive?

9. What types of specific health care services for maternal health has been designed in the policy.

10. What is the government strategy to improve gender equity in health system?

11. What type of steps has been taken while policy formulation to overcome maternal mortality.

12. In developing countries, health policies and programs scarcely achieve their targets because the health policy process is often characterized by many weaknesses and failures. What can be the possible reasons to not have gender sensitive health policy?

Health Financing

13. As the health needs of men and women are different, is there specific budget allocation has been made in the policy for maternal health?

14. Which types of the financial sources are used to fulfill the demanding women's health needs?

15. Which Factors leads to increase in health spending?

16. With the Passage of time, the number of women's health service user is increasing, so how government assured to access of maternal health services and increased in quality.

17. What are the impediments to efficient utilization of public sectors funds currently allocated for health service delivery?

_____

_____

18. How political, social and economic situation of the country affect the governance of health care system with reference to health of men and women. .

_____

_____

19. Do you think the allocated budget which is less than the demanded budget fulfill the required needs of maternal health?

    i) Yes ii) No iii) To some extent (If no what other sources will be utilize to cater the health need. _____

20. Do you think the percentage of budget allocation to Human resources, equipments, medicines; health facilities (hospitals), National Health programs etc fulfill the required health needs of men and women?

_____

_____

21. What is the criterion to allocate budget for provinces?

_____

_____

22. What type of mechanism is adopted to check the effective utilization of health budget?

_____

_____

23. I would like to know your response for following measures being adopted for effective gender balanced health governance.

s.no	Health status	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Disagree
1	National health policy fulfills the maternal health needs.					
2	Updated records of health resources					
3	Effectives policies and legislation for purchasing mother and child's life saving drugs					
4	Effectively functioning of national maternal health programs like					

	Women's Health projects, family planning program, LHWs programs etc.					
5	Maternal health programs are given priority in health policy.					
6	Documentation of annual health reports based on performance review of health system					
7	Strong evaluation mechanisms for obtaining timely client input.					
8	Availability and Functioning of adequate human resources for health.					

24. What types of social indicators can influence the health status of women in Pakistan.

_____

_____

23. In your point of view, what inputs and priorities should highly be considered in formulation of policy and utilization of health services?

_____

_____

Questionnaire For Hospital Administration

Gender Differentials in Governance of Health Care System in Pakistan: Effect on Women's Access and Utilization of Health Services

Code No.	

	Day	Month	Year
Date			

Name of Hospital: _____ District: _____

Background information of the Hospital

Area: _____ Population served:_____

Year of construction:_____

Information on records

1. How many male/female patients on average visited to the following departments of the hospital?

1) Medicine	Male		Female	
2) Surgery	Male		Female	
3) Maternal Health center	Male		Female	

2. Does the hospital have any proper procedure for enrolling and treating patients?
   i) Yes ii) No (If No → Q.4)

3. Which of the following procedure do you follow to enroll the patients at hospital.
   1) Fill enrollment form 2) Electronic record 3) Any other (please specify)_____

4. Does the hospital have following separate facilities for both men and women for getting treatment and utilizing health services?

S.no	Services	To great Extent	To some extent	Not at all
1.	Waiting room			
2	Consultation hours			
3	Separate Wards			
4	Separate Examination rooms			
5	Availability of female doctors for women patients			
6	Separate toilets			
7	Any other (specify)			

5. I would like to know the provision of the following services by the hospital.

Services	Provided (Mark those services provided)
BASIC Services	
short-term hospitalization	
Burn Care	
Emergency	
Laboratory services	
Blood bank	
x-Ray / Radiation	
Radiation Therapy	
Special services	
Physical Rehabilitation	
Pediatric specialty care	
Home nursing services	
Nutritional counseling	
Mental health care	
Financial services	
Social work	

6. I would like to know the number of availability of rooms in following department.

S.No		Medicine		Surgery		MCH
	Rooms	**Male**	**Female**	**Male**	**Female**	
1	Wards					
2	Private rooms					
3	VIP rooms					
	No of Bed in rooms					
4	Beds in Wards					
5	Beds in private room					
6	Beds in VIP					

7. Human resources in terms of administrative, paramedical, ancillary and clerical staff are very important for the effective and efficient provision of services to the client. Please indicate the availability of the staff as indicated as follows:

a) Administrative Staff

S.No	Posts	Number		Sanctioned	Filled	Present on duty	If Absent (Reasons)
		Male	**Female**				
1	Medical Superintendent						
2	Nursing						

	superintendent						
3	Budget and account officers						
4	Head clerk						
5	assistants						
6	Clerks						
7	Social welfare officer						
8	Others (Specify)						

b) Paramedical Staff

S.No	Posts	Number		Sanctioned	Filled	Present on duty	If Absent (Reasons)
		Male	Female				
1	Nurses						
2	Medical assistant						
3	Laboratory Technician						
4	Laboratory assistant						
5	Vaccinator						
6	Midwives						
7	X-ray Technician						
8	Others (Specify)						

c) Ancillary Staff

S.No	Posts	Number		Sanctioned	Filled	Present on duty	If Absent (Reasons)
		Male	Female				
1	Gaurds						
2	Naib Qasid						
3	Ward boy						
4	Electrician						
5	Sweepers						
6	Others (specify)						

d) Clinical Staff

S.No	Specialties	Gender	Specialist			Senior Medical Officers			Medical Officers			House officers		
			S[1]	F[2]	P[3]	S[1]	F[2]	P[3]	S[1]	F[2]	P[3]	S[1]	F[2]	P[3]
1	OPD Unit	Male												
		Female												

[1] Sanctioned
[2] Filled
[3] Present

2	Medical unit	Male												
		Female												
3	Surgical units	Male												
		Female												
4	Obstetric/Gynecological care	Male												
		Female												
5	Pediatric care	Male												
		Female												
6	Emergency unit	Male												
		Female												
7	Orthopedic unit	Male												
		Female												
8	Psychiatric unit	Male												
		Female												
9	Intensive care unit	Male												
		Female												
10	Others (specify)	Male												
		Female												

7. Do you have any system of orientation for the acquaintance of new staff working in different departments?
   i) Yes ii) No (If No go to Q.9)

8. What type following orientation system do you adopt?
   1) Training 2) Visit to the hospital 3) Brief Introduction 4) Personally visit

9. Are there any special training programs for the following staff?

S.no	Staff	Yes	No	Specify type of training
1	Administration			
2	Paramedic			
3	Medical officers			
4	Specialist doctors			
5	Laboratory staff			
6	Nurses			
7	Helpers			
8	Any other			

10. Who is the responsible for the financial arrangements of the trainings?
    1) Doctor/staff themselves 2) Hospitals budget 3) Ministry of health 4) Any other _____

11. Does you hospital conduct regular meetings within different departments.
    1) Yes 2) No (If yes fill Q.12)

12. How often these meeting are arranged?
    1) Weekly 2) Monthly 3) fortnight 4) any other (specify)_____

13. Can you please tell me are staff members receiving their salaries regularly?
    1) Always 2) Often 3) Rare 4) Never (If option 3 or 4 , Fill Q14 & 15)

14. What are the reasons to not pay the staff on time?
1) Lack of Funds 2) Poor performance of staff 3) Extra leaves by the staff 4) Any Other (plz Specify)_____

15. After how many delays (in months) the salary becomes late.
1) 1-2 Months 2) 3-4 Months 3) 5-6 Months 4) More than 6 Months

16. Is the hospital provides any bonus/incentive pay to employees?
1) Sometimes 2) Often 3) Rare 4) Never (If option 1 or 2 go to next question)

17. On what ground the bonus or incentive given to employees?
1) Extra duty hours 2) Duties on Holidays 3) Good performances 4) Any Other _____

18. Does the hospital have any program which monitors and evaluates physician performance?
1) Yes 2) No

19. If the staff performance is not satisfactory what measure the hospitals had been taken for that?
1) Replacement 2) Give Chance 3) Provide more education 4) Any Other _____

20. If the doctor or paramedic staff conducts any mistake or wrong treatment, what step the hospital may take on it.
1) Expel 2) Punishment 3) No Action 4) Any Other (Please Specify)_____

21. How many casual leaves are allowed to doctors and other staff in a year? _____

22. Which of the following mechanism hospitals used to upgrade the skill/ knowledge of staffs?
i) Seminars ii) Training workshops iii) Researches iv) Publication of Medical journal v) Magazines vi) Any other (specify)_____

23. Is hospital providing facility to research students? 1) Yes 2) no

General Facilities

24. Do you have central library in hospital?
1) Yes 2) No (If No fill Q.25)

25. What are the following reasons of not having library?
1) Lack of financial stability 2) Low interest of people 3) Lack of books availability
4) Any Other (Please specify)_____

26. How many following department has their own separate library?

S.No	Departments	Yes	No
1	Medicines		
2	Surgery		
3	Maternal Health Center		

27. Does the hospital have any complaint centers? 1) Yes 2) No

28. Do you have any mechanism of hospital waste management 1) Yes 2) NO

29. Is the hospital has separate cafeteria for doctors and staff? 1) Yes 2) No

Financing

30. Who is responsible to bear the financial expenditures of the hospital?

1) Government 2) Private sector 3) Both NGOs & Govt 4) Any other (specify)_____

31. What was the budget demanded for the hospital for year 2009-2010. Please specify _____

32. What was the total budget allocation provided by the government in last year _____

33. How much specific budget allocated for women's health?_____

34. Is there any separate budget allocation for the health needs of men and women in the following department?

s.no	Department	Yes	No	If no give Reasons
1	Medicines			
2	Surgery			
3	Obstetric & Gynecology			

35. What are other financial support systems available for the hospital to share the financial responsibility of the hospital?

1) Zakat 2) Charity 3) Patient's fee 4) any other (specify) _____

36. Do you charge any fee form general patients in terms of the following?

1) Regular checkup 2) Treatment 3) Surgery 4) Room charges

(Would you like to provide the rate list, as it will help me for comparative analysis for different hospitals).

37. What is the drug supply system of hospitals in terms of the following?

1) Purchase by department on open bidding 2) Provide by the Govt 3) Donation

4) Any other (Plz specify)_____

38. What type of monitoring system exists in your hospital to check the proper utilization of medicines?

1) Annual Audit 2) Verification 3) Record Checking 4) Any Other (Please Specify)_____

39. What is the Budget allocation for the following types of utilities?

S.no	Head	Amount Rs.	
		Allocation	Expenditure
1	Establishment charges		
2	Purchase of goods		
3	Repair and maintenance of goods		
4	Transportation		
5	Utilities		
6	Stationary		
7	Printing and		

	publication		
8	Medicines		
9	Equipment		
10	Bedding and clothing		
11	Food charges		
12	Others (specify)		
	Total		

40. How many time has been taken to repair any damage equipment?_____

41. Can you please tell the types of problem generally faced by women for availing health facilities from this hospital?

1) Facility far way from home 2) Women can not come to hospital independently
3) Lack of female staff 4) Any other (please specify)_____

42. How much the problems highlighted by the hospital have been incorporated while formulation of policy or health programmes.

1) To larger extent 2) To some extent 3) Not at all

43. Is the medical superintendent of the hospital consulted in making health policies and plans

1) To larger extent 2) To some extent 3) Not at all

44. How many times year the executives personnel of ministry of health visited hospital.

1) Quarterly 2) Twice in a year 3) Yearly

45. When was their last visit to the hospital?_____

46. Would you like to recommend what sort of improvement is needed to improve health care delivery system to make it more accessible for women?

_____

Hospital Functions observation checklist

Name of hospital _____ District:_____
Date: _____

S.no	Item	Response
1	Is the hospital easy to access to community	
2	Is the hospital clean	
3	Are the walls of the hospital clean	
4	Are the surroundings of the hospital clean	
5	Are dustbins present in the hospital	
6	Are the surroundings of the hospital quiet	
7	Does the hospitals have ramps/lifts for disabled patients and in working condition	
8	Does the OPD patient examination area provide privacy to the patient	
9	Is the OPD well lighted	
10	Is the OPD well ventilated	
11	Is the OPD at comfortable temperature (hot/cold)	
12	Is the waiting area in OPD provided with sufficient benches	
13	Does the OPD appear crowded	
14	Are all prescribed drugs/medications available to the patients for 24 hours	
15	Are the wards well lighted	
16	Are the wards ell ventilated	
17	Is the bed clothing clean	
18	Do the wards appear crowded	
19	Do the relatives and friends have access to inpatients wards	
20	Do the patients have food from the hospital	
21	Are wheel chairs/stretchers available for patients	
22	Are the counter service's staff available	
23	Does the staff appears to be cooperative	
24	Does the hospital have a canteen/cafeteria	
25	Is the cafeteria clean/hygienic	
26	Does the hospital have sign boards for directing patients to identify departments	
27	Are all types of medicines available at pharmacy	
28	Is the pharmacy crowded	
29	OPD clerk available	
30	Nurse available at time	
31	Availability of Emergency police counter	
32	Availability of Ambulances	
33	Availability of Cafeteria	
34	Nurses wear clean uniform	
29	Others	

Questionnaire for Doctors

Gender Differentials in Governance of Health Care System in Pakistan: Effect on Women's Access and Utilization of Health Services

Code No. ☐

Dated Day ____ Month ____ Year ____

DHQ: _____

Department: ☐ Medicine ☐ Surgery ☐ MCH

Socio-economic background

1. What is your Designation?
   1) House Job Officer 2) Medical Officer 3) Specialized doctor 4) Any other (specify)_____
2. What is your Qualification? 1) MBBS 2) FCPSC 3) MD 4) Any other (specify)_____
3. Would you like to tell me your current age (in completed years)?_____
4. I would like to ask your martial status? (i) Single (ii) Married (iii) Other (Please Specify)_____
5. I would like to ask your monthly income (Rs/month)?_____
6. What is the type of family you are living in? 1. Nuclear 2. Joint 3. Extended

Working Experience at hospital

7. From where you started your career as medical profession?_____
8. How long have you been working at this hospital? Time in Years_____
9. Do you have written job description? i) Yes ii) No (If No, why?)_____
10. Did the hospital management arrange any orientation training for you before assigning your regular assignment? 1) yes 2) No (If yes go to Q-11)
11. What type of the following orientation system your hospital follows for you?
    1) Training 2) Visit to the hospital 3) Brief Introduction 4) Personally visit
12. Did you receive any professional training for your current job i) Yes ii) No **(If no Go to Q 17)**
13. How many training you got for this job? 1) One 2) Two 3) Three 4) More than Three
14. What was the time duration of these training?
    1) Less than one week 2) One week 3) Two week 4) More than 2 week
15. Who bear the financial responsibility of training? 1) Hospital 2) Self 3) Any Other (specify)_____

16. Do you think the nomination system for training is fair? 1) Yes 2) No 3) To some extent

17. How many patients received consultation from you in a day in hospital?
1) 10-15 2) 15-30 3) 30-45 4) More than 45

18. Would you like to tell me how much time you give to one patient in terms of the following?
1) 10-20 Minutes 2) 21-30 Minutes 3) 31-40 Minutes 4) More than 40 Minutes

19. How many times do you have round to ward per day?
1) One round 2) Two rounds 3) Three rounds 4) More than three rounds

20. How much time you spend in hospital during duty?
1) 3 – 4 Hours 2) 5 – 6 Hours 3) 7 – 8 Hours 4) 9 – 10 Hours 5) More than 10 hours

21. Do you practice privately? 1) Yes 2) No (If no go to Q.24)

22. Would you like to tell at which time you practice privately?
1) When no duty in hospital 2) Evening 3) On holidays 4) Any other (Specify)_____

23. I would like to ask where you practice privately?
1) Own Clinic 2) In private hospitals 3) In same hospital where employed. 4) Any other (Specify)____

24. Do you think government should for private practice at government hospital? 1) Yes 2) No

25. How often do you reach late on your duty? 1) Often 2) Rare 3) Sometimes

26. What's your attitude and behavior towards the patients and their attendants?
1) Friendly 2) Cooperative 3) Less Friendly 4) Any Other _____

27. Do you give any priority to your friends and relatives while give consultation to general patients?
1. Always 2) Often 3) Sometimes 4) Not at all

Facilities at hospital

28. How frequently you receive pay on time? 1) Always 2) Often 3) Sometimes

29 If you get late pay, how many months it got late? 1) Two 2) Three 3) Four 4) More than 4

30. What are the reasons for late payment of salaries?
1) Lack of funds 2) Late processing by accounts department 3)Any other (Specify)_____

31. Do you think your salary matches your performance? 1) Yes 2) No (If no fill Q. 31)

32. Up to what extent are you satisfied with your salary?
1) Highly Satisfy 2) Satisfy 3) Moderate 4) Not Satisfy 5) Highly not Satisfy

33. Now I would like to know the availability of following facilities available to you at hospital?

Facilities	Yes	No	To some extent
Staff rooms			
Doctors rooms			
Transport			
Separate cafeteria			
Safe drinking water			
Separate washrooms for doctors			
Sufficient technical staff			
Sufficient paramedical staff			
Any other			

34. Do you face any of the following problems in hospital?

Facilities	Often	Rare	Sometimes
Poor Sanitation			
Unhygienic food			
Cafeteria is not clean			
Hostel facility is not up to mark			
Any other			

35. Whenever hospital need you and call in an emergency, what will be your response?
    1) Immediate and willingly reach 2) Immediate but unwillingly reach 3) Willingly but late
    4) Unwillingly and late

36. What you would recommend for the improvement for the hospital facilities?

_____

_____

Thank you for your time and cooperation

Name:_____

Questionnaire for Patients

Gender Differentials in Governance of Health Care System in Pakistan: Effect on Women's Access to and Utilization of Health Services

Code No. ☐

Dated Day ____ Month ____ Year ____

DHQ: _____

Department: ☐ Medicine ☐ Surgery ☐ MCH

Socio-economic background

1. What is your current age (in completed years)?_____

2. What is your martial status? (i) Single (ii) Married (iii) Other (Please Specify)_____

3. What is your monthly family income from all sources (Rs/month)?_____

4. What is the type of family you are living in? 1. Nuclear 2. Joint 3. Extended

5. What is your education (years of schooling)?
   0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 16+

6. Are you currently working for paid employment? 1) Yes 2) No **(If No go to Q 10)**

7. In which of the following profession you are working?
   1) Working outside home 2) Self-employed 3) Farm worker 4) Any Other (specify)_____

8. What is your monthly income from this job? Rs._____

9. Since how long are you working? Month or Year _____

Access to Hospital

10. Why do you prefer to visit this hospital? 1) Near to home 2) Availability of staff 3) Qualified doctors
    4) Medicines available 5) Family hospital 6) Refer to this hospital 7) Any other (specify)_____

11. How far is this hospital facility from your home?

    1) Within Half Km 2) Less than one Km 3) 1.5 Km 4) More than 1.5 Km

12. How long does it take to the hospital?

    1) Less than half hour 2) More than half to 1 hour 3) More than 1 to 1.5 hour 20 Minutes

    4) More than 1.5 to 2 hour 5) More than 2 hour

13. How do you reach the hospital?

    1) By foot 2) Public Transport 3) Private Transport 4) Taxi 5) Any other (Specify)_____

14. How much cost did you incurred for traveling to hospital? (Rs) _____

15. Who accompany with you to visit the hospital?

1) Husband 2) Mother in Law 3) Mother 4) Father 5) Any other (Specify)_____

16. Have you visited this facility in the last three months? 1) Yes 2) No **(If no go to Q 16)**
17. How many times you visited this hospital in last three months ?
1) Once 2) Twice 3) More than two times 4) Frequently

18. If Yes, you received treatment as 1) In-patient 2) Out-patient

19. Were you informed about various methods of treatment and places to get those during your visit?

1) In detail 2) Shortly 3) Not at all

Financial Feasibility

20. How much fee do you paid for one visit? 1) Not 2) 50 to 100 Rs 3) 101 to 150 Rs 4) More than 150

21. Why you pay consultation charges? 1) By will 2) Doctor's demand 3) Hospital's rule 4) Other (Specify)
_____

22. How much charges you pay for medicines? 1) All 2) < 25 % 3) 25-50 % 4) 51-75% 5) 76-90%

23. What percent of the prescribed medicines did you get from the hospital dispensary?

1) All 2) < 25 % 3) 25-50 % 4) 51-75% 5) 76-90%

24. How long you have to wait for the doctor's visit?
1) Less than half hour 2) Half Hour 3) One to Two hours 4) More than two hours

Satisfaction with services

25. If you have option to choose, which doctor (male or female) would you prefer for consultation?
1) Male 2) Female 3) No preference 4) Depends on type of treatment

26. What are the reasons to choose such physician for treatment?
1) Feel comfortable 2) Family doctor 3) Know pervious medical history 4) Any other (plz specify)_____

27. Since how long are you visiting such physician?

1) Less than 6 Months 2) More than 6 Months to 1 year 3) More than 1 Year

28. What do you feel about the extent of the improvement of your health condition after getting treatment from the hospital?

1) To greater extent 2) To some Extent 3) Not at all

29. To what extent are you satisfied with services provided by the health professionals?

1) To greater extent 2) To some Extent 3) Not at all

30. How much do you feel confident to discuss health problem with the health providers like doctors, nurses?

1) Confidently 2) Hesitantly 3) Cannot

Utilization of Health care Services

31. Now I would to like to know the extent of your level of satisfaction about the services provided by health care providers in terms of the following statements:

S.no	Categories	Strongly Disagree	Disagree	Neutral	Agree	Strongly Disagree
Communication						
1	Reception staff was courteous					
2	Attitude of doctors is good and cooperative					
3	Attitude of Paramedic staff (Nurses, medical assistants) is good and cooperative					
4	Laboratory staff provide services without any delay					
5	Concerned staff properly guides the patient about the procedures of tests, x-rays and treatment.					
6	Doctors checkup properly					
7	Doctor pay attention to listen to the patient's condition					
8	Doctor discuss all matters about the health condition of patients					
9	Doctors maintain the privacy of the patients during checkup and treatment					
10	Doctors properly guide and advice about the next visits according the patient's health condition					
Time spent						
12	Ample time is devoted by the doctors for examination					
13	Minimum time is consumed for laboratory test due to efficiency of laboratory staff					
14	Time taken for diagnosis is convenient to you					
14	Any other					

32. Now I would to like to know the availability of health services in the hospital.

S.no	Categories	Always	Often	Some time	Never
General Satisfaction					
1	Is the medicine available at hospital dispensary				

2	Is the Emergency aid available				
3	Is the required services available at relevant counter				
4	Is required vaccination easily provided				
5	Is the Patients wards overcrowded				
6	Is the OPD overcrowded with the patients				
7	Is proper seating available at waiting room				
8	Is comfortable seating available in the waiting room				
9	Is sufficient staff available at registration counter				
10	Is the separate examination room available				
11	Is the guide marks available at hospital				
12	Is the parking area available				

33. Now I would like to ask questions the types of problem you have to face at hospital:

Items	**Always**	**Often**	**Some time**	**Never**	**Always**
Long waiting for turn					
Unhygienic water					
Lack of good quality food					
Lack of transport					
Poor sanitation					
Not proper cleanliness at hospital					
Lack of indication boards for directing the patients					

34. Would you suggest any other patient in your peer group to this hospital 1) Yes 2) No (If No give three reasons)

1._____

2. _____

3._____

35. Would you like to give any suggestions for the improvement of health services of the hospital?

_____

District Bhawalpur

HISTROY

The founder of the state of Bahawalpur was Nawab Bahawal Khan Abbasi 1. The Abbasi family ruled over the state for more than 200 years (1748-1954). During the rule of the last Nawab, Sir Sadiq Muhammad Khan Abbasi V, Bahawalpur State was merged with Pakistan in 1954. Saraiki is the local language of the area. Urdu, Punjabi and English are also spoken and understood by most of the people. Bahawalpur was formerly the capital of the state and now is the district and regional headquarter of the Bahawalpur Division. Bahawalpur is one of the largest district of the Punjab covering an area of 24830 Sq.km.the population of District Bhawalpur is **24,10,566**.The population of Bahawalpur dist. has increased from 1.453 million in 1981 to 2.411 million in 1998 showing a growth rate of 3.88 % per year as compare with 3.3 % of Punjab. Population density has increased from 59 in 1981 to 97 in 1998 as compared witn 353 of the Punjab. Infant mortality rate in District Bhawalpur is 65/1000 live birth. Maternal Mortality Rate is 2.85/1000 Live Birth. Anemic Mothers are 45 % and Infant Mal Nutrition is 48%.one doctor serve the population of 16787people Except the BVH.

Popular places;

Bahawalpur was the modest museum with a fine collection of coins, medals, postage stamps of former state of Bahawalpur, manuscripts documents, inscriptions, wood carvings, camel skin paintings, historical models and stone carvings etc. of Islamic and pre Islamic period

The zoological garden of Bahawalpur is considered to be the one of the best in the country. Spread over an area of 25 acres of land, it has an interesting collection of 120 animals and 750 birds of tropical areas, particularly those found in this region.

Bahawalpur has one of the finest stadiums (Dring stadium) in the country having fine cricket grounds, 2 football grounds, one basketball court and six lawn tennis courts and a covered swimming pool.

The shrine of Muluk Shah, a popular saint of his time, is located in the city and visited by the devotees on every Thursday, ashura and Eid days.

Jamia Masjid Al-Sadiq was made by Nawab Sir Sadiq Muhammad Khan Abbasi V at the elevation of more than 12 feet from earth. It can house 50000 to 60000 people at a time during the Eid festivals.

Cholistan is locally known as Rohi. This famous desert is 30 km from Bahawalpur and comprises of an area of 16000 sq.km which extends upto Derawar Fort Derawar fort is located 48 km from Dera Nawab sahib. It is still in good condition. The rampart walls are intact and still guarded by personal guards of Ameer of Bahawalpur.

Health Facilities;

EDO (Health) is the administrative and financial head of the Health Department. The Department consists of more than three thousand employees including specialists, public health physicians, community health experts, hospital and health administrators, medical officers, women medical officers and paramedics of all type along with office establishment staff.

District Bhawalpur has 155 health facilities including 4 THQ Hospitals, 10 Rural Health Centers, 71 BHUs, 5 Dispensaries, 10 MCH Centers , 51 Zila Council Dispensaries, 1 Police Hospital and 2 T.B. Clinics.

The functions that are being performed are Treatment of major and minor ailments, Provision of Primary Health care, prevention of Communicable Diseases, expanded Programme of Immunization/ Vaccination, eradication / Control of Malarial Diseas,health Management Information System, health Education and Health Promotion, diagnostic Facilities, Procurement of Medicine, recruitment of Staff, medico-legal & Postmortem Services, polio Eradication Initiative , prevention of STIs, HIV / AID, control of Epidemics.

With the implementation of Devolution plan, the Health Department at District level has been reorganized and structured in a fashion to provide comprehensive medical care to the people both curative and preventive, main emphasizes has been laid on the

preventive services, which are being provided to the community at their door steps. The major policy decisions i.e. planning of health services, developmental activities, recruitment of paramedics, doctors, specialists, procurement of medicine and equipment has become District Govt. subject. All the aforesaid activities have been addressed to in a befitting manner, tremendous success have been achieved and national health policy for first time has been translated in to the operational form. Capacity building of the staff through training's, seminars and workshops have been improved.

Educational facilities;

Boys' schools, girls' schools, technical schools, collage (other then professional) sports, education and special education.

There are six offices under the control of EDO (Education) in Bahawalpur District.

1. DEO (Colleges)
2. DEO (SE)
3. DEO (Ele. M)
4. DEO (Ele. W)
5. DEO (Special Education)
6. DO (Sports).

Total Number of Male schools are 1267 in which Number of Male Schools at elementary levels are 86 and at primary level are 935, Masjid Maktab schools are 237 and Municipal Corporation Schools are 09.

Total Number of Female schools are 895 in which Number of female Schools at elementary levels are 133 and at primary level are756,community Model Schools are 22,at M.C.M/S level schools are 2 and At M.C.M/S are 2.

On the recommendation of District Govt. Govt of the Punjab Education Department has sanctioned 3 Colleges on permanent basis. one is Govt. Degree college (W) Satellite Town Bahawalpur.2nd is do- Uch Sharif and 3rh is do- Khairpur Tamewali More over Govt. has provided 20 posts BS-17 to BS-19 and 30 posts BS-I to BS-11 to each college to strengthen these newly establishment institutions.

8 posts of Lecturers have also been provided to the Govt. College for Women, Dubai Mahal Road, Bahawalpur to meet the requirements of students. Govt. of the Punjab Education Department has appointed 36 Lecturers/ Assistant Professor on contract basis to meet the shortage of teaching staff in Bahawalpur District. The District Govt. Bahawalpur released about Rs.16 Lacs in the previous financial year for the maintenance and repair works of the colleges,. The District Nazim Bahawalpur has allocated 1.2 Millions to Govt. Degree College Hasilpur for the leveling of sand dums and provided the boundary wall.

DISTRICT KHUSHAB

History

Khushab District is an important district located in Punjab, Pakistan. Name of this city "Khushab" was given by King Shar Shah Surry on arrival in area. Khushab means "Metha Pani" or Pure Water According to the 1998 census, the population was 9,05,711 with 24.76% living in urban areas. The district consists of 3 tehsils: Khushab, Nurpur, and Quaidabad, as well as a sub-tehsil Noshehra.Geographically this is quite unique district of Pakistan which has mountains, deserts, lush green harvesting land, lakes and river. Soon valley is one of the most beautiful hill stations of Pakistan. This district is quite rich in natural resources (salt & coal) etc. People are very hardworking and most of them are associated with farming and agriculture. Khushab is also known for its delicious sweets specially DHODA and PATEESA.

Places to visit:

Khabikki Lake; Khabikki Lake is a salt water lake in the southern Salt Range area in Pakistan. This lake is formed due to the absence of drainage in the range. Earlier its water was brackish. Now the water is sweet and a Chinese breed of fish is introduced in it.

Uchhali is a salt water lake in the southern Salt Range area in Pakistan. This lake is formed due to the absence of drainage in the range. Sakaser (1522 metre / 4946 feet), the highest mountain in the Salt Range, looms over the lake. it offers a picturesque scenery.

Sakaser is the highest mountain in the Salt Range area in Pothohar in Pakistan. It is 1522 metre / 4946 feet high. It is situated in Khushab District but it can be seen from adjoining districts of Mianwali and Chakwal.Uchhali Lake is just below it. It is a good picnic spot and moderately tough walking point. At its top there is a radar.

The Thal Desert

The Thal desert is a dry desert with scarce vegetation — mostly thorny bushes — over a breadth of 70 miles and is situated between the Indus river and the Jhelum

river. But in Thal the people are very poor because the whole land is arid and depends upon the weather condition. They cultivate grains only. Thal desert is basically is a triangle between the districts of Khushab, Bhakkar, Mianwali, Jhang, Leyiha and Muzzafargarh. Thal has very hot days and pleasant nights.

The Soon Valley

The soon valley sakasir is one of the beautiful area of Diss. Khushab.The Soon Valley is the cultural hub of Awan tribe. The Soon Valley is important as a hill station after Murree in the province of Punjab. The valley has beautiful lakes and gardens.

Educational facilities in Khushab:

Education rate is increasing in Khushab District. Top Schools and colleges include Fauji Foundation Khushab, DPS Khushab & The educators Jauharabad. Now there is a campus of Arid University in Khushab .There are many schools in the area mostly Secondary or Higher Secondary Education institutions. Students have to go to the other cities for higher education and further education. The literacy rate of Khushab is about 65% and due to recent research projects in the area, the literacy rate is increasing.

Health facilities in Khushab:

DHQ Khushab is located at Jauharabad city. It is 125 bedded hospital serving population of more than one million. The hospital has no specialist in the field of Obs/Gynaecology, Pathology, Radiology, Pediatrics and Orthopedics. The hospital has been linked with Holy Family Hospital via VSAT and is part of ongoing telemedicine project and seeking consultant advice through teleconsultations.

District Sialkot

History

Sialkot is one of the ancient cities of Punjab. It is said to have been founded by Raja Sul of Pando dynasty after whose name it was called Sulkot, which subsequently changed to Sialkot. Sialkot District is bounded on the north-east by the Jammu& Kashmir state, on the north-west by rivers of Tavi and Chanab, which separate it from the Gujrat District, on the west and southeast by Gujranwala and Narowal District respectively. It is an irregular tract occupying the sub-mountainous portion of Rachna. According to census of year 1998, the total population of District Sialkot is 2,7,23,481(1998).Average Annual Growth rate is 2.4%.Total area of District Sialkot is 3016 Sqr Km. Population Density is 903 Person Per Sqr Km.Prior to devolution, the city had the status of Corporation.District Sialkot is divided in four Tehsils Sialkot, Daska, Pasrur and Sambrial. The district is a plain, sloping down from the uplands at the base of the Himalayas to the level country in the south.. Allama Muhammad Iqbal (poet) was born in this city and his residential house is being used as Library now a days.

Famous things and places of Sialkot:

Sialkot is a barani district where almost entire irrigation is done through tube-wells. Sports goods, sportswear, surgical instruments, leather, gloves, hosiery are the major industries and almost the entire production is exported earning foreign exchange for the country. Sialkot is linked by rail and road with the rest of the country. In the west of Sialkot city there is an International Airport. Construction cost Rs.2 billion approximately funded by the business community.

Health facilities:

The Health Department is trying to improve the health status of the community by addressing its health needs through Primitive, Preventive, Curative and Rehabilitative Services so that Reduction of Morbidity and Mortality might be possible and increase Community Participation and satisfaction. The Health Department visualized its future as disease free health society, with improved health status of district population. Mission of Health Department is committed to improve the health status by provision of primary and secondary health care services in a cost effective, efficient and responsive manner to have sustainable

standards. The Health Department desires to be recognized as responsible and responsive to people needs by providing affordable standardized health services. The Department will remain flexible as learning organization, capable of remaining constantly relevant to public needs. Priorities of Health Department are to ensure provision of sanitation, safe blood, safe water, safe food, safe sex and safe drug. Providing facilities to the community like health education, nutrition, safe water supply, M.C.H. services, immunization, prevention and control of endemic diseases, treatment of common ailments, supply of essential drugs, mental health. The ultimate goal of health department is to provide quality health services, which are appropriate, accessible, available and acceptable

Functions of Health Department are

I. preventive and promotive services

- Prevention and control of communicable diseases.
- Expanded Programme on Immunization (EPI).
- Maternal and Child Welfare including family planning.
- Safe drinking water and environmental sanitation.
- Ensuring adequate Nutritional Status of population.
- Health Education.
- Mental Health.

II. Curative And Rehabilitative Services

- To promote curative health at different level of health care through
  (a). Timely diagnosis.
  (b). Provision of essential drugs
  (c). Provision of essential equipment.
- Referral procedure.
- Administration and management of hospitals and dispensaries.
- Free emergency services in the Hospitals.
- Drug Abuse Control.
- Treatment of communicable and non communicable diseases on affordable and equitable basis.

III. Human Resource Development For Health Department

- Pre-service training.
- In-service training
- Research

IV. Miscellaneous Functions

- Planning financing & regulation of health service.
- Control of medicines poisons and dangerous drugs.
- Provision of essential drugs.
- Medico-legal examination of the injured and deceased.
- Service matters except those entrusted to Punjab Service Commission and S & GAD.
- Purchase, storage and supply of medical stores and equipment.

Educational Facilities:

Sialkot is also noted for possessing famous schools and colleges which portray the fact that Sialkot education system is based on strong foundations. One of these is convent of Jesus and Marry School which was the first catholic mission school in Punjab established in 1856. Other schools in Sialkot who are contributing to the benefit of Sialkot education are City School, Beacon House and American School.

The oldest educational institute of Pakistan is the Government Murray College of Sialkot. It is established in 1889 by mission belonging to Church of Scotland. Allama Iqbal and Faiz Ahmad Faiz educated from Government Murray College of Sialkot. Another noteworthy and second oldest college of Sialkot is Jinnah Islamia College. Other colleges in Sialkot that are adding mores to the Sialkot education system are Government Allama Iqbal College, Government Christian Girls College. The strength of Sialkot education system is also addressed by educational institutes like Government Poly-Technic Institute, Government Para-Medical Institute and famous Sialkot University of Engineering Sciences & Technology or UET Sialkot. Other Sialkot education premises comprise campuses of famous universities like Fatima Jinnah Women University and Virtual university of Pakistan.

In quantitative terms the Sialkot education system is based on more than two hundred high schools, numerous inter colleges, a single law college, a single medical college, two cadet colleges, six commerce colleges, thirteen degree colleges and a university along with campuses of other ones. These figures indicate that Sialkot education has bright prospects.

District Rawalpindi

History

District Rawalpindi takes its name from its Headquarter town "Rawalpindi" which means abode of Rawals, a jogi tribe. This district is situated in the northwestern part of Pakistan. It is bounded on the north by Islamabad Capital territory, Abbotabad and Haripur Districts of NWFP; on the south by Chakwal and Jhelum districts and on the west by Attock district. The total area of the district is 5286^{4} square kilometers. Climate range from 2.6°C in month of January to above 38.6°C in June. Administratively, district Rawalpindi is divided into 6 tehsils i.e. Rawalpindi, Gujar Khan, Murree, Kahuta, Taxila, Kotli Sattian and Kallar Syedan (recently declared). It consists of 168 union councils including 114 rural and 54 urban ones whose elected representatives formulate Zilla and tehsil councils. Political constituencies include 7 national seats and 14 provincial seats of legislative assemblies.

Locality

The highest point of the Rawalpindi is at Murree, which is about 1,775 meter (75, 00 feet) above sea level. Greater part of the Rawalpindi rough, rolling plain extending from the foot of the outer Himalayas towards the Salt Range, but here and there, the continuity of this rolling plains is broken by regular hills and is cut up in all directions by ravines and nullah, locally known as 'Kas' or 'Khudar'. This forms a very characteristic feature of many parts of the Rawalpindi. The Murree and Kahuta hills are the out skirts of Himalayas and it is at the foot of these hills and it the valley of Kahuta, Gujar Khan and Rawalpindi tehsils, that the best irrigated lands are generally found. The Murree and Kahuta hills gradually end in the low Bagham hills. From these hills various streams run out westward into the plain, the important being the Soan. The main mountain in the Rawalpindi is the Murree Kahuta and Kotli Sattian hills, these hills consist principally of five main spurs, more or less parallel to each others of these, the Murree spur is the highest. Parallel to this spur is the Charghan spur, a few hundred meters lower. The total available labour force (i.e. population 15

years and above, working and looking for work) as per Rawalpindi Census Report of Rawalpindi 1998 in the Rawalpindi is 691 thousand person.

As regards availability of skilled labour, there are 23 technical/ commercial/ vocational institutions (13 for Men and 10 for Women) imparting training in various trades e.g. mechanical, electrical, auto-engineering, welding, wood working and commerce. Vocational institutions for women impart training in hand/machine embroidery, stitching and knitting. In all about 1748 technicians/artisans/workers are trained every year.

This district is well connected to other districts by the Grand Trunk (GT) Road, Silk Road, Motorway and rail network. GT road runs parallel to the main line of Pakistan Railways across the district. Rawalpindi has two military airports as well as Islamabad International Airport. Majority of the population living in urban areas is engaged in trade, restaurant and hotel industries and government services. In rural areas, the source of earning of most of people is through agriculture and dairy farming. The characteristics of the society, such as culture, gender, beliefs and health-seeking behavior, together with the environment and health service delivery system, determine the health status.

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Health System in District Rawalpindi

Health care delivery network is managed by the Executive District Officer (Health). He, being the team leader, is assisted by a team of various district health managers to run the district health system. There is an operational District Health Management Team (DHMT) in the district. The District Health System is the most critical component in the health sector relevant for the attainment of Health for All goal and MDG targets. This privilege is drawn from its direct proximity and affiliation to the grass root population. It is through the DHS operational levels that we define and respond to priorities, refine objectives and realize expected outcomes from the health care service delivery. Rawalpindi District has the unique opportunity of having opertionalized all these services in a satisfactory and commendable manner. For any health system to succeed in its health endeavor it needs to have strong leadership both at the policy level as well as at the health system stewardship level and Rawalpindi.

one of the common constraints faced by most Health System is the scarcity of qualified human resources that would operate the large network of health facilities. Rawalpindi has successfully overcome this problem by ensuring full time recruitment of medical doctors and qualified paramedical staff to each operational level. This has certainly been one of major reasons for enhancing the level of service utilization, which can be easily accounted by the high level of EPI coverage through which all theseven antigens of EPI are at a rate above the national average.

HEATH EDUCATION ACTIVITIES - 2003.

1. Launching of Health Education Campaign, on ARI, form January 2003, to create awareness among general public for timely case management and management by the trained health personnel.
2. Awareness regarding carmine Congo hemorrhagic fever (CCHF), to disseminate information to LHVs, LHSs & LHWs, beside health professional.
3. Training of TBAs, on safe motherhood practices, in cooperation with National Rural Support Project, Islamabad.
4. Launching of School Health Project, with Taxila, selected as pilot area.
5. Anti smoking campaign was launched for sensitization of public, through distribution of educational material.
6. Campaign on Hepatitis B & C, with conduction of two seminars for LHWs & LHVs, at DHDC, Rawalpindi.
7. Establishment of Heath Education staff at Literacy Festival at Fatima Jinnah University & Sehat Mela at BHU Kalli Mitti, promotional material was distributed during said activity.

DISTRICT HEALTH DEVELOPMENT CENTRE (TRAININGS)

Medical Officers, Women Medical Officers, LHVs and other staff recruited were imparted 45 No. technical trainings to enhance their skills and to improve quality of their performance at district health department Rawalpindi. On the job trainings were held, among the following domains:

- Health Management Information System
- Training of TBAs in Safe Motherhood Practices

- Safe Drinking water
- Iodine Deficiency Diseases
- Nutrition
- Mental Health
- Disease Early Warning System
- Community Based AFP Surveillance through LHWs
- School Health Services
- TB / DOTS Refresher trainings
- Integrated Management of Childhood Illnesses (IMCI)

EDUCATION

Education is the vehicle for human resources development and literacy is pre-requisite to consult and benefit from major sources of information and knowledge in today's world. Without education and literacy, it is not possible to realize the goals of a balanced and sustainable development. Literacy is considered as key for sustainable development and peace. It is also an instrument of stability within and among countries, and thus may prove an indispensable means of effective participation in the societies and the economics of the 21st century, which are affected by the rapid globalization. In order to meet the new challenges of the changing world, Literacy department was established in August, 2001 at the District level with the commencement of the devolution process. An Executive District Officer (Literacy) along with ministerial staff was appointed. The major task assigned them was to look after the promotion of literacy by creating awareness among the masses, continuing education and vocational training in the District.

District Lahore

Lahore lying close to Wagah, the Pakistan-India border is located near the Ravi River. The city of Lahore is bounded by the Sheikhupura District on north and south covers a total area of 1,772 sq km. Lahore located on the River Ravi is the capital of Punjab Province. The city has been named after King Lav who is purported to have ruled Lahore earlier. It also means 'Lohawar' with the meaning 'Fort as strong as Iron. Lahore serves as a commercial, educational, cultural and artistic center for Pakistan and has the University of Punjab, the oldest university in Pakistan. The city of Lahore has a rich architectural wealth from the Mughal Empire to the British Raj.

In 1981, the total number of Lahore people was 2,952,689. The growth rate of the Lahore demography was about 3.32% from 1981 to 1998. In the year of 1998, the total Lahore population counted to 5,143,495 people, which increased to approximately 10 million by mid 2006.Demography of Lahore, is spread over an area of 1,014 square kilometers. Average household size in 1998 was recorded as 7.12. In 1998, the total number of male population was estimated to be 2,707,220, while the total number of females residing in the territory was 2,436,275. Lahore demography is 5,143,495, according to 1998 census. Lahore is proud of the glorious past and hence it has preserved all the monuments from the past which embody its pride. Several of the mosques, graves, gardens and forts have been preserved till date. Urdu, which is the official language of Lahore, is mostly used in the city. However, the people in Lahore also use other languages like English, Punjabi and Pashto. It is noteworthy that Pakistan is an Islamic country, where the majority of the population is Muslim. Lahore, being a city in Pakistan, could not be an exception to this. As a result, 96% of the total population in Lahore is Muslim. Other religions in the city accounting for the rest 4% are Christianity, Hinduism, Qadianism and Sikhism.

Famous places;

Lahore, which has the monuments, built by the Mughal emperors gains the attention of one and all who visit the city. Badshahi Mosque, Lahore Fort and Shalimar Gardens, which can be considered as the good example of Mughal-Gothic style attracts tourists from far and wide. The Badshahi Masjid and the Alamgiri Gate situated next to the Lahore Fort are also the works of Mughal kings. Minar-e-Pakistan

-Tower of Pakistan is the major landmark of the city. Lahore Zoo, Hazuri Bagh Baradari, Chauburji and Shahi Mohalla also include the major interesting points in the city. Akbari Gate, Bhati Gate, Delhi Gate, Kashmiri Gate, Lahore Museum, Hazuri Bagh, Iqbal Park and Lawrence Gardens are often visited by tourists.

Many famous shopping centers exist in the city such as the Hall Road Electronics, Hafeez Center, Liberty Market, Fortress Stadium and many more. The Anarkali and the Ichhra Bazaar are famous centers for traditional wares.

Health facilities;

Lahore Health Department takes care of the public health and sanitation of the city.. It aims at the providing the citizens of Lahore cost effective and best health care services. In order to fulfill its aim the health department of Lahore has upgraded the existing health facilities and built new hospitals and dispensaries. The dispensaries and hospitals are well health staff, ambulances, medical equipments, emergency aid supplies and other service units such as burn units. It also takes care of the proper vaccination of the children and the maintenance of proper sanitation services of the city.

The health care department not only manages and executes the health care facilities within the city but also sees towards the distribution of health care services within the districts and tehsils of Lahore including in the District Headquarter Hospitals (DHQs), Tehsil Headquarter Hospital (THQs) Rural Health Centers (RHCs) and Basic Health Units (BHUs).

The other functions of the Lahore health department are:

- Prevention of the contagious diseases like tuberculosis, malaria, and leprosy
- Maintenance of medical aid for animal bites and other emergencies like food poisoning and accidents
- Regular nutrition surveys of food and food products
- Cleaning of streets and drains
- Regular spray of pesticides and insecticides
- Maintenance of pest control within the region
- Proper care of animal health within the region

Government Hospitals in Lahore;

The government of Lahore has maintained a number of hospitals and medical centers within the district in order to provide medical facilities to all. The government hospitals are reasonable in price and offer the best medical facilities. Well equipped with all modern medical equipments and technology the government hospitals of Lahore have been serving the province for more than a decade. The provincial government is the administrative authority of these hospitals and takes care of the maintenance of medical aid within these hospitals. Some of the popular hospitals of the city are:

- Lahore General Hospital
- Jinnah Hospital
- Fatima Memorial Hospital
- Gulaab Devi Hospital
- Lady Aitchison Hospital

- Punjab Institute of Cardiology PIC
- Psychiatric hospital
- Railway Cairns Hospital
- The Children's Hospital
- Govt. Maternity Hospital

Private Hospitals in Lahore

There are a number of private hospitals in Lahore. These hospitals are well equipped with the latest medical equipments. The provincial government keeps a strict check on the functioning of these medical units. The aim of these private hospitals of Lahore is to offer the best medical aid to the citizens and improve public health within the state. Some of the prestigious private hospitals housed within the city are:

- Doctors Hospital
- Umer Hospital
- Shoukat Khanum Cancer Hospital
- Nanotech Neurology Psychiatry & Joint Pain Center
- Malik Surgical Hospital & Shazia Maternity Home
- Mumtaz Bakhtawar Memorial Trust Hospital

- National Hospital
- Ihsan Mumtaz Hospital
- Jaanki Devi Hospital

The hospitals, dispensaries and medical centers in Lahore aim to provide the citizens best medical facilities and prevention from contagious and other harmful diseases.

Educational facilities;

Lahore also happens to be the center for education and there are a number of educational institutions like the schools, colleges. The Universities in Lahore dealing in Management studies and economics are some of the best academic institutions. Hence, the people of Lahore believe in the full fledged development of their personalities.

Lahore education system is formulated along specific religious, cultural, social, psychological and scientific injunctions. The educational framework is well integrated and aims at effecting social and individual awareness among the students. Modern methods of teaching are also taken into account.

The education system of Lahore also aims to imbibe a secular outlook among the students. Students are made aware of the rich cultural heritage of the country. Lahore has a wide range of schools, colleges and universities that caters to diverse streams. Humanities, science, commerce, technical science, applied science, medicine, law and management sciences are taught in the schools, colleges and universities of Lahore.

Secondary Education in Lahore:

Lahore has a lot of government, private and international schools that impart quality education to the students. Lahore Grammar School imparts education to boys and girls till the 'A' level. It follows the A level curriculum as prevalent in the schools of England. The Lahore American School is a co education school that prepares students for taking up higher education in American colleges. The International School of Choueifat, in Lahore is a privately owned school that offers Pre-K and K-12 education. Besides these there are numerous government schools that impart education to the students. Science, arts and commerce are taught in the schools at

Lahore. The Board of Intermediate and Secondary Education (BISE) in Lahore holds the Secondary School Certificate Examinations (SSC) and the Higher Secondary School Certificate Examinations. It was originally a part of the Punjab University.

Higher Education in Lahore;

Lahore has numerous colleges and universities that cater to a wide range of disciplines. The subjects taught at these colleges and universities are engineering and technology, management, computer science, information technology, fine arts, humanities, commerce, applied science and pure science. Some of the major colleges and universities in Lahore are listed below-

- University of Engineering and Technology, Lahore
- Forman Christian College
- King Edward Medical University
- Allama Iqbal Medical College
- National College of Arts Lahore
- Kinnaird College
- Aitchison College Lahore
- University of Central Punjab
- Government College University
- University of Lahore

The education institutions in Lahore offer choicest education to the students. All of the schools, colleges and universities impart an in-depth knowledge of the various disciplines. Lahore education system also aims at effecting an all round development of the students.

District Multan

History

Multan is a city in the Punjab Province of Pakistan, and capital of Multan District. It is located in the southern part of the province, and is steeped in history. It has a population of over 3.8 million (according to 1998 census), making it the sixth largest city in Pakistan. It is built just east of the Chenab River, more or less in the geographic center of the country, and about 966 km from Karachi. Multan is known as the 'City of Pirs and Shrines', and is a prosperous city of bazaars, mosques, shrines and superbly designed tombs. The Multan International Airport connects to flights to major cities in Pakistan and to cities in the Persian Gulf. The city's industries include metalworking, flour, sugar, and oil milling, and the manufacture of textiles, fertilizer, soap, and glass. Multan is also known for its handicrafts, especially pottery and enamel work.

One of the subcontinent's oldest cities, Multan derives its name from an idol in the temple of the sun god, a shrine of the pre-Muslim period. The city was conquered (c.326 BC) by Alexander the Great , visited (AD 641) by the Chinese Buddhist scholar Hsüan-tsang, taken (8th cent.) by the Arabs, and captured by Muslim Turkish conqueror Mahmud of Ghazna in 1005 and by Timur in 1398. In the 16th and 17th century, Multan enjoyed peace under the early Mughal emperors. Multan is an historical city of Pakistan. It is also known as the city of SAINTS. It is situated on the bank of river chennab, a central place in Pakistan.It has always been existing under the territory of Punjab Govt. since the regime of Mughal Empire. It was the Headquarter of Multan Division before the commencement of District Government Multan District has a distinct status due to the following characteristic:-

a) Peoples:-

i) Local(Saraiki Speaking) They are also the pioneer of the District Multan.

ii) Punjabi:- Migrated from East India during Partition 1947.

iii) Urdu Speaking:- Also migrated from India as well as east Pakistan up till now

District Multan is a beautiful mixture of all kinds of people. It is also a peaceful and lovely

place in Pakistan.

b) Languages:-

i)Saraiki(Local)

ii)Punjabi and

iii)Urdu.

c) Business:-

70% to 80% peoples are attached with agriculture directly or indirectly.

d) Education:-

The Literacy rate of the District Multan is about 45%.

In the common districts, spatial planning and municipal services are the exclusive function of the Tehsil Municipal Administration but in the City District some planning and macro-municipal functions will be managed centrally by a City District Government, in addition to all the common district functions. The nature of infrastructure and population densities in urban areas necessitates city wide planning to achieve economies of scale, rationalisation of investments, or the benefits of modern technologies among other reasons.

Like the common district, the City District will have three tiers: the City District Government (CDG), the Town Municipal Administration (TMA) and the Union Administration (UA). In recognition of the need for specific institutional arrangements to respond to the nature of integrated planning and municipal functions in City Districts, the three tiers are not analogous to the ones in the common district: in the City District, the TMA will be responsible for those functions assigned to the Tehsil Municipal Administration in the common district to the extent

that these can be performed by the TMA - i.e. those functions which due to technical reasons do not require a city level management.

Health

As the world is changing rapidly, the Internet has become an effective and imperative tool that allows the Department to reach and educate more and more people. Web visitors can quickly and conveniently access current health statistics and get the latest information on public health. It gives me immense pleasure to welcome you to the official website of District Health Department Multan.

Health Department is one of the largest Department of the District serving its population right at their door steps through an elaborate system of field workers, primary, secondary & tertiary level care facilities. The Health Department at district level is performing primary & secondary level care facilities. The tertiary level care, undergraduate & post graduate medical education is being provided by Nishtar Medical College & Hospital, which is an autonomous medical institution. The Multan Institute of Cardiology and Children Hospital Complex are specialized autonomous Hospitals. The Health Department at District levelis headed by Executive District Officer (Health).

Multan with District Officer Health (Headquarter), District Officer (Health) Multan and one Deputy District Officer (Health) at Tehsil level. One Medical Superintendent each is responsible for DHQ/Civil Hospital Multan, THQ Hospital Shujabad and THQ Hospital Jalalpur Pirwala.

Under new District set up, the following health formations were placed under the administrative control of Executive District Officer (Health) Multan:

1. District Officer Health Multan
2. Medical Superintendent, DHQ/Civil Hospital Multan
3. Chief Health Officer (Urban) Multan.
4. Zila Health Officer Multan

5. District Blood Transfusion Officer Multan.

:: **Goals**

- To improve the health status of the community by addressing its health needs through Promotive, Preventive, Curative and Rehabilitative Services
- Reduction of Morbidity and Mortality
- Community Participation and satisfaction

:: Vision of Health Department

The Health Department visualized its future "as disease free health society, with improved health status of district population"

:: Mission Health Department

The Health Department is committed to improve the health status by provision of primary and secondary health care services in a cost effective, efficient and responsive manner to have sustainable universally accepted health standards.The Health Department desires to be recognized as responsible and responsive to people needs by providing affordable standardized health services. The Department will remain flexible as learning organization, capable of remaining constantly relevant to public needs.

The Health Department is providing curative services through Civil Hospital, THQ Hospitals, Rural Health Centres, Basic Health Units, Rural Dispensaries, City Medical Centres and MCH Centres. The staff of these health facilities are well trained and they have full skill in their responsibilities. These health facilities are providing primary & secondary level care facilities. The tertiary level care, undergraduate & post graduate medical education is being provided by Nishtar Medical College & Hospital, which is an autonomous medical institution. The Multan Institute of Cardiology and Children Hospital Complex are also autonomous Hospitals and providing specialized care to the needy people.

The goals of the National Programme for Family Planning and Primary Health Care programme are as under:-

1. To develop the necessary health manpower in support of programme by selection, training and deployment of Lady Health Workers in the country.
2. To address the primary health care problems in the community, providing promotive, preventive, curative and appropriate rehabilitative services to which the entire population has effective access.
3. To bring about community participation through creation of awareness, changing of attitudes, organization and mobilization of support.
4. To expand the family planning services availability in urban slums and rural areas of Pakistan

The specific objectives of the programme are:

- A reduction of IMR from 85 to 55 per 1000 live births.
- A reduction of MMR from 400 to 180 per 100,000 live births.
- An increase in the Contraceptive Prevalence Rate from existing 22% to 42% in rural area and from 40% to 58% in urban area.
- An increase in Immunization coverage in children aged 12-35 months fully vaccinated from 45% to 80% in rural areas, and from 64% to above 90% in urban areas. (In liaison with EPI).
- An increase in TT-5 immunization coverage amongst women of childbearing age from 12% to 40%.
- An increase in the percentage of children being exclusively breastfed till age of 6 months from existing 18% to 50%.
- An increase in births assisted by skilled birth attendant from existing 12% to 30% in rural areas and from 43% to 80% in urban areas covered by the programme.

Education:

Prosperous nations are built on their educational system. Being one of the more rapidly developing countries in the world , Pakistan is striving to upgrade its educational infrastructure to enhance 100% literacy rate in the country up to 2015, to honour the commitment made by Govt. of Pakistan in the Dakar conference held in 2000. To achieve this goal, the Literacy and NFBE Department Govt. of the Punjab and District Govt. Multan launched various Literacy Programmes to eradicate the illiteracy from the country.

There are 304 Non Formal Basic Education Centres functioning in District Multan. (302 Non Formal Basic Education centres handed over to the District Literacy Department on 01-01-2002. Two more Non Formal Basic Education centres were established in December, 2002) These centres have been mostly established in rural areas of the District. The female teachers are imparting education in these centers at their own homes. The said centres are supervised by eight NGOs.

Prior to launch any Literacy Project in the District, PC-1 of the Project is submitted to the Zila Nazim through District Coordination Officer. After approval by Zila Nazim, it is put up in the District Development Committee meeting for approval. If the District Development Committee agrees with the scheme, the same is approved and the administrative approval accordingly issued by the Chairman DDC. After issuance of Administrative Approval, the funds are released by the EDO(F&P) after seeking permission from the DCO/Zila Nazim. The learning material is then purchased by the EDO l(Literacy) after completing all codal formalities. The literacy teachers are appointed after observing recruitment process according to the

PC-1 of the Project as well as Recruitment Policy. After issuing the appointment orders, the learning material is handed over to the teachers and centres start at the specific sites.

Federal Capital Islamabad

History

Islamabad is beautiful. It is a region-wide symbol of progress, innovation and architectural marvel. Settlement in Islamabad, the new capital after Karachi, began in the 1960s. As the city was newly founded, the growth of the population was slow. Being the seat of the Government of Pakistan, initially government servants and employees of the federal administration settled here. Since then, there has been a steady growth in the population of the city, which has swelled to somewhere in excess of a million inhabitants. The reason: at the moment, the capital city is the fastest growing urban settlement in the country. There is an increased interest in the city from The President and The Prime Minister, as well as a renewed drive from foreign investors to invest in the city. This has caused a growth in the economy, produced employment at all levels and ensured development. Owing to all these factors, Islamabad is now becoming a lively and bustling metropolis, full of vibrancy

Islamabad is Pakistan's most diverse metropolis in terms of the population makeup of the city. It has the largest expatriate and foreigner population in the city. The reasons are simple: its inviting and reasonably temperate climate, its lush green scenery and excellent basic infrastructure. The city is also a stopping point for tourists who desire to proceed to the Northern Areas of the country for trekking, hiking, adventure sports and mountaineering. Since the city has been growing into a major business and commerce centre, it has attracted a large highly skilled workforce from other major cities including Karachi, Lahore and Quetta. All of the country's diplomatic ties are maintained and exercised from Islamabad, as all major embassies, consulates and missions are operating from the city, as is the Foreign Office. There is a massive bureaucratic presence in the city as well, largely due to the fact that Islamabad, being the capital, is also the seat of the Government. The Presidency, the Prime Minister's House, the Diplomatic Enclave, the Supreme Court, the Shariat Court and other major government buildings are housed here. Punjabis account for 65% of the population followed by the Urdu Speaking Muhajirs at around 14%, Pashtuns at 10.51% and others (Sindhi, Balochi, Kashmiri's, etc) at 7%. (this does not include the refugee count).

Places

Combining a rich history, the confluence of many a civilization and temperate climate, Islamabad - the capital city of Pakistan, is one of the most beautiful cities in the South Asian region. Wide, tree-lined streets adorn the various sectors and zones of the city, making it accessible and spectacular. Administratively, the city is located within the Islamabad Capital Territory, which is federally controlled, even though historically Islamabad has been a part of the Punjab province; more specifically the Potohar Plateau. A meticulously planned city by renowned town planners Doxiadis Associates, Islamabad is the fastest growing city in terms of population, economy and urban development. As this trend continues, the city is shedding its reputation as a city without character, and is fast becoming truly metropolitan.

Islamabad nestles against the backdrop of the Margallah Hills at the northern end of Potohar Plateau. Its climate is healthy, pollution free, plentiful in water resources and lush green. It is a modern and carefully planned city with wide roads and avenues, elegant public buildings and well-organized bazaars, markets, and shopping centers. The city is divided into eight basic zones: Administrative, diplomatic enclave, residential areas, educational sectors, industrial sectors, commercial areas, and rural and green areas.

The metropolis of Islamabad today is the pulsating beat of Pakistan, resonating with the energy and strength of a growing, developing nation. It is a city which symbolizes the hopes and dreams of a young and dynamic nation and espouses the values and codes of the generation that has brought it thus far. It is a city that welcomes and promotes modern ides, but at the same time recognizes and cherishes its traditional values and rich history.

Health

Islamabad has both public and private medical centres. The largest hospital in Islamabad is Pakistan Institute of Medical Sciences hospital. It was established in 1985 as a teaching and doctor training institute. PIMS functions as a National Reference Center and provides specialized diagnostic and curative services. The hospital has 30 major medical departments. PIMS is

divided into five administrative branches. Islamabad Hospital is the major component with a 592 bed facility and 22 medical and surgical specialities. Children's Hospital is a 230 bed hospital completed in 1985. It contains six major facilities: Surgical and Allied Specialities, Medical and Allied Specialties, Diagnostic Facilities, Operation Theatre, Critical Care (NICU, PICU, Isolation & Accident Emergency), and a Blood Bank. The Maternal and Child Health Care Center is a training institute with an attached hospital of 125 beds offering different clinical and operational services. PIMS consists of five academic institutes: Quaid-e-Azam Postgraduate Medical College, College of Nursing, College of Medical Technology, School of Nursing, and Mother and Child Health Center.

PAEC General Hospital and teaching institute, established in 2006, is affiliated with the Pakistan Atomic Energy Commission. The hospital consists of a 100 bed facility and 10 major departments: Obstetrics and Gynecology, Pediatric, General Medicine, General Surgery, Intensive Care Unit/Coronary Care Unit, Orthopedics, Ophthalmology, Pathology, Radiology, and Dental Department.

Shifa International Hospital is a teaching hospital in Islamabad that was founded in 1987 and became a public company in 1989. The hospital has 70 qualified consultants in almost all specialities, 150 IPD beds and OPD facilities in 35 different specializations. According to the Federal Bureau of Statistics of the Government of Pakistan, in 2008 there were 12 hospitals, 76 dispensaries, and 5 Maternity and Child Welfare Centers in the city with a total of 5,158 beds.

Education

Islamabad boasts the highest literacy rate in Pakistan at 87%. A large number of public and private sector educational institutes are present here. The higher education institutes in the capital are either federally chartered or administered by private organizations and almost all of them are recognized by the Higher Education Commission of Pakistan. High schools and colleges are either affiliated with the Federal Board of Intermediate and Secondary Education or with the UK universities education boards, O/A Levels, or IGCSE. According to Academy of Educational Planning And Management's report, in 2006 there were a total of 904 recognized institutions in Islamabad (30 pre-primary, 2 religious, 384 primary, 157 middle, 291 high, 15 intermediate, and

25 degree colleges). There are seven teacher training institutes in Islamabad with a total enrollment of 581,068 students and 491 faculties.

The Gender Parity Index in Islamabad is 0.93 compared to 0.95 for Pakistan. There are 178 boys only institutes, 175 girls, and 551 mixed institutes in the capital territory. Total enrollment of students in all categories is 273,583; 139,961 for boys and 133,622 for girls. There are 17 recognized universities in Islamabad with a total enrollment of 279,820 students and 25,653 teachers. The world's second largest university by enrollment, Allama Iqbal Open University, is located in Islamabad. The two top engineering universities in Pakistan, Pakistan Institute of Engineering & Applied Sciences and National University of Sciences and Technology also have their headquarters in the capital. Quaid-i-Azam University in Islamabad is the top ranked university in Pakistan in the general category. Other universities include Air University, Bahria University, National University of Computer and Emerging Sciences, COMSATS, Hamdard University, National Defence University, Shifa College of Medicine, National University of Modern Languages, International Islamic University, Center for Advanced Studies in Engineering, and Muhammad Ali Jinnah University.

In 2006–2007, the Federal Government spent a total of 54,523.637 million Rs. on the education sector out of which 25,830.670 million was the developmental fund. This amount is 25.18% of the total educational budget spends in that year, which was 216,518.059 million Rs. The public expenditure on education as a percentage of total government spending that year was 14.09%.