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Citizen Report Card Survey

Education and Health Sectors in Peshawar, Mardan and Swabi Districts of Khyber Pakhtunkhwa Province (Pakistan)

Centre for Governance and Public Accountability (CGPA)
December 2013

Website: www.c-gpa.org, Email: info@c-gpa.org, Phone: +92-91-5701991

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RESEARCH TEAM

Saeed Ahmad
Dr. Aamer Taj
Mukhtiar Ahmad
Ijaz Haider
Aizaz Ahmad

FIELD TEAM

District Supervisors

Kamran Javed
Sadiq Ahmad
Zakirullah

Enumerators

Muhammad Aslam Khan
Israr Gul
Azhar Iqbal
Adnan Ahmad
Jan Ali
Jahangir Majid
Hadia
Nadia Khan
Naheed Akhtar
Maria Khan
Musarrat Begum
Mehnaz

Acronyms

BHU	Basic Health Unit
CGPA	Centre for Governance and Public Accountability
CRC	Citizen Report Card
CT Scan	Computed Tomography Scan
DHQ	District Head Quarter Hospital
ECG	Electrocardiogram
FAFEN	Free and Fair Election Network
KP	Khyber Pakhtunkhwa
MRI	Magnetic Resonance Imaging
PSU	Primary Sampling Unit
PTC	Parents Teachers Council
RHC	Rural Health Centre
THQ	Tehsil Head Quarter Hospital

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Executive Summary

This report presents the findings of Citizen Report Card (CRC) survey on public primary education and health service delivery in Peshawar, Mardan and Swabi districts of Khyber Pakhtunkhwa province of Pakistan. The survey was conducted in October and November 2013 with a total of 325 respondents of education and 326 respondents of health service users in both rural and urban areas of the mentioned districts.

Respondents of education CRC survey were children enrolled in class 4 and 5 in primary schools, both independent and those attached to middle schools, were interviewed in the presence of their parents/care takers at home. Themes of the CRC survey were availability, access and quality of education as perceived by respondents. There are significant differentials in more than one indicator across the rural/urban and gender divide. Overall the availability of schools was found satisfactory given the fact that the distance of schools from 91% respondents was reported to be one kilometre or less. The study found that 9% of the girls' schools in the rural areas do not have boundary walls and 23% girls' schools do not have drinking water facility. Although 98% toilets were reported in schools, 13% children do not have access to these toilets for various reasons. Most of the schools have floor mates and furniture was available to only 20% of the respondents while 3% did not have either. Play ground is not available to most of the children and co-curricular activities are very limited with only 14% reported participation. Teachers' absenteeism was reported by 14% respondents observed, teaching aid materials are not used in most of the schools and parents are not involved in their children's education. Parent Teacher Councils (PTCs) are not functional, and are not actively participating in school affairs. A pre-dominant majority of children i.e. 98% were motivated to continue education. However, policy interventions are needed for improvement in availability, access and quality of education. Activation of PTCs and their involvement in school affairs, provision of basic facilities in schools, bridging the rural/urban and gender gap through budgeting, capacity building of teachers on activity based learning, discouraging corporal punishment and awareness raising of parents on their active involvement in children's education are some of the critical and urgent steps needed for improvement in education.

Respondents for health CRC survey were patients and their attendants who were interviewed on the day they visited health facilities. 326 users of all types of health facilities were interviewed and their perception on the availability, access and quality of health services was recorded. The primary health care facilities at community level are Basic Health Units (BHU) which seems underutilized while teaching hospitals were found overburdened. Some of the major issues found in the health service were inadequate staff, cleanliness and inadequate medicines and supplies. The CRC survey found absenteeism of doctors and staff behaviour as key staff issues. The satisfaction level of users from services was found 76% which varied across focused districts. As many as 93% users were not aware of any grievance redress mechanism in the service and very few have experience of ever launching complaint. Policy interventions suggested include ensuring availability of staff in health by hiring more staff, especially doctors, providing adequate facilities like accommodation for staff and an incentive package in rural areas, and an effective monitoring mechanism having indicators of availability, access and quality of services and including users' feedback in the monitoring mechanism. Grievance redress mechanism as an integral part of the service delivery process is critical for continuous improvement in the health services. Capacity building program needs to have modules on public dealing for users' satisfaction. Furthermore, rural/urban and gender differential should be bridged through need based budgeting with a special focus on the underprivileged and vulnerable population.

CHAPTER 1

STUDY BACKGROUND, OBJECTIVES AND METHODOLOGY

1.1 Study background and objectives

Citizen Report Card (CRC) is one of the effective social accountability tools. It is used to find out citizens' perception about the availability, access and quality of social services. It helps present the findings to the stakeholders to highlight policy and implementation issues. The present report is based on the findings of CRC conducted by Centre for Governance and Public Accountability (CGPA) in three districts of Khyber Pakhtunkhwa (KP) including Peshawar, Mardan and Swabi. Services selected for the CRC were health and primary education and users' perception about the availability, access and quality of these services and service providers was captured. The objectives of the study were as following:

Education CRC

- To investigate the status of availability of education facility from children's perspective
- To assess the level of access to primary education along with any barriers that may exist in acquisition of primary education for children
- To understand and report children perception about the quality of education in government schools
- To assess gender differentials and rural/urban gap in the availability, access and quality of primary education

Health CRC

- To investigate the status of availability of health services from users' perspective
- To assess the access and relevant barriers to access in health services
- To understand and report users' (patients and attendants) perception about the quality of health services provided by government health facilities
- To assess gender differentials and rural/urban gap in the availability, access and quality of health service provided by government health facilities

1.2 Study Methodology

As per the standard practice, CRC is done on primary data using quantitative data from service users. The perception of users about different aspects of the service is mapped and gaps are identified and reported. Following the path, this CRC was designed as a purely quantitative study and was conducted with the primary users. To capture depth of important issues of education, in-depth interviews were conducted with Parents Teachers Councils (PTC) members in the sampled area. A semi structured questionnaire was designed based on the identified indicators and face to face interviews were conducted with the respondents. Respondents were selected based on the sampling frame.

1.3 Sampling Frame and Sample Size

Since the survey was intended from users of the above mentioned services, the universe for the sampling were people who have used, or who are intended users, of the these services. An ideal situation would be to get a list of users from the service providers and sample the required number of respondents through sampling techniques. However, this was not possible because we were covering more than one service and reliable lists of users were hard to find. Additionally, we assume that all people living in the program area were the indented users of services we were

going to cover. Therefore, we took the population of the area as our sampling universe and applied the sampling frame to the entire population of selected three districts.

Literature on social research suggest that that there is no rule of thumb in calculating the sample size as it depends on the variables of the study and the sub groups of key variables. A general practice is that minimum number of sample on each of subgroups should be 50 to 100 (Hoinville et al., 1977, cited De Vaus 2002). Therefore the final sample size has considerations for sampling error, confidence interval and sample reliability; it also considers the budget, time and access to respondents.

Sample frame was based on multistage cluster sampling method. The first stage was selection of districts which were identified during the conceptualization stage and included Peshawar, Mardan and Swabi. In the second stage, union councils/towns of each sampled district were listed based on rural urban strata according to municipality division within the district. In the third stage, three union councils were randomly selected from rural and two from urban areas in each district. In the fourth stage, one village/mohalla from each union council was selected as primary sampling unit (PSU) and individual households were selected for education CRC using right hand rule and Kish (1949) method. In-depth interviews were conducted with PTC members from the same PSU in order to have the same context for both quantitative and qualitative data. A slightly different approach was adopted for sampling of health respondents within the selected PSU. The health facility within or closest to the PSU was visited and patients/attendants visiting the facility were interviewed giving equal representation to men and women. The key reason for adopting this approach for health CRC was to avoid recall error in responses by the respondents and to capture the latest experience of interaction with the service providers.

Following is the list of union councils selected according to the sampling frame. Respondents' clusters for education were selected using centre point and right hand rule while the nearest health facility was visited for health respondents as mentioned above.

District	Primary Sampling Units (PSU) and Sample Size						Total by District
	Rural			Urban			
	PSU	Male	Female	PSU	Male	Female	
Peshawar	Sufaid Dheri	15	15	Faqir Abad	15	15	120
	Tehkal Payan	15	15	Nauthia Qadeem	15	15	
Mardan	Shehbaz Garhi	15	15	Bijlee Ghar	15	15	120
	Ghala Dher	15	15	Mardan Khas	15	15	
Swabi	Yar Hussain	15	15	Swabi	15	15	120
	Topi East	15	15	Nawa Kili	15	15	
Total by gender/PSU		90	90		90	90	360

Table 1: Primary Sampling Units and Sample Size

Sample size was calculated as 360 for both services. This was broken down as 30 respondents per PSU giving equal representation to both genders. The response rate was 90%; the final number of completed interviews for health and education was 326 and 325 respectively which were used in analysis. Number of PTC members' in-depth interviews was calculated 48 on convenience basis; four in each PSU giving equal representation to male and female members. With a response rate of 83%, 40 in-depth interviews were conducted with PTC members and were used for final report.

1.4 Survey respondents and questionnaires

Two separate questionnaires were developed for both education and health services since the respondents were not the same. As mentioned earlier, respondents for education were children studying in government primary schools. This is a special groups and the interview process needed to be different from adult interview. The interview process involved three cognitive skills; ability to remember the text, ability to process and decode the text, ability to search (in memory) and respond. According to Piaget's (1929) theory of cognitive growth, the 4th stage of cognitive development starts around 8 years of age and continues till 11 years and suggests that children of this age can answer simple questions with certain degree of accuracy. A number of research studies on children as respondents of survey research (like Bill:2007 and Fuchs:2008) have found that children can be respondents of survey research on questionnaires different than the one used for adults. Based on evidence from the literature, we chose to interview eight (8) years or older children in the education CRC.

Respondents of health CRC were adults but were slightly different given the fact that, being patient or attendant, most of them were under difficult conditions at that time. We therefore kept the questions simple and limited to key indicators to avoid any emotional backlash by directly discussing their problems or bitter experiences.

Given the special characteristics of respondents, questionnaires were designed keeping in view the cognitive ability and special circumstances. Questions were based on indicators identified from previous research studies and literature on the availability, access and quality of these services. The drafted questionnaires were presented to the participants of a workshop of stakeholders in Mardan; their inputs were taken and were incorporated in the draft. The improved versions were then pre-tested in the field to test the validity and appropriateness of language and were finalized after making necessary changes.

1.5 Field teams composition and training

Three teams were involved to conduct the survey in the three districts. Each team included one supervisor, two male enumerators and two female enumerators. Field training was conducted for detail discussion on the questionnaires, field ethics and safe enumeration. Enumeration exercises were done on both questionnaires for familiarity of interviewers with every question, effective time management and how to manage different types of respondents.

1.6 Data collection, data entry and analysis

Field teams were mobilized the very next day after completing the training. The data collection was completed smoothly in one week. Monitoring of the data collection was done by a field monitor who visited every team in the field randomly. A database was developed in STATA and data was cleaned, coded and entered by two data entry operators. The final database was used for analysis, tables and cross tabs were extracted and were used for report.

Chapter 2: CRC EDUCATION FINDINGS

2.1 Respondents

Consumers of primary education are children who are enrolled in schools. The CRC approaches children directly to take their feedback on quality and access of education, and not through their parents/guardians. Based on the sampling frame, the survey was conducted at household level to avoid the recall error in date of birth. The survey used class of enrolment as a proxy of age and selected children who were enrolled in class 4 and 5. Some basic characteristics of children interviewed are given below:

Most children in our survey population, especially boys in rural areas, have a busy schedule in terms of daily activities. After coming back from school in the afternoon, they take lunch and go to mosque or *madrassa* for religious education where they stay till late afternoon. In the early evening they normally play within their homes or in the streets as recreational facilities and playgrounds are very limited in the area as revealed by PTC members in the in-depth interviews. It was challenging for the survey teams to find the appropriate respondents and therefore the data collection took more time than initially planned. Total respondents of the education CRC survey were 325 children which consisted of 172 or 53% boys and 153 or 47% girls. Respondents enrolled in class four were 169 and the remaining 156 were enrolled in class five.

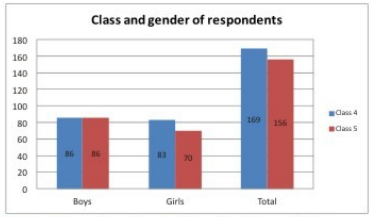

Figure 1: Class of enrolment and gender of respondents

In some cases, primary schools are operated in the same building with middle schools and therefore it was important to know which school the respondent is enrolled in to account for any difference in services. Though these schools are administratively independent from the attached middle schools and have separate budget allocation, we will mention middle/secondary school as school of enrolment of children who are enrolled in primary schools which are attached to a middle school. Since middle schools are less in number as compared to primary schools, 91% of our respondents were found enrolled in primary schools and the remaining 9% were enrolled in schools attached to a middle school. Rural/urban differential in services was captured through giving equal representation to rural areas in the sample. Out of the total respondents 50.46% were from rural areas and 49.54% were from urban areas.

2.2 Availability and Access

2.2.1 Average distance

The CRC survey starts with the availability of services in the area and users' access to the service. Distance of schools from users is a reliable indicator to establish whether the service is available in an accessible reasonable distance. In the total sample, on the average 91 % respondents reported that school is available within 1 km while the remaining 9% said that school is available within 2 km radius from their residence. The data shows gender disparity in availability of schools as girls' reported 88% schools within 1 km compared to 93% in the same distance category for boys. Given the local cultural context, distance of school is one of the contributing factors in low enrolment of girls compared to boys in the province. A relevant indicator is the ease of admission in these schools. A pre-dominant majority of the respondents did not report any problems while 4% said that had faced some problems in the admission process. Half of the problems were related to late admission and half were related to the catchment areas. Government schools have catchment areas and normally do not accept admission from out of that area until solid justification is provided.

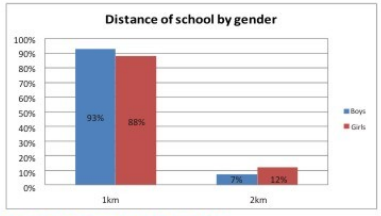

Figure 2: Distance of school by gender

Schools Without Building

Khyber Pakhtunkhwa has 22,760 primary schools according to Pakistan Education Statistics 2011-12, including 14,819 male and 7,941 female schools (In 2013, the total number of primary schools has increased to 23,073). Out of the total government schools, 286 have been reported without building which includes 218 male and 68 female primary schools. 10,318 schools have two rooms only. While some school buildings have been damaged in flood and militancy recently, there are schools operating in the province without building from day one with little or no attention from the education department. One such school is Government Primary School (GPS) No. 3 Hayatabad in the capital city of Khyber Pakhtunkhwa province, Peshawar. Hayatabad is one of the posh localities of Peshawar and a modern suburb, having most of the modern day facilities and maintained by Peshawar Development Authority (PDA). The upper middle class and upper class have a number of options for their children's schooling in Hayatabad, the low income class rely on government schools. Due to the recent influx of displaced people from Federally Administered Tribal Areas (FATA) and conflict affected areas of Khyber Pakhtunkhwa, the demand for government schools has increased. Though without building, GPS No. 3 Hayatabad has 240 enrolled children, which include both boys and girls while total number of teachers is four (4). The school has eight (8) kanal allotted land in phase-6 area of Hayatabad but was operated in different schools and private buildings including GPS No.1, 2 and 5 in Hayatabad, was shifted to the head teacher's (private) house in 2009, and was finally shifted to the allotted land (open space) in October 2013, as no rent was paid to the private building for four (4) years. Currently there is no building, furniture/floor mates, toilet and drinking water. There is no boundary wall and children have to sit beside a construction material dumping site,

Picture1: Around 240 children are enrolled

Picture2: Girls have no option but to join boys in the open school

Picture3: The school land has become a dumping si

surrounded by a tea stall and construction material on a dusty ground. There is no arrangement for protection from sun and rain. The school does not have any Parents Teachers Council (PTC) and therefore does not have any budget except for the teachers' salaries. The head teacher has written a number of applications for building arrangements but no attention has been paid by the department so far. The teachers and children requested immediate arrangements of basic facilities and a rented building until the building is constructed. While the government claims to have increased enrolment in the recent enrolment drive, lack of building and basic facilities will push the dropout rate higher in GPS No.3 Hayatabad and most of the existing 240 enrolled children will join their age group in the streets who are already out-of-school.

2.2.2 Facilities and Supplies

Availability of facilities and services is an important factor in maintaining a healthy learning environment, increasing enrolment and decreasing dropouts in the schools as identified by Farooq, M. S (2011) in his study on causes of primary school dropout and SDPI working paper series # 19 (2011) . The survey data shows that close to 9% of government girls' schools in the rural areas have no boundary walls and according to in-depth interviews boundary walls of some schools are in poor condition. This creates security issues for teachers and students, causes disturbance in both teaching and learning process and may be another important factor in lower girls' enrolment.

Availability of drinking water within the school was found not satisfactory based on the survey data. On the average 13% of the total respondents said that they do not have drinking water in their schools. This ratio is higher for girls at 23% than the 5% for boys who reported missing drinking water in their schools.

Toilets in the schools are critical both for health and hygiene and for the security of children who may opt for open defecation in absence of this facility. Government of Khyber Pakhtunkhwa has been successful in providing toilets in most of the primary schools as 98% of the respondents reported having this facility in schools. However, 13% respondents reported that they cannot use these toilets owing to number of reasons. Some toilets have no water connection, others have no cleaning staff or the staffs do not take responsibility for cleaning while in some schools toilets are 'staff only' facility and are not accessible to children.

Most of the primary and some middle schools have floor mates for the students' seating. The survey results show that less than 20% of the children interviewed said that they have furniture (desk/benches) in the schools, 77% reported they sit on floor mates while the remaining 3% reported that they have neither furniture, nor floor mates. In most schools the floors are broken and the floor mates, made of jute, collect all the dust and dirt and are cleaned by children themselves.
Electricity connections were reported by 92% of the respondents in their schools and fans were reported by 97% of the respondents. The higher availability of fans than electricity connection suggest that either the electricity is disconnected or the long hours load shedding make children think that there is no electricity connection.

According to in-depth interviews, drinking water and toilets are discussed in some PTC meetings and recommendations are given to the department. However, few of the recommendations are acted upon because of lack of interest and resources from the department. Most of the PTC members were not aware of the funds allocation for their schools. The head teachers utilize school funds with no or little consultation with PTC members.

2.2.3 Provision of Books and Teaching Aid Material

The government has been providing free books in government schools to encourage enrolment and help families to continue their children's education. Out of the entire respondents, 98% said that they have received free books in the school.

An important part of the learning process is use of teaching aid material which makes the teaching and learning more practical and pleasant. However, such material is not available for all children based on our survey findings. According to the data, 22% of all respondents said there is no black/white board for them in the school, for 45% there were no maps, for another 45% there were no pictures, for 80% there was no maths kit and for 86% there were no models. The availability of aid material differs across schools and for different classes. Availability of material by district gives a mixed trend as availability of white/black board was reported more in Mardan (96%), maps and pictures were reported more in Peshawar (71% and 85% respectively), and math kits and models were reported more in Swabi (38% and 29% respectively).

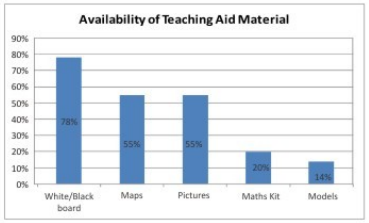

Figure 3: Availability of teaching aid material

2.2.4 Play ground and co-curricular activities

Physical activities are equally important in schools to keep children active and healthy physically, and productive and motivated mentally. However, not all children have play grounds in schools according to the survey findings where 81% children said they do not have this facility. In rural areas, respondents who reported to be without play grounds were 71% compared to 91% in the urban areas. The gender desegregation of the data shows that more boys (83%) are without play grounds than girls (78%). According to PTC members, there is no land available for play ground with the school. Data about co-curricular activities and participation in such activities as reported by the respondents further explains the utilization of play ground where available. Of all the respondents, 37% said that there are co-curricular activities in their schools. Boys reported more co-curricular activities at 43% as compared to 30% by girls. However, not all schools prepare their students for participation in the inter-school competitions. Even at school level participation, as reported by the respondents, is as low as 14%; 16% for boys and 13% for girls.

2.2.5 Critical needs

There are missing facilities in some schools, while facilities are either not in working condition or are not used in other schools. It was very important to understand the perception of children on the most wanted facilities. We included an open ended question asking children what facilities you need the most. Out of the total sample of 325 respondents, furniture was mentioned by 32%, play ground by

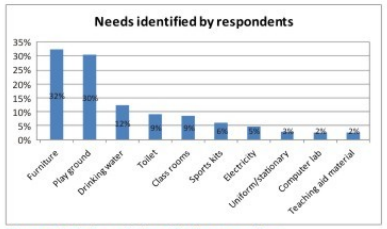

Figure 4: Critical needs identified by respondents

30%, drinking water by 12%, toilets by 9% and class rooms by 9%. Other facilities mentioned as needed by respondents were sports kits, electricity connections, uniform/stationary, computer lab and teaching aid material as shown in the chart. Critical needs flagged by PTC members in the interviews were drinking water and toilets.

2.3 QUALITY

2.3.1 Teachers' absenteeism

Given the cognitive ability of our study respondents, we included proxy indicators in the questionnaire about perception of quality. Questions on quality were framed close ended and easy to understand to facilitate the respondent in understanding and answering process. One of the key issues in education quality and high drop-out rate is teachers' absenteeism as identified by previous studies on the subject (Farooq: 2011, Hussain et al., 2010). According to our data, 14% respondents reported that their teachers do not come regularly to school. Absenteeism has been identified more by girls at 21% than boys at 8%, while the ratio is almost the same for rural and urban at close to 14% each. The data for districts shows that Swabi has the highest respondent reported absenteeism at 16% while Peshawar and Mardan have been reported with a proportion of 13% each. Some of the PTC members interviewed pointed teachers' absenteeism as a major weakness of the government schools. However, only few of them had taken practical steps like discussing the issue in the PTC meeting or registering complaint with the education department but reported no improvement in punctuality. Some of the reasons of higher absenteeism of female teachers may be because of the current security situation in the province, transfers/postings of teachers outside of home towns and the subsequent transportation problems and child bearing/child rearing. However, these issues need to be accounted for at the policy and planning level. Teachers' absenteeism has been attributed to low incentives for teachers, poor monitoring by the concerned authority and lack of interest by parents.

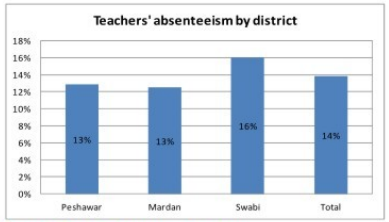

Figure 5: Teachers' absenteeism by district

2.3.2 Use of teaching aid material in schools

Earlier in this chapter we have discussed the availability of teaching aid material. The use of these materials is relevant in the quality section because use of teaching aid material assists in teaching and learning process. The data shows that not all of available materials are used by the teachers. When asked about use of teaching aid material, 46% respondents said that their teachers do not use these materials and the teaching process is limited to mere memorising of text without paying much attention to the learning part. There is

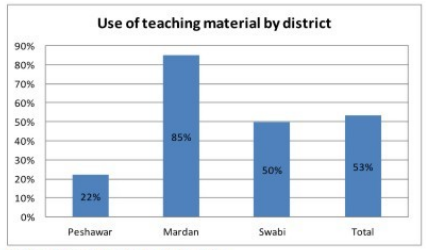

Figure 6: Use of teaching aid material

hardly any gender or rural/urban differential in this trend, suggesting that use of teaching aid material is low in both boys' and girls' schools across the rural/urban divide. The district level data shows significant differences in use of teaching aid material. The data shows that Peshawar has the worst situation having 22% responses that teachers use teaching aid material, followed by Swabi with 50% while Mardan has the highest proportion of 85% on this indicator. The relatively high use of aid material in Mardan (85%) may be because of comparatively very high score of this district on availability of white/black board (96%) as reported by children, although the relationship between these two variables are not statistically significant. The low use of teaching aid material can be attributed to poor (or lack of relevant) capacity building programs for teachers, lack of interest in the teaching methodology at the departmental level and poor or no monitoring of this aspect from the department. The awareness level of parents about this aspect of the quality is very low as no PTC member mentioned it as an issue during in-depth interviews.

2.3.3 Involvement of parents in children's education

Involvement of parents helps improve children's learning process, quality of education and reducing dropouts (Malik: 2002). Parents are supposed to be regularly contacted and updated on the progress/issues of their children. However, only 11% respondents said that their parents were called regularly by teachers to school and 32% said that their parents were called occasionally, while 45% said that their parents have never been called by teachers to school. According to in-depth interviews with PTC members, parents were called in to discuss (mostly) discipline related issues, whereas few parents were called for discussion on academic progress of children. Gender differential is evident from the data as female teachers have been reported, by the respondents, to be more active in involving parents than the male teachers. Rural and urban areas have almost similar trend on this indicator.

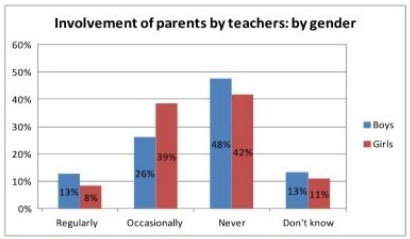

Figure 7: Involvement of parents by teachers: by gender

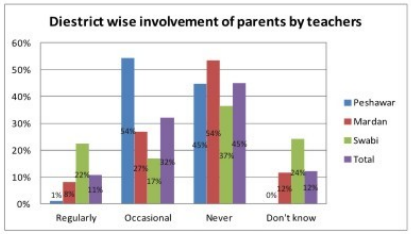

Figure 8: Involvement of parents by teachers: by district

The district wise data on this indicator shows a mixed trend. Overall, Mardan has the highest number of respondents saying that their parents have never been called by teachers, followed by Peshawar and then Swabi. Swabi is leading the other two districts on 'regular' category and Peshawar has the highest number of responses on occasional category. The three districts have statistically significant differences on different categories of this indicator; however, there is no specific pattern in this relationship suggesting that the overall situation of teachers' practices towards involvement of parents have close resemblance across districts.

It is also important from the policy and planning perspective to know whether parents take interest in their children's education in the context of government schools. There can be more than one indicator to investigate this, but having children as respondents we included an indicator on parents' pro-active visits to schools to discuss the progress of their children with teachers. On the average 48% of the respondents said that their parents had never visited school by themselves, 32% said that their parents visit school occasionally and 11% reported regular parents visits. There is evidence of higher proactive parents in boys' case in regular visits category and higher occasional visits in the girls' case. Parents who never visited schools are more for boys than girls with a difference of six percentage points.

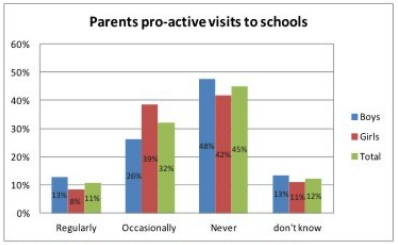

Figure 8: Parents pro-active visit to school: by gender

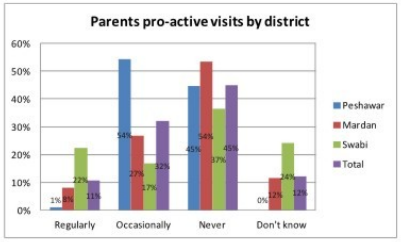

Figure 9: Parents' pro-active visits to schools: by district

The district wise data on this indicator, as with the earlier one, does not give any specific pattern. More parents in Swabi were reported by children to have been visiting schools regularly than the average, while parents in Peshawar were reported with higher occasional visits to school than the average. Data from Mardan shows that parents' visits, out of their own interest, are the least in this district.

The two indicators on the parents' involvement in their children schooling presents a clear picture of lack of a concerted effort on the part of school management and teachers, and low level of awareness of parents about the importance of engaging with the school for their children's education.

2.3.4 Corporal Punishment

Corporal punishment harms children physically, affects the self respect of individuals with long lasting impact on the mental health, makes learning a bitter experience for children and therefore affects the overall educational attainment of children (Arif and Rafi 2007, Naz et al., 2012) . Any type of corporal punishment is forbidden by law in all public and private schools. However, CRC survey findings show that it is still being practiced widely in schools. Overall, corporal punishment was reported by 84% of the respondents, with the highest in Peshawar by 93% followed by Mardan at 86% and then Swabi at 73%. The gender desegregated data shows that boys experienced more corporal punishment than girls with a difference of seven percentage points. There is slight rural/urban differential with rural areas having two percentage points higher reported punishment than the urban areas.

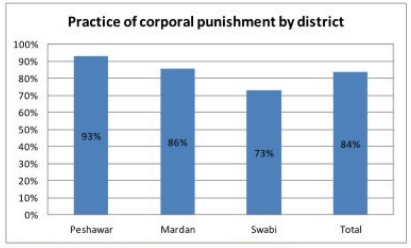

Figure 10: Corporal punishment practice by district

Equally important is the frequency of corporal punishment to understand severity of the problem. Respondents were therefore asked about time since last punished during the last one year. 63% of the respondents reported to have been punished within the last one month of the date of interview. Those who reported to have been punished between last 1 to 2 months were 10%. Collectively children who reported to have been punished in the last two months are 73%. It was found in the qualitative interviews with the PTC that parents are not against corporal punishment. They were of the opinion that some punishment is good for children's educational attainment and personality development. There seems lack of proper check on this issue from the department side and lack or poor level of awareness among parents about the pros and cons of physical punishment. PTC members were found divided on the issue of corporal punishment. Some members interviewed were of the opinion that corporal punishment is good for discipline and learning of children. Others considered it as a major problem, have discussed it with the teachers in their meetings and some have even reported to the department. However, they were disappointed with the departments' indifference on the issue like many others reported earlier.

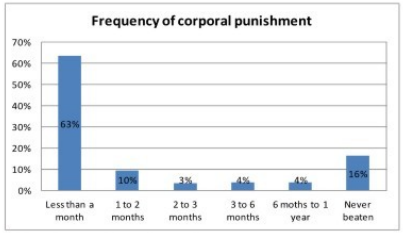

Figure 11: Corporal punishment frequency

2.3.5 Demand for service

Despite all the odds of reported inadequate facilities and services, low interest by the concerned officials, low motivation of teachers and less supportive education environment at home, 97% respondents said that they like their school and 98% said that they wanted to continue education. There seems little or no issues on the demand side from the children. However, the demand of education from parents and provision of services, facilities and quality by the department has some serious issues according to the survey findings.

2.4 Policy issues and recommendations

- Though the average distance of schools for most children is 1 km or less, there are many missing, inadequate and non-operational facilities. Some basic facilities like toilets, drinking water and furniture have been highlighted by the CRC survey findings as the urgent needs of children. Provision of facilities and supplies need to be rationalized with the number students in each school.
- Play ground is a critical need of schools and co-curricular activities needs special focus for motivation of children and a healthy learning environment in schools. Non-availability of land was reported as a key issue in lack of play grounds which can be addressed by having play grounds at the village/cluster level accessible to children of schools from the surrounding areas. Organizing co-curricular activities should be rewarded by the department and monitoring such activities should be included in the monitoring plan of schools.

- Teachers' absenteeism should be discouraged and incentive based reward package should be introduced on district level for teachers with best attendance record. Teachers, and especially female teachers, should be posted in the nearest possible school to cope with the security and transportation issues.
- Provision and use of teaching aid material should be ensured and teachers must be trained on the use of these material. Teaching methodology needs to be changed from memorising of text to activity based teaching.
- Although corporal punishment is no more allowed, it is still widely and frequently practiced in schools. This practice should be discouraged at all cost. Awareness of teachers and parents should be raised and checking corporal punishment should be part of the school monitoring plan.
- Low involvement of parents is a major issue and schools seem to be working in isolation from parents. This has serious repercussions for quality of education, well-being of children and accountability of teachers and education managers. Conducting regular meetings with parents should be made compulsory for the head teachers and parents should be encouraged to participate in such meetings.
- There exist rural/urban disparity and gender differential on a number of indicators in availability, access and quality of education. Concerted efforts need to be made to bridge the gap and to encourage girls' enrolment in the province along with enhancing boys' enrolment.
- The existing parent teacher councils (PTC) are not effective and some of the members' children are not enrolled in the same schools. Members have been selected by the teachers and most of the parents do not have any say in the affairs of schools. In many instances there are few or no meetings and teachers run the affairs themselves. PTC members should be elected by parents from among themselves for not more than 2 years in order to keep all parents involved with the schools.

Chapter 3: CRC HEALTH FINDINGS

3.1 Health CRC Respondents

To capture the perception of users of health services based on their most recent experience with the health service providers and avoid recall error in the responses, we chose to interview patients and their attendants visiting health facilities during the survey. Health facilities were selected based on the sampling frame as discussed in chapter 1. According to this CRC survey sampling frame the required age group for respondents was 18 to 65 years. Total respondents were 326, having 30% respondents in the 30-39 years age group in total sample followed by 23% respondents in the 20-29 and 40-49 groups each. The other two age groups were 18-20 and 50 years and above with 6% and 18% representation respectively. The rural urban mix shows that 41% respondents were interviewed in rural areas and 59% were interviewed in urban areas. To give proportionate representation to both genders, equal number of respondents were interviewed. The completed interviews include 52% men and 48% women respondents. Out of the total respondents, 52% were patients and 48% were attendants accompanying patients to the health facility. It is important to mention that the respondent was either patient or attendant, and not both at the same time, to avoid redundancy in the responses. The first choice for interview was patient; attendant was chosen in cases where patient had little interaction with the process of acquiring the service. Both indoor and outdoor patients and their attendants were interviewed, the final sample include 21% indoor and 79% outdoor patients and their attendants.

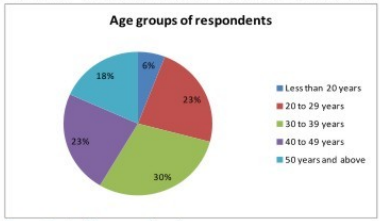

Figure 12: Health respondents' age groups

Based on the sample frame, users of a range of health facilities were interviewed in the survey. These included 11% users of teaching hospitals, 26% from district headquarter hospitals, 35% from rural health centres and 22% from basic health. Respondents also include 6% users of other specialized hospitals in Peshawar which includes police hospital and Molvi Ameer Shah Memorial Hospital commonly known as Molvi Gee hospital.

3.2 Availability and Access

3.2.1 Availability and Access of Health Facilities

Health services in the public sector are provided by teaching hospitals, District Headquarter Hospitals (DHQ), Tehsil Headquarter Hospitals (THQ), Rural Health Centres (RHC), Basic Health Units (BHU) and dispensaries. In addition there are specialized hospitals run either by the health department or other government departments, like Molvi Gee Hospital, as discussed above. It was important to understand the pattern of health facilities commonly used by the respondents. The data shows that RHC and DHQ are visited by most of the respondents with 15% share each in the sample, followed by

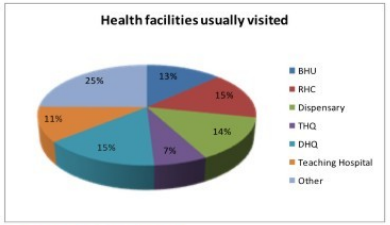

Figure 13: Health facility visited

dispensary, BHU and teaching hospitals. THQs were reported by 7% of the respondents for usual visits. One fourth of the respondents said that they visit private clinics and hospitals, charity hospitals, medical practitioners in the community, and other specialized hospitals within the government structure.

Comparing use of THQ with the upper tier (DHQ) and lower tier (RHC) raises certain questions. The average distance of THQ from community in its catchment area is less than the average distance of DHQ. On the other hand THQ supposedly have more facilities and services than RHCs. However, a nationwide study of THQs by Free and Fair Election Network (FAFEN) in August 2011 found that 57% THQs do not have pathology departments, 40% do not have paediatric services and 38% were without gynaecology and obstetrics department. This reflects well in our findings on the proportion of users visiting government health facilities. Equally important is the 13% reported use of BHU compared to 11% use of teaching hospitals which suggest that wither teaching hospitals are overburdened or BHUs are under-utilized, or both.

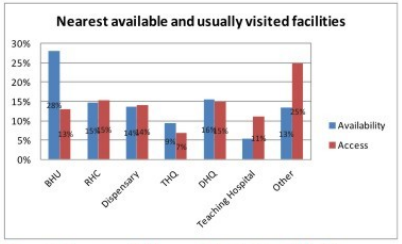

Figure 14: Nearest available vs usually visited health facility

Another way to look at the availability and access of health facilities is to compare the nearest available health facility with the facility mostly visited by the respondents. This comparison also shows the under utilization of BHU and THQ while overburdening of teaching hospitals. Again other facilities include private clinics and hospitals, local practitioners and specialized hospitals and the reported use of this category was 25%.

3.2.2 Health Facility Staff

Presence of relevant staff in the health facility at the time of visit is a critical indicator of health service provision. Missing staff in the facility hinders the process of service provision and may cause compromise on the quality of service and health of patients. The survey results show that 8% of the total respondents reported missing relevant staff at the time of their visit in the health facility. This ratio was the highest in Peshawar with 12% responses, followed by Mardan and then Swabi. Out of the total reported missing staff, 80% were doctors, 8% each nurses and dispensers and 4% technicians. Missing staff was reported more in rural areas (10%) than urban areas (6%). The gender desegregated data shows that women reported three times higher (12%) missing staff than men (4%).

Figure 15: Missing staff of health facility at the time of visit

3.2.3 Diagnostic tests

Secondary and tertiary health facilities have relevant pathology laboratories and the prescribed diagnostics tests are supposed to be conducted either free of cost or on subsidized rates. The respondents were asked about the diagnostic tests advised and conducted within the health facility they visited. The data shows that 40% of the respondents were advised different tests which included 13% x-rays, 27% blood tests, 18% urine tests, almost 2% ECG, less than 1 percent each MRI and CT Scan. The data further shows that most of the tests prescribed were conducted inside the facility. The difference between advised and conducted tests in X-ray, blood and urine tests was almost 2%, 3.5% and 3%. CT scan and MRI were all conducted inside the facility and one patient conducted ECG outside the facility. It is important to mention that the CT scan and MRI were conducted in teaching hospitals and not in GHQ and THQ.

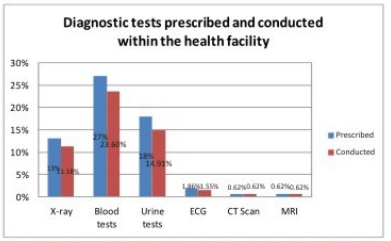

Figure 16: Diagnostic tests advised and conducted in health facility

Respondents who said that their tests were conducted inside the facility were also asked whether they have paid any money, other than official fee, to the staff of the facility for the tests. Out of those who conducted tests inside the mentioned health facilities, 8% said they have paid money (bribe) to the staff of the facility for the tests. This ratio was the highest in Mardan (13%) followed by Swabi (8%) and Peshawar (6%). It is important to note that this is a perception survey and respondents' educational level, awareness of services and exposure to the service providers determine their responses. For this question, the survey team had asked the respondents about incidence of paying money to the staff without obtaining receipt because some of the respondents were not aware of the official fee of the tests and the method of paying such fee.

3.2.4 Provision of medicines

Provision of medicines in the health facility has always been a key concern of users. Currently medicines are provided to indoor patients and patients visiting emergency departments of hospitals. However, not all medicines are available with the health facilities and have to be purchased from outside. According to our survey, 46% of the total respondents said that they were provided some or all medicines in the health facility. Respondents who were provided free medicines included 56% in Mardan, 50% in Peshawar and 32% in Swabi. When asked whether respondents have paid to the staff for medicines which were supposed to be provided free of cost, 11% responded in affirmative which included 2% in Peshawar, 1% in Mardan and 8% in Swabi.

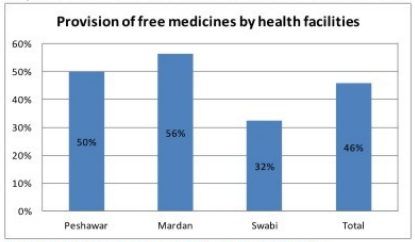

Figure 17: Provision of free medicines by health facility

3.3 QUALITY

3.3.1 Staff Behaviour

Health facility users need to be taken care of properly especially patients visiting hospitals as they are going through a difficult experience. Positive attitude and cooperative behaviour makes the service acquisition a pleasant experience and strengthens citizen-state relationship. Majority of the respondents i.e. 92% reported appropriate staff behaviour in the health facilities they visited. The district level data shows that 89% respondents in Peshawar reported appropriate behaviour, 88% respondents in Mardan and 97% respondents in Swabi reported appropriate behaviour. The gender desegregated data of respondents who reported inappropriate behaviour shows that women experienced more inappropriate behaviour of staff than men given their reporting of 9% and 7% respectively. There is a visible rural/urban differential on this indicator as the inappropriate staff behaviour reported by respondents in the rural areas was more than double (12%) compared to respondents in the urban areas (5%).

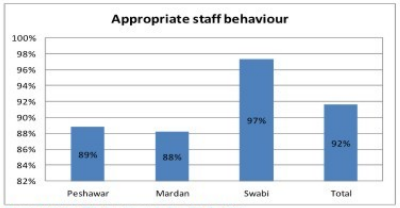

Figure 18: Staff behaviour in health facility

3.3.2 Health Facilities Users' Satisfaction

The overall satisfaction level of users based on their experience with the service providers needs attention as almost one fourth of the respondents were not found satisfied. A general practice of determining satisfaction level is using likert scale where responses are recorded on a scale from 1 to 5. However, we did not use this scale in our survey given the general literacy level of our respondents, complexity of quantifying the qualitative nature of the indicator and more importantly the objectives of the CRC. Therefore, we classified the categories as satisfied and not satisfied to make it simple for the respondents. The highest proportion of not satisfied users was found in Mardan, followed by Peshawar and then Swabi. Key reasons for dissatisfaction were quoted as staff behaviour, non-availability of medicines, non-availability of doctors, cleanliness and lack of space and facilities in health facilities.

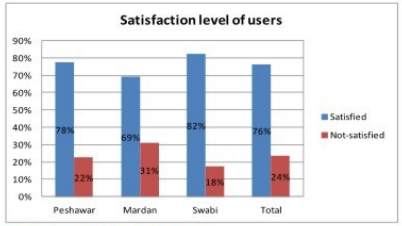

Figure 19: Satisfaction level of users

3.3.3 Grievance Redress Mechanism

Service providers should have an inbuilt mechanism of taking feedback from service consumers, identifying issues and resolving problems in the service provision. Consumers should be made aware of such mechanism with a proactive strategy to improve the quality of service. Our survey did not find good evidence of such a mechanism from the user perspective. Only 1.2% of the respondents said that they have ever launched complaint about health services. Half of the complaints have been launched within the health facility and half with the health department. Respondents who launched complaints were from Peshawar and Swabi. According to respondents, only half of the complaints were successful and the issues were resolved. Another indicator was knowledge of respondents of any complaint mechanism, 93% respondents had no knowledge, 3.4% said that complaint should be registered with the health facility staff, 2.5% identified health department at district and provincial level as the competent authority for receiving complaints while almost 1% said that complaint should be launched outside health department like elected representatives and district administration.

3.3.4 Suggestions for Improvement

When asked about suggestions for improvement in the government health facilities, 60% respondents asked for free treatment, although the services at these facilities are highly subsidized. Another 19% suggested increase in number of doctors and staff for improvement, 18% suggested better behaviour of staff will improve the service and 17% asked for more space and equipments. Space and facilities for attendants was brought up by 9% while availability of more staff at night was suggested by 5%. Respondents suggesting improved monitoring of health facilities, increased security and improvement in management were 3%, 2% and 2%. Other suggestions included new and equipped ambulances, un-interrupted electricity to health facilities and water treatment plants for availability of clean drinking water at health facilities.

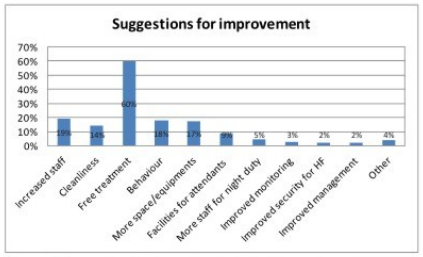

Figure 20: Suggestions for improvement in health services

3.4 Policy Issues and Recommendations

- The overburdening of teaching hospitals suggests that DHQs and THQs do not have the required capacity to take care of patients. Furthermore BHUs do not have the required capacity to provide primary health care at the community level which increases the work load of RHCs. It is recommended that capacity of health facilities at all levels should be built so that services can be provided quickly, with little cost of transportation and acquisition for the user and to avoid overburdening of teaching hospitals.
- Availability of staff, and especially of doctors, needs attention with a special focus on facilities in rural and remote areas. Urgent action is needed for hiring more staff for the health facilities on need basis, giving incentives and facilities (especially accommodation) in the rural areas for staff retention and effective monitoring to ensure attendance.

- Equipments for different diagnostic tests needs to be made available, maintained and utilized. Hospitals, especially DHQ and THQ, should be equipped to conduct all tests advised within these facilities and those referred by BHUs, RHCs and dispensaries. Most of the patients do not receive medicines in all health facilities and most of the medicines are not available in all health facilities. The range of medicines in hospitals should be broadened and the awareness of citizens should be raised so that they ask for it as a right and not as a privilege.
- Around 8% of the respondents were not happy with the behaviour of staff and this ratio was higher for female patients and their attendants. Special attention should be paid to this aspect in the capacity building programs of staff.
- Rural/urban differential should be bridged through allocation of resources, provision of staff and medicines, effective monitoring and involvement of public representatives.
- As a policy matter, there should be grievance redress mechanism in the health department asking proactively for users' feedback. Feedback about staff should be taken seriously by taking immediate action and making it part of the performance evaluation. Some specific areas covered in the feedback should be availability and behaviour of staff, duration of consultation and attention received satisfaction from service and recommendations for improvement.

Annex – A: CRC Education Questionnaire

Union Council	
District	
PSU	1. Rural 2. Urban

Enumerators name & Signature	Date of interview	Interview status 1- complete, 2- incomplete 3- Others (mention)

Instructions:

- Only choose to interview children who are currently enrolled in a government school
- If there are more than one eligible respondents in the household, use KISH Grid to select one
- Questions should be asked about the child own perception and experience
- Only fill with lead pencils clearly and legibly
- No questions should be left unanswered. Use generic codes to fill the boxes if the answers don't match with provided codes
- Follow the routing and don't ask irrelevant questions
- In case of "Other" response to questions, write down appropriate answer in the field: Only selecting "other" does not give any meaningful information

Generic codes

Don't know	Skip	Refused answer	Not applicable
888	777	666	555

For Data entry

Date of entry	Operators Name	Serial Number

A. Demographic and Socioeconomic information

A.1	Gender of respondent	1. Male 2. Female	
A.2	Age of respondent		
A.3	Class of enrolment		
A.4	School enrolled in	1. Primary School 2. Secondary (middle) School 3. High School 4. Higher Secondary School	

E Education

E.1	How many children in the household are school going: 5 to 16 years?		

E.2	Detail of school going age children?	Child age	Status (1. Govt school, 2. private school, 3. Madrassa, 4. Out of school

E.3	How far is your school situated? (KM)		
E.4	Is this the nearest school to your home?	1. Yes 2. No	

E.5	Did you face any problem in your admission in school?	1. Yes 2. No (Skip E6) 3. Don't know (Skip E6)	
E.6	What were the problems in admission?		

E.7	How much (if any) admission fee did you pay?	Class	Fee

E.8	Did you get books in the school in the current academic year?	1. Yes 2. No 3. Don't know	
E.9	Did you get any other supplies in your school?	1. Yes 2. No 3. Don't know	
E.10	Did you pay for books/supplies in your school? (Ask only in case of least one "Yes" response to E.8,9)	1. Yes 2. No (Skip E.11) 3. Don't know (Skip E.11)	
E.11	How much did you pay?		
E.12	Do your teacher/s come regularly to school?	1. Yes 2. No 3. Don't know	
E.13	Do you like your teachers?	1. Yes 2. No	
E.14	Reason for liking/disliking?		

E.15	What of these materials do you have in your school?	1. White boards 2. Maths kit 3. Maps 4. Pictures 5. Models	
		6. Other (write)_____	
E.16	Do your teachers use teaching aid materials?	1. Yes 2. No	
E.17	Which subject do you like the most?		
E.18	Why do you like this course the most?	1. The course is easy 2. The teacher is good 3. I like the lessons (contents) 4. Other_____	
E.19	Which course you dislike the most?		
E.20	Why do you dislike this course?	5. The course is not easy 6. The teacher is not good 7. I don't like the lessons (contents) 8. Other_____	
E.21	Does your school have drinking water for children?	1. Yes 2. No 3. Don't know	
E.22	Does the school have toilet facility?	1. Yes 2. No (Skip E.23)	
E.23	Can children use the toilet facility?	1. Yes 2. No	
E.24	Does the school have boundary wall?	1. Yes 2. No	
E.25	Does the school have electricity?	1. Yes 2. No	
E.26	Does the school have fans?	1. Yes 2. No	

E.27	What is the seating arrangement for children in the school?	1. Bench/desk 2. Floor mate 3. None 4. Other	
E.28	Does your school have play ground?	1. Yes 2. No	
E.29	Do you have co-curricular activities in school? (sports, debate etc)	1. Yes 2. No	
E.30	Do you participate in co-curricular activities?	1. Yes 2. No	
E.31	Do you like your school?	1. Yes 2. No	
E.32	Do you like to continue education in the future?	1. Yes 2. No	
E.33	Which facility your want the most in your school?		
E.34	Have your teacher ever beaten you?	1. Yes 2. No	
E.35	When did the teacher beat you?	1. Less than a month 2. Last two months 3. Last three months 4. Last six months 5. Within last one year 6. Other	
E.36	What do you think about the overall quality of education in your schools?	1. Excellent 2. Good 3. Reasonable 4. Bad 5. Very bad 6. Don't know	

E.37	Do you know your teachers ever call your parents to school to discuss your progress/issues?	1. Regularly 2. Occasionally 3. Never 4. Don't know	
E.38	Do your parents come to school to enquire about your progress?	1. Yes 2. No 3. Don't know	
E.39	When was the last time your parents visited school?	1. Last month 2. Last two months 3. Last three months 4. Last six months 5. Last one year	
		6. Other_____	
E.40	Any suggestions for improvement?		

Annex – B: CRC Health Questionnaire

Union Council	
District	
PSU	1. Rural 2. Urban

Enumerators name & Signature	Date of interview	Interview status 1- complete, 2- incomplete 3- Others (mention)

Instructions:

- Only choose to interview patients and their attendants who are either currently admitted in hospital or who used OPD service the same day.
- Questions should be asked about the patient/attendant own perception and experience
- Only fill with lead pencils clearly and legibly
- No questions should be left unanswered. Use generic codes to fill the boxes if the answers don't match with provided codes
- Follow the routing and don't ask irrelevant questions
- In case of "Other" response to questions, write down appropriate answer in the field: Only selecting "other" does not give any meaningful information

Generic codes

Don't know	Skip	Refused answer	Not applicable
888	777	666	555

For Data entry

Date of entry	Operators Name	Serial Number

A. Demographic and Socioeconomic information

A.1	Gender of respondent	3. Male 4. Female	
A.2	Age of respondent		
A.3	Status	1. Patient 2. Attendant	
A.4	Education	5. Illiterate 6. Primary 7. Secondary (8 years) 8. Metric 9. Graduate 10. Masters 11. Other	

H	Health		
H.1	What is the nearest government health facility from your house?	1. BHU 2. RHC 3. Dispensary 4. THQ 5. DHQ 6. Teaching hospital (Name:_____) 7. Other	
H.2	Where do you and your family usually go for treatment?	1. BHU 2. RHC 3. Dispensary 4. THQ 5. DHQ 6. Teaching hospital (Name:_____) 7. Other	
H.3	What is the nature of your current visit?	1. Indoor patient 2. Outdoor patient 3. Vaccination of children 4. Other_____	
H.4	Did you find relevant health staff?	1. Yes (Skip H.5) 2. No	
H.5	Who was missing from the health facility?	1. Doctor 2. Technician 3. Nurse 4. Dispenser 5. Other	
H.6	Did you find doctor/staff behaviour appropriate?	1. Yes 2. No	
H.7	Did the health facility provide medicines/supplies?	1. Yes 2. No (Skip H.8)	
H.8	Did you pay for the medicines/supplies?	1. Yes 2. No 3. Don't know	
H.9	Did you pay official fee for the treatment?	1. Yes 2. No 3. Don't know	

H.10	Did you pay any money to the staff of the facility (other than fee)?	1. Yes 2. No (Skip H.11) 3. Don't know (Skip H.11)	
H.11	Whom did you pay in the facility?	1. Yes 2. No 3. Don't know	
H.12	Did the facility ask for any medical tests/x-ray?	1. Yes 2. No (Skip H.13, 14,15,16) 3. Don't know (Skip H. 13, 14,15,16)	
H.13	What tests they asked for?	1. X-ray 2. Blood tests 3. Urine tests 4. CT Scan 5. MRI 6. ECG 7. Other	
H.14	Which of the tests were conducted in hospital?	1. X-ray 2. Blood tests 3. Urine tests 4. CT Scan 5. MRI 6. ECG 7. Other 8. None	
H.15	Did you pay any fee to **hospital** for these tests?	1. Yes 2. No 3. Don't know	
H.16	Did you pay anything to the **staff** for these tests?	1. Yes 2. No 3. Don't know	
H.17	Have you registered any complaint regarding the health services in the past one year?	1. Yes 2. No (Skip H.18,19) 3. Don't know (Skip H.18,19)	
H.18	Where did you register the complaint?	1. Health facility staff 2. Health department staff (please specify_____) 3. Other _____	

H.19	What was the outcome of the complaint?	1. Issue resolved 2. Issue didn't resolve 3. Other _____	
H.20	Do you know where to register complaint regarding health services?	1. Health facility staff 2. Health department staff (Please specify_____) 3. Other_____ 4. Don't know	
H.21	Are you satisfied with the treatment at govt facility?	1. Yes 2. No	
H.22	What is the reason for satisfaction/dissatisfaction?		
H.23	Suggestions for improvements?		

Annex – C: In-depth interview themes

Themes for in-depth interviews with the members of Parents Teachers Council (PTC)

Age and gender of respondents

School, Union Council and District

- How long you have been member of Parent Teacher Council (PTC)?
- Process of election/selection to the PTC
- Frequency of PTC meetings
- Issues discussed in the meeting
- PTC budget and utilization
    - Signatories of account
    - Knowledge of annual allocated budget
    - Prioritization and spending
- Availability of drinking water, boundary wall, toilets, electricity connection, fans, furniture and play ground
    - Status
    - Steps taken
    - Outcome
- Punctuality of teachers
    - Status
    - Steps taken
    - Outcome
- Corporal punishment in schools
    - Practice of punishment in the school
    - Perception about punishment
- Experience of receiving complaint from parents
    - Issue
    - Process
    - Outcome
- Experience of launching complaint by PTC members with the department
    - Issue
    - Process
    - Outcome
- Strengths and weaknesses of government schools
- Strengths and weaknesses of private schools

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