

EFFECTS OF LITERACY ON COST OF HEALTH CARE IN DISTRICT RAJANPUR



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CERTIFICATE

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Author's Declaration

I **Muhammad Sultan** hereby state that my MPhil thesis titled **Effects of Literacy on Cost of Health Care In District Rajanpur** is my own work and has not been submitted previously by me for taking any degree from this University **Pakistan Institute of Development Economics** or anywhere else in the country/world.

At any time if my statement is found to be incorrect even after my Graduation the university has the right to withdraw my MPhil degree.

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Dedication

I dedicate this Research to my beloved parents, have been a great source of inspiration and support; their love encouraged me at every step-in life and particularly during my studies at PIDE. I dedicate my effort to my Mother (late), brothers Mian Farhan, Mian Zeeshan and sisters whose love, trust, support and prayers are unforgettable for me.

(Muhammad Sultan)

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Abstract

The main purpose of the study is to assess the effects of literacy on the cost of health care in district Rajanpur, and to determine the association between health literacy and medical cost. The cross-sectional studies were acted in random sample of the population of different areas of District Rajanpur in 2019 according to the monitoring trends and determinants in procedure of effect of literacy in health care. In this study primary and secondary data were used. For primary data questionnaires were designed for compilation of the data. Questionnaire filled from patients and health service providers in hospitals and basic health units at primary level and at Tehsil and district hospitals at secondary level. In these cities of District Rajanpur, Tehsil Jampur and Tehsil Rojhan the literacy level of population is matriculation just completed primary/secondary education level (30.8%), inter to graduate in these areas (16.5%) and master level are (9.3%). But most of the respondents are illiterate (43.4%). There are major portion of the participants have age period of 18-30 years. (27.5%) out of 100%. The educational or other expense often father affords or pays. In this report, the father's spending percentage is (40.7%). The study shows that in deciding health care spending in Pakistan, socio-economic factors play an important role. Hard efforts and concerted actions by the government, education institutions and health organizations are needed to promote literacy in health care particularly among educated segments of Pakistani society.

Keywords: Health, Literacy, Awareness, Economics, Pakistan, Rajanpur, Jampur, Rojhan.

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Abbreviations

AMA	American Medical Association
ASER	Annual Stats of Education Report
UNICEF	United Nations International Emergency Fund
UN	United Nations
WHO	World Health Organization
MDG's	Millennium Development Goals
SDG's	Sustainable Development Goals
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
TB	Tuberculosis
UHC	Universal Health Coverage
THQ	Tehsil Headquarter
DHQ	District Headquarter
LHV's	Lady Health Visitors
MO	Medical Officer
WMO	Women Medical Officer
MS	Medical Superintendent
MCH	Maternal and Child Health
RHU	Rural Health Unit
BHU	Basic Health Unit
PDP	Pakistan Demographic Profile
UNESCO	United Nation Educational Scientific Cultural Education
US	United States
NALS	National Adults Literacy Survey
PBS	Pakistan Bureau of Statistics
ACSQHC	Australian Commission on Safety and Quality in Health Care
MLR	Multinomial Logistic Regression
SAP	Social Action Program

CHAPTER 1

INTRODUCTION

The definition of health according to the WHO is that “A state of complete physical, mental and social. well-being and not merely the absence of. disease or infirmity. And the definition of literacy according to the WHO is that “Literacy is the ability to identify, understand, interpret, create, communicate and compute, using printed and written materials associated with varying contexts. The concept of health literacy evolved from a history of defining, redefining, and quantifying the functional literacy needs of the adult population. Along with these changes has come the recognition that sophisticated literacy skills are increasingly needed to function in society and that low literacy may have an effect on health and health care. We present a brief history of literacy in the United States, followed by a discussion of the origins and conceptualization of health literacy. Increased attention to this important issue suggests the need to review existing definitions of the term "health literacy," because despite the growing interest in this field, one question that persists is, "What is health literacy?" (Berkman, et, al., 2010).

According to the WHO “Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions. "Health literacy" refers to a collection of abilities that individuals need in the medical services climate to work successfully (Berkman et al., 2011). These capacities incorporate the capacity to peruse and understand text and to discover and read data in reports (print ability); the capacity to utilize quantitative information for assignments, for example, perusing food names, learning blood glucose levels and holding fast to composed schedules (numeracy); and the capability of talking and modification in (oral education) (American Medical Association, 1999; Baker, 2006). Older, ethnic and burdened

individuals and those with not exactly a secondary school certificate have higher paces of low health education (Kutner et al., 2006).

Education can be characterized as "a person's capacity to peruse, compose, and talk in English and process and tackle issues at levels of capability important to work at work and in the public field, to accomplish one's objectives, and to build up one's information and potential" (Tabb and Lawless, 1991). Education likewise characterizes the office of an individual with or information on a particular subject. Health education is a group of stars of abilities in this setting that establish the capacity to perform essential perusing and mathematical spending for working and following up on medical services information in the medical services setting. People today are more qualified than already and are a lot of educated in issue of health (Leino-Kilpi et al., 2005).

Healthcare System in District Rajanpur has been facing problems due to lack of resources, there are human resources, mismanagement, and availability of logistics, supplies and referral facilities. Openness and moderateness for Health benefits particularly for country public in Rajanpur is a huge issue on the grounds that the deficiency of medical care experts and scarce portion of assets for Primary medical care areas and clinics. Solid Health Information Management framework isn't accessible at essential and optional level to assess and improve the administrations. Lack of medical research and technology at national as well as the district level is one of the hurdles in delivery of quality healthcare services.

There are not many reasons, for example, scarce medical services financing in open area, violation, political barrier and absence of responsibility for low implementation. These are: double weight of infection, improvement of insufficient human asset in health area, population

explosion, neediness, and unawareness, absence of health mindfulness in local area, helpless sterilization and sewerage (Khattak, 2019).

According to census 2017, total population of District Rajanpur is almost two million. Male's population is 1,028,015 (rural 855,347 and 172,668 urban) females are 967,878 (rural 803,380 and 164,498 urban) and Shemale / Transgender are 65 (rural 29 and 36 urban). Average annual growth rate is 3.16 from 1998 to 2017. In the district Rajanpur 45% men and 22% women age 10 years and older are literate. Overall the district Rajanpur ranked 37 is last district in literacy indicators (ASER).

Health and medical services frameworks in Pakistan are confusing and delayed by many issues. There is incredible range of communicable and non-communicable diseases. High paces of baby and maternal mortality are combined with a heavy weight of non-communicable diseases like diabetes, hypertension and coronary illness (Khattak, 2019).

Also, general health frameworks in Pakistan are outdated with summary foundation. Various health suppliers actually work in normal every significant part, on occasion settling on uneducated choices for their patients. Moreover, health looking for conduct adds to the complexity of infection and its administration. It is normal for doctors to experience patients that quit accepting their anti-hypertensive (a drug that reduces high blood pressure) meds when their blood pressures reversal. Patients now and again present with harsh edge stage tumors, overlooking starting side effects. Intense risky diseases present late as information on key symptomatology is poor (Khattak, 2019).

Health economics is one of the many disciplines used to examine public health care problems. Health economics provides ideas and strategies used to resolve health problems in favor of human benefits. Study of economics typically judges the manner in which limited resources are used according to the two main criteria; performance and fairness. These two principals have technical definitions; performance refers to achieving the greatest production for a given collection of resources in very broad terms, and fairness refers to an equal distribution among the population of that output (Khattak ,2019).

Lack of education can block working in the medical services local area, influence the elements of patient-doctor contact, and accidentally add to helpless clinical consideration. It is correlated with poor comprehension of written or spoken medical advice, adverse health effects, and negative impacts on the population's health. Financial gap in the creating scene not just impacts the arrangement of emotional health care benefits however has other direct and unusual negative effects on psychological wellness (Ganasen et al., 2008). In non-industrialized nations, investigations of the connection among proficiency and wellbeing status normally utilize the level of instructive accomplishment (e.g., number of long periods of training) as a proportion of education. Education capacities (understanding levels) are only from time to time directly surveyed. The vast majority of these investigations show a reasonable relationship between educational accomplishment (as an education proxy) and primary health status estimates, for example, future, child survival, and maternal endurance rates. These records of health status secure as the helpful execution of local area increments. As referenced already, proficiency might be a significant sponsor of psychological wellness education. This remembers essential perusing abilities for medical services settings, for example, having the option to comprehend

composed and oral data given by health (specialists, attendants, drug specialists), read acceptance frames, and follow medicine marks (Kickbusch, 2001).

Studies say that with every time of maternal training, decreases in child death rates change from 3.5 percent to as high as nine percent. Although irregular examinations have discovered no connection among instruction and health status, multivariate measurable investigations keep on considering a positive connection between the two components in many investigations, even after possibly confusing sociodemographic factors, for example, pay, work status and dietary status (Cleland and Van Ginneken, 1988). At the point when useful achievement and ability of the female population are analyzed, the connection between training/education and health is particularly solid. In non-industrialized countries, maternal teaching is one of the most grounded single associates of child survival. The public authority of Pakistan consumes 3.1 percent of its money related, social and community and 43 percent is spent on health (Ahmed and Shaikh, 2008). The solid autonomous connection between maternal education and child survival, which is regularly thought to be causal, has prompted calls for solid activities to expand ladies' education as a method for improving children's status in these nations. Then again, it was likewise suggested that a "easy route impact" on improving child survival must be refined by instructing mothers about specific family exercises that upgrade their prosperity, as opposed to first improving their understanding abilities and afterward utilizing education as a vehicle for ability to train propensities identified with health. (UNICEF, 1998).

The study significantly more notable concern is those with psychological disturbance who proceed through life restricted, limited by obliviousness and shame, now and again making interruption in their own lives as well as their families after the disappointment of MDGs the SDGs presented in 2015-2030. In which the third one objective is identified with health and

fourth one is identified with the impartial quality education and deep-rooted learning openings for all without the exclusion of sex, age, shading, station, religion and zone. There is an objective by 2030 to lower neonatal mortality rate around 70% by 2030, infants and under long term children. It is planning to reduce the neonatal mortality in any event as low as 12 deaths for each 1000 live births and less than 5 as low as 25 deaths 1000 live births (Khattak, 2019).

In future 2030 end the infectious diseases, AIDS, tuberculosis, malaria and neglected tropical diseases and combat the communicable diseases, water borne diseases and hepatitis. The main objective is to achieve the universal health coverage, including the financial risk protection, access to quality essential healthcare services and access to safe, effective, quality, and affordable essential medicines and drugs for all (Khattak, 2019).

In the case of Pakistan, the literacy rate is around 57 percent with less than 45 percent women and 70 percent men are being literate (Statist). While the maternal mortality rate in Pakistan is 178 deaths per 1000 live births which is alarming. Birth rate in Pakistan is 21.9 births and 6.3 deaths per 1000 population which is too alarming and different from the Sustainable development goals (Pakistan demographic profile). Neonatal Under five mortality rates in Pakistan is 74.9% per 1000 births and neonatal mortality rate is 44 per 1000 births. As per UNICEF statistics the major cause of mortality is Pneumonia (64%), diarrhea (38%), unsafe delivery, lake of pediatricians. The inexperienced midwives, unhygienic practices usually in rural areas can become a hazard to the baby and children (UNICEF STATISTICS). A 2012 United Nations Educational, Scientific and Cultural Organization (UNESCO) report on training positioned Pakistan 113 out of 120 in the Education improvement record, featuring the condition of instruction in the nation (Khattak, 2019).

As per the World Health Organization (WHO), health ability includes the capacity to get to medical care, impart and comprehend issues emerging in health-related experiences. This meaning of health education incorporates having abilities that empower patients to improve illness the board, center around health advancement and, above all, give a feeling of strengthening and empower mental to medical services beneficiaries.

Pakistan keeps on battling with low health education that regularly brings about late introduction of illness, helpless adherence to treatment and me ager comprehension of health and infection avoidance. In a nation troubled by illnesses of the creating and the created world, with helpless medical services foundation and low education levels improving medical services ability could have significant effect on health and personal satisfaction of individuals. Using quickly extending useful innovation and media for spread of health data is a practical arrangement. Public assistance declarations for media and health data applications for useful innovation can be created by the public authority, health area and media association. An orderly, shocked focused on way to deal with health ability would permit wellbeing searchers the chance to comprehend constantly sickness avoidance, symptomatology and therapy (Khattak, 2019).

Incidentally, the baby death rate in the United States (10.0 per 1,000 live births) is higher than in 22 other industrialized nations. The associated impact of newborn child mortality and low birth weight is expensive for the U.S. medical services framework. Whenever improved public or maternal proficiency rates in the United States could improve U.S. child survival visions, even a little effect would have huge outcomes. For example, late measures recommend that if just 20% of current low birth weight children weighed only 250 grammas more upon entering the world, the quick expense investment funds to the U.S. medical care framework would be at any rate \$75

to 90 million. It has been called attention to in ongoing surveys of the subject that, although the connection between useful achievement and health status in non-modern nations is hard and huge, there is no disagreement about the course of causality. Improved instruction and proficiency in a non-industrialized country could be the outcome, not the reason, of improved training. Sex disparity has impacted the health of the women in Pakistan too by putting an uncompensated regenerative load on them, achieving in front of timetable and useless child bearing. This has encouraged a normal maternity being suffered with infections and diseases (Hasan & Khanum, 2000).

Low skill is regular in the United States; 40 million grown-up Americans scored the most minimal of five levels (level 1) in the National Adult Literacy Survey (NALS) 10 years back; one more 50 million at level 2. These levels relate to experiencing issues discovering snippets of data or numbers in a long content, coordinating numerous snippets of data into an archive, or discovering at least two numbers in a graph and making a calculation. Reacting to the fundamentals of a consistently expanding level of occupations and to the frequent requests of everyday life requires abilities over these NALS levels (Comings et al., 2001).

Vital strategy arrangement taking all things together medical services frameworks must to be founded on data identifying with the advancement, search and use of health practices and the elements deciding those practices. All such practices happen inside certain institutional constructions, for example, family, local area or health administrations. The variables deciding health practices can be found in a range of settings: physical, financial, social and political (Kroeger, 1983).

The utilization of the medical care framework, regardless of whether public or private, formal or non-formal, may in this manner rely upon socio-segment factors, social designs, the degree of training, social convictions and practices, sex exclusion, the status of ladies, the natural states of the monetary and political frameworks and the infection design and the medical care framework itself (Katung, 2001). Both areas public & private partnership makes best model in social sector but preferably public assets must be liberated for poor people. Dynamic, formal or casual collaboration between the two areas is an absolute necessity, yet the private area is infrequently considered in health arranging situations (Giusti et al., 1997).

The public and private areas may enhancement or replace one another. There are frequently asset balances in with specialists working in the public area that likewise set up their own private practice. The highlights of the help outlet and trust in the specialist cooperative likewise assume a critical part in the dynamic cycle on the decision of a health office (Newman et al., 1998).

The examination combines and investigations the range of writing that has been delivered to date on the connection among ability and health results and proof of mediations intended to improve the strength of individuals with low education. This examination looks at the relationship of variables influencing health looking for conduct in the utilization of health administrations in the creating scene, including Pakistan, both in general society and private sectors. The medical care framework in Pakistan is showed and the writing audited by local and worldwide diaries, utilizing tags (health, medical services, conduct health chasing, utilization of health administrations, Pakistan) and utilizing the calculated system design to survey health looking for conduct.

1.1. Problem Statement

Health awareness is strongly dependent on education; the Pakistani population is further disadvantaged. According to the Pakistan Bureau of Statistics, one-third of the population has primary level education and only 20% attain middle school education with women lagging behind men. The study identifies the level of literacy and health status of the literate and illiterate population. This study recommends focusing on health education and awareness to receive timely healthcare facilities from the healthcare providers.

1.2. Research Objectives

The major objectives of the study are following,

- To investigate the level of health awareness in district Rajanpur
- To check the association between health literacy and medical cost among the population in district Rajanpur

1.3. Research Question

1. What kind of relation between literacy and health care existence?
2. What is the level of literacy required for health awareness?
3. Does health literacy and education decrease the medical cost of the patients?

1.4. Research gap

There is a lot of space in this field and less availability of the data and outcomes in the area as well. And more importantly there is not a single study on Rajanpur district.

1.5. Significance of the Study

Every study is attempted for betterment of the society and has a great importance and significance. The place where this study is focused deserves many studies to be done for filling

the research gap. It is the most backward district of the Punjab (Rajanpur). The literacy rate is very poor overall and in case of girls it is alarming. The main issue in the world is health of the people and literacy. This study brings out the real result of literacy on health consequences. It is essential for successful access to care and use of services, self-care of chronic conditions, and maintenance of health and wellness. Health literacy is fundamental to healthcare that requires individuals to have a more active role in decisions making and management for the health system at the district level. We additionally perceive that health skill must be perceived in a more extensive health setting that envelops the wellbeing framework, the instruction framework, and society and culture. It is recommendation that future examinations rise above regarding health education as an individual issue and investigate components that people use to survive or improve health ignorance inside the clinical and social frameworks inside which they are implanted, frameworks that change in the measure of health ability they request from patients and in the level of health literacy sustain they give.

CHAPTER 2

LITERATURE REVIEW

Literacy and health are strongly correlated. We know that the countries where literacy rate is high are enjoys a better health. And in daily life there are some indicators which help us to know that how good they are in their health and some of the indicators are average age; mortality rate birth rate working efficiency etc. literacy has positive and significant impacts on health. The literature is full of such kind of studies mainly the international studies. But in case of Pakistan there is lot of space in this field.

However, there are a few potential components through which improved training and ability could improve health status, and there is critical help in the writing to recommend that this is the situation. As the degree of training and social attention to the local area expands, the population is "triggered" and bound to start health related mediations. This increased mindfulness can prompt higher paces of support in immunization projects and more dynamic inclusion in local area cleanliness and disinfection mediations, all of which can prompt reduction in the recurrence and pervasiveness of irresistible sicknesses. The financial polarization inside the general public and absence of government managed retirement framework makes the helpless more unprotected regarding moderateness and decision of health supplier (Nyamongo, 2002).

Capable females are bound to be associated with family arranging administrations. Improved information and utilization of data on family arranging can, reduce the birth rate and the size of the family, the two of which are significant variables in improving the health status of female's and youngsters in nations. Each nation has its own medical care framework to provide explicit medical care needs of its public in a remarkable social environment. Fundamental

objective of medical care framework is to convey impartial, convincing, and open medical services administrations to improve understanding fulfillment (World Health Organization, (2000).

Improving the proficiency abilities of patients in non-industrialized nations gives them more current health related information and makes them bound to share the clinical social estimations of their medical services suppliers. This one brings about more prominent conflict with the standards of logical medication. Patients with higher education abilities are subsequently bound to follow the directions of medical services suppliers, to be bound to go to persistent illness facilities, and to be bound to go to from the get-go in the sickness cycle (Weiss et al., 1991).

(NANCY A. HARDIE, 2011) Analyzed health ability and medical services spending and usage by connecting reactions of three health education inquiries to 2006 cases information of enrollees new to customer driven health plans (n ¼ 4,130). Better health education on each of the four health proficiency measures (three thing reactions and their total) was related with lower all out medical care spending, explicitly, lower crisis office and inpatient affirmation spending ($p < .05$). Additionally, less inpatient affirmations and crisis division visits were related with higher satisfactory wellbeing education scores and better self-reports of the capacity to peruse and find out about ailments (p -esteem $< .05$). Individuals with lower wellbeing education scores seem to utilize benefits more proper for cutting edge medical issue, despite the fact that office visit rates were comparable across the scope of health proficiency scores.

(Nielsen-Bohlman, 2004) discovered that people with restricted health education announced less fortunate health status and were more averse to utilize preventive consideration.

(Angelo E. Volandes, 2007) Discovered that people with low degrees of health education were bound to be hospitalized and to encounter terrible illness results.

Friedland (2002) assessed that low utilitarian proficiency may have been responsible for an extra \$32 billion to \$58 billion dollars in medical services spending in 2001. A considerable piece of these uses is financed by Medicaid and Medicare.

Weiss (1999) found that grown-ups with low health education are more averse to follow endorsed treatment and self-care regimens, make more prescription or treatment blunders, and come up short on the abilities expected to explore the medical care framework.

(Mitic, 2009) Presumed that to work well in the 21st century an individual should have a wide scope of capacities and abilities, fundamentally many 'proficiencies'. These 'proficiencies' from having the option to peruse a paper to understanding data given by a medical care supplier are different, dynamic, and pliant. Health proficiency' is an arising idea that includes the uniting of individuals from both the health and education fields. Health proficiency expands on the possibility that both health and education are basic assets for ordinary living. Degree of proficiency straightforwardly influences capacity to follow up on health data as well as to assume greater responsibility for wellbeing as people, families and networks. While numerous definitions for health education exist, the definition that has been received in this paper is, how much individuals can get to, comprehend, assess and convey data to draw in with the requests of various health settings to advance and keep up great wellbeing across the existence course.

2.1. Functional literacy

Abilities that permit a person to peruse approbation structures, medication names, and medical services data and to comprehend composed and oral data given by doctors, attendants,

drug specialists, or other medical services experts and to follow up on bearings by taking prescription effectively, clinging to self-care at home, and keeping arrangement plans.

(Michael K. Paasche-Orlow, 2005) Low health education has been related with a wide scope of health related results, including helpless general health status and high danger of hospitalization (Institute of Medicine, 2004). There keeps on being a constant flow of general health research recreating these affiliations. To give one late model, in a cross-sectional local area investigation of 2,512 more seasoned grown-ups, even after change for sociodemographic factors, grown-ups with just a 6th grade perusing level were bound to report chronic weakness, diabetes, and burdensome manifestations and twice as liable to report chronic frailty care access.

(Rebecca L. Sudore, 2006) Danger of hospitalization has likewise been utilized as a marker of health results. In a study of crisis office patients who took an interest in the Literacy in Health Care Study, those with lacking wellbeing education were twice as prone to have been hospitalized during the 2-year study period. After change for sociodemographic factors, the danger of being hospitalized was 1.7 for patients with insufficient wellbeing proficiency contrasted and patients with satisfactory health education, ascending to 3.1 for readmission among the individuals who had been hospitalized in the prior year passage into the investigation.

(Howard Gazmararian & Parker, 2005) In the wake of controlling for age, sex, race/nationality, schooling, pay, liquor and tobacco utilization, and co morbid conditions, the examiners found that people with insufficient health proficiency care spent a normal of \$108 more than people with sufficient health education on crisis care during the investigation time frame.

(Sabzwari, 2017) Pakistan keeps on battling with low health care education that frequently brings about late introduction of ailment, poor adherence to treatment and small comprehension of health and sickness counteractive action. In a nation troubled by illnesses of the creating and the created world, with poor medicinal services framework and low proficiency levels improving medicinal services education could have real impact on health literacy and health of masses. Using quickly extending versatile innovation and media for spread of health literacy data is a feasible arrangement. Open assistance declarations for media and health segment and media organization. A deliberate, staggered focused on methodology to health literacy proficiency would permit health searchers the chance to comprehend and fathom infection counteractive action, symptomatology and treatment.

(Fahad Saleem*, 2015) A satisfactory degree of health skill is identified with place health education information applications for compact development can be made by the organization, have treatment results. The current investigation is meant to inspect factors related with health education. The investigation was planned as a cross sectional, engaging study. A pre-approved survey was utilized for information assortment. 100 and 63 patients going to the Cardiology Outdoor Patients Department of a tertiary consideration emergency clinic in Karachi were enrolled for the examination. Out of 163 patients, the partner was practically equivalent in term of sexual orientation appropriation.

The 61 percent had metropolitan residency of Karachi city and 62 (38.04%) were classified as old patients. Generally speaking, chronic frailty education status was accounted for among the examination respondents. Health proficiency was clear with patient's information about drugs; information on unfavorable impacts; language hindrances and discernment about part of activity in improving personal satisfaction. Critical measures by utilizing a shared

methodology of doctors, drug specialist and attendants are needed to improve health ability of Pakistani population.

(Khattak F.H. January, 2019) Characterizes the general health that all coordinated estimates taken in broad daylight and private areas to forestall illness, advance health and delay life assumptions for individuals. It incorporates essential and major mediations to defend the soundness of the local area as opposed to people. The three significant general health capacities are to evaluation and checking of local area's wellbeing and populaces in danger to distinguish medical issues and needs. The subsequent one is to plan of public arrangements intended to recognize and take care of neighborhood and public medical issues and decide the needs. The third capacity is confirmation, that all populace approach proper and savvy care, including assets for health advancement and infection counteraction administrations. Public health is a science of disease prevention and injury protection by promoting and safeguarding the health communities through education, policy formulation, plan preparation and conducting research.

2.2. Health Economics in Pakistan

For an effective and equitable health system, the role of health economics is well recognized. Although health system problems vary slightly from developed countries in developing countries, tools in health economics are similarly relevant. Pakistan is a developing nation with low-intermediate incomes. The country's health system has developed into a well-planned district-based network of health facilities with highly trained staff and the availability of indigenous-capable lifesaving medicines. Meanwhile, over the past few years, the health system's demands have also risen. It is difficult for the new health system to cope with that criticism from the media, politicians and civil society (Chalkidou et al., 2010). (Khattak F.H. January, 2019) In Pakistan, through the wellbeing area, both in subjective and quantitative terms

has consumed, yet the current wellbeing framework isn't sufficiently skillful to give satisfactory offices to the developing populace. A particularly sorry situation can be credited to some vital scarcity of assets, restricted admittance to health administrations and their insufficiency, outrageous neediness; obliviousness and absence of mindfulness among the majority, and insufficient health framework have been distinguished as essential issues in improving general health.

The medical care arrangement of Pakistan has been dealing with issues of imbalance, shortage of assets, wasteful and undeveloped HR, sexual orientation heartlessness, and underlying mistake. With the uncertain health status of individuals and helpless markers of health are in the district. Administration of Pakistan dispatched medical care changes in 2001. (Khattak F.H. January, 2019) Health financing in Pakistan is to a great extent dependent on cash based uses from families. The private consumption establishes 61% of complete health uses in Pakistan, out of which 89% are cash, based health uses. Low open area health going through with a nonattendance of appropriate monetary insurance instrument, brings about disastrous wellbeing use in helpless families with an expanded danger of impoverishment. That health allotment is low, yet there is likewise absence of evenhanded financing system where the neediest regions are ignored.

The public authority spending is additionally powerless, with a conventional slant towards framework and tertiary consideration, incessant covers across general society and private area just as inside various public area elements coming about failures. (Khattak F.H. January, 2019) There have been a few accomplishments in health financing including acknowledgment of financing as a key change issue at the approach level. There has additionally been an expanded assignment and spending in wellbeing area in the last five years. Also, there

are endeavors in following health consumptions through National and Provincial Health Accounts. The public authority has likewise presented social insurance plans at Federal and Provincial levels, just as some interest side activities have additionally been dispatched. To accomplish general wellbeing inclusion, there is a need to upgrade the monetary envelope for the health area.

According to Khattak F.H. January, 2019 World Health Organization (WHO) positioned Pakistan 122nd in generally health care framework execution among 191 nations. The health pointers, health subsidizing and health and disinfection framework are by and large poor in Pakistan, especially in country territories. Around 19 percent of the general population malnourished of which 30% are kids under age five. The fundamental sources of hardship and end passion gastroenteritis, respiratory, infections, diabetes, unchallengeable irregularities, tuberculosis, stomach affliction, and typhoid fever. The United Nation evaluated that in 2003 Pakistan's HIV normality rate was 0.1 percent among 15-49, with a normal 4,900 passing's from AIDS. Hepatitis B and C are in like manner uncontrolled with around 3 million cases in the country at this moment.

2.3. Illiteracy and health care providers

According to Weil et al., 2005 utilizing the normal stature grown-up endurance rate and future as a pointer of health status Weil (2005) finds that health is a significant determinant of pay varieties in various nations. Slight proficiency abilities in non-industrialized nations may require uncommon variations in instructing medical care suppliers. In certain nations with low satisfactory quantities of understudies with the degree of instruction expected to prevail in optional or clinical schools might be hard to identify. Similarly, low proficiency rates may rapid an absence of accessibility of local biomedical educators, driving future clinical experts in non-

industrialized nations either to get preparing outside their nation of origin or to be prepared at home by unfamiliar teachers. (Kichbusch, 2001) The job of health education becomes crucial which helps people in surveying, understanding, and evaluating and applying health related data all the more adequately for better health results. Health proficiency which arose as a discrete type of education has gotten progressively significant for social, monetary, and health improvement. Thus, the need to depend on outside help for clinical instruction has prompted an irregularity between clinical schooling and the main medical issues of the non-industrialized country. In most non-industrialized nations, medication is instructed in English and endorsed course books are written in British or European languages. The substance of clinical schooling is frequently founded on a therapeutic, infection situated, high-innovation model that isn't appropriate to the assets of a non-industrialized country or local area.

In light of this request, prosperity schooling can be tended to as the scholarly limit having social capacities which choose the limit of individuals to get to, appreciate and utilize information in habits which advance and take care of wellbeing. Indeed, even in those nations where without a doubt the quantity of possible doctors (for example those with agreeable essential and preliminary training) is sufficient, there keeps on being a genuine deficiency of specialists in provincial areas. In non-industrialized nations, the more profoundly taught metropolitan social layers from which potential doctors are commonly attracted in general stay in urban communities in spite of government motivating forces and transient necessary country administration (Nutbeam, 2000).

Health training limits are imperative to diminish bungles through improving the correspondence between clinical benefits provider and patients. These issues have been settled by numerous non-industrialized countries by utilizing a scope of non-doctor local area health

laborers to offer direct clinical types of assistance and educate their populaces about general wellbeing activities. Yet, on the grounds that local area wellbeing laborers are regularly picked dependent on highlights that may not include instructive accomplishment, numerous health laborers have helpless education abilities. In view of the logical model, some local area wellbeing laborers could likewise be less responsive to medical care exercises. In mix with an absence of fundamental numerical abilities, low paces of proficiency among non-doctor wellbeing laborers regularly make challenges in gathering and dispersing significant data on clinical and general health care (McCune, 2010).

2.4. The level of literacy and patient education

Composed materials for understanding instruction, for example, pamphlets and gifts, lately, they have gotten generally utilized. Proof exists that the utilization of composed instructive materials may expand quiet consistence, increment understanding information and review of clinical data, and diminishes the rate of drug errors. Patient preparing materials are of worth, obviously, just on the off chance that they can be perused and perceived by the patients to whom they are disseminated (Johnson et al., 1986).

The segment attributes of the members may have affected the discoveries of that examination; half of the patients in that review were individuals from minority gatherings (which are genuinely bound to have helpless understanding abilities). Practically identical outcomes were however, gathered somewhere else in trauma centers (Weiss et al., 1991).

The perusing level for multicenter disease preliminaries of educated assent structures has types of careful assent are frequently composed at the level of an expert logical diary and have been found to lie at the degree of school or graduate school. For other instructive gifts, for

example, smoking end and heart restoration writing, and for medico-authoritative records proposed for quiet crowds, comparative discoveries have been noted (Morrow, 1980).

2.5. Illiteracy and Health status in Pakistan

In Pakistan, the medical services framework is confronting various difficulties. Medical services area is should have been rebuilt to bring enhancements. Albeit the public authority comprehends the significance of advantages given by data innovation arrangements, yet it appears to be basic to zero in on e-health strategy for its usage. The reason for this examination work is to investigate the impact of health on the medical care framework in Pakistan by getting reactions from medical care suppliers.

The extent of examination was restricted to specialist co-ops because the investigation seemed, by all accounts, to be the main scientific report of its sort on the wellbeing viewpoint; patients overviewed in the following period of exploration in this specific circumstance. The explanation is that in not-so-distant future wellbeing give advantages to patients and health experts; at the end of the day, it utilized by wellbeing expert to encourage patients. Along these lines, input from medical care suppliers is required on how agreeable they in using the said framework. It can assist government with examining in regard to health prior to giving assets to the correspondence framework needed for inescapable the medical care framework.

Hanchate, (2008) found that restricted wellbeing proficiency is firmly connected with financial climate and socioeconomics. Age, instructive accomplishment, sex, race, and identity are its key factors that could be licensed to chronic frailty status, health results, and medical care use. The examination point is extremely complete, tremendous and confounded in nature as it covers various elements of wellbeing scholarly and emotional prosperity.

Thai and George (2010) found that the possibility of health instruction had been fundamental considering the way that it associates the different periods of health like constant fragility, low health and better health. The higher the level of training finally provoke the better strength of people. Simply those people are charmed to learn, peruse and teach about the meaning of prosperity capability that requirements to have extraordinary level of health. The lower level of health education is related with the chronic weakness where individuals experience the ill effects of different sicknesses as they have helpless contemplations of ailments, data and preventive measures. These individuals are more hospitalized due to absence of fundamental health education. Yet, then again, individuals who have satisfactory degree of health education appreciate great health.

Speros (2005) examined that health proficiency is a scholarly idea and various existing ideas are remembering for it. It very well may be characterized from multiple points of view identifying with offices, capacities and awareness to individual health. According to it prosperity capability can be described as, "Prosperity schooling tends to such capacities which may be social and academic likewise through which individuals are sufficiently competent to get to, grasp and utilize information to progress and keep up extraordinary health". This definition definitely determines that prosperity training is direct related with the individual credits and linkages with information about health. It should be productive when there is near and dear commitment to accomplish the anticipated degree of prosperity that should be possible with strong capacity.

Rowlands et al. (2015) found that the chronic weakness proficiency has become a significant issue since it isn't just the detachment of the information about essential health rather it prompts chronic weakness that makes numerous different issues for government. It depicts that

individual engaged with undesirable ways of life having lower level of health proficiency. They despise a similar degree of joy like others having great degree of health education. Individuals with less schooling, less fortunate, more seasoned and ethnically burdened are associated with it.

Paasche-Orlow et al. (2005) established that the subject of health proficiency has become a significant worry of the clinical understudies now. The specialist quiet relationship is crucial for handle with the distinctive health related issues. We can accomplish the undeniable degree of wellbeing proficiency just when there a decent connection among specialist and patients. It is the part of health education which brings nearer the two of them and gives better outcomes. The Australian Commission on Safety and Quality in Health Care suggests that synchronization is exceptionally worthwhile between medical services suppliers and purchasers. This can be accomplished through embedding's health proficiency into strategies and the works on, guaranteeing the clear data, the engaged consideration of both medical care suppliers and customers, instructing individuals about health education and acclimatizing it with experts.

Osborne et al. (2013) investigated that the conventional proportions of health education incorporate the computation and perusing the data identified with health. It is unconceivable that the whole of the experts of clinical area is exceptionally proficient about their concerned fields. Some of them have little data about their fields and they rely upon their partners in the standard everyday practice. It is their obligation to learn first about health proficiency with the goal that they may encourage the health administration to customers about this data. The examination was led on the college understudies who were taken on various health programs. The study was accomplished for this which found that health proficiency assumes a part like spine in human body since it gives the more opportunities to play out their health-related assignments all the more adequately.

Unexpectedly Nutbeam (2000) introduced three degrees of health education-based reformist model including: (1) useful health proficiency that remembers satisfactory fundamental abilities for perusing and writing to be capable capacity adequately in ordinary circumstances. (2) Interactive health education that incorporates further developed mental and proficiency abilities which, along with social abilities, can be utilized to effectively partake in regular exercises, to remove data and get importance from various types of correspondence, and to apply new data to evolving conditions. (3) Basic health capability that fuses additionally created scholarly capacities, which alongside social capacities, can be applied to fundamentally separate information, and to use this information to apply more noticeable order over life events and conditions.

Mitsutake et al. (2016) coordinated an assessment about E-health capability. For this a cross-sectional survey has been done to see the association between E-Health capability and general execution of the respondents. The cross-sectional audit relied upon online web access that was coordinated to pull in the thought of different arrangements of the respondents. In the general health related lead, respondents were gotten some information about step-by-step plan for instance smoking, usage of alcohol, the step-by-step timetable of genuine exercise, the snoozing hours, the quality and measure of breakfast, the dinners, they take typically, and the balance of sustenance. This investigation was done in Japan in which Japanese rendition of E-Health Literacy Scale was utilized by experts for information collection. The consequences of the examination were estimated utilizing calculated relapse investigation. The respondents with high E-Health related administrations have great wellbeing when contrasted with different respondents who don't get advantage from e-health administrations. The examination likewise

presumed that decent nourishment and routine of actual exercise additionally help to keep up great wellbeing.

Wang, (2014) raised that prosperity capability recognizes the particular limits about the pointers of prosperity. It incorporates the thoughts that are associated with patients and endeavor to test it tentatively their conditions. The makers moreover analyzed about the psychometric examinations that help the possibility of wellbeing instruction in a broader construction. It is moreover famous that wellbeing instruction is a blend of different sub pointers that oversees whole mass of capacities about health.

Ahmed et al. (2018) examined the adult people of Karachi, Pakistan to find the level of health instruction among youth. The data on the crucial economics and health capability network was assembled from adults and applied health education study review. The investigation found that most the member of the examination don't have adequate measure of health education for example 82.4% of the respondents demonstrated lower level of health proficiency. Essentially, a larger part of the respondents for example 70% detailed that it is hard to oversee and comprehend the health-related data. Along these lines, the investigation reasoned that the job of health experts is vital to raise the degree of information on the grown-ups with respect to health education.

Bread cooks et al. 2002 indicated an investigation to see the connection between health proficiency and induction to the medical services supplier. The examination utilized diverse term of health proficiency like practical health education and utilized emergency clinic confirmation as the danger factor. It was found in the investigation that lower level of useful health proficiency is straightforwardly identified with the more significant level of medical clinic

affirmation. The investigation likewise investigated that candidate with more elevated level of health education demonstrated more significant level of preventive estimates conduct.

At present in Pakistan, World Health Organization (WHO) gives the reference rules to the wellbeing framework, and the proposed e-health strategy is another reformist advance where WHO might be the principal warning body. Pakistan is resolved to work in a joint effort with global associations including WHO for creating best in class inventive innovation to improve its medical services and conveyance framework (Naseem et al., 2014).

Paper by Green et al 2001 built up a norm for cost piece of the essential medical services offices including fundamental health units. For fundamental wellbeing unit they pushed pay and non-advantage share as 49% and 51% separately and spending improvement based on same measures. In view of the expense creation in this examination an improvement in non-pay financial plan to essential medical care could be a suggestion (Loevinsohn et al., 2009). A new administration change in Punjab has shown improvement in patient visits and fulfillment with administrations through contracted administration of essential health units. Rather than upgrade of spending plans same assets were re-appropriated by excusing staff posted at fundamental health units and changing investment funds over to provisions and so forth This improved the expense proficiency and exhibited huge improvement in essential health unit usage and populace fulfillment (Malik et al., 2015).

The main problems in pushing forward toward this path are as per the following: (1) regardless of whether the public wellbeing framework is fit for engrossing this creative framework and (2) on the off chance that it is actualized, how many human limits run the framework. Both these viewpoints straightforwardly influence the health framework

productivity; anyhow, if wellbeing experts at the public level are very much aware of the health framework and its functionalities, this would be the vital driver in the medical care achievement in Pakistan (Khoja, 2006).

The public authority of Pakistan consumes 3.1 percent of its GDP on monetary, social and neighborhood and 43 percent is spent on commitment servicing.¹² About 0.8 percent is spent on clinical consideration, which is even lower than Bangladesh (1.2 percent) and Sri Lanka (1.4 percent). Regardless, the prosperity status of the general population has improved throughout the most recent thirty years, the speed of immunization of children has significantly expanded, and the data on family organizing has extended shockingly and is essentially broad (Bloom et al., 2000).

2.6. Lack of education and diagnosis of disease

As of late, examiners have become mindful that techniques for diagnosing and assessing different intellectual and neurological problems are affected by the education abilities of then patient being assessed. For example, appearances of aphasia (talk adversity) following stroke contrast in literates and untalented individuals, and the degree of outstanding incapacity can be evaluated wrongly if capability status isn't considered (Lecours et al., 1987).

There is verification suggesting that oblivious individuals show a degree of bi-hemispheric control of language fill in instead of the regular left-hemispheric strength of literates. Moreover, there have been signs that ear power changes among literates and incompetent individuals, yet this has not been attested (Castro and Morais, 1987).

Essentially, assessments of dementia, which clearly should consider a person's instructive fulfillment and local language, should likewise think about a person's proficiency status.

Extraordinary instruments have been created to quantify intellectual debilitation in more established people with helpless proficiency abilities. Instruments have furthermore been expected for use in oblivious patients to measure various components of psycho conduct prosperity, for instance, agony and various issues; these instruments may likewise be helpful in the assessment of patients with perusing/composing issues other than lack of education.

Given the unusual thought of the clinical benefits transport system in Pakistan and the confined resources open to the clinical consideration region, it is central for the various regions to plan and collaborate to improve the strength of Pakistanis. Thusly it is basic to hold the prosperity searching for lead of the general population and the parts driving this direct.

CHAPTER 3

DATA AND METHODOLOGY

A cross sectional studies were acted in irregular sample of the population of different areas of Rajanpur district in 2019 according to the monitoring trends and determinants in protocol of effect of literacy in health care. In this study primary and secondary data were used. For primary data through questionnaire had designed. The portion of males are more in this study than females. The questionnaire had filled through interview of the patients in hospitals and health service providers in the basic health units at primary level at tehsil and district hospital at upper level. Questionnaire filled by personal in the hospital of random patients in 2019.

A questionnaire had developed to know the response of the respondent. Where health care unit's Basic health unit, Rural health center, Maternal and child health center, Tehsil headquarter, District headquarter, Multiple indicator cluster survey, District health information system were assessed.

The main area of study was District Rajanpur. It is the backward district of the Punjab Province, therefore it deserves more attention in the field of health and education for growth and development through better healthcare and quality of life that's why we choose this area to study for research. We were analyses the Patients, Doctors, Nurses, LHVs and other staff members in this study.

In this study Stratified random sampling technique and logistic regression model were used. The following hospitals from Rajanpur were included in the study:

1. DHQ Rajanpur
2. THQ Rojhan
3. THQ Jampur

$$\left(\frac{N_i}{N}\right)$$

$$n_i = n\left(\frac{N_i}{N}\right)$$

N_i Shows the number of patients in the hospital

N = Shows the total number of patients in all of the stratum

n = the stratum from each stratum

$$n_1 = N_1/N$$

N_1 = represent the number of patients from Tehsil Rojhan

$$n_2 = N_2/N$$

N_2 = represent the number of patients from Tehsil Rajanpur

$$n_3 = N_3/N$$

N_3 = represent the number of patients from Tehsil Jampur

While N is the total population

Microsoft Excel and SPSS were used to analyze the data and generate results. The details of results were shown through tables and graphs. It served as a baseline study and its finding/results were help out making for a policy to reduce out of pocket spending.

3.1. Descriptive statistics

For results we collect the data of women and men different areas of Rajanpur district of 182 participants. It is the backward district of the Punjab Province; therefore it deserves more attention in the field of health and education for growth and development through better

healthcare and quality of life that's why we have choose this study for research. We analyse the Patients, Doctors, Nurses, LHVs in the study. The results indicate that given below.

Frequency table from patient's perspective.

Table 1: Q1. Area of Respondent

Area	Frequency	Percent	Valid Percent	Cumulative Percent
Rajanpur	62	34.1	34.1	34.1
Jampur	59	32.4	32.4	66.5
Rojhan	61	33.5	33.5	100.0
Total	182	100.0	100.0	

The areas of respondents are mainly from Rajanpur, Jampur and Rojhan. The total participants are 182 and 34.1 percent of people belong from Rajanpur.

Table 2: Q2. Age of the respondent

Age	Frequency	Percent	Valid Percent	Cumulative Percent
Less than 18	42	23.1	23.1	23.1
18 -30	50	27.5	27.5	50.5
30-50	48	26.4	26.4	76.9
Above 50	42	23.1	23.1	100.0
Total	182	100.0	100.0	

The percentage of the participants is more in the range of 18-30. Out of 100% the 27.5% are in the range of 18-30. After this range, more ratios found in 30-50 (26.4%). The ratio is same in less than 18 years and above 50 years. Both are 23.1% and the total participants are 182.

Table 3: Q3. Education of the respondent

Education	Frequency	Percent	Valid Percent	Cumulative Percent
Primary –Matric	56	30.8	30.8	30.8
Inter-graduates	30	16.5	16.5	47.3
Above Master	17	9.3	9.3	56.6
Illiterate	79	43.4	43.4	100.0
Total	182	100.0	100.0	

When we study and collect the data, the illiteracy rate is greater than literacy in these cities. While the people who just Matric passed or just complete primary/secondary level education were (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%) out of the 182 participants. The ratio of illiterate people is greater than the literate people.

Table 4: Q4. Marital status

Marital Status	Frequency	Percent	Valid Percent	Cumulative Percent
Single	34	18.7	18.7	18.7
Married	133	73.1	73.1	91.8
Widow	10	5.5	5.5	97.3
Divorced/ separated	5	2.7	2.7	100.0
Total	182	100.0	100.0	

The married people are more participate in the study. The ratio of married people is (73.1%). And percentage of single people is (18.7%) and Widow is 5.5% and 5 participants are divorced out of the 182 participants.

Table 5: Q5 What is your type of family?

Type of family	Frequency	Percent	Valid Percent	Cumulative Percent
Single parents' family	173	95.1	95.1	95.1
joint family	9	4.9	4.9	100.0
Total	182	100.0	100.0	

Mainly participants are single parent's family (95.1%) and lived separately from joint family. Remaining 4.9% participants are from joint family out of the 182 participants.

Table 6: Q6 What is your occupation?

Occupation	Frequency	Percent	Valid Percent	Cumulative Percent
Own business	3	1.6	1.6	1.6
Private job	67	36.8	36.8	38.5
Unemployed	67	36.8	36.8	75.3
Farmer	45	24.7	24.7	100.0
Total	182	100.0	100.0	

Major participants are unemployed 36.8% and same percentage of the people having private jobs 36.8%. while 3 participants have own business and remaining 24.7% are farmers. Due to illiteracy in people of these cities the mostly people are unemployed. While the survey none of the participant was from government sector or government job holder in 182 participants

Table 7: Q7 What is your monthly income?

Monthly income in rupee	Frequency	Percent	Valid Percent	Cumulative Percent
Less than 20000	65	35.7	35.7	35.7
21000-30000	100	54.9	54.9	90.7
31000-45000	5	2.7	2.7	93.4
45000 above	12	6.6	6.6	100.0
Total	182	100.0	100.0	

Due to illiteracy rate more in people than the income level low in most of the respondents. The (35.7%) people earned Less than 20,000rupee. And most of the people (54.9%)

people earned between the ranges of 31000-45000rupee. And just 12 participants (6.6%) earned above 45000rupee out of the 182 respondents.

Table 8: Q8. What is your housing condition?

Housing	Frequency	Percent	Valid Percent	Cumulative Percent
Katcha	85	46.7	46.7	46.7
Concrete	76	41.8	41.8	88.5
Mixed	21	11.5	11.5	100.0
Total	182	100.0	100.0	

Mostly people 85 participants having low quality home katcha (46.7%) due to unemployment, lack of resources and low salary budget. While 76 participants (41.8%) having concrete-based houses and remaining 21 participants the (11.5%) having mixed type houses. While total number of respondents were 182.

Table 9: Q9. What is your family position in community where do you live?

Family position	Frequency	Percent	Valid Percent	Cumulative Percent
Upper class	7	3.8	3.8	3.8
Middle class	31	17.0	17.0	20.9
Lower middle class	101	55.5	55.5	76.4
Poor	43	23.6	23.6	100.0
Total	182	100.0	100.0	

The family level is most of the participants are lower middle class 101 participants about more than half of the participants (55.5%) due to illiteracy and unemployment. Then the (23.6%)

about 43 participants are found in poor class. 31 participants (17.0%) are from middle class. While just 7 participants (3.8%) are from upper class out of the 182 participants.

Table 10: Q10. How many family members are income generators?

Income generators	Frequency	Percent	Valid Percent	Cumulative Percent
1	54	29.7	29.7	29.7
2	100	54.9	54.9	84.6
3	25	13.7	13.7	98.4
Above 4	3	1.6	1.6	100.0
Total	182	100.0	100.0	

The 100 participants respond that just 2 members are income generator in a family (54.9%). Then 54 respondents respond that only 1 member generate the income in the family (29.7%). While the 25 respondents respond that 3 members of the family generate the income (13.7%) and just 3 participants respond that above 4 members of the family generate the income which is about (1.6%). The total number of the participants were 182.

Table 11: Q11. How many family members are student?

Student	Frequency	Percent	Valid Percent	Cumulative Percent
1	89	48.9	48.9	48.9
2	39	21.4	21.4	70.3
3	19	10.4	10.4	80.8
Non	35	19.2	19.2	100.0
Total	182	100.0	100.0	

In this area the greatest number of students in a family is 1 and 89 respondents (48.9%) respond. While 39 respondents respond that the 2 members of the family are student which are (21.4%) and just 19 respondents respond that the 3 members of the family are student (10.4%). And then the 35 respondents which are 19.2%) responds that none of the family member are student in the family. While the total number of respondents were 182.

Table 12: Q12. Who pays or affords your educational expenditure?

Educational expenditures	Frequency	Percent	Valid Percent	Cumulative Percent
Own	13	7.1	7.1	7.1
Brother	48	26.4	26.4	33.5
Sister	5	2.7	2.7	36.3
Father	74	40.7	40.7	76.9
Non	42	23.1	23.1	100.0
Total	182	100.0	100.0	

In most of the families' father affords or pay the educational and other expenditure. In this study the 74 respondents respond that father afford the educational expenditures the percentage of father pays expenditure is 40.7%. After this the respondents who said that brother affords or pays the educational expenditures are 48 respondents who are (26.4%). Then 42 participants (23.1%) respond that no one can bear the educational expenditures. While 13 members respond (7.1%) that they afford their educational expenditures by own. A little bit ratio 5 respondents (2.7%) respond that sister can afford the educational expenditures while the total number of the respondents were 182.

Table 13: Q13Can you find information about symptoms of illnesses that Concern you

Symptom's info		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	125	68.7	68.7	68.7
	No	57	31.3	31.3	100.0
	Total	182	100.0	100.0	

The participants 125 which are about (68.7%) know the disease or symptoms of disease that they have concern. While the 57 respondents (31.3%) respond that they don't know about the symptoms of disease that they concern. The total number of the participants are 182.

Table 14: Q14Do you know what to do in case of a medical Emergency?

Medical emergency		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	134	73.6	73.6	73.6
	No	48	26.4	26.4	100.0
	Total	182	100.0	100.0	

The fast internet era or having smart cell phone they know the many cases of emergency in medical or anything else. The 134 participants (73.6%) know what they do in emergency. While the 48 participants (26.4%) do not know what to do in an emergency. Most of the participants who do not know what to do in an emergency are illiterate. The total number of participants were 182.

Table 15: Q15Do you understand what your doctor says to you?

Understanding		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	102	56.0	56.0	56.0
	No	80	44.0	44.0	100.0
	Total	182	100.0	100.0	

Most of the participants 102 which are (56.0%) respond yes, it means they understand that what doctors says to them. While 80 participants (44.0%) respond that they don't understand what a doctor says to them. The total participants in the research were 182.

Table 16: Q16.Can you understand your doctor's or pharmacist's Instruction on how to take a prescribed medicine?

Instructions		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	161	88.5	88.5	88.5
	No	21	11.5	11.5	100.0
	Total	182	100.0	100.0	

The 161 participants (88.5%) respond that they understand the instruction on taking the medicine which are prescribed but 21 respondents about (11.5%) respond that they don't understand the instructions which are prescribed. While total number of respondents are 182.

Table 17: Q17.Are you capable of judging the advantages and disadvantages of different treatment options?

Treatment options		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	77	42.3	42.3	42.3
	No	105	57.7	57.7	100.0
	Total	182	100.0	100.0	

Most of the participants 105 which are (57.7%) are not capable of judging the advantages and disadvantages of the different options because of the illiteracy. While 77 participants (42.3%) can judge the advantages and disadvantages of the different options while total number of participants are 182.

Table 18: Q18.Can you make a call to ambulance in an emergency?

Emergency call		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	130	71.4	71.4	71.4
	No	52	28.6	28.6	100.0
	Total	182	100.0	100.0	

Then most of the participants 130 which are (71.4%) know that they make a call to ambulance in an emergency. And 52 respondents (28.6%) respond that they don't make a call to ambulance because of illiteracy and unavailability of the mobile phone and services. While the total number of the participants are 182.

Table 19: Q19.Can you manage mental health problems like stress or depression?

Manage stress		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	90	49.5	49.5	49.5
	No	92	50.5	50.5	100.0
	Total	182	100.0	100.0	

The 92 participants (49.5%) respond that they do not know how to manage the mental health problems while on the other hand the 90 respondents (49.5%) respond that they know that how to manage the mental health like stress or depression. The total number of the respondents are 182.

Table 20: Q20.Can you find information about vaccinations and health screenings (such as breast exam, blood test, sugar test, blood pressure) that you should have?

Vaccinations info		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	182	100.0	100.0	100.0

All participants 182 responds that they do not find information about any vaccinations and health screenings such as breast exam, blood test, sugar test, blood pressure) that they have any of the disease.

Table 21: Q21.Do you know how to prevent or manage conditions like being overweight, high blood pressure or high cholesterol?

Manage Conditions		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	49	26.9	26.9	26.9
	No	132	72.5	72.5	99.5
	Total	182	100.0	100.0	

A large portion of the members 132 which are (72.5%) do not know about how to prevent or manage conditions like being overweight, hypertension or high cholesterol. On the other hand, 49 of the participants (26.9%) are known about how to prevent or manage conditions like being overweight, hypertension or high cholesterol, because most of the participants who knows information were literate. While the total number of the participants were 182.

Table 22: Q22.Do you understand why you need vaccinations?

Need of vaccinations		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	19	10.4	10.4	10.4
	No	163	89.6	89.6	100.0
	Total	182	100.0	100.0	

Most of the participants 163 which are (89.6%) don't know about the need of vaccinations. They go to the hospital when they become sick. While just 19 of the participants (10.4%) understand the need of vaccinations. The total number of the participants are 182.

Table 23: Q23.Can you decide how you can protect yourself from illness based on information in the media (such as Newspaper, leaflets, Internet or other media)?

Info in media		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	11	6.0	6.0	6.0
	No	171	94.0	94.0	100.0
	Total	182	100.0	100.0	

The 171 participants (94.0%) responds that they do not know about how to decide to protect their self from illness based on information in the media (such as Newspaper, leaflets, Internet or other media), because most of the respondents were illiterate. On the other hand, just 11 of the participants (6.0%) respond yes, that they know the information to protect them self because the use of media, internet and reading habits of newspapers. While the total number of the respondents are 182.

Table 24: Q24.Can you find out about activities (such as meditation, exercise, walking, Pilates etc.) that are good for your mental health?

Activities		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	82	45.1	45.1	45.1
	No	100	54.9	54.9	100.0
	Total	182	100.0	100.0	

Most of the participants 100 which are about (54.9% do not know about activities (such as meditation, exercise, walking, Pilates etc.) that are good for mental health. The 82 respondents (45.1%) respond yes that they know about activities (such as meditation, exercise, walking,

Pilates etc.) that are good for mental health. The 82 respondents respond yes, most of the participants were illiterate while overall participants in the research were 182.

Table 25: Q25.Do you know any activities that improve health in your community?

Improve health		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	117	64.3	64.3	64.3
	No	65	35.7	35.7	100.0
	Total	182	100.0	100.0	

The 117 participants (64.3%) capable of knowing the activities that improve health in community. Then 65 of the participants (35.7%) respond no, they don't know any activities that improve health status in community. While the total number of the participants are 182.

Table 26: Q26.How much you pay per visit?

Pay per visit in rupee		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	100-1000	88	48.4	48.4	48.4
	1100-2000	70	38.5	38.5	86.8
	2100-3000	5	2.7	2.7	89.6
	More than 3000	19	10.4	10.4	100.0
	Total	182	100.0	100.0	

The 88 participants about (48.4%) pay small amount that ranges between 100-1000 rupee. And after this the participants who pays 1100-2000 rupee are 70 which are about (38.5%). Then the 19 participants (10.4%) who have the major type of the disease pay the more than 3000rupee per visit. While the 5 respondents (2.7%) respond that they pay 2100-3000rupee per visit. While the total number of the participants are 182.

Table 27: Q27.How many visits do you have for treatment in a month?

Visits in a month		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	27	14.8	14.8	14.8
	2	12	6.6	6.6	21.4
	3	42	23.1	23.1	44.5
	4	101	55.5	55.5	100.0
	Total	182	100.0	100.0	

The 101 participants (55.5%) responds that they visit hospital 4 times in a month for treatment. Then the 42 respondents (23.1%) respond they visit 3 times in a month and 27 participants (14.8%) respond that they visit just 1 time in a month to the hospital. While just 12 participants (6.6%) respond that they visit the hospital 2 times in a month for the treatment. The total number of the participants in the study are 182.

Table 28: Q28.How much you pay for the whole treatment?

Pay for treatment in rupee		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-500	8	4.4	4.4	4.4
	600-1000	50	27.5	27.5	31.9
	1100-1500	63	34.6	34.6	66.5
	Above 2000	61	33.5	33.5	100.0
	Total	182	100.0	100.0	

Major portion of the participants 63 which is (34.6%) pay amount that ranges between 1100-1500 rupee. And after this the 61 participants (33.5%) respond that they pay above 2000 rupee. Then the 50 participants (27.5%) respond that they pay 600-1000rupee for whole

treatment and just 8 participants (4.4%) respond that they pay between 1-500rupee. While the total number of the respondents are 182.

Table 29: Q29.What is your source of payment?

Source of payment		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Own	118	64.8	64.8	64.8
	Borrowed	59	32.4	32.4	97.3
	Other	5	2.7	2.7	100.0
	Total	182	100.0	100.0	

Major portion of the participants 118 afford own payment which are the (64.8%). Then Some of the (32.4%) participants 59 respond that they get loan or borrow the amount to visit the hospital for treatment and a little bit portion 5 participants (2.7%) have support of other sources for the treatment as like NGOs, Insaf card, BISP etc. while the total number of the participants are 182.

Table 30: Q30.What is your travelling cost to and from the health facility center?

Traveling cost in rupee		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	100-300	59	32.4	32.4	32.4
	400-700	77	42.3	42.3	74.7
	800-1200	43	23.6	23.6	98.4
	Above 1500	3	1.6	1.6	100.0
	Total	182	100.0	100.0	

The 77 participants (42.3%) respond that their travelling cost is in ranges between 400 to 700 rupees. And after this the 59 participants which are (32.4%) range is 100-300 rupee. The 43 participants (23.6%) respond that they bear 800-1200rupee traveling cost and just 3 respondents (1.6%) respond that they spent above 1500rupeeon traveling cost according to the distance from home to the hospital. While the total number of the participants are 182.

Table 31: Q31.What is your food cost?

Food cost in rupee		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	100-500	100	54.9	54.9	54.9
	600-1000	78	42.9	42.9	97.8
	1100-1500	4	2.2	2.2	100.0
	Total	182	100.0	100.0	

Major portion of the participants 100 which are (54.9%) spend on food cost in small amount that ranges between 100 to 500 rupees. And after this the 78 participants (42.9%) respond that they bear the food cost range is 600-1000 rupee. And just 4 participants (2.2%) respond that the food cost they bear ranges 1100-1500rupee. While the total respondents in the study are 182.

Table 32: Q32.What is your medicine cost?

Medicine cost in rupee		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	100-300	21	11.5	11.5	11.5
	400-700	10	5.5	5.5	17.0
	800-1500	120	65.9	65.9	83.0
	Above 2000	31	17.0	17.0	100.0
	Total	182	100.0	100.0	

Most of the participants 120 responds (65.9%) that the medicine cost is ranges between 800 to 1500 rupee. And after this the 21 respondents (11.5%) respond that their medicine cost range is 100-300 rupee. Then the 31 participants who are (17.0%) spend above 20000 rupee depends on their budget and treatment of illness. While the total number of participants in the study are 182.

Table 33: Q33.What is your x-ray or lab tests cost?

Tests cost in rupee		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	100-300	147	80.8	80.8	80.8
	400-700	34	18.7	18.7	99.5
	Above 1500	1	.5	.5	100.0
	Total	182	100.0	100.0	

Major portion 147 participants (80.8%) have x-ray or lab tests cost is in small amount that ranges between 100 to 300 rupees. And after this the 34 participants (18.7%) range is 400-

700 rupee. Some of the tests which are important for treatment and yet not available in the hospital performed from out of the hospital from private test labs. The cost of such type of tests are above 1500 rupee and just 1 participant (0.5%) respond in the range of above 1500rupee pay for the x-ray or lab tests cost. While the total number of the respondents are 182.

Table 34: Q34.Is any financial support available to you from?

Financial support		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Government	31	17.0	17.0	17.0
	No	151	83.0	83.0	100.0
	Total	182	100.0	100.0	

Major portion 151 participants (83.0%) respond that they have not any financial support available. While 31 respondents (17.0%) have financial support from Government, NGOs and some of the friends and relatives. The total number of the respondents are 182.

3.2. Cross tabulation from patient's perspective

Table 35:Q3. Education * Q2. Age of the respondent * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q2. Age of the respondent				Total
			Less than 18	18 -30	30-50	Above 50	
Rajanpur	Education	Primary – Matric	4	10	9	4	27
		Inter-graduates	2	1	2	2	7
		Above Master	2	2	3	2	9
		Illiterate	6	6	3	4	19
	Total		14	19	17	12	62
Jampur	Education	Primary – Matric	2	3	2	7	14
		Inter-graduates	13	6	1	3	23
		Above Master	4	2	0	2	8
		Illiterate	0	3	5	6	14
	Total		19	14	8	18	59
Rojhan	Education	Primary – Matric	1	4	7	3	15
		Illiterate	8	13	16	9	46
	Total		9	17	23	12	61
Total	Education	Primary – Matric	7	17	18	14	56
		Inter-graduates	15	7	3	5	30
		Above Master	6	4	3	4	17
		Illiterate	14	22	24	19	79
	Total		42	50	48	42	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these cities because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). The age of the participants is more in the range of 18-30. Out of 100% the 27.5% are in the range of 18-30. After this range, more ratio is found in 30-50 (26.4%). The ratio is same in less than 18 years and above 50 years. Both are 23.1%.

Table 36: Q3. Education * Q4. Marital status * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q4. Marital status			
			Single	Married	Widow	Divorced/ separated
Rajanpur	Education	Primary – Matric	11	15	1	0
		Inter-graduates	0	7	0	0
		Above Master	1	3	5	0
		Illiterate	5	9	0	5
	Total		17	34	6	5
Jampur	Education	Primary – Matric	6	7	1	
		Inter-graduates	5	18	0	
		Above Master	2	5	1	
		Illiterate	3	9	2	
	Total		16	39	4	
Rojhan	Education	Primary – Matric	1	14		
		Illiterate	0	46		
	Total		1	60		
Total	Education	Primary – Matric	18	36	2	0
		Inter-graduates	5	25	0	0
		Above Master	3	8	6	0
		Illiterate	8	64	2	5
	Total		34	133	10	5

Mostly the participants are married. Due to the illiteracy and villages customs and traditions they get married early. The ratio of married people is (73.1%). And percentage of single people is (18.7%) and Widow is 5.5% and 5 participants are divorced.

Table 37: Q3. Education * Q5 What is your type of family? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q5 What is your type of family?		Total
			Single parents' family	Joint Family	
Rajanpur	Education	Primary -Matric	27		27
		Inter-graduates	7		7
		Above Master	9		9
		Illiterate	19		19
	Total		62		62
Jampur	Education	Primary -Matric	14		14
		Inter-graduates	23		23
		Above Master	8		8
		Illiterate	14		14
	Total		59		59
Rojhan	Education	Primary -Matric	13	2	15
		Illiterate	39	7	46
	Total		52	9	61
Total	Education	Primary -Matric	54	2	56
		Inter-graduates	30	0	30
		Above Master	17	0	17
		Illiterate	72	7	79
	Total		173	9	182

When we study and collect the data, it knows mostly are Matric passed or complete primary/secondary level education (30.8%). More participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. Mainly participants are single parent's family (95.1%) and lived separately from joint family. Remaining 4.9% participants are from joint family.

Table 38: Q3. Education * Q6 What is your occupation? * Q1. Area of Respondent Crosstabulation

Q1.Area of Respondent			Q6 What is your occupation?				Total
			Own business	Private job	Unemployed	Farmer	
Rajanpur	Education	Primary – Matric	1	13	13		27
		Inter-graduates	0	4	3		7
		Above Master	1	8	0		9
		Illiterate	1	14	4		19
	Total		3	39	20		62
Jampur	Education	Primary – Matric		7	7		14
		Inter-graduates		10	13		23
		Above Master		3	5		8
		Illiterate		2	12		14
	Total			22	37		59
Rojhan	Education	Primary – Matric		0	1	14	15
		Illiterate		6	9	31	46
	Total			6	10	45	61
Total	Education	Primary – Matric	1	20	21	14	56

		Inter-graduates	0	14	16	0	30
		Above Master	1	11	5	0	17
		Illiterate	1	22	25	31	79
	Total		3	67	67	45	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these cities because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Major portion of the participants are unemployed 36.8% and some having private jobs 36.8%. While 3 participants have their own business and remaining 24.7% are related to the (agriculture sector) farmers. Due to illiteracy rate more in people of these areas the mostly people are uneducated and unemployed.

Table 39: Q3. Education * Q7What is your monthly income? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q7What is your monthly income?				Total
			Less than 20000	21000-30000	31000-45000	45000 above	
Rajanpur	Education	Primary - Matric	9	13	5		27
		Inter-graduates	0	7	0		7
		Above Master	7	2	0		9
		Illiterate	7	12	0		19
Total			23	34	5		62
Jampur	Education	Primary - Matric	0	12		2	14

		Inter-graduates	0	15		8	23
		Above Master	0	7		1	8
		Illiterate	1	12		1	14
	Total		1	46		12	59
Rojhan	Education	Primary - Matric	12	3			15
		Illiterate	29	17			46
	Total		41	20			61
Total	Education	Primary - Matric	21	28	5	2	56
		Inter-graduates	0	22	0	8	30
		Above Master	7	9	0	1	17
		Illiterate	37	41	0	1	79
	Total		65	100	5	12	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. After the research we find the results that, the literacy rate more in these areas because most participants are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, most of the participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). In the district Rajanpur the tehsil Rojhan is most backward area. Due to illiteracy rate more in these areas than the income level is low. Most of the respondents earned less than 20,000. Some people earned between the ranges of 31000-45000. And just 12 participants earned above 45000.

Table 40:Q3. Education * Q8. What is your housing condition? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q8. What is your housing condition?			Total
			Katcha	Concrete	Mixed	
Rajanpur	Education	Primary -Matric	6	20	1	27
		Inter-graduates	0	4	3	7
		Above Master	1	7	1	9
		Illiterate	4	10	5	19
	Total		11	41	10	62
Jampur	Education	Primary -Matric	6	8		14
		Inter-graduates	9	14		23
		Above Master	3	5		8
		Illiterate	6	8		14
	Total		24	35		59
Rojhan	Education	Primary -Matric	9		6	15
		Illiterate	41		5	46
	Total		50		11	61
Total	Education	Primary -Matric	21	28	7	56
		Inter-graduates	9	18	3	30
		Above Master	4	12	1	17
		Illiterate	51	18	10	79
	Total		85	76	21	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Mostly people having low quality home due to unemployment and low salary budget and limited resources. In Jampur no one participant have mixed type of the house quality while in Rojhan

major portion of the participants live in Katcha type of the housing quality. While in Rajanpur the concrete type of housing quality is greater than other type of houses.

Table 41: Q3. Education * Q9. What is your family position in community where do you live? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q9. What is your family position in community where do you live?				Total
			Upper class	Middle class	Lower middle class	Poor	
Rajanpur	Education	Primary - Matric		4	19	4	27
		Inter-graduates		5	2	0	7
		Above Master		5	4	0	9
		Illiterate		6	7	6	19
	Total			20	32	10	62
Jampur	Education	Primary - Matric	0	1	13		14
		Inter-graduates	5	2	16		23
		Above Master	1	5	2		8
		Illiterate	1	2	11		14
	Total		7	10	42		59
Rojhan	Education	Primary - Matric		1	5	9	15
		Illiterate		0	22	24	46
	Total			1	27	33	61
Total	Education	Primary - Matric	0	6	37	13	56
		Inter-graduates	5	7	18	0	30
		Above Master	1	10	6	0	17
		Illiterate	1	8	40	30	79

	Total	7	31	101	43	182
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The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). The family level is most of the participants are middle class and lower middle class due to illiteracy, unemployment, and lack of resources. Then the most are found in poor class. From overall participants just 7 participants from Jampur found in the upper-class level.

Table 42: Q3. Education * Q10.How many family members are income generators? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q10. How many family members are income generators?				Total
			1	2	3	Above 4	
Rajanpur	Education	Primary - Matric	9	15	3		27
		Inter-graduates	4	3	0		7
		Above Master	0	7	2		9
		Illiterate	0	14	5		19
	Total		13	39	10		62
Jampur	Education	Primary - Matric	1	6	7		14
		Inter-graduates	4	17	2		23
		Above Master	1	6	1		8
		Illiterate	2	7	5		14

	Total		8	36	15		59
Rojhan	Education	Primary - Matric	8	5		2	15
		Illiterate	25	20		1	46
	Total		33	25		3	61
Total	Education	Primary - Matric	18	26	10	2	56
		Inter- graduates	8	20	2	0	30
		Above Master	1	13	3	0	17
		Illiterate	27	41	10	1	79
	Total		54	100	25	3	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these cities because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). The income generators mostly 2 members of one home are earned (54.9%). Then mostly participants respond that only 1-member family is income generator. While just 3 participants respond that above 4 family members are income generators.

Table 43: Q3. Education * Q11.How many family members are students? * Q1. Area of Respondent Cross tabulation

Q1. Area of Respondent			Q11.How many family members are students?				Total
			1	2	3	non	
Rajanpur	Education	Primary – Matric	16	5	6		27
		Inter-graduates	1	4	2		7
		Above Master	2	7	0		9
		Illiterate	8	10	1		19
	Total		27	26	9		62
Jampur	Education	Primary – Matric	12	2	0		14
		Inter-graduates	16	2	5		23
		Above Master	5	3	0		8
		Illiterate	13	1	0		14
	Total		46	8	5		59
Rojhan	Education	Primary – Matric	2	0	1	12	15
		Illiterate	14	5	4	23	46
	Total		16	5	5	35	61
Total	Education	Primary – Matric	30	7	7	12	56
		Inter-graduates	17	6	7	0	30
		Above Master	7	10	0	0	17
		Illiterate	35	16	5	23	79
	Total		89	39	19	35	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master

level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). In most of the families just 1 family member is student which are 89 participants respond out of 182. While 39 respondents respond that 2 family members are student, and 19 respondents respond 3 members of a family are student. Then 35 participants respond that no one of the family member is student.

Table 44: Q3. Education * Q12. Who pay or afford your educational expenditure? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q12. Who pay or afford your educational expenditure?					Total
			Own	Brother	Sister	Father	non	
Rajanpur	Education	Primary - Matric		13		14		27
		Inter-graduates		2		5		7
		Above Master		4		5		9
		Illiterate		10		9		19
	Total		29		33		62	
Jampur	Education	Primary - Matric	1	3	1	9		14
		Inter-graduates	1	7	2	13		23
		Above Master	0	0	0	8		8
		Illiterate	1	4	2	7		14
	Total		3	14	5	37		59
Rojhan	Education	Primary - Matric	1	1		1	12	15
		Illiterate	9	4		3	30	46
	Total		10	5		4	42	61
Total	Education	Primary - Matric	2	17	1	24	12	56
		Inter-graduates	1	9	2	18	0	30

		Above Master	0	4	0	13	0	17
		Illiterate	10	18	2	19	30	79
	Total		13	48	5	74	42	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Mostly in a family father affords or pay the educational or other expenditure. In this study the percentage of father pays expenditure is 40.7%. After this the range is 48 participants who respond that brothers afford and just 5 participants respond that sister afford the educational expenditures. While 13 participants afford their expenditures by own.

Table 45: Q3. Education * Q13Can you find information about symptoms of illnesses that Concern you * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q 13. Can you find information about symptoms of illnesses that Concern you		Total
			Yes	No	
Rajanpur	Education	Primary -Matric	27	0	27
		Inter-graduates	4	3	7
		Above Master	9	0	9
		Illiterate	14	5	19
	Total		54	8	62
Jampur	Education	Primary -Matric	11	3	14
		Inter-graduates	20	3	23
		Above Master	6	2	8
		Illiterate	14	0	14
	Total		51	8	59

Rojhan	Education	Primary -Matric	1	14	15
		Illiterate	19	27	46
	Total			20	41
Total	Education	Primary -Matric	39	17	56
		Inter-graduates	24	6	30
		Above Master	15	2	17
		Illiterate	47	32	79
	Total			125	57

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Major portion of the participants 125 respond yes, that they know the symptoms of disease that they have concern. On the other hand, 57 participants respond no, that they do not know the symptoms of disease that they have concern.

Table 46: Q3. Education * Q14Do you know what to do in case of a medical Emergency? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q 14. Do you know what to do in case of a medical Emergency?		Total
			Yes	No	
Rajanpur	Education	Primary -Matric	27		27
		Inter-graduates	7		7
		Above Master	9		9
		Illiterate	19		19
	Total		62		62
Jampur	Education	Primary -Matric	14		14

		Inter-graduates	23		23
		Above Master	8		8
		Illiterate	14		14
	Total		59		59
Rojhan	Education	Primary -Matric	4	11	15
		Illiterate	9	37	46
	Total		13	48	61
Total	Education	Primary -Matric	45	11	56
		Inter-graduates	30	0	30
		Above Master	17	0	17
		Illiterate	42	37	79
	Total		134	48	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Most of the participants 134 know that what to do in any emergency. But 48 respondents respond that they do not know what to do in any emergency because of unavailability of the resources, services and mainly the illiteracy. The 48 participants who respond no are from Rojhan.

Table 47:Q3. Education * Q15Do you understand what your doctor says to you? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q15. Do you understand what your doctor says to you?		Total
			Yes	No	
Rajanpur	Education	Primary -Matric	6	21	27
		Inter-graduates	5	2	7
		Above Master	4	5	9
		Illiterate	16	3	19
	Total		31	31	62
Jampur	Education	Primary -Matric	7	7	14
		Inter-graduates	19	4	23
		Above Master	6	2	8
		Illiterate	6	8	14
	Total		38	21	59
Rojhan	Education	Primary -Matric	9	6	15
		Illiterate	24	22	46
	Total		33	28	61
Total	Education	Primary -Matric	22	34	56
		Inter-graduates	24	6	30
		Above Master	10	7	17
		Illiterate	46	33	79
	Total		102	80	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more

people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Then most of the participants 102 understand that what doctor suggest them. In Rajanpur, the ratio of respondents who respond yes are 31 and who respond no are same 31 as well. While 80 participants respond no that they do not understand that what doctors says to them.

Table 48: Q3. Education * Q16.Can you understand your doctor’s or pharmacist’s Instruction on how to take a prescribed medicine? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q16.Can you understand your doctor’s or pharmacist’s Instruction on how to take a prescribed medicine?		Total
			Yes	No	
Rajanpur	Education	Primary -Matric	27		27
		Inter-graduates	7		7
		Above Master	9		9
		Illiterate	19		19
	Total		62		62
Jampur	Education	Primary -Matric	14		14
		Inter-graduates	23		23
		Above Master	8		8
		Illiterate	14		14
	Total		59		59
Rojhan	Education	Primary -Matric	10	5	15
		Illiterate	30	16	46

	Total		40	21	61
Total	Education	Primary -Matric	51	5	56
		Inter-graduates	30	0	30
		Above Master	17	0	17
		Illiterate	63	16	79
	Total		161	21	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more participants are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). The 161 participants respond yes that they know the pharmacist instructions and how to take a prescribed medicine. Then the 21 participants respond no that they don't understand that what a doctor or pharmacist prescribed medicine and all of them (21) are from tehsil Rojhan.

Table 49: Q3. Education * Q17.Are you capable of judging the advantages and disadvantages of different treatment options? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q17.Are you capable of judging the advantages and disadvantages of different treatment options?		Total
			Yes	No	
Rajanpur	Education	Primary –Matric	12	15	27
		Inter-graduates	1	6	7
		Above Master	9	0	9
		Illiterate	17	2	19

	Total		39	23	62
Jampur	Education	Primary –Matric	7	7	14
		Inter-graduates	15	8	23
		Above Master	4	4	8
		Illiterate	12	2	14
	Total		38	21	59
Rojhan	Education	Primary –Matric		15	15
		Illiterate		46	46
	Total			61	61
Total	Education	Primary –Matric	19	37	56
		Inter-graduates	16	14	30
		Above Master	13	4	17
		Illiterate	29	50	79
	Total		77	105	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). The 77 participants respond yes that they can judge the advantages and disadvantages of different treatment options. Then the major portion of the participants respond no that they don't know and not capable of judging the advantages and disadvantages of different treatment options. And no one participants respond yes from tehsil Rojhan.

Table 50: Q3. Education * Q18.Can you make a call to ambulance in an emergency? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q18.Can you make a call to ambulance in an emergency?		Total
			Yes	No	
Rajanpur	Education	Primary –Matric	27		27
		Inter-graduates	7		7
		Above Master	9		9
		Illiterate	19		19
	Total		62		62
Jampur	Education	Primary –Matric	14		14
		Inter-graduates	23		23
		Above Master	8		8
		Illiterate	14		14
	Total		59		59
Rojhan	Education	Primary –Matric	3	12	15
		Illiterate	6	40	46
	Total		9	52	61
Total	Education	Primary –Matric	44	12	56
		Inter-graduates	30	0	30
		Above Master	17	0	17
		Illiterate	39	40	79
	Total		130	52	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more

people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Major portion of the participants 130 respond yes, they know to make a call to ambulance in an emergency. Then most of the participants 52 respond no, all (52) respondents are from Rojhan. They do not know what they do in case of emergency and how to make a call to ambulance because of illiteracy, unavailability of services, mobile phones and lack of resources as well.

Table 51: Q3. Education * Q19.Can you manage mental health problems like stress or depression? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q19.Can you manage mental health problems like stress or depression?		Total
			Yes	No	
Rajanpur	Education	Primary -Matric	12	15	27
		Inter-graduates	0	7	7
		Above Master	4	5	9
		Illiterate	9	10	19
	Total	25	37	62	
Jampur	Education	Primary -Matric	12	2	14
		Inter-graduates	23	0	23
		Above Master	8	0	8
		Illiterate	13	1	14
	Total	56	3	59	
Rojhan	Education	Primary -Matric	2	13	15
		Illiterate	7	39	46

	Total		9	52	61
Total	Education	Primary -Matric	26	30	56
		Inter-graduates	23	7	30
		Above Master	12	5	17
		Illiterate	29	50	79
	Total		90	92	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). The participants who respond no, are 92. They respond that they do not know how to manage mental health problems like stress or depression. Then the ratio of participants who know how to manage mental health problems like stress or depression are 90 respondents.

Table 52: Q3. Education * Q20.Can you find information about vaccinations and health screenings (such as breast exam, blood test, sugar test, blood pressure) that you should have? * Q1. Area of Respondent Cross tabulation

Q1. Area of Respondent			Q20.Can you find information about vaccinations and health screenings (such as breast exam, blood test, sugar test, blood pressure) that you should have?		Total
			Yes	No	
Rajanpur	Education	Primary -Matric	5	22	27
		Inter-graduates	2	5	7
		Above Master	2	7	9
		Illiterate	3	16	19
	Total		12	50	62
Jampur	Education	Primary -Matric	1	13	14
		Inter-graduates	3	20	23
		Above Master	1	7	8
		Illiterate	4	10	14
	Total		9	50	59
Rojhan	Education	Primary -Matric	2	13	15
		Illiterate	14	32	46
	Total		16	45	61
Total	Education	Primary -Matric	8	48	56
		Inter-graduates	5	25	30
		Above Master	3	14	17
		Illiterate	21	58	79
	Total		37	145	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). The major portion of the participants 145 respondents do not have information about vaccinations and health screenings (such as breast exam, blood test, sugar test, blood pressure) that they have.

While just 37 participants respond yes that they know information about vaccinations and health screenings (such as breast exam, blood test, sugar test, blood pressure) that have.

Table 53: Q3. Education * Q21.Do you know how to prevent or manage conditions like being overweight, high blood pressure or high cholesterol? * Q1. Area of Respondent Cross tabulation

Q1. Area of Respondent			Q21.Do you know how to prevent or manage conditions like being overweight, high blood pressure or high cholesterol?		Total
			Yes	No	
Rajanpur	Education	Primary -Matric	18	9	27
		Inter-graduates	3	4	7
		Above Master	7	2	9
		Illiterate	12	6	19
	Total		40	21	62
Jampur	Education	Primary -Matric	0	14	14
		Inter-graduates	6	17	23
		Above Master	0	8	8
		Illiterate	0	14	14
	Total		6	53	59
Rojhan	Education	Primary -Matric	0	15	15
		Illiterate	3	43	46
	Total		3	58	61
Total	Education	Primary -Matric	18	38	56
		Inter-graduates	9	21	30
		Above Master	7	10	17
		Illiterate	15	63	79

	Total	49	132	182
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The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Major portion of the participants 132 respondents do not know about how to prevent or manage conditions like being overweight, high blood pressure or high cholesterol. While 50 respondents respond yes, they know how to prevent or manage conditions like being overweight, high blood pressure or high cholesterol.

Table 54: Q3. Education * Q22.Do you understand why you need vaccinations? * Q1. Area of Respondent Cross tabulation

Q1. Area of Respondent			Q22. Do you understand why you need vaccinations?		Total
			Yes	No	
Rajanpur	Education	Primary -Matric		27	27
		Inter-graduates		7	7
		Above Master		9	9
		Illiterate		19	19
Total				62	62
Jampur	Education	Primary -Matric		14	14
		Inter-graduates		23	23
		Above Master		8	8

		Illiterate		14	14
	Total			59	59
Rojhan	Education	Primary -Matric	3	12	15
		Illiterate	16	30	46
	Total		19	42	61
Total	Education	Primary -Matric	3	53	56
		Inter-graduates	0	30	30
		Above Master	0	17	17
		Illiterate	16	63	79
	Total		19	163	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). The 163 of the participants are do not know about understand why they need vaccinations. While just 19 of the participants respond that they know why they need vaccination and all of those are from tehsil Rojhan.

Table 55: Q3. Education * Q23.Can you decide how you can protect yourself from illness based on information in the media (such as Newspaper, leaflets, Internet or other media)? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q23.Can you decide how you can protect yourself from illness based on information in the media (such as Newspaper, leaflets, Internet or other media)?		Total
			Yes	No	
Rajanpur	Education	Primary -Matric	0	27	27
		Inter-graduates	2	5	7
		Above Master	1	8	9
		Illiterate	2	17	19
	Total		5	57	62
Jampur	Education	Primary -Matric	3	11	14
		Inter-graduates	0	23	23
		Above Master	0	8	8
		Illiterate	3	11	14
	Total		6	53	59
Rojhan	Education	Primary -Matric		15	15
		Illiterate		46	46
	Total			61	61
Total	Education	Primary -Matric	3	53	56
		Inter-graduates	2	28	30
		Above Master	1	16	17
		Illiterate	5	74	79
	Total		11	171	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Most of the participants 171 respond that they do not know how they can shield themselves from illness dependent on information in the media, (for example, Newspaper, flyers, Internet or other media). Because most of the areas have not the accessibility of media, internet, newspaper and many services. While just 11 participants respond that they have information that how to protect themselves from illness based on such type of services like internet, media, newspaper, and others. The people who have information mostly are from city and literate people.

Table 56: Q3. Education * Q24.Can you find out about activities (such as meditation, exercise, walking, Pilates etc.) that are good for your mental well-being? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q24.Can you find out about activities (such as meditation, exercise, walking, Pilates etc.) that are good for your mental well-being?		Total
			Yes	No	
Rajanpur	Education	Primary -Matric	16	11	27
		Inter-graduates	6	1	7
		Above Master	5	4	9
		Illiterate	13	6	19
	Total	40	22	62	
Jampur	Education	Primary -Matric	10	4	14

		Inter-graduates	8	15	23
		Above Master	5	3	8
		Illiterate	10	4	14
	Total		33	26	59
Rojhan	Education	Primary -Matric	3	12	15
		Illiterate	6	40	46
	Total		9	52	61
Total	Education	Primary -Matric	29	27	56
		Inter-graduates	14	16	30
		Above Master	10	7	17
		Illiterate	29	50	79
	Total		82	100	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). The 100 participants are do not know about activities, (like, meditation, exercise, walking and Pilates) that are useful for mental health. While 82 participants respond yes that they know about activities.

Table 57: Q3. Education * Q25.Do you know any activities that improve health and well-being in your community? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q25.Do you know any activities that improve health and health status in your community?		Total
			Yes	No	
Rajanpur	Education	Primary -Matric	24	3	27
		Inter-graduates	4	3	7
		Above Master	1	8	9
		Illiterate	15	4	19
	Total		44	18	62
Jampur	Education	Primary -Matric	14	0	14
		Inter-graduates	21	2	23
		Above Master	5	3	8
		Illiterate	14	0	14
	Total		54	5	59
Rojhan	Education	Primary -Matric	3	12	15
		Illiterate	16	30	46
	Total		19	42	61
Total	Education	Primary -Matric	41	15	56
		Inter-graduates	25	5	30
		Above Master	6	11	17
		Illiterate	45	34	79
	Total		117	65	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). The fast internet era or having smart cell phone the 117 participants respond yes that they capable of knowing any activities that improve health status in community. While 65 participants respond that they have not any information or do not know any activities that improve the health status in the community because of the illiteracy.

Table 58: Q3. Education * Q26.How much you pay per visit? * Q1.c Area of Respondent Crosstabulation

Q1. Area of Respondent			Q26.How much you pay per visit in rupee?				Total
			100-1000	1100-2000	2100-3000	More than 3000	
Rajanpur	Education	Primary - Matric	13	14			27
		Inter-graduates	2	5			7
		Above Master	6	3			9
		Illiterate	13	6			19
	Total		34	28			62
Jampur	Education	Primary - Matric	9	5			14
		Inter-graduates	15	8			23
		Above Master	6	2			8
		Illiterate	5	9			14
	Total		35	24			59

Rojhan	Education	Primary - Matric	4	4	1	6	15
		Illiterate	15	14	4	13	46
	Total		19	18	5	19	61
Total	Education	Primary - Matric	26	23	1	6	56
		Inter- graduates	17	13	0	0	30
		Above Master	12	5	0	0	17
		Illiterate	33	29	4	13	79
	Total		88	70	5	19	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Most of the participant 88 respondent pay small amount the ranges between 100-1000rupee. And after this the 70 participants respond that they pay 1100-2000rupee. While 5 participants are in the range of 2100-3000 rupee, and 19 respondents are in the range of above 3000rupee pay per visit according to their disease.

**Table 59: Q3. Education * Q27.How many visits do you have for treatment in a month? *
Q1. Area of Respondent Crosstabulation**

Q1. Area of Respondent			Q27.How many visits do you have for treatment in a month?				Total
			1	2	3	4	
Rajanpur	Education	Primary - Matric	4		8	15	27
		Inter-graduates	0		0	7	7
		Above Master	0		1	8	9
		Illiterate	3		3	13	19
	Total		7		12	43	62
Jampur	Education	Primary - Matric	1		5	8	14
		Inter-graduates	1		3	19	23
		Above Master	4		0	4	8
		Illiterate	0		0	14	14
	Total		6		8	45	59
Rojhan	Education	Primary - Matric	4	4	3	4	15
		Illiterate	10	8	19	9	46
	Total		14	12	22	13	61
Total	Education	Primary - Matric	9	4	16	27	56
		Inter-graduates	1	0	3	26	30
		Above Master	4	0	1	12	17
		Illiterate	13	8	22	36	79
	Total		27	12	42	101	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more

people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Major portion of the participants 101 respond that they visit hospital 4 times in a month for treatment according to the disease. When there is increase in unemployment and the illiteracy rate than also the health problems increase major seen in elderly. Then 42 participants visit a hospital 3 times 27 respond that they visit just 1 time in a month and 12 respondents respond that they visit hospital 2 times in a month according to the health issues.

Table 60: Q3. Education * Q28.How much you pay for the whole treatment? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q28.How much you pay for the whole treatment in rupee?				Total
			1-500	600-1000	1100-1500	Above 2000	
Rajanpur	Education	Primary - Matric		5	9	13	27
		Inter-graduates		0	4	3	7
		Above Master		4	1	4	9
		Illiterate		4	10	5	19
	Total		13	24	25	62	
Jampur	Education	Primary - Matric	1	7	6	0	14
		Inter-graduates	1	9	1	12	23
		Above Master	3	1	1	3	8
		Illiterate	0	10	2	2	14
	Total		5	27	10	17	59
Rojhan	Education	Primary - Matric	1	4	5	5	15

		Illiterate	2	6	24	14	46
	Total		3	10	29	19	61
Total	Education	Primary - Matric	2	16	20	18	56
		Inter- graduates	1	9	5	15	30
		Above Master	3	5	2	7	17
		Illiterate	2	20	36	21	79
	Total		8	50	63	61	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Majority of the participants 63 respondents pay in the ranges between 1100-1500rupee. And after this the range is above 2000rupee according to disease. Then the 50 participants respond that they pay the range between 600-1000rupee and just 8 participants are pay 1-500rupee for the whole treatment.

Table 61: Q3. Education * Q29.What is your source of payment? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q29.What is your source of payment?			Total
			Own	Borrowed	Other	
Rajanpur	Education	Primary – Matric	4	21	2	27
		Inter-graduates	3	4	0	7
		Above Master	8	1	0	9
		Illiterate	10	7	2	19
	Total		25	33	4	62
Jampur	Education	Primary – Matric	12	2	0	14
		Inter-graduates	15	7	1	23
		Above Master	8	0	0	8
		Illiterate	14	0	0	14
	Total		49	9	1	59
Rojhan	Education	Primary – Matric	9	6		15
		Illiterate	35	11		46
	Total		44	17		61
Total	Education	Primary – Matric	25	29	2	56
		Inter-graduates	18	11	1	30
		Above Master	16	1	0	17
		Illiterate	59	18	2	79
	Total		118	59	5	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more participants are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Major portion of the participants 118 have afford their own payment. While 59 participants

respond that they borrow the payment to visit the hospital. Just 5 of the participants have other sources like BISP, Insaf sehat card, NGOs and some have the support of friends and relatives.

Table 62: Q3. Education * Q30.What is your travelling cost to and from the health facility center? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q30.What is your travelling cost to and from the health facility center in rupee?				Total
			100-300	400-700	800-1200	Above 1500	
Rajanpur	Education	Primary - Matric	6	16	5	0	27
		Inter-graduates	4	1	2	0	7
		Above Master	1	5	0	3	9
		Illiterate	2	6	11	0	19
	Total		13	28	18	3	62
Jampur	Education	Primary - Matric	0	10	4		14
		Inter-graduates	11	9	3		23
		Above Master	0	7	1		8
		Illiterate	4	3	7		14
	Total		15	29	15		59
Rojhan	Education	Primary - Matric	7	7	1		15
		Illiterate	24	13	9		46
	Total		31	20	10		61
Total	Education	Primary - Matric	13	33	10	0	56
		Inter-graduates	15	10	5	0	30
		Above Master	1	12	1	3	17
		Illiterate	30	22	27	0	79
	Total		59	77	43	3	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Most of the 77 participants (42.3%) have travelling cost between 400 to 700rupee. And after this the 59 participants range is 100-300rupee. And 43 participants respond that they pay 800-1200rupee while just 3 participants respond that their traveling cost is above 1500rupee according to the distance from home and private or rental vehicles expenditure as well.

Table 63: Q3. Education * Q31.What is your food cost? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q31.What is your food cost in rupee?			Total
			100-500	600-1000	1100-1500	
Rajanpur	Education	Primary -Matric	17	9	1	27
		Inter-graduates	5	2	0	7
		Above Master	7	2	0	9
		Illiterate	8	11	0	19
	Total		37	24	1	62
Jampur	Education	Primary -Matric	5	9	0	14
		Inter-graduates	13	8	2	23
		Above Master	3	5	0	8
		Illiterate	8	5	1	14
	Total		29	27	3	59

Rojhan	Education	Primary -Matric	8	7		15
		Illiterate	26	20		46
	Total		34	27		61
Total	Education	Primary -Matric	30	25	1	56
		Inter-graduates	18	10	2	30
		Above Master	10	7	0	17
		Illiterate	42	36	1	79
	Total		100	78	4	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduatess (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Major portion of the participants 100 respondents (54.9%) respond that food cost ranges is between 100 to 500rupee. And after this the 78 participants respond in range 600-1000rupee. While 4 participants have 1100-1500rupee food cost depends on their budget.

Table 64: Q3. Education * Q32.What is your medicine cost? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q32.What is your medicine cost in rupee?				Total
			100-300	400-700	800-1500	Above 2000	
Rajanpur	Education	Primary - Matric			12	15	27
		Inter-graduates			2	5	7
		Above Master			9	0	9
		Illiterate			19	0	19
	Total			42	20	62	
Jampur	Education	Primary - Matric			11	3	14
		Inter-graduates			20	3	23
		Above Master			8	0	8
		Illiterate			14	0	14
	Total			53	6	59	
Rojhan	Education	Primary - Matric	7	2	4	2	15
		Illiterate	14	8	21	3	46
	Total		21	10	25	5	61
Total	Education	Primary - Matric	7	2	27	20	56
		Inter-graduates	0	0	22	8	30
		Above Master	0	0	17	0	17

		Illiterate	14	8	54	3	79
	Total		21	10	120	31	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). A major portion of the participants 120 respondents which is about (42.3%) respond that their medicine cost is in the ranges between 800 to 1500rupee. And after this the 31 participants range is above 2000rupee. Then 21 participants have the cost between 100-300rupee and just 10 participants respond that their medicine cost is between 400-700 rupee.

Table 65: Q3. Education * Q33.What is your x-ray or lab tests cost? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q33.What is your x-ray or lab tests cost in rupee?			Total
			100-300	400-700	Above 1500	
Rajanpur	Education	Primary – Matric	20	6	1	27
		Inter-graduates	7	0	0	7
		Above Master	7	2	0	9
		Illiterate	5	14	0	19
Total			39	22	1	62
Jampur	Education	Primary – Matric	14			14

		Inter-graduates	23			23
		Above Master	8			8
		Illiterate	14			14
	Total		59			59
Rojhan	Education	Primary – Matric	12	3		15
		Illiterate	37	9		46
	Total		49	12		61
Total	Education	Primary – Matric	46	9	1	56
		Inter-graduates	30	0	0	30
		Above Master	15	2	0	17
		Illiterate	56	23	0	79
	Total		147	34	1	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these areas because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). Major portion of the participants 147 which is (42.3%) respond that x-ray or lab tests cost is in the ranges between 100 to 300rupee. And after this the 34 participants range is 400-700rupee. And just 1 of the overall participants have the x-ray and lab tests cost above 1500 according to the disease and unavailability of the equipment's in the government hospitals respectively.

Table 66: Q3. Education * Q34.Is any financial support available to you from? * Q1. Area of Respondent Crosstabulation

Q1. Area of Respondent			Q34.Is any financial support available to you from Government?		Total
			Yes	No	
Rajanpur	Education	Primary -Matric	9	18	27
		Inter-graduates	0	7	7
		Above Master	1	8	9
		Illiterate	2	17	19
	Total		12	50	62
Jampur	Education	Primary -Matric	3	11	14
		Inter-graduates	8	15	23
		Above Master	0	8	8
		Illiterate	0	14	14
	Total		11	48	59
Rojhan	Education	Primary -Matric	1	14	15
		Illiterate	7	39	46
	Total		8	53	61
Total	Education	Primary -Matric	13	43	56
		Inter-graduates	8	22	30
		Above Master	1	16	17
		Illiterate	9	70	79
	Total		31	151	182

The areas of respondents are Rajanpur, Jampur and Rojhan. The total participants are 182. When we study and collect the data, the literacy rate more in these cities because more people are just Matric passed or just complete primary/secondary level education (30.8%). Then after this, the more participants are in the group of inter-graduates (16.5%). And above master level are 17 participants (9.3%). But most of the participants are non-educated (43.4%). A major portion of the participants 151 are not having any financial support from government. While just 31 participants respond that they have the government financial support.

Frequency Table from service provider perspective

Table 67: Q1. Health facility at?

Health facility		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	THQs Jampur	12	30.0	30.0	30.0
	THQs Rojhan	12	30.0	30.0	60.0
	DHQs Rajanpur	16	40.0	40.0	100.0
	Total	40	100.0	100.0	

In the hospital of DHQ Rajanpur I have collect the data from service providers (Doctors, Nurses, LHVs, MOs, M.S, etc). The participants include in the study from Rajanpur are 16 and include from THQ Rojhan the participants are 12 and the participants from THQ Jampur are 12 as well. While the total number of the participants are 40.

Table 68: Q2. Gender?

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	36	90.0	90.0	90.0
	Female	4	10.0	10.0	100.0
	Total	40	100.0	100.0	

The male's strength is more in the facility centers than females. There are 36 males' (90.0%) participants and just 4 females' (10.0%) respond in the study. While the total number of the participants are 40.

Table 69: Q3. For how long have you worked at this HealthCare Hospital?

Worked at the center		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-3 years	19	47.5	47.5	47.5
	4-7 years	19	47.5	47.5	95.0
	7-10 years	2	5.0	5.0	100.0
	Total	40	100.0	100.0	

The ratio of the participants who worked at the facility center from 1-3 years and 4-7 years is same (47.5%). Just 2 participants (5.0%) respond that they worked at the facility center 7-10 years. The total number of the participants are 40.

Table 70: Q4. Position held at healthcare

	Position held	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Medical superintendent	3	7.5	7.5	7.5
	Additional Medical Superintendent	3	7.5	7.5	15.0
	Deputy Medical superintendent	3	7.5	7.5	22.5
	Physician	3	7.5	7.5	30.0
	Surgeon	3	7.5	7.5	37.5
	Gynecologists	2	5.0	5.0	42.5
	Orth surgeon	1	2.5	2.5	45.0
	Urologist	1	2.5	2.5	47.5
	T.B and chest specialist	1	2.5	2.5	50.0
	Medical officers	12	30.0	30.0	80.0
	Women medical officers	5	12.5	12.5	92.5
	Dental surgeon	2	5.0	5.0	97.5
	Psychologist	1	2.5	2.5	100.0
	Total	40	100.0	100.0	

The medical officers are 12 which is (30.0%) involved in this study. Women medical officers are also 12.5% involved. After this medical superintendent, additional medical superintendent, deputy medical superintendent, physician and surgeon were participating in this study. While the total number of the participants are 40.

Table 71: Q5. Professional qualification

Professional qualification		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Nurse	32	80.0	80.0	80.0
	MBBS	6	15.0	15.0	95.0
	if other specify	2	5.0	5.0	100.0
	Total	40	100.0	100.0	

The nursing staff participants are 32 responds (80.0%). The MBBS doctors are 6 which is (15.0%) and 2 participants are from pharmacist (5.0%). While the total number of the participants are 40.

Table 72: Q6. Any job specialization?

Job specialization		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	7	17.5	17.5	17.5
	No	33	82.5	82.5	100.0
	Total	40	100.0	100.0	

The 33 participants (82.5%) respond no that that have not any job specialization while just 7 of the respondents (17.5%) respond yes, that they have a job specialization. The total number of the participants are 40.

Table 73: Q7. Job title

Job title		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In charge	2	5.0	5.0	5.0
	Doctor	37	92.5	92.5	97.5
	Clinical officers	1	2.5	2.5	100.0
	Total	40	100.0	100.0	

The doctors are 37 which are (92.5%) in the study. The 2 participants are in charge (5.0%) and just 1 of the participants is clinical officer (2.5%). While the total number of the participants are 40.

Table 74: Q8. What is your job responsibility in this hospital?

Job responsibility		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Facility in charge	1	2.5	2.5	2.5
	Unit in charge	3	7.5	7.5	10.0
	Service provider	36	90.0	90.0	100.0
	Total	40	100.0	100.0	

The ratio of the service provider respondents is 36 which is (90.0%) at the facility centers. Then 3 are unit in charge (7.5%) and the 1 is facility in charge (2.5%) at the centers. While the total number of the participants are 40.

Table 75: Q9. Ratio of the patients who visits your clinic is literate or illiterate

Ratio of patients		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Literate A	9	22.5	22.5	22.5
	Illiterate B	21	52.5	52.5	75.0
	Both A&B	10	25.0	25.0	100.0
	Total	40	100.0	100.0	

The ratio of the patients who visits in facility centers are mostly illiterate 21 which is (52.5%). Then 10 respondents (25.0%) respond that both literate and illiterate patients visit the hospital while 9 of the participants (22.5%) respond that literate patients visit the clinic. The total number of the participants are 40.

Table 76: Q10.What you think, which patients are easy to treat

Patients easy to treat		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Literate	40	100.0	100.0	100.0

The all of the respondents 40 respond that the literate patients are easy to treat because they know most of the symptoms and well in to describe the problem. While the total number of the participants are 40.

Table 77: Q11. From your experience which patients recovered early?

Patients recovered early		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Literate	30	75.0	75.0	75.0
	Illiterate	10	25.0	25.0	100.0
	Total	40	100.0	100.0	

The 30 participants which is (75.0%) are respond that literate patients recover early. They can listen and read the precautions about their health and disease. From the experience of the 10 participants (25.0%) respond that illiterate patients recovered early according to the disease pattern. The total number of the participants are 40.

Table 78: Q12. Have you faced any language barrier during treatment of patients because of their illiteracy?

Language barrier		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	40	100.0	100.0	100.0

The 40 of the respondents respond Yes, the doctors and other staff members faced language barrier during treatment of patients because of their illiteracy. While the total number of the participants are 40.

Table 79: Q13. At which stage of illness patients visits you.

Patient's stage of illness		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 st	12	30.0	30.0	30.0
	2 nd	28	70.0	70.0	100.0
	Total	40	100.0	100.0	

The 28 of the participants (70.0%) respond that most of the patients visit to the facility center at 2nd stage. And 12 participants (30.0%) respond that patients visit to the facility center at 1st stage. While the total number of the participants are 40.

Table 80: Q14. At which stage of illness illiterate people visits you

Illiterate patients visit		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 st	10	25.0	25.0	25.0
	2 nd	30	75.0	75.0	100.0
	Total	40	100.0	100.0	

Major portion of the participants 30 which is (75.0%) respond that illiterate patients visit to the hospital at 2nd stage while 10 of the participants (25.0%) respond that illiterate people visit at the 1st stage. From the experience of the service providers mostly illiterate people follow quack slaver (who pretend to be a doctor) and use homemade drugs, after the critical situation then they come to the hospital. While the total number of the participants are 40.

Table 81: Q15. At which stage of illness literate people visits you

Literate patients visit		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 st	25	62.5	62.5	62.5
	2 nd	15	37.5	37.5	100.0
	Total	40	100.0	100.0	

The 25 of the participants (62.5%) respond that literate people visit to the hospital at 1st stage and 15 of the participants (37.5) respond that they visit at 2nd stage. The literate people are conscious about their health and mostly know about the symptoms of the disease. The total number of the participants are 40.

Table 82: Q16.From your experience which patients follow your instructions more?

Follow instructions more		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Literate A	15	37.5	37.5	37.5
	Illiterate B	11	27.5	27.5	65.0
	Both A&B	14	35.0	35.0	100.0
	Total	40	100.0	100.0	

The 15 participants (37.5%) respond that literate people are easy to treat. Literate patients follow more instructions than illiterate. Then 11 participants (27.5%) respond that illiterate patients follow more instructions, on the other hand 14 participants (35.0%) respond that both are follow the instructions carefully. While the total number of the participants are 40.

Table 83: Q17.What you think who spends more of their income on health?

Who spends more on health		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Literate A	4	10.0	10.0	10.0
	Illiterate B	28	70.0	70.0	80.0
	Both A&B	8	20.0	20.0	100.0
	Total	40	100.0	100.0	

Major portion of the participants 28 which is (70.0%) respond that illiterate patients spend more on their health. From the experience of the service providers mostly illiterate people follow quack slaver (who pretend to be a doctor) and use homemade drugs, after the critical situation then they come to the hospital. Then 4 of the participants (10.0%) respond that literate people spend more to enjoy and maintain a good health status. While 8 participants (20.0%) respond that both literate and illiterate people spend their income in same way on the health. The total number of the participants are 40.

Table 84: Q18.Who visits you more for diagnosing their body after Six month or a Year?

Visit for diagnosing their body		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Literate A	25	62.5	62.5	62.5
	Illiterate B	8	20.0	20.0	82.5
	Both A&B	7	17.5	17.5	100.0
	Total	40	100.0	100.0	

A major portion of the participants 25 which is (62.5%) respond that the literate people visit the facility centers more for diagnosing their body after six months or in a year. While 8 respondents (20.0%) respond that illiterate people visit them as well for checkups and diagnosing their body after six months or a year. And 7 of the participants (17.5%) respond that both literate and illiterate people visit to diagnose. While the total number of the participants are 40.

Table 85: Q19. Who participate more in health awareness seminars, campaigns etc

More participation in health programs		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Literate A	2	5.0	5.0	5.0
	Illiterate B	16	40.0	40.0	45.0
	Both A&B	22	55.0	55.0	100.0
	Total	40	100.0	100.0	

The 2 participants (5.0%) respond that literate people participate less than the illiterate people in the health awareness seminars, campaigns and programs. From the experience of the service providers literate people are busy in doing jobs in sectors they cannot manage time for such type of the programs. While 16 of the participants (40.0%) respond that illiterate people participate more in health awareness seminars and campaigns. And 22 participants (55.0%) respond that both literate and illiterate people participate in health programs. The total number of the participants are 40.

Table 86: Q20.How much you or your center helps them?

How much you or your center helps them		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Maximum	40	100.0	100.0	100.0

The all the participants 40 respond that they help the patient's maximum. The participant respond that we help the patients as much we have.

Table 87: Q21.Types of illness which exist in district Rajanpur.

Types of illness		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	All of above	40	100.0	100.0	100.0

All the participants 40 respond that the common disease burden exists in district Rajanpur like, accidental patients, diabetes, pneumonia, communicable and non-communicable disease, tuberculosis, chronic disease, malaria and typhoid etc.

Table 88: Q22.Major three recommendations for the provision of healthcare in the facility center

Three recommendations		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	All of above	40	100.0	100.0	100.0

All the participants 40 respond about the recommendations are equipment's, meditation, increase in staff to decrease the burden, building, accountability, monitoring and evaluation and increase in developing budget for the provision of healthcare in the facility center.

3.3. Crosstabulation from service provider perspective

**Table 89: Q2. Gender? * Q3. For how long have you worked at this HealthCare Hospital?
* Q1. Health facility at? Crosstabulation**

Q1. Health facility at?			Q3. For how long you have worked at this HealthCare Hospital?			Total
			1-3 years	4-7 years	7-10 years	
THQ Jampur	Gender	Male	6	3	1	10
		Female	1	1	0	2
	Total		7	4	1	12
THQ Rojhan	Gender	Male	3	7		10
		Female	2	0		2
	Total		5	7		12
DHQ Rajanpur	Gender	Male	7	8	1	16
	Total		7	8	1	16
Total	Gender	Male	16	18	2	36
		Female	3	1	0	4
	Total		19	19	2	40

The ratio of the male's participants in the facility centers are 16 who worked about 1-3 years and just 3 females. While 18 males' and 1 female worked at the facility center 4-7 years and 2 males worked for 7-10 years and no one females were in this category. The total number of male's participants are 36 and 4 females are in the facility center.

**Table 90: Q2. Gender? * Q5. Professional qualification? * Q1. Health facility at?
Crosstabulation**

Q1. Health facility at			Q5. Professional qualification?			Total
			Nurse	MBBS	if other specify	
THQ Jampur	Gender	Male	8		2	10
		Female	2		0	2
	Total		10		2	12
THQ Rojhan	Gender	Male	7	3		10
		Female	2	0		2
	Total		9	3		12
DHQ Rajanpur	Gender	Male	13	3		16
	Total		13	3		16
Total	Gender	Male	28	6	2	36
		Female	4	0	0	4
	Total		32	6	2	40

In the nursing staff there are 28 males', and 4 females participate. While 6 MBBS male doctors and 0 female MBBS doctor and 2 are the clinical psychologists are in the health facility centers. The total number of male's participants are 36 and 4 females are in the facility center.

**Table 91: Q2. Gender? * Q6. Any job specialization? * Q1. Health facility at?
Crosstabulation**

Count					
Q1. Health facility at?			Q6. Any job specialization?		Total
			Yes	No	
THQ Jampur	Gender	Male	1	9	10
		Female	0	2	2
	Total		1	11	12
THQ Rojhan	Gender	Male	3	7	10
		Female	0	2	2
	Total		3	9	12
DHQ Rajanpur	Gender	Male	3	13	16
	Total		3	13	16
Total	Gender	Male	7	29	36
		Female	0	4	4
	Total		7	33	40

The 7 male participants respond yes that they have the job specialization. While 29 males' and 4 female's participants respond no that they have no nay job specialization. The total number of male's participants are 36 and 4 females are the participants.

Table 92: Q2. Gender? * Q7. Job title? * Q1. Health facility at? Crosstabulation

Q1. Health facility at?			Q7. Job title?			Total
			In charge	Doctor	Clinical officers	
THQ Jampur	Gender	Male		9	1	10
		Female		2	0	2
	Total			11	1	12
THQ Rojhan	Gender	Male	1	9		10
		Female	0	2		2
	Total		1	11		12
DHQ Rajanpur	Gender	Male	1	15		16
	Total		1	15		16
Total	Gender	Male	2	33	1	36
		Female	0	4	0	4
	Total		2	37	1	40

The job title of male participants 2 are the in charge and 33 males' and 4 of the female participants are doctors. Females are only 10% participants in the study. The percentages of doctors are 92.5% in the study. Then 1 of the male participants is clinical officer. The total number of male's participants are 36 and 4 females are the participants.

Table 93: Q2. Gender? * Q8. What is your job responsibility in this hospital? * Q1. Health facility at? Crosstabulation

Q1. Health facility at?			Q8. What is your job responsibility in this hospital?			Total
			Facility in charge	Unit in charge	Service provider	
THQ Jampur	Gender	Male		1	9	10
		Female		0	2	2
	Total			1	11	12
THQ Rojhan	Gender	Male			10	10
		Female			2	2
	Total				12	12
DHQ Rajanpur	Gender	Male	1	2	13	16
	Total		1	2	13	16
Total	Gender	Male	1	3	32	36
		Female	0	0	4	4
	Total		1	3	36	40

The 1 male participant is facility in charge 3 males are unit in charge and 32 males' and 4 female's participants are service provider at the healthcare facility center. The total number of male's participants are 36 and 4 females are the participants.

Table 94: Q2. Gender? * Q9. Ratio of the patients who visits your clinic is literate or illiterate? * Q1. Health facility at? Crosstabulation

Q1. Health facility at?			Q9. Ratio of the patients who visits your clinic is literate or illiterate?			Total
			Literate A	Illiterate B	Both A&B	
THQ Jampur	Gender	Male	1	9		10
		Female	0	2		2
	Total		1	11		12
THQ Rojhan	Gender	Male	1	6	3	10
		Female	0	1	1	2
	Total		1	7	4	12
DHQ Rajanpur	Gender	Male	7	3	6	16
	Total		7	3	6	16
Total	Gender	Male	9	18	9	36
		Female	0	3	1	4
	Total		9	21	10	40

The 9 of the male participants respond that literate, 18 males' and 3 female's participants respond that illiterate patients visit more at the facility center. Then 9 of the male's and 1 female participant respond that both literate and illiterate visit the healthcare facility center. The total number of male's participants are 36 and 4 females are the participants.

Table 95: Q2. Gender? * Q10.What you think, which patients are easy to treat? * Q1. Health facility at? Crosstabulation

Q1. Health facility at?			Q10.What you think, which patients are easy to treat?	Total
			Literate	
THQ Jampur	Gender	Male	10	10
		Female	2	2
	Total		12	12
THQ Rojhan	Gender	Male	10	10
		Female	2	2
	Total		12	12
DHQ Rajanpur	Gender	Male	16	16
	Total		16	16
Total	Gender	Male	36	36
		Female	4	4
	Total		40	40

The ratio of male's (36) is more in this study than females. The 4 Female is only 10% participants in the study. All the 40 participants respond obviously the literate persons are easy to treat. The total number of male's participants are 36 and 4 females are the participants.

Table 96: Q2. Gender? * Q11.From your experience which patients recovered early? * Q1. Health facility at? Crosstabulation

Q1. Health facility at?			Q11.From your experience which patients recovered early?		Total
			Literate	Illiterate	
THQ Jampur	Gender	Male	8	2	10
		Female	2	0	2
	Total		10	2	12
THQ Rojhan	Gender	Male	8	2	10
		Female	2	0	2
	Total		10	2	12
DHQ Rajanpur	Gender	Male	10	6	16
	Total		10	6	16
Total	Gender	Male	26	10	36
		Female	4	0	4
	Total		30	10	40

The major portion of the male participants 26 and 4 of the female's participants respond that literate patients recover early because they follow all the precautions which are prescribed by the doctor and take medicines properly. While 10 of the male's participants respond illiterate patients recovered early. The total number of male's participants are 36 and 4 females are the participants.

Table 97: Q2. Gender? * Q12. Have you faced any language barrier during treatment of patients because of their illiteracy? * Q1. Health facility at? Crosstabulation

Q1. Health facility at?		Q12. Have you faced any language barrier during treatment of patients because of their illiteracy?		Total
		Yes	No	
THQ Jampur	Gender	Male	10	10
		Female	2	2
	Total		12	12
THQ Rojhan	Gender	Male	10	10
		Female	2	2
	Total		12	12
DHQ Rajanpur	Gender	Male	16	16
	Total		16	16
Total	Gender	Male	36	36
		Female	4	4
	Total		40	40

The ratio of male's is more (36) in this study than females. All the male's (36) and female's (4) participants respond Yes, the doctors and other staff members faced language barrier during treatment of patients.

Table 98: Q2. Gender? * Q13. At which stage of illness patients visits you. * Q1. Health facility at? Crosstabulation

Q1. Health facility at?			Q13. At which stage of illness patients visits you.		Total
			1 st	2 nd	
THQ Jampur	Gender	Male	3	7	10
		Female	1	1	2
	Total		4	8	12
THQ Rojhan	Gender	Male	4	6	10
		Female	0	2	2
	Total		4	8	12
DHQ Rajanpur	Gender	Male	4	12	16
	Total		4	12	16
Total	Gender	Male	11	25	36
		Female	1	3	4
	Total		12	28	40

The 11 of the male's and 1 female participant respond that patients visit at 1st stage in the healthcare facility center. While a major portion of the male 25 and female 3 participants respond that patients visit at the facility center in 2nd stage. From the experience the service provider because of the illiteracy most of the people use homemade drugs, go to the quack slaver (who pretend to be a doctor) and after the critical situation then people visit to the hospital. The total number of male's participants are 36 and 4 females are the participants.

Table 99: Q2. Gender? * Q14. At which stage of illness illiterate people visits you * Q1. Health facility at? Crosstabulation

Q1. Health facility at?			Q14. At which stage of illness illiterate people visits you		Total
			1 st	2 nd	
THQ Jampur	Gender	Male	2	8	10
		Female	1	1	2
	Total		3	9	12
THQ Rojhan	Gender	Male	3	7	10
		Female	0	2	2
	Total		3	9	12
DHQ Rajanpur	Gender	Male	4	12	16
	Total		4	12	16
Total	Gender	Male	9	27	36
		Female	1	3	4
	Total		10	30	40

Major portion of the male's participants 27 and 3 of the female's participants respond that illiterate patients visit to the hospital at 2nd stage while 9 males' and 1 female of the participants respond that illiterate people visit at the 1st stage. From the experience of the service providers mostly illiterate people follow quack slaver (who pretend to be a doctor) and use homemade drugs, after the critical situation then they come to the hospital. While the total number of the participants are 4 females' and 36 males.

Table 100: Q2. Gender? * Q15. At which stage of illness literate people visits you * Q1. Health facility at? Crosstabulation

Q1. Health facility at?			Q15. At which stage of illness literate people visits you		Total
			1 st	2 nd	
THQ Jampur	Gender	Male	7	3	10
		Female	2	0	2
	Total		9	3	12
THQ Rojhan	Gender	Male	5	5	10
		Female	1	1	2
	Total		6	6	12
DHQ Rajanpur	Gender	Male	10	6	16
	Total		10	6	16
Total	Gender	Male	22	14	36
		Female	3	1	4
	Total		25	15	40

The 22 male and 3 females of the participants respond that literate people visit to the hospital at 1st stage and 14 males' 1 female of the participants respond that literate patients visit the healthcare facility center at 2nd stage. The literate people are conscious about their health and mostly know about the symptoms of the disease. The total number of the participants are 36 males' and 4 females.

Table 101: Q2. Gender? * Q16.From your experience which patients follow your instructions more? * Q1. Health facility at? Crosstabulation

Q1. Health facility at?			Q16.From your experience which patients follow your instructions more?			Total
			Literate A	Illiterate B	Both A&B	
THQ Jampur	Gender	Male	6	1	3	10
		Female	1	0	1	2
	Total		7	1	4	12
THQ Rojhan	Gender	Male	4	3	3	10
		Female	1	1	0	2
	Total		5	4	3	12
DHQ Rajanpur	Gender	Male	3	6	7	16
	Total		3	6	7	16
Total	Gender	Male	13	10	13	36
		Female	2	1	1	4
	Total		15	11	14	40

The 13 male is, and 2 females of the participants respond that literate people are easy to treat. Literate patients follow more instructions than illiterate. Then 10 males' and 1 female participant respond that illiterate patients follow more instructions, on the other hand 13 male and 1 female participant respond that both are follow the instructions carefully. While the total number of the participants are 36 males' and 4 females.

Table 102: Q2. Gender? * Q17.What do you think who spends more of their income on health? * Q1. Health facility at? Crosstabulation

Q1. Health facility at?			Q17.What do you think who spends more of their income on health?			Total
			Literate A	Illiterate B	Both A&B	
THQ Jampur	Gender	Male	2	4	4	10
		Female	0	1	1	2
	Total		2	5	5	12
THQ Rojhan	Gender	Male		8	2	10
		Female		2	0	2
	Total			10	2	12
DHQ Rajanpur	Gender	Male	2	13	1	16
	Total		2	13	1	16
Total	Gender	Male	4	25	7	36
		Female	0	3	1	4
	Total		4	28	8	40

Major portion of the male's 25 and 3 female's participants 28 respond that illiterate patients spend more on their health. From the experience of the service providers mostly illiterate people follow quack slaver (who pretend to be a doctor) and use homemade drugs, after the critical situation then they come to the hospital. Then 4 of the male participants respond that literate people spend more to enjoy and maintain a good health status. While 7 males' and 1 female participant respond that both literate and illiterate people spend their income in same way on the health. The total number of the participants are 40 in which 4 females' and 36 male's participants.

Table 103: Q2. Gender? * Q18. Who visits you more for diagnosing their body after Six month or a Year? * Q1. Health facility at? Crosstabulation

Q1. Health facility at?			Q18. Who visits you more for diagnosing their body after Six month or a Year?			Total
			Literate A	Illiterate B	Both A&B	
THQ Jampur	Gender	Male	6	2	2	10
		Female	2	0	0	2
	Total		8	2	2	12
THQ Rojhan	Gender	Male	6	2	2	10
		Female	1	0	1	2
	Total		7	2	3	12
DHQ Rajanpur	Gender	Male	10	4	2	16
	Total		10	4	2	16
Total	Gender	Male	22	8	6	36
		Female	3	0	1	4
	Total		25	8	7	40

A major portion of the male's 22 and 3 female's participants respond that the literate people visit the facility centers more for diagnosing their body after six months or in a year. While 8 of the male respondents respond that illiterate people visit them as well for checkups and diagnosing their body after six months or a year. And 6 males' and 1 female of the participants respond that both literate and illiterate people visit to diagnose. While the total number of the participants are 40 in which 4 females' and 36 are male's participants.

Table 104: Q2. Gender? * Q19. Who participate more in health awareness seminars, campaigns etc.? * Q1. Health facility at? Crosstabulation.

Q1. Health facility at?			Q19. Who participate more in health awareness seminars, campaigns etc.?			Total
			Literate A	Illiterate B	Both A&B	
THQ Jampur	Gender	Male	2	4	4	10
		Female	0	1	1	2
	Total		2	5	5	12
THQ Rojhan	Gender	Male		1	9	10
		Female		1	1	2
	Total			2	10	12
DHQ Rajanpur	Gender	Male		9	7	16
	Total			9	7	16
Total	Gender	Male	2	14	20	36
		Female	0	2	2	4
	Total		2	16	22	40

The 2 of the male's participants respond that literate people participate less than the illiterate people in the health awareness seminars, campaigns and programs. From the experience of the service providers literate people are busy in doing jobs in sectors they cannot manage time for such type of the programs. While 14 of the males and 2 female's participants respond that illiterate people participate more in health awareness seminars and campaigns. And 20 participant's males and 2 females respond that both literate and illiterate people participate in health programs. The total number of the participants are 40.

Table 105: Q2. Gender? * Q20.How much you or your center help them? * Q1. Health facility at? Crosstabulation

Q1. Health facility at?			Q20.How much you or your center help them?	Total
			Maximum	
THQ Jampur	Gender	Male	10	10
		Female	2	2
	Total		12	12
THQ Rojhan	Gender	Male	10	10
		Female	2	2
	Total		12	12
DHQ Rajanpur	Gender	Male	16	16
	Total		16	16
Total	Gender	Male	36	36
		Female	4	4
	Total		40	40

The all the 36 male's and 4 female's participants respond that they help the patient's maximum. The participant respond that we help the patients as much we have.

Table 106: Q2. Gender? * Q21.Types of illness which exist in district Rajanpur. * Q1. Health facility at? Crosstabulation

Q1. Health facility at?			Q21.Types of illness which exist in district Rajanpur.	Total
			All of above	
THQ Jampur	Gender	Male	10	10
		Female	2	2
	Total		12	12
THQ Rojhan	Gender	Male	10	10
		Female	2	2
	Total		12	12
DHQ Rajanpur	Gender	Male	16	16
	Total		16	16
Total	Gender	Male	36	36
		Female	4	4
	Total		40	40

All the 36 male's and 4 female's participants respond that the common disease burden exists in district Rajanpur like, accidental patients, diabetes, pneumonia, communicable and non-communicable disease, tuberculosis, chronic disease, malaria and typhoid etc.

Table 107: Q2. Gender? * Q22.Major three recommendations for the provision of healthcare in the facility center * Q1. Health facility at? Crosstabulation

Q1. Health facility at?			Q22.Major three recommendations for the provision of healthcare in the facility center	Total
			All of above	
THQ Jampur	Gender	Male	10	10
		Female	2	2
	Total		12	12
THQ Rojhan	Gender	Male	10	10
		Female	2	2
	Total		12	12
DHQ Rajanpur	Gender	Male	16	16
	Total		16	16
Total	Gender	Male	36	36
		Female	4	4
	Total		40	40

To improve the health status of the community and decrease the ratio of diseases all the 36 male's and 4 female's participants respond about the recommendations are equipment's, meditation, increase in staff to decrease the burden, building, accountability, monitoring and evaluation and increase in developing budget for the provision of healthcare in the facility center.

3.4. Reliability Analysis

In this analysis Cronbach's Alpha is the accurate measure of reliability scale (Field et al. 2010). Alpha was developed by Lee Cronbach in 1951 to provide a measure of the internal

consistency of a test or scale. The value of alpha must be greater than 0.6 which are acceptable range (Hajjar, S. T. (2018).

Table 108: Reliability Analysis

Variables	Cronbach's Alpha
Travel Cost	0.746
Food Cost	0.731
Lab Test cost	0.870
Medicine cost	0.933
Area of Respondent	0.604
Marital status	0.755
Monthly Income	0.569

Cronbach's alpha at $0.9 \leq \alpha$ is Excellent, at $0.8 \leq \alpha < 0.9$ is Good at $0.7 \leq \alpha < 0.8$ is Acceptable, at $0.6 \leq \alpha < 0.7$ is Questionable, at $0.5 \leq \alpha < 0.6$ is Poor, at $\alpha < 0.5$ is Unacceptable.

3.5. Multinomial logistic Regression

Regression analysis measures that how much independent variable is positively & significantly associate with dependent variable. In regression when we are aware how all the four variables used in this research are correlate with dependent variable, after that we can easily get the information about independent variables. Multinomial logistic regression is used based on several independent variables to estimate categorical placement or the possibility of group inclusion on a dependent variable. The independent variables may be either dichotomous or continuous (i.e., binary) or (i.e., interval or ratio in scale). Multinomial logistic regression is a basic extension of binary logistic regression that requires the dependent or outcome variable to have more than two types. Multinomial logistic regression, like binary logistic regression, uses

full probability estimation to determine the likelihood of categorical inclusion (Starkweather, J., & Moske, A. K. 2011).

Table 109: Multinomial logistic Regression

Predictor	Education Status (DV)			
	B	R ²	ΔR ²	Sig.
Travel Cost	.128	.324	.320	0.000
Food Cost	.117	.399	.389	0.004
Lab Test cost	.234	.345	.334	0.000
Medicine cost	.034	.378	.378	0.001
Area of Respondent	.049	.266	.257	0.054
Marital status	.254	.340	.337	0.003
Monthly Income	.342	.223	.214	0.421
Note: N=100 ***= p<0.01, **=p<0.05, *=p<0.10*				

The table 109 results of regression show that, the Travel Cost, Food Cost, Lab Test cost, Medicine cost, Area of Respondent, and Marital status from sample were contacted and to discuss that they have recommended and positively and significantly correlated with dependent variable education status. But monthly income insignificantly effects the education status.

CHAPTER 4

DISCUSSION

This study survey incorporates material unique in relation to that in past audits of writing of health proficiency in Rajanpur city. The areas of respondents are Rajanpur, Jampur and Rojhan. We examined the different categories of people which linked mainly to literacy and education health economics. Moreover, it avoids significant articles since they did not address two key inquiries. Prior audits arrived at resolutions like own about the overall connection among education and health (American Medical Association, 1999). This study thorough methodology should give images trust in the end that low understanding ability and chronic weakness are obviously related. Decisions about the adequacy of intercessions to relieve the impacts of low proficiency stay less all around upheld as of now.

In a controlled fundamental, individuals with low capability appeared to show higher data with a tape informative tool than with a present formed at an intelligibility level like the tape's substance, anyway this end is limited by methodological issues with various correlations (Murphy et al., 2000). In another examination, ladies of lower education comprehended outlined materials about cervical malignant growth better than text materials (Murphy et al., 2000). Another controlled starter took a gander at a secretly developed freebee about polio immune response planned for patients with low capability and a flyer from the Centers for Disease Control and Prevention that had similarly been expected for basic coherence; (Davis et al., 1998) patients with lower instruction did not differentiate in their comprehension of the two flyers. Finally, a randomized primer of 1,100 patients broke down the practicality of enlightening materials on colorectal danger screening (tape or easy- to- read freebee proposed to be legitimate for people with low training) to typical thought.

This study shows that low wellbeing proficiency is additionally connected with differential utilization of certain medical care administrations, including expanded hospitalizations and crisis care in district Rajanpur. Contrasts in wellbeing related results incorporate a less fortunate capacity to show taking drugs appropriately and read prescription names and health messages and, among older people, more unfortunate by and large health status and higher mortality. Proof is arising that lower health proficiency can intervene (clarify or halfway clarify) traditional differences in health results. The impact was shown across a few investigations, each estimating an alternate result. Interestingly, we discover a connection between health education and costs or different kinds of abnormalities. In the two cases, a couple of studies analyzed these connections. Additionally, the group of proof concerning the connection between low numeracy and results is new and still uncertain. A more extensive proof base is expected to comprehend this relationship, including the overall significance of the print education and numeracy parts of health proficiency.

Scarcely any examinations inspected the investigated the effect of interventions on prosperity results that people can truly feel. The only assessment to look at the effect of an intervention that included direct literacy- skill building showed that a careful family benefits center, differentiated and standard Head Start, could improve parental getting capacity and decreases the regularity of protective debilitation.

Considering other late audits that investigated the connection between health education and wellbeing results, the ends from examination can be thought of. Each focused on a smaller patient population and settings and fewer results, particularly patients with healthcare and adults of working age (evaluating their health literacy or that of their parents or caretakers).

After the research and generate the results in tables and figures, it is clearly showing that literacy mainly effect the healthcare cost. The visitors at the facility centers in district Rajanpur most of the illiterate people and they have consuming more than literate people on treatment. Social Action program (SAP) was forwarded to improve social administrations transmission in Pakistan.

In this study the literacy is important to decrease the with health problems and literacy rate is very low in these areas (Rajanpur, Jampur and Rojhan) In the district Rajanpur 45% men and 22% women aged 10 years and older are literate. Overall, the district Rajanpur ranked 37 is last district in literacy indicators (ASER).

In Pakistan as somewhere else, by far most of the nation's serves developed zones, and this is particularly valid for lady's specialists. Provincial zones are underserved. The initial move toward treatment to the issue of lady's specialists in underserved country regions is to perceive the hidden center issues: helpless compensation bundles, insufficient assistance structure for female's specialists willing to work in rustic territories, and security issues. The public authority of Pakistan should offer better advantage packages, improved and straightforward help structures, furthermore, grant projects to encourage further postgraduate investigations to woman's specialists willing to work in country territories. Another issue of public level arrangement is security for these females.

The current health framework in Pakistan is considered very scarce basically in light of the fact that it is the act of essentially all administrations to assign fewer than 2% of public item on the country's yearly health spending plan of health literacy. It is imperative to support and improve existing first reference medical services places and guarantee arrangement of open and

reasonable crisis obstetric consideration. Activities to make them more open to people must similarly zero in on smoothing out the reference framework to try not to over-burden tertiary medical clinics.

In last the regression shows that, the Travel Cost, Food Cost, Lab Test cost, Medicine cost, Area of Respondent, monthly income and Marital status from sample were contacted and to discuss that they have recommended and positively and significantly correlated with dependent variable education status.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

The study shows while deciding health care budget in Pakistan, socio-economic factors play an important role. These factors include GNP, individual income, education, marital status and health. A strong and clear correlation of literacy with health has been shown as important regardless of culture, economic growth, and other determinants. It is necessary for the government to increase the proportion of expenditure on health, education to improve health services for enhanced living standard. Literacy rates are indicating a positive association with spending on health care. At the point when helpful fulfillment and proficiency of the female population inspected, the connection between schooling/education and health was found stable. As for all health indicators, there is a major effect on long-term economic development. The outcome shows that the health factor acting a very significant character in assessing long-term economic growth. Like other health indicators, they have incredible consequence on long-term financial growth. Education is strongly and positively linked to two self-reported health and physical functioning measures.

Adjusting to work and market circumstances, cultural resources and healthy lifestyles, education is strongly linked to good health. Healthcare System in District Rajanpur has been facing problems due to lack of resources like, human resources, mismanagement, and availability of logistics, supplies and referral facilities. Availability and accessibility for Health benefits particularly for the population in Rajanpur is incredible issue because the lack of medical services specialists and scarce allocation of assets for Primary medical services areas and emergency clinics. This study highlights many gaps in the area, such as the lack of

psychometrically reliable methods for evaluating awareness of mental health, helping to seek actions, and current stigma and attitude towards the activities of life. A good tool for managing is literacy. It is a vital factor in supporting the health of communities that communicate with others in a complex way. To promote digital health literacy, particularly among educated segments of Pakistani society, rigorous efforts and coordinated actions from government, education institutions and health organizations are required.

Recommendations

- Public service announcements for media and health information Apps for mobile technology can be developed by the government for health and media partnership, to be more easily educated and adopt the better living standard and sustain their socio-economic status.
- A systematic, multi-level targeted approach to health literacy would allow health seekers the opportunity to understand and comprehend disease prevention, symptomatology diagnoses and treatment.
- There should be increase in the number of education sectors, and facilities like medicine, equipment and staff in all types of facility centers to decrease the cost on patients through better diagnoses and treatment, similarly healthy people make the family mostly informed about their social and economic status.

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