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Establishing Grievance Redressal System in Effective Service Delivery: A Case Study of the Sehat Sahulat Program (SSP) in Pakistan

Shujaat Farooq
Nabila Kunwal

Pakistan Institute of Development Economics
Islamabad, Pakistan

E-mail: publications@pide.org.pk
Website: http://www.pide.org.pk
Fax: +92-51-9248065

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Shujaat Farooq
Pakistan Institute of Development Economics, Islamabad.

and

Nabila Kunwal
Pakistan Institute of Development Economics, Islamabad.

PAKISTAN INSTITUTE OF DEVELOPMENT ECONOMICS
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ABSTRACT

A robust Grievance Redressal System (GRS) improves citizens' trust and confidence in health service deliveries and promotes equitable health services. Mostly, supply-driven health insurance programs face a GRS as clients belong to the low-income segments. The current study has examined the existing Grievance Redressal (GR)/complaint system of the Sehat Sahulat Program (SSP) using qualitative and quantitative approaches.

The analysis reveals that the program offers multiple choices for complaint registration, including a web portal, call centre and postal letters, with the call centre the primary source of complaint registration and information provision. The SSP call centre requires a massive upgradation including automation, the taxonomy of complaints and integration with field teams. Each complaint requires defining a complete loop along with a stipulated resolution time. A dashboard can further help in monitoring the grievance redressal system.

Currently, the program lacks field offices to interact with the public, awareness-raising and a register of complaints. Overall, beneficiaries have limited knowledge about the complaint mechanisms. In addition, the program requires an integrated complaint management system where registered complaints through various sources can be pooled, analysed and concluded.

Keywords: Sehat Sahulat Programme, Health Insurance, Complaints, Hospital Management, Grievance System

1. INTRODUCTION

Developing countries face numerous challenges in their health systems, including accessibility and affordability issues. Primarily low-income groups utilise public health facilities which are often compromised due to a host of challenges, including the quality and attitude of the staff (Bredenkamp, Mendola, & Gragnolati, 2011). There are complaint mechanisms for improving the patients' engagement in health services and upgradation of quality of services (Piette et al., 2016; Reader, Gillespie, & Roberts, 2014), but they often become the victim of red-tapism and bureaucratic hurdles (Mirzoev & Kane, 2018). As a result, accountability and public satisfaction are essentially conceded (Al-Abri & Al-Balushi, 2014).

An effective patient complaint management system is one of the crucial components to improving the functionality of health systems (Mirzoev & Kane, 2018). Information from patient complaints and feedback is widely used to raise patients' satisfaction (Piette et al., 2016). Regular feedback helps in improving the quality of health services (Bouwman, Bomhoff, Robben, & Friele, 2016), behavioural change in the attitude of the staff (Barragry et al., 2016; Ivers et al., 2012), strengthening monitoring and accountability (Schedler, Diamond, & Plattner, 1999), reduced abuse and ensuring assured compliance with standards (Dubosh et al., 2020). It also helps improve GR or the complaint management system and ultimately promotes equitable health services where a country's citizens trust services (Conway, et al. 2014).

Grievance is defined as a complaint that shows dissatisfaction with the services regardless. It is worth mentioning that every complaint may not be genuine; however, the GR system must be capable of responding to every complaint (Bawaskar, 2014; Lancet, 2014). There could be multiple ways to register a complaint, including postal letters, dedicated offices and online mechanisms (Mirzoev & Kane, 2018; Reader & Gillespie, 2013). An efficient GR system must have a complaint coding taxonomy (Mirzoev & Kane, 2018) and multiple ways to register a complaint (Chakraborty, Ahmad, & Seth, 2017). All complaints must be pooled in one place, which may be called an integrated complaint management system. The GR system must be user-friendly, having a complete loop for each complaint (Chakraborty et al., 2017; Rana, Dwivedi, Williams, & Weerakkody, 2016). To ensure GR system accountability, nodal persons must be identified at each level responsible for addressing the complaints.

The principal element of an efficient GR system is its structure, with the following aspects (Priyadarshi & Kumar, 2020; Putturaj, et al. 2021):

(i) The system is reachable to all citizens for registering a complaint in a user-friendly manner through multiple ways.

Acknowledgements: We acknowledge the support of the Health Services Academy (HSA), the World Health Organisation (WHO) and the Federal Sehat Sahulat Programme (SSP) for their overall strategic guidance and facilitation for field support and secondary data provision.

(ii) The system can handle every complaint where the taxonomy of complaints is clearly defined.
(iii) A capable system must have certain modern features, e.g., automation, clear roles and responsibilities of concerned stakeholders, a loop of each complaint, an escalation process, a tracking facility, an accountability mechanism and feedback to the complainant.
(iv) Sufficient human resources and resources are available for improving the system.
(v) GR system is dynamic, having the flexibility and capability for upgradation over time.

Mostly the demand-driven health insurance programmes perform proficiently due to their 'customer's nature' where both the health insurance companies and clients know the terms and conditions of a health plan (Hines, 2014). In contrast, the supply-driven health insurance programmes for low-income groups often face a host of risks as mostly the beneficiaries don't have a financial contribution and health premium is generally paid by the government. Such programmes are commonly run under social protection schemes and face both the demand and supply side risks that may result in lower utilisation of health services. On the demand side, the targeted population often lacks sufficient awareness about the programme due to poverty, illiteracy, remoteness and cultural norms etc. (Setswe, Muyanga, Witthuhn, & Nyasulu, 2015; Thakur, 2016).

In addition, public behaviours and political factors also matter (Thabrany, 2008). On the supply side, the services are often compromised due to various factors, including issues of empanelled hospitals (i.e., limited in number, denial of services, lack of requisite health services), the politicisation of schemes, insufficient package amounts, coordination challenges among stakeholders and manual complaint management system etc. (Fusheini, 2016; Sakyi, Atinga, & Adzei, 2012).

Another critical challenge that public health insurance programmes often face is the lack of a robust GR system where each possible complaint is not adequately defined in the system. As a result, the targeted population often faces constraints in enrolment and service delivery (Okoroh et al., 2018). They sometimes have to pay partial payments from their pockets or bribes to avail of health facilities (Akweongo, Aikins, Wyss, Salari, & Tediosi, 2021).

Another key challenge that public health insurance programmes often face is the lack of a robust GR system against each category of a possible complaint. As a result, often the targeted population face constraints in enrolment and service delivery. Sometimes they have to make partial payments from own pocket or bribe to avail health facilities Sometimes they have to make partial payments from own pocket or bribe to avail health facilities

2. AN OVERVIEW OF THE SEHAT SAHULAT PROGRAMME (SSP)

Launched in 2015, the Sehat Sahulat Programme (SSP) aims to provide in-door free-of-cost health services without any contribution from the public. Initially, the programme targeted the poor and vulnerable segments using the Benazir Income Support Programme (BISP) data to identify its beneficiaries.[1] Health cards were issued to eligible families. In

[1]BISP holds a national database gathered in 2010/11 through a census survey from all households. The proxy mean test (PMT) was used to calculate the score of each household. All the households/families having score upto 32.5 were declared eligible for SSP.

2021, the government decided to expand the benefits of in-door health services to all citizens, making it a Universal Health Insurance (UHI) initiative. No separate health card is required now; instead, the National Identity Card (NIC) serves as the eligibility document. NADRA, which issues NICs, maintains the official citizenship data and has information at the family level. It is worth mentioning that the in-door benefits are provided at the family level, where a family is defined as parents with unmarried children.

Table 1

Roles and Responsibilities of SSP Operational Stakeholders

Department	Role in SSP operation
Federal Sehat Sahulat Programme	• Custodian of programme • Formulate policies and regulations and engage stakeholders • Hire the services of an insurance company
Provincial Health Departments	• Custodian of the programme at the provincial level • Supervise and monitor the operational activities • Public awareness
NADRA	• Provide updated family-level data by issuing B-form/CNIC • Data verification, as demanded by SSP • Managing an out-bound call centre to acquire feedback from those beneficiaries who have used in-door health services.
State Life Insurance Corporation (SLIC)	• Sole insurance company to manage entire operational responsibility • Hire empanel hospitals as per agreed packages • Manage front desk in each empanel hospital to ensure that beneficiaries admit and acquire in-door health services • Resolve all grievances related to enrolment, admission and in-door • Managing an in-bound call centre (0800-09009) to address the queries of the general public and to register complaints.
Empanel Hospital	• Provide in-door health services to eligible beneficiaries by charging no money on admission, surgery, doctor fee, medicine etc. • Provide five days of medicine and transport charges after a patient's discharge.
Partner NGOs	• Enrol beneficiaries by delivering cards at dedicated Beneficiary Enrolment Centres (BECs) • Disseminate key messages

The programme is a federal-provincial joint venture where the provinces financially contribute, with the federal government mainly providing technical and policy-level assistance. The province of Khyber Pakhtunkhwa (KP) has been managing the programme independently, whereas Punjab is closely working with federal SSP management. Punjab has established a company, the Punjab Health Initiative Management Company (PHIMC), to execute the programme in the province. The governments of Azad Jammu & Kashmir

(AJK) and Gilgit Baltistan (GB) provide no financial contribution to the programme; they only ensure that the government DHQs act as the empanel hospitals of SSP. Currently, the programme is operational in all the provinces and regions, except in Sindh and Balochistan, where provincial authorities have not yet adopted it.[2] So far, the programme has enrolled 37.3 million families by covering 180 million population (around 80 per cent of the total) of the country. More than 5.2 million population has used in-door health facility (till November 01, 2022).

The programme has six stakeholders for its operational activities (Table 1). The primary stakeholder of the programme is the State Life Insurance Company (SLIC), hired through a competitive bidding process. SLIC is responsible for executing all the operational activities, including onboard empanel hospitals, providing free-of-cost in-door health services and addressing all service-related grievances. Settled package rates against each illness are decided by the SLIC and SSP management. The package rate could vary across regions and depend on a hospital's rating. For example, a hospital with better infrastructure and/or located in a major urban city would receive a better package rate than the smaller hospitals in remote areas. In the early phase, the programme hired the services of partner NGOs for awareness and delivering the health cards to beneficiaries at their nearest BEC.[3] The health card is no longer a requirement, and a NIC serves as the identity for in-door treatment.

The programme has placed a Health Management Information System (HMIS) in empanel hospitals to facilitate the beneficiaries for enrolment, in-door treatment, updating of records and general information provision, i.e., eligibility, details of registered members in the database, balance inquiry etc. Similarly, there is a dedicated SMS service (SMS CNIC at 8500) through which the public can check their eligibility status and register family members.

The SSP has established a GR system, both manual and automated, to cater for the need of its beneficiaries. The manual systems allow the beneficiaries and general public to register their grievances through email, complaint box and postal letter. The automated system includes two call centres, one managed by the SLIC (in-bound facility) and the other by NADRA (out-bound facility).

The SSP is a unique worldwide programme as it provides universal in-door health services to all citizens of the country. We consider that the programme requires a robust GR system for improving value for money (VFM) by ensuring good governance, optimal utilisation and trust of citizens. There are examples where earlier public spending was compromised in similar initiatives. For example, Benazir Income Support Programme (BISP) started a health programme in 2012 called the Waseela-e-Sehat (Wes) in the district of Faisalabad, Punjab. Around 75,000 BISP families were given in-door health insurance facilities in eight empanelled hospitals. All medical inpatient facilities up to Rs. 25,000 per family per year were covered under the package. However, during one year, only 0.8 per cent of the families availed of health insurance, primarily due to lack of awareness, lower package limit, lack of monitoring and evaluation etc.

[2] The programme is operational in district Tharparker (Sindh) with the financial assistance of federal government.

[3] BECs were established when programme targeted only poor segments by using BISP data to deliver SSP cards

The proposed research aims to evaluate the existing GR system of SSP, including its efficiency and effectiveness. We consider that an effective GR system improves its utilisation rate and citizens' trust in the programme. A SWOT analysis is also carried out to highpoint the weaknesses in the existing GR system at various stages, including enrolment, service delivery and post-service delivery. The analysis will help in improving and upgrading the GR system.

3. DATA COLLECTION AND METHODOLOGY

3.1. Analytical Framework

There could be various reasons why a grievance is not addressed appropriately, eventually leading beneficiaries to lose confidence in the programme. For example, the existing GR system is inadequate and not accessible to a large number of beneficiaries. Sometimes even if the complaint is genuine existing rules and procedures don't allow to facilitate complainant. Other challenges could be a manual and/or a complex GR system to resolve complaints.

As listed in Table 2, we have built an analytical framework for analysing the GR system of Sehat SSP, where we have analysed the possible grievances related to enrolment, service delivery and quality of services.

Table 2

Category-wise Possible Grievances in SSP

Type of grievance	Details
Enrolment	• A beneficiary considers him/herself eligible, but data is unavailable or shows non-eligible. • Non-delivery of card or card is not functional • Wrong data entry. No information on some family members in the database due to incomplete registration with the NADRA. • Lack of facility to update the data
Health Card related grievance	• The health card is lost, captured or replaced. • Health card is misused by someone else. • An insufficient balance on the card or balance checking facility does not exist. • Facilitation in HMIS is missing for updating data, i.e., addresses, telephone numbers, name correction and enrolment of non-registered members.
Service related grievance	• No in-door treatment exists near the beneficiary. • Non-availability of staff at a hospital.
Denial of benefits	• Denial of services by a hospital or the SLIC. • Non-availability of medicines and other accessories, i.e., diagnostic facility • Cash benefits are not provided. • As detailed in the programme, specific incentives, such as transport charges, burial support, free post-follow-up visit, etc., are not provided.
Poor quality services	• Sub-standard care by the hospital. • Poor attitude of the staff (SLIC or hospital). • Irregular cleanliness and replacement of linen etc. • The patient's experience with clinical processes is not up to the mark.
Administrative procedures	Complex admission process. Administrative procedures are complex.
Corruption/bribe	Staff asking for any monetary/non-monetary benefit.

3.2. Data and Methodology

Before explaining the methodology, it is worth mentioning that each empanel hospital has a front desk where a representative of SLIC (an HFO) is available for data updates, information provision, admission and overall coordination with the hospital. Similarly, a medical doctor representative of the SLIC at the district level, a District Medical Officer (DMO), is available to monitor the overall operational activities. The DMO monitors the admissions, medicines and claims of empanel hospitals. To understand the challenges in the existing GR system, our evaluation approach consists of in-depth interviews with the supply-side stakeholders, an evaluation of two call centres, and in-depth interviews with the beneficiaries.

The analysis mainly focuses on the key supply-side challenges in enrolment and service delivery. The in-depth interviews with the supply-side stakeholders are conducted at the federal, provincial and district levels. At the federal and provincial levels, we managed interviews with the SSP management, provincial health departments, NADRA and SLIC. At the district level, we visited more than 45 empanel hospitals in 26 districts, where in-depth interviews were conducted with district medical officers (DMOs), health front officers (HFOs), hospital management and partner NGOs responsible for enrolment.

Table 3

Districts where in-depth interviews were conducted with Empanel Hospitals and Field Teams (HFOs and DMOs)

Province/region	Name of districts
AJK	Bhimber, Neelum, Bagh, Muzafarabad, Mirpur
ICT	Islamabad, Rawalpindi
Ex-FATA	Peshawar, Khyber
GB	Hunza, Astore, Gilgit, Ghizer, Nagar
Punjab	Gujrat, Sargodha, Bahawalpur, Rajanpur, DG Khan, Lahore, Faisalabad, Sahiwal
Sindh	Tharparkar, Mirpur Khas, Badin, Karachi

There are two call centres managed by the SLIC and NADRA, respectively. NADRA manages an out-bound call centre, whereas SLIC manages an in-bound call centre. The out-bound call centre is responsible for informing the pending beneficiaries to collect their SSP cards from dedicated points and to acquire post-feedback on the quality of services from those who receive in-door treatment. While receiving feedback from treated beneficiaries, a complaint is automatically registered if a beneficiary reports some grievances, i.e., non-provision of good quality services, non-provision of medicine, bribe etc.

The in-bound call centre is used for information provision and complaint registration. The role of this call centre is critical in registering complaints as it is almost the sole source to register complaints by the public and beneficiaries.

There were more than 51,000 complaints registered by SLIC and NADRA call centres from 2016 to June 2021. We have analysed the registered complaints and managed in-depth interviews with the call centre operational team. The analysis covers causes and sources of complaints, turnaround times to settle complaints, etc.

An effort is made to ensure representation at the potential category-wise of complaints and province/region. Three types of interviews were conducted with the beneficiaries. First, during the field visit, we conducted in-depth interviews with 215 admitted beneficiaries in 45 hospitals. Second, using the complaint database, a random sample of 750 complainants is drawn who registered a complaint in the last year. These beneficiaries were interviewed through a computerised assisted telephonic interview (CATI) survey to receive feedback on complaint registration and resolution. *Third*, a door-to-door survey was conducted (for another study) in 25 districts where a complaint module was added to gauge the knowledge of beneficiaries about the complaint system of SSP. A total of 1,845 beneficiaries were interviewed for their feedback on the complaint registration process.

4. AN APPRAISAL OF COMPLAINT REDRESSAL SYSTEMS

There are two mechanised systems to facilitate the beneficiaries' and citizens for their awareness and grievances. *First, the* public can use the SMS service (by sending the NIC number at 8500) to check the family eligibility status and details of unmarried registered children with their parents. *Second*, Health Management Information System (HMIS) is placed in empanel hospitals for multiple purposes, including; enrolment of families and unregistered members,[4] balance inquiry and health utilisation records. The HFO operates HMIS in empanel hospital.

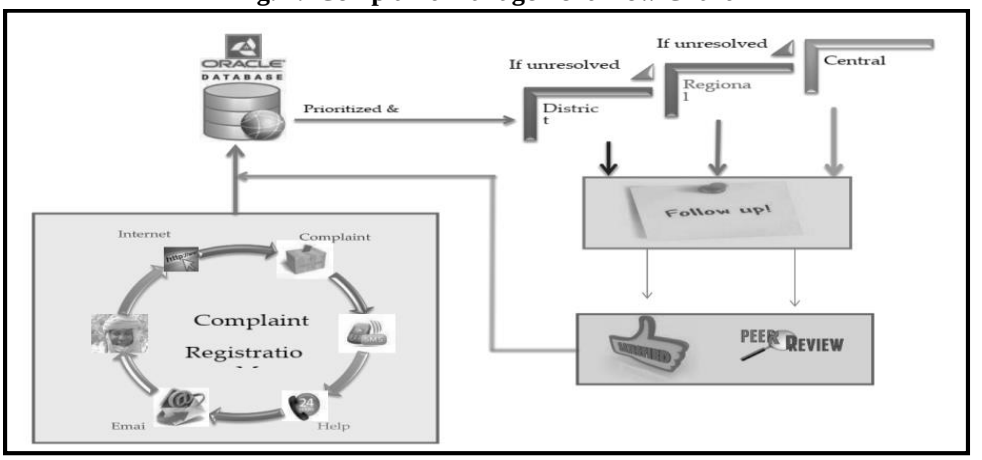
The programme offers three mechanisms for complaint registration:

(i) A web portal is placed on the SSP website where citizens can register complaints through email.

(ii) A call centre managed by the SLIC (0800-09009) to address the queries of the general public and to register a complaint. It is an in-bound call centre and is operational 24/7.

(iii) The NADRA manages another out-bound call centre to acquire follow-up feedback only from those beneficiaries who utilise in-door health services. The feedback is acquired on five questions, and if a beneficiary responds of poor feedback (i.e., purchase of medicine, bribe taken by empanel hospital etc.), it is forwarded to SSP management for action.

Fig. 1. Complaint Management Flow Chart



[4] An unregistered member can be enrolled by showing the valid B-form or CNIC at front desk.

The SLIC and SSP management have developed a complaint management chart where complaint registration through multiple sources is investigated. The escalation process is also defined in case a relevant tier does not resolve a complaint (Figure 1). However, the following limitations were found in the existing complaint management system.

(i) There is no operational manual in Figure 1 having clear roles and responsibilities of various stakeholders to address grievances. No loop and a stipulated time are defined against each complaint. Neither the complaint taxonomy prevails.
(ii) The integrated complaint management system is entirely missing. Only the complaints registered through the call centres are analysed, whereas the complaints registered through web/portal emails and postal letters are pending.
(iii) The SSP presence is at the federal and provincial headquarters; there are no field offices for monitoring and complaint registration. There is only the HFO at the front desk office in empanel hospitals to guide beneficiaries and to provide assistance in admission. As per his/her job description, HFO cannot register a complaint against SLIC or empanel hospital. The HMIS available in hospitals have no module for complaint registration. It has limited features for data updates and balance inquiries. The public hospital lacks an HMIS system in AJK and GB.
(iv) The only source of complaint registration is the call centre managed by the SLIC. Here again, conflict of interest involves the same company managing the operation and call centre.

5. AN EVALUATION OF CALL CENTRES

As mentioned earlier, the complaint loop is currently not defined; hence, there is no automated escalation process against a registered complaint. SLIC has a dedicated call centre, which operates 24/7, with 18 agents. The call centre can register a complaint; similarly, SLIC receives complaints from the NADRA call centre (through the SSP office) if a beneficiary reports a grievance in a follow-up call, i.e., denial of services, non-provision of medicine, bribe etc. The analysis reveals that both call centres registered more than 51,000 complaints till June 2021. Mostly the complaints were received from Punjab. The SLIC call centre is supposed to register more complaints as its helpline number is disseminated everywhere; however, the NADRA call centre received more complaints (only during the follow-up call from treated beneficiaries). It reflects the under-utilisation of the SLIC call centre.

Table 4

Province-wise Secondary Complaint Database (in Numbers)

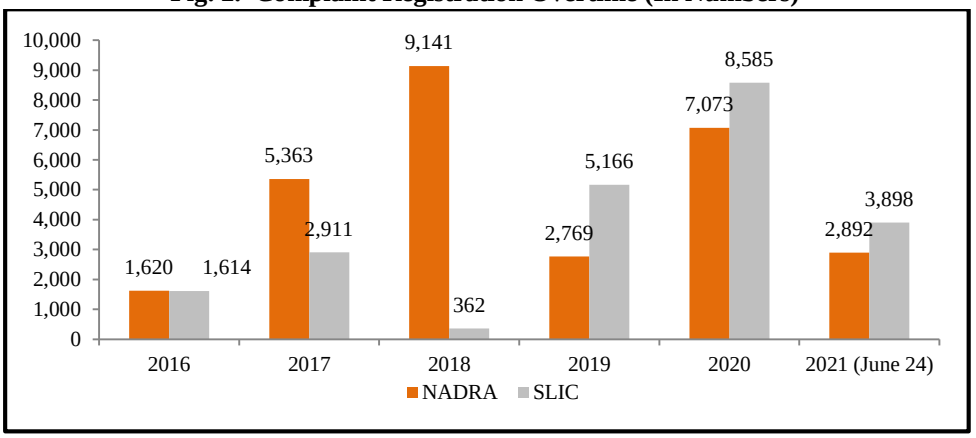
Region	NADRA	SLIC	Total
AJK	3,174	1,764	4,938
Balochistan	862	3,442	4,304
Ex-FATA	2,481	80	2,561
GB	471	132	603
Islamabad	2,137	405	2,542
Khyber Pakhtunkhawa	2,683	5,992	8,675
Punjab	15,034	7,086	22,120
Sindh	2,016	3,635	5,651
Total	**28,858**	**22,536**	**51,394**

Source: Complaint database provided by SSP till June 24, 2021.

With time, the SLIC call centre has witnessed a rising caseload of complaints, especially in 2019 and 2020 (Figure 2). It is worth mentioning that the data lacks details of those calls where the public/beneficiary has made a call for information purposes. The SLIC call centre is not fully automated enough to provide a good summary report and automatically records every call, whether for information or a complaint.

We found that complaint taxonomy is not defined, where the data is maintained in the excel sheet rather than developing an automated Complaint Management System (CMS) by the SLIC. Once a complaint is registered or received from NADRA, it is forwarded to the DMO through WhatsApp. After receiving the DMO response, the call agent marks the complaint as 'resolved'. Regrettably, there is no precise implantation of investigation procedures, escalation processes, etc. Out of the total registered complaints, our analysis reveals that 60 per cent of the complaints were marked as 'resolved', 29 per cent as 'invalid', 7 per cent as 'acknowledged', and 4 per cent set as 'pending'. The 'invalid' number is relatively high as it shows that a complaint is registered, but it was found 'invalid' and closed after an investigation.

Fig. 2. Complaint Registration Overtime (In Numbers)



Source: Complaint database provided by SSP till June 24, 2021.

Since the database at a call centre is maintained manually, we found various issues in the database. First, various complaints, marked as 'acknowledge' lack resolution date (3,716 in number). While analysing these complaints, we found that 58 per cent of the 'acknowledge' complaints had certain grievances and should not be marked as 'acknowledge' (Annexure Table 1). SSP must conduct a sampled-based investigation against the 'resolved', 'acknowledged', and 'invalid' marked complaints by the SLIC, as our telephonic survey with the complainants show that significant 'resolved' and 'invalid' marked complaints are pending.

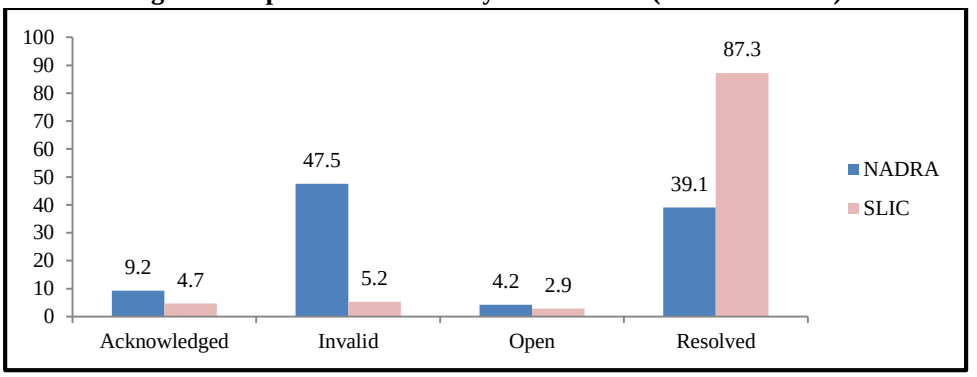
Another limitation is the limited caseload on the SLIC call centre on grievances related to service delivery. The SLIC call centre has been widely communicated to the beneficiaries to register complaints; however, the NADRA's call centre reported genuine grievances during a follow-up call from patients rather than SLIC. The SLIC call centre had a limited caseload on genuine complaints, i.e., transport changes not given, additional payment taken, beneficiary deceased and certain payments taken by the hospital against

medicine and lab tests etc. (Annexure Table 2). Annexures to Tables 3 to 5 show that a significant percentage of complaints related to the service delivery were marked 'invalid' and 'acknowledged', i.e., transportation charges are not given, additional charges and certain payments are taken during treatment.

The SSP authorities must carefully analyse the resolution status of complaints by the type of call centre. Interestingly the SLIC has been declaring a significant percentage of the complaints as 'invalid' compared to NADRA. Similarly, the resolution rate of complaints reported by the NADRA is significantly less than the SLIC call centre (Figure 2).

Two reasons may hold for under-reporting by SLIC: *first*, mostly the complaints reported through NADRA call centre are on service delivery, and it is unlikely that around half of the complaints are 'invalid', so there is a matter of 'conflict of interest' as SLIC itself investigates such complaint against itself and SLIC authorities may intentionally declare it 'invalid'. *Second*, the less resolution of complaints by the NADRA and more by SLIC depends on the nature of the complaint, as complaints reported on the SLIC call centre are mostly on data-related issues rather than service delivery. Both the call centres have improved their turnaround time to resolve the complaint (Annexure Table 6).

Fig. 3. Complaint Resolution by Call Centres (% Distribution)



Source: Complaint database provided by SSP till June 24, 2021.

The following limitations are found in the SLIC call centre for reporting and resolving grievances:

(i) The call centre lacks an automated system. Data is maintained in an excel sheet. There is no integration of call centre complaints with the field offices for investigation and complaint resolution. The SLIC defines no complaint loop and stipulated time. No complaint number is generated.

(ii) The call centres (managed by the NADRA and SLIC) are not integrated. NADRA shares the complaints data with SSP through a manual system.

(iii) SLIC lacks a business model to run the call centre. There is no analysis of the call centre caseload and monitoring of call agents. The call agents lack proficiency in interacting with citizens in regional languages or call transfer facilities.

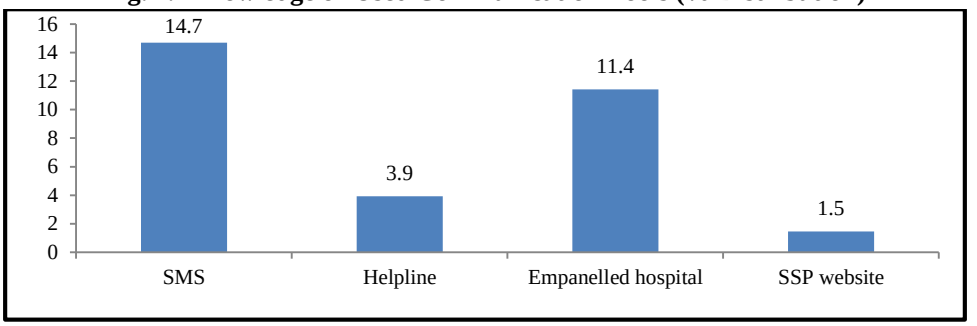
(iv) The SSP management lacks its M&E capacity to conduct periodic analysis on registered complaints, especially those reported as 'resolved' by the SLIC. During our telephonic survey, we found that various complaints tagged 'resolved' complaints in the database have not been practically resolved as reported by the respondents.

6. DEMAND SIDE CHALLENGES ON ENROLMENT AND SERVICE DELIVERY

6.1. Communication Challenges

The analysis in this section is carried out using a household survey (1,845 beneficiaries), a telephonic survey (750 beneficiaries) and 215 admitted beneficiaries in 45 hospitals. One of the main constraints on beneficiaries is the lack of sufficient information about the programme. They don't know where to get information as the programme lacks ground-level field offices for personal interaction. Mostly, the beneficiaries lack information on the eligibility threshold, card expiry, and package amount. Only a minor proportion of the beneficiaries know or have used the available communication tools of SSP, e.g., 15 per cent know about the SMS service, 11 per cent know about empanel hospitals and 4 per cent know about the helpline. Only 2 per cent know about the SSP website (Figure 4).

Fig. 4. Knowledge or Used Communication Tools (% Distribution)



Source: SSP Beneficiary Survey 2021.

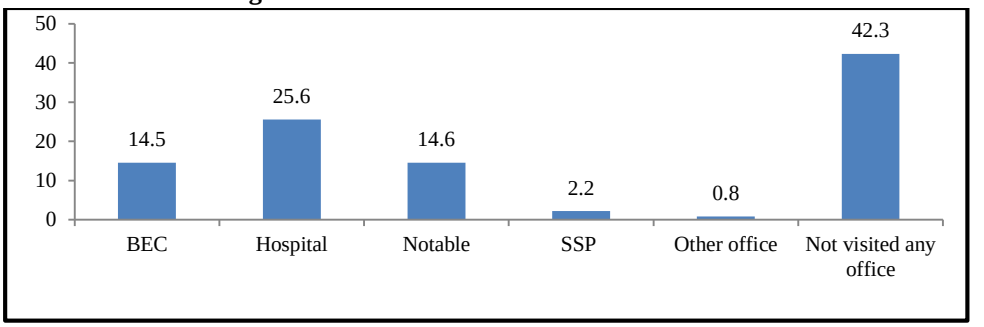
The findings from the household survey revealed that only 0.6 per cent of the interviewed beneficiaries had registered a complaint after enrolment in the programme, 1 per cent had attempted to register the complaint, and the rest, 98.4 per cent, had never registered a complaint. Only 1 per cent knew the mechanism of complaint registration among those who attempted or never registered a complaint. The rest, 99 per cent, were unaware of the mechanism.

This information is mainly consistent with our finding that the programme requires a massive focus on creating citizens' awareness of the programme's features and available complaint registration mechanisms. Most beneficiaries live in remote rural areas and usually don't know how to interact with the authorities. The public mainly relies on 'word of mouth' or desire to interact with some office to report their grievances; however, currently, the programme lacks a ground-level presence where the representatives can interact with the beneficiaries. Although the empanel hospital forum allows the beneficiaries to acquire information through the front desk (managed by the SLIC), this forum has no option for complaint registration, mainly due to conflict of interaction, as the hospital or SLIC cannot register the complaint itself.

The findings from the telephonic survey show that before registering the complaint on the call centre, more than 42 per cent of the complainants have not visited any other

office. The key sources that provided information about the call centre are; communication material given with a health card (40 per cent), notable/friends and family (21 per cent), hospital (13 per cent), BEC (6 per cent) and others, including the SSP website etc. The other main visiting points were the hospital, BEC and notables.

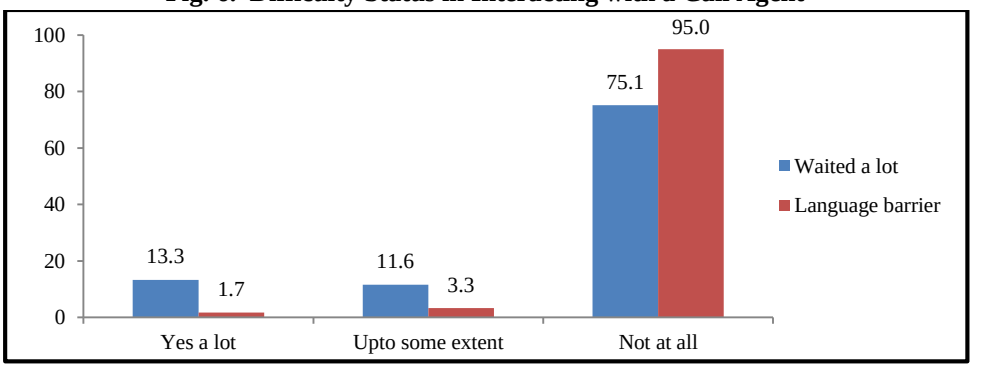
Fig. 5. Status of Visiting Some Office Before Complaint Registration Through a Call Centre



Source: Telephonic survey from beneficiaries, 2021.

Overall the respondents reported not having faced great difficulty interacting with the call agents. Seventy-five per cent of them reported that they don't have to wait a long time before being connected with the call agent, whereas around 95 per cent reported that they had not faced any language barrier. However, a vast majority reported that they were not given a complaint ID (59 per cent).

Fig. 6. Difficulty Status in Interacting with a Call Agent



Source: Telephonic survey from beneficiaries, 2021.

An interesting element was the lack of proper awareness about the beneficiary and whether their complaint was resolved or not. A significant percentage reported that they were not adequately informed about the way forward and whether their complaint was resolved. For example, the SLIC's call centre data shows that 57 complaints are invalid; however, the respondent considers them unresolved. Similarly, the data of the call centre reports that 250 complaints as resolved; however, respondents still consider them unresolved. Ideally, the beneficiary and/or complainant must be briefed entirely on complaint status rather than making a one-sided solution.

Table 5

Complaint Resolution Matrix (in Numbers)

	Resolution Matrix	Call Centre Database			
		Invalid	Open	Resolved	Total
Reported by Beneficiary	Fully Resolved	26	12	131	169
	Partially Resolved	7	1	16	24
	Not Resolved	57	48	250	355
	Don't Know	1	0	13	14
	Not applicable	6	6	44	56
	Total	97	67	454	618

Source: Telephonic survey from beneficiaries and database, 2021.

6.2. Enrolment Challenges

The in-door service utilisation is conditioned with the enrolment of a family or member in the programme based on a NIC or Birth registration form (B-form). After an interval of a few months, the SSP receives updated data from NADRA as NADRA is the authority to register citizens (NIC and B-form). The data is available in HMIS. A family member can also enrol him/herself at the front desk office in HMIS in empanel hospitals through HMIS.

We found the following key grievances in enrolment that are yet to be resolved:

(i) The programme requires a massive communication strategy, so every citizen has a NIC and B-form. A significant percentage of citizens, predominantly female and children in remote areas, lack NICs and B-forms. Since a patient visits a hospital in an emergency for in-door treatment, the programme must be flexible to give treatment without a NIC.

(ii) The treatment is linked with a NIC and B-form, and every citizen can check his/her enrolment status by using the SMS service. Still, most citizens don't know what documents are required for enrolment. Again a massive communication/awareness effort is required.

(iii) Marital status updating is a key issue. In case of a change in marital status, newly married females face issues of enrolment and treatment. Newly married women cannot receive treatment due to changes in marital status. The programme requires a policy through which newly married couples should be declared separate families.

(iv) Updating data is limited to the addition of a new family member. There could be other features currently missing in HMIS, i.e., address change, mobile phone number change, change of name, change in marital status, death reporting etc. If a beneficiary has a name mismatch in the SSP database and CNIC, they do not know how to correct it.

(v) The programme requires a live integration of HMIS with the NADRA database. Once a family gets a NIC and B-form, HMIS should automatically update its data.

6.3. Service Delivery Challenges

The programme has a mixture of empanel hospitals, both public and private—around 80 per cent of them are private hospitals. The programme has a lower annual in-door utilisation rate (around 3 per cent) than the global rates of 5 to 7 per cent. We found

that annual in-door health utilisation rates vary from 1 to 6 per cent across districts—highly associated with the number of available empanel hospitals, quality of hospitals, district-level poverty, and urbanisation. For example, district Astore has the lowest health utilisation rate, primarily that after inception of programme there was not a single empanel hospitals. Similarly, Tharparker has very few empanel hospitals and lacks doctors and good quality services. In the household survey, we found that some hospitals are adopting a pick-and-choose option, i.e., denial of services for sickness, where they have a lower margin. Similarly, some government hospitals have not been providing medicine during in-door treatment. The household survey reveals that:

(i) Around 4 per cent of the beneficiaries reported that they faced a situation where in-door health facilities were required for a family member. They had health cards but had not visited a hospital, primarily because they lacked knowledge of where to go, the necessary documents required, or the hospital was too far etc.
(ii) Around 3 per cent of the beneficiaries visited empanel hospital but could not utilise services due to the lack of family names in the database, non-availability of treatment or denial of services etc.

Our discussion with the empanel hospitals reveals that no proper operational manual clearly clarifies the roles and responsibilities of empanel hospitals, SLIC and SSP. A complaint manual, however, is available to the hospitals. Some hospitals admit that package constraint is the main reason for the denial of services, especially in medical sickness. Another challenge is the attitude and behaviour of staff belonging to government hospitals.

Currently, the provincial health regulations do not empower the empanel public hospitals to utilise the revenues generated from SSP beneficiaries. Keeping this in mind, they consider the programme a burden rather than an incentive. Another constraint is the lack of competition in the insurance market, as there is a single company (SLIC) to provide services. In some districts, there is only one empanel hospital, and despite its complaints, the authority has no option but to close its services. We also found that HFOs require sufficient training to guide beneficiaries, as most lack accurate programme information. HFOs are primarily available during the daylight hours, and there could be a denial of services if a patient visits the hospital at night are at the weekend when HFO is not present.

6.4. Coordination Challenges among Stakeholders

We found no operational manual with clear roles and responsibilities for all the stakeholders. The absence of such a document often originates certain anomalies and confusion. As reported by the managers of governmental hospitals of AJK, they lack sufficient guidelines and clarity on the programme, both from SLIC and the AJK government. The programme is operational, but they don't know how to utilise the funds generated from service delivery. *Second*, empanel hospitals have severe reservations about treatment packages. The reservation mostly holds in big cities. As a result, hospitals are making 'pick and choose' behaviour and providing in-door treatments against that sickness where they have profit and denial for the others, i.e., medical-related sickness. *Third*, empanel hospitals are facing delays in receiving funds after claim submission. Fourth, no referral system exists where one hospital can refer the patient to another. Ideally, HMIS must have the features of a referral system.

7. CONCLUSIONS AND POLICY IMPLICATIONS

The SSP has been providing in-door health insurance with the support of various stakeholders. SLIC is the main player as the operational manager of all in-door health services and is responsible for ensuring the availability of empanel hospitals and good quality in-door treatment.

Although the SSP lacks its presence in the field through dedicated field offices; however the programme provides multiple channels to register a complaint to its beneficiaries, including a web portal, email, call centre and postal letter. Two call centres are operational: one is managed by NADRA to acquire feedback from only those who received in-door treatment; the SLIC manages the other for the general public to provide information, register complaints and guide the citizens.

Grievance redressal is highly linked with beneficiaries' knowledge, attitude and awareness. We found that many beneficiaries lack sufficient information about various features of the programme. A minimal percentage of them know about the available complaints registration facilities. One primary reason is the lack of gross-root level presence of SSP offices (i.e., at tehsil or district level) to disseminate information and to register grievances. As a result, many don't know where to go for information, treatment, or complaint registration. The SLIC's call centre is the only forum for acquiring information and complaint registration; however, a minimal percentage of the population knows about it.

We have thoroughly evaluated the operations of SLIC's call centre and registered complaint data, including secondary data. At present, the call centre is managed manually and lacks automation and integration with the field team. Complaint taxonomy is not defined. An encouraging element is a significant improvement in the call centre's turnaround time and registration of more complaints at the call centres.

Our analysis suggests the following recommendations for improving the GR system.

(a) *Upgradation in Call Centre*

The SLIC's call centre requires a massive up-gradation including:

(a) A fully automated call centre with horizontal and vertical integration with all stakeholders and no manual system. Specific dashboards can help in monitoring progress.
(b) Each complaint must have a taxonomy, complete loop and stipulated time for resolution.
(c) Operatable in all regional languages.

The SSP management should manage the call centre itself to avoid 'conflict of interest' as SLIC is responsible for providing health services, and the same company has been managing the call centre and complaint investigation. At the least, the SSP must conduct a sample-based analysis either through itself or through the NADRA call centre or any other third party on 'resolved' and 'acknowledged' complaints as reported by SLIC. NADRA can be tasked to acquire a secondary review on 'acknowledge', 'resolved' and 'invalid' complaints as tagged by the SLIC.

(b) ***Integrated Complaint Management System (ICMS)***

Currently, the complaints registered through a web portal, email and postal letter are pending due to limited staffing. These complaints must have a complete record for analysis. All the complaints must be pooled at one point, named ICMS if necessary, where the taxonomy and loop of each complaint must be defined along with the stipulated time for complaint resolution. Currently, the complaints received at the SLIC's call centre are managed in an excel sheet, then it is informed to HFO/DMO through email/WhatsApp, which can lead to errors and skipping. All this must be done through an integrated system linked with HMIS/ICMS. The NADRA call centre should also be integrated with the SLIC call centre.

(c) ***Ground-level presence to register complaints***

The programme must have a ground-level presence to interact with the public, guide them, and register their complaints. It will improve communication and awareness, as it would be challenging to streamline the grievance system without proper awareness. Alternatively, the programme can liaise with other social protection departments (e.g., BISP, Bait-ul-Mal, Zakat etc.) in their district/tehsil level offices.

(d) ***Improvement in service delivery***

Certain grievances are pending and linked with the policy or efficient service delivery. For example:

(i) Enrolling in the programme requires policy-level decisions to enrol newly married couples and declare them separate families. In addition, live data updates should be managed with the NADRA.
(ii) HMIS requires up-gradation to resolve specific data-related grievances, i.e., name mismatch, temporary address issue etc.
(iii) Sufficient numbers of hospitals will resolve specific grievances, i.e., denial of services, doctor's availability, provision of medicine etc.

(e) ***Training of HFOs***

HFOs are the primary source for interacting with the beneficiaries and general public in hospitals. We learned that their knowledge varies; ultimately, communication with beneficiaries sometimes yields misleading guidelines. SLIC must have an operational manual where each stakeholder's roles, responsibilities and guidelines must be mentioned.

(f) ***Modern technology use***

The programme requires modern technology, i.e., a referral system, as various regions in remote areas, including AJK and GB, lack any tertiary-level hospital. Some android applications are required to find the nearest empanel hospital and available services related to sickness, hospital ratings and a dashboard to review performance on a submitted grievance.

(g) ***Strengthening M&E***

Currently, both the federal SSP management and provincial SSP team lack monitoring systems. Regular monitoring of operational activities, periodic process evaluations, sampled-based follow-up surveys and impact evaluations would create deterrence to service providers (e.g., SLIC and empanel hospitals) for improving their services. The SSP requires strengthening of their in-house evaluation unit.

Annexure Table 1

Nature of Complaints that have been Just 'Acknowledged' in Database

Nature of complaint	In numbers
Transportation charges not paid	800
Bribe, extra payment, payment for test	176
Poor quality services, i.e., misbehave, medicine not given	305
Additional amount taken	344
Card issues	264
Denial of services	247
Total	2136

Annexure Table 2

Nature of Complaint as Reported by the Call Centre

Nature of complaint	NADRA	SLIC	Total
Transportation charges are not given	12,191	56	12,247
Additional charges taken	4,798	127	4,925
Ambulance not available	0	2	2
Asking bribe to issue card	7	179	186
Bad service given	0	330	330
Beneficiary deceased	5,874	5	5,879
Card lost	0	1,616	1,616
Card registration problem	0	2,397	2,397
Centre does not exist/could not find	54	11,821	11,875
Hospital staff misbehave	0	130	130
Medicines not available	0	103	103
No attendant at hospital	0	108	108
Not allowed by SLIC/PMNHP represent..	0	18	18
Not allowed by SLI/PMNHP doctor	0	2	2
Paramedic staff negligence	0	3	3
Payment for admission discharge	857	31	888
Payment for medicine	1,939	46	1,985
Payment for tests	2,365	34	2,399
Service not given by hospital	0	2,626	2,626
Treatment not availed	773	460	1,233
Update CNIC in record	0	2,441	2,441
Total	28,858	22,536	51,394

Source: Complaint database provided by SSP till June 24, 2021.

Annexure Table 3

Nature of Complaint by Status of Resolution (in Numbers)

Nature of complaint	Acknowledged	Invalid	Open	Resolved	Total
Transportation charges are not given	800	8,751	3	2,693	12,247
Additional charges taken	344	1,797	183	2,601	4,925
Ambulance not available	0	2	0	0	2
Asking bribe to issue card	23	17	1	145	186
Bad service given	17	63	28	222	330
Beneficiary deceased	1,067	1,321	693	2,798	5,879
Card lost	66	23	8	1,519	1,616
Card registration problem	198	69	37	2,093	2,397
Centre does not exist/could not find	143	173	367	11,192	11,875
Hospital staff misbehave	35	7	0	88	130
Medicines not available	4	14	3	82	103
No attendant at hospital	17	11	4	76	108
Not allowed by SLIC/PMNHP represent.	4	1	1	12	18
Not allowed by SLIC/PMNHP doctor	0	0	0	2	2
Paramedic staff negligence	2	0	1	0	3
Payment for admission discharge	44	274	37	533	888
Payment for medicine	82	605	141	1,157	1,985
Payment for tests	109	809	139	1,342	2,399
Service not given by hospital	104	603	177	1,742	2,626
Treatment not availed	259	339	29	606	1,233
Update CNIC in record	398	10	6	2,027	2,441
Total	3,716	14,889	1,858	30,931	51,394

Source: Complaint database provided by SSP till June 24, 2021.

Annexure Table 4

Nature of Complaint by Status of Resolution (NADRA Call Centre)

Nature of complaint	Acknowledged	Invalid	Open	Resolved	Total
Transportation charges are not given	794	8,735	0	2,662	12,191
Additional charges taken	336	1,756	182	2,524	4,798
Asking bribe to issue card	0	3	0	4	7
Beneficiary deceased	1,067	1,320	693	2,794	5,874
Centre does not exist/could not find	13	14	0	27	54
Payment for admission discharge	40	267	35	515	857
Payment for medicine	81	599	139	1,120	1,939
Payment for tests	106	801	139	1,319	2,365
Treatment not availed	227	216	26	304	773
Total	2,664	13,711	1,214	11,269	28,858

Source: Complaint database provided by SSP till June 24, 2021

Annexure Table 5

Nature of Complaint by Status of Resolution (SLIC Call Centre)

Nature of complaint	Acknowledged	Invalid	Open	Resolved	Total
Transportation charges are not given	6	16	3	31	56
Additional charges taken	8	41	1	77	127
Ambulance not available	0	2	0	0	2
Asking bribe to issue card	23	14	1	141	179
Bad service given	17	63	28	222	330
Beneficiary deceased	0	1	0	4	5
Card lost	66	23	8	1,519	1,616
Card registration problem	198	69	37	2,093	2,397
Centre does not exist/could not find	130	159	367	11,165	11,821
Hospital staff misbehave	35	7	0	88	130
Medicines not available	0	0	0	1	1
No attendant at hospital	4	14	3	82	103
Not allowed by sli / pmnhprepresent..	17	11	4	76	108
Not allowed by SLI/PMNHP Doctor	4	1	1	14	20
Paramedic staff negligence	2	0	1	0	3
Payment for admission discharge	4	7	2	18	31
Payment for medicine	1	6	2	37	46
Payment for tests	3	8	0	23	34
Service not given by hospital	104	603	177	1,742	2,626
Treatment not availed	32	123	3	302	460
Update CNIC in record	398	10	6	2,027	2,441
Total	1,052	1,178	644	19,662	22,536

Source: Complaint database provided by SSP till June 24, 2021.

Annexure Table 6

Turnaround Time to Resolve Complaints (% Distribution)

Number of days	2016	2017	2018	2019	2020	2021	Overall
			Overall				
Within 30 days	69.2	46.5	61.4	77.3	90.0	97.6	75.7
31 to 60 days	3.8	6.0	26.4	8.2	7.3	1.5	9.8
61 to 90 days	9.3	2.0	6.9	6.4	2.0	0.5	3.8
91 and above days	17.7	45.5	5.4	8.1	0.7	0.3	10.7
Total	100	100	100	100	100	100	100
			NADRA Call Centre				
Within 30 days	37.2	21.7	60.6	90.1	84.9	96.2	64.0
31 to 60 days	6.4	8.5	26.9	5.0	10.9	2.3	14.1
61 to 90 days	18.2	2.7	6.9	2.2	3.5	0.8	4.8
91 and above days	38.3	67.1	5.6	2.7	0.7	0.7	17.2
Total	100	100	100	100	100	100	100
			SLIC Call Centre				
Within 30 days	96.2	98.9	82.4	71.2	94.2	98.3	89.7
31 to 60 days	1.5	0.7	12.5	9.7	4.3	1.2	4.6
61 to 90 days	1.9	0.4	5.1	8.4	0.8	0.4	2.7
91 and above days	0.4	0.0	0.0	10.8	0.8	0.2	3.0
Total	100	100	100	100	100	100	100

Source: Complaint database provided by SSP till June 24, 2021.

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Pakistan Institute of Development Economics
Post Box No. 1091, Islamabad, Pakistan

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