The Role of Community Spaces and Mechanisms in Health Promotion amongst the Poor Communities in Rural Pakistan

A study funded by the Maternal and Newborn Health Programme – Research and Advocacy Fund (RAF)

Research Report

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Co-Investigator: Dr. Ayesha Aziz

February 2014

DECLARATION:

"We have read the report titled 'The Role of Community Spaces and Mechanisms in Health Promotion amongst the Poor Communities in Rural Pakistan', and acknowledge and agree with the information, data and findings contained".

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ABBREVIATIONS AND ACRONYMS

AKRSP	Aga Khan Rural Support Programme
AKHSP	Aga Khan Health Services of Pakistan
AusAID	Australian Agency for International Development
BHU	Basic Health Unit
BISP	Benazir Income Support Programme
CI	Co-Investigator
CMW	Community Midwives
DFID	Department of International Development
DHO	District Health Office
EmOC	Emergency Obstetric Care
FALAH	Family Advancement for Life and Health
FGDs	Focus Group Discussions
FWC	Family Welfare Centres
FWW	Family Welfare Worker
GB	Gilgit-Baltistan
GoP	Government of Pakistan
ICPD	International Conference on Population and Development
IDIs	In-depth Interviews
KII	Key-Informant Interviews
LHV	Lady Health Visitors
LHW	Lady Health Worker
LHWP	Lady Health Workers Programme
LPP	Lodhran Pilot Project
MDG	Millennium Development Goals
MM	Male Mobiliser
MNCH	Maternal, Newborn and Child Health
MSU	Mobile Service Units
NGO	Non-Government Organisation
NRSP	National Rural Support Programme
PAIMAN	Pakistan Initiative for Mothers and Newborns
PC	Planning Commission
PI	Principal Investigator
PoA	Plan of Action
PRA	Participatory Rural Appraisal/ Participatory Reflection and Analysis
PRIDE	Primary Healthcare Revitalization, Integration and Decentralization
PRSP	Punjab Rural Support Programme
PWD	Population Welfare Departments
RAF	Research and Advocacy Fund
RHSC	Reproductive Health Service Centres
RSPN	Rural Support Programmes Network
RSPs	Rural Support Programmes
TFR	Total Fertility Rate
UC	Union Councils
WHO	World Health Organization
WMO	Woman Medical Officer

EXECUTIVE SUMMARY

Health promotion strategies have been employed in several maternal, newborn and child health (MNCH) programmes in Pakistan, yet over the past five years the country's maternal mortality rate (per 100,000 live births) has shown a marginal improvement from 276 to 260, while the infant mortality rate (per 1000 live births) has declined only by four points. The women, poor people and marginalised groups living in rural communities are the worst affected as their access to healthcare is limited by financial and non-financial barriers. This study aims to highlight the different kinds of community spaces and mechanisms created by MNCH programmes, if and how these spaces have included or excluded the vulnerable and what is their contribution in empowering people and promoting MNCH.

Health promotion process views communities as the main health resource and aims at enabling them to increase control over and to improve their health, while responding to health inequities within and between societies. Community participation and empowerment lies at the heart of health promotion, therefore, enhancing abilities of the disempowered and supporting them with structural mechanisms are part of the empowering process. Since power is enacted in social spaces and settings that determine human behavioural patterns and are in turn transformed by them, this study differentiated and examined the formal community spaces that are created or facilitated by external agents like MNCH programmes and the informal spaces that are indigenous places where community people interact and have dialogues.

Considering the interaction between concepts, the study used a qualitative case study design and an action oriented approach to balance the purposes of knowledge generation and action. One village in each of the three most socially and economically deprived districts of Pakistan, namely Thatta, Rajanpur and Ghizer was purposively selected as study sites. The villagers in each study site, particularly women, poor persons and marginalised groups were considered as the case and the impact of formal and informal spaces on their MNCH was studied. Data was collected through document review and 25 key informant interviews from the staff of six MNCH programmes working in the three study sites. A total of 37 focus group discussions using participatory rural appraisal tools were done with 15-20 women and 15-20 men in each study site. Inclusiveness and diversity of opinions was ensured by including group participants from different areas, castes and socio-economic strata in each study village. Several in-depth interview sessions were conducted with some women and men in each site to document their MNCH related experiences and interactions in informal spaces in form of case studies.

We found that the MNCH programmes have created or facilitated the creation of four types of formal community spaces which include the fixed, small transitory, large transitory and emerging institutional spaces. The different types of formal spaces have limited functionality, but together they have contributed to an overall increase in health awareness and positive behaviour change. However, no MNCH programme is utilising all the four types of formal community spaces and empowerment and collective action for social change is not the agenda of MNCH programmes.

Social exclusion in Thatta and Rajanpur, was based on land ownership, caste, economic class, occupation and pattern of settlement, while in Ghizer the society was stratified mainly on the basis of religious sect. Exclusion from formal community spaces was due to community behaviours underpinned by these patterns of social stratification and MNCH programme design and implementation strategies. The programmatic mechanisms of exclusion favoured the community notables and healthcare workers by reinforcing the existing power dynamics.

Some informal spaces made way for participation of community people across social strata, while others allowed for infiltration of information imparted in the formal spaces to reach from the better-off to the excluded. The informal spaces also provided ground for the solidarity of the poor and marginalised where they helped each other in livelihood activities and accessing healthcare services. On the basis of the study findings, it is recommended that:

1. To improve the MNCH indicators it is important to address the health needs and empower the poor and marginalised. A move from awareness raising on health issues and availability of healthcare services to mobilisation for rights and entitlements and citizen-state interaction for local accountability is necessary. The radical discourse of health promotion that favours social justice and empowerment should be adopted as the agenda of MNCH programmes. This means that the purpose and strategies of formal spaces of MNCH programmes should be critically reviewed and aligned with the agenda of health promotion and empowerment.

2. All the four types of formal community spaces must be used for health promotion, while avoiding conflicting messages, since each space has its benefits and

limitations and together they are likely to produce a synergistic effect on MNCH.

3. Performance indicators for healthcare providers should also include functionality of health committees.

4. The programmatic criteria for registering nomadic population groups as clients should be reviewed and mechanisms for their inclusion need to be developed.

5. The objectives, roles, structure and operating procedures of the formal community spaces should be reviewed with explicit consideration of existing social and power structures. The objective of this should be to find ways to improve these institutions and make them more inclusive and representative of the whole community and not merely limited to the inclusion of notables.

6. Monitoring systems of MNCH programmes should ensure inclusion of all vulnerable groups.

7. The training curriculum of MNCH programme facilitators and local healthcare providers should include overcoming of socially constructed biases; understanding social mobilisation and empowerment processes and understanding the existing informal and formal spaces and their utilisation for better health outcomes.

8. The informal spaces where community people participate irrespective of their social strata should be frequently utilised by the MNCH programmes for health promotion and empowerment of the poor and marginalised.

9. The informal spaces that are occupied exclusively by the women, poor people or marginalised groups should be used as outreach sites for MNCH programme activities geared towards encouraging equity in healthcare services. Specific modules should be designed to train the healthcare workers in engaging the excluded without exploiting them.

10. The MNCH programme design should encourage their facilitators to develop understanding of the existing informal spaces and their interaction with the formal spaces.

1. INTRODUCTION

This is the report of a qualitative research study on the role of community spaces and mechanisms in health promotion amongst the poor communities in rural Pakistan. The study was conducted by the Rural Support Programmes Network (RSPN) with support from the Research and Advocacy Fund (RAF). The introduction of this report lays out the study background, rationale and objectives.

1.1   BACKGROUND

The national indicators of Pakistan are far from meeting the targets set for the Millennium Development Goals (MDGs) 3, 4 and 5. Women living in rural areas are at a higher risk of dying from pregnancy related causes than those from urban areas (319 vs. 175 per 100,000 live births) (National Institute of Population Studies and Macro International Inc., 2008). Neonatal mortality is about 55% higher for the poorest 20% households as compared to the richest 20% (Alam, Nishtar, Amjaz, & Bile, 2010). Government initiatives to improve maternal, newborn and child health (MNCH) in Pakistan have included the Traditional Birth Attendant (*Dai* [1]) training programmes of 1950s, the Lady Health Visitor (LHV) training programme of 1975, the Family Health Projects of 1983, the National Programme for Family Planning and Primary Healthcare of 1994, the Women Health Project of 2001, the projects of the National Commission on Human Development since 2003 and the MNCH programme since 2005 (Research and Advocacy Fund, n.d.). The international donor agencies and local non-government organisations have also played their role in improving MNCH through interventions like the Pakistan Initiative for Mothers and Newborns (PAIMAN), the Primary Healthcare Revitalization, Integration and Decentralization (PRIDE) in earthquake affected areas, the Family Advancement for Life and Health (FALAH) and the Marvi (community health workers) projects. Many of these projects emphasised upon providing and strengthening healthcare services, while others have stressed upon enabling and engaging local people in mechanisms like health groups, committees or community support organisations for promoting practice of healthy behaviours. Yet, the recent surveys have shown that the contraceptive prevalence, total fertility and maternal, infant and under five mortality rates have shown marginal improvements over the past few years as shown in table 1.

Pakistan's health policies related to maternal and child health and the National Maternal and Child Health Policy and Strategic Framework, 2005-2015 have committed to tackling the broader gender, social exclusion and poverty (GSEP)

issues that indirectly affect MNCH (Siddiqui, Haq, & Mahaini, 2004; Jaferey, Kamal, Qureshi, & Fikree, 2008; Government of Pakistan, 2005). However, the overall conclusion of researchers is that Pakistan and its MNCH programmes must review and revise their strategies to achieve equitable distribution of healthcare services, especially of maternal healthcare.

To reach a state of complete physical, mental and social well-being, individuals must be able to identify and realise their aspirations, satisfy their needs and change or cope with their environment. Health promotion is recognised as the process of enabling people to increase control over and to improve their health (World Health Organization, 1986). Justice and equity are the prime concerns of health promotion action that aims at empowering people, particularly the most vulnerable. The different ways of empowering people that range from capacity building to mobilisation, stress community participation and strengthening those whose voice is rarely heard (Luttrell, Quiroz, Scrutton, & Bird, November 2009). This study contends that empowerment and health exist in community spaces, therefore it applies the idea of community spaces to MNCH programmes and aims to highlight the different kinds of community spaces and mechanisms created by MNCH programmes, if and how these spaces have included or excluded the poor and marginalised and what is their contribution in empowerment and health promotion of the vulnerable. The study recognises the rural and poor women and men as vulnerable groups whose access to services is limited by financial and non-financial barriers on both the demand and supply sides of the healthcare system. The findings and recommendations from the study can be utilised by decision makers at the policy making, programme design and implementation levels in the health and development sector in designing reform strategies for MNCH promotion.

Table 1: Trend of MNCH Indicators in Pakistan

Indicators	2006-07	2012-13
Contraceptive Prevalence Rate (CPR), percentage of married women	30	35
Total Fertility Rate (TFR), children born per woman	4.1	3.8
Maternal Mortality Rate (MMR), maternal deaths per 100,000 live births	276	260*
Infant Mortality Rate (IMR), infant deaths per 1000 live births	78	74
Under Five Mortality Rate, child deaths per 1000 live births	94	89

Sources: Pakistan Demographic and Health Survey 2006-07
and 2012-13; *UNICEF Pakistan 2012

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[1] Dai is a term used in Urdu language to refer to traditional birth attendants in villages and other community settings. These women are usually not formally trained in conducting deliveries.

1.2   RATIONALE

The idea of promoting health through behaviour change and awareness raising by creation of dialogic community spaces has been employed in several health projects including many MNCH programmes in Pakistan such as the National Programme for Family Planning and Primary Healthcare (commonly known as the Lady Health Workers Programme, LHWP). An assumption embedded in this notion is that as soon as people become aware of the healthy behavioural patterns they will change their behaviours. In Pakistan's context where cultural norms are heavily gendered and social stratification is based on economic status, this seems a remote reality, particularly for the poor and vulnerable groups including the women and children. The health policies and programmes in Pakistan have not adopted collective action aimed at achieving equity and socio-political justice as their strategic agenda. Therefore, empowerment and health promotion processes have failed to become part of programmatic outcomes, strategies and indicators. Likewise, the inclusion or exclusion of vulnerable population groups like those of women and poor people is also largely ignored.

This implies that the role, effectiveness and sustainability of the MNCH programmes in empowering individuals and communities that indirectly has positive impacts on their health have not been studied or measured. As a result, the potential of investing in and scaling up participatory community mobilisation activities as a means to achieving far reaching health goals remains unappreciated. This study aims to suggest ways in which community spaces can increasingly be loci where discourses and activities empower the vulnerable and excluded groups to demand improved governance and accountability for promoting MNCH. Therefore, it is important to first identify the type of community spaces and mechanisms created or existing in the communities. Subsequently, the role of such spaces in empowering or inhibiting mothers and children of Pakistan can be assessed and lessons for improving the utilisation of such spaces can be drawn.

1.3   STUDY OBJECTIVES

The following are the objectives of this study:

- To identify the type of community spaces available for maternal, newborn and child health promotion;
- To understand the role of community spaces as loci for empowering women, poor persons and marginalised groups;
- To suggest ways in which community spaces can be used more effectively for maternal, newborn and child health promotion.

This report begins with an introduction to the key concepts invoked in the study. The literature review discusses the notion of space and its relationship with empowerment and health promotion. The literature review has been used to construct the conceptual framework for the study and is followed by the delineation of research questions and methodology that emerged from it. The findings of the study have been laid out with respect to the study contexts and then discussed in light of theory and practice. The report ends with some suggestions for policy makers and programme designers and implementers of MNCH programmes.

2. LITERATURE REVIEW

The arbitrary nature of time and location of space and the complexities of the process of empowerment necessitate a review of literature on the concepts. The linkage of these ideas with the concept of health promotion in the context of Pakistan must also be understood to construct an analytical framework for the study. Therefore, the literature review below discusses the notion of place and space and the transition in its understanding from an absolute to a relative entity. It builds upon the fluid and transitory nature of spaces and the interactive relationship between human behaviour and spaces. The literature on empowerment describes how abilities and structures affect the power dynamics in social relations and the significance of agency in negotiating space (access and control over resources and knowledge). The literature on health promotion links empowerment with community participation and the creation of spaces for dialogue and accountability processes.

2.1   SPACES

In daily life affairs we take for granted the spatial distribution of people, places, objects and events. However, when considering how people behave and what factors influence their behaviours, it is important to recognise space as one of the factors that both shapes and is shaped by human behaviours.

The discussion about space and place in social sciences dates back to the seventeenth century or even before that when geographers considered place as the term for physical location, for example the latitude and longitude, while space was recognised as an abstract area ('milieu') in which particles or objects were located (Agnew, 2011). Some social scientists are of the opinion that the term of space is a marker of modernity as after the seventeenth century it subordinated the term of place (*Ibid*). However, in this study we are concerned with the inter-relationship between place and space and how it was viewed and redefined.

For many years, the concept of space was usually understood with respect to the Newtonian and the Leibnizian view. In the Newtonian view, space was considered as an absolute entity, which has its separate powers independent of whatever objects and events occupy it. Newton's absolute space resembled the previous conception of place, as a concrete and real entity (Disalle, 2002). In the Leibnizian view, space was viewed as relational. In that sense, it had no independent power but its powers were construed by the relation of objects and events occupying it (Antognazza, 2008). The passive and parasitic understanding of space depicted in the Leibnizian view emphasised upon the role of positional and relational causal forces in human life that construct the spaces around them. The Newtonian and Leibnizian views have different priorities of power, but they both have lent to spatial analysis by focusing on the co-occurrence and the relationship between objects, events and spaces.

In the 1970s, these views were challenged by those who claimed that the nature of space and its effects depend on the economic conditions under which space is produced (Harvey, 1973). Some of them ascribed to the Zipfian view that described space as a constraint for human behaviour as people attempted to limit their efforts and maximise the efficiency with which they overcame space, while others adopted the Marxist view, in which space was produced by powerful economic forces that commodified objects and events (Zipf, 1949; Smith N., 1984). Therefore, the focus shifted towards the forces and relations that led to the production of space in the course of time (Smith N., 1984). Yet, behaviourists insisted on developing the understanding of how space is mentally mapped and used by individuals without prior assumptions of minimising effort or distance (Wolpert, 1964; Cox & Golledge, 1969). In their opinion, this would allow for appreciation of cultural differences in space and its usage (Abler, Adams, & Gould, 1971; Bonnemaison, 2005).

In the recent years, four theoretical approaches have been used to characterise the different kinds of spaces or to put place and space together. These include the humanist or agency-based, the feminist, the performative and the neo-Marxist approaches. All of them reject the either/or logic in relation to space and place. The humanist perspective draws upon the writings of Robert Sack (1997), who had considered places as invariable parts of spaces, while spaces provided the resources and frames of reference in which places were made (Sack, 1997). The feminist perspective recognised that identities of subjects and places are constructed (Massey, 1999). It associated the construction of space with higher politics and personified place by home and the lives of women and children. Feminists argued that for socio-political change, the progressive political agenda must be introduced into the places at home. In the performative perspective, Nigel Thrift (1999) claimed places to be open spaces consisting of 'actants' (people and things) and made by the associations

constructed between them and the practices adopted by them in the course of time (Thrift, 1999).

The neo-Marxist approach which is the most popular of the four was best represented in the writings of Henri Lefebvre (1974), who proposed that the capitalist forces have constructed an abstract space that has colonised everyday life, but a movement against such colonisation can occur in the concrete spaces of discourse and representation to reclaim the spaces of everyday life (Lefebvre, 1991). Lefebvre distinguished the physical, mental and social dimensions of spaces and recognised the linkage and presupposition of these dimensions (Lefebvre, 1991). The conflict between abstract and social space is a basic one in modern society.

Spaces and places have been considered as settings within which social activities of various kinds occur. This view is consistent with the observation that certain spaces or places are institutionalised and tied to the performance of particular activities. Such spaces constrain and shape action (Goffman, 1961). The World Health Organization (WHO) has used the term of 'setting' to describe the locations where people interact and shape their environment and as a result create or solve health related problems (World Health Organization, 1998).

Settings can normally be identified as having physical boundaries, a range of people with defined roles and organisational structures such as schools, work sites, hospitals, villages and cities. The Community Space and Security Commission (2005), defined community space as any internal space used by the community, either by a group or individuals and includes spaces established voluntarily or by external groups.

For the purpose of this study, the community spaces were distinguished into formal and informal ones. The formal community spaces were regarded as those created or facilitated by external agents or organisations. They may include male, female or community groups, village health committees or community support groups or local organisations which are expected to generate inclusion and internal democracy and can be seen as sites for encouraging behaviour change, empowerment and health promotion. The informal community spaces include the existing indigenous places or spaces where people get together and have conversations on various social and economic issues. These may include (but are not limited to) peer groups, gatherings on religious and festive occasions, casual discussions within the home, neighbourhood gatherings at common areas, workplaces, agricultural fields or local shops, leisurely visits to friends' homes, communal washing points and so on. The essential difference between the formal and informal spaces is that the former are created with the support of some external factors/people like the MNCH programmes and

follow some sort of structured process (defined objectives, meeting dates, having office bearers, etc.). Informal spaces, on the other hand are indigenous spaces that have been made by the community people and have evolved over time.

2.2 EMPOWERMENT

As a concept, empowerment links individual strengths and competencies, natural helping systems and proactive behaviours to social policy and change (Rappaport J., 1981). The concept has often been related to gaining 'mastery', 'control' or 'power' (Rappaport, Swift, & Hess, 1984; Sen & Presser, 1995). Empowerment has generally been viewed as a process as well as an outcome, suggesting that actions, activities or structures may be empowering and the outcomes of such processes will result in some level of empowerment (Swift & Levin, 1987).

The term empowerment has been derived from the word power and to empower someone means to authorise them and/or to enable a person to gain power (Okeke, 1995). Rowlands (1997) distinguished power into four types, namely 'power over' (influence and coercion), 'power to' (organisation and change in existing hierarchies), 'power with' (power from collective action) and 'power within' (power from individual consciousness) (Rowlands, 1997). This categorisation has been widely used to analyse power based social relations.

By and large, the conceptualisation of empowerment remains indebted to popular education (Freire, 1970) that invoked the personal and inner dimensions of power for bringing about social transformation. It lent a great deal to the feminist perspective that visualised empowerment as the exercise of power and a political struggle to gain control over and access to resources (Barlett, 2004). Empowerment has also been recognised as increased exercise of agency that is aimed at transformation of institutions and structures in different domains of life (Alkire, 2005). Empowerment has been visualised to have intrapersonal (psychological), interactional (thinking about and relating to the environment) and behavioural (taking action and engaging in issues) components as it operates at the individual, organisational and community levels (Zimmerman, 1993; Spreitzer, 1995).

Women's empowerment was understood as a process of challenging oppression to come to terms with inequitable structures (Medel & Medel-Anonevo, 1997). Though contestation has been seen as a characteristic of women's empowerment, there is consensus that it is not about achieving power to dominate others, rather to act with others to effect change that gets reflected at the individual, organisational or institutional and community level (Currie & Wiesengberg, 2003). Kabeer's (2001) framework has proposed the necessity of means (structural factors), abilities

and accountability for empowerment practice and has urged the importance of categorising women's choices on the basis of their practical and strategic needs (Kabeer, 2001). She has related women's empowerment with making choices for the fulfilment of strategic needs. Other frameworks developed to understand women's empowerment have emphasised on women's access, awareness of causes of inequality, capacity to direct one's own interests, and taking control and action to overcome obstacles to reducing structural inequality (United Nations Children's Fund (UNICEF), 2009). Malhotra (2002) has also asserted the importance of enhancing assets and capabilities of women to engage, influence and hold accountable the institutions that affect them (Malhotra, Schuler, & Boender, 2002). In the development paradigm, empowerment of the poor and disadvantaged has been given utmost importance. The empowerment of poor and disadvantaged groups has been associated with their voice and participation in decisions and processes affecting their lives (Friedmann, 1992; Oxfam, 1995). Chambers (1993) pointed towards the need for enabling people, especially the poor to take control over their lives and secure a better livelihood with ownership and control over productive assets (Chambers,1993). Craig and Mayo (1995) stressed upon class conscientisation and collective community for understanding the sources of powerlessness and initiating political struggle to transform reality (Craig & Mayo, 1995). People have been graded as empowered or disempowered relative to others and even themselves in similar or different time frames (Mosedale, 2005). Efforts to measure empowerment have visualised it in the economic, political, socio-cultural, familial, legal and psychological dimensions (Malhotra, Schuler, & Boender, 2002). However, Narayan (2002) has identified access to information, inclusion and participation, accountability and local organisational capacity as the key elements for empowerment and Alsop (2006) has elaborated that people's agency is constrained by opportunity structures in institutions, society and the political arena (Narayan D. , 2002; Alsop, Bertelsen, & Holland, 2006).

Both feminists and development practitioners have stressed the necessity of 'agency' for sustainable empowerment. Feminist literature distinguished 'agency' that was the capacity of individuals to act independently and to make their own free choices from 'structure' that was formed by rules and social forces (such as social class, religion, gender, ethnicity, customs, etc.) that limit or influence the opportunities for exercising agency (Mayoux, 2000). Agency connotes that empowerment cannot be given to people, but has to come from processes through which people empower themselves. External agents have been seen as catalysts of actions or spaces where people can learn and practice empowerment. However, sustainability of empowerment depends on the social bases from which people start, individual skills and

collective action capacities and the results people are able to obtain (World Health Organization, 2006).

2.3 HEALTH PROMOTION

Health promotion is recognised as a process of engaging people and the government in fulfiling their responsibilities for realisation of complete physical, mental and social well-being of individuals and groups (World Health Organization, 1986). Realising the importance of health determinants, the Ottawa Charter for Health Promotion considers peace, shelter, education, food, income, environment, sustainable resources, social justice and equity as the prerequisites for health promotion process. Community participation and empowerment lies at the heart of health promotion action that is based on the following five approaches:

1. Building healthy public policies for more equitable and accountable health systems;
2. Creating a supportive environment to address social, economic and political issues related to health;
3. Strengthening community actions through community participation in need identification, implementation and monitoring of local health activities;
4. Developing personal skills for local leadership to identify local needs and gain power and skills to address these needs;
5. Re-orienting health services from curative to preventive and equitable client-centred health services

Health promotion process views communities as the main health resource and aims at enabling them to increase control over and to improve their health, while responding to health inequities within and between societies (World Health Organization, 1986). Health promotion programmes have focused on improving structural conditions at home or work or changing dietary and physical activity patterns of individuals. The mainstay of health promotion strategies has been health education and behaviour change models. Brofenbrenner (1979) proposed the ecological model that identified the micro, meso, exo and macro level influences on individual human behaviour. This model was adapted to design the ecological model for health promotion that identified the intrapersonal, interpersonal, institutional, community and public policy factors that influenced human behaviour of individuals as well as groups (Brofenbrenner, 1979). However, system change approaches have rarely been adopted as health promotion strategies as they are very challenging and rely on governance systems and democratic practices (McLeroy, Kenneth, Bibeau, Steckler, & Glanz, 1988).

Labonte (1994) argued that health promotion represented the health system's response to the knowledge challenges

posed by progressive social movements (Labonte, 1994). However, in effect, two different health promotion discourses have evolved and co-exist (Laverack & Labonte, 2000). The conventional discourse that emphasised upon disease prevention through lifestyle management and control of disease spreading vectors and the more radical discourse that stressed upon social justice through community empowerment and advocacy. Subsequently, the health promotion programmes tend to utilise the top-down or bottom-up approaches rather than a judicious combination of both.

After the health promotion movement of the 1980s, empowerment was legitimised in the World Health Organization's strategic position papers and declarations (Robertson & Minkler, 1994; World Health Organization, 1997). In health, empowerment has been defined as a process through which people gain greater control over decisions affecting their health (Tengland, 2007). It has been linked to social transformation and is seen as a social action process targeted towards changing the social and political environment to improve equity and quality of life (Minkler & Wallerstein, 1997). Participation forms the backbone of empowerment strategies, but it alone is not sufficient as it can be manipulative and passive. Empowering participation aims to reduce social exclusion and has been found to have a positive impact on the health of vulnerable groups of population like women and youth, especially in improving their coping skills and access to healthcare services (World Health Organization, 2006).

Access to services is a critical element of negotiation between the demand and supply sides, particularly when equity and social justice is an aspiration in the healthcare system. Access has been theorised with respect to resources that include materials and the physical and social structures associated with them (Schaffer & Huang, 1975). It has been found that generally a selected group of people (gatekeepers) have access to resources, while a larger group of population accesses resources through these gatekeepers. Several layers of behavioural patterns (like corruption, coercion, voicing demands and participation) and systemic regulations (like eligibility criteria, placement, timings and staffing)

determine the negotiation of access between the resource structures, gatekeepers and the larger population. Whether a healthcare system will facilitate people's empowerment or not is dependent upon the discourse and negotiations that occur in community spaces where power based relationships between community people and healthcare workers exist.

2.4 THE NEXUS OF SPACES, HEALTH PROMOTION AND EMPOWERMENT

As we set out to examine the community spaces and their effect on MNCH and empowerment of women and poor people, it will be important to comprehend the interaction between the concept of spaces, empowerment and health promotion.

Though there is little evidence to directly relate the progression in empowerment with improvement in health (Labonte, 1992), it has been found that the more powerful are usually healthier (Smith N. , 1984). Recognising participatory processes as the base of empowerment, health professionals have stressed upon building community capacity and social capital as epidemiological studies have correlated the variables of trust, reciprocity and civic engagement with improvement in morbidity and mortality statistics (World Health Organization, 2006).

Gaventa's (2006) model is useful in visualising the relationship between spaces, places and power. He distinguished three types of spaces, the 'provided or closed' spaces controlled by the elite groups, the 'invited' spaces created by policy makers and the 'claimed' spaces constructed by community people. He was of the opinion that 'places of engagement' exist within one or more spaces where different forms of power (visible, hidden and invisible) operated in the form of inclusion or marginalisation (Gaventa J. , 2006). In this study, we have adapted Gaventa's model to understand the social stratification and gendered relationships that exist in spaces that are rather fluid and sometimes transitory. This will make way for understanding the exercise of agency and the structural support for empowerment that promotes inclusion, voice, participation and access of women and poor people to the healthcare system.

3. RESEARCH METHODOLOGY

3.1 RESEARCH QUESTIONS

The primary research question for this study is 'in what ways do community spaces empower, or inhibit women, poor persons, and marginalised groups, particularly with respect to maternal and child health issues?'

Aspects of empowerment considered as part of this question include:

- Raising awareness about health issues and the availability of health services
- Raising awareness about entitlements
- Providing women with a 'safe space' where they can engage with each other
- Promoting citizen-state interaction
- Supporting women's mobilisation
- Supporting inclusion in local accountability processes

As a first step, the research question and objectives were compared with the key concepts entrenched within them to sharpen the primary research question into the following secondary research questions:

1. What community spaces have been created by the MNCH promotion programmes?
2. What are the key functions, practices of the externally created spaces?
3. Who is included and/or excluded from the community spaces and mechanisms in MNCH promotion programmes?
4. What are the nature and modes of inclusion and/or exclusion in the community spaces and mechanisms in MNCH promotion programmes?
5. What is the role of facilitators and the community spaces and mechanisms created by them in empowering and engaging the poor and women in MNCH service delivery?
6. What lessons can be learnt with respect to accountability and governance in MNCH promotion programmes and the identification, training and selection of their community facilitators?
7. What is the impact (negative and positive) of local existing internal community spaces upon poor and marginalised women's empowerment in relation to maternal and newborn health?

3.2 STUDY DESIGN AND FRAMEWORK

Considering the nature of research questions being explored and the interactive nature of concepts in the study framework, the study made use of a qualitative case study design and an action oriented approach to balance the purposes of knowledge generation and action (Khan, Bawani, & Aziz, 2013). The design considered villagers or people of a community, particularly women, poor persons and marginalised groups as the case and studied the impact of informal and formal spaces created by MNCH programmes on the empowerment and promotion of MNCH (see figure 1).

Figure 1: Conceptual Framework of Study
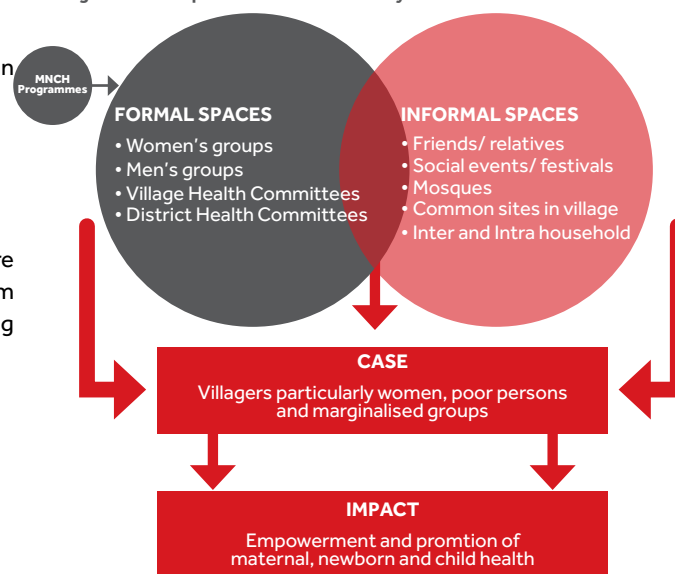
We hypothesised that the most common factors that affect the construction of formal and informal spaces are gendered in socio-cultural norms, class, caste and economic inequalities, which limit the access of the poor and the socially excluded to health education sessions and healthcare service points. Therefore, the excluded are unable to acquire health benefits and/or engage in any form of socio-political action for their empowerment. Studies have highlighted that the uptake of reproductive health services in Pakistan cannot merely be determined by women's mobility and autonomy as it is affected by the complex socio-cultural dynamics that surround women's lives (Mumtaz & Salway, 2005; Mumtaz & Salway, 2009). We understand that the inclusiveness and participatory nature of community spaces, both formal and informal is an important consideration, especially when maternal, newborn and child health is at stake. From the vast experience of social mobilisation the Rural Support Programmes Network (RSPN) realises that there are many reasons due to which poor persons, women and socially excluded groups are unable to participate in community

spaces. In patriarchal societies like Pakistan, women are not always free to participate in community discussions. Lack of education also affects women's ability to negotiate with their spouses in the informal spaces and to demand participation in the formal ones. In many cases, local culture and norms restrict women's and poor people's participation in the community level discussions. Often, the poor and socially excluded people lack the skills and confidence to share their problems in community meetings, hence they do not participate, or if they participate they do not share their problems or experiences. Poverty also fuels gender and social exclusion, because the poor are preoccupied with earning a livelihood and do not have time to participate in community discussions. Construction of community spaces, for example membership criteria, relationships between members and non-members and the participatory and empowering practices of external facilitators or local leaders also have an important role in determining inclusion or exclusion and engagement of specific population groups. In this study we will explore if the above observations apply to formal spaces created or facilitated by MNCH programmes and to the informal spaces where MNCH related topics are discussed.

Based on our understanding of the two types of community spaces we think that norms and power structures in the informal community spaces affect the participation of women, poor persons, and marginalised communities in formal spaces, both positively and negatively. For example, women's mobility patterns within or outside their village directly limit their access to healthcare facilities, while their illiteracy and lack of confidence indirectly inhibits their participation and voice in community groups. Given this socio-cultural context, a study of informal community spaces will give a better understanding of the reasons and mechanisms of exclusion in formal spaces that are likely to adopt the dynamics of informal spaces rather than changing them. Therefore, to find pathways for improvement in the lives of the socially excluded, the social system needs to be treated as a whole so that the problems of participation are unearthed. The advantage of such an approach is that it provides a more practical direction in terms of building improved MNCH programmes which are both inclusive and effective.

3.3   STUDY METHODS

3.3.1   Site Selection

The qualitative case study design mandated narrowing the geographic scope of the study. Therefore, three of the most socially and economically deprived districts of Sindh, Punjab and Gilgit-Baltistan were purposively selected as study sites keeping in mind the geographical diversity of

Pakistan and the deprivation ranking of districts (see figure 2). Thatta and Rajanpur are ranked high among the vulnerable districts of Sindh and Punjab, respectively (Khan & Salman, 2012), while Ghizer is the second most food insecure district of Gilgit-Baltistan, where 64.4% of the population is food insecure (Sustainable Development Policy Institute, 2009). The health indicators in the selected districts also reflect the poor state of MNCH. In Thatta, the maternal mortality rate (MMR) is 365/100,000 live births, the infant mortality rate (IMR) is 63/1000 live births, while in Rajanpur the MMR is 203/100,000 live births and the IMR is 110/1000 live births (Bureau of Statistics, Government of Sindh, 2007; Bureau of Statistics, Government of Punjab, 2011). For district Ghizer the data on these indicators is not available, however, in Gilgit-Baltistan the MMR is 600/100,000 live births and the IMR is 122/1000 live births (National Institute of Population Studies, 2008). After selection of the districts, a mapping of MNCH programmes working in each of the selected districts of Thatta, Rajanpur and Ghizer was done to choose and compare three large MNCH programmes across all districts (see annexure 1 for mapping of MNCH programmes in each district).

As the focus of the design were villagers or people living in a community, therefore one village was selected in each of the three districts, in consultation with the local stakeholders. District consultative workshops that called upon key government functionaries and decision makers of MNCH programmes working in the area were conducted to choose the village which satisfied the following selection criteria:

• Presence of at least three MNCH programmes

• Presence of population groups with varying levels of poverty (high ranking on poverty indicators)

• Would agree to cooperate with the research team

• Was physically and politically accessible for the research team

3.3.2 Data Collection, Monitoring and Analysis

The research questions and key concepts of community spaces, inclusion/exclusion, equity, gender, participation, voice and empowerment were used to identify data collection methods and subsequently design the research tools, as shown in table 2.

As part of the assessment of community spaces and their role in promoting MNCH, data of MNCH programmes was gathered from documents and key-informant interviews (KIIs) of programme staff, while the data from community women and men was collected through focus group discussions (FGDs) and in-depth interviews (IDIs). Considering the qualitative design and action oriented approach of the study, participatory rural appraisal (PRA) tools were adapted to encourage reflection, analysis and plan for action during FGDs with women and men. The PRA (also called participatory reflection and analysis) tools emphasise upon the usage of symbols, figures and pictorials to facilitate collective reflection, analysis and directions for future actions (Chambers, 1997). The PRA tools were found to be of specific relevance to this research because they are rooted in the ideology of participation and peoples' abilities and right to transform their conditions for the better. PRA tools when used with skills that respect people's experiences and knowledge facilitate people to be analysts of their own realities. The understanding that rises with this facilitation prepares them to take collective action for the betterment of their conditions.

The data collection tools designed for this study included the guidelines for (see annexure 4):

• Transect walk

• Social mapping

• FGD on community spaces

• Network diagram

• Cause and effect diagram

• Key-informant interviews

• In-depth interviews

Along with the roles and responsibilities of field teams and the guidelines for entering the field, the research tools were compiled into a manual for field work (Rural Support Programmes Network, 2013). A total of 25 KIIs were conducted with the programme management and field staff

of the following MNCH programmes in the selected districts:

1. The National Programme for Family Planning and Primary Healthcare

2. The Population Welfare Department

3. The Maternal Newborn and Child Health Programme

4. The Maternal and Child Nutrition Porgramme of the Lodhran Pilot Project

5. The Maternal and Child Health Programme of Merlin

6. The Aga Khan Health Services of Pakistan

Two separate groups of 15-20 women and 15-20 men were formed in each of the three selected villages by inviting individuals from different areas, castes and socio-economic strata during the transect walk. This was done to ensure inclusiveness and diversity of opinions and also to include the perspectives of both the included and excluded groups. The included were those women and men who had participated in activities of MNCH programmes working in their village, while the excluded were those women and men who had not participated in most of these activities or had been excluded. A total of 37 FGDs (10-15 FGDs in each village – half with women's group and half with men's group) using the PRA tools were conducted in the three selected villages.

Some women who had faced significant MNCH issues and some men were selected for IDIs to document their case studies. Several interview sessions were conducted with each participant to gather a total of 13 case studies from the three study villages. The researchers accompanied the interviewees in various informal settings like event celebrations and water channels to observe and understand their experience and culture.

Data from MNCH programme staff was collected and recorded in Urdu, while that from community women and men was gathered in local languages like Sindhi, Saraiki, Khowar and Shina that all participants could easily understand. All recorded data that was in the form of mp3 audio files was used to transcribe field notes in Urdu, which were translated into English and maintained as word documents.

Report of each day's field work done by the field teams was shared through email on the 'Activity Report' format with the principal investigator and the co-investigator to inform them of progress and information gathered. The quality of audio records and matching transcriptions was checked by the principal investigator and the co-investigator during field monitoring visits that were conducted to each field site during the district consultative workshops and the initial and middle phases of data collection. The principal investigator, co-investigator and RSPN's Chief Operating Officer (COO) scheduled their monitoring visits to ensure their presence in different study sites at the same time. The monitoring visits were aimed at ensuring completeness and accuracy in data

Table 2: Research Questions, Themes and Tools

Research Questions	Themes	Research Tools
In what ways do community spaces empower, or inhibit women, poor persons, and marginalised groups?	1. Generic understanding about empowerment in terms of MNCH 2. Contribution and effectiveness of community spaces for: • raising awareness about health issues and the availability of health services • raising awareness about entitlements • providing women with a 'safe space' where they can engage with each other • promoting citizen-state interaction • supporting women's mobilisation • supporting inclusion in local accountability processes • creating good linkages of the members and non –members with the service providers • raising the issues regarding services, non-availability of the providers etc. at the service delivery points • addressing the broader socio-cultural issues faced by local communities for accessing information and services • interface with government service providers and hold them accountable for availability of the quality services 3. Any remedial action has been taken by the government/service providers in response to community voices for improvement in services 4. Any roles played by community spaces and its members in shaping the conducive public policy that effectively empowers the poor and women to access MNCH services, and ensures the inclusion of excluded groups	Cause and effect diagram
What is the nature and mode of inclusion and/ or exclusion in the community spaces and mechanisms for MNCH promotion?	Knowledge about MNCH issues and sources of information: • Broader issues related to maternal and child health with respect to, gender, social exclusion and poverty • Particular issues of community with respect to gender, social exclusion and poverty • Sources of the information/awareness in the community about MNCH and gender, social exclusion and poverty	Transect walk
	Knowledge about Poverty, Gender and Social Exclusion: • Key issues of exclusion, poverty and gender • Mode of inclusion or exclusion in community spaces • Forms of exclusion (self-exclusion, forced exclusion, exclusion due to social and cultural norms etc.) • Reasons behind the exclusion (why some people participate and some not participate in these community spaces?)	Social mapping
What community health promotion spaces have been created by the MNCH promotion programmes? What are the key functions and practices of the externally created spaces? Who is included and/ or excluded from the community spaces and mechanisms in MNCH promotion programmes?	Role and Function of the Community Spaces: • Types of community spaces existing in the village • Knowledge about the community spaces for MNCH services • Mandate and objective of these community spaces • Key functions and practices of the community spaces • Composition and Socio-economic characteristics of the community spaces • Membership size, selection criteria and process • Role of men members of the community in supporting or creating hurdles in MNCH in general and with respect to GESP in particular • Operational mechanism of these spaces (formation, meeting frequency& place, participation of members in meeting and decision making and dissemination of decisions and action taken) • Role of office bearers/community leaders in inclusion and exclusion • Perception of the members and non-members about the role of office bearers/community leaders	Focus group discussion on community spaces
How do facilitators, and the community spaces and mechanisms they create, empower and engage the poor and women in MNCH service delivery?	Role of Supporting Organisation: • Knowledge about the organisation managing the community spaces • Role of supporting organisation and staff of the spaces for inclusion or exclusion • Familiarity of the supporting organisation with local culture and norms to ensure the inclusion of poor, women and socially excluded people • Overall perception of the community about the support of these organisation	Network diagram
What is the impact of local internal community spaces on poor persons and marginalised women's empowerment?	Knowledge about existing internal community spaces: • Forms of the existing internal spaces in the community • Links of culture norms with internal community spaces • Positive or negative impact of the internal spaces on externally created community spaces • Positive or negative impact of the internal spaces on poor and marginalised women's empowerment in relation to MNCH	Guideline for in-depth interviews/ case studies

collection guided by the quality control mechanisms identified in the project monitoring plan developed during the inception period (see annexure 2). A pictorial record of field activities was also maintained for supporting the narrative description during report writing. Extended discussions in debriefing meetings were held with the field teams during the monitoring visits to encourage deeper probing on specific MNCH issues or cultural norms and practices identified in the data.

To ensure completion, the data gathered was compared with the questions and probes identified in the research tools and subsequent field activities were planned if more information was required. After completion of the first round of field work, two representatives from each field team were called to a collective debriefing meeting with the principal investigator, the co-investigator and the international technical advisor. The collective debriefing made way for the field teams to review each other's findings and make comparisons across the study sites to identify similarities and differences in cultural norms, practices and MNCH issues and experiences. The collective debriefing also facilitated a preliminary analysis and identification of deeper probes that were taken back to the communities during the second round of field work.

Data analysis was performed using the NVivo 10.0 version. The translated data files were imported in NVivo for content analysis that resulted in identification of themes and sub-themes. Data from the themes and sub-themes was compared with research questions and re-coded into emerging themes that were shared in a consultative workshop with programmatic stakeholders, the members of the project advisory committee (PAC) and the national and international technical advisors. The input from all these stakeholders was used to form the basis of recommendations given in this report.

3.3.3 Study Team and Training

Three field teams were constituted for conducting field work. Each team comprised of five members that included a field supervisor, two female field researchers and two male field researchers (see annexure 3). To facilitate qualitative data collection, field researchers and supervisors with educational backgrounds in anthropology, sociology, social work and development studies were included in the field teams.

The three field teams were supervised by the principal investigator and the co-investigator who who were advised and supported by the national and international technical

advisors and RSPN's Chief Operating Officer (COO).

To ensure uniformity of conceptual understanding and data collection skills, the field teams underwent a 10-day training that included field based pilot testing of the data collection tools (Rural Support Programmes Network, 2013).

3.4 ETHICAL CONSIDERATIONS

The project proposal, semi-structured guidelines for FGDs and the informed consent form were submitted to the Research and Advocacy Fund (RAF) for ethical review. Written informed consent was taken from respondents of KIIs, while the community women and men usually resorted to giving verbal informed consent for all field activities including audio recording and taking pictures (see annexure 5). Efforts were made to ensure confidentiality and privacy. Field teams were trained in research ethics during their 10-day training and discussion of field activities and findings was forbidden in presence of any outsider. Any information related to personal identification of research participants was removed at the time of reporting.

3.5 STUDY LIMITATIONS

The major limitation of qualitative studies like this is that researchers and development practitioners often question the validity and generalisability of the findings. Though the findings from this study may not be generalisable in the quantitative sense, our qualitative methods were applied robustly and the results are trustworthy such that they can be used to inform the development of various health programmes and similar community settings in and outside Pakistan.

This study has proposed interactional models between different kinds of spaces and the power dynamics that operate in them and affect people's health. Inclusion increases voice and empowerment of the poor and marginalised and improves their health. However, on the basis of its data it is not possible to predict the level of empowerment or health achieved from inclusion in community spaces. The data also does not allow for quantification or disaggregation of the benefits gained from formal and/or informal community spaces. However, the models proposed by the study can be used to design quantitative tools for conducting such research to study the empowerment and health related impact of formal and informal community spaces and their interaction.

4. STUDY RESULTS AND FINDINGS

4.1 THE SOCIO-DEMOGRAPHIC CHARACTERISTICS OF COMMUNITY PARTICIPANTS

The community participants included women and men from different strata. Table 3 shows the socio-demographic characteristics of the community women and men who participated in the FGDs conducted in the study villages of each of the three selected districts.

Table 3: Socio-Demographic Characteristics of Community Participants

Characteristics/Districts	Thatta (n=30)	Rajanpur (n=55)	Ghizer (n=35)	Total (n=120)
Sex				
Females	15	28	16	59
Males	15	27	19	61
Age Group (Years)				
16-30	13	15	12	40
31-45	11	30	15	56
46-60	4	10	5	19
>60	2	0	3	5
Educational Status				
Not-literate	17	39	0	56
Primary	9	5	3	17
Higher Secondary	3	9	30	42
Above Higher Secondary	1	2	2	5
Marital Status				
Unmarried	7	2	2	11
Married	23	53	33	109
Economic Status				
Very Poor (Nomads and Landless Peasants)	9	15	5	29
Poor (Tenants and Small Land Owners)	11	27	19	57
Better-off (Big Land and Business Owners)	10	13	11	34

4.2 THE CONTEXTS AND SOCIAL STRUCTURES IN THE SELECTED SITES

4.2.1 District Thatta

District Thatta is located about 98 kilometres east of Karachi and has an estimated population of 1.4 million (Population Council, 2009). The word 'Thatta' is derived from the Persian term '*Tah*' which literally means layer over layer. The term signifies the settlement of various civilisations in the town that was given the status of a district in 1948. Thatta is administratively divided into nine talukas/tehsils, 55 union councils (UC) and more than 6,500 villages. Eighty nine

Figure 3: Map of District Thatta

percent of Thatta's population is rural. The village selected for this study is called Jani Memon, which is located in UC Bathoro of taluka Mirpur Bathoro, shown in figure 3.

The village of Jani Memon is connected to the main road between the Talukas of Sujawal and Mirpur Bathoro by an unmetalled link road. The village is sub-divided into three settlements (*paras*), namely the Khaskheli *para*, the Sheikh *para* and the Memon *para*, named after the respective castes that reside in each one of them. As shown in figure 4, the Sheikh para is located on the right side of the link road, while the Khaskheli and Memon paras are located on its left side separated by a primary school and a community guest house (*otaq*) owned by the Memon people. The village constitutes of almost 75 households, 25 of which belong to the Sheikh community, 30 to the Khaskheli community and 20 to the Memons.

Figure 4: Social Map of Village Jani Memon, Thatta

The agricultural fields are located in the outskirts of the three settlements. The fields are usually owned by the Memon people and the Khaskhelis and some Sheikhs worked on them as peasants. The village has two primary schools, one *madrassa* and two mosques. One school and mosque are located in the Memon settlement and used by them alone. Electricity and mobile phones are available in the village (usually used by the younger generation), but there is no gas, piped water supply and sanitation system or any healthcare facility in the village. The community people informed us of the existence of a civil hospital and several private ones in Mirpur Bathoro that is around 2-3 kilometres away from their village (45 minutes walk and 15 minutes drive by rickshaw). They also said that there are several private healthcare facilities in Thatta's district centre that is located almost 70 kilometres away from the village. The lady health worker (LHW) assigned for the area lives in the neighbouring village, very close to the Memon settlement. Her catchment area consists of this village and the one that she lives in.

People from the same caste are usually related to each other, closely or distantly. According to the women, each settlement was further divided into neighbourhoods (*mohallas*). A Khaskheli woman described the distribution of her settlement saying that:

'There are three parts of Khaskheli para, though the whole para is located in one compound bounded by thorny bushes (khardar baar)…… the first Zebu's para, the second Marvi's para and the third Arboo's para.' (FGD Thatta)

Among women the neighbourhoods are known by the name of their female leaders, some elderly women and others who are younger but able to exercise influence on others due to their relationship with the more influential women like the traditional birth attendant. The most well off and influential people are Memons, while the Sheikhs are the poorest. A male respondent from the Sheikh community described their situation saying that:

'Sir, it is mostly Memons that have the most influence in the village, even the name of this village is Jani Memon and we are their peasants. Memons have the highest authority around here because they have their own businesses in the city and they also own most of the land of the village that makes them more influential.' (FGD Thatta)

A man from the Khaskheli community reinforced this opinion and said that:

'It is the Shiekhs that are the poorest of us all to an extent that they all and their children also must work on the lands to have one time food on their table. Some of them work in the fields owned by the Zaur and Memons.' (FGD Thatta)

In the Memon settlement, most houses are made of mud, except the three houses that belong to well to do Memon

people and landlords (*waderas*) were made of bricks. They have pit latrines and water supply for both drinking and washing that is acquired from the four hand pumps and three motor pumps installed in the settlement. Women gather around the hand pumps and talk to each other, while washing clothes or utensils and fetching water. Some people are land owners, while many run small shops or businesses in the city. All Memon children go to the primary school and to the Madrassa for religious education. The boys are sent to secondary and higher level schools in the city. Many people own motorcycles that they use for personal activities and business. A man from the Memon community proudly stated that:

'We, Memons are also getting little bit developed now, because we have launched our own businesses and own some land, which has become a source of income for us. Some people have recently started going to the city for education, they dress well and eat well. They keep company of good people. We have our businesses in the city as well that is why people come and visit us.' (FGD Thatta)

In the Khaskheli settlement, the houses are made of mud and have no latrines. The backyards of houses are used for open defecation. Each house has one room, in front of which is the courtyard (*verandah*). There is a kitchen on one side of the courtyard where wood is used for cooking on mud stoves. Most houses have a small mud house (*palli*) for preserving grain/cereal. Some houses own cattle on '*Adh*' (half sharing of dairy products and calves born). The cattle and goats are reared in the courtyard of the house. Most Khaskheli people work as peasants, but some go to the city to work in shops. Two families in the settlement own a rickshaw that is used for business, but is sometimes hired by fellow villagers for transportation of women to healthcare facilities in the city. Some Khaskheli houses also own a motorcycle. The whole settlement has two hand pumps, but the water from them is saline and undrinkable, so the Khaskheli women cross

Figure 5: Cattle and Children Bathing in the Same Water Swamp, Thatta

the main road and walk for 20-25 minutes to reach another nearby village of the Mallah caste for fetching water. For washing clothes, dishes and bathing they use the stagnant muddy water from a flood and rain water swamp that is located adjacent to their settlement. Their cattle also drink and bath in the swamp water along with their children, as shown in figure 5.

In the Sheikh settlement, the houses are made of reed stems tied together to construct a wall and thatched roofs. They have no latrines, so the open areas in the surrounding are used for open defecation. The inhabitants follow a nomadic pattern of settlement. They usually move from place to place in search of labour and for harvesting reed plants that grew seasonally in different places. They usually earn a living by making and selling reed leaf mats that are sold as roof tops in the market. None of the Sheikhs own any land or cattle. In fact, they survive on a day to day basis. A Sheikh woman remarked that:

'We are migrants and go to different places to cut reed leaves (kaani) and then make roof tops (pakhas) from it. Like the one that is lying in courtyard but it is still incomplete. We do not own any cattle and whenever we have money then we bring powdered milk from the city. At times we simply drink black tea. As we do not have any land and grass so we cannot feed cattle and no land owner (Zamindar) will allow us to graze our cattle on his land.' (FGD Thatta)

The Sheikhs have no hand pump in their settlement, so like the Khaskheli women the Sheikh women also cross the main road and go to another nearby village of the Mallah caste to fetch water. For washing clothes, dishes and bathing they use the stagnant muddy water from a flood and rain water swamp that is located in the centre of their settlement. Whenever, we visited them they brought a new, clean reed mat and placed it on the ground and asked us to sit on it, while they themselves sat on the ground. Their children were dressed in ragged clothes and looked weak and malnourished. Women were also weak, but were usually surrounded by multiple children. When asked about the reason for their poverty they said that:

'Although, Sheikhs do all kinds of work that other people do, but they lack the awareness about how to earn more and how to help each other in financial matters. Everyone stands alone in earning. Sheikhs work only for about three to five months and then they move to some other place to find work.' (FGD Thatta)

4.2.2 District Rajanpur

District Rajanpur, is located in the southwest of Punjab province and has an estimated population of 1.5 million (Population Council, 2010). The district is bordered by the river Indus on its east and the Sulaiman mountain range on its west. As shown in figure 6, Rajanpur is administratively divided into three tehsils and 43 UCs. Tehsil Rajanpur, with 82% rural population is the District headquarters. The village selected for this study is called Basti Basheer Nagar. It is located in UC Hajipur of tehsil Rajanpur.

The village is located 2-3 kilometres from the main road that comes from the UC of Hajipur. The connecting road is partially metalled and leads straight to the centre of the village where there is a red brick road called 'soling' made around a few houses, as shown in figure 7. A right turn on the connecting road leads to the Basti Sindhi. The houses inside the soling belong to the Punjabi Arain caste, which consists of the small and medium land owners of the village. The houses outside the soling are widespread, divided by 6-7 water canals and agricultural fields. These houses belong to the Jhangar, Makwal, Babbar, Pathan and Baloch castes. People from these castes are usually tenants living on the land owned by Punjabi Arain caste. The tenants rear land and livestock for the land owners and get a 12% or 50% share of the produce. Another caste that lives in the Basti Sindhi that is also part of the village is that of Sindhi Arain people who are small land owners as well as tenants, but consider themselves equal to the Punjabi Arain. Due to some previous conflicts the Punjabi and Sindhi Arain castes do not meet each other or sit together in decision making forums.

Most of the land in the village is owned by a chief landlord who has great influence over the smaller landlords and villagers who are tenants on his land. The villagers told us that any financial or material aid that came to the village went to the chief landlord who handed it over to the small and medium landlords for distribution and the smaller landlords usually distributed the aid among their own friends, while ignoring the poor. They gave examples of distribution of rice and pulses after the 2010 flood and the making of cards for acquisition of financial aid. They also showed the house of a small landlord

Figure 6: Map of District Rajanpur

Figure 7: Social Map of Basti Basheer Nagar, Rajanpur

within the soling whose women were nominated by the chief landlord for training on sewing skills and later awarded a sewing machine by some non-government organisation (NGO). The village has a system of canals that receive water according to a predetermined schedule. The village has one mosque and two primary schools. The girls' primary school is located near the Jhangar houses. The land for this school was donated by a Punjabi Arain man and now it has been turned into a co-education school where two female teachers teach girls and boys up to class 5. Many organisations and programmes including the National Rural Support Programme (NRSP) and the Benazir Income Support Programme (BISP) have worked in the village, but the villagers complained that after the 2012 flood no organisation came to help them.

Electricity and mobile phones are available in the village, but there is no gas, piped water supply and sanitation system or any healthcare facility in the village. The community people informed us of the existence of a government healthcare facility and several private clinics in the UC centre that is around two to three kilometres (40 minutes drive) away from their village. They also said that there are several private healthcare facilities in Rajanpur district centre that are usually accessed by those who can afford going there and utilising their services. The lady health worker (LHW) assigned for the area lives in the neighbouring village, very close to where the Sindhi Arain caste resides. Her catchment area consists of this village and the one that she lives in.

The Punjabi Arain are more influential than people from any other castes. They have brick houses which are well structured and have electric supply and water and sanitation facilities. They use electric motors to pump out ground water for drinking and washing. Some (three to four) houses have hand pumps, which are also used by other members of the caste during the extended power breakdowns, for collecting water for drinking and washing. The Punjabi Arain live in nuclear families and three to four related families share the same boundary, but have different household units. They also

have a trend of educating their children so they sent them to the village primary school and later on to better private schools located in UC centre. However, educating girls is not as common a practice as educating boys. The women of this caste are responsible for domestic chores and taking care of children, but are not expected to work in agricultural fields. While distinguishing their women, a Punjabi Arain man proudly remarked that:

'There is a difference between their women and our women. Our women do less work as compared to their women. We have grass cutter machines in our homes, we bring grass from outside and our women cut it on machine. If the male is not present, then females do every work otherwise males do it. In our caste we care for our females and stop them from doing extra work during pregnancy. After delivery, women do not work for 20-40 days, because there are some people available who do the work for them. In other castes women start to work within six to seven days after delivery and they work in seventh and eighth month of pregnancy too.' (FGD Rajanpur)

The families of Punjabi Arain caste usually have two to three children as opposed to the other castes in which families have five or more children. The men from the Punjabi Arain caste own agricultural land and some of them are educated so they own small shops and businesses in the Tehsil centre.

In all other castes, the houses of people are made of mud and bricks. Most houses have an open space for livestock and no electricity, water and sanitation facilities. People live in joint families and rooms for each couple and their children are located around the open courtyard that is used for rearing livestock. The water from irrigation canals or the single hand pump located in the Sindhi Arain basti is the source of washing and drinking water for most people from other castes. The Sindhi Arain people also sent their children for education in schools of the UC centre, while the people from other castes educate their children in the government primary schools located in the village or did not send them to school. Most villagers employ their children in the fields where they work and earn money for their family. The women from all other castes take care of domestic responsibilities and also share an equal burden of agricultural work, especially during times of sowing seeds and harvesting crops. A Jhangar man related the plight of their women by saying that:

'Our females work in every condition. There is no care. They work in the eighth or ninth month of pregnancy too. Women have to do every work. She definitely has to because there is no one to help her with her work.' (FGD Rajanpur)

The people of the Baloch caste follow a nomadic pattern of settlement. They cultivate the land of one landlord for a few months and then move on to another landlord's land. The Baloch strictly follow their traditional practices. Their women

wear traditional dresses (long frocks) that marked their distinct identity. Their houses are situated in the farthest area of the village and men from any other castes were not allowed anywhere near them as such an act was considered indecent and dishonourable by the Baloch men and could raise a serious conflict.

4.2.3 District Ghizer

District Ghizer, is located in the northwest of Gilgit Baltistan region and has an estimated population of 150,000 (World Bank, 2010). As shown in figure 8, Ghizer is administratively divided into four tehsils and with Ghakuch, in tehsil Poniyal is the capital of the district. The village selected for this study is called Sumal, which is located in tehsil Gupis.

The Sumal village is located at a drive of 30 minutes from the district head quarter of Ghakuch. The village is connected

Figure 8: Map of District Ghizer

to the main Gilgit-Chitral road by a suspension bridge that crosses over the Ghizer River. The village has upper and lower portions divided by a water stream (*nalla*). The upper portion is relatively more mountainous and consists of dense pastures. It is inhabited by the landless peasants from the Gujjar caste. The lower portion of the village is plainer and

Figure 9: Social Map of Sumal Village, Ghizer

divided into thirteen neighbourhoods as shown in figure 9. The inhabitants in the thirteen neighbourhoods belong to five different castes, namely the Syeds, Rajas, Sheens, Yashkuns and Gujjars.

The neighbourhoods situated near the road connecting to the suspension bridge seem to be better off as they have houses, schools and praying places made of concrete. Within the boundary wall, each house usually has a kitchen and store located at some distance from the sitting room and bedrooms. People usually live in joint family structures and have small kitchen gardens in the backyards of their houses. The agricultural land owned by a family was usually located around the house, outside the boundary wall. Some houses had an indigenous cold storage (*goonj*) made near the stream outside their boundary. The running stream water generates cooling inside the *goonj* that is used to preserve milk and other food items.

The neighbourhoods away from the road have scattered population with many houses made of mud that are inhabited by the poor people who have no land and livestock. These houses belong to the few Gujjars who have migrated from other villages or the upper portion of Sumal in search of livelihood. The Gujjars are the nomadic tenants who live on the land owned by Rajas. They earn a living by cultivating the land and rearing the livestock of the Rajas and their women work in the households of Rajas. The Gujjars also live in joint family structures and their houses have only one or two rooms and very little outside space for kitchen gardening.

The villagers told us that the most distinguishing identity in the area is based on religious sect. Majority of the villagers belong to the Ismaili sect. There are some people from the Sunni sect, but they tend to live together in one neighbourhood. The Gujjars also belong to the Sunni sect. The two sects spent their lives in almost separate social circles as they have different religious celebrations and praying areas. On rare occasions marriages across the sects and economic strata had taken place.

The most popular occupations in the village include agriculture, teaching and army service. The village seemed quite developed as we could observe a general trend of educating children, both girls and boys. Women were free to move around within the village and some of them had set up a small shop of female items in their houses. The village had a water tank that supplied drinking water to all houses. The houses also had pit latrines. The villagers informed us that the water supply and sanitation system had been made with help from the Aga Khan Rural Support Programme (AKRSP). The villagers had also made a system of water channels for irrigation in collaboration with AKRSP. The village also has a market place with different shops including a flour grinding mill. The village also has two government schools

and a government first aid post that is being upgraded and reconstructed into a government dispensary. The villagers said that the government dispensary has a dispenser who checked people and prescribed medicine which they have to purchase from their own pocket. The village also had one private and one NGO school. The Aga Khan Health and Education Programme had also set up a health centre and the Diamond Jubilee School in the centre of the village, where people from all sects and backgrounds are served at subsidised costs. The health centre also offers indigenous insurance schemes to support acquisition of healthcare services by the poor Ismaili population. There are two Sunni (*Masjid*) and two Ismaili (*Jamat Khana*) prayer places in the village. The village also has two 'health houses', where the LHWs assigned for the area, live.

4.3 MATERNAL, NEWBORN AND CHILD HEALTH ISSUES IN THE SELECTED SITES

Maternal and neonatal mortality and morbidity remain a

Table 4: Maternal, Newborn and Child Health Indicators of Provinces and Selected Districts

MNCH Indicators	Pakistan	Sindh	Thatta	Punjab	Rajanpur	GB	Ghizer
Maternal Mortality Rate (MMR) per 100,000 live births	276	314	365	227	203	600	NA
Infant Mortality Rate (IMR) per 1000 live births	78	81	63	81	110	122	NA
Contraceptive Prevalence Rate (CPR) (%)	26	24	21	29	25	28	NA
Total Fertility Rate (TFR) per woman	3.8	4.3	4.9	3.9	4.6	4.9	NA
Percentage of women receiving antenatal care from a skilled provider	73	78	65	77	54	64	NA
Percentage of deliveries conducted by a skilled birth attendant (SBA)	52	60	70	52	49	43	NA
Percentage of fully immunised children under 2 years of age	36	25	63	40	93	29	NA

Sources: Pakistan Demographic and Health Survey 2012–13 and 2006–07; Multiple Indicator Cluster Survey, Punjab 2011 and Sindh 2007; Pakistan Social and Living Standards Measurement 2011; Demographic and Health Survey Gilgit Baltistan 2008.
NA: not available

significant challenge for the healthcare and development sectors of Pakistan. The MNCH indicators vary by province and the worst of are the poor women and children living in rural areas of Pakistan. The districts selected for this study are one of the most vulnerable ones in their respective province or region. Table 4 shows some of the basic MNCH indicators for the provinces and the study districts. However, the data shown is from various sources and years.

The biggest MNCH issue in the Jani Memon village of Thatta was the high rate of child births and deaths. People from all the three castes married their girls soon after they reached pubertal age. It was usual for the young married women to have early age pregnancies, year after year. However, many women reported that their children died some weeks or months after birth, mostly due to some infection. A woman from the Khaskheli caste said that:

'I got married to my cousin soon after puberty and gave birth to twin boys with the help of dai (traditional birth attendant). By now I have had a total of 10 pregnancies including a twin pregnancy and two miscarriages. Out of these five died including the twins and six of my children are alive. All my pregnancies were complicated. First I used to try the home-made remedies for illness, later when the condition did not get better, my husband and mother-in-law used to take me to the hospital. Once, I was four months pregnant and was fetching dried sun flower sticks for firewood, there was a big stone placed on the pile of sticks, when I pulled the sticks, the stone rolled downwards and struck me in the back and I started bleeding immediately and had a miscarriage. Having gone through multiple pregnancies, I am now determined to use some family planning method because pregnancy and delivery have become too much expensive and difficult to bear. It is better not to have any more children. When a woman is pregnant, she still has to undergo both pains of pregnancy and the routine chores. I remain busy with household chores and agricultural work throughout my pregnancies, then what else would you expect besides miscarriages and weak children.' (IDI Thatta)

The poorer households had economic reasons to prefer having more children, especially boys as a woman said that:

'More children are better because they are supports for our old age. Our men say that it is good to have sons as they will earn and feed us, girls are married off. These are the benefits of having more children.' (FGD Thatta)

The better off Memons accessed healthcare from private clinics and hospitals, but most Khaskheli and Sheikh women stated that their deliveries were conducted at home by the traditional birth attendant (*dai*) from the Khaskheli community. They complained about not having a healthcare facility in their village and said that the government healthcare facility

was located at 45 minutes walking distance in the UC centre. During the day they went to the government hospital where they did not have to pay any fees to seek treatment, but they were usually treated disrespectfully by the staff, inadequately attended by the doctors and ordered to purchase medicines from outside. Even the X-ray and laboratory tests had to be done from outside. Therefore, if people had money they preferred to go to private healthcare facilities. At night and in emergency situations, it was very difficult for them to reach the government or private hospitals as they barely owned any means of transportation and to hire a rickshaw they had to borrow money from fellow villagers. A Khaskheli woman stated that:

'One of my children was born at home at night. We are poor so we could not arrange any transport at that time. In the morning, we took the child to hospital, but the child died on the way. When we reached the hospital the doctors told us that the child had died one hour ago.' (FGD Thatta)

The village men related that the women of the Sheikh community were the worst off as they could not afford to leave work and go for regular antenatal check-ups. The situation became even more difficult if a woman had labour pains at night, since the government hospital and all means of transportation were closed and the private healthcare facilities in the tehsil headquarter charged a lot of money. A Sheikh woman related that to earn a living it was usual for them to carry on their work of cutting reed leaves, even during pregnancy. They went for antenatal check-ups only if they had any problem during the pregnancy. She described the case of her sister-in-law who had suffered from a miscarriage while cutting reed leaves near a water swamp. In the whole village, we came across only one Sheikh woman who reported using contraceptives, but that was also after she had experienced several child births and deaths. She related that:

'I am almost 34 years old. I was born in a large family of eight siblings and was engaged at the age of four or five years with my cousin. We (women) do not have any right on our lives, we cannot choose our marital partner and can be married to any deaf, lame or dumb person without consent. We are left with no other choice but to accept it as our fate. I was married when I was 15 and moved to my husband's house which consisted of a small room and courtyard. We Sheikhs occasionally go to the lakes to harvest reed plants, work in banana plantations, or pick tomatoes or potatoes from the field. I was nearly 16 when I got pregnant for the first time. I had eight pregnancies, three boys and five girls. Two of my twin daughters and one of my twin sons died a few weeks after birth. I desperately tried to save them, borrowed money from relatives and went to different hospitals, but could not save them. Now, I have three daughters and two sons. Both of my sons are very weak and cannot walk or stand properly. When any of my children

die, I cry a lot and wail loudly when the male members carry their little coffin away. Then my father or brother console me by saying that this was a gift from God, and if God needs it who are we to interfere. Poverty is the biggest hurdle in accessing health care services as I visit a doctor only if I have a serious problem. I had many problems in my third pregnancy. We went to the civil hospital for treatment, but they told us to go to Thatta or Makli hospital, instead we came home as we did not have money. I was in a terrible condition. When I went to the bathroom, my baby was born there so we called the dai (traditional birth attendant) who gave me some phakki (traditional herbal medicine). Despite that, I had swelling and felt miserable for the next two days. I continue to do all household work and weave reed mats till the ninth month of pregnancy, since that is our source of income. I even walk all the way to Bathoro city (40 to 50 minutes walking distance) during my pregnancy because we are so poor that we cannot even afford to get a rickshaw. We do not own cattle, nor can we afford milk or proper diet during pregnancy. But now after taking advice from the Merlin staff I am using injections for contraception. Due to these injections my abdomen swells and my menstrual cycle is also disturbed and I often have excessive blood flow. Yet, I continue to use them. After my experiences I know which healthcare services are good. This gains me some authority over other women, so they listen to me and I give them advice and sometimes take them with me to the healthcare facilities.' (IDI Thatta)

The most significant MNCH issue in Basti Basheer Nagar of District Rajanpur was the practice of home based deliveries conducted by fellow women or the single traditional birth attendant (*dai*) residing in Sindhi Basti. This was especially true for the women from the poorer castes of Jhangars, Balochs and Sindhi Arain. They could not afford to go to the private hospitals in the UC centre, located at a drive of 40 minutes and they did not utilise government healthcare facilities because there they were not treated well and had to buy medicines out of their own pocket. A young woman from the Jhangar caste related that:

'I am 17 years old. I was 13 years old when I got married in exchange (watta-satta) with my uncle's son. My husband is a daily wage labourer and we live in a nuclear family. I do all the household chores and also do the agricultural work equal to my husband. I go to any events at the village, NGO sessions and also do laundry at the water channel where I can have other womens' company. I had two pregnancies both delivered by a dai. One of my children died in my womb, while the other is alive. I know a bit about some family planning methods like tablets and injections, but I have not used any contraceptives as I want more children. I do not go for proper check-ups during pregnancy as it is not considered to be a serious matter and my husband also shows no interest in my health and medication during my pregnancy and delivery. My

husband is cooperative at times, but sometimes he beats me without any reason. I have good terms with the lady health worker (LHW), but she does not come to our village except during the polio campaigns. I went to the basic health unit (BHU), but they did not treat me well.' (IDI Rajanpur)

Talking about the quality of care at the government healthcare facilities, a woman stated that:

'I went to the government hospital when my daughter in law was in pain, but they did not take care of her. They gave her tablets and said the baby will grow, but nothing like that happened. Then I went to the private hospital where the doctor prescribed other medicines and her condition improved.' (FGD Rajanpur)

Some women related instances of miscarriage and death of newborns during delivery or some weeks/months after that. A woman said that:

'My first daughter was delivered at home. She died due to bleeding as the dai had cut the navel incorrectly. She is not a trained birth attendant, she just comes in emergency.' (FGD Rajanpur)

Other women complained that their children were usually weak at birth and the birth attendants did not advise them about child care, yet others related that they had no time to take care of their children's needs as they were too busy in work and soon they got pregnant again. Except Punjabi Arain women, all others stated that they worked in the agricultural fields throughout their pregnancy and had to bear many children to support their families in earning a living by working in fields. Some also thought that refusing their men and using contraceptives was a sin. A woman said that:

'No we do not take any rest even during the last month of pregnancy. Now the season of cotton cultivation is going on, so we have to work regardless of pregnancy. Although, we face a lot of problems during pregnancy, we have pain in back and abdomen, but we do this work because it is our main source of income.' (FGD Rajanpur)

All villagers, except the Punjabi Arain people related that their children commonly suffered from diarrhoea as they had very limited supply of clean water from the single hand pump in Sindhi Basti. It was customary to marry young girls with men in the same caste, irrespective of their choice or age difference. The Baloch women related that they usually had exchange marriages and if there was no single man in their caste then they were married off as second wives. Describing her experience of marriage, pregnancies and negotiating contraceptive usage, a woman from the Baloch caste related that:

'I was born in a family where sons were given a lot of preference. We were very poor and not literate as there is

no trend of female education in our caste. I got married in exchange (Watta Satta), right after I had my second menstrual period and delivered a baby 10 months after my marriage. My in-laws live as a joint family in a mud house. My husband and brothers-in-law are tenants and work for one eighth part of the total produce. So far, I have had six pregnancies, three of which resulted in birth of weak and jaundiced babies who died a few weeks after birth. Currently, I am in the ninth month of my seventh pregnancy. When I got married, I had a very low status in the house as compared to other daughters-in-law because I came in exchange marriage. Many issues settled down with the birth of my first baby, who was a boy. I have a lot of responsibilities regarding domestic work that keeps me busy all day. I do all kinds of household chores and look after the domestic animals even during pregnancy. Although, I had good relation with my husband but he beats me when I ignore the household chores. Once he beat me for not making his breakfast because I was having labour pains. In our family women are not allowed to go outside alone so I only go to death and marriage ceremonies in the village, with the permission of my husband and my husband buys clothes and household goods for us. Our children do not go to schools but contribute in earning as they start working in the fields at the age of five to seven. I never visited any hospital for vaccination of children, but once some team came to my house and gave vaccination to my children. I do not use any family planning method for birth spacing, except one time before the recent pregnancy. I took contraceptive tablets from the LHW, but the tablets reacted on me and I started to bleed severely so I never used the tablets again. Recently some Punjabi women have told me about the major operation (removal of uterus) and I discussed it with my husband. He did not allow me to get the operation done because he says it is against Islam, but he agreed to use some other contraceptive method.' (IDI Rajanpur)

During discussion with the male group in Basti Basheer Nagar the issue of family planning was discussed with reference to the high number of children that most families other than the Punjabi Arain ones had. Most village men were against using any form of contraceptive method though they accepted that their wives did not want to bear any more children. They justified that having children was rather natural after marriage and it signified the couple's happiness. Two men related that their wives had used contraceptive pills and experienced side effects so they were reluctant to continue usage.

In Sumal village of District Ghizer, the major MNCH issue was inadequate nutrition of girls and women. Most females related that since there was no wheat plantation in their area so families usually ate barley bread with tea and in the joint family structures they felt obligated to share whatever they had with everyone else. A man stated that:

'Women in the poor households are affected due to their poverty [they cannot buy food], while the rich are affected due to lack of awareness [about nutritional needs during pregnancy]. In joint families, if one daughter in law is pregnant while the other is not, then the pregnant one cannot be served with separate food. So what she needs in her pregnancy is not provided and she is deprived just like the poor women.' (FGD Ghizer)

Some women described their experience of early age pregnancies soon after marriage. A woman who had two children related that in the early years of her marriage it was difficult for her to conceive due to weakness and anaemia, but after taking proper diet and medicines from a doctor she became pregnant and then had two children, one after another. Complaining of high work load and multiple household responsibilities she said that:

'If you take proper diet then automatically you become healthy but after heavy work we just take flatbread with tea so how can we become healthy? If one does birth spacing then the mother remains healthy. Due to no birth spacing, our health is severely affected.' (FGD Ghizer)

The Ismaili women said that their sect had shunned marriages before the age of 18 years and as more and more people were gaining education it had become customary for elder men and women to ask for the girl's preference and consent before marriage. They stated that after the opening of the Aga Khan Health Centre their problem of access to healthcare services had been resolved. For last many years, it had become usual for them to have regular antenatal check-ups, immunisations and growth monitoring of their children. Most deliveries were conducted by the trained lady health visitors (LHVs) in the centre. The centre also conducted awareness raising sessions to promote practice of healthy behaviours. The older women said that since they were better informed so now the animal barns in their houses are located outside as opposed to inside the boundary wall. They also said that many younger women had fewer children and used contraceptives.

Some Gujjar women related that they had difficulty in accessing the centre as they came from the higher pastures and the LHVs in the centre could not understand their language. A Gujjar woman said that:

'There is no easy access from Maulabad and Durnak [the two far flung neighbourhoods]. There we have no health facilities and transport so we have to come here [the Dalti neighbourhood where the Aga Khan Health centre is] and that is quite troublesome.' (FGD Ghizer)

On the other hand, the Ismaili women thought that:

'They [Gujjars] do not have good environment, they do not give importance to health and education that is why they do not like to attend such [health education] programmes.' (FGD Ghizer)

Some health education sessions were also organised at the *Jamat Khanas*, where the Gujjar and other Sunni women were not permitted. However, the poor women of the Ismaili sect also had to face several MNCH issues due to social isolation of the poor. A woman related her story saying that:

'I am 39 years old from Ismaili community. My husband is a drug addict, but he once served the army. He calls me a psycho. May be I am mentally disturbed. I had a total of nine pregnancies; six daughters and a son are alive. One son died after three months of birth and I also had a miscarriage. I have only one room in my house and two of my babies were born in maize fields at the back of my house. I have never visited any hospital or LHW. I go for amulets (taweez) if my children or I face any problem. My last delivery was very difficult as my husband was not at home and I gave birth to my child in the garden. My uterus came out of my body and my daughters were horrified. They called the health workers from the Aga Khan Health Centre and they came and treated me well. I rarely go anywhere except to the neighbours, but they do not come to our place may be because we are very poor. After the birth of my last baby I have started contraception and my husband takes me to the hospital for taking injections. Now my health is not well I have pain in my whole body all the time and it is getting worse day by day. I do not go to the Jamat Khana very often, but whenever I go I feel better.' (IDI Ghizer)

By and large, all women agreed that in their culture women usually kept their problems to themselves because they felt shy in discussing them with male members of the family. The young girls were particularly reluctant in discussing menstrual problems and minor aches with the lady health workers as they feared that if their problems became known to others they will have to face social stigmatisation.

4.4 FORMAL SPACES OF MNCH PROGRAMMES

Table 5 shows the MNCH programmes working in each of the study villages and were included in the study as part of the document review process and key-informant interviews. The description following the table is a critical reflection on the information gathered from the document review, key-informant interviews of programme staff and the focus group discussions with community woman and men.

4.4.1 The National Programme for Family Planning and Primary Healthcare

The National Programme for Family Planning and Primary Healthcare is one of the largest government health programmes in Pakistan. It was initiated in 1994 with the mandate of overcoming the financial and mobility barriers related to primary healthcare and family planning access and

Table 5: MNCH Programmes Studied in the Selected Villages

District	Village	MNCH Programmes
Thatta	Jani Memon	• The National Programme for Family Planning and Primary Healthcare • The Population Welfare Programme • The Maternal and Child Health Programme of Merlin
Rajanpur	Basti Basheer Nagar	• The National Programme for Family Planning and Primary Healthcare • The Population Welfare Programme • The Maternal and Child Nutrition Programme of the Lodhran Pilot Project
Ghizer	Sumal	• The National Programme for Family Planning and Primary Healthcare • The Population Welfare Programme • The Maternal, Neonatal and Child Health Programme • The Aga Khan Health Services of Pakistan

ensuring continuous availability of these services at the doorsteps of rural communities. The programme places special emphasis on maternal and child health and is commonly known as the Lady Health Workers Programme as its prime workforce consists of community based Lady Health Workers (LHWs) (Government of Pakistan, 2003). The LHWs are responsible for health education, advice and creating awareness for promoting the community's health. The work of LHWs includes counselling, provision of family planning services, antenatal care and referrals, immunisation, basic curative care and mobilisation of support from community leaders (Government of Pakistan, 2003). The most recent evaluation of this programme conducted in 2009 has revealed that there are a total of 90,000 LHWs employed in the programme, across the country (Oxford Policy Management, 2009). Each LHW serves about 1000 people living in the 100-200 households around her own house that is called the 'health house'. Over the years, the LHWs have gained a lot of respect and influence in their communities and their contribution in ensuring availability of affordable primary healthcare has been valuable. However, despite all efforts the programme has had limited success in mobilising communities (Oxford Policy Management, 2009).

As a part of this study, we interviewed different levels of three LHW programme personnel from each selected district. All LHW programme personnel that were interviewed knew about the high rates of population growth and the relationship between social determinants of health and maternal and child mortality and morbidity. They mentioned the gaps in availability and quality of services and were of the opinion that illiteracy, lack of awareness and poverty were the root causes of all MNCH issues. Most interviewees related MNCH promotion to improvement in healthcare seeking behaviours that were an automatic result of raised health awareness in communities. One of them said that:

'Health promotion means to educate people regarding health. If people are informed about health issues then slowly and gradually they themselves will begin to act on it.'(KII Thatta)

The LHW programme links community participation to increasing awareness and improving attitudes related to health through formation of women's groups and health committees. The implementation strategies and training modules of the programme also emphasise upon inclusion of community notables, decentralised decision making and partnerships between women's groups, NGOs and citizens community boards (Government of Pakistan, 2003). The interviewees elaborated that local leadership had a vital role in bringing about behaviour change in communities. Therefore, the LHW programme mandated LHWs to form committees that included community notables and local representatives whose words and behaviours will be adopted by other people in the community. An interviewee said that:

'We include the people who are socially active and the women who can talk easily....people listen to the local leader (Lumberdar) so we have included him too.' (KII Ghizer)

After interviewing programme personnel from different cadres, we found that the lower ranking staff had an in-depth understanding of issues faced by the poorest population groups, but they could not include them in health committees because the nature of work demanded that members should be socially acceptable and influential so that others would listen to them. Some interviewees told us that the function of committee members was to propagate health education messages in their community. However, we found that the roles and responsibilities of committee members were not clearly laid out in programme documents. In Sumal village of Ghizer, a health committee had been formed two years ago, but was no more functional. In the other two study sites there was no existence of health committees or women's group. We also found that the monitoring system of the programme noted the presence of committees but paid no attention to their activities or membership criteria. On one hand the programme documents ignored the inclusion of the poorest, while on the other hand the programmatic records showed the presence of health committees and women's group which did not exist in reality, in the three study sites.

The LHWs are also responsible for organising monthly health awareness sessions in their catchment area. We found that the LHWs in all three study sites conducted awareness sessions, but not regularly. A few days before the session, the LHW called her relatives or friends in the area and asked them to gather participants on a specified time in some household or communal place in the village. At other times, the place and participants for the session were chosen on the spot. Explaining the mechanism for organising these sessions, an interviewee said that:

'There is neither policy for the number of people, nor any target for the number of participants [in the session]. If it is the area of LHW....then every month she holds health

sessions and it is not necessary that how many households she includes. Besides this the residents of surrounding houses can also participate and if there are guests in those houses they can also be included.' (KII Rajanpur)

The programme documents and interviewee accounts highlighted that the selection of LHWs was based on their residence in or near the catchment area and their level of education. The selection criteria mandated hiring of females who had completed at least eight years of education. However, the programme personnel mentioned that the hiring of LHWs was adversely affected by political influence therefore the selected LHWs usually belonged to the upper class. The community women and men in all the three sites stated that the LHW of their area had strong ties with specific households who were either her relatives or friends and were usually from the more literate and better-off castes. Many times the LHW asked her friends and relatives to gather participants for the health awareness sessions. This reinforced disparities in the community as the LHW's friends and relatives usually called upon their relatives and neighbours and in the process excluded women from other castes and the nomadic population groups. Moreover, women from the better-off castes blamed the others for refusing to participate in awareness sessions, while those from the other castes considered such participation useless as they were of the opinion that the information and advice imparted by the LHW was meaningless as they had no money to go for check-ups or buy the food or take the hygienic measures she suggested. Sometimes the LHWs conducted sessions with whoever was available and chose the topic of discussion according to the audience. A LHW explained that:

'For example I am available in any of the village, and there are children then I give a session on hand wash. If there are young girls, then we tell them about the issues of body change in young age. If there are mothers, then we tell them about breast feeding.' (KII Rajanpur)

The LHWs were mandated to conduct door to door visits of five or six households per day in their catchment area. They were supposed to register married couples, counsel them on family planning, provide antenatal and post natal care to mothers, immunise children and monitor their growth, provide treatment and advice for diseases like diarrhoea and pneumonia, advise on nutrition, impart information on and make referrals to available healthcare services (Government of Pakistan, 2003). We found that in all three study sites, the LHWs usually utilised their monthly door to door visits for giving polio drops to children. The community women related that she visited a known household in each caste and called the children there for giving polio drops. Sometimes she visited pregnant women and advised them about nutrition and family planning. At other times she handed out products

given by other programmes, like mosquito nets distributed by the National Rural Support Programme (NRSP) in Thatta and Rajanpur. She also informed women about the service centres of programmes distributing nutrition supplements to pregnant women and to undernourished children. Women, who lived near the LHW's house in Ghizer, usually visited her or just took advice when they met her on the way. The nomadic population groups in the three sites were barred from the door to door services provided by the LHWs due to the registration criteria that permitted registration of permanent residents only. A LHW described that:

'There is a reason for their [nomadic population] exclusion. The people who are living on 1/8th [as peasants] change their location after every six months. According to our criteria we cannot register people unless they have been living in an area for more than six months. If they settle in a place, then we register them. But, if we have achieved our target of fifteen hundred people then we leave them. In case our target is not achieved till then and the house of tenants is in our area, then we register them.' (KII Rajanpur)

None of the interviewees could appreciate the association of health promotion action with group formation, community mobilisation and collective action for better governance in health systems. Nonetheless, they identified lack of resources, equipment and transportation as the main challenges of the LHW programme. They recognised that how and the extent to which LHWs functioned in the programme was largely associated with personal relationships. Thus well-connected staff members could get away with anything and functioned if at all, at a minimal level. Other LHWs complained that the limited medicines and supplies like mosquito nets given to them for distribution in communities promoted disparity between different population groups. While still others recognised the unavailability of educated females as a limitation for programmatic outreach and identifying gaps in the capacity to mobilise communities an interviewee said that:

'For this purpose [community action] we lack capacity building. The other thing is that the acceptance rate of the community is always very low. People are stuck in their personal issues. For example when you are talking about health, the mother will say that she has to cut grass for her cattle. When you talk to her about health promotion, she will be so entangled in her social system that she will talk about herself. These are the things that cause hindrance.' (KII Rajanpur)

With respect to accountability and community action, the community women and men were found to support the LHWs as they never held her accountable or complained against her services because some of them who were her friends and relatives did not want to harm her professional standing and source of livelihood, while others thought

that their complaint will be disregarded as the LHW had connections with influential people who would save her from any form of accountability. The general lack of knowledge and functionality of accountability structures in the LHW programme prompted people who could afford to purchase services to seek healthcare from private facilities, while those who did not have the power to purchase services were left on their own.

4.4.2 The Population Welfare Programme

Population welfare efforts in Pakistan were initiated in the mid-1950s by a national level non-government organisation (NGO). The government family planning programmes began in the 1960s under the Federal Ministry of Health. In the 1980s, the government's population welfare activities were transferred to the provincial Population Welfare Departments. In 1990, the agenda of population welfare was recognised at the national level and the programme was placed in the Federal Population Welfare Ministry. Later, Pakistan committed to the Plan of Action (PoA) of the International Conference on Population and Development (ICPD) in 1994, and introduced the Reproductive Health Package in the Population Welfare Programme. Recently, the Population Ministry was abolished and the programme was devolved to the provincial level as the Population Welfare Department housed within the provincial health department (Population Welfare Department, 2013). The programme/department aims to take family planning services to the doorsteps of people and to ensure provision of quality services with the right to choose small family norm to achieve population stabilisation (Government of Pakistan, 2011). The Population Welfare Departments (PWDs) provide family planning information and services through Family Welfare Centres (FWCs), Mobile Service Units (MSUs) and Reproductive Health Service Centres-type A and B (RHSC-A and RHSC-B). They reach out to train local religious leaders, traditional healers and private medical practitioners, so that they can spread the message of family planning and provide services to more and more people.

According the PWD's PC-1, the FWCs are the main hub of population welfare activities that serve as the static facility for about 7,000 people in their surrounding area. Through satellite clinics the FWCs cover a population of 12,000 people. The staff at each FWC consists of a Family Welfare Worker (FWW), a male and female Family Welfare Assistant (FWAs) and support staff of an *aya* and a *chowkidar*. The FWCs provide family planning information, counselling, services and follow-up facilities. They also provide treatment for minor ailments and advice on growth and nutrition of infants. With help of the FWAs, the FWW provides family planning advice and services to far flung villages in the catchment area by organising weekly satellite clinics/camps. The female

FWAs communicate with groups of satisfied clients and local female leaders like teachers and social workers to organise health education sessions in different communities. The male FWAs work with the Male Mobilisers (MMs), a separate cadre in the Population Welfare Programme, to increase male involvement in family planning by forming group of local opinion leaders and elected representatives. One MM is assigned to cover a population of 10,000 and he is supposed to hold monthly meetings with his group to spread the message and products of family planning (Government of Pakistan, 2011). In all the three study sites FWCs were located outside the study villages in government basic health unit. Among the different cadres of PWD personnel that we interviewed, all recognised the FWC as the static facility for family planning advice and services. However, only some lower ranking staff members were able to describe the role of satellite clinics, health education sessions and groups formed by MMs. They related health promotion to awareness raising and behaviour change that could be influenced by the local opinion leaders and community notables.

The people of Jani Memon village of Thatta, told us that the female FWA of their area had organised a health education session with the help of her relatives in the Memon settlement, two years ago. Most Khaskheli and Sheikh women and men had only heard about the session and had a faint memory of it because they were working in the fields and were not able to attend the session. A Memon man who was distantly related to the FWA said that:

> *'She [FWA] came here two years ago, told us not to have too many children and use birth spacing methods, tablets etc. She also used to take us for operation [at the FWC]. She gave tablets in the village and in our neighbourhood, but it seems nobody has used them. Apart from it, some people went for operation and got money in exchange of operation.'* (FGD Thatta)

The PWD personnel in Rajanpur informed us of the wide coverage of their FWCs. They further said that the satellite camps had been conducted a few years ago and were no more possible due to lack of resources in the department. The FWW said that:

> *'In the past we used to have satellite camps every Tuesday, but now it has been stopped. We went to different areas and people from those areas visited us as clients. In the satellite camps, we informed people and provided them services. Now, we are at the Basic Health Unit (BHU) and providing services to those who visit the BHU. We motivate them from here.'* (KII Rajanpur)

She elaborated that the MM associated with the FWC had a shop in his village and he helped in organising the camps by making announcements in the community two to three days

in advance. Relating the challenges faced after enforcement of devolution, she mentioned that at the programmatic level there was no collaboration between the PWD and LHW programmes as they did not share any data, though they were working for the same purpose. She also said that sometimes the LHWs asked her for oral pills and injections or referred clients to her, but in either case the record of such clients was either duplicated or not entered in the system as PWD only kept record of clients coming to the centre for services. When asked about PWD, the community women and men in Basti Basheer Nagar of Rajanpur had no recollection of any satellite camp in their village. None of them knew the MM, while some of them recognised the FWW who provided family planning services at the BHU, but they also complained about staff absenteeism at the health facility.

In Sumal village of Ghizer, the PWD personnel told us that they paid particular attention to the people from Gujjar caste since they were the ones who usually had six to seven children. There was no FWC in the village, but the MM in Sumal said that he had formed a group of male teachers who helped him spread the message of family planning among their students. He told us that he supplied contraceptives to the group members and the LHW and other health workers in the area. Many community men knew the MM, but we could not find anyone who was part of the MM's group.

Another service providing facility of the PWD is the RHSC-A centres which are located in the District or Tehsil/Taluka Headquarter hospitals of the area. These centres serve as a point of referral for FWC clients opting for surgical family planning methods, including vasectomy (Government of Pakistan, 2011). Among the different cadres of PWD personnel that we interviewed, all related the functioning of a referral system. However, the community women and men in all the three study sites had no knowledge about such centres or the referral mechanism.

The MSUs are meant to provide family planning and reproductive health services at the doorstep of underserved communities. The MSUs are headed by the Woman Medical Officer (WMO). With the help of FWC staff, MMs and other community based health workers the MSUs are required to organise 10-12 camps every month in the district. Besides providing services, the MSUs are supposed to conduct awareness sessions with community people and local opinion leaders and elected representatives (Government of Pakistan, 2011). The PWD personnel told us that the MSUs were introduced as an innovative strategy and remained functional only for one to two years because the resources required to sustain the strategy could not be procured by the departments. In Thatta, we came across a WMO who resided in Karachi and travelled infrequently to provide services at the BHU. She described the political interference and inaccuracy

in data recording and reporting that were adversely affecting the department's performance. Relating the injustice faced by a girl child and women she said that:

'The work we are doing is not to empower women. We are only here to provide proper health services. Empowerment does not come in one night. The whole society is structured in a way that the rights of girls are violated from the very beginning to the end…..Empowerment does not come easily, it takes a lot of time. This will happen only from the grass root level where the mid-wives and LHWs need to spread awareness. They need to conduct awareness raising sessions for women. By giving one day in a year to observe Women's day will not result in empowerment.' (KII Thatta)

None of the community people in the three study sites had any knowledge about the MSUs. Moreover, the review of records of the PWD showed that data for clients visiting the FWCs was being kept and this facility based data was being used to estimate contraceptive prevalence rate of the community. The records had little information about the client's background, so it was difficult to judge the socio-economic background of users. The records had provision for noting the number of health education sessions and community groups, but no details of who was included in the sessions and groups.

4.4.3 The Maternal, Neonatal and Child Health Programme

The Government of Pakistan (GoP) launched the Maternal, Neonatal and Child Health (MNCH) Programme in 2007. The overall vision of the MNCH Programme is to reduce maternal and child deaths and illness by improving the health status of all, particularly for the poor and marginalised. The programme aims to improve the quality and coverage of MNCH services, especially at primary and secondary levels of the health care system, coupled with community outreach services through integrated system-wide approaches. The programme strategies for achievement of its objectives included:

1. Integrated delivery of MNCH services at district level;
2. Training and deployment of a new cadre of community midwives (CMWs);
3. Provision of comprehensive family planning services;
4. Strategic communication for MNCH care;
5. Strengthening programme management.

The mid-term evaluation of the MNCH programme conducted in 2011-12 by the Technical Resource Facility, showed that the programme was very successful in increasing skilled birth attendance and institutional deliveries. However, the CMWs were less trusted by the communities and their success was further marred by the weak transportation system, social and cultural gaps between CMWs and clients, and out of

pocket payments for deliveries. The evaluation study also found that the MNCH programme lagged behind in providing comprehensive family planning services and undertaking communication interventions for improving MNCH care (Technical Resource Facility, 2012).

The MNCH programme personnel interviewed in Ghizer told us that the programme had been initiated in their district in 2008, under the Department of Health. They stated that they had trained a total of 28 CMWs in the district, who focused on providing awareness about nutrition as that was the main problem affecting women in Ghizer. The MNCH programme personnel linked health promotion to awareness raising and behaviour change in communities. The CMWs in Ghizer formed committees of government LHWs and the lady health visitors from the Aga Khan Health Centre and notable community women in their area and conducted monthly meetings with them. The committee members were supposed to spread the messages related to better nutrition and the availability of CMW services. The MNCH staff explained that the poor and nomadic population groups were excluded from the groups formed by CMWs because:

'There is a particular selection criterion, so only educated women belonging to the community are selected. We cannot include any Gujjar women because they are not educated.' (KII Ghizer)

The interviewees explained that they were working together with the LHW and Population Welfare programmes at the district level. They also said that due to lack of resources and transportation they were focusing on the more educated people living in and near the district centre because they could be easily convinced. One of them stated that:

'We have started it initially in Ghakuch [the District headquarter] and our focus is pregnant women, especially. People of Ghakuch are literate and they can understand and accept the things that we tell them – what to eat and how much to eat during pregnancy. But, if we move on towards other places like Darmadar [a remote village where the Gujjars live], they are totally different. There the people are not literate and do not even recognise these [MNCH] issues. It is a difficult area and the situation of maternal mortality rate and infant mortality rate and other health related issues is at a dangerous level. If we receive vehicles, we will move into these communities.' (KII Ghizer)

The MNCH personnel criticised the programme design and said that:

'Whosoever had designed this [structure] made a mistake. In the plain areas people live together and 5000 population is easily accessible for the CMW, but here it is very difficult to provide coverage to so many people [due to difficult terrain and scattered population].' (KII Ghizer)

When asked about the CMW and the MNCH programme, the community women and men in the Sumal village told us that the CMW of their area lived in another village. She had formed a group consisting of LHWs, some community women and men in the village and the group had regular monthly meetings. A pregnant woman, who was a member of the group formed by the CMW told us that the staff of the Aga Khan Health Centre in the village had helped in selecting the group members. They had selected one socially active woman from each neighbourhood and each group member had been assigned the responsibility of raising awareness in their neighbourhood. She explained that:

'We are total eleven members, eight females and three males. We visit pregnant ladies and tell them about their diet, check-ups and other issues during pregnancy. We also tell them if they cannot go to the Aga Khan Health Centre for delivery, then they should call the community midwife (CMW).' (FGD Ghizer)

However, another pregnant woman from the Gujjar caste stated that she had not received any such information from the CMW group member of her neighbourhood. The women from other castes knew about the CMW's services, but they did not trust or call upon her for conducting deliveries.

4.4.4 The Maternal and Child Health Programme of Merlin

Merlin is a United Kingdom based agency which aims to provide basic healthcare to all, responds to save lives in times of crisis and safeguards long term health. The agency provided health and nutrition packages to flood affected people in Sindh after the 2010 floods (Merlin, n.d). The Maternal and Child Health Programme of the agency aims to integrate emergency obstetric care (EmOC), post abortion care and family planning services in the existing reproductive health services in districts Dadu and Thatta. Merlin's programme has built the capacity of government healthcare staff at nine government dispensaries, one rural health centre and one Taluka hospital in district Thatta. As part of the on-going capacity building process, the programme has also placed its own human resource at the aforementioned government healthcare facilities. Health promotion activities of the programme include organisation of community based camps and celebration of health days (Merlin, n.d).

The Merlin programme personnel in Thatta described the multiple causes of MNCH problems that included inadequate training of healthcare staff, lack of resources in programmes and lack of education and awareness about MNCH issues among community people. One of them said that:

'But, the most important problem pertaining to health is lack of education and awareness; everything else comes afterwards.' (KII Thatta)

The interviewees recognised that the nomadic population groups had the worst situation of MNCH because they temporarily stayed in one place and could not use all the health facilities effectively. They related health promotion to awareness raising and behaviour change for creation of an enabling and healthy environment. They also emphasised upon the importance of resource allocation, provision of good quality healthcare services and institution of healthy public policies and facilities like roads and transportation. The interviewees told us that the Merlin programme had strong linkages with government healthcare programmes. It envisioned capacity building and support of government health facilities as a sustainable step for healthcare provision as they hoped that it will continue even after the Merlin programme had ended. The interviewees also identified the need to spread awareness through mass media and to establish a functioning referral system between community and facility based healthcare workers.

The community women and men of Jani Memon village of Thatta did not know much about the Merlin programme, but when provided some hints they told us that a female Merlin staff had visited their village only once, a few months ago. It was difficult to discern the exact time of her visit because different people gave different accounts about the time of her visit. However, they all elaborated that she contacted one of the educated Memon men, who had previously worked with some NGO and asked him to help her in organising an awareness raising camp in the village. Through the camp she informed people about health and nutrition. She also gave cooking oil to the pregnant women and nutrition supplements to the undernourished children of the village. Some women complained about her rude behaviour when they visited the Taluka hospital and asked her to give them cooking oil and nutrition supplement. Realising the dearth of information about Merlin's programme a Memon man said that:

'The ones who do go to the Taluka hospital might know about this [Merlin programme]. There is something that Merlin should really do and that is that they should set up a camp in the village and let everyone know that Merlin representatives are working at the Taluka hospital and their team consists of two doctors, so that these people can go there for the treatment of their health issues.' (FGD Thatta)

4.4.5 The Maternal and Child Nutrition Programme of the Lodhran Pilot Project

The Lodhran Pilot Project (LPP) started working as a local non-government organisation (NGO) in the district of Lodhran in 1999. In the beginning it was primarily concerned with improving the sanitation facilities of the area. Later on, the project took up the task of helping people in the 2010 flood affected districts of Punjab and then to developing skills and empowering children (Lodhran Pilot Project, 2013). The organisation aims to propagate sustainable and equitable development by using the participatory approach for improvement in livelihood of vulnerable communities in Southern Punjab. Community participation, capacity building and advocacy are the mainstay of LPP's work.

The Maternal and Child Nutrition Programme of LPP has started working in Rajanpur in late 2012. The LPP is implementing this programme in 12 out of 24 Union Councils (UCs) of Rajanpur, using the community action process (CAP). An interviewee explained that:

'The aim of this project is to increase the personal capacity of people. This project aims to make people capable of identifying their needs, so that they may solve their problems themselves rather than knocking at someone else's door. After this, we will help them in accessing concerned authorities.' (KII Rajanpur)

All interviewees, who were LPP staff working at different levels in the programme recognised that the issue of home based antenatal care, deliveries and postnatal care that led to the poor health of mothers and children was mainly due to lack of awareness and planning among people. They elaborated that it is mostly the not-literate and more traditional people who give little value to maternal health, therefore they do not care to find out about the available healthcare services or to save money for accessing good quality healthcare services. The male and female field officers of the LPP programme formed clusters in each of the 12 UCs. They began by conducting a survey of the cluster and noting all MNCH information on a community information board. The status of the board was updated every month to gauge progress and to identify points for action. Explaining the process of cluster formation and group sessions, an interviewee said that:

'We create a cluster of 40 households for capacity building. A male and a female field officer work with the people of the cluster. The female holds sessions with females, while the male holds sessions with males from the cluster.....We do not have any hard and fast criteria for inclusion in the cluster. The session participants include literate, not-literate, poor and wealthy. The session is not for a particular group or individuals. [In the sessions] we prefer to select a man or woman as group facilitator who have the ability to understand to our messages and spread them to the community members. The education of group facilitator does not matter in this case.' (KII Rajanpur)

In Basti Basheer Nagar of Rajanpur, the LPP programme staff had formed a cluster of 40 households that included all the houses of Punjabi Arain caste and some adjacent houses of the Jhangar caste. We found that the primary village contact of the LPP staff was a young and educated Punjabi Arain

male who had a shop in the district centre and maintained close contacts with many NGO people. The LPP staff had asked him to help them in making a cluster. He had offered them to choose the Punjabi Arain households in their cluster and had taken them to the Babbar and Pathan castes to ask them for inclusion in the cluster. The people from the Punjabi Arain caste consented to participate in the LPP cluster, but the people from the Babbar and Pathan castes refused to be included in the cluster because they were not getting any material benefit from participation. Therefore, the LPP staff and their primary village contact asked the adjacent Jhangar households to be part of the cluster. The primary village contact from the Punjabi Arain caste and his sister were chosen as the group facilitators for the male and female groups, respectively. The group facilitators were contacted on the phone two to three days in advance of the awareness session and asked to gather the men and women from the cluster. The community men who were part of the cluster told us that the male field officer of LPP had conducted an awareness raising session on ways of saving money for facility based delivery in their families. The community women who were part of the cluster said that the female field officer of LPP had conducted an awareness raising session on antenatal care. All the cluster women said that the session was like a lecture so they just sat through it and tried to remember the key messages in it. The Jhangar women who were part of the cluster and had participated in the session said that:

'We do not know her and we could not understand what she said so we remained silent. We were sitting right at the back and she was speaking in Urdu, so we could not understand her. If she would have spoken in Saraiki then we would have understood her.' (FGD Rajanpur)

We noticed that there was a constant debate between the community people as women and men from all other castes blamed the Punjabi Arain people for usurping all opportunities and financial or material aide that came to the village. On the other hand, the Punjabi Arain people justified that they were not getting any aide from NGOs, but were being contacted by them because they had previously worked with them and understood their role in supporting people. The Punjabi Arain people explained that a few years ago the National Rural Support Programme (NRSP) had visited their village and helped them form groups of 10-12 people. Many Punjabi Arain men and women had been part of the community based groups formed by them and had contributed finances and worked with the NRSP to build the street soling around their houses. They also agreed with the idea of building people's capacity to resolve their problems instead of handing over aide to them. But the men and women from all other castes complained that they were excluded from the groups formed by the NRSP because they were poor and had no money to contribute. They said that:

'Here organisations came and included those who were in position to save money [for contribution in development activities]. They registered their name, but the names of those people who were not able to save were not registered.' (FGD Rajanpur)

As mentioned by the LPP personnel, the poor and not-literate were not deliberately excluded from their cluster. However, the interviewees related health promotion to behaviour change and demand for rights. They urged that inclusion of local leaders in programme implementation was very important for the success of their programme. They also stated that giving incentives to community people will encourage participation. The lower ranking LPP staff preferred to set up clusters and groups by establishing contact with the literate villagers because they could better understand their point of view and purpose of their programme and showed readiness to work with them. An interviewee said that:

'I think the real activists of the area are the notables, the ones who are influential. They must be part of the programme. If such people own the implementation of the programme then I think the programme cannot be unsuccessful.' (KII Rajanpur)

The LPP personnel also emphasised the importance of forming collaborations between NGOs and government line departments, in order to encourage accountability and improve the quality of healthcare services.

4.4.6 The Aga Khan Health Services of Pakistan

The Aga Khan Health Services of Pakistan (AKHSP) has the mandate of providing primary healthcare and curative medical care in the country. Besides setting up primary, secondary and tertiary healthcare facilities in the country, the AKHSP has also designed community health programmes to reach the vulnerable groups, including women and children (Aga Khan Development Network, 2007). The AKHSP focuses on providing information and services that are needed and wanted by the community. The organisation has well defined quality protocols that form the basis of their staff selection, training and services (Aga Khan Development Network, 2007).

In the Sumal village of Ghizer, the AKHSP provided information and services to the community through a health centre located in the centre of the village. The community women told us that they were facing a lot of problems related to accessing antenatal care and delivery services in their village so in the late 1970s their men requested the AKSHP to open a health centre in the village. The Aga Khan Health centre was opened in 1980 and since then had been providing maternal and child health related services to the community people. The staff deputed at the centre included two lady health

visitors (LHVs) and one male paramedic (compounder). We found that the staff of the health centre was well trained and certified in providing services. The community people using the services seemed extremely satisfied with the quality of care provided at the centre. They said that they did not have to wait for long hours, they were treated well by the staff and received services at an affordable cost. Some Gujjar women said that they did not know about the Aga Khan Health Centre as they lived in higher pastures and did not come down for seeking healthcare, but those who lived in the lower areas were aware of the centre and went there for healthcare services. We found that the centre had a record of all pregnant women, their deliveries and children's growth in the village. The community women told us that to encourage regular antenatal check-ups there was a system of charging slightly extra fee for clients who missed their last antenatal visit. The men from the Ismaili community told us that in collaboration with the *Jamat Khana* the health centre had instituted a mechanism for providing services to the poor. Expensive services were provided to the poor on credit that could be gradually returned through the *Jamat Khana* in instalments.

The different cadres of AKHSP staff that we interviewed told us that the health centre was the main hub for their work related to curative medical care, but they also reached out to the community by organising health awareness sessions. To them health promotion was related to awareness raising and change in health seeking behaviours. To organise awareness sessions the health centre staff contacted socially active community women and men and asked them to gather participants for forming a health committee and arranging transportation. The awareness sessions were held at mosques, *Jamat Khanas*, schools and sometimes in one day camps. The female or male group organiser was given the role of chairman of the health committee, while the other members included notable community women and men, the LHWs and CMWs. Discussing the inclusion criteria of health committee members, an interviewee explained that:

> *'We include only notables. Gujjars cannot understand our language and it is difficult to converse with them, so we do not include them.'* (KII Ghizer)

The AKHSP staff collaborated with other government and NGO programmes working in the village and had strong linkage with the District Health Office, in order to pursue collective goals related to MNCH.

4.5 FORMAL SPACES OF OTHER PROGRAMMES

In Basti Basheer Nagar of Rajanpur, we found that the Punjab Rural Support Programme (PRSP) had formed a credit group of shopkeepers and businessmen who worked in the district centre, while the NRSP had formed two separate groups of men and women who could save money and work with NRSP to improve their livelihoods. These groups were called community organisations and talking about them a Punjabi Arain man said that:

> *'NRSP came in 2010 and made a committee of 10 to 12 people. After this they provided us fertilizer (DAP) and seeds for planting wheat. They said that you must organise yourselves into a committee that has three designations, a president, vice president and secretary. You must collect savings every month and open a bank account.'* (FGD Rajanpur)

The community people told us that initially their community organisation had worked with the NRSP to make the street soling around the Punjabi Arain houses. Later, the community organisation had also made some savings in a bank account, but eventually each member withdrew their share and used it according to their own interest. They also said that the groups were not active any more, but some group members were in touch with the NRSP and other NGO people and facilitated them while working in the village.

In the Sumal village of Ghizer, we came across several committees of men and women. There was a retired soldier's society, a women's committee, a peace committee, an education committee and the *Jamat Khana* committee. Some of these groups had a well-defined formal structure with clear roles and responsibilities and membership criteria/fees, while others operated on the basis of an unwritten structural code. The committee members told us that the committees had been made by the villagers who had been part of the community based organisations formed by the Aga Khan Rural Support Programme (AKRSP). The villagers informed us that in collaboration with AKRSP they had made the water supply and sanitation system in their village and constructed water channels for irrigation. They explained that:

> *'Based on the training given by the Aga Khan Rural Support Programme (AKRSP), we had made village organisation and women's organisation in this village. The AKRSP had suggested gathering a group of people who could make savings, five to ten rupees daily. They advised us about opening bank accounts, but both the village organisation and women's organisation could not work properly and stopped functioning. Later, the village organisation took the shape of a society. Learning from that the women also started their society and then the retired army men made their society.'* (FGD Ghizer)

4.6 INFORMAL SPACES IN SELECTED VILLAGES

The informal community spaces included the existing indigenous places or spaces where people get together

and had conversations. These included the private spaces where discussions were held within the boundary of some household. Discussions in private spaces were held between spouses or some family members living within the same household or between a small group of women/men who gathered in a household to celebrate an event (like child birth or marriage) or for a religious or cultural ceremony (*milad, khairat* or funeral). The women in all three communities informed us that their conversations in the private informal spaces usually consisted of daily life events and customary practices, but they also shared information about their health problems, availability of healthcare services, attitude of healthcare providers and side effects of medicines or procedures. A woman said that:

'We ask each other about operations, medicines and injections. We also take advice from each other' (FGD Rajanpur)

A Sheikh woman from Thatta told us about how other women gave her information about formal spaces of MNCH programmes, yet she faced several challenges related to quality of care and access to healthcare facilities. She related that:

'I am 20 years old and belong to the poor Sheikh community. In our community, it is customary to engage a girl at very early age and then the marriage is arranged after she gets mature and starts menstruating. My fiancé was my cousin living in the adjacent house, he was two years older than me. My marriage was arranged after I had five or six menstruations. My in-laws live in a joint family system and I do all kinds of indoor and outdoor work. I was 15 years old when I got pregnant after two or three months of my marriage, and I knew almost nothing about pregnancy or child birth, then my mother and sister-in-law helped me a lot in giving information about it. My sister-in-law took me to the government hospital twice, for treatment as I was very weak during my first pregnancy since we take only the routine diet. The doctor said that I had blood deficiency and needed a proper diet, but we cannot afford milk and butter. Then some Khaskheli woman told my sister-in-law that in civil hospital they are distributing cooking oil cans among the pregnant women, so I got one after a detailed check up at the hospital. I could not breast feed my first baby as I was weak and underweight and had no milk. Then I was pregnant again after six months and felt lethargic throughout the pregnancy. In the eighth month of pregnancy, I had pain in my back and lower abdomen. During the day, I visited government hospital in Bathoro, but they sent me back saying that it is not the time for delivery. But, I continued to have severe labour pains so at night my husband and sister-in-law decided to take me to the hospital in Bathoro on a rented donkey cart, the only available transport. My pains were so severe that my daughter was born in the donkey cart

and remained connected to me with the umbilical cord till we reached the hospital.' (IDI Thatta)

Occasionally, women visited the households of relatives and friends or got together at one woman's house in their settlement or neighbourhood. In Ghizer, many women had kitchen gardens in the backyards of their houses where they found some relief from household chores. A common feature of women's informal spaces within the households was that, the elderly women were almost always around the younger ones and closely watched their activities and associations. They shared home based remedies for illnesses with the younger women and taught them how to take care of the neonates and children. They were also a source of reinforcing gendered social norms that the younger women felt obligated to fulfil. We observed that within the households, women had no 'safe space' as in all their interactions they were judged against the stereotypical image of 'good' and 'bad' women. So when our researchers accompanied women in their transitory public informal spaces they opened up and shared a lot of their experiences and feelings. Describing the power dynamics in the house of her in-laws a woman from the Sindhi Arain caste of Rajanpur stated that:

'I am 29 years old and eight months pregnant. I am conceiving for the seventh time. I got married at the age of 18 and my husband is a tenant. He has four brothers and three sisters. I gave birth to six children, of these two baby boys died and now I have three daughters and a son. We live in a joint family system and I have one room, but that is not suitable for living during summer season, so we use the courtyard for sleeping and cooking. The elder brother of my husband is the head of the family and takes all the decisions for the family, so my elder sister-in-law (jithani) also takes preference over me. She brought more dowry than me. My mother-in-law gives her more importance and takes all domestic decisions with her consent. I do all the household chores even during pregnancy like fetching water, cleaning and cooking etc. Although, I have good relations with my husband I have to go through a lot of confrontation with my elder sister-in-law. I do not have enough information about MNCH issues except that the mother should take proper diet, including milk and fruits and do less work during pregnancy. I had bleeding in the ninth month of my first pregnancy. Yet, my first baby was born alive, but he died when my jithani compressed his nose. After this, my second baby was born at home in the presence of my husband. Then I had two daughters who were born at my mother's house with the help of an expert dai, but after delivery she did not give any instructions or suggestions [about child care]. Then after two years I gave birth to a baby boy in the hospital, but he died soon after birth because he had no heart beat and the doctors said that he had very little blood [low level of haemoglobin]. I also had bleeding during the fifth month of my current pregnancy. This time I have

visited a private clinic in Fazilpur [20-30 kilometres away from the village] every week with my sister-in-law. The doctor there has told me that my baby's growth is not normal and I am worried about this delivery. I have sold my dowry items and livestock to get money for health check-ups and now we are left with only two beds (charpais) and a few kitchen utensils. We have to sell a goat for delivering the baby in a hospital. Although, I know the LHW and her centre but I never go to government hospitals because of unavailability of facilities. I participate in NGO sessions and breast feed my children about one and a half year and also complete their vaccination from private hospitals. After delivery, I rest for five days, but I call my niece for help with household work as no one shares my responsibilities at home. Sometimes my elder daughter who is seven years old helps me when I am not feeling well. I go out in my neighbourhood almost every evening to chit chat with women. I have no restriction to participate in any social gathering in the village except going to houses with which we have family disputes. I have never used any family planning method except condoms, but now my jaith (husband's elder brother) has advised us for birth spacing. My husband and I have planned to use multi-load after this delivery, but we have not decided from where we will get this done.' (IDI Rajanpur)

We found that communication between women and men took place in the family, but in all the three study sites the event celebrations had separate gatherings that prevented any detailed conversations between women and men. When women came to know something from other women, that information made way to the household based dialogue between males and females and resulted in behaviour change. A man elaborated that:

'Women share their grievances with each other. If they have any illness, they get suggestions about doctor. Once, my wife told me about a renowned lady doctor and following that information I took my wife to her.' (FGD Ghizer)

Some women from the poorer castes worked in or occasionally visited households of the better-off castes. They stated that the more educated women belonging to better-off castes were a good source of information related to nutrition, hygiene and healthcare services. Some of them related that after acquiring information from the better-off women they had started using family planning methods. A poor woman who worked in the household of the better-off stated that:

'The two of my younger children were born at the health centre and the others at home. The hospital was far away from home, but seeing them [the women from the better-off caste] I also started going to the health centre.' (FGD Ghizer)

The public spaces for women's meeting and dialogue were different from those of men and usually transitory. In all

the three study sites the women from the poorer castes gathered at points of washing clothes like the muddy water swamps in Thatta and the water channels in Rajanpur and Ghizer. In Thatta and Rajanpur, the women from the poorer castes worked together in agricultural fields and went as groups to collect drinking water from hand pumps located at some distance from their houses, while in Ghizer they went in the woods to graze animals. In all the three sites, the women from the better-off castes usually stayed indoors as their houses had pumps or piped water supply. The women from the better-off castes also felt their social status lowered, whenever they interacted with the poorer women. In fact, both the poor and better-off women stated that their men forbade them from developing very close relationships with each other. In Ghizer, the women had less restriction on their mobility so they also gathered at the shop that sold women's items and at the Ismaili community centre, '*Jamat Khana*'. In public spaces, women in all the three sites helped each other in carrying clothes for washing and clay pots for collecting water. At other times they worked together to sow seeds or harvest one field and then moved on to another. Occasionally, one or two of the more experienced women helped the younger women by accompanying them to healthcare facilities. The women supported each other in practical ways, but did not have the capacity for collective and organised effort towards achieving their strategic interests, even those related to their own or children's health.

In all the three sites we found that the male members spent very little time within the household, particularly with their spouses and children. In Thatta and Rajanpur, the houses of better-off castes had separate sitting/residential areas for male guests. These were called '*Otaq*' in Thatta and '*Wisakh*' in Rajanpur. The *Otaq* and *Wisakh* were also open for use as a sitting area for guests of the poor community men. The public spaces for men's meeting and dialogue included road sides, shops, praying places (Mosque and *Jamat Khana*), graveyards and agricultural fields. In Rajanpur and Ghizer, we found a male informal space in the shade of old trees. In Rajanpur, this space was located in the settlement of Sindhi Arain caste and was called the '*Jamun*', while in Ghizer it was called the '*Elanthoi*'. These spaces formed a leisurely area for the male villagers and they used it for playing cards, *Ludo* or smoking '*hukka*'. In most of public informal spaces, matters related to livelihood formed the main content of conversations between men from all castes. Men from different castes lent money to the ones in need and supported each other in agricultural activities. The frequent interaction and strong sense of communal bonding between men reinforced conformity to traditional norms and practices, particularly the construction of the concept of masculinity. Stereotyping of male behavioural patterns encouraged the practice of patriarchy as men gradually acquired a sense of honour and

learned about the importance of their say in all decisions. The story of a man from the Jhangar caste of Rajanpur discusses the responsibilities women are expected to fulfil and describes the mechanisms that limit their mobility and access to healthcare. He said that:

'I am 39 years old and live as a tenant by cultivating someone's land and grazing his cattle. I have two wives and 17 children including eleven daughters and six sons. Three of my daughters died at the age of two or three. Sometimes, to crack a joke I say to my wives that I want to marry the third time and they say they both will find me a girl from Biradri. I had arranged marriage with both of my wives. I do routine agriculture work like digging land (Darooghi) and cleaning the drain of water with hoe. My wives also do equal household chores and agricultural chores. They help me in sprinkling the fertilizer in the field and anything else I ask them to do. Obviously, I always prefer the one [wife] who does every domestic work. My five to nine years old kids and wives participate in agricultural activities. In my eyes, all my sons and daughters are equal, as far as their health is concerned. I buy my wives clothes and shoes of same price and colour and also give them cash or gifts on festive occasions. They are not allowed to go for recreation or outside without my permission and I accompany them to the doctor. Doctor tells us to stop having more children and advises usage of injections and tablets, but I think that God is giving these children and God will provide their living as well. I have some information about family planning which I got from a friend during a discussion in my home. My second wife faced some health problems.

She had not told me that she had used an injection for birth spacing when her second last child was feeding. She suffered from body aches, menstrual pains [dysmenorrhea], irregular menstruation and allergy. When I observed her condition I asked her what was wrong so she told me. I was unclear about it so I took her to the hospital and consulted the doctor who gave her the injection again. I do not have any information about medical check-ups of females during pregnancy or about LHW visits. My wives use home-made herbal remedies for curing the pregnancy pains. I could not save any money for delivery of my wives, but I believe in Allah and sometimes I also go to Pir [religious healer] to take Taweez [amulets] for several health problems with any family member.' (IDI Rajanpur)

Sometimes meetings of male villagers were held in the government school buildings and madrassas, while at other time the health programmes organised awareness raising sessions at these places. These special meetings of male villagers were held when a matter related to the whole village was being discussed and the villagers did not want to take it to the landlords. In Rajanpur, the big landlords held meetings of male villagers at their '*deras*', which were sitting areas in the male section of their houses where villagers gathered to discuss village matters and disputes. The public spaces where both women and men worked together and had informal dialogue included agricultural fields and the *Jamat Khanas* in Ghizer. Sometimes women and men also visited the market places and religious shrines (*mazaars*), together.

5. DISCUSSION

The data gathered from the key informants and community women and men facilitated the identification of spaces as places or points where people interacted and talked to each other. The spaces where MNCH related issues were discussed were distinguished into formal spaces that were created or facilitated by the MNCH programmes and the informal spaces that were indigenous places or points of women and/or men where they got together and discussed social, economic and health issues. The following presents an analysis of the typology of formal and informal spaces, their mechanism of inclusion and exclusion, the information flow from formal to informal spaces and their effect of spaces on the empowerment and MNCH promotion of the poor and marginalised groups.

5.1 Formal Community Spaces: A Reflection on Typology and Effects

Based on our findings we identified the different kinds of formal community spaces and categorised them into the following four types:

1. Fixed spaces that were static as they existed in healthcare facilities and were formed during consultation and interaction for healthcare provision between healthcare providers and clients who were usually women of reproductive age.
2. Small transitory spaces that were not fixed in a particular common place but were formed during door to door visits of healthcare workers as they provided home based consultation and interacted with clients who were usually married women of reproductive age.
3. Large transitory spaces that were not fixed in a particular place but were formed when and where awareness raising sessions were conducted by healthcare workers. The place for these spaces was selected within the community settings and included courtyards of a big house or some public space like a school building or *madrassa*. The healthcare workers usually contacted a known focal person (female and/or male) in the village and asked them to gather participants for the awareness session. The audience of these spaces usually consisted of women of reproductive age, but sometimes separate sessions were also held with groups of men.
4. Emerging institutional spaces that were not necessarily fixed in a particular place and were created or facilitated by external (MNCH programme) agents. These spaces were expected to have formal institutional mechanisms such as defined objectives, regular frequency of meetings, specific membership criteria and responsibilities for constant members. However, in reality the healthcare workers usually contacted the active women, healthcare workers of other programmes and notable community men (big land owners, teachers, elected representatives, etc.) and formed their group. Then they convened the group meetings in community settings like courtyards of a big house or some public space like a health dispensary or school building. Mostly, separate groups of women and men were organised by female and male facilitators of MNCH programmes, but sometimes health groups or committees had both female and male members. The emerging institutional spaces were formed when and where the group meetings of the members of health groups or committees were held.

Table 6, shows the types of formal spaces created or facilitated by the MNCH programmes selected as part of this study in the three sites. The type of spaces created or facilitated by each programme have been shaded with different colours. The colour grey depicts that the space is fully functional, which means that it has resources and it is able to fulfil programmatic objectives. The red colour shows partial functionality of a space, which means that the space exists, but functions irregularly (in comparison to the programme guidelines) and has a limited contribution in fulfilment of programme objectives. The black colour denotes non-functionality, which means that the space is part of the programme design, but was found to have no real existence in the study sites at the time of the study.

Table 6: Typology of Formal Community Spaces

MNCH Programmes	Fixed Space	Small Transitory Space	Large Transitory Space	Emerging Institutional Space	Total
National Programme for Family Planning and Primary Healthcare		Fully Functional	Partially Functional	Non-Functional	3
Population Welfare Programme	Fully Functional		Non-Functional	Non-Functional	3
Maternal, Neonatal and Child Health Programme		Partially Functional		Partially Functional	2
Maternal and Child Health Programme of Merlin	Fully Functional		Partially Functional		2
Maternal and Child Nutrition Programme of the Lodhran Pilot Project				Partially Functional	1
Aga Khan Health Services of Pakistan	Fully Functional		Partially Functional		2
Total	3	2	4	4	

● Fully Functional ● Partially Functional ● Non-Functional

Source: Created on the basis of findings from this study

Table 6, also shows that none of the MNCH programmes have created or facilitated all the four types of formal spaces. The MNCH programmes (government and NGO) were found to be more inclined towards creation of large transitory spaces and/or emerging institutional spaces, the structure and functionality of which was highly questionable as we found that awareness sessions were held irregularly and their participants were chosen rather arbitrarily. We also found that the structure of all community based groups/committees was not very well-defined, the roles and responsibilities of members were not clear and this posed a difficulty in ensuring accountability of healthcare workers and group members.

Community participation in health is advantageous as it promotes responsiveness to the needs of the poor and marginalised groups, encourages ownership and healthy behaviours among people and allows for expansion in scope of healthcare systems (World Health Organization, 1999). The participatory and empowering approaches have been recognised for their particular relevance and effectiveness in dealing with MNCH issues that are marked with inequitable service distribution, delays in healthcare seeking behaviours and demand and supply side barriers in the healthcare system (Mushi, Mpembeni, & Albrecht, 2010; Ogwang, Najjemba, Tumwesigye, & Orach, 2012). While empowering participation has been found to have a positive effect on the health of the vulnerable, it emphasises upon community development by engagement of people in deliberative discourse to promote voice, choices and local accountability (World Health Organization, 2006; Mansuri & Rao, 2013). Drawing upon the five approaches and radical discourse of health promotion (World Health Organization, 1986; Laverack & Labonte, 2000), we posit that formal spaces which encourage participation and empowerment of the poor and marginalised are important for improving quality of life and equitable access to healthcare. This means that the formal spaces should not only focus on raising awareness about health issues, but also inform communities about their rights, entitlements and availability of different kinds of services as suggested by the community men in Thatta. The formal spaces should also institute mechanisms for mobilising community people for encouragement of local accountability and good governance in health systems.

Contrary to this, we found that the formation of all community groups/committees focused upon inclusion of community notables and regarded them as the 'real activists' who could influence others to change behaviours thereby ensuring successful programme implementation. Our findings suggest that such understanding and strategies not only excluded the poor and marginalised groups, but also reinforced the existing power structures without much improvement in the behaviours and practices of the excluded. This is in agreement with the notion that externally induced participatory development is often captured by the wealthier, more educated, politically well-connected and socially influential (belonging to higher caste and ethnicity) people (Mansuri & Rao, 2013). However, carefully designed and implemented participatory health programmes have resulted in better healthcare seeking behaviours, timely referrals and reduction in maternal and infant mortality (Mansuri & Rao, 2013; Leppard, Rashid, Rahman, Akhter, & Nasreen, 2011). We found that the four types of formal spaces have contributed a great deal to raising awareness about MNCH issues like nutrition and hygiene, antenatal care, birth spacing and family planning, immunisation and improved healthcare seeking behaviours in all the three study sites. Figure 10 shows the cause effect diagram drawn

Figure 10: Effects of MNCH Programme depicted by the Community Women in Ghizer
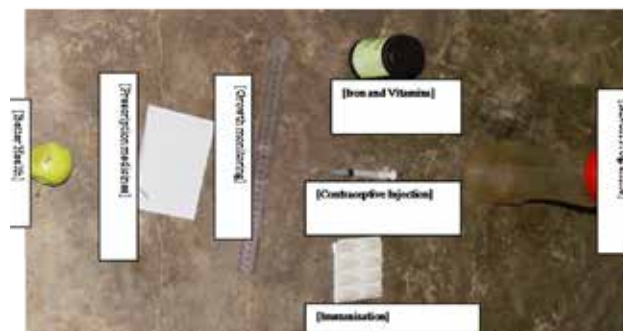
by the community women in Sumal village of Ghizer. The figure shows that the community women had benefited from the MNCH programmes in different ways that had resulted in improvement of their health. They also said that the information and services provided by the formal spaces of MNCH programmes had facilitated active healthcare seeking behaviours among community women and men. The better-off and the poor were found to go for regular antenatal check-ups, the younger couples opted for smaller families with no more than two children, many young women reported using injectable contraceptives, most children were fully immunised and no maternal, neonatal or child death had been reported in the area for the past several years. After being educated on hygienic practices, the people had begun constructing houses that had an animal barn situated outside the boundary wall as opposed to inside it. Most households also paid attention to sanitation facilities. The MNCH programme staff working in Sumal referred clients to each other and sometimes even shared medical and contraceptive supplies. As part of an integrated approach adopted in the Ghizer District, all MNCH programmes met under the umbrella of the District Health Office. The integrated approach was aimed at sharing resources, data and strategies among MNCH programmes and the broader healthcare services, so that MNCH indicators could be improved by enhancing effectiveness and

efficiency of the healthcare system. In Thatta and Rajanpur, more and more people from all socio-economic strata had started taking active interest in giving polio drops to their children. A man from the Shiekh caste in Thatta told us that if his children were working in the fields with him and they were missed by the LHW during polio drop campaigns, then he took them to the basic health unit (BHU) for vaccination. Many women from the better-off castes in the study villages of Thatta and Rajanpur were relatives or friends of healthcare workers. They reported that through discussions with the healthcare workers they had clarified their misconceptions related to contraceptive usage and were able to convince their husbands to permit them to use contraception. Talking about change in her community, a woman from the Memon caste in Thatta said that:

'There is a lot of change, we were empowered because of her [healthcare worker], and we got operated for stopping pregnancies. Due to her, our husbands agreed on getting the surgery done. If she would not have given us awareness then today we would be having a lot of children.' (FGD Thatta)

A woman from the Punjabi Arian caste in Rajanpur said that:

'It was the LHW who took me to [a private healthcare facility in] Hajipur for getting tubal-ligation for birth spacing. Everybody had scared me of side effects, but nothing happened.' (FGD Rajanpur)

However, the benefits of the MNCH programmes were not uniformly distributed as only some women from the poorer castes in Thatta and Rajanpur reported receiving material benefits from the MNCH programme spaces as under specific time bound projects, pregnant women had been given mosquito nets, food and cooking oil supplies, while the undernourished children had received nutrition supplements.

The pattern of distribution of information and healthcare services implies that the MNCH programmes are well aware of the social power dynamics. In fact, in order to achieve their objectives related to behaviour changes, the programmes seem to be making use of this power in their formal spaces. However, an inherent fallacy in this understanding and utilisation of power is that the powerful will eventually recognise the rights of the poor and vulnerable and delegate power to them. This feeds into the debate about the powerful empowering the powerless and questions the role of the state and institutions in reinforcing the power imbalance or challenging it. Gaventa (2006) identified that the adoption of visible and hidden forms of power from the closed spaces into the invited ones will be decided by the institutions and state (Gaventa J. , 2006). The critical choice that health and related development programmes in Pakistan will have to make is with respect to defining their political position as providing or increasing healthcare

access of the vulnerable population will require taking their side and redefining programme structures and strategies in their favour (Schaffer & Lamb, 1981). None of the awareness sessions or group discussions informed community people about their rights and entitlements or helped them in making collective and organised efforts for change. In fact the staff of five out of the six MNCH programmes under study related health promotion merely to awareness raising and behaviour change. On one hand this reflects a paradox in the purpose and successful implementation of MNCH programmes, while on the other hand it poses questions for the scope of MNCH programme activities and the capacities of the healthcare workers. If the purpose of MNCH programmes is limited to raising awareness about health issues in order to promote healthcare seeking behaviours then several interpersonal and media based behaviour change communication methods like printed educational material, short messaging service or television advertisements can be employed (Rahman, Leppard, Nasreen, & Rashid, 2011). However, if the agenda of MNCH programmes is geared towards equitable access and provision of good quality care then usage of participatory and empowering strategies is inevitable. A step-wise approach to participatory empowerment of communities combined with an enabling environment of trained healthcare providers and accountable governance systems is called for (Longwe, 1991; Mansuri & Rao, 2013).

5.2 INFORMAL SPACES: A REFLECTION ON TYPOLOGY AND EFFECTS

The informal spaces identified in our study can be categorised on the basis of their domain into private and public spaces. We have also differentiated the type of informal spaces with respect to gender as we found that besides the household there are only few transitory informal spaces where women and men intermingle and interact with each other and discuss issues related to MNCH. Figure 11, shows the different types of informal spaces that exist in the private and public domain. The circles showing spaces have been colour coded, the grey circles show women's spaces, while the red ones show men's spaces. The circles shaded red and grey depict spaces where women and men both are present, but in segregated gatherings. The black dotted circles show the spaces where women and men intermingle. The size of circles in the figure depicts the frequency and/or the transitory nature of spaces such that the more frequently occurring spaces are shown by larger circles, while the transitory ones are shown by smaller circles. As shown in figure 11, the informal spaces are considerably gender segregated as most of them are occupied only by women or only by men. The large size of circles of the men's informal spaces in the public domain shows that men claimed a larger share of public informal spaces. Women's

claim over public informal spaces was infrequent and rather transitory. These findings are of no surprise as they match those of previous studies which have also suggested that the notion of public space for women in Pakistan is determined by familial proximity, kinship and bonding (Gazdar, 2003). We also found that women of all castes and classes had no restrictions in visiting the households of their relatives and neighbours who belonged to the same caste. However, only women from the poorer castes went further away from their households to wash clothes, fetch drinking water and work in agricultural fields. Women's solidarity was found to be limited by socio-economic boundaries as the poorer women shared their problems openly and helped each other in resolving them. They helped in each other's deliveries, arranging transportation and accompanying each other to healthcare facilities. On the other hand, the social capital of the women

from the better-off castes was quite limited as they stayed in their own houses and usually interacted with their own family and friends. They felt low while interacting with the poorer women and did so only in some event celebrations or when the poor women came to work in their households. Both the poor and better-off women told us that their men forbade them from developing very close relationships with each other.

The networks formed and matters discussed in the informal spaces need special consideration as they affect social capital and decisions related to MNCH issues. We found that discussions among men were usually focused on livelihood information and opportunities, while the women spoke to each other about the various issues affecting their lives which included family disputes, economic problems, relationship with husband and in-laws and even health problems. The

Figure 11: Typology of Informal Spaces

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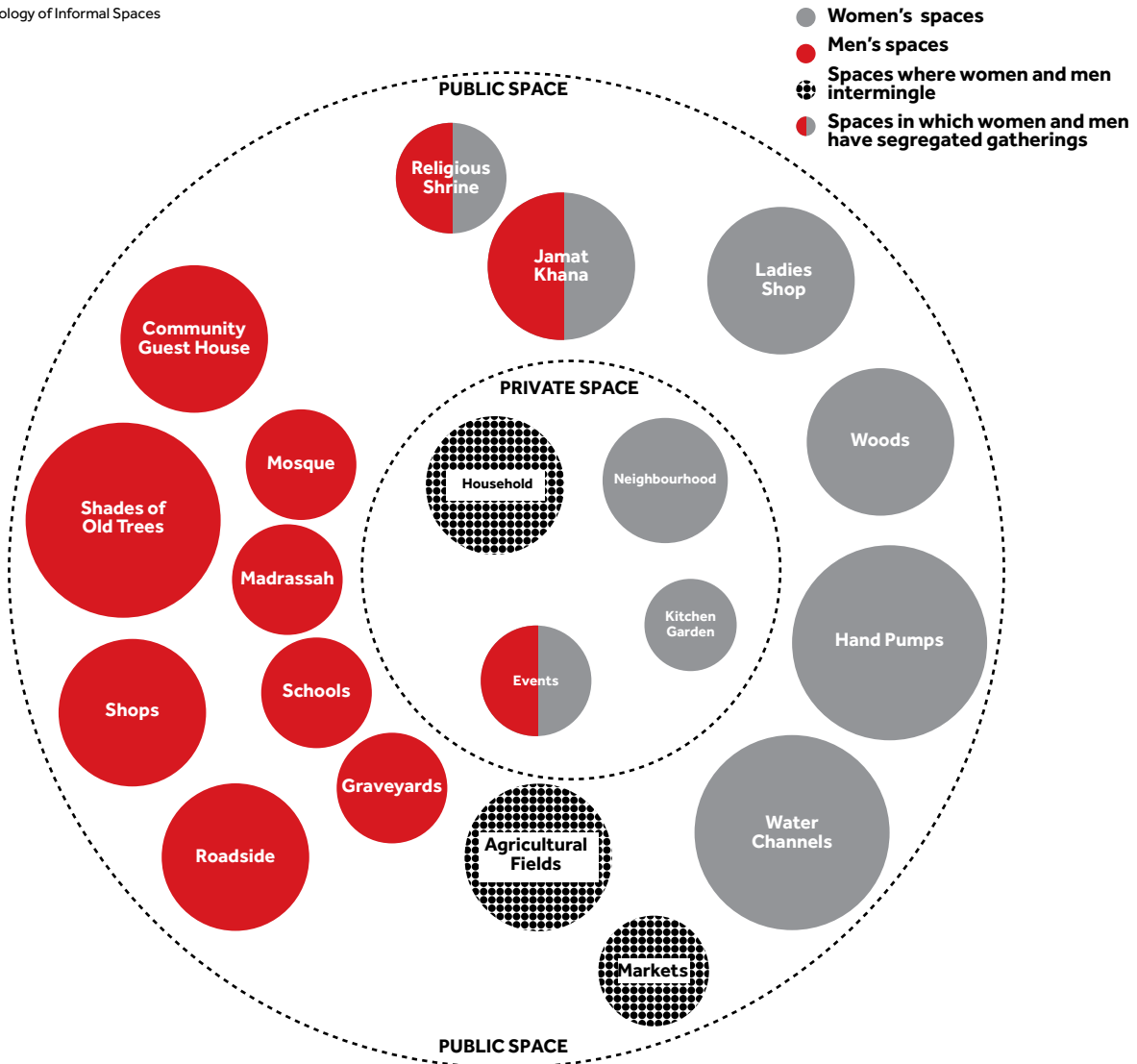
difference in focus of conversations between men and women depict their interests and reflect the construction of social norms and gendered practices. It is worth noting here that both women and men came together to resolve issues related to their practical needs, but they did not exhibit the agency to coalesce and identify or work towards fulfilling their strategic interests (Kabeer, 2001). The difference in focus of conversations between men and women pose questions for the construction of formal spaces. The MNCH programmes will have to decide whether to adopt the segregation embedded in the informal spaces or to devise mechanisms for challenging it. Like feminists (Massey, 1999), we posit that women's strategic interests and their health needs can only be served by challenging the roots of patriarchy that reside in the informal public and private spaces. Penetration in informal spaces and encouraging dialogue and understanding between the opposite genders is a big challenge for health and development programmes in Pakistan. However, given that the overall knowledge base of the whole society has improved it is difficult to ignore the need for identifying ways to improve practices.

Women's mobility and the intermingling of women and men in public spaces like the *Jamat Khanas* was fairly more frequent and easier in the Ghizer district. This was mainly because a vast majority of the population belonged to the Ismaili sect and ascribed to a certain set of socio-cultural norms. On one hand this secluded them from the rest of the village, while on the other hand it gained them the advantage of being taken care of by their own sect as we found that their community men came together to support the women and requested their institutional authorities to open a health centre in their village. Warren (2001) highlighted the advantages of solidarity in such bonding, while Woolcock (1998) has discussed the dynamic relationship between intra-community ties and extra-community networks (Saegert, Thompson, & Warren, 2001; Woolcock, 1998). We also found that most public informal spaces occupied by men like the mosques, shops, agricultural fields, *Jamat Khanas*, shade of old trees and the road sides provided opportunities for the men to interact within (bonding) and across (bridging) their castes and class. Therefore, men's access to information and opportunities was far more than that of women whose interactions were usually limited within their own families and castes. Spaces like events and celebrations in the private domain and the religious shrines and *Jamat Khana*s in the public domain were open to both women and men from all socio-economic strata. Though the gatherings of women in these spaces were segregated from that of men, sometimes these were sites for information exchange related to MNCH issues as they were utilised by MNCH programmes to conduct separate health awareness sessions for women and men. Narayan (1999) has provided a framework and emphasised

the role of the state in encouraging cross-cutting social ties between different community groups as well as institutional actors (Narayan D., 1999). This implies that an interactive relationship exists between the informal and formal spaces and warrants a comprehensive understanding of both for addressing community development and MNCH issues.

5.3 INFORMAL AND FORMAL SPACES: INTERACTION AND INFORMATION FLOW

In the design of this study, our premise was that the informal community spaces strongly influence the participation and behavioural patterns of different groups of community people in the formal spaces. We found that this is of special relevance to the context of Pakistan where the socio-cultural practices are highly gendered and women's voice within their household and their mobility and participation in the public space is determined by patriarchal norms. The bonding and bridging relationships within and across social castes and economic class were found to determine the access of the poor people and marginalised groups to resources and opportunities for acquiring healthcare services and other development opportunities.

We found that sometimes the poor women visited the better-off women or worked in their households. During these transitory transactional interactions the better-off women who participated in the formal spaces or had familial relations with the healthcare workers shared some of the information gained from the formal spaces with the poor women. The same was true in the segregated gatherings of women from different socio-economic strata during event celebrations and visits to religious shrines and/or *Jamat Khana*s. This infiltration of information from the formal community spaces through the informal ones is illustrated in figure 12.

Figure 12: Information Flow from Formal to Informal Spaces
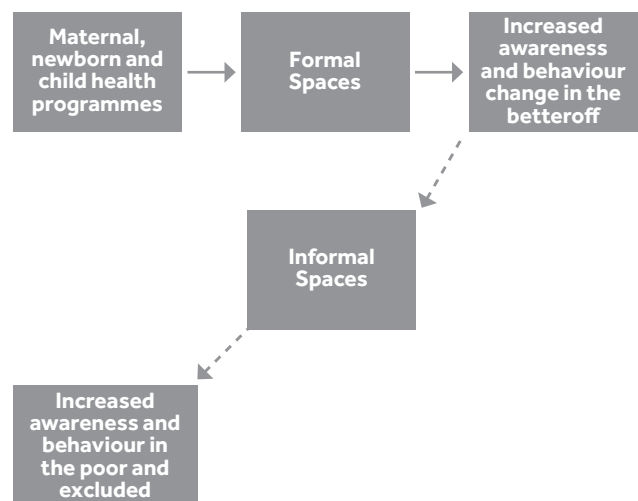
When any MNCH related information reached one or more of the poor and excluded women in the village it was further shared with other poor women and with men in the household where negotiations for changing behaviours and practices occurred and were sometimes overshadowed by gender based stereotyping of roles and patriarchal practices that limited women's ability to make decisions for betterment of their own health. We also found that sometimes the public informal spaces of men and women were used by the MNCH programmes for conducting health awareness sessions, however this was not part of the strategies or guidelines of any programme. The lower cadres of healthcare workers were relatively more aware of the dynamics of informal spaces and their effect on the health of the poor women and children, but they did not do much to benefit the poor by suggesting better strategies for programme design. This poses questions with respect to the interests, motivation, authority and capacities of healthcare workers. Studies have found that the lower cadres of healthcare providers are respected by communities as they are interested in serving them (Oxford Policy Management, 2009). However, public healthcare providers are often demotivated by resource constraints, political interference and lack of incentives and appreciation for their work (Population Council, 2013). This calls for instituting mechanisms for motivating the healthcare workforce, training and supporting them in addressing the needs of the poor and marginalised groups.

### 5.4 INFORMAL AND FORMAL SPACES: INCLUSION AND EXCLUSION

Socio-economic class determined people's participation in both informal and formal community spaces. The informal spaces were mostly occupied by the poor and marginalised groups, while the formal spaces were dominated by the better-off. The relationship between the socio-economic class and participation of people in the formal and informal community spaces is shown in figure 13. Social and economic class stratification was found to vary by context and affected the mechanisms of inclusion and exclusion in both the formal and informal spaces. In Thatta and Rajanpur, social stratification was based mainly on land ownership, caste, economic class, occupation and pattern of settlement, while in Ghizer the society was stratified mainly on the basis of religious sect. Exclusion of the poor and marginalised groups from the formal community spaces was primarily due to MNCH programme design and implementation strategies. We found that the MNCH programmes registered people as clients only if they had been living in an area for more than six months, thereby excluding those who followed a nomadic pattern of settlement. The MNCH programme guidelines mandated the inclusion of notables, literate people and health workers in the transitory large and emerging institutional spaces, while no such specifications were made for inclusion of the poor and marginalised groups. This reinforced the power and social influence of the notables. The MNCH programme facilitators were selected on the basis of their educational level and belonged to the better-off castes, therefore in the formal spaces they tended to associate with their relatives or friends and continued to carry their prejudices against the poor and marginalised groups. Lack of resources in the MNCH programmes also limited activities that were meant to reach out to the poor and marginalised communities who usually lived in remote areas.

The limited inclusion of the poor in the formal spaces had to be sanctioned by the better-off who were the primary stakeholders of formal spaces and did not feel very comfortable in intermingling with the poor. The participation of the poor in the formal spaces was also found to be either consultative or passive as they could barely understand the language and/or use the information given to them by the healthcare workers. The poor and the marginalised excluded themselves from the formal spaces because they remained heavily engaged in earning their livelihood and they gave little value to maternal health. On one hand, this depicts the difference in values held by the poor and better-off, while on the other hand it questions the abilities and means of the poor to make choices that serve their practical or strategic needs and interests (Kabeer, 2001).

In the informal spaces, the poor were able to set their own agenda for dialogue. The men usually gathered to resolve community disputes or problems related to their livelihood, while the women helped each other in fulfilling responsibilities and at times in accessing healthcare facilities. This implies that the informal spaces can be used as avenues for raising awareness and empowering the poor and marginalised. However, careful consideration is required while intervening in the informal spaces as use of authority by the healthcare workers may limit the autonomy of the poor and marginalised.

Figure 13: Social Inclusion and Exclusion in Formal and Informal Spaces
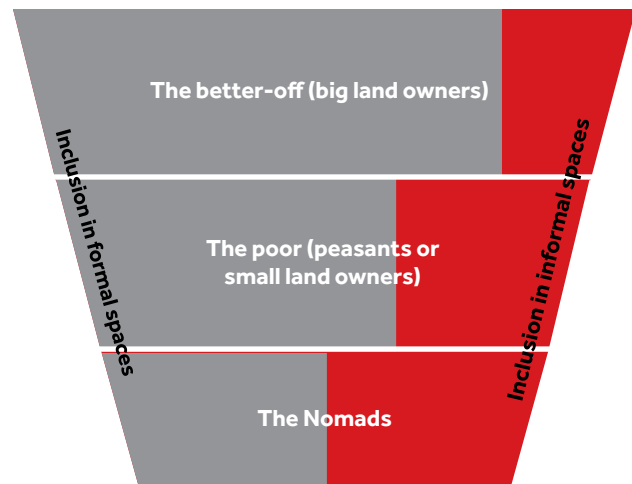
6. CONCLUSION AND RECOMMENDATIONS

6.1 FORMAL COMMUNITY SPACES AND EMPOWERMENT

We found that the MNCH programmes have created or facilitated the creation of four types of formal community spaces which include the fixed, small transitory, large transitory and emerging institutional spaces. The different types of formal spaces created or facilitated by different MNCH programmes have contributed to an overall increase in awareness of community people. The increased awareness on MNCH issues has also prompted behaviour change, especially with respect to healthcare seeking and contraceptive usage. However, no MNCH programme is utilising all the four types of formal community spaces and empowerment and collective action for social change is not the agenda of MNCH programmes. The functionality of formal spaces is also limited.

To improve the effectiveness and efficiency of MNCH programmes it is recommended that the following may be considered:

1. To improve the MNCH indicators it is important to address the health needs and empower the poor and marginalised. A move from awareness raising on health issues and availability of healthcare services to mobilisation for rights and entitlements and citizen-state interaction for local accountability is necessary. The radical discourse of health promotion that favours social justice and empowerment should be adopted as the agenda of MNCH programmes. This means that the purpose and strategies of formal spaces of MNCH programmes should be critically reviewed and aligned with the agenda of health promotion and empowerment.

2. All the four types of formal community spaces must be used for health promotion, while avoiding conflicting messages, since each space has its benefits and limitations and together they are likely to produce a synergistic effect on MNCH.

3. Performance indicators for healthcare providers should also include functionality of health committees.

6.2 COMMUNITY SPACES AND SOCIAL EXCLUSION

Social exclusion is strongly observed in all the three study sites. In Thatta and Rajanpur, social exclusion was based mainly on land ownership, caste, economic class, occupation and pattern of settlement, while in Ghizer the society was stratified mainly on the basis of religious sect. Exclusion in the formal community spaces was due to community behaviours and MNCH programme design and implementation strategies.

Community behaviours: The poor and the marginalised did not participate in the formal spaces because they were heavily engaged in earning their livelihood, and they gave less value to maternal health. The better-off did not feel comfortable in intermingling with the poor.

Programme design and implementation strategies: The MNCH programmes criteria registers people as clients only if they have been living in an area for more than six months, thereby excluding those who follow a nomadic pattern of settlement. The MNCH programme guidelines mandate the inclusion of notables, literate people and health workers in the transitory large and emerging institutional spaces, while no such specifications are made for inclusion of the excluded. The MNCH programme facilitators are selected on the basis of their educational level and belong to the better-off; therefore in the formal spaces they tend to associate with their relatives/friends and continue to carry their prejudices against the other social groups. Lack of resources in MNCH programmes limited their outreach to the poor and marginalised communities who usually live in remote areas.

To counter social exclusion in community spaces it is recommended that the following may be considered:

1. The programmatic criteria for registering nomadic population groups as clients should be reviewed and mechanisms for their inclusion need to be developed.

2. The objectives, roles, structure and operating procedures of the formal community spaces should be reviewed with explicit consideration of existing social and power structures. The objective of this should be to find ways to improve these institutions and make them more inclusive and representative of the whole community and not merely limited to the inclusion of notables.

3. Monitoring systems of MNCH programmes should ensure inclusion of all vulnerable groups.

4. The training curriculum of MNCH programme facilitators and local healthcare providers should include overcoming of socially constructed biases; understanding social mobilisation and empowerment processes and understanding the existing informal and formal spaces and their utilisation for better health outcomes.

6.3 UTILISATION OF INFORMAL COMMUNITY SPACES

In some informal spaces, especially religious gatherings, celebrations and events the community people participated irrespective of their social stratification. In others the poor women had transitory transactional interactions with the better-off women and this made way for infiltration of

information imparted in the formal spaces to the excluded. The informal spaces also provided ground for the solidarity of the poor and marginalised where they helped each other in livelihood activities and accessing healthcare services.

To increase the impact of formal spaces it is recommended that the following may be considered:

1. The informal spaces where community people participate irrespective of their social strata should be frequently utilised by the MNCH programmes for health promotion and empowerment of the poor and marginalised.

2. The informal spaces that are occupied exclusively by the women, poor people or marginalised groups should be used as outreach sites for MNCH programme activities geared towards encouraging equity in healthcare services. Specific modules should be designed to train the healthcare workers in engaging the excluded without exploiting them.

3. The MNCH programme design should encourage their facilitators to develop understanding of the existing informal spaces and their interaction with the formal spaces.

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ANNEXURES

Annexure 1: Mapping of MNCH Programmes in Selected Study Districts

District	Organisation/Programme/Institutions working in the districts	Mechanism to health promotion in community
Rajanpur	National Programme for Family Planning and Primary Health Care (NPFP&PHC)/ LHW programme	Door to door visit by LHWs, VHCs and support group meetings
	Chief Minister Initiatives for Primary Health Care (CMIPHC)	Support group meeting, School Health Session, Community Health Session and outreach programme
	MNCH	Works through Community Midwives who conducts deliveries in the community and also provide information about MNCH
	Population Welfare Department (PWD)	Provide FP services through Family Welfare Clinics (FWCs) and mobile camps; LHVs of the also conducts the community meetings on FP/RH issues of women in the catchment area of the FWC
	Green Star Social Marketing (GSM)	Neighbourhood meetings, meetings with Married women of reproductive age and meeting with Husbands. Provision RH/FP services through franchise clinics and clinic sahulats in rural areas
	RDPI	School Safety programme and children school health by dissemination of the information among children in school
	Marie Stopes Society (MSS)	Door to door visit by workers, and hold Clinics on RH and FP
	Save the Children	Rehabilitation of BHUs and refer for MNCH services through LHWs. They also involve LHWs in health promotion through group meetings and household visits
	Community Support Concern	Provision of MNH services through establishing birthing stations at community level. Dissemination of information about MNCH through community gathering
	National Commission for Human Development (NCHD)	Mobilisation of community on prevention BY organising the community level meeting. Provision of basic health needs at community level through camps
	National Rural Support Programme (NRSP)	Organises the community in form of Community Organizations (COs), Village Organizations (VOs) and Local Support Organizations (LSOs) to undertake the development activities. Through these institutions health related information are also disseminated among the community members regarding health. Through health projects, MNCH related information are also disseminated by organising the meetings with men and women.
	Health and Nutrition Development Society (HANDS)	Mobilise the community on health issues, provides information about MNCH issues by organising the meeting sin community, empowering communities through micro entrepreneur skills, TBAs trainings to improve their practices.
	Red Crescent Society	Provision of primary health services through mobile camps
	Qatar Charity	Procurement of health equipment of community based facilities, renovation of public health facilities
	SAYA Foundation	Dissemination of Reproductive health issues in community via meetings and provision of MNCH services at community level through camps
	Help Foundation	Establishing of free dispensaries and hospitals in rural communities, mobile camps
	CHIP	Information and services on immunisation through GAVI funding in rural and urban areas
	Sungi Foundation	Mobilisation for health related issues, livelihood, and empowerment of women of reproductive health.
	TBAs	Visit pregnant women for delivery (add any other work regarding their work)
	Hakeems/Homeopaths	Medicine, herbs, personal shops in small town
	Faith healers	Provides Taweez and suggest spiritual treatments
	Dispensers etc.	Basic medicines and injections.
Thatta	National Programme for Family Planning and Primary Health Care (NPFP&PHC)/ LHW programme	Door to door visit by LHWs, VHCs and support group meetings
	People's Primary Health Care Initiatives (PPHI)	Support group meeting, School Health Session, Community Health Session and outreach programme
	MNCH	Works through Community Midwives who conducts deliveries in the community and also provide information about MNCH
	Population Welfare Department (PWD)	Provide FP services through Family Welfare Clinics (FWCs) and mobile camps; LHVs of the also conducts the community meetings on FP/RH issues of women in the catchment area of the FWC
	Green Star Social Marketing (GSM)	Neighbourhood meetings, meetings with Married women of reproductive age and meeting with Husbands .Provision RH/FP services through franchise clinics and clinic sahulats in rural areas
	Marie Stopes Society (MSS)	Door to door visit by workers and hold Clinics on RH and FP
	Aga Khan CHS	Research in communities about nutrition, provide micronutrients and other supplements
	MERLIN	Health session on Nutrition in community and supply of services in community.
	German Red Cross	Health camps in rural areas for services
	SAFCO	Bridging between community and health department for provision of services at community level through organised groups
	National Rural Support Programme (NRSP)	Organises the community in form of Community Organizations (COs), Village Organizaitons (VOs) and Local Support Organizations (LSOs) to undertake the development activities. Through these institutions health related information are also disseminated among the community members regarding health. Through health projects, MNCH related information are also disseminated by organising the meetings with men and women.
	Health and Nutrition Development Society (HANDS)	Mobilise the community on health issues, provides information about MNCH issues by organising the meeting sin community, empowering communities through micro entrepreneur skills, TBAs trainings to improve their practices.
	Church World Services	Capacity building of community for better health outcomes, advocate and lobbing with public sector
	ACF	Work for rehabilitation of public health facilities in rural areas
	Khidmat Foundation	Help the communities during disaster and provision of health facilities at community level
	Action AID	Procurement of health equipment of community based facilities, renovation of public health facilities
	PLAN	Construction of latrines, community mobilisation for health and hygiene related issues, advocate for community sanitation system
	Handicap Organization	Identification and support for disables to empower them

District	Organisation/Programme/Institutions working in the districts	Mechanism to health promotion in community
	TBAs	Visit pregnant women for delivery (add any other work regarding their work)
	Hakeems/Homeopaths	Medicine, herbs, personal shops in small town
	Faith healers	Provides Taweez and suggest spiritual treatments
	Dispensers etc.	Basic medicines and injections.
Ghizer	Aga Khan Health Services Pakistan (AKHSP)	AKHSP provides the health services through its clinics established in rural area. At these clinics the health promotion services through counselling and outreach workers of the AKHSP also provide information to community through community meetings.
	Aga Khan Rural Support Programme (AKRSP)	Organises the community in form men and women Village Organizations (VOs) and Local Support Organizations (LSOs) to undertake the development activities. Through these community institutions/ spaces health related information are also disseminated among the community members regarding health.
	National Programme for Family Planning and Primary Health Care (NPFP&PHC)/ LHW programme	Door to door visit by LHWs, VHCs and support group meetings
	People's Primary Health Care Initiatives (PPHI)	Support group meeting, School Health Session, Community Health Session and outreach programme
	MNCH	Works through Community Midwives who conducts deliveries in the community and also provide information about MNCH
	Population Welfare Department (PWD)	Provide FP services through Family Welfare Clinics (FWCs) and mobile camps; LHVs of the also conducts the community meetings on FP/RH issues of women in the catchment area of the FWC
	Green Star Social Marketing (GSM)	Neighbourhood meetings, meetings with Married women of reproductive age and meeting with Husbands. Provision RH/FP services through franchise clinics and clinic sahulats in rural areas
	Rahnuma-Family Planning Association of Pakistan (FPAP)	FPAP provides RH/FP services through its Family Health Clinics (FHC). The provider (LHV) of the FHC also organises Sukhi Ghar Mehfils (group meetings) on monthly basis in catchment area of FHC with women of reproductive age and adolescents girls to provide them information related to MNCH and adolescent health.
	TBAs	Visit pregnant women for delivery (add any other work regarding their work)
	Hakeems/Homeopaths	Medicine, herbs, personal shops in small town
	Faith healers	Provides Taweez and suggest spiritual treatments
	Dispensers etc.	Basic medicines and injections.

Annexure 2: Quality Control Process of PMP

Performance and Quality Control Indicators	Frequency	Responsible Party/Person
1. Ensure transparency in selection of field sites and research participants		
1.1 Mapping of MNCH programmes and villages in each study district	Within 30 days of project start	PI/CI
1.2 Consultative workshop with MNCH programme staff in each study district	Within 45 days of project start	Field researchers, supervisors, CI/PI
1.3 Selection of one village for data collection in each study district according to the criteria mentioned in project proposal	Within 60 days of project start	Field researchers, supervisors, CI/PI
1.4 Mapping of MNCH programmes in villages of each study district in consultation with local communities	Within 60 days of project start	Field researchers, supervisors
1.5 Selection of 3 MNCH programmes working in the selected village	Within 60 days of project start	Field researchers, supervisors, CI/PI
1.6 Selection of participants including women, poor persons and socially marginalised people as research participants	During field data collection	Field researchers and supervisors, CI/PI
2. Ensure training on and testing of data collection tools		
2.1 Development of data collection tools/ field manual	Within 30 days of project start	CI/PI and National Technical Advisor
2.2 Training of field teams on data collection process and tools/field manual	Within 60 days of project start	CI/PI and National Technical Advisor
2.3 Field based pilot testing of data collection tools	Within 60 days of project start	CI/PI and National Technical Advisor
2.4 Review and approval of data collection tools/ field manual by donor	Within 60 days of project start	CI/PI and RAF team
3. Ensure authenticity during data collection from the research participants		
3.1 Verbal consent taking (signed by witnesses) before any data collection activity	During data collection activities spanning over 40-45 days (3-4 months of project)	Field researchers and supervisors
3.2 Recording of data in form of audio files	During data collection activities spanning over 40-45 days (3-4 months of project)	Field researchers and supervisors
3.3 Documentation of field observations and pictorial data	During data collection activities spanning over 40-45 days (3-4 months of project start)	Field researchers and supervisors
3.4 Debriefing and compilation of activity reports	At the end of daily field activities, during the 40-45 days of data collection (3-4 months of project start)	Field researchers, supervisors, CI/PI
3.5 Documentation of reflexive notes in daily diaries	At the end of daily field activities, during the 40-45 days of data collection (3-4 months of project start)	Field researchers and supervisors
3.6 Compilation and record keeping of hand written and computerized field notes based on transcription of audio files, field observations and reflexive notes	During the 40-45 days of data collection (3-4 months of project start)	Field researchers and supervisors, CI/PI
3.7 Maintenance of privacy and confidentiality of research findings by avoiding any open discussion in public places and sharing data only within the project team	During the 40-45 days of data collection (3-4 months of project start)	Field researchers and supervisors, CI/PI
3.8 Monitoring of data collection activities in each field site	During the 40-45 days of data collection (3-4 months of project start)	CI/PI/COO
3.9 Pictures or videos of data collection activities	During the 40-45 days of data collection (3-4 months of project start)	Communication officer
4. Ensure triangulation and saturation during data analysis		
4.1 Review of field notes from brief ethnography, PRA tools and key-informant interviews in each field site to triangulate the findings and check if a point of saturation has been reached	During the 40-45 days of data collection (3-4 months of project start)	Field researchers, supervisors, CI/PI
4.2 Thematic analysis of field notes using themes from the project proposal and research tools and any emerging themes	During the 40-45 days of data collection and 30 days after that (3-5 months of project)	Field researchers, supervisors, CI/PI
4.3 Presentation of preliminary analysis to community for validation	During the 40-45 days of data collection (3-4 months of project)	Field researchers, supervisors, CI/PI
5. Ensure confidentiality during dissemination and reporting		
5.1 Anonymous quotation of data in dissemination material and reports	During 6-8 months of project	COO/CI/PI
5.2 Accurate translation and proper referencing of data quotes in dissemination material and reports	During 6-8 months of project	COO/CI/PI

Annexure 3: Project Team

Sr. No.	Name	Designation	Location
1	Khaleel Ahmed Tetlay	Chief Operating Officer	PMU
2	Fazal Ali Khan	Principal Investigator	PMU
3	Dr. Ayesha Aziz	Co-Investigator	PMU
4	Zakia Rubab Mohsin	Communication Officer	PMU
5	Fazeelat Aslam	Finance Officer	PMU
6	Imran Masih	Admin Assistant	PMU
7	Zahida Rehman Jatt	Field Supervisor	Thatta
8	Majid Hussain	Field Supervisor	Rajanpur
9	Mughees Uddin Ahmad	Field Supervisor	Ghizer
10	Shahbaz Ali	Field Researcher	Thatta
11	Iftikhar Ahmed	Field Researcher	Thatta
12	Paras Solangi	Field Researcher	Thatta
13	Mahwish Yousaf	Field Researcher	Thatta
14	Salma	Field Researcher	Thatta
15	Tahir Abbas	Field Researcher	Rajanpur
16	Jahanzeb Leghari	Field Researcher	Rajanpur
17	Kiran Zainab	Field Researcher	Rajanpur
18	Attiya Irfan	Field Researcher	Rajanpur
19	Mukhtar Hussain	Field Researcher	Ghizer
20	Jamal	Field Researcher	Ghizer
21	Madeha Gulzar	Field Researcher	Ghizer
22	Farzana	Field Researcher	Ghizer
Technical Advisors			
1	Dr. Geoffriy Dixon Wood	International Technical Advisor	
2	Kauser Saeed Khan	National Technical Advisor	
Project Advisory Committee (PAC) Members			
1	Dr. Shehla Zaidi	Member PAC	
2	Dr. Saleem ud Din Ahmad	Member PAC	

1. GUIDELINES FOR TRANSECT WALK

Purpose

The purpose of the transect walk is to get a general feel of the community (walk about). It can also be accompanied by a discussion with the community members on MNCH issues as the observations are being made. It will facilitate the purposive selection of participants to be included in the groups.

Objectives

1. To observe the inequalities and exclusion in social interactions between different population groups

2. To identify the type of community spaces and structures (physical and social) existing in the village (including the formal ones created by the selected MNCH programs and the informal ones)

3. To mark community spaces existing in the village and their distances.

Participants

The participants of the transect walk will include the field researchers and 3-4 community members. The community members must include a woman and a man from one of the marginalised groups in the village. If local customs are not supportive of taking a woman and man together, then two separate transect walks should be conducted to get the different perspectives in data.

Step 1 – Getting started

Action 1) Request some community members like women activists, lady health workers or visitors, elderly women and men or members of civil society organisations, etc. to accompany you when possible and walk through the community

Action 2) Observe the following (Observation checklist)

1. Overall environment – i.e. sights, sounds, smells, buildings construction, roads, religious places, institutions(governmental and non-governmental), health facilities, lady health worker's health house, traditional birth attendants house, drainage, garbage, water/phone/electricity lines, open spaces and formal and informal community spaces?

2. Where are the public or private healthcare facilities located and their distances? Are they accessible to the women, poor and marginalised?

3. Which castes are living in this area/community? What is their influence in the community?

4. What kind of maternal, newborn and child health problems exist here?

5. Where are the communities with more maternal, new born and child health problems?

6. What informal and formal community spaces exist in the village?

7. Who participates in each of the identified spaces?

8. Where are the formal community spaces created by the selected MNCH programs located? Are they accessible to the women, poor and marginalised?

9. What is written on advertisements, signboards, and the kinds of images visible? What messages are coming across?

10. Where are the women, poor and marginalised visible? Market as buyers as sellers? Health facility, Basic Health Unit (BHU)? Public transport?

NB:
- Body language
- Conversations
- Tones

11. What are they doing? Activity?

12. How are they dressed?

13. How do the women, poor and marginalised interact among themselves?

14. How do they interact with others?

15. How do others interact with them?

2. GUIDELINES FOR SOCIAL MAP

Purpose

The social map sketches out the physical and social universe of the participants making the social map. It shows resources within their immediate geographical boundary (village/mohalla) and the resources outside those boundaries. Participant's access to resources can also be gauged by asking them when and how they access the resources shown, and whether they face hurdles to access, and what constitutes those hurdles. (For example, in accessing health resources, women may face financial and non-financial barriers). Access thus can be seen as a proxy indicator of empowerment.

Objectives

1. To identify who lives (different communities/groups) in the specified space under review (mohalla/village)

2. Identify households/clusters of the poor and the better off

3. To understand the location/placement of the formal community spaces created by the selected MNCH programmes

4. To explore the accessibility of the formal community spaces created by the selected MNCH programmes, especially with respect to the women, poor and

marginalised

5. To identify those at risk with respect to maternal, newborn and child health issues.

Participants

The participants of the social mapping exercise will include the field researchers and 8-10 women and 8-10 men from the community. Separate social maps will be constructed for the women's group and the men's group. Members in each group must include people living in different areas of the village as well as those who have a good understanding and more information about the whole village.

Step 1 – Making the social map

Action 1) Invite participants to make the social map using locally available resources

Action 2) Choose a suitable space (try a courtyard or open space that is acceptable to all if possible as maps have a tendency to expand)

Action 3) Help participants to get started by explaining the process

Note: You may start by saying, we want to learn about your village/mohalla, can you make a map on the floor/ground to explain where the households are, what are the resources?

You may also start by making a circle on the ground, and say: if this is your village/mohalla, could you now show us where the households are and what you think are the important resources/ areas that you would want us to know about?

PROBES:
- **Where are we right now – can you locate us?**
- **What are important places and roads for you in your community?**

  (NB: buildings, construction, market places, schools, roads, religious places, institutions(governmental and non-governmental), health facilities, lady health worker's health house, traditional birth attendants house, drainage, garbage, water/phone/electricity lines, open spaces and formal and informal community spaces)
- **How are the households distributed/divided in your area?**
- **Are there different sections allocated to different population groups like poor and rich or different ethnicities/tribes? (division of space)**
- **How is the space (within and outside the house) divided between women and men?**
- **Who can go to places like schools, bazaars, water sources, roads, transport depots/Addas, BHUs/Clinics/Hakims/Hospitals and government offices)?**
- **Where are the formal community spaces created by the selected MNCH programmes located within your village/mohalla?**
- **Who goes there? And why?**
- **Who does not go there? And why?**
- **Who cannot go?**
- **Why do some people have more MNCH problems as opposed to others? Are they extremely poor? Do they live too far? Are they uniformed about the existent healthcare services? Are they unable to afford healthcare services? Any other reasons?**

Step 2 – Feedback and thank you

1. Ask the participants how do they feel about this session? Would they like to say something about it?

2. What did you learn from today's interaction?

3. Was there anything new? What?

4. What didn't you like?

5. What did you find difficult?

6. Anything specific that you remember from today's session?

7. Facilitator should relate his/her thoughts

Thank the participants for their time; for the ideas they shared; and that this would help everyone to learn from each other.

3. GUIDELINES FOR FGD ON COMMUNITY SPACES

Objectives

1. To explore participants' understanding of community spaces

2. To identify the type of community spaces existing in the village (including the formal ones created by the selected MNCH programmes and the informal ones)

3. To explore the participants' perspectives of the mandate and objective of the formal community spaces created by the selected MNCH programmes

4. To explore the processes within the formal community spaces created by the selected MNCH programmes

Participants

The participants of the focus group discussion will include the field researchers and 8-10 women and 8-10 men from the community. Separate group discussions will be held with the women's group and the men's group. Members in each group must be purposively selected to include 4-5 people who have participated in activities of the MNCH programmes and 4-5 of those who have been left out or who have not participated in activities of the MNCH programmes. People living in different areas of the village must be selected as participants to get the different perspectives in data.

Step 1 – Understanding community spaces

Q1) What is meant by community spaces?

NB: Note the Urdu translation for community spaces is 'baat karnay ki jagah ya muqae'

Q2) What kind of community spaces exist in your village?

NB. Encourage examples of both informal and formal spaces

Q3) Ask participants to share their understanding of the mandate and objective of the formal community spaces created by the selected MNCH programmes in their village.

Step 2 – Processes in community spaces

Q1) How is a formal MNCH health promotion community space set up/organised?

PROBES:
Which programme personnel contact community people? Who do they meet first? How do they select community participants? How are participants included or excluded? Where do meetings/discussions take place? How is the place for meetings/discussions selected?

Q2) What usually happens in the formal community spaces created by the selected MNCH programmes?

PROBES:
What is the frequency of meetings/discussions? How many community people participate? What are the age group, gender, poverty level and social status of participants? What topics are discussed? Do these topics include maternal, newborn and child health issues like antenatal care, tetanus immunisation, delivery by trained birth attendant, postnatal care, family planning, breast feeding, child care and immunisation and social determinants of health like transportation, education and livelihood?

Q3) Which participants in the formal community spaces created by the selected MNCH programmes raise voice, make decisions and take actions?

PROBES:
How do participants act? Any differences with respect to gender, age groups, poverty level and social status of participants?

Q3) Which participants in the formal community spaces created by the selected MNCH programmes raise voice, make decisions and take actions?

Step 3 – Feedback and thank you

1. Ask the participants how do they feel about this session? Would they like to say something about it?
2. What did you learn from today's interaction?
3. Was there anything new? What?
4. What didn't you like?
5. What did you find difficult?
6. Anything specific that you remember from today's session?
7. Facilitator should relate his/her thoughts

Thank the participants for their time; for the ideas they shared; and that this would help everyone to learn from each other.

4. GUIDELINES FOR NETWORK DIAGRAM

Purpose

The network diagram shows the relationships between people and institutions. The modes of communication, influence and strength of relationships can be studied through it.

Objectives

1. To understand the relationship between facilitators and participants of the formal community spaces created by the selected MNCH programmes
2. To identify the role of MNCH programmes and their facilitators in influencing decisions and happenings in the village/mohalla.

Participants

The participants of the network diagram will include the field researchers and 8-10 women and 8-10 men from the community. Separate network diagrams will be constructed with the women's group and the men's group. Efforts must be made to include the same participants in each group as those in the focus group discussion on community spaces. Members in each group must be purposively selected to include 4-5 people who have participated in activities of the MNCH programmes and 4-5 of those who have been left out or who have not participated in activities of the MNCH programmes. People living in different areas of the village must be selected as participants to get the different perspectives in data.

Step 1 – Relationship between facilitators and participants

Action 1) Draw a point (or use a symbol) and tell the participants that it represents the facilitators of the selected programme

Action 2) Ask the participants to draw a point or choose a symbol representing themselves

Action 3) Ask each participant to connect the point or symbol representing themselves to the point or symbol representing the facilitators

NB: Separate network diagrams can be drawn for each selected MNCH programme.
NB: Show them how the points or symbols can be connected by means of arrows. The thickness of arrows can be used to represent the strength of association while the direction of arrows can be used to show the information flow or power dynamics in the relationship.

Action 4) Also ask participants to show connections between themselves using the arrows.

Step 2 – Role of MNCH programmes

Action 1) Ask participants to show the connection of the selected MNCH programmes to the facilitators and themselves

NB: Note the distance between programmes, facilitators and participants in the network diagrams.

Action 2) Ask the participants about the decisions or happenings in their village/mohalla that the selected MNCH programmes and their facilitators have been able to influence so far.

PROBES:

How do the MNCH programme management and their facilitators interact with office bearers/community leaders? How do they support the community? How do they influence decisions or happenings in the village? What efforts (if any) do they make to include the women, poor and marginalised in community decision making processes?

What is the difference (if any) between the three selected MNCH programmes, their management and facilitation mechanisms, especially with respect to modes of inclusion and exclusion of the women, poor and marginalised?

Step 3 – Feedback and thank you

1. Ask the participants how do they feel about this session? Would they like to say something about it?
2. What did you learn from today's interaction?
3. Was there anything new? What?
4. What didn't you like?
5. What did you find difficult?
6. Anything specific that you remember from today's session?
7. Facilitator should relate his/her thoughts

Thank the participants for their time; for the ideas they shared; and that this would help everyone to learn from each other.

5. GUIDELINES FOR CAUSE AND EFFECT DIAGRAM

Purpose

The cause and effect diagram depicts the outcomes and impact of phenomenon/problem/issue. In this case the community spaces are being considered as a phenomenon that is expected to have immediate and long term effects on the community, particularly the empowerment of its people.

Objectives

1. To understand the impact of the formal community spaces created by the selected MNCH programmes

Participants

The participants of the cause and effect diagram will include the field researchers and 8-10 women and 8-10 men from the community. Separate cause and effect diagrams will be constructed with the women's group and the men's group. Efforts must be made to include the same participants in each group as those in the focus group discussion on community spaces. Members in each group must be purposively selected to include 4-5 people who have participated in activities of the MNCH programmes and 4-5 of those who have been left out or who have not participated in activities of the MNCH programmes. People living in different areas of the village must be selected as participants to get the different perspectives in data.

Step 1 – Impact of formal community spaces

Action 1) Draw a point (or use a symbol) and tell the participants that it represents the formal community spaces created by the selected MNCH programmes

Action 2) Ask the participants to identify the impact of the formal community spaces in form of symbols or writing emerging from the first point

NB: Separate cause effect diagrams can be drawn for each selected MNCH programme.

NB: Ask for examples of how the formal community spaces created by the selected MNCH programmes have empowered communities and have

- Raised awareness on health issues and availability of health services
- Raised awareness about rights and entitlements related to availability of healthcare services and providers
- Provided a safe space for interaction for the women, poor and marginalised
- Supported community mobilization
- Created linkages between healthcare consumers and providers
- Promoted local accountability of healthcare providers and quality of healthcare services
- Promoted citizen-state interaction for addressing the broader socio-cultural issues affecting access to information and healthcare services

How have the formal community spaces affected the empowerment of women, poor and marginalised individuals, especially in their personal lives?

What actions have been taken by the community as a result of the formal community spaces created by the selected MNCH programmes to ensure inclusion of the voice of the women, poor and marginalised in shaping local public policies?

What actions have been taken by the government and/or healthcare providers in response to the community actions?

Step 2 – Feedback and thank you

1. Ask the participants how do they feel about this session? Would they like to say something about it?
2. What did you learn from today's interaction?
3. Was there anything new? What?
4. What didn't you like?
5. What did you find difficult?
6. Anything specific that you remember from today's session?
7. Facilitator should relate his/her thoughts

Thank the participants for their time; for the ideas they shared; and that this would help everyone to learn from each other.

6. GUIDELINES FOR KEY-INFORMANT INTERVIEWS

Purpose

The key-informant interviews are meant to understand the

design, implementation and impact of Maternal, Newborn and Child Health (MNCH) programmes with respect to gender, social exclusion and poverty (GSEP).

Objectives

1. To understand the purpose and objectives of selected MNCH programmes
2. To understand the implementation processes of selected MNCH programmes with respect to GSEP
3. To identify the outcomes and achievements of selected MNCH programmes with respect to GSEP

Participants

The key-informants will include the designer/planner of the selected MNCH programme and a programme manager and field staff of the same.

Questions

1. What are the important issues related to maternal, newborn and child health in Pakistan?

(NB: MNCH issues may include problems related to antenatal care, immunisation for tetanus, delivery by a trained birth attendant, postnatal care, breast feeding, family planning, child care and immunisation. Respondent may identify issues like livelihood, education, transportation and others that are included in social determinants of health)

2. What are the maternal, newborn and child health issues in this village?

3. Which population groups are more affected by the maternal, newborn and child health issues in this village?

(NB: Probe about differences with respect to gender, poverty and social exclusion)

4. What do you understand from the term health promotion?

(NB: Health promotion may include healthy public policies, supportive environment, community actions, local leadership and preventative approach to health services)

5. How do you think health promotion is related to maternal, newborn and child health?

6. How (when and why) was the MNCH programme that you are part of conceived and initiated?

7. Why was this area/village chosen for implementation of the MNCH programme that you are part of?

8. What are the objectives of the MNCH programme that you are part of?

9. How is the MNCH programme that you are part of funded?

10. What change does the MNCH programme that you are part of wishes to bring about? (What are the expected outcomes of the MNCH programme that you are part of?)

11. How does the plan (scope of work and activities) of the

MNCH programme that you are part of promote MNCH in this village?

(NB: Probe about awareness sessions, capacity building activities, community spaces and mechanisms, advocacy initiatives, policy dialogues, referral mechanisms, service delivery)

12. How does the plan (scope of work and activities) of the MNCH programme that you are part of support the inclusion women, poor persons and the marginalised?

(NB: Probe about role of project staff, inequities based approach in work and modes of inclusion and exclusion in community spaces) (NB: Also ask what kind of informal community spaces exist in the village)

13. How do the human resource policies and arrangements in the MNCH programme that you are part of support women, poor persons and the marginalised?

(NB: With respect to hiring, selection and deputation of staff. E.g. How does your programme depute human resource in the area/village? How does this arrangement support women, poor persons and the marginalised?)

14. How do the budgeting and financial arrangements in the MNCH programme that you are part of support women, poor persons and the marginalised?

(NB: with respect to fund allocation)

15. How does the monitoring, information and reporting system in in the MNCH programme that you are part of support women, poor persons and the marginalised?

16. How is the effectiveness or success of the MNCH programme that you are part of measured?

17. How far do you think has the MNCH programme that you are part of been successful in promoting MNCH in this village?

(NB: Ask about evaluation studies/mechanisms or any reports)

18. How far do you think has the MNCH programme that you are part of supported empowerment of the women, poor persons and the marginalised?

(NB: Empowerment may include awareness, capacity building, inclusion and action to ensure state-citizen interaction and accountability)

19. What were the major challenges that faced by the MNCH programme that you are part of in including and supporting the women, poor persons and the marginalised?

20. What lessons can be learnt from the MNCH programme that you are part of, to make future MNCH programmes more inclusive and empowering for the women, poor persons and the marginalised?

21. What changes have you made or suggested for improvement of the MNCH programme that you are part of? v

7. GUIDELINES FOR BRIEF ETHNOGRAPHIC STUDY

Purpose

Brief ethnographic studies aim to find out in-depth realities of respondents' lives. Collection of case studies can be used as a method to achieve this objective in a limited time frame. The method of life story will provide insight on maternal newborn and child health issues in the community, particularly those existing in the informal community spaces and the ones emerging from the effect of formal community spaces on the informal ones and vice versa.

Objectives

1. To gain in-depth understanding of MNCH issues in the community/village
2. To understand the interaction of formal and informal community spaces
3. To get deep insight of the impact of formal and informal community spaces on the empowerment and health of women, poor and marginalised people

Steps

Action 1) Researcher will find residence in the village with the help of community

Action 2) Rapport building in the community by frequent tours in the village accompanied by informal conversations with the villagers

Action 3) Researcher will make a village profile

1. Collection of primary data to know the socio-economic demographic characteristics of the village
2. Participation in informal community spaces to understand social structure (caste, class, political organisation, livelihoods, economic structure, access and control over resources, kinship)
3. Village profiling that will comprise of gathering information about physical structures, landmarks, kinship, social and political organisation of community, resources (health, economy, water, sanitation, electricity, and security), places for social gatherings/ceremonies, population demographics, interactions, influences, presence and work of MNCH programmes, roads and transportation, religious places and groups and any other important detail

Action 4) Researcher will identify the respondents for collection of life histories.

Respondents will be identified on the basis of gender, poverty, socio-economic status, inclusion or exclusion in community spaces, caste, tribe, ethnicity or any other form of social class

Action 5) Researcher will collect case studies from the identified respondents

Process will begin from informal discussions and consent taking from the respondent

Observations will continue throughout the collection of case studies

Issues for discussion will follow a general to specific approach

Discussions will be completed in several sittings

COLLECTION OF CASE STUDIES

Please tell me about your life and your household.

> **PROBES:**
> Number of males, females, age stratification, children, school going children, other relations, division of roles and responsibilities, power structure (with respect to gender, age, economic status, relationship), physical structure of house and division of space in it.

Please tell me what you do during the day (daily routine).

> **PROBES:**
> Work, responsibilities, time spent on different activities, entertainment, sleep/rest, frequency of visits to places like fields, tube well, neighbourhood, relatives, social gatherings.

Please tell me what you understand from mother and child health.

> **PROBES:**
> Issues (marriage, family planning, birth spacing, pregnancy, antenatal care, delivery, postnatal care, child care, nutrition, hygiene, medication, emotional and mental health, physical structure of living place, relationship with spouse and family, household responsibilities and workload, violence, awareness of rights, information and access to health facilities, access to economic resources and transportation, decision making) sources and kind of information (where, when, how, what, why, who), benefits of information, impact of information on MNCH health, ways of information sharing (direct and indirect), spaces (formal and informal) to share MNCH information, ability to share MNCH information, existence of safe spaces to share MNCH information, time and space (when and where you got information)

Tell me about your marital status. Also ask about the issues of maternal and child health during different stages of life. health.

Pre-pregnancy	During pregnancy	Child birth and care
Knowledge about puberty/ menstruation and issues related to that, tetanus immunisation, marital age, choice of marital partner, consent, situation, feelings on marriage day, any health issue, relationship with spouse, division of labour, roles and responsibilities, relation with household members, level of interaction, decision making about first pregnancy, mobility (access to market and other places), financial problems in the family, family planning, permission to participate in formal MNCH spaces	Nutrition, hygiene, vaccination, blood pressure, diabetes, swelling of hands , feet and body, bleeding/spotting, anaemia, fits, LHW/V visits, medication (traditional and modern), visits to BHU and hospital, (with someone?) dietary care, workload and division of labour in household, relationship with spouse, relations between household members, behaviour of household members (accommodative or non-cooperative, violent), mobility (access to market and other places), issues related to change in physique, antenatal care, registration in hospital, planning for delivery, saving money, permission to participate in formal MNCH spaces, place of child birth (hospital-public or private, home, maternity home), financial problems in the family, incidental delivery in field or other places, other forms of medication or treatment *(taweez, peer, darbar,* ceremonies, *dam darood)*	Place of delivery, person who conducted delivery (LHV/W, *Dai/* Doctor/Lady doctor/mid wife/ natural), health issues (blood pressure, diabetes, breast feeding, visits of/ to health provider, birth spacing and contraception), behaviour of the family (accommodative or non-cooperative, violent), division of labour in household, diet, issues regarding child health care (vaccination, diet, transportation), financial problems in the family, celebrations, other forms of medication/treatment or gratitude *(taweez, peer, darbar,* ceremonies, *dam darood)*, mobility (access to market and other places), permission to participate in formal MNCH spaces

Can you please tell me about miscarriage? Have you had a miscarriage?

> **PROBES:**
> Causes of miscarriage (marital relation with spouse, workload, diet, tension, anxiety, accident, domestic violence, inadequate health care, anaemia, weight loss), intentional abortion (forced, self, financial problems in family, disease in family) premature delivery (before the 7th month of pregnancy), Effect of miscarriage (on respondent, family members, relationship with spouse and other family members, fears, information seeking, motivation, health care, understanding of the problems, results)

Tell me what you know about family planning and birth spacing?

> **PROBES:**
> No information, receiving first time information, husband response to family planning, visit to family planning office, attitude of household members with regards to family planning, challenges for using or making decisions of family planning, benefit of family planning, impact of FP on your health, information of *Dai* regarding FP, centres of FP, methods of FP used, times of using FP (on the birth of which child), impact of FP on family (economy), religious response to FP

Tell me about *Dai* for MNCH in your village?

> **PROBES:**
> Experience of *Dai*, expertise of *Dai*, status of *Dai* (caste), economic relations with *Dai*, roles of *Dai* (pre delivery, delivery and after delivery, responsibilities of *Dai*, complications during pregnancy due to *Dai*, availability of *Dai*, communication with *Dai*, assistance of *Dai*, knowledge of *Dai* (use of modern tools related to MNCH), use of traditional medication, advices, visits, decision making

Tell me what do you know about MNCH programmes?

> **PROBES:**
> Information about LHW/V centres, maternity homes, family planning (FP) centres, FP products, sources of mobilisation, offices, NGOs, public health centres, criteria of programme (inclusion, exclusion), spaces (formal), access, resources (benefits), purpose and structure of MNCH programmes

Tell me about spaces existing around you with reference to MNCH programs?

> **PROBES:**
> Types of spaces (hospitals, BHU, THQ, RHC, Dispensary, LHW/V house or centres, FP centres, shops, maternity homes, mid wife house or centre, any other), location, nature of spaces, culture of spaces, information, type of facilities, motivation or mobilisation, products, assistance, concept of inclusion and exclusion, behaviour of facilitator, who will address to whom (according to socio-economic), agenda of discussion, your participation, days for formal community spaces, community action after participation in spaces

Tell me about informal community spaces?

> **PROBES:**
> Fields, neighbourhood, social gatherings, ceremonies, religious events, social events, funerals, *bemar pursi* (enquiring after one's health)

Tell me about the effect of formal community space on informal community spaces?

> **PROBES:**
> Discussion on MNCH issues, impact on females (ability and freedom of expression, feeling safe, information sharing, modifying the social structure, norms and values, religious expressions, adaptation in terms of changing behaviours, dealing with conflicts, improvement in inter-person communication, impact on MNCH, birth spacing (willingness), empowerment)

Tell me about the impact of informal community spaces on formal community spaces?

> **PROBES:**
> Beliefs, values, relationships, status in family and society, ability to communicate, fatalistic behaviours, victimisation, ability to challenge, freedom, motivation, mobilization, sensitivity towards MNCH, personal experience of MNCH problems like death of child, etc.

How have the informal and formal community spaces affected your health and empowerment?

> **PROBES:**
> Impact on your life, challenges to be faced in this regard (domestic restrictions), views of household members on participation, relationship with other female participants, relationships with non-participating members in family, social circle and community, decision making, mobility, mobilisation, collective action by community, awareness about rights and entitlements related to health, accountability of healthcare providers and state machinery, ability and authority to decide about health related matters (access, medication, selection of products and medicine, traditional ways of health medication with comparison to modern one, hygiene, family planning products, birth spacing and etc.), empowerment

Project Information	
Research Title: The Role of Community Spaces and Mechanisms in Health Promotion amongst the Poor Communities in Rural Pakistan	Project Number: TBD
ERC Ref No: TBD	Sponsor: Research and Advocacy Fund (RAF)
Principal Investigator: Mr. Fazal Ali Khan	Organisation: Rural Support Programmes Network (RSPN)
Location: Islamabad	Phone: 051 2822476
Co- Investigator: Dr. Ayesha Aziz	Organisation: Rural Support Programmes Network (RSPN)
Location: Islamabad	Phone: 051 2822476

1. Invitation to participate

We ask you to participate in a research study on the role of community spaces and mechanisms in health promotion amongst the poor communities of rural Pakistan. Your participation is requested because we think that you can provide a good perspective of the situation in your village and you will openly share your views with us.

2. Purpose of the Study

The main purpose of this study is to see in what ways do community spaces empower, or disempower women, poor persons, and marginalised groups in the selected villages with respect to maternal and child health issues.

3. Procedures and Process of the Research Study

If you agree to participate in this study, you will be asked questions about your village and its community spaces (places for dialogue). We think that a community usually has informal places for dialogue that include tea houses or communal water pumps, while sometimes formal places for dialogue on certain issues are created by external people like the Maternal, Newborn and Child Health (MNCH) programmes create village committees or women's groups. We would like to ask you about the type of community spaces that exist in your village, which of them have been created by the MNCH programmes, how they include or exclude the women, poor persons and marginalised groups and how they affect empowerment, accountability and citizen-state interactions. A trained researcher will be asking you questions that you may refuse to answer at any point. Your refusal will not affect your relationship with us; however we would appreciate if you respond to all our questions to the best of your understanding. In case you need some health related information or service we will refer you to a suitable and accessible source.

4. Possible Risks and Discomforts:

We think that the whole discussion will not pose any risk to you. The session may take about 60-90 minutes of your time and with your permission we would like to record the discussion on audio and paper. Recording is important for us because the data collected will be transcribed and used for reporting later. We would like to ensure you that all information gathered will be treated as confidential. While reporting our findings we will ensure that all information is de-

identified so that your responses remain anonymous and cannot be linked to you. In group discussions we will encourage all participants to refrain from disclosing the contents of the discussion outside of the group; however we cannot control what other participants do with the information discussed.

5. Possible Benefits

There are no direct benefits to you for participating in this study. However the results of this study will help to develop programme and policies for improvement in community spaces for inclusion and empowerment of the poor, women and socially excluded people for Maternal, Neonatal and Child Health services.

6. Financial Considerations

There is no financial compensation for your participation in this research study.

7. Termination of this Research Study and Voluntary Participation

We understand that sometimes some people chose not to participate in the study for many reasons. You are free to choose whether or not to participate in this study. If you do choose to participate, you are free to withdraw from the study at any time. If you choose not to participate or you choose to withdraw, your decision will not adversely affect your position in community or relationship with any health programme in the village.

8. Available Sources of Information and Questions

Please feel free to ask about anything you don't understand and consider this research and consent form carefully. If you would like to ask for further clarifications then you can contact the Field Supervisor [Name] and research team available in the village for three weeks or contact the local community leader [Name]. You can also contact the Co-Investigator of this study.

Dr. Ayesha Aziz at xxxxx

9. Authorization (VERBAL)

I have understood the content form and decided that I will voluntarily participate in the study described above. Its general purposes, the procedures, and possible risks and benefits have been explained to me.

The consent taken by: _____

Signature: _____

Consent verified by: _____

Signature: _____

The Field Supervisor verifies that a verbal consent was obtained, by signing this document.