Choice and Voice: People's Perspectives of Health Services in Pakistan

Acknowledgements

The Reality Check Approach (RCA) study 'Choice and Voice: People's Perspectives on Health Services in Pakistan' has been made possible by the support of EVA-BHN project, the UK Department for International Development and the work and commitment of an enthusiastic team. RCA was originally an initiative of the Swedish Embassy in Bangladesh where it was first commissioned in 2007 and has since been adopted in different context in different countries. The data collection and analysis approaches were designed and undertaken by a team of local and international researchers (see Annex 1) with technical guidance from the RCA+ Technical Advisor. The dedication of the team members in taking part in this study and carrying out their work with professionalism, motivation and respect for their host communities, is much appreciated.

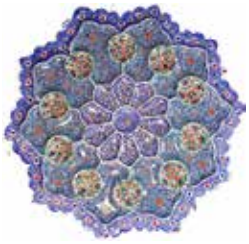
Most importantly, this study was only possible thanks to the many families, neighbours and communities who welcomed our researchers into their homes and shared their lives with them for a short while. We are grateful to them for this opportunity and for openly sharing their lives, activities, perspectives and aspirations. We hope that the report reflects well their views and experiences and helps to make the programmes implemented in their name, relevant and meaningful for them.

Support for this study and publication has been provided EVA-BHN Programme, which is funded by the UK Department for International Development.

To request copy of the report or for more information, please contact the EVA-BHN Programme. The report is also available on the Reality Check Approach website: www.reality-check-approach.com

Suggested citation: The Reality Check Approach Team, 2017 'Choice and Voice: People's Perspectives on Health Services in Pakistan' Jakarta: Palladium
Author: The RCA Team
Photographs: The RCA Team, Pakistan
Cover photo: the RCA Team, Pakistan

Identifying features have been removed to protect the identities of individuals photographed.



Contents

Glossary

BHU Basic Health Unit, These units are located in each Union Council and serve catchment populations of up to 25,000 people. Services provided at the BHU include health education, preventive and primary curative health care as well as referrals

BISP Benazir Income Support Programme, a federal unconditional cash transfer poverty reduction programme

Chota doctor literally translated as 'small doctor', but usually used to refer to male health practitioners including dispensers, pharmacists and compounders who practice privately, sometimes running medicine shops in villages

C-section Caesarean section

CT scan Computerised tomography, a medical radio-diagnostic tool

DFID UK Department for International Development

ECG Electrocardiogram

EVA-BHN Empowering Voice and Accountability for Better Health and Nutrition Programme

FHH Focal households

Ghee Clarified butter

Gujjar A pastoral agricultural ethnic group

Hakim Practitioner of Unani medicine

Halva Traditional grain flour-based dessert which has ghee, sugar and dried fruits

HHH Host households

Hukka An instrument for smoking tobacco

Imam Islamic religious leader

IMU Independent Monitoring Unit as operating in Khyber Pakhtunkhwa which regularly evaluates performance of public health facilities

INGO International Non Government Organisation

Jirga Traditional assembly of elders that makes decisions by consensus among the Pashtun people in Pakistan and Afghanistan

Kacchi sharab Alcohol

Kameez Traditional long shirt

Khan A title and family name, also used to refer to landlords in some places in Khyber Pakhtunkhwa

Lakh A hundred thousand (100,000), a unit of measurement, especially of money in South Asia

LHV Lady Health Visitor

LHW Lady Health Worker

Madrassa Islamic religious school

Maulvi Title given to an Islamic religious scholar

Mehndi Henna ceremony at a wedding

Mela local gathering or fair for religious, cultural, commercial or sports purposes

MNA Member of National Assembly

MPA Member of Provincial Assembly

Naan Local bread

Namkeen Traditional savoury snack

Nazim Union Council Chairman

Numbardaar A hereditary title assumed by powerful families and landlords which endows state-sanctioned local governance privileges including representation and policing, mostly in Punjab

ORS Oral Rehydration Salts

Paratha Type of bread

PHNP Provincial Health and Nutrition Programme

RCA Reality Check Approach

Purdah A state of seclusion practiced by women –living in a separate room or behind a curtain, dressing in all-enveloping clothes –in order to stay out of the sight of men or strangers

RHC Rural Health Centre, These centres have 10-20 in-patients beds and each serves a catchment population of up to 100,000 people. in addition to the services provided at BHUs, these centres have more advanced diagnostic services and in-patient services. They provide clinical, logistical and managerial support to BHUs

RMNCH-N Reproductive Maternal New-born, Child Health and Nutrition

Roti	Type of bread
Sardar	Title given to a landlord in some places of Punjab
Sehat Insaf Health Card	Health card provided to the beneficiaries of the Sehat Sahulat Programme, a Department of Health programme which aims to improve health status of their target population in Khyber Pakhtunkhwa
Shalwar kameez	Traditional outfit worn by men and women in Pakistan
Suit piece	Length of material used to make *shalwar kameez*
TB	Tuberculosis
Tehsil	Administrative sub-division of a district. A *tehsil* is further sub-divided into Union Councils
Unani	A system of alternative medicine practiced in Pakistan and India. Its being based on the classical four humours: phlegm, blood, yellow bile and black bile, has also been influenced by Chinese traditional systems.
Union Council	Union councils are the fifth tier of government in Pakistan. They are elected local government bodies consisting of 21 councillors, and headed by a *Nazim* now called Chairman (which is equivalent to a Mayor). They comprise a large village and surrounding areas, often including nearby small villages
USG	Medical ultrasonography

Exchange rate
1,000 Pakistani Rupee = £7.48 (pound sterling)

Summary

Background and approach

This report presents the main findings from Reality Check Approach (RCA) study conducted in April and May 2017. The study was designed to gather insights from people living in poverty on how they perceive, understand and engage with health services. It was commissioned by Palladium Pakistan's Empowerment, Voice and Accountability for Better Health and Nutrition (EVA-BHN), a DFID-funded programme which aims to empower and facilitate people to hold two provincial governments in Pakistan (Punjab and Khyber Pakhtunkhwa) to account for the delivery of quality reproductive, maternal, new-born, child health and nutrition (RMNCH-N) services.

The RCA is an internationally recognised qualitative research approach which seeks to try to understand people's experiences, choices, and day to day lives through their eyes. To do so, researchers stay in people's own homes for several days and nights and use this opportunity to interact informally and experience their daily lives. This approach reduces power distances between researchers and study participants and creates the conditions for rich insights into people's reality to emerge. The approach provides opportunities to triangulate findings through observations and experiences, ensuring highly accurate findings are gathered and conclusions are drawn.

Locations for this study were purposefully selected to include eight Union Councils (UCs) in four districts of Khyber Pakhtunkhwa and Punjab provinces. The UCs were selected based on the following criteria: i. location diversity (rural and peri-urban) with varying access to public facilities including the BHU, ii. ethnic diversity , and iii. length of time that EVA-BHN has been working in each Union Council. The team lived with families in 11 villages across eight Union Councils. All members of the four sub-teams sought to stay with families in the same village to ensure better triangulation of findings. However, in cases where villages were less populated, researchers stayed with families in an adjacent village within the same Union Council. To help readers identify each study location, labels have been assigned to each and are used throughout the report.

Setting and context

Over the course of the study, the RCA study team lived with 25 families for four days and three nights and interacted with 1082 people, including neighbors and service providers. Unlike RCA studies in other countries where typically one researcher lives with one family (except in cases where a translator accompanies a researcher), language issues, security concerns and cultural factors meant that two researchers of the same sex often lived with each family. However, where the environment was conducive, the pair split up and lived and interacted with different households.

Of the 25 families we stayed with, 12 are three generational and home to grandparents, parents and children; one family has four generations living in the same house. All but one family derive their income from at least two sources, including agriculture. This includes families who farm their own land, as well as those who work as tenant farmers (paying yearly rent or sharecropping) or renting out their farmlands to others.

All of our villages were accessible by vehicle, either on dirt roads (Nowshera hill), or on asphalt roads of variable condition and had access to government services like Union Council office, schools and Basic Health Units (BHU), which were in or near the village. In addition to the BHUs, people told us and we observed a range of informal and formal health service providers in all of the study locations. All study locations also had government or private hospitals and clinics within one hour driving distance. People usually referred to these as '*bada haspatal*' (big hospital), and made distinctions between the '*sarkari*' (government) and private ones. Private medical practitioners (in all cases male) who were referred to as *chota doctors,* were also generally available in all of the villages, relatively more in the Punjab locations. While in some of these *chota doctors* were compounders, dispensers or pharmacists by training, in other cases they had not received any formal training. Likewise, belief in the power of alternative healing was strong in all but the Layyah locations, with all the other villages having traditional/spiritual healers or *hakim* (practitioner of *Unani* medicine) that people went to with their health issues.

Families in the study locations lived in either mud, concrete or part-concrete houses within family compounds, usually including a boundary wall. People either built these houses on their own land, or rented houses as tenants on land owned by landlords.

Men, in all but the Nowshera hill location, described themselves as farmers and they either farmed their own land, or worked as tenant farmers on the landlord's land. The produce is primarily for the families' own consumption and surplus is sold on an irregular and small scale. In some locations men and women explained that they supplement their farming income with a variety of other sources like seasonal construction work (Layyah desert), brewing and selling alcohol (Sahiwal near E1) and selling archaeological artefacts (Mardan hill). In Nowshera hill, where many families did not own agricultural land, men supported their families by working as waged labourers on a slate quarry nearby. In all locations, fewer women were engaged in income generation compared to men.

Women described limitations on their mobility and, in all except the Sahiwal locations, shared that they rarely left their homes. The restrictions were higher for women in the Khyber Pakhtunkhwa locations, while women in Punjab left their homes more frequently and worked either in their families' fields or as labourers on others' lands. The only location in Khyber Pakhtunkhwa where women worked outside was Mardan hill, where they worked in the fields generally with a male family member. Across locations men and women also shared that certain places like the *hujra* or *dhera* (place to entertain male guests, and for male members in the community to hang out) were male-only spaces, excluding women from the social activities that happened there. Additionally, women in all but the Sahiwal far location rarely went to the shops in the village and would be accompanied by a man, child or another woman when going to the BHUs. Travelling outside the village too was uncommon for women and only done for medical check-ups and emergencies or occasionally visiting relatives, albeit always with a male relative.

Findings

Families shared their perception of poverty and while not all of them felt they were '*poor',* people often referred to common indicators to describe their poor economic situation and choices, including: i) not owning farming land and house; ii) depending on '*hard work*' like farming; iii) not having a reliable monthly income; iv) having no or less cash income as most farm for own consumption and only sell surplus irregularly; v) having few people in the family that can earn money; vi) depending on a single livelihood source; vi) having debt; vii) having no political networks or connections; and viii) having less access to transport and public facilities like BHU, hospitals, schools (in terms of cost, distance, service availability).

In addition to illness, people frequently related 'not being healthy' to what they eat, the medicine they use and working habits. Often families could not say exactly why they did certain things that they thought were 'healthy', but told us these had been doing this for a long time. People often linked being healthy to the type and amount of food they consumed; many thinking meat, chicken and fruit were healthy foods and '*needed for children to grow'.* Eating homegrown and freshly cooked food was thought to be healthy and most people explained that they

made fresh food every day to try to limit eating leftovers. Mothers felt that being healthy meant having a good appetite, explaining *'if a child can eat roti and eat well, he is healthy; a sick person can't eat food'* (Mother, Mardan hill). Many parents also felt that their children had increasingly begun to snack on '*unhealthy*' packet chips and *namkeens* (traditional savoury snack) and said that their children often pestered for money to buy these from the local shops.

Being able to work as usual was another thing people said that keeps them healthy. People constantly shared that keeping a routine lifestyle meant that a person is healthy, including many women who considered themselves healthy because they do chores everyday. Women in particular also felt that being thin was healthy and that people became fat because they did not do any physical work.

Across locations, people constantly linked being ill to long-standing conditions like diabetes or high blood pressure for which people consulted someone or occasionally took regular medicines. These and other diseases like cancer, heart diseases, tuberculosis and hepatitis, which they referred to by these medical names, people said, were '*serious conditions'* and not like fever, cough or joint and muscular pains that happened because they were '*farmers who worked all day*'. While some people attributed diabetes to their diet, one household father in Mardan hill told us his wife had '*sugar* (diabetes)…*because she is a woman, she eats everything, everywhere.'* However, many people did not mention any link between the disease and their eating or lifestyle.

In all but the Layyah and Mardan hill locations, many children and adults had physical deformities or a mental disability. While many people considered these disabilities to be an illness, others also believed it was a person's fate. A few people also explained these physical deformities as having occurred because children were not given polio drops, while some others in Nowshera river and Sahiwal near speculated that this was because of inter-marriages in families.

In the Mardan, Sahiwal far and Layyah inland locations, many people we met had different types of hepatitis and in Mardan inland many had died of hepatitis A. In contrast, diarrhoea in adults was not considered a serious illness and usually treated with home remedies, but many mothers worried when their babies and toddlers had diarrhoea and took them to the *chota doctor* or BHU for medicines. While some people in Layyah inland, Sahiwal far and Mardan hill blamed the sanitation situation (exposed drains, stagnant water, garbage dumps) of their villages and pervasiveness of flies for the spread of hepatitis and diarrhoea, no one else in other locations connected sanitation with these ailments.

Women, across locations, shared that they went about their routine as usual when pregnant. Most had done chores as usual during their pregnancies and only took a break from work for something '*serious*' like heavy vomiting, severe back-pain or if they fainted. Most women shared that they had eaten '*anything that was available*' during their pregnancies and '*special*' food was only eaten after the baby was born. Taking medicines and involving doctors during pregnancy was generally avoided '*unless it was serious'* and only a few women in Sahiwal far had gone for regular check-ups (including ultrasound) while pregnant. Typically women went back to their usual work about 10-14 days after birth.

Breastfeeding was common across locations and most women feel breastfeeding keeps the baby healthy, except in the Layyah desert and Sahiwal far locations where mothers give formula milk to their babies. Women in the Layyah inland and Sahiwal far locations a few women mentioned that babies are given solid food after six months but one four-month old baby in the latter was being given *roti*. Five of our 25 families had babies who had died days or few weeks after birth. Except for one family in Mardan inland A1 who knew that their two babies had died after four weeks because of '*heart problems*', other families did not know the cause of their babies' deaths and believed *'it was fate that babies died'.*

Deciding where to go to in case of an illness depends much on the perceived seriousness of the ailment. In cases of '*smaller, everyday issues'* like fever, cough, stomach ache, minor injuries, people prefer home remedies as they are '*well tested cures',* only visiting the *chota doctor* or the medical shops if the problem persists beyond a few days. However, people preferred to take very young children or babies to *chota doctors* immediately for consultation and medicines. Families also visit hospitals or clinics in the districts in case of serious illness (cancer, other long term illnesses), at times even travelling to a different district for treatment. These trips to hospitals are made, typically through referrals, when people feel that the treatment provided by the *chota doctor* is not useful or if the illness is beyond their capacity in terms of competence and resources.

Across locations men and women shared that they usually went to service providers with 'facilities', using

the term to refer to all kinds of diagnostic services, and preferably where these were '*under one roof*'. For these services people preferred going to private hospitals and clinics as they have '*specialist doctors*' and pathology and radio-diagnostic facilities. People also overwhelmingly emphasized the importance of having access to ultrasound facilities. Most women shared that they had done an ultrasound when prescribed by the BHU or doctors during pregnancy, as well as on occasions when it was not prescribed. More often than not, these ultrasound facilities are private initiatives of BHU staff, requiring separate payment. Women also told us that they were not just getting ultrasounds when pregnant but also when they feel generally unwell because they '*liked being checked by the TV*'.

People trust what is perceived as '*modern medicine*', injections in particular. They preferred going to *chota doctors* over the BHUs because there they would be given injections for almost all complaints. Similarly, people also chose health providers based on who they trust. This trust was based on previous experience of the service, whether these cures had worked and familiarity with the person. In all but the Layyah locations, our families and other men and women from our communities also visited a variety of spiritual and traditional healers, *hakims* and shrines when they were ill. As most of the spiritual/traditional healers are in the village, in some cases living just a few doors away from our families, people said they knew the healers' specialisation and go to specific ones based on their needs. While people also go to *chota doctors* because these men are usually from the village, much of this preference for them is also related to their willingness to give medicines and treatment on credit.

People felt that the services at the BHU are for '*poor people*' and one of our fathers in Sahiwal far explained this because '*there are no fees at the BHU*'. Researchers noted that the better off families would talk highly of the services at the BHU while poorer families would tell us *'nothing is fine there'*. People said this is because *'the rich families like the BHU because they don't use it*' and could afford to use private services instead. People in all locations frequently compared the cost of being treated at the BHU to costs elsewhere to indicate that the services at the BHU were not satisfactory. Medicines, when available, are provided for free at the BHUs and consultation fees are nominal. Due to this some people, particularly in Nowshera hill and Layyah desert, were concerned that their BHU provides medicines that were inferior in quality with many telling us '*what's free cannot be trusted*'. Barring a few people who told us they could not afford services at a private hospital or clinic, most are using or had at some point used one of these because they felt that they got better treatment by paying.

The choice to go to a certain health provider is also based on access for some of our families. People prefer the *chota doctors* or the medical shops in the village because these are close-by and make house-calls when needed, whereas they need to wait for an appointment at hospitals.

In almost all locations, people commented that BHU staff did not respond to their patients, including *'shouting at people,' 'doing nothing'* and *'not giving medicine.'* In Sahiwal far people explained that the BHU staff were *'good with rich people, bad with poor people'* because he had been shouted at and *'not talked to with respect,'* while in other locations they were accused of giving preferential treatment to their relatives. People also frequently accused BHU staff of arriving late or being absent, with many people speculating that this was related to doctors running private practices nearby where, they believed, many BHU medicines are sold. A few men in Sahiwal far also told us about seeing a few medicines which were labelled 'not for sale' being sold at the local medical shops which made them suspect that these were coming from the BHU.

In a few locations families also said that at times the staff at the BHU would let unqualified staff treat patients, including both gardeners and security guards. People also seemed to feel that some of the senior staff at the BHUs were not very qualified and would often delegate their responsibility to junior staff like medical technicians and LHW. In a number of locations, both men and women complained that few if any female staff were present at the BHU. A few pregnant women who had gone to the BHU for check-up told us that she had referred them to the LHV instead of checking them herself and would ask the male medical technician to treat the men.

In every village, there were certain people or groups who people said they go to in case of personal or communal disputes. While some of these are men who are traditionally considered politically 'influential', people also told us they often went to the elder in their community or to their landlords with complaints. Though people told us that politically connected people would give them advice, some men said they were more interested in building roads *'because election is coming'*, rather than addressing problems. Women explained that issues were generally handled by men, and that women

could not join the conversation and are represented by their male family members. People told us they rarely sought help from the police.

However, people would rarely complain to these individuals or others about poor quality services in the BHU. People explained this saying that nothing would happen as a result, and noted occasions in which there was retribution against someone in their village who had made a similar complaint. Most people felt that complaining or asking for help would be akin to *'bowing down to someone'* which they were too proud to do so they did nothing about their problems. In Nowshera hill and in Sahiwal far people shared that they 'lived with their problems' because '*we are poor people, why would anyone listen to us*?' Others also pointed to previous examples where they had complained with little result as further discouraging them from complaining, noting that the only time anything changed was around election time. However, in some cases, particularly in Nowshera, people's complaints related to the BHU had been addressed, largely related to issues of unqualified staff.

For some people complaining means facing reprisals by well-connected BHU staff and administrators. Men told us complaining about BHU staff would 'create problems' not just with the MNA but also with others in the village. The same principles applied to *chota doctors*, even when they had made grave mistakes, given that they were from the village. Others didn't complain because they thought it would take up time that they could be spending working. In different locations men shared that although they had made complaints, at what they thought were 'appropriate places' like the Nazim or the MPA, the issues had not been resolved. Because of this, people thought these 'people with authority' either did not have the influence to raise these issues, or chose not to. In some locations doctors told us that the Independent Monitoring Unit (IMU) came to monitor the BHU occasionally, but the team just '*went to the Nazim's house and drank tea with him.* '

While our families often told us they made decisions 'which affected the family' jointly, the final decision, women said, was usually the man's. Women might make decisions regarding what to buy for the home, though this was limited to small items. In almost all families, men would accompany women outside the village. Men tended to have the final decision regarding health care, particularly if this requires seeking health services outside the village. Mothers in law also had a significant input into these decisions, particularly as they relate to children.

Most people told us that voting was a family decision, or sometimes done in accordance with their patronage. Men explained that they consulted other men in the family when deciding who to vote for and typically the entire family vote for the same political party, and they often follow the advice of local landlords as to who to vote for. Women in most locations said they were expected to follow their husband's voting advice. In Sahiwal, people also told us that candidates had 'bought' their votes for PKR500.

Implications

These findings suggest a number of implications for further programming and initiatives.

Firstly, many people see themselves as 'ill' and were unusually focused on health, medicine and health services. However, people generally lacked an understanding of their 'ailments' and broader principles of heath were very poor and preventative healthcare is poorly practices. The preoccupation with illness could be related to the prevalence of private providers, whose interests would also lie more in curative than preventative healthcare. This interest suggests a potentially fertile ground for initiatives related to preventative healthcare.

Secondly, we also observed strong norms shaping acceptable behaviour for each gender. This included various forms of purdah, which often created distinctly 'male' and 'female' spaces.

Though at times people explained this separation in terms of conservative Muslim values, they also consistently returned to the concepts of trusted (known) individuals - and suspicious (unknown) individuals. This distinction impacted who people sought help from in all aspects of life. Men and women equally seemed to define acceptable spaces and relationships for women in terms of trusted individuals, limiting these to family members and other women. High levels of suspicion of strangers and their intentions implies the need to work within coalitions of known people in villages. This includes providing information to communities, expanding access and service use, and creating outlets for engaging with policy makers, taking into account the separate spheres and bodies of knowledge occupied by men and women.

Thirdly, people have a huge range of health providers to choose from, and choose based on the perceived severity of their illness. However, the BHU was the last resort, explained by the idea that paying for services guaranteed better quality, despite noting

that private local providers often lacked credentials. People overwhelmingly viewed BHUs as providing poor quality health care, often explained in terms of a BHU's lack of medicine and 'modern' facilities. As a result, only the poorest people we met relied on the BHU, with all others who opting to pay for private providers. People also highlighted the importance of their personal relationships with private health providers in their preference for them over BHUs, run by staff from outside the village. This highlights the importance of addressing issues of quality, social expectation and community outreach for programmes seeking to improve use of public health services.

Fourthly, people across all locations shared that they experienced poor quality of care from the BHU yet would not complain about this. People explained that there was no point in complaining as little progress was likely to be made because *'people don't listen to the poor.'* Beyond this, people often equated the idea of complaining about services to asking for a favour rather than demanding an entitlement. Often, people looked to the most influential individuals in their community for such favours, which varied hugely from location to location. These individuals largely derived their influence from their relationships and broader networks, which, in turn, shaped how this influence could be used to bring about change. People often shared that these individuals are very powerful, which made them want to minimise the number of 'favours' they asked. Complaining about health services were complicated by people's often poor understanding of how BHU services are managed and which individuals have the power to address each issue. The exception to this were people's suspicions that doctors colluded with private providers to earn extra money. . However, they did not confront doctors about this issue and rarely engaged with BHU staff, compounding people's suspicion and pushing them toward private providers.

These factors suggest the need for more opportunities for local communities to engage with doctors and BHU staff constructively to improve their understanding of their roles, as well as more engagement with communities to clarify roles and responsibilities regarding the public health system. The variation in local power holders, further suggests the need to identify who is most influential in each community and create links with duty bearers, particularly those who are part of the health system, in each community.

Introduction

This report presents the main findings of the Reality Check Approach (RCA) study which was conducted in April – May, 2017. The study was designed to gather insights from people living in poverty and those who are marginalised on how they perceive, understand and engage with health services. It was commissioned by Empowerment, Voice and Accountability for Better Health and Nutrition (EVA-BHN), a DFID Pakistan funded project that aims to empower, organise and facilitate people to hold two provincial governments in Pakistan (Punjab and Khyber Pakhtunkhwa) to account for the delivery of quality reproductive, maternal, new-born, child health and nutrition (RMNCH-N) services.

Health care in Pakistan has been devolved to provincial level since 2011. It comprises a complex mix of state and non-state provision. Non-state provision includes both profit-making and not-for-profit provision. Informal health providers operate side by side formal health providers.

EVA-BHN began in 2014 with the aim of reframing citizen-state relations in order to achieve better health outcomes through better state health services. It intends to achieve this through a mix of social accountability measures at community, provincial and national level. It works through a network of citizen forums at community, district and provincial levels which are empowered to use community based monitoring and grievance redress mechanisms. These local efforts are assisted by a range of supported media engagement. The project seeks particularly to include the poor and marginalised and ensure that their concerns can be raised and issues with health service provision can be resolved.

EVA commissioned research[1] has noted that the low status of the poor may be a significant factor in their poor treatment; that the poor self-exclude from community groups because they are '*unable or afraid to directly engage powerholders;*' 68% of Basic Health Unit (BHU) users are likely to be poor or extremely poor but that 61% of users also use private health services. The RCA was commissioned to address the gaps in knowledge about the poor and marginalised, their everyday realities, experiences and context and, in particular, their health-seeking behaviour and interactions with health providers. The study was expected to provide insights useful for both EVA-BHN and the Provincial Health and Nutrition Programme (PHNP) as they explore ways to better engage and support the poor and marginalised with improved and expanded basic health services. In addition, it was expected that findings related to the everyday experiences, lives and challenges of the poor and marginalised will also be useful to inform current and future DFID Pakistan programming.

1 Cited in Reframing Citizen-State relations from the bottom-up (p7and 9), 2016 and Year 3 Annual Report, 31st January 2017 (p7-8).

Structure of this report

This report begins with methodology, including adaptations required for this first study in Pakistan as well as study limitations. The findings section begins with describing the context of study locations. The subsequent sections then cover people's perspective on poverty and its contemporary indicators, health and their experiences accessing different informal and formal health services available in each study location and how people make these health choices. The final section of the findings focuses on people's voices, citizen engagement and sources of information. The report concludes with a section providing study implications drawn from the findings and discusses programme options and policy interventions.

2. Methodology

The Reality Check Approach (RCA) is a qualitative research approach involving researchers staying in people's homes for several days and nights and experiencing people's everyday lives. It involves researchers 'hanging out' and chatting informally with all members of the household, their neighbours and other community members. Researchers build rapport with the families and communities by informal interaction and through acknowledging their own behaviour and attitudes, challenging assumptions and positioning themselves as learners. This relaxed approach ensures that power distance between researchers and study participants is diminished and provides enabling conditions for rich insights to emerge. Having informal conversations with different people and opportunities for experiencing first hand as well as observing people's context and reality, means that insights gathered are rich and in-depth and complement findings from other research methods.

RCA differs from many other research approaches by comprising a combination of four essential elements; Firstly, it is not theory-based and has no preconceived research framework or research questions. Researchers rely on iteration from progressive and multiple conversations led by people themselves. The premise for researchers is one of learning directly from people while only guided by 'areas for conversations' (see the study process). This approach seeks to enable emic (insider) perspectives to emerge and to limit etic (outsider) interpretation or validation. Secondly, RCA requires living with the study participants, immersion in everyday lives. Thirdly, RCA is always carried out in teams in order to minimise bias and to optimise opportunities for triangulation. Fourthly, RCA teams are independent and make this clear to people who participate in the study. Our objective is to ensure that people's own views, perspectives and experiences are respectfully included into policy dialogue without any interpretation and both the findings and implications are grounded in what people themselves share and show to us.

The approach extends the tradition of listening studies (see Salmen 1998 and Anderson, Brown and Jean 2012[2]) and beneficiaries' assessment (see SDC 2013[3]) by combining elements of these approaches with actually living with people. RCA is sometimes likened to a 'light touch' participant observation. Participant observation involves entering the lives of the subjects of research and both participating in and observing their normal everyday activities and interactions. It usually entails extensive and detailed research into behaviour with a view to understanding peoples' perceptions and their actions over long periods of time. The RCA is similar in that it requires participation in everyday life within people's own environments but differs by being comparatively quick and placing more emphasis on informal, relaxed and insightful conversations than on observing behaviour and the complexities of relationships. It also differs by deriving credibility through multiple interactions in multiple locations and collective pooling of unfiltered insights so that emic perspectives are always privileged.

Important characteristics of the RCA are:

- **Living with** rather than visiting (thereby meeting the family/people in their own environment, understanding family/ home dynamics and how days and nights are spent);
- **Having conversations** rather than conducting

2 Salmen, Lawrence F 1998 '*Towards a Listening Bank: Review of best Practices and Efficacy of Beneficiaries Assessment*' Social Development Papers 23, Washington, World Bank; Anderson, Mary B, Dayna Brown, Isabela Jean 2012 '*Time to Listen: Hearing People on Receiving End of International Aid*' Cambridge, MA: CDA.
3 SDC; Shutt, Cathy and Laurent Ruedin 2013 '*SDC How-to-Note Beneficiaries Assessment*' Berne, Swiss Agency for Development and Cooperation.

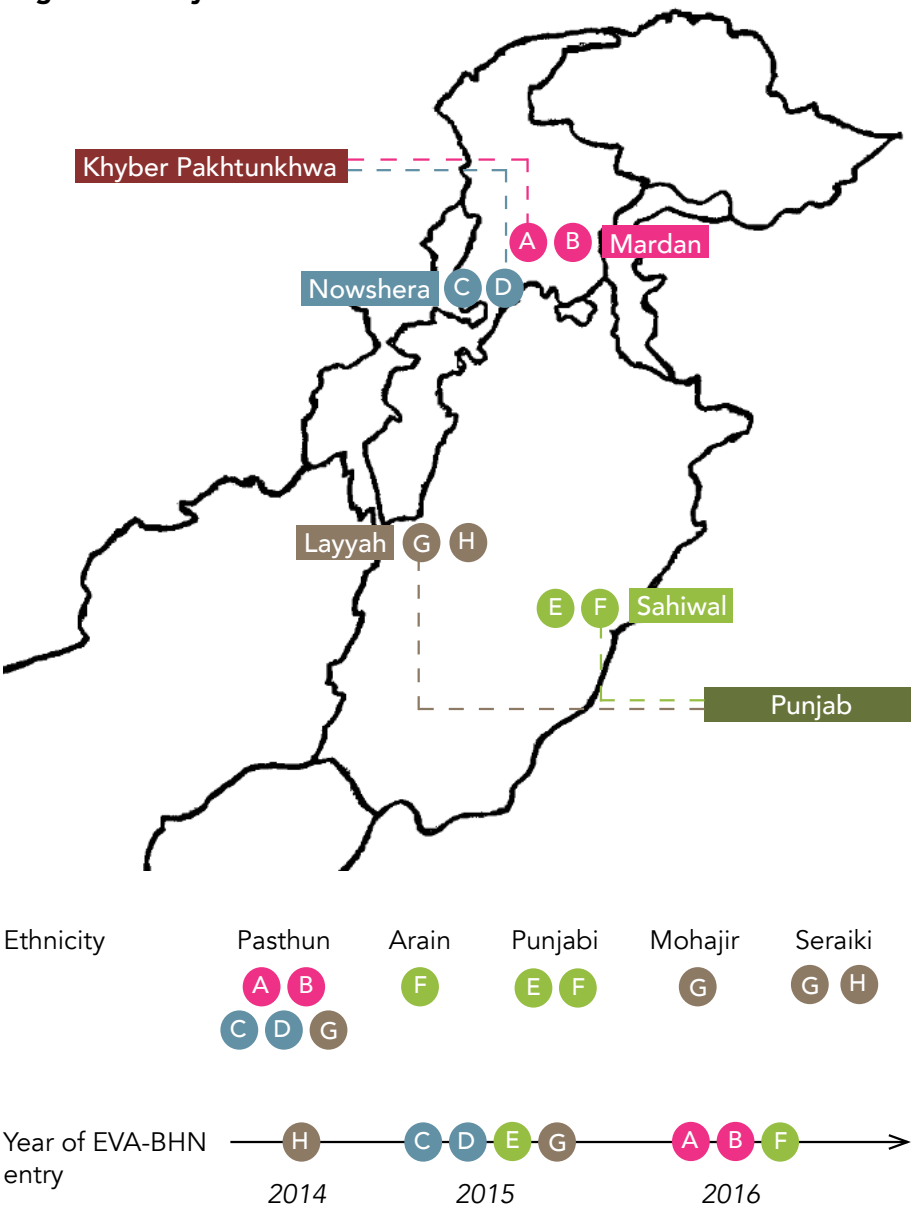
interviews (there is no note taking thereby putting people at ease and on an equal footing with the outsider);
- **Learning** rather than finding out (suspending judgement, letting people take the lead in defining the agenda and what is important);
- **Centring on the household** and interacting with families/ people rather than users, communities or groups;
- **Being experiential** in that researchers themselves take part in daily activities (collecting water, cooking, working in the fields, hanging out) and accompany people (to markets, to social activities, to health facilities);
- **Including** all members of households/living in units;
- **Using private space** rather than public space for disclosure (an emphasis on normal, ordinary lives);
- **Accepting multiple realities** rather than public consensus (gathering diversity of opinion, including 'smaller voices');
- **Interacting in ordinary daily life** (accompanying people to health providers, interactions within their usual routines);
- **Taking a cross-sectoral view**, although each study has a special focus, the enquiry is situated within the context of everyday life rather than simply (and arguably artificially) looking at one aspect of people's lives;
- **Understanding longitudinal change** and how change happens over time.

2.1. Study locations

The study was conducted in four districts of Khyber Pakhtunkhwa and Punjab provinces. The eight Union Councils (two in each district) for the study were purposefully selected to include those where EVA-BHN has been working, using criteria worked through in consultation with EVA-BHN as follows;

- Location diversity (rural and peri urban) with varying access to public facilities including the BHU;
- Ethnic diversity;
- Length of time that EVA-BHN has been working in each Union Council.

Figure 1: Study locations



2.2. Study team

Level 1 training

As this was the first time RCA was undertaken in Pakistan, a new team had to be formed and trained. All Pakistani team members completed a full five-day RCA Level 1 training facilitated by the three international RCA researchers from Nepal, Indonesia and UK who are level 3 RCA practitioners with experience of doing field immersion in other countries. The Level 1 training emphasised the good practice of reflexivity, understanding and mitigating researcher bias and judgement, maintaining informality and ethical considerations in conducting this kind of work. A detailed session on risk and security was also led by Palladium's Security Manager to address researchers' concerns. The training included two-nights immersion in a village on the outskirts of Islamabad, where researchers applied in-classroom learning directly in the field. One day of reflection followed the two-night immersion to internalise lesson learns, both from in-classroom training and field immersion.

After the completion of Level 1 training, all study team members participated in study briefing to familiarise themselves with the goals and processes related to this study. Study briefing included clarification of the selection criteria to be used in identifying families to stay with, developing areas for conversation together with the team members (see Annex 2), having overview of EVA-BHN project and re-visiting the security briefing with Palladium security coordinator.

Study team

The study team comprised 18 researchers, including three international researchers in the roles of team leader and co-team leaders (see Annex 1). The selected Pakistani researchers were enthusiastic young persons from a range of academic backgrounds including anthropology, economics, development studies, political science, and sociology. While most members of the team had conducted ethnographic studies, participatory rural appraisal, other qualitative approaches and mixed methods research, they were keen to learn from people's realities by living with them and ready to adapt to difficult and basic living conditions.

Each of the four sub-teams comprised of three or four team members. The teams were designed to include men and women researchers as well as members with the appropriate local language skills (Pashtu speakers in Khyber Pakhtunkhwa, Punjabi and Seraiki speakers in Punjab). As the international researchers could not participate in field immersions because of security reasons, all four field sub-teams were led by Pakistani researchers who were provided additional sub-leader training.

2.3. Study participants

The study involved living with a total of 25 families in 11 villages. Where possible the researchers chose to live with households with a view to meeting the following criteria:

- Multi-generational families, including grandparents, parents, children and other members of the extended family to explore health needs of different age groups;
- Households with pregnant women, toddlers or babies;
- Poorest households.

All study households were selected by team members through informal discussions with people in the community e.g. at shops, mosques, *in situ.* Care was taken to ensure that people understood the nature of the RCA study and the importance of staying with ordinary and modest family and not being afforded 'guest status.'

The households selected were, wherever possible, at least fifteen minutes' walk away from each other, to ensure interaction with a different constellation of neighbour households and other community members and service providers allowing good triangulation.

Each team member discreetly left a 'gift' of basic food items for each host household (i.e. rice, sugar, bar soap, cooking oil, etc) on leaving, to the value of about PKR 1,500 to compensate for any cost incurred in hosting them. As team members insist that no special arrangements are made for them, they help in domestic activities and do not disturb income-earning activities, the actual cost to 'hosts' are negligible. The timing of the gifts was important so people did not feel they were expected to provide

Table 1: Study participants

Study Participants	Number	Intention
Host household (HHH)	25 families (61 men, 44 women, 54 boys and 44 girls)	Close interactions, observations and conversations with all members of the family to get comprehensive understanding of context and understanding choice and behaviour at household level
Neighbour households (Focal household, FHH)	520 people	Less detailed interaction than host household, mostly conversations to explore diversity of family experience, perspective, different views, common issues and to triangulate the HHH insights
Health services related	88 people	Opportunistic engagements through informal conversations to explore their role, multiple perspectives, and understanding context for triangulation
Community leaders and other community members	271 people	

better food for the researchers or get the impression that they were being paid for their participation.

The study team had further detailed conversations with neighbours and other opportunistic conversations with members of the communities including local informal and formal service providers, especially health providers like traditional healers, spiritual healers, traditional birth attendants, medical practitioners, doctors and medicine shop owners.

The team had extended conversations over the period of three nights and four days with a total of 1,082 people (762 men and boys, 320 women and girls). The details of study participants can be found in Annex 3.

2.4. Study process

RCA studies are generally implemented in five main phases (see figure 2). Phase 1 and 2 has been discussed in the previous section.

Immersion (fieldwork process)

Entering Community. Although EVA Project Officers had been informed previously about the study and were also involved in the selection of the Union Councils, the names of the study locations were not shared with them to maintain the independence of the RCA team and findings. The team members entered the communities independently on foot to keep the process 'low key'. They then spent time going around the communities getting to know people and being known, as well as making the purpose of the study clear. Care was taken to ensure that people understood the nature of RCA (i.e. learning about everyday lives, staying with people for several days and nights, and the importance of listening to ordinary stories and experiencing everyday life of people). This provided people with the space to question the difference between RCA study and other research they might have been familiar with (like surveys, interviews or focus group discussions) and emphasised the importance of not making special arrangements and not being afforded guest status.

Figure 2: Study process

Immersion. Having understood the purpose of the study, people were mostly comfortable to share the context of the villages and some families offered to host us. In contrast to RCA studies in other countries where typically one researcher lives with one family (except in cases where a translator accompanies a researcher) for several days and nights, language issues, security concerns and cultural context of working in Pakistan required researchers of the same sex to be paired and these pairs lived with a family for a period of four days and three nights. However, where the environment was conducive, the pair split up and lived and interacted with different households. The researchers progressively built insights and understanding by having multiple informal conversations with various people at different times and places, as well as engaging in daily activities together with family members.

To illustrate context and findings, photos were taken with people's consent. Whenever possible, families and neighbours were encouraged to make visuals while chatting with the researchers to elaborate their stories. For example, children made drawings of extended families and some family members made charts to explain their household expenditures.

Researchers also participated in their host families' daily activities like harvesting wheat, cooking together, playing with children and accompanied people to health facilities whenever opportunities arose. Whilst researchers did not take any notes in front of people while having conversations, they did jot down quotes and details discreetly where necessary.

Debriefing. Immediately after completion of each round of field immersion, each sub-team spent a full day sharing their conversations, experiences and insights with the team leaders. These sessions explored the areas for conversations and expanded on these based on insights from the field. The recalled conversations, experiences and observations were recorded in detail in written and coded de-briefing notes. Detailed notes documenting this debriefing, along with photographs and field notes from the immersion, formed the 'data set' or basis of information from which study findings were drawn. In total, the study team spent eight full days de-briefing with the team leaders.

Researchers having informal conversations with people in the villages and joining in people's daily activities.

Archiving. The team also spent additional eight days to record detailed households and villages information, along with documenting each researcher's field notes, box stories, photographs as well as visuals created with people.

Sense Making Workshop. After completing all debriefing and archiving sessions with each sub-team, the entire team came together for a 'sense making workshop' to critique and extend the analysis as well as to exercise reflexivity regarding possible bias. The team was asked to take the position of the study participants, and to identify the emerging narratives to ensure that researchers did not overlay their own interpretations on the findings.

This processes (debriefing, archiving and sense making workshop) enables extensive triangulation as the same themes emerge and are explored by different researchers from different perspectives, different locations, times and research methods (observations, conversations, experiences, visual and photographs). This process also reflects how each researcher engaged with people to ensure that the key elements of this approach were well practiced.

Analysis. The team leader and co-team leaders then undertook further analysis and prepared preliminary findings for EVA-BHN. This process used the established framework analysis procedures involving three of the typical four stages process:

1) Familiarisation (immersion in the findings);
2) Identification of themes and;
3) Charting (finding emerging connections).

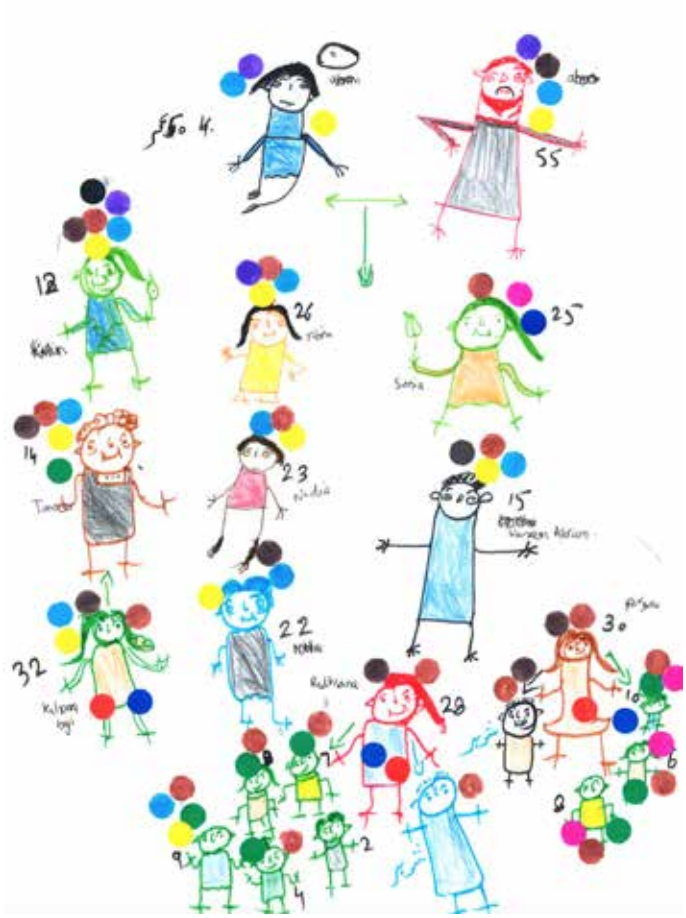
The conventional fourth step is 'interpretation' which RCA purposely eschews in order to maintain closeness to what people themselves share.

Three different researchers undertake the analysis independently of one another as a test of validity when they reach the same conclusions about the emergent themes form the findings. These key emerging narratives from this process were used as a basis for the report writing. Quality assurance was carried out through internal peer review with special concern to ensure the research retained the positionality of people themselves.

2.5. Ethical considerations

The RCA team takes ethical considerations very seriously, especially considering the fact that the research involves living with people in their own homes. Like most ethnographic-based research, there is no intervention involved in RCA studies. At best, the study can be viewed as a way to empower study participants to be able expressing their opinion

People creating an expenditure diagram together.



Example of children's drawing showing the family relationships from Sahiwal far.

freely in their own space. Researchers are not covert but become 'detached insiders'. People are informed that this is a learning study and are never coerced into participation. As per American Anthropological Association Code of Ethics, RCA adopts an ethical obligation to people '*which (when necessary) supersede the goal of seeking new knowledge.*'

Researchers '*do everything in their power to ensure that research does not harm safety, dignity and privacy of the people with whom they conduct the research*'. Researchers asked people's verbal consent to be able to use their stories and insights, and assured people that they would keep their sharing off the record if they did not give their consent. Researchers then signed a declaration they had received people's verbal consent to share the insights in the collaborative analysis process.

All the researchers were required to undergo Child Protection and Data Protection training in the level 1 training and study briefing. All researchers were also required to sign the Child Protection and Data Protection policies as part of their contracts. All data (written and visual) is coded to protect the identity of individuals, their families and communities. As a result, the exact locations and identities of households and others are not revealed in this report.

2.6. Study limitations

As with other research methods, this study has a number of limitations as follows:

- As *purdah*[4] practices varied across locations, men researchers experienced difficulties communicating directly with women. Some men researchers were only able to interact with women and girls from their host families, while others could only interact with older women (Mardan hill, Nowshera river C2, and Layyah inland), and in stricter locations like Mardan inland and Nowshera hill they could not interact with women at all. Likewise for women researchers, *purdah* practices not only limited their interactions

4 a state of seclusion for women, living in a separate room or behind a curtain, dressing in all-enveloping clothes, in order to stay out of the sight of men or strangers.

with men but also restricted their mobility. While some women researchers could not go to male-only spaces like the mosques, they were able to walk around the village accompanied by other women members of their families (Mardan inland, Mardan hill, Layyah desert, Sahiwal near, Sahiwal far). This restriction on their mobility was particularly higher for the women researchers in Nowshera hill where they were only able to interact with women in their families and a few women neighbours.

- The study team comprised of more men researchers than women (six women and nine men). This and the cultural context of Pakistan (like the *purdah* practices discussed above) meant that researchers interacted with more men than women, with the number of men and boys being double than women and girls. (see Annex 3).

- In one study location (Sahiwal near), people had a particularly negative perception towards non-government organisations and outsiders which hampered the sub-team's relation with the community on the first day. The team was unable to stay in the village for the first two nights but worked to overcome this limitation by joining the families early in the morning and staying until late in the evening, participating in everyday activities and sharing meals with them, hence building rapport. In the end, the sub-team was able to spend one night with their families in this location.

- In the Layyah desert location, the community was not comfortable having the researchers live with them. Additionally, as other villages in the area were not given security clearance, the team was unable to stay in the field. Like the Sahiwal near sub-team, researchers in this location commuted from the nearby town early each morning and stayed until the evening.

- While all of the other sub-teams stayed in the village, men researchers in Nowshera hill, Mardan hill, Nowshera river locations were not permitted to live with families in their homes. While they spent their days working and chatting with the male members of the family, nights were spent in mosques or community guest-houses. Due to this, researchers missed out on much of the conversation and family interaction during night time.

- As three sub-teams were in the field during weekend and a public holiday they were not able to visit the BHUs or interact with formal health service providers who did not live in the village (Mardan inland, Nowshera river, Sahiwal near and Sahiwal far).

- Use of local language was a constraint for two Urdu-speaking researchers who missed side talk and the nuances of what people shared, especially elder people who were not able to communicate in Urdu. However, as both of these researchers were working in different pairs, they relied on their partners for translation of the local language.

- Due to security concerns, the EVA-BHN Project Officers in each of the four districts were briefed about the methodology and been informed previously that researchers will be staying in communities for several days and nights. In addition, each of the Union Councils had an assigned focal person to be contacted in case of emergencies. This project team briefing slightly affected the dynamics between the researchers and the community people in the Sahiwal locations where the focal person insisted on being present when the sub-team entered the community and to some extent influenced their household selection.

- The international researchers were not given clearance to join in the field immersions due to security concerns. Instead, they accompanied local researchers on the training immersion to help with the process of entering community and stayed in the location for few hours until researchers were able to find families that agreed to host them. For the main study, international researchers made day-long visits to see the context of study locations in three of the districts (Mardan, Nowshera and Sahiwal).

Findings

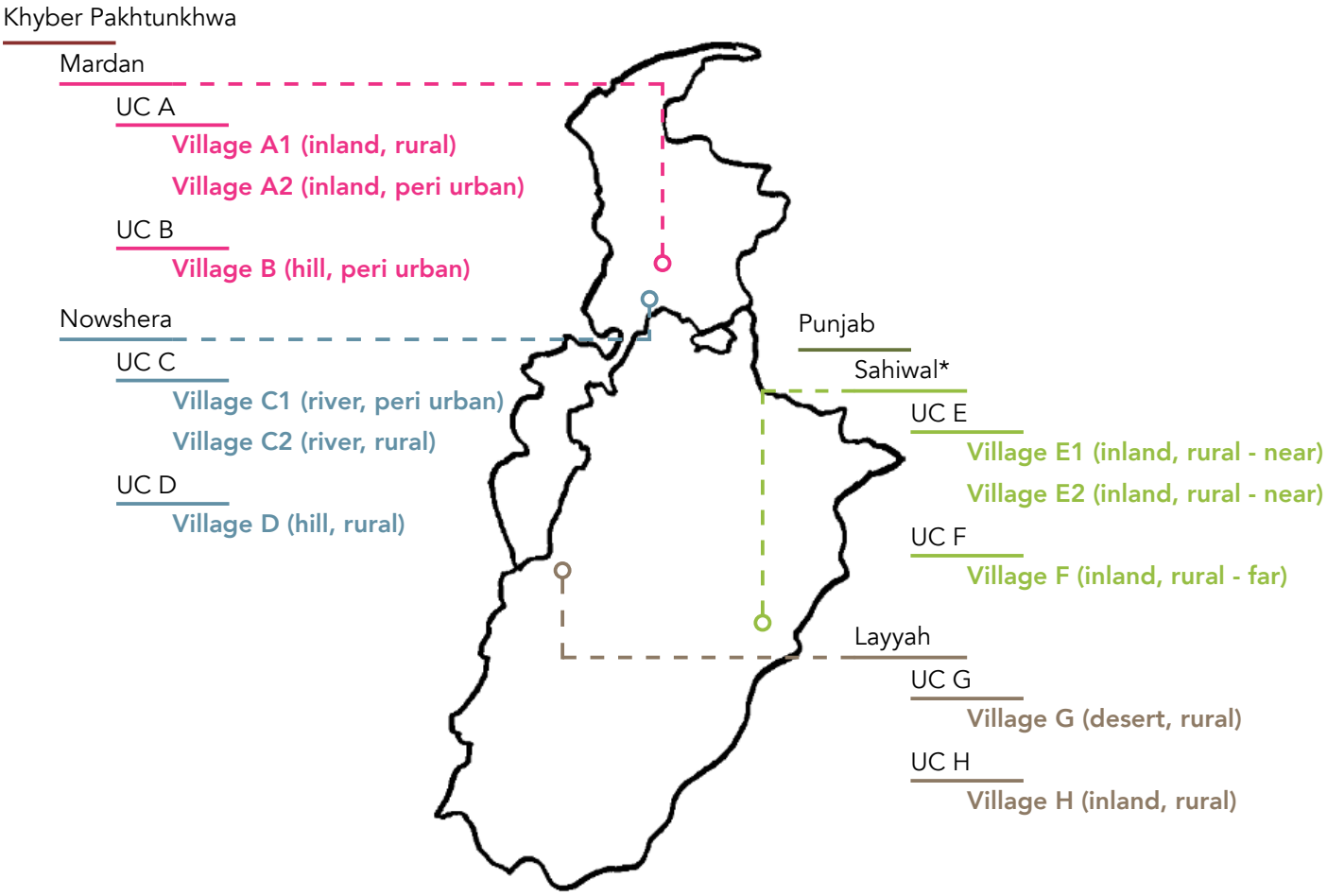
The findings section is divided into two parts. Section 3.1 sets the scene for the rest of the findings by providing a contextual overview of the study locations. It describes these in detail including physical access to services and facilities, people's living situation and livelihoods, religious observance and women's mobility. As there have been very few contemporary anthropological studies in Pakistan, the insights in this section aim to update the reader on current lived experience of people in villages. The following sections (3.2, 3.3, 3.4 and 3.5) describe people's perception of their own poverty, their health seeking behaviour, including their perspectives of available health services and preference for these; their experience of raising their voices and participation in decision-making and political processes. The findings are also intended to provide insights into family and community dynamics and interactions within and networking outside family and community. As stated above in the study limitations, cultural context of Pakistan meant that researchers interacted with more men than women (762 men, 320 women), but efforts were purposefully made by researchers to include women of their host families and neighbouring households in conversations, even as they went about their daily chores and also during free time. The findings highlight their views where appropriate.

3.1. The setting

The study was carried out in the two provinces of Khyber Pakhtunkhwa and Punjab. The Khyber Pakhtunkhwa province is in the north-western region of Pakistan and has a predominantly Pashtun majority. Punjab shares an international boundary with India and is home to Punjabis, the largest ethnic group in Pakistan with people speaking many different languages including Punjabi and Seraiki.

The team went to two districts each in Khyber Pakhtunkhwa and Punjab and lived for several days and nights with families in 11 villages across eight Union Councils. All members of the four sub-teams tried to stay with families in the same village to ensure better triangulation of findings. However, in cases where villages were less populated, researchers stayed with families in an adjacent village within the same Union Council. To aid the readers of this report, the 11 study locations have been categorised in figure 3 below. The assigned labels, for example Mardan inland A1 or Nowshera hill, in figure 3 is used to refer to the different locations throughout the report:

Figure 3: Study locations



**The Sahiwal locations, which are all rural and inland, have been given the tag of 'near' and 'far' depending on their proximity to the main road.*

Sahiwal near E1 is the least populated of all the study locations with only 30-40 households while the two Nowshera river villages (C1 and C2) have about 700-800 households each. Except for the Mardan hill A1 village where the houses are scattered, all of the other villages are largely nuclear with the houses in one part of the village and farmland in another.

Access: Roads

All of our villages were accessible by vehicle, either on dirt roads (Nowshera hill), or on asphalt roads of variable condition. People explained to us that while public transport like buses do not come directly to the villages, they are available on the main roads. It is usual practice to take smaller transportation like motorcycle-rickshaws (Nowshera river; Layyah inland), donkey carts (Layyah inland; Sahiwal near) or hire privately owned vehicles that doubled as taxis (Nowshera hill; Layyah desert) to the main road from where the buses operate, or in case of medical or other emergencies, to the towns.

Access: Services

Apart from the Mardan inland, Nowshera hill and Layyah desert location, people told us the Union Council office was near or in the village. In Layyah desert, the Union Council was 25 kilometres away from the village, while it was about six kilometres from the Nowshera hill location. Families everywhere told us they only went to the Union Council to get documents attested, register births and deaths, get land certification and occasionally to make complaints about land disputes. Table 2 shows our study locations' access to different government services.

Every study location had at least one government primary school with middle and high schools located either in the village or in nearby villages. Most of the parents we chatted with had sent their children to school at least until completion of primary level (Grade 5). In Layyah desert, families told us they had not sent their daughters to the primary school in the

village until three years ago because the teachers had all been young and male and only changed their minds when an older male teacher started teaching. While boys here could continue their middle and high school education (Grades 6-10) by commuting daily to the schools in nearby villages (by sharing costs for renting a vehicle or using family motorcycles), girls discontinued their schooling after primary level. This was similar for the Mardan inland A1 location which only has government primary, middle and high schools for boys. While girls can study at the boys' primary school, they are not allowed by their parents to continue their education along with boys and parents were reluctant to send their daughters to schools in other villages.

The Nowshera hill location, which is the least poor of our villages (see section 3.2), does not have a government high school for girls. Some girls here told us they rented a village taxi to go to the high school in a town 15 kilometres away. The taxi charged PKR 1,000/month/girl and was shared by eight of them. A few fathers here told us about the decreasing enrolment in the government girls' middle school and worried that the school would have to close down if enrolment rates did not pick up. They explained that in 2012 a new tribe from areas bordering Afghanistan had settled near the village and they did not believe in formal education for their girls and were encouraging locals to take their girls out of school and send them to *madrassas* (Islamic religious school) instead.

In contrast to RCA studies in other countries which have noted that health options are typically limited in villages, men and women across locations told us and we observed a huge range of informal and formal choices available for people's health needs either in or nearby the village or in the district towns. People told us that health service providers were often close by and choices were made based on practicality, nature of illnesses, facilities available and level of trust upon the service provider (discussed further in section 3.4). Table 3 shows the different health options noted by families in each location.

In all villages except Sahiwal near, families told us that there was a Basic Health Unit[5] (BHU), which people referred to as either *chota hospital*, *haspatal* or *sarkari hospital*[6]. In Sahiwal near, people described a government '*dispensary*' near the Union Council which had '*doctors and gave medicines for fever*' [7](women neighbours, Sahiwal near). While a few people in Nowshera hill had heard that the BHU was going to be upgraded to a Rural Health Centre[8] (RHC)

5 The Basic Health Unit (BHU) is located at a Union Council and serves a catchment population of up to 25,000. Services provided at BHU are promotive, preventive, curative and referral. Outreach/community based services are part of package provided by the BHU. In addition, BHU are supposed to provide free medicines and treat minor injuries (cleaning wounds or those requiring minor stitches).
6 Variations in terminology for a small government hospital.
7 As the researchers did not visit this 'dispensary' it cannot be said for certain if this was a BHU.
8 Rural Health Centre, The RHCs have 10-20 in-patients beds and each serves a catchment population of up to 100,000 people. The RHC provides promotive, preventive, curative, diagnostics and referral services along with in-patient services. The RHC also provides clinical, logistical and managerial support to the BHUs.

Table 2: Access to government services

Locations	Services							
	Union Council office	Schools						Basic Health Unit
		Boys			Girls			
		Primary	Middle	High	Primary	Middle	High	
Mardan inland (A1)	□	○	○	○	○	□	□	○
Mardan inland (A2)	□	○	○	○	○	○	○	○
Mardan hill (B)	○	○	○	○	○	○	○	○
Nowshera river (C1)	○	○	○	○	○	○	○	○
Nowshera river (C2)	○	○	○	○	○	○	○	○
Nowshera hill (D)	□	○	○	○	○	○	□	○
Sahiwal near (E1)	○	□	△	△	□	△	△	○
Sahiwal near (E2)	○	□	△	△	□	△	△	○
Sahiwal far (F)	○	○	○	○	○	○	○	○
Layyah desert (G)	□	○	□	□	○	□	□	□
Layyah inland (H)	○	○	□	□	○	□	□	○

○ In or within 5km from village
□ More than 5km from village
△ Not mentioned

Table 3: Availability of health service providers

Locations	Private and non-government services													Government services			
	Home remedies	Shrines	Traditional healers	Spiritual healers	Hakim	Barber shop	Medical practitioner/'*chota doctor*'	Traditional birth attendant	Private clinic	Medical store	Private hospital	Cancer hospital	NGO hospital	Basic Health Unit	Lady health workers	Public hospital	1122 rescue call
Mardan inland (A1, A2)	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Mardan hill (B)	✓		✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Nowshera river (C1, C2)	✓	✓	✓	✓			✓	✓	✓	✓	✓			✓	✓	✓	✓
Nowshera hill (D)	✓	✓	✓	✓			✓	✓	✓	✓	✓			✓		✓	
Sahiwal near (E1, E2)	✓	✓		✓	✓		✓	✓	✓	✓	✓			✓		✓	✓
Sahiwal far (F)	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓			✓		✓	✓
Layyah desert (G)	✓						✓	✓	✓	✓	✓			✓		✓	
Layyah inland (H)	✓						✓	✓	✓	✓	✓			✓	✓	✓	

and said this meant '*being able to stay in the BHU at night, if needed*', the BHU staff in both the Layyah locations and Sahiwal far mentioned they provided 24/7 maternity facilities and had ambulances. People typically told us the BHU charged a consultation fee of PKR 10 and did 'check-ups' (fever, blood pressure).

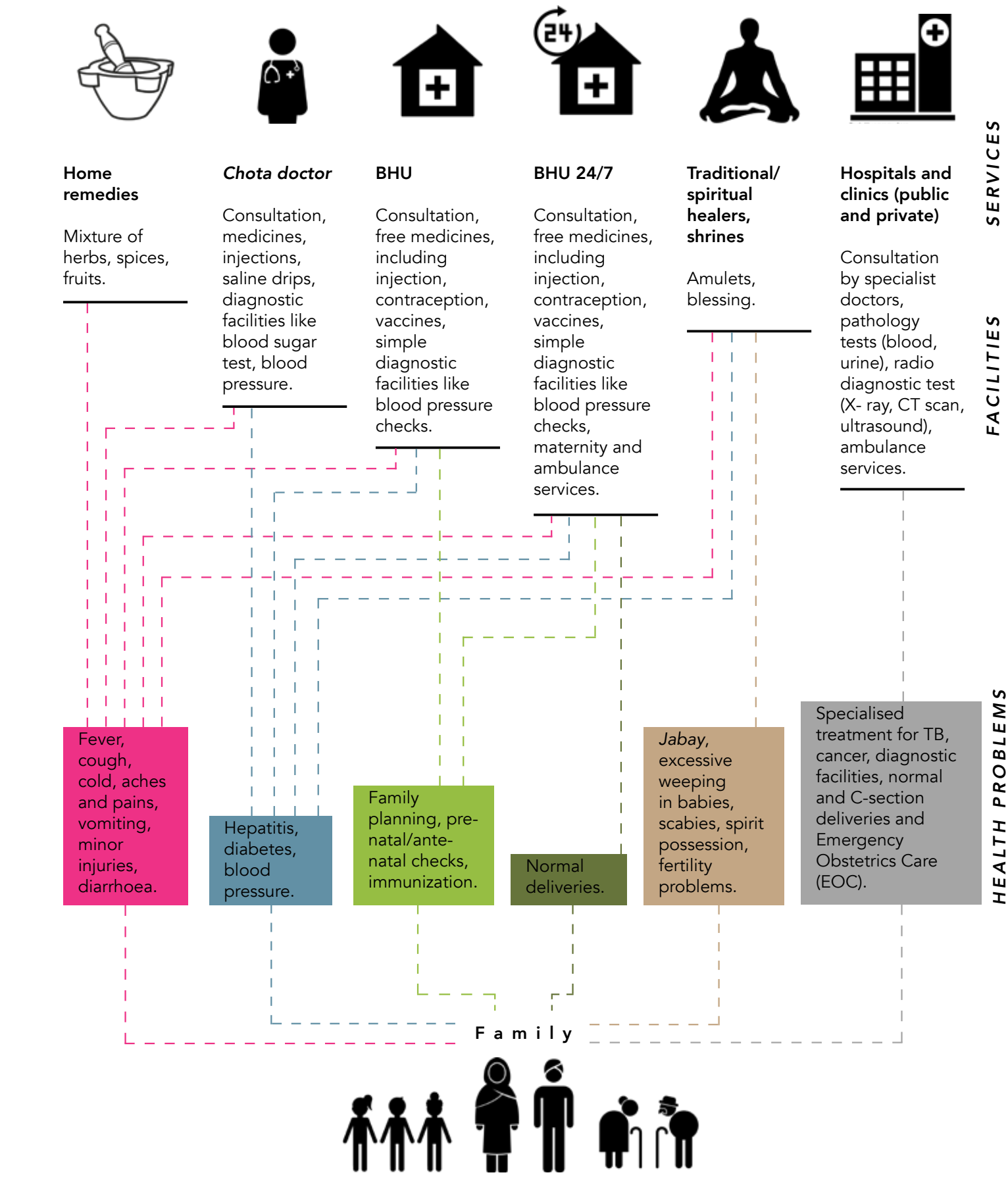
All study locations also had government or private hospitals and clinics within one hour driving distance. People usually referred to these as '*bada haspatal*' (big hospital), and made distinctions between the '*sarkari*' (government) and private ones. The government hospitals[9] were located at the *tehsil* and district headquarters and '*specialist doctors*' for different illnesses and also diagnostic facilities like blood tests, X-ray, among others. People who visited these hospitals had to pay a registration fee of PKR 10-20 while rest of the consultation was free. While the private hospitals and clinics were also largely located at the *tehsil* and district, people in only a few locations had these nearby. Unlike the government hospitals, private hospitals charged a fee for consultations (between PKR 500-1000). People said the private hospitals and clinics also had '*specialist doctors*' to treat specific ailments.

Private medical practitioners (in all cases male) who were referred to as *chota doctors,* were generally available in all of the villages, relatively more in the Punjab locations. While in some cases these *chota doctors* were compounders, dispensers or pharmacists by training, in other cases they had not received any formal training. People typically do not distinguish between the trained and untrained providers and would go to either. While people in Nowshera river told us they knew these men were '*not real doctors*' with MBBS[10] degrees, one of the two *chota doctors* in Sahiwal near E1 had failed his Diploma in Pharmacy and another, people said was currently doing a Diploma in Pharmacy. In all our study locations these men either made house calls or had a small medicine shop or clinic in the village or nearby which sold medicines, injections and provided basic diagnostic services such as blood pressure and blood sugar testing (Mardan hill). In Layyah inland, people visited a *chota doctor* in the market three kilometres away as this was the only village where there was no resident medical practitioner or *chota doctor.*

Belief in alternative healing was strong in all but the Layyah locations, with all the other villages having traditional/spiritual healers or *hakim* (practitioner of

9 The Tehsil Head Quarter (THQ) and District Head Quarter (DHQ) hospitals are secondary health care level in Pakistan, serving a population of 0.5 to 1.0 million and 1 to 3 million, respectively. These hospitals provide promotive, preventive, curative, diagnostics, in patients, referral services, specialist care and are also supposed to provide basic and comprehensive Emergency Obstetric and New born Care (EmONC). These hospitals provide referral care to the patients including those referred by the Rural Health Centers, Basic Health Units, Lady Health Workers and other primary care facilities.

10 Bachelor of Medicine, Bachelor of Surgery, professional degree awarded upon graduation from medical schools.



Graphic 1: Where people go for health services

A solar panel in Layyah desert. One solar panel of this size costs PKR 6,000 and buying an inverter and batteries would cost extra (PKR 2,000 for inverter and PKR 6-12,000 for batteries depending on capacity).

Unani medicine) that people went to with their health issues. These healers were commonly available in and around the village, but families also often visited healers in other districts for specific health problems. (discussed below in section 3.4).

People also told us that they had government 'polio teams' visit their village from time to time and in the Layyah inland and Nowshera hill locations announcements were made from the mosque to inform people about these teams' arrival. In Sahiwal near, families said a motorcycle with a loudspeaker would go around the village to tell people that a visiting team of polio workers were in the village. Here people also told us that for the past five years a team of women workers had been coming to the village to vaccinate children and adults against chicken pox and another team of eye doctors came frequently. In Mardan inland, Nowshera river, Layyah inland, people told us there were Lady Health Workers (LHW) who came to visit and advise women on family planning.

Access: Facilities

All locations except Layyah desert have metered electricity but people complained about the constant electricity load-shedding. This included load-shedding five to six times a day (Sahiwal far and Layyah inland), plus power cuts of over five hours a day in both villages in Nowshera river. People here expressed frustration saying that even with five hours of load shedding, they are still paying very high electricity bills. In Layyah desert families are using solar panels for electricity but only to charge mobile phones or operate fans during the day. Even with the solar panels, the village is dark at night as buying batteries and inverters (for converting current) costs extra (see photo).

With the exception of Mardan hill and Nowshera river locations, none of the other villages have pipeline gas supply. People either buy gas cylinders (Mardan inland) or use firewood for cooking (Layyah) or a mix of both.

Water for drinking and washing in all locations was usually through communal tube-wells, spring wells or private hand-pumps in people's homes. Overall, people did not complain about the quantity or quality of water. The exception to this was Nowshera hill, where people told us the spring wells dried up during long summers, and in Mardan hill where people said the tube-well water was '*bitter and undrinkable.*' There was at least one mobile network coverage in all of our study locations.

All of the study locations have small shops that sell packet food, cold carbonated or fruit drinks, and household items. Some villages also have shops selling local snacks, vegetables, cosmetics and clothes. Two shops in both Layyah locations, which have no electricity (Layyah desert) or unsteady supply (Layyah inland), kept huge blocks of ice in their freezers to keep their drinks cold. The shop in Layyah desert would have blocks of ice delivered

each day from a town 25 kilometres away. A few of our villages also have larger markets nearby which sold a larger variety of items including clothes and household utensils. The Sahiwal locations also have weekly markets where people bought household items and clothes.

Living situation and livelihoods

With the exception of the Nowshera locations, families either lived in mud, concrete or part-concrete houses within family compounds, usually including a boundary wall. People either built these houses on their own land, or rented houses as tenants on land owned by landlords. In the Nowshera hill location, the houses are made of stones and slate mined from the nearby quarry. Here, boundary walls are particularly tall, not allowing a view of the house inside. All of the houses in both the Nowshera river locations are made of bricks. People here told us the '*shape of the village had changed*' after the big flood of 2010 which caused '*a massive destruction*' to the mud homes, fields and livestock, requiring them to rebuild (see box 1).

Men, in all but the Nowshera hill location, regarded themselves as farmers and they either farmed their own land, or worked as tenant farmers on the landlord's land. Tenancy arrangements varied within and between locations. Some families pay rent yearly (for example, PKR 40,000/ acre land in Sahiwal near E2) while others practice sharecropping, either keeping just a portion of the harvest (Sahiwal far, Mardan inland) or half of what is harvested (Layyah inland). Farmers grow a variety of food grains (wheat, maize), vegetables (okra, gourd, bitter gourd, chickpeas, cucumber), fruit (watermelon, sugarcane, orange, mango) and cotton with wheat being grown across all locations. People everywhere told us that the produce is primarily for own consumption and they only sold surplus on an irregular and small scale.

Unlike other locations, men in Nowshera hill, told us they largely supported their families by working as waged labourers on the nearby slate quarry. A few men here had businesses where they hired others from the village to mine slate and then sold the slate slabs in the towns nearby. Families here told us that people had been mining the quarry freely until four months ago when, a committee had been formed of locals from the village to oversee this practice (see box 2).

Retention wall being built to mitigate future floods in Nowshera river.

People generate income from sale of artefacts in Mardan hill. 'Every family here has at least one artefact kept in their home' (Mother).

Box 1: The 'big' flood led to development

I was told there had been many floods in the village, but none had caused devastation of the scale caused by the big flood of 2010. The whole village had submerged under water that came '*up to the roof*' and was '*over 10 feet*' and swept away their mud houses. Men and women referred to most events and incidents in the village as having occurred 'before' or 'after' the big flood. We talked with many people who told us that the flood had been *'good for us'*. They said '*development had started* (in the village)' after the flood when NGOs had started coming in. Many men talked about an international non-government organisation (INGO) that had helped to build one-room brick shelters and toilets for 283 families and some women had heard that families had received PKR 70,000 to build these shelters while they temporarily lived in tents. The shelters had been built using local labourers who had been paid double the local daily wage. These homes now have extensions that families had added later. Another NGO installed hand pumps, tube wells, two water filtration systems for clean drinking water and drainage systems. Another had provided four solar street lights- all of which were outside the *Nazim's* (Union Council Chairman) house. Some people were given hybrid seeds and fertilisers and others were given 'hygiene training'. The NGOs had all left now.

We saw a retention wall under construction on the banks of the river to mitigate future floods. People told us that the provincial government was spending PKR 800 million on the wall, which they knew from the different signboards around the village. People said they are happy now, because this wall is being built and because their village is developing.

Field notes, Nowshera river

In some locations men and women explained that they supplement their farming income with a variety of other sources. In Layyah desert, many men between the ages of 16-45 migrate seasonally to work as construction workers in a town three hours away. These men told us they *'went to the town every winter* (when there was no planting or harvest), *worked for a month, came back home to rest for 10 days and went back again'*. They explained that they worked in building construction and were paid PKR 550/day and were provided living quarters in partially constructed buildings. Families of these men shared that they used most of the money earned to buy fertilisers, seeds and to pay for labour at harvesting.

The Mardan hill location had developed around the remains of a Buddhist archaeological site. People here indicated that they could still find artefacts and coins there. One of our household mothers shared that she had found a gold coin 22 years ago and her family had sold it for PKR 95,000. Many people here had also been excavating and selling the artefacts illegally for years. Others told us about a few '*richer families'* who hired '*professional diggers'* who came with metal detectors and charged these families about PKR 2-3,000/hour to look for coins and other objects.

In Sahiwal near E1, many families brew, drink and sell alcohol made from wheat and a variety of fruits, which they call '*kacchi sharab'*. A few people here shared that the alcohol is usually made at night or early morning and taken to Sahiwal city to sell. This is sold in imported scotch whiskey bottles and while a three-month old alcohol bottle cost PKR 500, fresh alcohol is sold for PKR 100. Some expressed concern regarding this telling us about the 16 young men who had died in the past three months after drinking the alcohol which one women said was made using '*bad wheat husk, rotten watermelons and lots of chemicals'*.

Box 2: The mosque committee takes control of village assets

'Did you see the 'mountain' when you came to the village?' asked an old neighbour lady when I sat chatting with the women of the house and neighbourhood. She was referring to the slate quarry and the woods near the village we saw when entering the village. *'It's the property of the mosque now'*, she continued, *'earlier people could cut trees when they wanted, now it's not allowed'.*

A Mosque committee had been formed three months ago for the general upkeep of the mosque. It was also entrusted with *'looking after the trees in the woods'* and keeping the slate mining under check. Before the committee was formed, people from 'our' village and nearby villages would cut trees for personal use (firewood and building) almost daily, but the committee had now put a stop to this. Now people could cut trees only when there was a communal event like a marriage or death for which they needed committee permission. For those who violated this, there was a PKR 2,000 fine.

The committee had also imposed a tax of PKR 500/year for slate mining and a toll of PKR 100 for vehicles that came to transport the slate to nearby market towns. The money is to be used for mosque maintenance and paying the *Imam's* (Islamic religious leader) salary.

Field notes, Nowshera hill

Fewer women were engaged in income generation compared to men with most of these activities based inside homes. The Mardan locations had shops which sold clothes and cosmetics and were run and frequented by women. The shop in Mardan inland A1 sells *suit pieces* (length of material used to make *shalwar kameez*, a traditional outfit worn by women) for double the price compared to the market outside but women still go there as they can '*buy one of my choice'* (Woman). In the Sahiwal locations, a few women keep sewing machines at home and make clothes for women relatives and neighbours, while another woman operated a beauty parlour from her home in Nowshera river C1.

Religion and groups

While people in all our study villages follow Islam, communities were diverse and all had numerous ethnic/caste groups, clans, tribes and ethno-linguistic groups living together in mixed settlements. The ranking

The stone quarry where most men from the village are employed as daily wage earners - Nowshera hill.

done by researchers during preliminary analysis of findings show the locations in Khyber Pakhtunkhwa were generally more religiously strict than Punjab (see figure 4 and box 3), but people everywhere told us they largely existed peacefully with others and conflicts, if any, happened not for religious reasons but often within families over land issues (Mardan inland A2), or when young people from different caste groups eloped (Sahiwal near, Mardan hill). In all three of these locations, these conflicts resulted in someone getting injured or killed. These conflicts, however, were rare and for the most part men told us they went to people from other ethnic/caste groups for advice and help to resolve potential conflicts. Most women told us they did not involve themselves in conflict resolution but left it to the men.

There is at least one mosque in every study location, with the Nowshera river C1 location having, as people told us, at least 15 mosques. These mosques usually run on donations made by the community and some had boxes placed outside for people to make anonymous donations (Nowshera river). Others in the same location associated different mosques with specific caste groups or people like the *Nazim* and explained that the maintenance of the mosque was their responsibility.

Figure 4: Religious strictness

A women researcher used a shuttlecock burqa in Nowshera

Box 3: *'The man must not defecate inside his home'*

I chatted with many men in 'my village' who told me that until 10 years ago the toilets inside the compound of their homes were only used by women and children and all the men in the family either used public toilets inside the mosque or went to the open fields to poo. While some of those I chatted with were still doing this, a few had now built separate toilets for themselves in their homes. They explained to me that the reason for not using the toilet inside their homes was to do with a story they and their fathers/grandfathers before them had heard. In the story a man asked the Prophet about the kind of man he should marry his daughter to, to which the Prophet answered *'the man who does not defecate inside his home- it is a shame if a man defecates inside his own home'*.

Field notes, Nowshera hill

Even though all of the locations have mosques, researchers noted men going to the mosque more frequently in the Nowshera and Mardan locations. Of the seven or eight mosques in Mardan hill, two were being visited regularly while the others held preaching sessions after the night prayers. While all the Sahiwal locations had mosques, researchers did not hear the call to prayer at all during the four days that they were there (Sahiwal near) and did not notice many men going to pray (Sahiwal far and Layyah). Women, on the other hand, did not go to the mosque to pray, except in Sahiwal near E1 where they told us they could go to the mosque '*whenever we want, but we only go during Eid*' (mother).

Women's mobility and purdah

Women, in all except the Sahiwal locations, shared that they rarely left their homes. When they did, this was only after getting permission from the men of the house or mothers-in-law. In all locations, people explained that women typically stayed indoors unless there was a reason for them to be outside. Women in Nowshera hill described the most significant limitations on their mobility (box 6), Women here and in other Khyber Pakhtunkhwa locations told us that when they did go outside, they either used a *shuttlecock burqa* (a *burqa* that completely covers the body as a single piece of cloth with cutwork for the eyes). Women in the Punjab locations however, left their homes more frequently and wore a *dupatta* (a length of material used as a scarf or head covering) to cover their heads, but not their faces (box 5). The exception was Mardan hill, in Khyber Pakhtunkhwa, where women wore *shuttlecock burqa* or *dupatta* (box 4). Table 4 shows the limitations on women's mobility in the different study locations.

With the exception of Mardan hill, we observed that women more commonly worked outside the home in Punjab, either in their families' fields or as labourers on others' land. In Sahiwal near E2 one of our families' daughters worked as a contractor to manage women labourers to work on other people's land during planting and harvest. The daughter was a 34 year-old divorcee and the women she worked with were between 9-30 years old. In Mardan hill many women (around and over 40) and young girls (below 13) worked in their families' fields generally with a male family member.

Like in Mardan hill, women in Layyah inland worked in the fields but with a male relative working alongside or nearby. Researchers here observed that other household chores like fetching water from the communal hand-pumps were usually done by older, married women, while the younger women either remained inside the house or, when outside, were accompanied by a male or children. In Sahiwal far, a daughter from one of our families told us that she did not go to plant cotton because men and women had to work together, but as they planted peas separately from the men that was *'ok'*.

Box 4: Increasing restrictions

I was talking to a neighbour who told me that previously this village was '*more liberal*' where women did not cover their faces when going out. A few years ago a new *madrassa* for girls had started and 'expert' *maulvis* (male religious teachers) from other areas began teaching there. Teaching took place with a curtain between the teacher and the pupils. After the *madrassa* started, more women began wearing the *shuttlecock burqa* and even girls started going to school wearing the *burqa*.

Field notes, Mardan hill

Table 4: Do's and don'ts for women as described by people themselves

Restrictions		Punjab				Khyber Pakhtunkhwa			
		Sahiwal far (F)	Sahiwal near (E1, E2)	Layyah inland (H)	Layyah desert (G)	Mardan hill (B)	Nowshera river (C1, C2)	Mardan inland (A1, A2)	Nowshera hill (D)
Ranking (lowest to highest observance of purdah)		→							
Cannot go to friend's house without permission (Girls)						At times		At times	✓
Cannot go out of the house without permission from men			✓	✓	✓	Can be from mother in law	✓	Can be from mother in law	✓
Cannot go outside the house without covering face						✓	✓	✓	✓
Cannot leave the village without being accompanied by men		✓	✓	✓	✓	✓	✓	✓	✓
Cannot go to market alone			✓	✓	✓	✓	✓	✓	✓
Cannot work in fields or graze animals							✓	✓	✓
Cannot go out freely				✓	✓	✓	✓	✓	✓
Cannot hold jobs outside home								✓	✓
Cannot talk to male strangers/ non-related men	Women					✓	✓	✓	✓
	Girls and young women (13-25)	✓	✓	✓	✓		✓		✓
Cannot watch TV						✓		✓	✓
Cannot use mobile phones						✓		✓	✓
Cannot join community gatherings (festival etc)				✓	✓	✓		✓	✓

'How can women (in the family) demand anything from me? They aren't even allowed to shout in front of me. I provide the food, clothes, everything for them. They cannot raise their voice to me'.

Father, Mardan hill

Across locations men and women told us that certain places like the *hujra*[11] or *dhera*[12] were male-only spaces, excluding women from the social activities that happened there. Some men and women discussed this concern with us in Nowshera river C1, where previously immunization drives by the BHU had happened in the *hujra.* Women told us that there had been an announcement for women and children to come to the *hujra* for tetanus vaccination. However, they did not attend as this space was normally off-limits to them. Consequently, they had not received the vaccination for themselves or their children. Though female polio teams from outside the village were allowed to stay in the *dhera* in Layyah desert, women here also mentioned that they did not typically go there. Many women here shared they had never watched TV as the only televisions in the village were either in the shops or the *dhera*, both of which they did not feel comfortable to go to.

With the exception of Sahiwal far, women in all locations told us they either did not go to the shops in the village or, when they did, there was always someone accompanying them- either a man, child or another woman (see box 8). Seeking services at the BHU or medicine shops in the village too meant that women would go there with another person. One household mother in Mardan hill, who lived alone with her children as her husband worked outside, went with a woman neighbour to the *chota doctor* and the BHU. In other locations researchers met women at the BHU who were accompanied by children who were ill or acting as chaperones (Nowshera river C1) or with older women and husbands (Mardan hill).

Very few women from our study locations had travelled outside of their villages. For those who had, it had been for medical check-ups, emergencies or occasionally visiting relatives. In such cases, men in most locations told us they always accompanied women when going outside the village. One of our families in Sahiwal near E2 was an exception to this when four years ago the eldest daughter who worked as a contractor for women labourers (then 30 years old and divorced) would regularly take her youngest sister (then 9 years old) to Lahore for regular eye treatment. In Layyah desert, while women are permitted to go outside the village to visit hospitals or private clinics accompanied by men, they could not go to the yearly *mela* (fair) in the neighbouring village as it is considered *'inappropriate'* while the rest of the village (men and children) go.

Across locations both men and women have a strong sense of the restrictions that apply to women. Women often shared that they face no problems as long as they adhere to rules (see boxes 7 and 9). People described a failure to adhere to these rules in terms of shame, associating it with dishonouring their families. This was particularly the case when people shared stories of elopements or inter-caste marriages, leading to *'honour killings'*. The common narrative in all the stories people shared with us was that *'the girl had done wrong by dishonouring her family'* and *'girls should not be given so much freedom that they dishonour their families'*

Box 5: Fewer restrictions for women

On my first day in the village, I was surprised to see so many women walking around outside. Compared to the village I had previously been in (Sahiwal near), it seemed more women here were outside their homes; some were going to fetch water from the common tube-well, others were working in the fields. Later one of 'my sisters' told me they often worked alongside male cousins and neighbours in the fields and conversation was generally allowed as long as girls did not initiate it. They would also '*listen to the music they (boys) play when we work together*'.

Over the next few days I saw that women and girls (between 13-18 years old) mostly went to the shops in the village together. The eldest sister in 'my family' (21), who worked as a teacher at the school, said it was also fairly common for a girl to go to the shop, school or Quran classes alone and I noted that they would usually cover their heads with a scarf, with some covering their faces as well. The girls in 'my family' would often go over to their neighbour's home, a house with more men than women, to watch TV soaps and generally spent a lot of time there chatting with their neighbours. 'My sisters' told me that it was common for boys and girls who '*liked each other*' to talk through text messages. Although it was 'not okay' for a girl to express her will to marry a certain boy, if the boy's family approached the girl's with an official proposal they would get engaged.

Field notes, Sahiwal far

11 The *hujra* is especially prevalent in the predominantly Pashtun areas of Pakistan. Pashtun *hujras* are used mainly to entertain male guests in a household, although sometimes community *hujras* are also maintained by tribal units. Other than a place to accommodate collective ceremonies, it is also a place for male members and male guests of the community to hang out and associate like a larger family.
12 Punjabi equivalent of a Pashtun *hujra.*

Box 6: Women-only alleys; men and women researchers different experiences

When we reached the village in the afternoon, we met Nazir who worked as a clerk in a school outside the village. He showed the men in our team around the village and pointed out the different alleys that interconnected throughout the village and explained that there were separate ones for men and women. Women never used the men's alleys. Men might sometimes enter the women's, but only after sending a child to inform women that they would be entering the alley.

While he showed us around the village we saw houses which were enclosed by very tall boundary walls made of stone and slate. There were at least two gates leading out of every house. Nazir told us that the different gates opened up to the men and women alleys – a woman would always use the women's gate to access the women's alley. We noticed that all of the boundary walls had a small opening in them. When we asked about these openings, Nazir explained that these were used by the women of the house to throw out trash so that they would not have to step outside into the open. The trash that was thrown out accumulated in a stone container which was directly under this opening.

Many men told us we should not roam around the village by ourselves as we might lose our way and end up in women-only alleys. We didn't see any women in the first and the second days. On the third day I saw a few women at a distance going into a house where a wedding was happening.

Field notes (men), Nowshera hill

Our four days in the village were mostly spent inside 'our home' or talking to a few neighbourhood women. To go to the neighbours' homes we would use the women's gate out into the alley and enter their homes through another women's gate. Women and girls told us that they moved around in the village and went to the school or BHU, accompanied by other women or children, using the women-only alleys. While they would cover their heads carefully with a *dupatta* when inside the house, stepping out of the house meant they would wear a *burqa.*

The women in 'our family' hardly ever went to the terrace of the house and we did not see other women on their terraces ever. 'Our sister' told us that going to the terrace was permitted, but one had to do *purdah* (cover their heads and face) lest a man see them. While on the terrace with her we saw a man at a distance and our sister said *'we should go down now because our faces are uncovered'.*

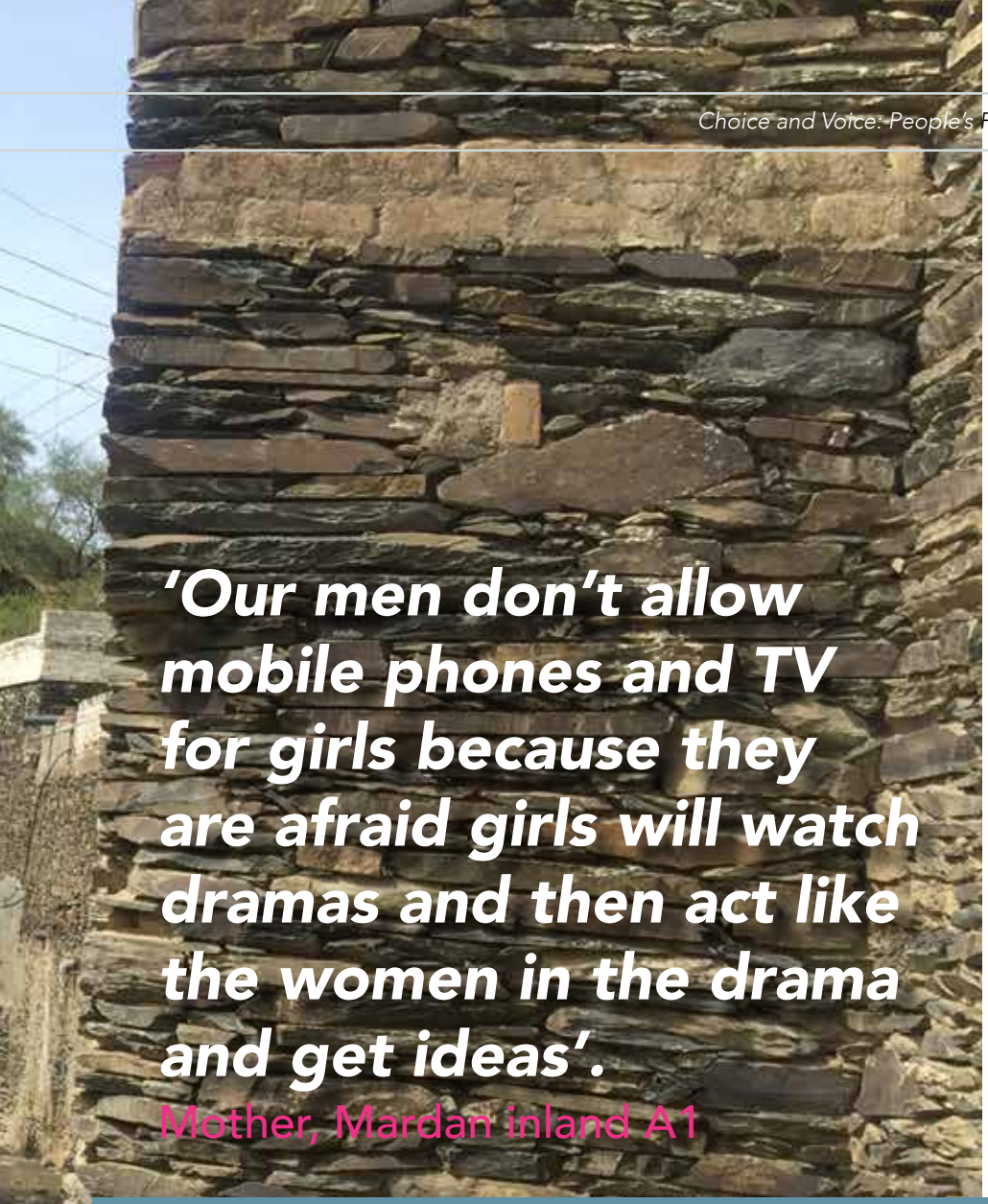
We saw children running between the different alleys and in and out of people's homes all the time. These children were described as 'pigeons' carrying messages and things between homes and people. Most of them were younger than 12 years old- both boys and girls. We noticed that once a girl was around 12, she would not be asked to carry messages around but would spend most of her time inside the house or going to a friend's house.

We met a few girls who were studying at the high school in the town 15 kilometres away and also other girls who hardly ever went out of the village. The girls who studied outside were much more open with us and would discuss clothes and fashion with us and their friends. The ones who didn't go outside the village did not talk about these things.

During our stay there, we never saw any men in the village, not even our household dad. We only saw his photo when the men in the team showed it to us once we left the village.

Field notes (women), Nowshera hill

Separate alleys are used for men and women to walk around the village in Nowshera hill.



'Our men don't allow mobile phones and TV for girls because they are afraid girls will watch dramas and then act like the women in the drama and get ideas'.

Mother, Mardan inland A1

Box 7: Religious education more important for girls

Families in 'our village' prefer to send girls to the different *madrassas* in the village rather than school, not only because these are free, but also as many people told us they don't allow women to have jobs so going to *madrassa* means *'at least they will follow religion properly'*. *Madrassa* teachers told us parents send their daughters there so they will have *'good honour and respect'* for having studied the Quran and making them *'attractive for marriage'*. My household dad is proud that his daughter knows parts of the Quran and was running a *madrassa* inside their home. He never talked about her formal education. He was most proud about her religious education.

Field notes, Mardan inland A2

Box 8: How women shop

The women in 'my family' showed a lot of interest in the clothes I was wearing. One afternoon when we were sitting together, 'my mother' touched the sleeve of my *kameez* (traditional long shirt) and asked me whether I bought my own clothes. When I nodded, all the women sitting there told me that '*everything*'- clothes, jewellery, shoes and makeup- was bought by their husbands or brothers and that they *'had no choice in what we wear'*. They explained that since they hardly ever left the home, once the men had bought the *suit piece* for them, they would send children to the tailor with the material, measurements and pattern. They would never go to the tailor themselves.

Field notes, Nowshera hill

I was sitting inside the house with some women from 'my family' and neighbourhood when the children came running inside carrying plastic tubs and steel bowls. One of the women guessed that it was probably one of the utensil vendors who came to the village frequently. She explained that when the vendors usually came, they would come to the house through the men-only alley and would stand at the men's gate with their wares. The children of the house would then bring in the different kinds of utensils to show to their mothers and other women in the house. Once the women decided what they wanted to keep, they would send the children back out with the wares and the money. None of the women there had ever seen the vendor.

Field notes, Nowshera hill

The shop in 'my village' kept lipstick, nail polish, fancy buttons and laces. The shopkeeper bought them from the city. He told me that the women themselves never came to the shop but sent their children with the *suit piece*. He would then match the buttons and lace to the material and send a few options back with the children. The children would come back to return what the women didn't want and also pay him.

Field Notes, Layyah desert

Box 9: Women researchers' experiences of how villagers view women

The women in 'my family' asked how my husband let me stay away from him for three days and if I needed permission from my (real) family to go out of my home. I told them I had to inform my husband of where I was going so that he would know I was safe. They said to me, *'your life is easy, our life is more difficult because we have to take permission from our husbands for everything'*. They wanted to know how my husband let me stay away from him for three days.

Field notes, Nowshera hill

In 'our *madrassa*' there is a teacher who observed very strict *purdah* and said she never interacted with men outside her family if she could help it. She said my (researcher) husband was a 'good man' to allow me to travel and meet so many people. She thought I was *'quite liberal'*.

Field notes, Mardan inland A1

The grandma in 'my family' told me, *'you should be patient with the things that Allah gives you. There is no need for you to go outside your home and work. You should care much more about your honour'*

Field notes, Mardan inland A1

One man I met in the village told me, *'you are working against your religion. We don't send our girls outside like this'*. One of his sons worked providing water to the pilgrims in Medina. He said, *'my son calls me every day to ask if his sisters stepped outside of the house'*. He pointed to his daughter and said that she had got 800 marks in her Grade 10 exam, but he hadn't allowed her to study further because *'we don't let our women step out of the village'*.

Field notes, Sahiwal far

Women in the village repeatedly told me '*women who go outside the house to work are not considered good'*.

Field notes, Sahiwal far

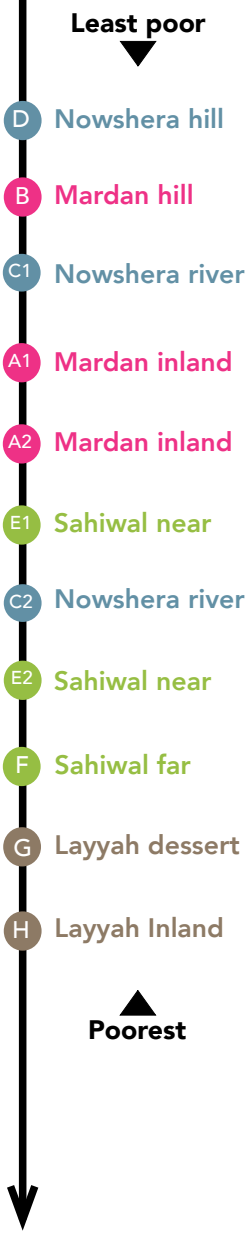
Researchers harvesting wheat together with the host family

The families we stayed with

Of the 25 families we stayed with, 12 are three generational and home to grandparents, parents and children and one family has four generations living in the same house. The rest of the families comprise parents and their children. Two of the families are headed by widows living with their children. Many of our families live on and farm their own land but some live as tenants on other people's land and houses.

All but one family derive their income from two or more sources and apart from four families, all others depend to some extent on agriculture, either farming their own land, working as tenant farmers on others' land (paying yearly rent or sharecropping) or renting out their farmlands to others. Other livelihoods for our families include working as daily-waged labourers, rearing livestock, selling milk, bee-keeping, tailoring, owning and driving taxis and donkey carts, slate mining, car mechanic, blacksmith, teacher, selling cooked snacks and working as clerks in schools. Annex 4 provides more details about the families.

Figure 5: Poverty ranking



3.2. People's perception of poverty

In conversations, people were encouraged to share what they thought was 'being poor' with the intention to understand families' perception of their own poverty and how this affects their lives and the choices they make. While not all those we chatted with felt that they themselves were '*poor*', people across locations use certain common indicators when talking about poverty. During preliminary analysis of the findings, the study team ranked all 11 study locations from poorest to least poor using these emic indicators of poverty as follows (figure 5).

The first six points are related to individual and family poverty whereas the last relates more to public poverty (access and services).

- Not owning farming land and house
- Engaged in '*hard work*' like farming, not having a stable job with monthly income
- Having no or less cash income
- Having less people who can work in the family and limited or one livelihood source
- Having debts
- Having no political networks or connection
- Less access to transport and public facilities like BHU, hospitals, schools (in terms of cost, distance, service availability)

Being poor is ...not owning farming land and house

Across locations, people determined whether the family was rich or poor by the land they owned. People often talked about themselves as being poor because *'we are living on the land of others'* (Mother, Mardan inland A1),*'we don't have enough land'* (farmer, Layyah inland) and '*even if we have land, it is very small'* (Father, Layyah inland). In all locations, families agreed that those who did not have any land at all were the '*poorest'*.

'Having land means you can grow your own crops, you can be independent'.

Father, Sahiwal far

People shared with us that they felt 'better off' by having their own land and that '*it was better to have one's own land than to work on others'* (as tenant farmers)' (Father, Mardan hill) and *'the poor worked on other people's land, not the rich'* (young girls, Sahiwal near E2). Working as a tenant on a landlord's land meant they would either have to '*give him a portion of the harvest'* or pay a sum to him yearly, both of which did not benefit them.

'If we have land then we are less poor. Right now we are poor. We are powerless as we have no land'.

Father, Sahiwal near E2

People explained that the decision to grow a crop, although supposed to be a joint one, would be more influenced by the landlord and as one woman told us '*we are rich because we have orange trees in our field; people who don't have fields, don't have orange trees because they work on others' lands'* (Sahiwal near E1).

Men and women would most often tell us that the landlords were the '*richest person'* in villages because their family owned most of the land and '*ordinary people like us'* either rented land from them or worked on their lands. These landlords were commonly referred to as *Khan*[13] in Khyber Pakhtunkhwa and *Numbardar*[14] or *Sardar* in Punjab. In Nowshera river C2, where most men we met were tenants on the landlord's land told us '*he is even more powerful than the Nazim because he has land and is rich'*. Although people seemed cautious in talking about their landlords for the fear of being evicted, a few men here told us *'everyone in the village was under Khan's* (landlord) *control because he has all the land'*. Others explained that because the landlord owned most of the land, he was also a very powerful person. In Mardan hill men shared that landlords also had a say in whom the tenants should marry their daughters to and '*they could not refuse the landlord's choice'*. In Sahiwal far, where the *Numbardar* had families evicted from where they lived on his land, people told us they lived in constant fear of this happening to them again. One of our families here had been evicted and had to move to a different part of the village a few times already. They felt that people in the village did not want to live next to them as they were from a lower caste and they were routinely evicted because their neighbours would pressure the landlord to make them leave the area.

Being poor is...being engaged in 'hard work' and not in a stable waged job

Families often described being or not being poor in terms of the work that they did. Across locations men and women told us that those with stable jobs (usually jobs like lawyers, doctors, teachers, clerks)

13 A title and family name, but also being used to refer to landlords in some places in Khyber Pakhtunkhwa.

14 *Numbardar* is a title which applies to powerful families of landlords of the village or town, a state-privileged status which is hereditary and has wide ranging governmental powers: the policing authority of the village, and many other governmental and administrative perks.

were less poor than them as '*their life is easier*' and '*they earned well*'. Those families in the village who had members working in government jobs were the ones that were '*doing well for themselves*' and a household mother in Sahiwal far who was looking for suitors for her daughter explained that she wanted a son-in-law with a government job because *'one can retire with a pension'*.

The Nowshera hill location, which from our ranking is the least poor, has many houses abandoned by families that could afford to move elsewhere. People told us that of the 500 families that lived there originally, 100-150 families had moved out to nearby towns or Islamabad (2 hours' drive) where many of the men worked as doctors and lawyers. As the majority of the families remaining in the village were relatives, men explained that those who had left would send money, donate notebooks to the school and send food items for the village during Ramadan.

Having one's own business also means that a person was better off than others in the village. People explained these 'businesses' as typically that of middlemen who traded outside of the village. In the Mardan hill location those who worked as middlemen to sell artefacts and coins that villagers dug up were said to be rich as they usually traded in Islamabad (about 2 hours' drive) and *'made money from this'*. These men had '*bungalows and cars*' and were richer than the rest of the village. In Nowshera hill, the middlemen who exported slate to nearby towns were thought to be better off by others. One of these men supplied slate slabs to make graves and tombstones and people told us it was a '*profitable business*' where he sold one slab for PKR 1,000-1,500.

People feel that they or someone else was poor when they have to work as a daily labourers either on other people's fields, working in nearby towns as unskilled labourers or pulling donkey carts for transporting people and goods (see box 10). This is most commonly related with the fact that these families did not have their own land or were not in the position to be tenant farmers and people share that more often than not that these were the ones '*who did not have enough to eat*' (Nowshera river C1).

'We are poor, no one is poorer than us. My sons don't have jobs, they go for daily wages'.

Mother, Mardan inland A1

'Poor people are those working in the fields. They take care of other people's animals, work on their land or in their homes for money or clothes'.

Mother, Mardan hill

Box 10: The rich don't work in the fields

The eldest sister in 'my family' was a contractor who collected women workers to work in other people's fields. Her 12 year-old sister was also a part of that crew. Every time we went to work in the field, she would cover her face up with a *dupatta* and keep it wrapped up even while she was working. On the second day I laughingly asked her if it was because she feared she would become dark by working under the sun all day. She said she kept her face covered *'so people wouldn't recognize me'*. She said women from richer families did not work in the fields, only poorer women did because '*poor families like us don't own land*'. She worked with her sister's crew to earn money which she used to buy snacks and other school things.

Field notes, Sahiwal near

Being poor is .....having no or less cash income

People in all but the Nowshera hill location told us they are poor because they farmed for their own consumption and, unless they sold some of the surplus, typically do not have any cash. In Layyah inland, which is the poorest of the study locations, families depend on farming and are tenants who live and work on the landlords' lands. Here, people shared that cash was usually '*hard to come by*' as most of what they farm is kept for the family. Men told us they often gave the barber a sack of wheat (50 kilograms) in return for a year's worth of haircuts, as they could not pay in cash. Others here told us families would also give food grains to workers who repaired their houses as they were short of cash.

With the exception of Nowshera hill and two Mardan locations, we did not hear about people migrating abroad for work. In Mardan inland A1 people told us that some men from the village are working in Dubai and send remittances regularly to their families. These families were said to be '*doing better than others*'. Families in the Mardan hill location too have men living and working abroad and one particularly affluent family was said to have a brother working in the United Kingdom who is seen as a role model for many young men who want to go abroad to work. Another young man we met here showed us a pair of sunglasses his uncle had sent him from the UK which cost PKR 40,000. While there were no families that had migrant workers in Sahiwal far, we were told of the neighbouring village where *'families had health insurance because their children were in the US, UK and Saudi and sent remittances'.* People told us about and we saw a money transfer service along the main road near the neighbouring village.

Being poor is....having fewer people who can work in the family and limited or one livelihood source

Having more people in the family who could work is also considered an advantage. Families in Nowshera and Mardan inland locations told us they were '*lucky*' because they had able-bodied men who work in the fields. In the Sahiwal, Layyah and Mardan hill locations, people shared that having women in the house too '*was good*' as they are not just responsible for household chores but also helped the family in the fields (see box 11).

Others referred to families who had men with physical or mental disabilities as '*poor*'. These men could not support their families by working and their families were described as '*unfortunate'.* By contrast, in Layyah

Women's income generating activities. A neighbour's daughter makes clothes for the family and neighbours in Sahiwal near (top); a beauty parlour run by a woman in Nowshera river (bottom) and women working in the fields in Mardan hill (top right).

'We are poor, no one listens to us. The government doesn't pay attention to us'.

Grandfather, Layyah inland

desert where there has been a long time practice for young men to go to the nearby town every winter as daily waged construction workers, their families were considered better off. Mothers told us that parents waited for their sons to turn 16 so they could go away to earn additional cash income to augment the livelihood from farming.

Being poor is …. being indebted

Families who had taken loans from relatives or neighbours particularly felt that they were poor as they were '*now indebted to them*' and told us it was a '*burden that we have to pay off*'. Loans are usually taken by families for buying land or medical treatment and, more often than not, are large sums of money. One of our families in Sahiwal near had taken a loan of PKR 10 million to buy land and had also bought hybrid seeds from a travelling vendor. When the seeds did not have a good yield, the family had to sell off most of their land to pay off the debt and were now *'back where we started..poor'*. Another family in Mardan hill had pawned their relative's gold jewellery to pay for their son's travel expenses to Saudi Arabia. The son had not found a job for six months now and family was worried about getting back their relative's jewellery.

Being poor is….not having political networks and connections

People connected being rich to having networks or '*being powerful*' explaining that those who have networks with '*rich people*' or '*men with power*' often benefit from these connections. In Layyah desert people told us about '*the richest man in the village*' who had received a tractor and plough under a government scheme for poor farmers (see box 12). Most were frustrated that even though '*he had more land than anyone else*' resources that came to the village went to him because of which '*he was getting richer*'. In Mardan inland A2, people told us about the *Imam* who was not a rich person but very powerful. He knew *'people outside the village'* and led protests against blasphemy. Men told us they had gone to some of these protests because he had told them they were '*doing their duty to Allah* (by protesting against those who committed blasphemy) *and would be rewarded in Heaven'*.

For some people being poor meant being neglected by the government and not having a say over basic services and facilities. In Layyah inland, families on one side of the village considered themselves '*neglected*' because the government irrigation

Box 11: *'We are farmers, we need children'*

'My father' who had four children said he wanted more children and he and his wife did not practice family planning. He told me, *'we are farmers, we need children'* to help in the fields and do other work. He said he wanted boys, but having girls also didn't matter because they *'milk cows, graze animals and cut grass'.*

Field notes, Layyah inland

Box 12: The rich use their contacts

The grandfather of 'my family' *Baba ji* told me about the time there was a government scheme in the village to provide tractors and ploughs to two poor farmers in the village. When the two richest men of the village received the tractors and ploughs there was some discontent among people. *Baba ji* went to one of the men and asked him why he had received the tractor when there were families that were poorer than him, to which he replied, *'the computer picked my name'.* While telling me about this incident, *Baba ji* remarked to me, '*the computer is intelligent, it also knows how to pick rich people'.*

Field notes, Layyah desert

scheme only supplied water to the fields on the other side of the village. While the families who had fields on the irrigated side got a good harvest each year and became richer, others had to either make do with rain-fed fields or paid to use pumps to irrigate their fields. A few men told us that the irrigation canal could be re-routed to their side of the village, but as they did not have '*good contacts with politicians we cannot get water to our side'.*

Being poor is…less access to transport and public facilities

People sometimes described their communities as being '*poor*' because of difficulty in accessing government services like BHUs, hospitals or schools as these were farther away from their villages. Families explained that unlike people who lived in the cities and have '*services at their doors*', they often had to travel long distances for school, health services and big markets. Additionally, few people told us they felt '*vulnerable*' taking public transport on the main road or motorway as they could not read. Most public transport have their destinations written on them but they would often flag down every passing bus and get yelled at by bus conductors for '*stopping the bus without reading where it is going*'. Others in Layyah desert, where the nearest BHU and government hospital were 25 and 40 kilometres respectively, shared that they felt '*ignored*' because these services were far.

Families shared that going to government and private hospitals or clinics, which were often located outside the village, also required additional costs for transport, which they did not have. While in most locations people could travel to the main road on a motorcycle- rickshaw or a donkey cart and take a public bus from there, people said they rented vehicles in times of emergency as public transport was unreliable. These rented vehicles charged money depending on the distance and cost extra if they were required to wait.

3.3 People's views on '*being healthy*'

In order to understand our families' and communities' health-seeking behaviour, it was important for us to grasp what people mean when they say they were healthy or ill. While men and women would at times find it difficult to describe what 'being healthy' meant, researchers encouraged them to share what they thought was not healthy. People frequently related 'not being healthy' to what they eat, illnesses, medicine use and working habits. Often families could not say exactly why they practiced certain habits or behaviours that they thought were 'healthy', but told us these had been followed for a long time. Typically people did not differentiate between what was 'healthy' for adult men and women, but women would often make distinctions for when they were pregnant and parents shared what they thought was healthy for babies and children. The following summarises the main perceptions of 'being healthy'.

Families like eating freshly cooked food. People feel what they eat is healthy as everything is grown by them.

Being healthy is ….eating well

Across locations, people relate being healthy to the type and amount of food they consume. Families we stayed with routinely ate *naan*, *roti* and *paratha* (types of bread made from different kinds of flour) with vegetables and lentils at least twice a day, but many people we met thought meat, chicken and fruit were healthy foods and '*needed for children to grow*'. Some of our families kept chickens, but except for one family in Mardan hill who have a poultry farm and said they prepared chicken for guests, others told us they kept poultry only for the eggs which families either eat or sell to the local shops or neighbours. Echoing others, a father told us, *'the only time we eat our chickens is when I (or someone else in the family) am ill, or if the chicken is ill'*.

Eating freshly cooked food was thought to be healthy and most people told us they made fresh food every day and tried to limit eating leftovers. Many people also thought what they ate was healthy as it is grown by them and, like many others, a daughter from one of our families told us that city food was '*unhealthy because people add chemicals in food*'.

Mothers told us that being healthy means eating well and *'if a child can eat roti and eat well, he is healthy; a sick person can't eat food'* (Mother, Mardan hill). Others like one mother in Layyah desert shared that being healthy was eating more food and told us the son of the richest man in the village was the healthiest because *'the family has more land, so they grow more food and eat more than the rest of us'.* Some of our families would insist that we eat an extra *roti* or *naan* because we were working in the fields with them and mothers would tell us they themselves ate a lot of *roti which was made from wheat flour* as *'we do a lot of hard work in the fields, that is why wheat is needed*' (Sahiwal near E2).

Many parents we chatted with shared that their children had increasingly begun to snack on '*unhealthy*' packet chips and *namkeens* (traditional savoury snack) and pestered them all the time for money to buy these from the local shops (see box

13).[15] A few parents, like a father in Mardan hill, were frustrated at this and said the '*shopkeepers have spoilt our kids*' and one mother in Layyah desert complained about her 10 year-old daughter being unhealthy because she only eats biscuits and chips. This family had one chicken that lay only one egg each day and the mother told us this egg was given to the daughter because she did not eat anything else that was 'healthy'.As discussed in section 3.1, shops, even in villages without electricity, had freezers to keep bottled drinks cold and researchers noted a lot of children drinking these cold drinks. One mother in Mardan hill told us her two year-old daughter could drink almost half of the litre bottle of Pepsi and '*it made her happy*' (see box 14).

Across locations researchers noted that families took 2-3 spoons full of sugar in their drinks and in Sahiwal near were also taking sugar with rice and *roti* in between meals. People here told us they did this because sugar gave them energy to work in the fields. Similarly, while men and also women (only in Sahiwal near) smoke cigarettes, *hukka* (an instrument for smoking tobacco) and chew tobacco, no one thought it was unhealthy except for one man in Layyah desert who said '*why quit now when I will just die soon?'*.

Being healthy is…. keeping active

Being able to work as usual was another thing people said that keeps them healthy. People constantly shared that keeping a routine lifestyle meant that a person is healthy and many women we chatted with considered themselves healthy because they do chores everyday. Similar to this, people in Layyah desert refer to one of our household grandfathers (in his late 60s and suffering from a lung ailment) as an '*active man*' who sits in his *dhera* every day and listens to people's problems, while men everywhere else told us working in the fields and rearing cattle keeps them healthy.

'Those who are not lazy are healthy'

Father, Mardan hill

Women in particular also felt that being thin was healthy and told us people became fat because they did not do any physical work. One mother in Mardan hill explained to us that being fat was unhealthy because *'fat people get short of breath and cannot work'* whereas she herself was thin and '*can do all the work around the house*'. Girls in Sahiwal far compared themselves to girls in the city whom they thought *'were fat because they did not work outside* (in the fields), *while we are thin and healthy'*.

15 This 'snacking culture' has also been highlighted by other RCA studies in Bangladesh, Indonesia and Nepal.
Listening to Poor People's Realities about Primary Healthcare and Primary education, Bangladesh 2007-2012.
Reality Check Approach Midline Report for DFID Nepal Rural Access Programme (RAP 3), Monitoring, Evaluation and Learning Component, Nepal 2016.
Children and Their Families Perspectives and Experiences on Poverty and Social Protection, Indonesia 2017.

Box 13: Money for snacks

One afternoon we were sitting with our neighbour who has three children. Our conversation was interrupted every 20-30 minutes when one of her children would come demanding money for packet chips or biscuits which they bought at a shop nearby. They cried when she refused and continued crying till she gave them some money. She told us she spent about PKR 20-50 each day on snacks for the children.

Field notes, Nowshera hill

Packet snacks and cold drink sachets in a shop in Layyah inland. Parents are giving pocket money to children regularly to buy snacks in all locations.

'If you are not hospitalised then you are healthy'.

Man, Sahiwal near E1

Being unhealthy is...having to take medicines

Many people told us that one was healthy if they were not taking 'tablets'. These 'tablets' were often wide-ranging from *taqat ki goliyan* (tablets that give one strength) to painkillers and medicines for diabetes and blood pressure. While many people felt that those who had to take medicines regularly were not healthy, a few told us even taking medicines for headaches was unhealthy. Others believed that a person was unhealthy if they had to go to the hospital and one young girl in Sahiwal near E2 told us she was healthy '*because all I have is a toothache for which I never have to take medicines or go to the hospital'*.

Box 14: Knowledge and practice

My household ma told me that her aunt had died because of complications arising from diabetes. She said '*eating a lot of sugar*' was a reason diabetes happened but while I was there in the house I saw her give toffees and Pepsi to her 2 year-old daughter all the time.

Field notes, Mardan hill

People's views of 'being ill'

Across locations, people constantly linked being ill to long-standing conditions like diabetes (commonly referred to as '*sugar*') or high blood pressure (which they referred to as 'BP') for which people consulted someone or took regular medicines. These and other diseases like cancer, heart diseases, tuberculosis (TB) and hepatitis, which they referred to by these medical names, people said, were '*serious conditions*' and not like fever, cough or joint and muscular pains that happened because they were '*farmers who worked all day*'.

In locations except Layyah desert, we met men and women who told us they were 'ill' as they had diabetes and were taking regular medication and blood tests every 2-3 months. Some people attributed diabetes to their diet, with one household father in Mardan hill telling us his wife had '*sugar* (diabetes)…*because she is a woman, she eats everything, everywhere'*, and another father told us his diabetes was '*hereditary.'* While a shopkeeper here explained that *'earlier people worked very hard- now they don't work, just sit and eat'*, people in other locations did not mention any link between the disease and their eating (as discussed above like taking lots of sugar with their drinks) or lifestyle.

Most people with high blood pressure told us they took regular medication and checked their blood pressure regularly. With the exception of one family in Nowshera river C1, who used less salt in their food and made *naan* without salt because the father has high blood pressure '*from always shouting loudly across the fields'*, no one else was taking other precautions. People told us more than one person in their family had '*sugar'* or *'BP'* and the cost for their medicines and tests would come to about PKR 1,000-1,500/ month. Families either went to the *chota doctor's* shop in the village, or to the pharmacies or laboratories in nearby towns to buy medicines and get blood test for diabetes. While some men told us families keep their own blood pressure machines, only one of our families in Mardan inland A1 had a machine with which the grandfather would check his blood pressure regularly. Others told us they went to the BHU or *chota doctor*'s clinic to check their blood pressure.

Layyah desert was the only location where people did not complain about '*sugar'* or '*BP'* but told us that many men and women in the village had trouble breathing and many had been diagnosed with lung problems because they were '*breathing in the desert sand all the time'*. In the other Layyah location, neighbours told us about 2-3 families where almost all members had TB. They explained that as TB is transferable by coughing, they avoided interacting with these people and made sure not to eat with any of them. Another person whose wife had early stage TB told us it was because the water in their tap was '*salty and acidic'* which caused different lung problems.

In all but the Layyah and Mardan hill locations researchers saw many children and adults who had physical deformities and mental disability. While

Box 15: Heart attack from stress

'My mother' is a widow with three daughters and two sons, one of whom lives outside the village. She told me her husband had died of a heart attack three years ago. He was attending a wedding in another district and on the night of the *mehndi* (henna ceremony) he had a heart attack and died on the way to a hospital. She said he had no health problems but was constantly stressed because *'he had three daughters in the house'* whom he had to get married.

Field notes, Sahiwal far

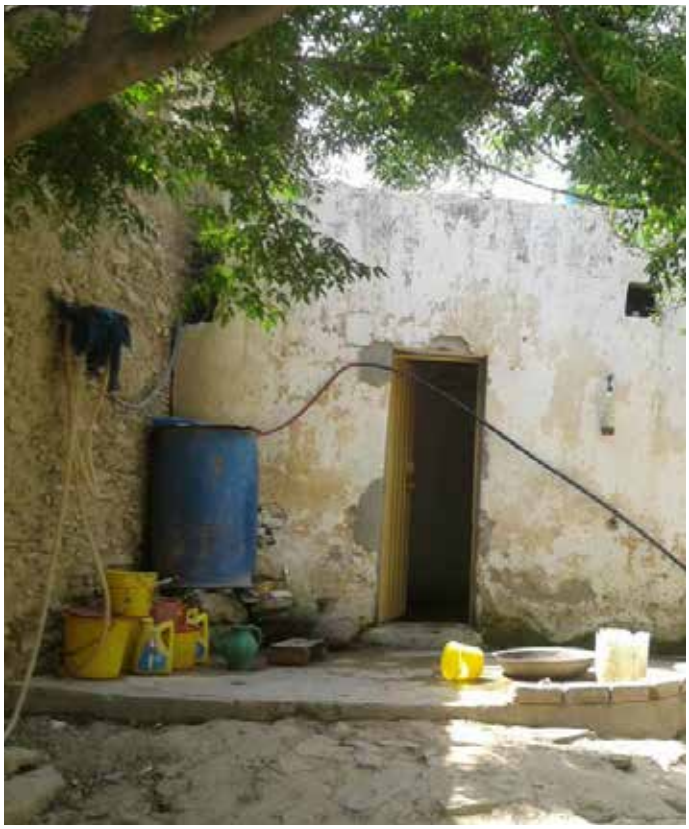
many thought of these disabilities as an illness, a few told us it was a person's fate. Others explained these physical deformities as having occurred because children were not given polio drops. One of our household sisters (26) in Sahiwal near E2 said she had polio as a child because her parents had missed her vaccination. She shared *'it was a small thing because of which I am disabled'* and after she had grown up she made sure her father took all of her siblings to get polio drops at the clinic if the immunization team did not come to the village. In Layyah desert a group of mothers told us they took their children to the team of polio workers who came to the village to get polio drops otherwise '*our children will get disabled'.*

People in other locations usually did not know how to explain why these disabilities happened in children. While a few in Nowshera river and Sahiwal near speculated that it could be because of inter-marriages in families, men in Layyah desert had heard '*getting married within families causes mental and physical disabilities'*. They told us about a village 40 kilometres away where '*at least one child in every home is mentally or physically disabled'* as everyone married their relatives. However, in the same village (Layyah desert) where inter-marrying between cousins and the clan was the norm, researchers did not see any children with mental or physical disability.

In the Mardan, Sahiwal far and Layyah inland locations, many people we met said they had different types of hepatitis and in Mardan inland location where there were many people with both hepatitis A and C, men told us many people had died of hepatitis A. Another man here thought that hepatitis was widespread in the village because the *chota doctor*s used the same syringe to inject many people. In Sahiwal far, one of our household fathers had hepatitis A and told us he knew it was transferable which was why he did not share a bed with his wife.

While most people did not consider diarrhoea in adults to be a serious illness and usually treated it with home remedies, many mothers told us they worried when their babies and toddlers had diarrhoea and would either go to the *chota doctor* in the village (Layyah desert, Sahiwal near, Mardan hill, Nowshera river) or to the BHU for medicines and oral rehydration solution (which they referred to as 'ORS') (Layyah inland, Nowshera river). Others told us that diarrhoea in babies itself was *'worrying'*, but when it happened along with vomiting then the *chota doctors* give the babies a saline drip.

People sometimes blamed the sanitation of their villages for the spread of diarrhoea and hepatitis. Layyah inland had no drainage system which caused water to stagnate in different parts of the village. People here complained about being '*fed up with the flies'* and blamed these for spreading diarrhoea. While people in other locations complained about



A family's toilet in Mardan hill. Not all families in study locations had toilets and peeing/pooing outside was common.

A researcher washes hands before eating. While hand washing is common before meals, it is generally done without applying soap.

the flies and one family in Sahiwal far, where the drains were not covered, was also using cleaning liquid to ward away flies, no one else linked diarrhoea to flies. In Sahiwal near people did not seem to mind the flies that much while in Layyah desert although mothers mentioned they *'should cover the babies with a cloth'* so the flies did not *'cause diseases'*, they did not actually do so. In the Mardan hill location a *chota doctor* explained that people usually threw their garbage outside their homes which attracted a lot of flies. Children too played around the garbage dumps and *'touch their hands to their mouths'*. This, he said, was why many children in the village had diarrhoea or hepatitis.

While there were toilets in all locations, researchers observed that all families in the village did not have toilets and except in Mardan hill, Nowshera river (C2), and Layyah inland people were using open fields to poo. In Sahiwal near E2 young boys would also sometimes poo on the streets alongside their homes. Table 5 presents a visual assessment by researchers about the general sanitation situation in the study locations.

Table 5: Observations of garbage, drainage and defecation

Locations	Garbage	Drainage	Defecation
Nowshera Hill (D)	●		●
Mardan Hill (B)	●		
Nowshera river (C1)		●	●
Mardan inland (A1)	●		●
Mardan inland (A2)	●		●
Sahiwal near (E1)			●
Nowshera river (C2)			
Sahiwal near (E2)		●	●
Sahiwal far (F)	●	●	●
Layyah desert (G)			●
Layyah inland (H)		●	

● lots of garbage ● open drainage

● open defecation

Being healthy….. for pregnant women and babies

Women, across locations, told us that they went about their routine as usual when pregnant. Most had done chores as usual during their pregnancies and only took a break from work for something '*serious*' like heavy vomiting, severe back-pain or if they fainted. Many women felt that going about their daily chores makes the delivery easier and, except for a few women who told us they avoided doing '*heavy work*' like lifting, everyone said they had worked up until the day they delivered their babies.

While women told us about special food that are considered 'healthy' for pregnant women, most women shared that they had eaten '*anything that was available*' during their pregnancies. Except a few families who had actively given pregnant daughters or daughters-in-law meat, milk, eggs and fruits, most women told us they ate as usual. Many explained that while they drank milk with *ghee* (clarified butter) for a few days before delivery '*to ease the process*, 'special' food was only eaten after the baby was born. New mothers, in all but the Layyah desert location, are usually given eggs, chicken broth, ghee, *halva* (traditional grain flour-based desert which has ghee, sugar and dried fruits) and these are believed to strengthen the mother and increase milk production. Women in the Mardan and Nowshera locations said it was preferred that they eat this for the first 40 days, but were only doing it for at least 10-15 days.

Along with going about their usual routine and eating as usual, women also did not take medicines or visit doctors when pregnant. Many women shared that they had not taken medicines or involved doctors '*unless it was serious*' and insisted that they did not see the need for regular check-ups if '*everything was fine*'. Echoing many others, one woman who was six-months pregnant explained that she had not gone for a check-up until now because she '*felt fine*'. She told us that for her last pregnancy two years ago she had gone for regular check-ups to a gynaecologist in the nearby town as '*there had been complications with bleeding*' and had even had given birth at the clinic there. This time she was thinking of using the services of a traditional birth attendant (TBA) in the village. In Sahiwal far, we met some women who had gone for check-ups when they were pregnant and at least one of these check-ups had involved getting an ultrasound.

Typically women told us that they went back to their usual work about 10-14 days after their babies were born. Most felt that being able to go back to working so quickly after giving birth meant they were healthy. Only one of our families told us that the daughter-in-law had rested for 40 days after her two sons were born, but when she gave birth to a daughter the next time her mother-in-law had made her start working after 10 days.

Breastfeeding is common across locations and most mothers we chatted with had breastfed their babies. While there is no specific time mentioned for how long they had breastfed, many mothers told us it was '*until we have milk*'. Women feel breastfeeding keeps the baby healthy and except in the Layyah desert and Sahiwal far locations mothers do not give formula milk to their babies. In Layyah desert where families only farmed chickpeas and wheat throughout the year, women told us babies are given a combination of mother's and cow milk from the very first day. They explained that this is done because mothers do not produce enough milk as their diet during pregnancy consists only of wheat and chickpeas and occasional eggs. In instances where babies are said to not digest cows milk, families buy formula milk which cost PKR 600/box. In the Layyah inland and Sahiwal far locations a few women mentioned that babies are typically given solid food after six months but one four-month old baby in the latter was being given *roti.* Women also thought it was okay to give their babies water to drink after they were a few days old and families in Layyah thought giving honey to a baby after two months was '*good for the baby*'. In the two Nowshera locations, women told us they often give a mix of herbal tea, cardamom and sugar to babies when they are a few days old if the mother is unable to breastfeed in the first couple of days.

Five of our 25 families told us that they had babies who had died days or few weeks after birth. Except for one family in Mardan inland A1 who knew that their two babies had died after four weeks because of '*heart problems*', other families did not know the cause of their babies' deaths. They and other people we spoke to in the village told us '*it was fate that babies die*' and '*if they are supposed to die, they will die. Nothing can help*' (Mother, Sahiwal near E2). One of our families in Nowshera hill had 10 babies who had died after two days and the father said '*God alone knows why they had died*'.

He told us that he and his wife had visited many doctors to understand why the babies were dying but no one had been able to explain the cause. He said he knew that '*nothing was wrong*' with his wife because she had given birth normally, it was just that the babies were dying.

3.4. Why people make the health seeking choices they do

While section 3.1 outlines the different health options available to people in our study locations, this section describes how people exercise agency in choosing between these options. During conversations people were open to discuss these, sometimes complex, decisions and how they weighed the options and their preference for certain providers, being mostly focused on the facilities, nature of illness, facilities, trust, costs, privacy, timing and access and attitude of staff as reasons for choosing one over the other.

Choosing a health provider depends on the seriousness of the illness

Families explained to us that deciding where to go to in case of an illness depends much on the perceived seriousness of the ailment. In cases of '*smaller, everyday issues*' like fever, cough, stomach ache, minor injuries, 'body pain' and diarrhoea that happen frequently, people generally opt to do what has worked before. Families prefer home remedies for these issues first as they are '*well tested cures*' and, in some cases, guaranteed that they would feel better in a few days. Others, like our household father in Sahiwal near, thought *'why spend money outside when I have all the ingredients at home?'* as he made a rice-based drink to cure his diarrhoea. Families shared that they use a mixture of herbs, fruits and spices to treat minor issues and know of ways to prepare these to cure certain ailments.

While home remedies are generally preferred for adults, they told us that if the problem persists beyond a few days they visit the *chota doctor* or the medical shops in the village to get medicines. However, parents consistently told us they do not use home remedies for very young children or babies because '*something might happen*' but go to the *chota doctors* immediately for consultation and medicines. Older children are sometimes given home remedies, but parents usually prefer to take them to the *chota doctor* for fever and other ailments. People explained that these *chota doctors* either give medicines to the children or make home visits to set up a saline drip (in case of diarrhoea) (see box 16 and 17). One of our

Box 16: The *chota doctor* who carries his 'shop' in a plastic bag

We met Dr. Z on our first day in the village. He was on a motorcycle carrying a plastic bag that contained his supply of medicines and syringes. As he was showing us around the village we stopped at a field where men and women were working and while the men (from the team) joined the men in the fields, we sat talking to the women who were there. After a while, an older woman came along with a young boy and approached Dr. Z. From their conversation we followed that the woman was there to get her daily dose of insulin and had brought her grandson along as he had been complaining of itching on his arm.

After Dr. Z injected the grandmother with the insulin, he took out a vial of medicine and another syringe from his plastic bag. The boy was wearing a full-sleeved shirt but Dr. Z did not raise the sleeve to see the arm that itched. He filled the syringe with the medicine from the vial and injected the boy's arm with it. This was done through his shirt. He then gave the boy other medicines and ointment and took PKR 150 from the grandmother, after which they both left.

While we were sitting there we saw Dr. Z give this used syringe to another boy telling him '*don't re-use it'*. One woman who was sitting there took this syringe from the boy and disposed of it by breaking the needle on the ground.

Field notes, Sahiwal near

Herbs used as home remedy. A mother in Mardan inland with the herbs she uses for treatment of fever and cough.

Box 17: Seeking health services for the baby with diarrhoea

While I was living with them, the 8 month-old baby in 'my family' had diarrhoea so the family phoned for the 'doctor' who lived in another village 4 kilometres away. This *chota doctor* arrived, talking to someone on his mobile phone. While still on his phone he held up the baby's wrist to check her pulse. He then took a syringe from behind his ear, took a vial of medicine from his bag and injected the baby with it. All of this was done while he was still on the phone.

The next day the baby was worse and had begun vomiting. The family decided to take her to a private hospital which was 75 kilometres away. The father rented a jeep from a neighbour which cost him PKR 1,600 (to be paid later) and he and the grandma took the baby to the hospital. The doctor at the hospital told them the baby had malaria and asked them to buy a mosquito net and also gave prescription for medicines. When they went to buy the medicines from the hospital pharmacy, they were given a bag of saline drip. The grandma worried about who would administer the IV to the baby. The father and grandma decided to ask the father's brother who was studying to be a 'dispenser' in a town which was 60 kilometres away from the village to come and give the drip.

While grandma was recounting her hospital experience to me, she kept thanking Allah that they were able to start the drip because of which the baby had stopped vomiting.

Field notes, Layyah desert

A baby being given saline drip by a chota doctor. Families say having a chota doctor in the village is convenient as they make house calls.

researchers in Nowshera river C2 observed a *chota doctor* treating a young child for diarrhoea where he gave him an injection and a syrup. In Layyah inland and Nowshera river C1, parents told us they took their children to the BHU to get ORS for diarrhoea.

Families also visit hospitals or clinics in the districts if the illness is serious, at times even travelling to a different district for treatment. People shared that they go to the hospitals in town when they feel that the treatment provided by the *chota doctor* is not helping or if the illness is beyond their capacity in terms of competence and resources. They typically go to these hospitals through referrals, either from the BHU or from someone else who had used the service before. In Mardan hill, one household father had been referred to the government hospital in Mardan where he went every three months to get his blood sugar tested. Another one of our fathers in Nowshera hill had a severe chest infection for which he was going to a hospital in Islamabad (2 hours' drive) and another daughter-in-law in Mardan inland A1 was going to a hospital in Lahore (5-6 hours' drive) monthly for cancer treatment.

A good health provider has ..... diagnostic facilities, especially ultrasound

Across locations men and women told us that they usually went to service providers with 'facilities' and preferably where these were '*under one roof*'. People often loosely used the term 'facilities' to refer to all kinds of diagnostic services including pathology (blood, urine testing) and radio-diagnostic (X-ray, ultrasound, CT scan). Many people had, at some point, had blood tests, X-rays or ultrasound and they told us they like going to private hospitals and clinics because they have '*specialist doctors*' and these facilities. People explained that while government hospitals also offer services like X-rays and CT scans, more often than not they were told that the machines were out of order and would be referred to a private facility anyway (see box 23). Going to private hospitals means that once they had paid they would not have to go to a different place for medicines and tests.

People overwhelmingly emphasised the importance of ultrasound facilities and told us they like going to private hospitals or clinics because these provide ultrasound facilities for women. Most of our families told us that although the BHU provides free check-up for pregnant women, this was done manually by the LHW or midwife as there are no ultrasonography (USG) machines.

The new and unused ultrasound machine at the BHU in Nowshera hill.

'Why would my wife go there (to the BHU) *if there is no ultrasound?'*

Father, Mardan hill

Most women shared that they had done an ultrasound when prescribed by the BHU or private doctors during pregnancy. In Layyah inland, Mardan inland and both Nowshera locations, women told us the BHU staff had their own private ultrasound facility outside the BHU where women are usually directed (see box 29)[16]. The costs varied between PKR 200-300/visit in all locations. While the LHW in Nowshera river runs an ultrasound facility from a small shop in the village, another LHW in Mardan inland has a USG machine at her home. In Nowshera hill before

16 The five-year longitudinal RCA study titled *'Listening to Poor People's Realities about Primary Healthcare and Primary education'*, Bangladesh 2007-2012 has also highlighted the trend of government health service providers over-prescribing ultrasound for pregnant women, driven mainly by a profit motive on the service providers' part.

Box 18: The 'NGO hospital'

Three years ago a NGO centre started in 'my village'. People said it provided health services and sewing classes for women and while the sewing classes took place everyday, the 'hospital' opened on Wednesdays and Friday from 8am to 2pm for women and children only. While previously the NGO hospital had been operating from the BHU, people said they had shifted to a building near 'my house' because of a '*conflict*' with the doctor at the BHU. The medical technician at the BHU told me that when the NGO hospital was running from the BHU the NGO provided free medicines and the BHU staff provided consultations and referrals. He said the number of women patients coming to the BHU had dropped after the NGO hospital moved out. He did not seem very happy about it.

While both the NGO hospital and the BHU charged PKR 10 as fees, women said there were more facilities like lab tests and ultrasound, which cost an extra PKR 200, at the former and many women liked going here for ultrasound. They also said it gave free medicines which were *'more in variety and number'* than what was given at the BHU. There was also a labour room at the NGO hospital whereas the BHU did not have any maternity facility.

Field notes, Mardan hill

the new USG machine had arrived, people said the previous LHW would bring her private USG machine to the BHU and do tests for women. She charged PKR 30 for this which people said was split between her and the BHU.

Women, however, are not just getting ultrasounds when pregnant but also when they feel generally unwell. In the Mardan hill location, where there was a 'NGO hospital' many women who went there to get an ultrasound are not pregnant and told us they went for an ultrasound because they '*liked being checked by the TV*' and it was '*good that the doctor can check us from the inside* (using the ultrasound)' (see box 18). Others felt that when the '*TV checks* (them), *our problem can be better understood by the doctor*' and made it easier for the doctors to treat them. The medical technician at the Nowshera hill BHU told us that when the USG machine had first arrived, a 75 year-old woman had come to see if she could get an ultrasound. She only wanted to see her insides on the screen and wanted to know *'what my body looks like from the inside'*.

People trust what is perceived as 'modern medicine'

Most people we chatted with liked the *chota doctors* because they gave them injections with one old woman in Layyah desert saying she felt better immediately after the *chota doctor* gave her an injection for fever. In Mardan inland, many women told us they did not like that the BHU only gives them medicines for pain so they go to the *chota doctor* for injections. In four of the study locations, our researchers had either accompanied their families or were present in the home when the *chota doctors* treated their patients and in all five instances (fever, rash, diarrhoea, cough and injury) people were given injections (see box 16, 17 and 19). In Mardan hill, the *chota doctor* gives two injections regardless of the ailment and one researcher here observed a toddler complaining of cough being given two injections, of which one was a steroid, after the *chota doctor* casually felt his chest with his hand.

'Medicines and syrups are fine but if he doesn't give an injection he is not a good doctor'.

Woman neighbour, Layyah desert.

In Nowshera river C1 people said the *chota doctor* charges PKR 50 to anyone who comes to his medicine shop for injection, but shared that they like him as he gives injections to everyone, even *'for a pain in the finger'* and '*we feel better afterwards'*. In Sahiwal near E1, people told us that sometimes the *chota doctor* offers injections to people and one grandma told us about the time when the *chota doctor* had given her an injection for pain and then offered to inject other people with the rest of the fluid that was left in the vial. She said this was normal as '*there is always someone who wants an injection*'.

Box 19: *Chota doctor* always gives 'two injections'

The 12 year-old son of 'my family' came home from school and would not eat. The mother checked him for fever and gave him a syrup which she said had been leftover from last time and that she had kept in the refrigerator. She explained that with all of her four children she gave them the fever syrup (Calpol syrup) first and if that didn't work would take them to the '*chota doctor's clinic*' and '*he'll give him two injections and the boy will be fine*'. The next day I accompanied her and the boy to the clinic. The *chota doctor* checked the boy's pulse and took him to another room where he gave him two injections. He asked her if she had other medicines at home and she told him she had the syrup but not the '*powder wali dawaai*' (powder medicine). He gave her the powder medicine and we left.

When walking home the mother told me that anytime any one went to the *chota doctor* he would give them two injections and they felt better because the injections always worked. The next day the boy was better and went to school. The mother smiled at me and said, *'see I told you the injections work'.*

Field notes, Mardan hill

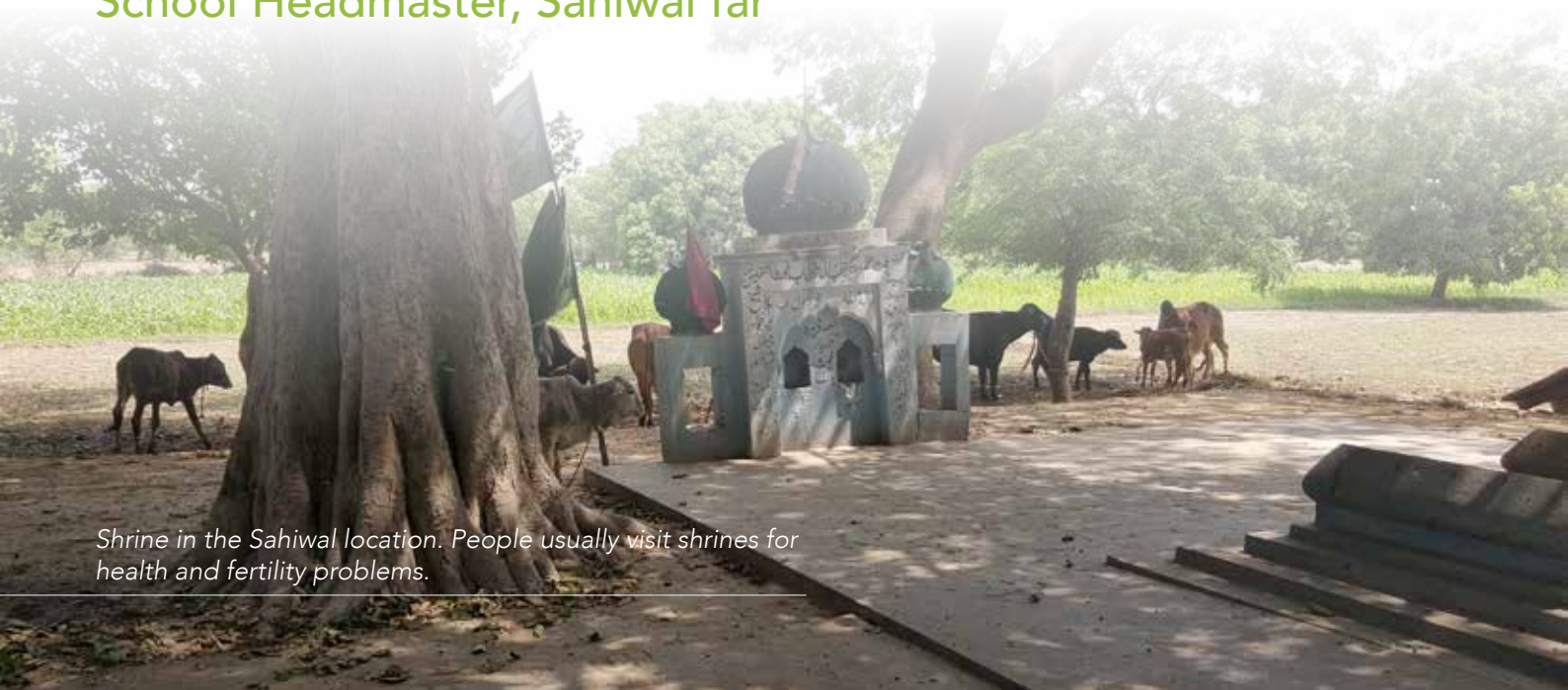
'Anyone who gives an injection is a doctor here'.

School Headmaster, Sahiwal far

Having trust in the provider is key

Across locations people chose to go to trusted providers and/or places to address their health needs. This trust was based on previous experience of the service, whether these cures had worked and familiarity with the person. In all but the Layyah locations, our families and other men and women from our communities also visit the different spiritual and traditional healers, *hakim* and shrines as turning to these in times of need had helped them. People of all ages told us they usually go to shrines when they were *'unable to have a baby'*, '*wanted a boy child*' or when someone in the family has health problems. One of our mothers in Sahiwal near E1 told us that she had gone to a shrine to pray and made a vow because she *'wanted a son after having seven daughters'* and was '*blessed with two sons*' afterwards. Another family in Sahiwal far went to a specific shrine in Lahore when they '*passed through challenging times*' like when the mother was not able to conceive a son.

People told us they trust traditional and spiritual healers for ailments like *jabay* (for babies who get sick because they miss someone or something), fever, diarrhoea and excessive weeping in babies and toddlers and spirit possession, fertility problems, body pain, scabies and jaundice in adults. These healers were said to '*recite Quranic verses and blow on people*' and also give amulets to wear. One of our neighbours in Nowshera river C1 told us that after two of his babies had died a few hours after birth, he had gone to a spiritual healer in the village at the time of his wife's next delivery. The woman had given



Shrine in the Sahiwal location. People usually visit shrines for health and fertility problems.

him an amulet for the baby who had survived. People told us that these traditional and spiritual healers did not charge a fee but people left some money of their own will (PKR 10-100 in different locations).

As most of these healers are in the village, in some cases living just a few doors away from our families, people said they knew the healers' specialisation and go to specific ones in times of need. In Mardan inland where many people had suffered from hepatitis C there is a healer who treated hepatitis. One man told us he had gone to many doctors but his hepatitis had got worse, but when he went to this healer his condition '*had started to improve'.* Some people told us they found it '*comforting'* that these healers *'would tell them they would be cured and when'* which was not something that usually happens when they go to doctors and took medicines. In Mardan hill, one woman told us the healer had explained to her to avoid drinking cold water if she wanted to be rid of her body pain and within a week she was pain free, while another shared that she had gone to the spiritual healer when she couldn't breastfeed her baby and two days after that '*the milk had started to flow'*.

Women told us they trust TBAs during delivery and prefer to give birth at home. In Layyah desert people only go to the BHU (which was 25 kilometres away) for deliveries in case of an extreme emergency and that too only because it has an ambulance which *'could reach the village within minutes'.* They otherwise trust the TBA to have their babies delivered at home or go to hospitals and clinics in the next district. In Sahiwal far, while a few women had their babies delivered at the BHU, most said they trust the TBA more as they knew her and so '*it was less painful'* and '*we are in our own home'*. In Mardan inland A1 women told us they liked having babies at home as the TBA or midwife '*gave us individual attention'* not like in the hospital where '*you are in pain but no one gives you any attention'.*

People told us they also go to *chota doctors* because these men are usually from the village and people know them or their families. In Sahiwal far, the doctor at the BHU admitted that people went to the *chota doctor* in the village because '*I am not from this village but he is'.* This *chota doctor* is someone who had done a Diploma in Pharmacy and is the *Numbardar's* cousin. In Nowshera river C1 even though people had heard that one medicine shop owner had in the past given wrong medicines to people, they still go to him because '*he is from the village'.* However, in Mardan hill where the NGO hospital has women staff who came twice a week, women shared that they feel comfortable discussing their '*personal health issues*' as the staff were all from outside the village.

Of the three 'doctors' in Sahiwal near E2, most people said they trust the '*real doctor'* who they know has a MBBS degree over the two other pharmacists. The MBBS doctor was said to be kind and honest and '*he listens to you and will tell you what is wrong with you'* (Father) and *'we feel better afterwards'* (Woman). Others said he charges a lower fee than the other pharmacists (PKR 90 compared to PKR 120 charged by the pharmacists) who people said were '*liars'* and '*thieves'* and gave wrong medicines. One girl who had gone to one of them told us '*when I went to him, I felt more ill'*.

Box 20: Pressure for Caesarean section birth

In 'our village' most people told us that all babies born in the past 7 years had been by caesarean section (c-section) and women had stopped having normal deliveries. As there was no BHU in the village people told us they go to private clinics or hospitals in Sahiwal town to have their babies delivered and all private doctors would suggest the woman undergo a c-section. People said the doctors in these hospitals rush them into making a decision and give them only 5 minutes to decide whether to get the c-section else '*the mother or baby will die'.* Husbands told us they felt they had no choice when the doctors said this and decided to get the c-section.

We met a *chota doctor* in the village who told us that this was the doctors' way of making money as a c-section usually costs between PKR 22,000-40,000 depending on which doctor the family visits. He explained that as women did not attend regular check-ups during pregnancy and only went to the private doctors when they thought their delivery date was nearing, families did not have an idea whether the baby was healthy or not. The private doctors exploited this and demanded the women get c-sections. He told us of his own experience of taking his pregnant wife to a private doctor who suggested a c-section '*as it was an emergency'*. He said his wife had not started her labour pains so he took her back home and a few days later she gave birth to a boy assisted by a TBA.

Field notes, Sahiwal near E1

Much of this preference for *chota doctors* is also related to their willingness to give medicines and treatment on credit. While four of our families in different locations had at some point taken medicines from the *chota doctor* on credit, we met many others who told us they appreciate getting these medicines when they were needed and being able to pay for them when they have the money. One of our household mothers in Mardan hill told us she had a debt of PKR 250 for medicines and injections which she planned to pay when her husband, who was a public transport driver, comes home with the money. In Sahiwal near E1 one household father said that along with giving medicines on credit, the doctor with the MBBS degree sometimes gives medicines for free if he sees that '*people are too poor to pay the money'.* Another family in Nowshera river C2 told us they took credit from the medicine shop all the time and paid back when they sold some of their crops with the father telling us '*this is the season* (wheat harvest) *they* (*chota doctors* and medicine shops) *trust us'*.

Perception that paying for services means they are better

In the Sahiwal far, Layyah inland and two Nowshera locations people felt that the services at the BHU are for '*poor people'* and one of our fathers in Sahiwal far explained this because '*there are no fees at the BHU '*. Here researchers noted that the better off families, including a headmaster at the primary school, would talk highly of the services at the BHU while poorer families would tell us *'nothing is fine there'*. People said this is because *'the rich families like the BHU because they don't use it'* and could afford to use private services instead. People in both Nowshera locations were of the same view. Men in Nowshera hill, which is the least poor of our locations, told us people from another village (*'other village is poor'),* use the BHU while they use it less and only for family planning advice, vaccinations and also for ailments like fever, diarrhoea, injuries and bites.

People in all locations frequently compared the cost of being treated at the BHU to costs elsewhere to indicate that the services at the BHU were not satisfactory. Medicines, when available, are provided for free at the BHUs and in all, except the Sahiwal far and Layyah inland locations, consultation fees are PKR 10, while the other two charge a nominal PKR 1. Compared to this, the *chota doctors* do not charge anything for consultation, but as they invariably gave injections or medicines the cost of this ranges between PKR 50 to 200 (for all locations). Due to this some people, particularly in Nowshera hill and Layyah desert, were concerned that their BHU provides medicines that were inferior in quality with many telling us '*what's free cannot be trusted'* (Neighbour, Layyah desert) and '*I get these medicines* (for flu*) for PKR 500 in private medical shops, why would the BHU give me the same medicines for free?'* (Old neighbour woman, Layyah desert). In Sahiwal far the doctor at the BHU complained that the *chota doctor* in the village had told people that the '*medicine from the BHU were not good and will make them sick'* because of which people are buying medicines from him and not visiting the BHU.

'What doesn't cost money is not good' (dismissing the nominal fees charged at government health facilities).

Old man, Nowshera hill

Notice about BHU consultation fees in Layyah inland and Sahiwal far. People feel services at the BHU are unsatisfactory as they only charge a nominal fee compared to private clinics and hospitals which charge more.

As mentioned above, most of the government hospitals in the *tehsil* or district charge a registration fee of PKR 10 or 20 and people's feeling of not trusting what was 'free' extended to services at these hospitals as well[17]. Many people we talked with are not happy with their experience at the government hospitals. One man in Layyah desert described his experience of going to a government hospital in the district with an eye allergy. The doctor there gave him an ointment tube for PKR 10 which he used for a week with no change in his condition. He said he later went to the same doctor's private clinic and was given an injection for PKR 2,000. His eye got better in two days. Another man here told us that he had gone to the same government hospital one time when he hadn't been able to pass urine. The hospital staff there did not have the skills to insert a catheter and his family moved him to a private hospital where the *'staff put in the pipe in 15 minutes'* and also charged him PKR 15,000 for it.

Barring a few people who told us they could not afford services at a private hospital or clinic, most we chatted with are using or had at some point used one of these because they felt that they got better treatment by paying. Families across locations told us that the cost of consultation in private hospitals and clinics varied between PKR 500 (a gynaecologist in Mardan hill) to PKR 1,000 (in Sahiwal near). People explained that these costs were only for consultations and additional diagnostic services like X-rays, CT scans, blood tests required having to pay more.

Families who had members being treated for a serious illness like cancer shared that the cost of treatment was huge (usually in lakhs) and many had either borrowed the money from a relative or sold their livestock to pay for treatment. In Nowshera hill where a young man told us his brother had died of cancer a year ago said the expenses for his treatment had been *'huge'.* In Mardan hill, one of our household fathers told us he had spent *'all my life savings* (earned from working abroad)' for his mother's cancer treatment and another one of our family's father had died of cancer and his wife told us they had spent almost PKR 2 million on his treatment in Islamabad. She said the money had been spent mostly on the hospital bill as they had relatives living there with whom they had stayed. The family had taken a loan from their relatives for the treatment and had yet to pay back PKR 600,000 (Mardan hill).

A few families who had stayed overnight or a few nights when getting treated at the hospitals and clinics in the district told us that they also had to arrange food and accommodation for the patient and accompanying relatives. Those who had family or relatives in these places generally stayed with them and said they gave them gifts as a way to reciprocate their kindness (Sahiwal near and Mardan

17 The perception among people that payment for health service confers quality has also been highlighted by the five-year longitudinal RCA study in Bangladesh titled '*Listening to Poor People's Realities about Primary Healthcare and Primary education'*, Bangladesh 2007-2012.

Box 21: *'I didn't buy the rest of the medicines because there was no money'*

'My grandma' told me she injured her foot while working in the fields. She went to the BHU where the staff told her they did not have the medicines to treat her injury but wrote a prescription and sent her to a medicine shop. Here the shopkeeper told her the medicines would cost PKR 600. As grandma only had PKR 300 with her at that time, she only bought half of the medicines and came back home. She told me, '*I didn't buy the rest of the medicines because there was no money'*, and said whatever money the family earned was spent on other things like food. Her injury was not a priority and '*anyway it was almost healed now'.*

Field notes, Layyah inland

Box 22: Willing to pay money for medicine that works

People told me about a *hakim* who has a big shop in the village. They said there is a diploma hanging on the wall of his shop which show his qualifications and that people from villages far away also visit his shop. The *hakim* usually sells Unani medicines, but when I met him he told me he also made and sold his own compositions for different ailments. A few people told me the medicines he made were very expensive and cost PKR 20,000. A man who had gone to him for a stomach complaint told me he was given half a glass of medicine which cost him PKR 500. However, most people also said they did not mind paying because his medicines most certainly worked.

Field notes, Mardan hill

Box 23: Costs of X-rays and CT scans

People in 'my village' preferred to go to a town in another district even though it was 40 kilometres away rather than go to their own district town (25 kilometres away). They explained that this was a long time practice and that they had always gone to this town for '*everything*' including health needs.

On our second day in the village 'my grandfather' told me that last year on Eid, he had suddenly had some trouble breathing. He and his son went to the 'doctor' in the neighbouring village who asked them to get an X-ray. They then went to a private clinic in the next district and paid PKR 400 for an X-ray. After a month when he had to go get an X-ray again, the same clinic demanded he pay them PKR 800. When he told them that on the previous occasion he had only paid PKR 400, they agreed to negotiate the price down to PKR 700.

--

A few men in the village told me about an old lady who went to the government hospital in the next district because she felt short of breath. The doctors there asked her to get a CT scan but as the machine in the hospital was not working, she was referred to a private facility. The CT scan cost PKR 16,000 and the doctor in the private clinic told her she needed another procedure. The family could not afford the procedure because they had spent all the money on getting the CT scan. The men told me that she was now '*counting her days*' as she could not get the procedure.

Field notes, Layyah desert

hill), others told us they had to live in hotels for a few days. For one of our families in Sahiwal far, this was another reason for choosing private hospitals over government ones as the latter do not have '*space for patients, let alone guests*' whereas in private hospitals they are allowed to have one attendant with them in their room because they '*paid more*'.

Importance of privacy in service provision

Maintaining one's privacy when visiting a service provider is also very important for people. For example, some men in Mardan hill explained they feel more comfortable discussing sexual problems with a private doctor in the city, while others told us they take their wives to either male or female private doctors for consultations during pregnancy or other illnesses as they can then go with their wives and discuss their issues with the doctors.

Women shared their preference for private services with women doctors or staff as it is easier to discuss things with them. In Mardan hill women told us they liked going to the NGO hospital because they have three women staff and it is easy to discuss menstrual and other issues with them. In Nowshera hill the medical technician told us they wanted a female staff who could operate the USG machine as '*it requires someone to put gel on the patients and women would feel more comfortable with a female staff*'. In Mardan inland women told us if they choose to deliver their baby outside of the home they prefer going to a private clinic as '*at least they maintain our privacy*' whereas in a government hospital they would be in a labour room '*with 20 other women*'.

'Because we are honourable people we don't allow our women to go alone' (on going with their wives to the doctor for medical check-up).

Husband, Mardan inland A2

Importance of convenience and home visits

The choice to go to a certain health provider is also based on access for some of our families. People told us they prefer the *chota doctors* or the medical shops in the village because these are close-by. The *chota doctors* also make house-calls when needed, particularly during times of emergency which is appreciated by most of our families. People in Layyah desert were particularly happy about this because the *chota doctor* there lives in the next village but comes when families need him. Families in other locations also told us having these *chota doctors* is convenient when someone in the family needs an IV drip. The *chota doctors* usually come to people's homes for this rather than people having to go to elsewhere.

In locations where mothers told us they prefer to use the services of the TBA for giving birth, some told us this was because they live nearby and could be counted on to come to their homes if it was an emergency. One household mother in Mardan hill who is still deciding between going to a private doctor or the TBA for her delivery shared that she prefers the TBA who lives close to her sister's home and her sister could accompany her if needed. In Layyah desert where the TBA would go to people's homes at the time of delivery, women told us they were '*happy to not travel during labour*'.

Importance of opening and appointment times

Getting an appointment at the hospitals (both government and private) takes a long time and there are long queues for many hours just to pay fees or have their turn to see the doctor. For example, for the grandma in Layyah desert who had to take her eight-month granddaughter to the hospital (see box 17) it took seven hours to get medical assistance; four hours travel and three waiting for an appointment. While a few people in Sahiwal far explained to us that having contacts at the hospital means they could arrange appointments, others, particularly women, told us their husbands or sons go a few days earlier to register and get an appointment and the women leave a few hours earlier on the appointed day so they are there on time to see the doctor. This means that they do not have to wait at the hospital for a long time.

Not being given enough time for consultation is also a problem for many people we talked with who told us that not just the BHU staff but also doctors in the government hospitals at the *tehsil* and district see them for '*less than five minutes*', write a prescription and send them on their way. A grandmother described her experience of going to the doctor at the BHU in Mardan hill for throat pain. She said the doctor did not examine her and even before she had explained the symptoms, he had already written a prescription for her. She told us she was angry at this and went to the *chota doctor*, who examined her and gave her medicines, instead.

Others in Sahiwal near, Nowshera hill and Layyah desert told us about government hospital doctors who also have their own private practice in the *tehsil* or district. Men told us that the behaviour of the same doctors were '*poles apart*' depending on whether one met them at the government hospital or at their private clinics. People said when the doctors see them at the government hospitals they are usually rude during consultations and see them only for a few minutes because *'there was always a rush to see other patients'*. The same doctors at their private clinics, spend at least *'15 minutes with us'*, '*check us properly*' and *'talk to us politely because we have paid their fees'*.

BHU in different study locations.

People's experience of using the BHU

Opening hours for the BHUs in our villages were between 9am-2pm. The BHUs in Sahiwal far and the Layyah locations were open 24 hours to provide maternity services. While only the BHU in Mardan hill displayed a notice with the timings, people we chatted with knew the timings as they had either heard from someone or had the experience of going after 2pm and finding it was closed. Although people knew the BHUs closed after 2pm, many were unaware that services are not provided on public holidays as well (see box 24).

We noted more women and children going to the BHUs compared to men in all study locations. While there were some men at the BHU in Mardan hill, they had accompanied their wives and children who had come for immunization, and a few men had come with an injured boy in Nowshera hill BHU. Men, in most locations, told us this was because they are generally at work when the BHU was open. In Nowshera hill men explained that they start work at the slate quarry at 6am each morning and work until late afternoon and prefer to go to the medicine shop in the village or to the town after work if they feel ill. In Nowshera river C1, one of our household fathers who is a daily wage earner explained to us that going to the BHU means missing time working in the field because of which his wage could get deducted, *'if I visit the BHU, what will I eat?'* Others explained that their wives go more frequently with the children as they are free in the day and they themselves go to medicine shops in the village in the evenings if needed.

Nevertheless, a few men in all locations told us they would prefer if the BHU is open beyond 2pm, particularly in the evenings as well as public holidays so they could visit when it is more convenient. However, as discussed below, this typically comes with the caveat of having a qualified staff present and being provided with the needed medicines, '*otherwise what is the point of going?'*

People told us they visited the BHU for **minor ailments** like fever, cough, cold, to get vaccinations (all locations except Sahiwal near) and family planning advice (Nowshera locations, Mardan locations, Sahiwal far) and for baby deliveries in Sahiwal far and Layyah locations. As the BHU is 25 kilometres away from the village in Layyah desert, families here typically use its services only for emergency deliveries and vaccination for babies and toddlers, and for other ailments prefer going to a town in another district.

In all locations people go to the BHU for **immunizations and family planning**, but many complained that the BHUs would not give them medicines for other illnesses (discussed below) but only write prescriptions or give verbal advice. One father in Mardan hill felt there was no point in using the BHU services when they only referred you elsewhere and said he by-passes the BHU's referral

by just going to a medicine shop in the village or to the town if the problem was serious enough. Others, like one grandfather in Layyah inland, told us that families usually assessed the seriousness of the ailment and decided where to go, explaining that they had gone to the BHU and government hospital for the daughter-in-law's delivery but were using a private clinic for his respiratory ailment which was considered more serious.

Men and women told us that the BHU provides family planning advice and services. In most cases women told us they prefer going to the BHU for family planning services as the BHU had a better supply of contraceptive injections and pills as compared to its other medicine supply. In Nowshera, Mardan and Sahiwal far locations women said they would usually meet with the LHW at the BHU to talk about the different contraception methods. They shared that they mostly prefer injections (for three months) over the pills because these were '*less confusing'* and that they would *'sometimes forget to take pills'*. One household mother in Mardan hill told us that she took the three-month injection and was given a card by the Lady Health Visitor (LHV) in the BHU which had the date for the next dose which made it easier to remember. In Sahiwal far women shared that they '*took a break'* from having children and that this was typically done through pills which were given by the LHW. Staff at the Nowshera river BHU also told us that a few men also come to take condoms from the BHU.

In all but the Sahiwal near location we met BHU staff who shared that they provided condoms, pills, injection, copper T and implants for contraceptive use but the midwife at Nowshera hill BHU told us they referred women who wanted implants to other hospitals even though they had the product as this was '*easier'*. One LHV at the Mardan hill location told us she checked with the women if they had their husbands' permission before giving them any family planning suggestion. Women who had not consulted their husbands commonly discontinued contraception once the husbands found out and she advised women to decide with their husbands first before starting pills or injections. LHW and LHV were also said to make home visits to give family planning advice. In Nowshera hill the medical technician at the BHU told us a LHW went every month to give family planning advice to women in the village but women here confided that no LHW ever came. In Layyah desert, the village was not covered by the LHV services.

Only three out of the eight BHUs in our study locations (Sahiwal far, Layyah desert and Layyah inland) had **24/7 maternity facilities**. People told us these are for normal deliveries only and the BHUs refer women to district hospitals or private clinics and hospitals in the nearby towns in cases that required emergency obstetric care. Women in these locations told us that while there is a labour room at the BHU, it did not have an USG machine, and in the rare cases where they did (Nowshera hill), these are often not working, or do not have anyone who could operate them (see box 26). Staff at these three BHUs also confirmed this with one LHW at the Layyah desert BHU explaining that they could not meet the *'government target of 80 deliveries a month'* because they do not have a USG machine while most women who came to the BHU prefer to have an ultrasound during their pregnancy. Another LHV at the Mardan hill BHU told us that the patient flow had dropped steadily in recent years as

Box 24: Vaccination days at the BHU

I was at the BHU talking to the LHW who was alone there as it was a public holiday. While she was explaining to me that apart from the 24/7 maternity services, the BHU did not provide other services like consultations or vaccinations on public holidays, a few women arrived with their toddlers for vaccination. One of the women showed the LHW the 'yellow card' which had a date written for the toddler's next vaccination (the date had already passed). The LHW looked at the card and told her that she couldn't give them the vaccine as it was a public holiday that day and told them to come back the next day. When the woman complained that they had walked almost an hour from their village to come to get her toddler immunized, the LHW apologised and asked the woman, *'do you have other children and do they go to school?'* When the woman nodded, she asked if the children had gone to school that day. The woman answered that they hadn't because it was a holiday. The LHW then explained to her that like her children's school the BHU also closed on public holidays. The women nodded and were turning to leave when the LHW told them *'jo teeke haath pe lagenge woh Monday ko lagenge, jo paion waale teeke hai unke liye Tuesday se Friday aana'* meaning *'For the injections which are supposed to be given on the arm -come on Monday, for the ones that are given on the leg- come between Tuesday and Friday'*. The women nodded and left.

Field notes, Layyah desert.

Box 25: The NGO hospital offers everyone USG

I went with my neighbour to the NGO hospital in the village. When we reached there was a man sitting outside writing down names of the patients who came. When it was our turn, the first thing he asked us was if we wanted an ultrasound. When my neighbour said that she was only there for a consultation, he gave her a slip of paper and asked her for PKR 10. When we went inside, I saw about 15 women sitting in the waiting room. Some of them had slips of paper like the one the man had given my neighbour and others had a bigger form. When I asked my neighbour what those forms were for she told me it was given to women who wanted an ultrasound. The man whom they met when they came in first asked every woman (regardless if she had been referred for an ultrasound) if she wanted an ultrasound and would give them the bigger form and take PKR 200 from them, while the women who were there for a consultation only got a slip of paper.

Field notes, Mardan hill

more women wanted an ultrasound to know the sex of their baby. Since the NGO hospital here had a USG machine, they prefer to go there instead (see box 18 and 25).

In Sahiwal far and Layyah locations where the BHU had 24/7 maternity services, **ambulances** were available at the BHU for mothers who wished to seek services of the BHU for deliveries. In Layyah desert where people knew about the ambulance, families thought the BHU was '*doing good work*'. They explained that it was a free service but only for deliveries and *'picked women up from the village and also dropped them back with their babies'.* In cases where the delivery could not be handled by the BHU staff, the ambulance takes the mother to *tehsil* or district hospitals. In Sahiwal far, the ambulance covers three BHUs in the area and while the contact number for the ambulance is displayed outside the BHU, very few people in our village know about the ambulance and none had ever used it. The ones who know about the ambulance compared this to the 1122 Rescue service which also operates there but unlike the BHU ambulance '*can be used for all emergencies'* (see box 27).

Apart from women not preferring to go to the BHUs because these lack facilities like USG, families also told us that the BHUs are supposed to provide

'When the BHU gives a prescription, we go to the chota doctor to buy the medicines. So if we have to go to the chota doctor anyway, why go to the BHU at all?'

Man, Mardan hill

The BHU ambulance in Layyah inland. Unlike the 1122 Rescue service which can be used for all emergencies, the ambulance is only for transporting pregnant women for deliveries.

Box 26: The 'machines' at the BHU

On my third day in the village, I went to visit the BHU. I had been talking to the medical technician for a while when he proudly showed me the freezer, Electrocardiogram (ECG) and ultrasound machines. Both of the machines looked 'brand new' and the ultrasound machine still had a plastic covering its monitor. The medical technician told me that the BHU had got these machines because it was being upgraded to a RHC soon. The government had announced a few months ago that the building would be upgraded with a labour room and also have a female medical officer working there. He said the machines would come in use when the BHU was upgraded as right now no one in the BHU could operate either the ECG or ultrasound machines. The freezer, he said, was for keeping vaccines but sometimes the government gave them vaccines which none of the staff at the BHU were trained to administer. He gave the example of a snake-bite vaccine which had been provided but none of the staff at the BHU knew the correct dosage as '*different snakes have different venoms*' and there had been no additional information given.

While I was at the BHU a young boy from the neighbouring village had fallen from a tree and came with a leg injury. The medical technician put him on the bed next to the ultrasound machine. While the medical technician was preparing an injection, the boy was thrashing about in obvious pain. A few times his leg would almost reach the ultrasound machine which was close to the bed. When the medical technician came back into the room, the first thing he did was shout at the boy saying, '*don't touch the ultrasound machine. It is worth PKR 7 lakhs!*'

Field notes, Nowshera hill

The freezer at the Nowshera hill BHU for storing vaccines and other medicines.

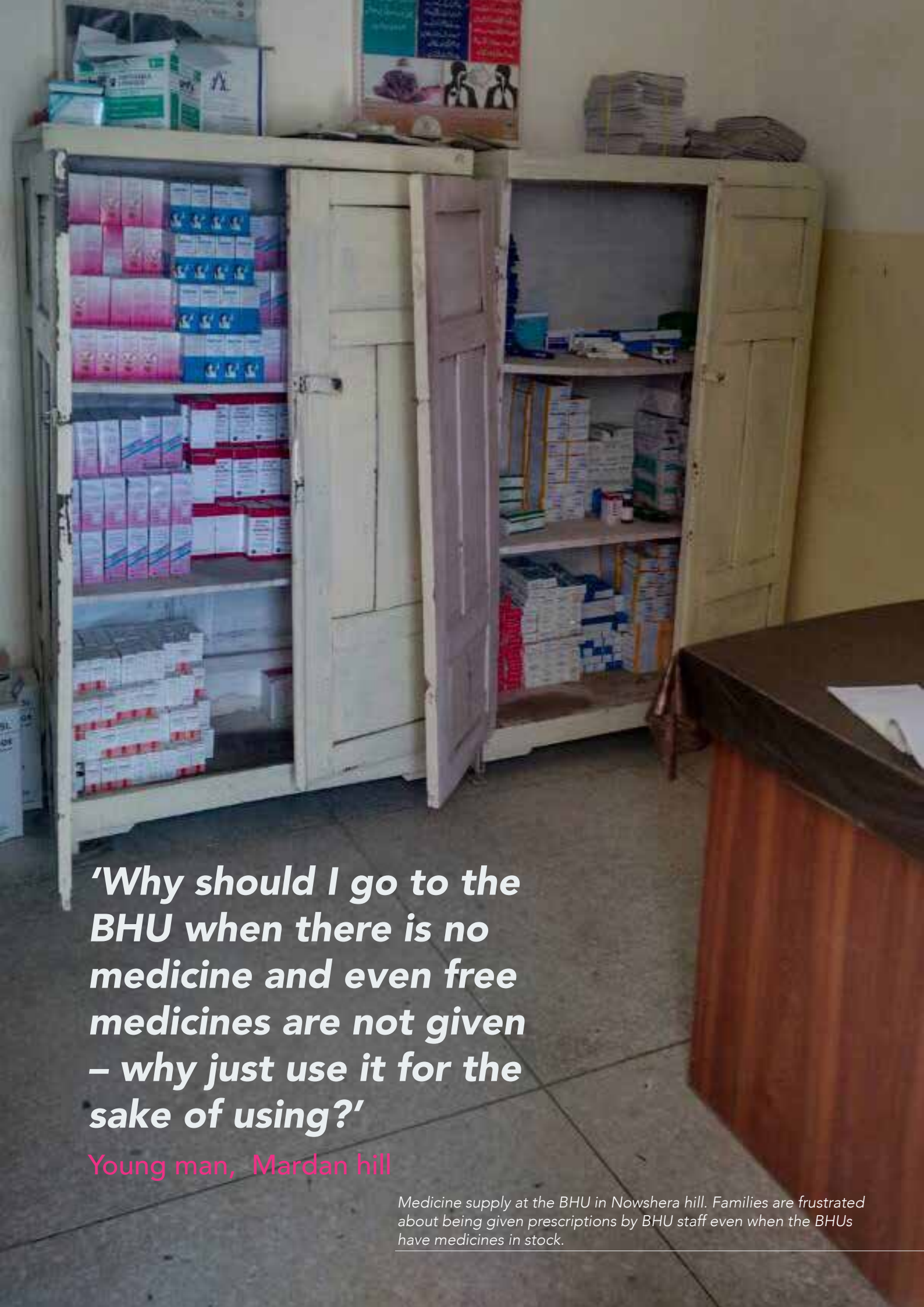
Box 27: The 1122 Rescue service

The 1122 Rescue service was available in five of the study locations (Mardan, Sahiwal and Nowshera river). People in these locations told us that this ambulance was always available and came *'even when someone cuts their finger'* (man, Mardan inland) and within 5-7 minutes of calling them. One woman told us it had come when she was in emergency labour (Mardan inland) and another man told us the ambulance had come within 5 minutes when there had been a fire in the village

Mardan hill.

'**free' medicines**. However, many people had the experience of being sent away from the BHU with just a prescription or had been given '*less than one strip of medicine,* and at times even '*given the same medicine for fever and cough*' (woman, Mardan inland). Many men and women expressed frustration about being given a prescription at the BHU and said they would rather go to a medicine shop or *chota doctor* if they had to buy medicines on their own. A daughter-in-law from one of our families in Layyah inland told us about the time when she had hepatitis and had gone to the BHU for an injection. The BHU staff told her to buy the medication at a medicine shop saying the ones at the BHU were of '*low quality*'.

This feeling of frustration was particularly strong in Mardan hill where many people had been sent away from the BHU without any medicine or given a few tablets and asked to leave. One older woman here shared with us her experience of visiting the BHU for her *'body pain'*. She had fought with the dispenser when he only gave her two tablets and asked to buy the rest by herself. When she questioned him about getting only two tablets when the BHU was supposed to provide all medicines for free, he shouted '*don't teach me my job*' at her. She then left without taking the two tablets. Another mother here shared that the same dispenser had not given her all the medicines prescribed for fever, but only the syrup, and asked her to buy the rest outside. A few people in Layyah inland and Mardan inland told us they got the same tablets and syrup for all problems and one mother in Mardan inland A1 asked, '*how can they give us the same strip of tablets and syrup for all illnesses?*' She had been given the same medicines for flu and cough.



'Why should I go to the BHU when there is no medicine and even free medicines are not given – why just use it for the sake of using?'

Young man, Mardan hill

Medicine supply at the BHU in Nowshera hill. Families are frustrated about being given prescriptions by BHU staff even when the BHUs have medicines in stock.

'Even though all services are said to be free (at the BHU)***, there are no services there and we don't end up getting anything. So why waste time going to the BHU, why not just go to the private hospital instead?'***

Woman neighbour, Mardan hill

In Nowshera river, a doctor shared that medicines are delivered at the BHU once in a month and they have to make do with that supply until the end of the month. These medicines are often in short supply and, at times, not delivered on time. He shared that the staff had to be careful to ration the medicines to last the whole month but even then they had to write prescriptions for people to fill outside. Another medical technician at the Nowshera hill told us that the district often sends them vaccines for which they do not know proper dosage while failing to send those for which there is an actual need in the village (see box 26 and 28).

'There is no special service at the BHU. The BHU has a medical technician, but so does the medicine shop'.

Father, Mardan hill

Women told us they prefer going to private doctors over the BHU because they want **privacy** when visiting doctors. BHUs lack waiting rooms, and more often than not, most consultations are carried out within the hearing of others who are waiting their turn. In Nowshera hill, the midwife at the BHU told us that when women came for a family planning consultation they are reluctant to discuss options as they are conscious of their voices carrying. In contrast to this, women who go to the NGO hospital in Mardan hill explained that they feel comfortable going there as there is a waiting room where everyone waits until their names are called and they go into the doctor's room. There is also a woman who was stationed at the doctor's door so others could not enter mid-consultation.

Box 28: Medicine donation without proper administration

There was a 'Leishmania' (disease spread from the bite of certain types of sandflies) outbreak in 'my village' a few years ago. The BHU did not have medicines (injections) for this. People say a man from outside the village provided 2,000 injections for free. Many people got these injections and stored them away either in refrigerators or somewhere at home for *'future use'*. The medical technician told me a lot of the injections were wasted because *'people hoarded these up'*. He said that one day, a pick-up van driver came to him with one injection and asked him what it was for. He had been given the injection by someone in the village and had left it on the dashboard of his van for three days. The medical technician told him to throw it away as it had probably gone bad by then.

Field notes, Nowshera hill

Many men in Nowshera hill complained that apart from a midwife, there was no other female staff at the BHU. They said that while there had been a female medical technician before, she had been transferred to the District Health Officer's (DHO) office and now there is only one male technician. A few of them also shared that there is only one toilet at the BHU which is inside this male technician's office and their wives had been reluctant to use the toilet even for giving urine samples.

Over our four days with families, people also shared their **experiences with service providers**, particularly those at the BHU and government hospitals at the district. Except in the Nowshera river location where the staff were said to be '*helpful and nice',* men and women in other locations, especially in Nowshera hill and Mardan hill told us about particular staff who were rude and did not pay attention to patients. In Nowshera hill, people complained about the medical technician who was '*rude and shouted at people when they asked for medicines'* and '*only wrote on a piece of paper and doesn't give medicines even when he has them'.* The medical technician here seemed to know people did not like him in the village and told our researchers '*now you have been here* (to the BHU) *and met me, people* (in the village) *will complain about me to you'.*

In Mardan hill, the dispenser who gave out medicine at the BHU was said to be especially bad because he '*shouts at people even when we are just sitting there'* even when he himself *'only sits and chats with the other staff'*. Two of our women researchers experienced this first hand when he asked them *'why are you walking around here like mad women?'* when they were waiting to talk to the LHW there. Like the older woman who had a run in with him when he did not give her medicines (see above), others also told us he only gave a few tablets even when there were stacks of the same medicines kept there. In Sahiwal far people explained that the BHU staff were '*good with rich people, bad with poor people'* (Neighbour man) because he had been shouted at and '*not talked to with respect'*. Another mother in Mardan inland A1 told us the staff at the BHU '*treated their relatives well but treated us poorly*' meaning that their relatives would get priority if there was a queue in the BHU, or be given more medicines compared to the rest. In Mardan hill another woman told us that the BHU staff had refused to take the PKR 100 bill she offered as fee saying he had no change to pay her back. He made her ask different people at the BHU for change even though she could see he had enough change in the box where he kept the rest of the money.

In both the Nowshera locations, people also complained that some of the BHU staff were either **late or absent** even though they lived close by. The medical technician at the Nowshera hill BHU was said to always come late and the midwife here told us '*he is never on time even though he lives only 10 minutes away'.*

Like the LHWs in different locations who operate their private ultrasound facilities (discussed above), people also told us about the other staff at the BHU who had their own **private practice** in the village. People in different locations speculated about the shortage of medicines at the BHU suggesting that the staff take these medicines and sell them to people privately. In Mardan inland women told us about one LHV who tells them to come to her home and sells them medicines which, they presume, are taken from the BHU. Similar to this, in Nowshera river, people complained about the medical technician who runs his own medicine shop after hours and said that he takes some medicines from the BHU and sells them together with the rest of the stock he had bought. Others said the same medical technician tells them there is no medicine at the BHU and asks them to come to his shop where he gives them injections and other medicines. A few men in Sahiwal far also told us about seeing a few medicines which were labelled '*not for sale'* being sold at the local medical shops which made them suspect that these were coming from the BHU.

In a few locations families also complained that at times the staff at the BHU would let **unqualified staff** treat patients. In Sahiwal far, men told us the BHU gardener would sometimes give them injections and others had seen the doctor show the gardener which medicine to give for what ailment by describing it by its colour. Another security guard at the Nowshera hill BHU was said to stitch up people's wounds when the medical technician was absent. People also seemed to feel that some of the senior staff at the BHUs were not very qualified and would often delegate their responsibility to junior staff like medical technicians and LHW. In Nowshera hill, people told us the medical technician was more experienced than the doctor who, people said, '*did not even know how to drain pus from a wound*' and had once told a man to come back the next day after which the medical technician drained the pus with a syringe. In Mardan hill, the woman doctor was new and had only just completed her MBBS degree. A few pregnant women who had gone to the BHU for check-up told us that she had referred them to the LHV instead of checking them herself and would ask the male medical technician to treat the men.

Box 29: A family's experience of the BHU and government hospital

The grandma in 'my family' told me of their experience of the BHU for her daughter-in-law's delivery. When her daughter-in-law was pregnant they went to the *'chota hospital'* (BHU) three kilometres away. The LHW who was at the BHU asked them to go to the clinic behind the BHU building for an ultrasound which cost them PKR 300. When the woman saw the ultrasound report she told them that their daughter-in-law was very weak and prescribed medicines. When they went to get the medicines from a medicine shop, the total cost for the medicines was PKR 1,200. As they did not have that much money they only bought a portion of medicines worth PKR 200. Grandma said someone from the family would go and buy more medicines every 10-12 days and her daughter-in-law was able to complete the medicine course that way.

Throughout the daughter-in-law's pregnancy, the BHU would ask her to get an ultrasound and every two months the family spent PKR 300 for it. Towards the end of the pregnancy the woman at the BHU said that the baby was not growing properly and to take her daughter-in-law to the district hospital for delivery. The baby girl was born at the district hospital and she was fine but very weak. They showed her to the child specialist who said the baby was fine so they brought her home. Once home, the baby kept ill and after three months the family took her to the BHU. They were told that the baby's kidney was not functioning and were referred to the district hospital again. The baby died at the district hospital at 5am the morning the family took her and the hospital staff asked them to take the body home. The family asked for the ambulance but they said it wasn't there. *'I walked 12 kilometres from the hospital to my daughter-in-law's maternal home holding the dead baby in my arms'*, grandma said. Her son came with a motorcycle-rickshaw and they took the baby home for the funeral.

The second time the daughter-in-law was pregnant, they went to BHU and repeated the same cycle of ultrasound examinations and medicines. The BHU staff told them again that the baby was not growing. When the daughter-in-law went into labour, the BHU staff told her the baby had died inside the mother. It took five women to push the baby out as there were no surgical facilities. While bringing the dead baby back home, the family asked the BHU staff to have the BHU ambulance drop them back to the village. On their way back, the ambulance driver told them he would charge them PKR 1,200 just to drive 3 kilometres to the village. The baby's father told him that they were poor and could not give that much money. He gave the driver PKR 300 when they reached home. The grandma told me the driver has done this many times to other families in the village and said '*they charge money from the poor, but not the rich people'*.

Field notes, Layyah inland

Box 30

Summary of the extent to which BHUs meet people's expectations of good health service

Ideal criteria	How BHUs meet these criteria
Seriousness of illness	People see BHUs as '*for the poor*' and providing basic primary care only. There is preference for home remedies for minor ailments and by-passing BHU for more serious ones since they will be '*referred anyway*'. BHU somewhat redundant for curative care as a result but used in preventative care e.g. vaccination, family planning
A good health provider has diagnostic services, especially USG	BHUs do not provide diagnostic services like blood tests, X-ray or ultrasound facilities. Those in need are either referred to other, often private, facilities, or by-pass the BHU to go to these facilities by themselves. BHUs not meeting their government target for deliveries because women prefer ultrasound check-up during pregnancy
Must have medicines and supplies	People are often sent away by BHU staff without the 'free' medicines and asked to fill prescriptions at private medicine stores. Also complaints of getting the same medicines for different ailments
Trust in 'modern medicine'	People trust 'modern medicines' like injections which they say '*works*' and which makes them '*feel better immediately*'
Trust in provider	BHU staff are from outside the village and people more trusting of *chota doctors* who are locals and at times related to them. Spiritual and traditional healers preferred for smaller ailments as they usually tell people when they will be healed which people find '*comforting*'
Perception that paying for services means better treatment	People believe '*free is not good*' and do not trust BHUs as they only charge a nominal consultation fee and provide free medicines. This feeling extends to other government hospitals as well
Importance of privacy	No waiting rooms, separate toilets for women or labour rooms at BHU. Consultations done in open with others present. Women particularly preferring female staff for consultations
Importance of opening and appointment times	BHUs close at 2pm and on public holidays so not convenient for men who are generally working in the afternoons. Women usually going to BHUs with children as they are at home and free
Importance of convenience and home visits	People prefer *chota doctors* who have medicine shops in the village as they also do home visits when needed. The *chota doctors* often also provide medicine to people on credit
Good staff attitudes and behaviour	BHU staff often absent or late to the BHU; '*rude and often shouted at patients*'; do not give proper time for consultation. Staff in different locations operating their own private clinics or medicine shops to which people are referred typically. Complaints of a few 'unqualified staff' at BHUs treating patients

3.5. People's views and experience of participation

During our four days in the study locations, we were able to learn about the various issues people encountered when accessing health services. Given the different problems people faced, we tried to explore if they took a specific course of action to resolve these issues. These small chats led to larger conversations about their views and experience of dispute resolution, decision-making, and political processes including voting. These conversations were encouraged by researchers in order to get a sense of how people engaged with service providers, if and how they demanded accountability and also to understand the larger social and political context for raising their voice. This section presents people's views and experience of social and political participation.

Who do people go to with problems?

In every village we stayed, there were certain people or groups who people said they go to in case of personal or communal disputes. While some of these are men who are traditionally considered 'influential' because of the political position they hold, for example the *Nazim*, people also told us they often went to the elder in their community or to their landlords with complaints. Table 6 lists the person who most people in the community said they went to solve their problems.

In most locations men told us they went to their landlords to resolve issues. They explained that since they mostly worked, and at times lived, on the landlord's property he was who they go to resolve disputes pertaining to land. In the case of Sahiwal far, the *Numbardar* told us that while the better-off people solve their family issues at home, the poorer families also come to him to resolve their domestic disputes, with the women going to his wife with their problems. These families live on his land in the houses he had built so they thought it was '*ok to share their private matters*'.

While men were also going to the *Nazim* in Nowshera river C1 and Mardan hill, these are for different purposes. In Nowshera river C1 people shared that all problems are put forward in the *Nazim's* house on

Table 6: The 'go-to' person

Location	Go-to person							For
	Landlord							
	Khan	Numbardar	Sardar	Nazim	Village elder	Other ethnic group	Not mentioned	
Mardan inland (A1)	✓							Small disputes related to land, political consultations (voting)
Mardan inland (A2)	✓							Small disputes related to land, political consultations (voting)
Mardan hill (B)				✓				Land disputes (borders, animals, irrigation)
Nowshera river (C1)				✓				Issues related to village (education, health, infrastructure)
Nowshera river (C2)	✓							Land disputes
Nowshera hill (D)							✓	-
Sahiwal near (E1)		✓						Petty quarrels, land disputes
Sahiwal near (E2)			✓					Land disputes (borders)
Sahiwal far (F)		✓						Land and money disputes, also family quarrels
Layyah desert (G)					✓			Family matters, village concerns (electricity, social assistance)
Layyah inland (H)						✓		Disputes

the days he is in the village and '*he listens and gives feedback'*. However, some men also told us that he seemed more interested in building roads and other infrastructure, *'because election is coming',* rather than addressing problems they face at the BHU or with the schools (discussed below). The *Nazim* in Mardan hill mostly resolved disputes related to land borders by linking the disputing parties with the land records office and also settled smaller land disputes related to irrigation.

In Layyah inland, a few people mentioned that the Gujjars (an ethnic group) in the village have political links, however, except for a few issues of personal disputes and one issue relating to the school infrastructure, which men thought the Gujjars could take to the Member of Provincial Assembly (MPA), most did not particularly go to them with problems. In the Nowshera hill location, most men would often repeat '*no one is powerful here, we are all equal*' when asked about who solved problems in the village, but a few referred to the system of *jirga* (traditional assembly of elders that makes decisions by consensus) where the elders in the village decided disputes. Those we talked to thought it was a '*fair'* system because both parties were listened to. However, older men we chatted to in Mardan hill told us the '*jirga had finished now'* because people had stopped respecting the instruction of elders and *'no one listens to anyone anymore…the jirga has lost its roots'.*

Women described a similar process in Nowshera river C1 where complaints are made at the village *jirga* but said that traditionally they are not allowed in. They told us they are '*used to this*' as they had never been involved in village-level decisions, anyway. Everywhere men and women concurred that women do not go to landlords or the *Nazim* with problems but sometimes consult their wives (Sahiwal far). Others told us that if there is a specific problem related to a woman (elopement or honour killings), they are represented by their male relatives at the *jirga.* Women we talked with shared that they discuss issues they face at the BHU or school with male relatives and said these are then shared with others by their husbands or fathers.

Except for a few men in Sahiwal near and Mardan inland who said that they involve the police for murder cases, people in other locations told us they never go to the police for disputes. In Sahiwal near one man told us he had gone to the police when his relative had been murdered because of a land dispute, while men in Mardan inland A2 explained that they '*took revenge by ourselves if someone is killed'* and did not go to the police.

'We will die, but we will not complain or ask anyone for help'.

Man, Nowshera hill

Why people don't raise their problems

While the options discussed above are available to people to raise their problems, most of the issues being resolved through landlords and the *Nazim* are related to land and personal or communal disputes. In matters related to complaints about broader service delivery, many people we chatted with told us they themselves '*did nothing*' because '*no one listens'*, because of fear of reprisals or because complaining took '*too much time'*. Many referenced their own or the community's past experiences of making complaints in order to explain the situation to us more clearly.

In the Nowshera hill location where people complained to us about the lack of medicines, attitude and shortage of staff at the BHU, many men felt that complaining to an authority for things to improve or change meant asking for a favour rather than getting something they were entitled to. Most people here felt that complaining or asking for help would be akin to *'bowing down to someone'* which they were too proud to do so they did nothing about their problems (see box 31).

In general many people felt complaining to authorities is not a guarantee that they would be helped while others are unaware of complaint mechanisms. Like Nowshera hill, people in Sahiwal far too shared that they '*lived with their problems'* because '*we are poor people, why would anyone listen to us?*' and '*we don't even know where to complain'* with one man asking our researchers if they could tell him where he could complain about the behaviour of

the BHU staff. Here we met a landlord who had a Masters degree in Economics and thought people were uneducated and hence unaware of what they were promised (see box 32). However, other men here told us it was useless to complain as '*nothing ever happens'*. Similarly, in Mardan hill a few women told us they had never seen a complaint box in the BHU and what was the use of complaining about things they did not have when '*there were so many choices of doctors and schools*' and '*if I don't get help in this one, I will just go to another '.*

In Mardan hill and both the Layyah locations, men shared that there was no point in complaining because their past experience had shown that '*nothing will change'*. One household father in Mardan hill said that during elections when candidates came around asking for votes, he never demanded anything from the candidates while others might. He explained this saying that the candidates already knew '*everything that is wrong but even then they don't improve the services- what is the point in complaining even more?'* Others in Layyah desert described similar experiences of having complained about the lack of electricity in the village, but said their complaints had not been acknowledged by the MNA (see box 34).

Box 31: Too proud to ask for help

There was a major water problem in 'my village'. People said the natural springs dried up during long summers and they had to bring in water tankers from the town which would fill up the communal reservoirs or personal tanks that families kept in their homes. Men I talked with said that there was a government water pipeline which was constructed about 30 years ago but because of a design flaw (where the water source was lower than the reservoir) it had remained non-functional from the day it was built. People shared that in the elections afterwards, the Member of National Assembly (MNA) who had built that pipeline lost from that constituency. When a few men from the village went to meet him, he told them that since the village had not voted for him in the elections '*you will die for water'*. He became a MNA in the next election but did not do anything to help the water problem in the village. Many men I spoke with told me they had never gone back to the MNA again because '*we aren't the kind of people who will ask him for water'* and '*we will not bow down to a man like this'*. Instead they would pay for water tankers from the town when their water source dried up.

Field notes, Nowshera hill

For some people complaining means facing possible reprisals. In Layyah inland, where a few people had heard that most of the BHU staff had got their jobs after being recommended by the MNA, this fear of reprisal was strong. Men told us complaining about BHU staff would *'create problems'* not just with the MNA but also with others in the village. Everyone, including some of the BHU staff who were from the village, were connected by birth or marriage and if '*we bring politics into this'* people in the village would exclude them so '*life without complaining was easier'*. For the same reason people had not complained against the LHV who hardly came and had told a few people *'if anyone comes to check, please tell them I have visited and helped you'.*

Others echoed the same in Nowshera river C1 when telling us about the *chota doctors* who had their private practice in the village. There had been a few cases where the *chota doctors* had misdiagnosed and given wrong medicines to people, because of which some had become critically ill. A few men told us that these *chota doctors* did not have certificates but were still treating people. They explained that they could not complain as most of the *chota doctors* were from the village and related in some way to them and complaining against them directly would stir up problems in the village.

Box 32: *'People here are uneducated, they won't ask for their rights'*

One landlord in 'our village' was an educated man with a Masters in Economics. We were talking about the different problems faced by people in the village and he told us about how the BHU lacked medicines and often sent poor people away empty-handed. He explained that he had seen many people come back from the BHU without being seen by a doctor because there was no staff present but '*people go back home and do nothing except complain amongst themselves'*. He said, *'people here are uneducatedt, they won't ask for their rights'* and explained that this was because they were '*uneducated and not aware about the things that the provincial government has promised them* (like basic health services)'. 'My father' who was with me when I was talking to the landlord later told me he was 'crazy' for talking like that because '*where are we to complain?*'.

Field notes, Sahiwal far

Others explained that making complaints meant that there would be an investigation and many felt that they would be tied up trying to sort out the problem for a long time. One grandma in Mardan hill confided that though she faced issues at the BHU and had also seen the complaint box there, she had never complained. She explained this saying that the only able-bodied male in the family was her 19 year-old grandson and he was already handling a lot of responsibilities for the family. She thought that if she complained there will be '*many people coming to talk to us and my grandson will have to handle all of that as well'.* In Nowshera river C2, a few 30-40 year-old men told us they were busy in their fields all day and '*did not have the time to give information to people who would come to sort out the issues if we complain'.*

In different locations men shared that although they had made complaints, at what they thought were '*appropriate places*' like the *Nazim* or the MPA, the issues had not been resolved (see box 36). Because of this, people thought these '*people with authority*' either did not have the influence to raise these issues, or chose not to. In Nowshera hill, the doctor at the BHU told us that he had complained to the *Nazim* time and again that the BHU did not have enough medicines, waiting room facilities and though they had oxygen cylinders, constant electricity load-shedding and the lack of an inverter meant these could not be used. The *Nazim* had responded to his concerns by telling him that he could upgrade the building for the BHU, the medicines and electricity were not his worries. The medicines were supposed to be provided by the Health Department and he had '*already done his bit for electricity by installing a transformer'.* While the *Nazim* had been able to provide funds for the school, this was only for construction of buildings, and not for other facilities like drinking water, because *'buildings and roads are what he is most interested in'*. The doctor told us that while there was an Independent Monitoring Unit[18] (IMU) which came to monitor the BHU occasionally, the team just '*went to the Nazim's house and drank tea with him*' and did not talk about the problems at the BHU with the staff. He said that apart from discussing these issues with the *Nazim*, he had also written an application to the Health Department and felt that he *'had done his part'.*

In some locations, authority figures like the *Nazim* and councillors told us there was a limit to how much they could influence at the higher level. In Nowshera hill, the former *Nazim* shared that during his tenure

18 An independent monitoring unit in Khyber Pakhtunkhwa to regularly evaluate performance of public sector health facilities.

Box 33: *'The ambulance might not come for us in the future'*

'My grandma' used to be a traditional birth attendant. She said that when the daughter-in-law was pregnant she knew it was time to deliver the baby. They called for the BHU ambulance which charged them PKR 500 for both way. At the BHU the lady doctor told them to go back home because it wasn't time for delivery and there were still a few days left. They came back home but at 2am that night the daughter-in-law went into labour. As the family had already spent PKR 500 on the ambulance that morning, they decided not to call for it again but to keep the money for medicines. They asked a neighbour for his motorcycle to go to the BHU and the baby was born there.

The family kept telling me '*it is not right that the (BHU) ambulance charges money, but we don't have any option'*. They worried that if they complained, '*the ambulance might not come for us in the future'.*

Field notes, Layyah inland

Box 34: Our voice does not matter

'My village' did not have electricity. Most families used lights from solar panels during the day but as many did not have an inverter or battery, the village would be mostly dark at night. *Baba ji*, ('my granddad'), who was the village elder, told me that during the last elections in 2013, the MNA candidate from the area promised that he would '*bring electricity to the village'* if they elected him so the whole village voted for him. The MNA won the elections and *Baba ji* and other men hired three jeeps to go to the city to congratulate him. When he was there, the MNA refused to recognise him or anyone else from the village so *Baba ji* got offended and left. The other men tried to talk to the MNA about the electricity problem and he told them he would take care of it. Four years on, the village still does not have electricity.

Field notes, Layyah desert

Complaint box at the BHU in Mardan hill. Complaint boxes in BHUs are usually kept locked and people say they have never used them.

a few men had brought him a written application detailing the water shortage and lack of toilet facilities at the BHU. He explained that as these were '*beyond his control*' he had forwarded the application to the *tehsil* member to be discussed at the *tehsil* or district-level but that had been the last he had heard of it. Another woman councillor in Mardan hill shared with us that although she had received applications for the Benazir Income Support Programme (BISP) cards from many women in the village, she had not been able to provide any of them with these cards. She said this was because she had been an Independent candidate in the election and not run from a party seat. As she was not a political party candidate she did not get any support at the *tehsil* level and also did not receive any funds to work with.

Others like the *Numbardar* in Sahiwal near E1 shared that the '*local representatives* (like the Nazim) *were useless*' but the MPA for the area listened to people and he had been the one who had upgraded the buildings in the school. Other men too thought that the MPA was good and able to extract funds from the provincial government as he had '*good connections with the Chief Minister and his son*'. The *Numbardar* told us that he had *'a number of meetings'* with the MPA and would be able to raise issues with him provided people discussed these with him first.

In the Nowshera hill location we heard that there had been a few cases where making complaints against the BHU had worked. As mentioned above, the LHW who brought her own USG machine to the BHU in Nowshera hill had to stop this practice as '*someone from the village complained*' and a team from the Health Department came to monitor. Similarly, the security guard who cleaned and stitched up people's wounds in the absence of the medical technician was asked to stop doing so as a few people from nearby villages had complained that he was '*unqualified to do so*'. The medical technician here told us that this was probably because of one 'NGO' worker who had been 'stirring problems' for the BHU (see box 39), adding that people in the village were foolish for complaining in both cases. As compared to ultrasound check-up, which cost at least PKR 200 outside, the LHW there had only been charging PKR 30 in the BHU. He also explained that he had given the BHU keys to the security guard and taught him to stitch up wounds as there were many men who worked in the slate quarry and would need services in case of emergencies. With the BHU closing at 2pm they would have to travel 15 kilometres for emergency services.

Box 35: The unused complaint boxes

There was a complaint box in the BHU in 'our village'. It was in the main room and I noticed it was locked and the lock had rusted as if it had not been opened in a long time. When I met the doctor there, I asked her if people ever put anything in the complaint box. She seemed surprised that there even was a complaint box in the BHU. She said she had been working in the BHU for only a month and maybe the medical technician knew about it and kept the key. I couldn't meet the medical technician as he wasn't there. I later asked 'my mother' if she had ever used the complaint box. She had never seen the complaint box, let alone used it.

Field notes, Mardan hill

I saw the BHU had a complaint box which was right outside the doctor's office. I went to have a closer look and saw that it was wooden, locked and there were bees coming out of the paper slot.

Field notes, Nowshera hill

Box 36: Complaining but disappointed

A year ago 'my mother' had been charged PKR 300 for medicines at the BHU. When she came home and told her husband, he says he shouted at her because he knew medicines were supposed to be free at the BHU and the BHU should not charge more than PKR 10 for consultation. Later on he launched a complaint along with three other people. He says they wrote an application to the Health Department about the medical technician who charged his wife for medicines. Within a week the medical technician got transferred to another BHU, but in a few month's time was back at the same BHU again. He says he was happy when the man was transferred but it annoyed him when he came back to the same BHU. He did not complain again because '*this is the way it is*'.

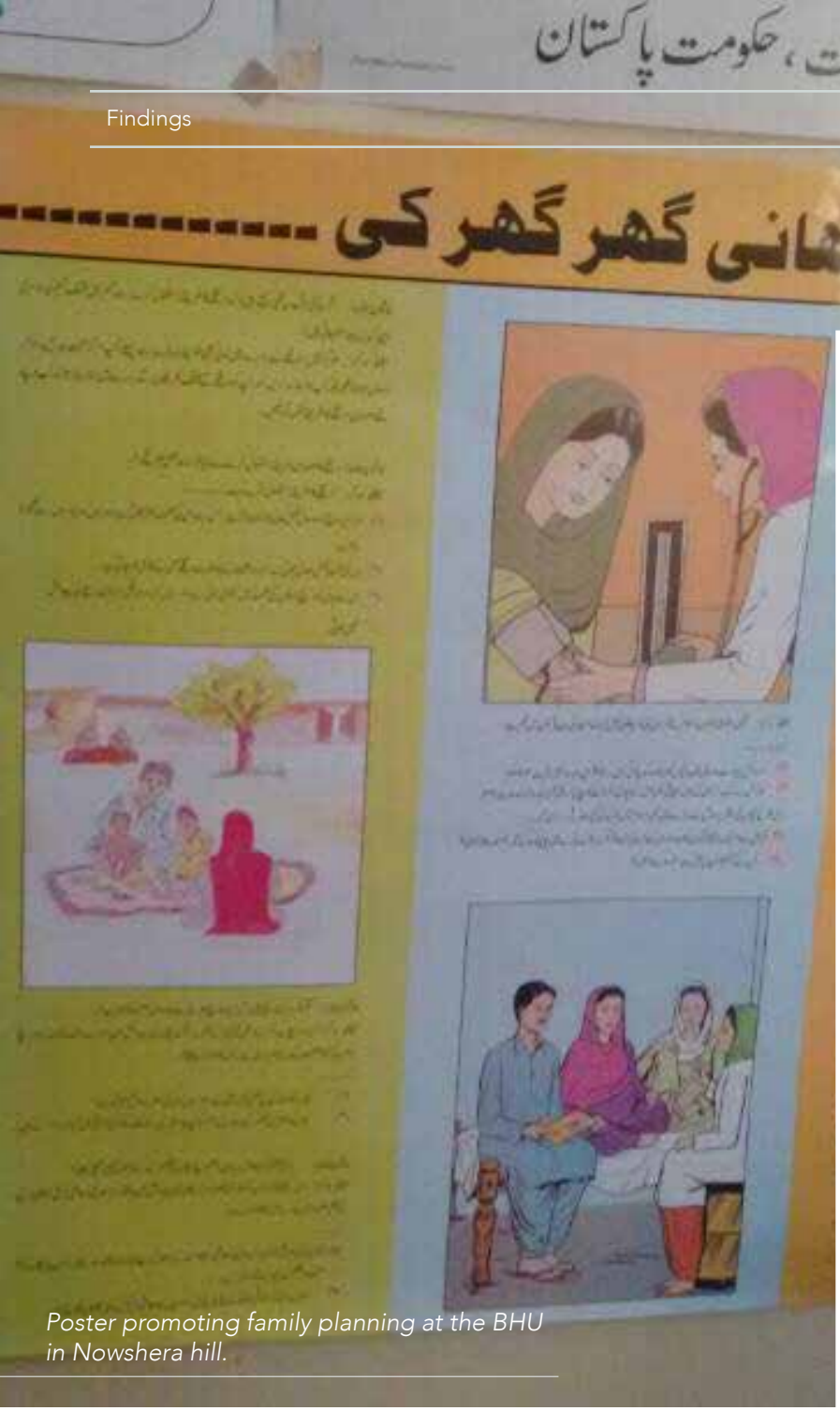
Field notes, Nowshera river C2

Box 37: The team *'which came to check'*

'My brother' told me the BHU only charged PKR 10 for consultations and also had a free ambulance service which could be used in cases of emergency deliveries. When his wife was about to give birth to their daughter they called the ambulance which came and took him and his wife to the BHU. After his daughter was born, he offered PKR 500 to the 'doctors', as a way of showing his gratitude, but the money was refused. Explaining this 'my brother' told me about an incident from a few years ago when some of the BHU staff had taken PKR 1,600 from another father whose baby had been delivered at the BHU. They said it was fuel charges for the ambulance which had picked and dropped the mother and the baby to their village. After a few months, this man received a phone call asking him if he had paid for any service at the BHU. When he told them he had paid for the ambulance fuel, they asked him to come to the BHU to take back his money. The man did not go because he wasn't sure about the authenticity of the call, but *'had the money sent to him in the village a few days later*'.

After this everyone in the neighbouring villages knew that there had been a team at the BHU '*which came to check'* every two months. This team picked up cases randomly and called people to verify about the services they had received at the BHU. 'My brother' said that the reason the BHU staff did not take the money he offered was because of this.

Field notes, Layyah desert



Poster promoting family planning at the BHU in Nowshera hill.

Box 38: Demanding action from the DHO

When there was a Leishmania outbreak in and around my village there were no medicines or vaccines provided for this at the BHU. A group of men from the area went to the DHO and protested saying that getting vaccines for Leishmania was important for them right now. They told him that unless free vaccines were provided at the BHU they would not allow the polio campaign to continue in their villages. After this, people say, the BHU finally received the vaccines from Mardan.

Field notes, Nowshera hill

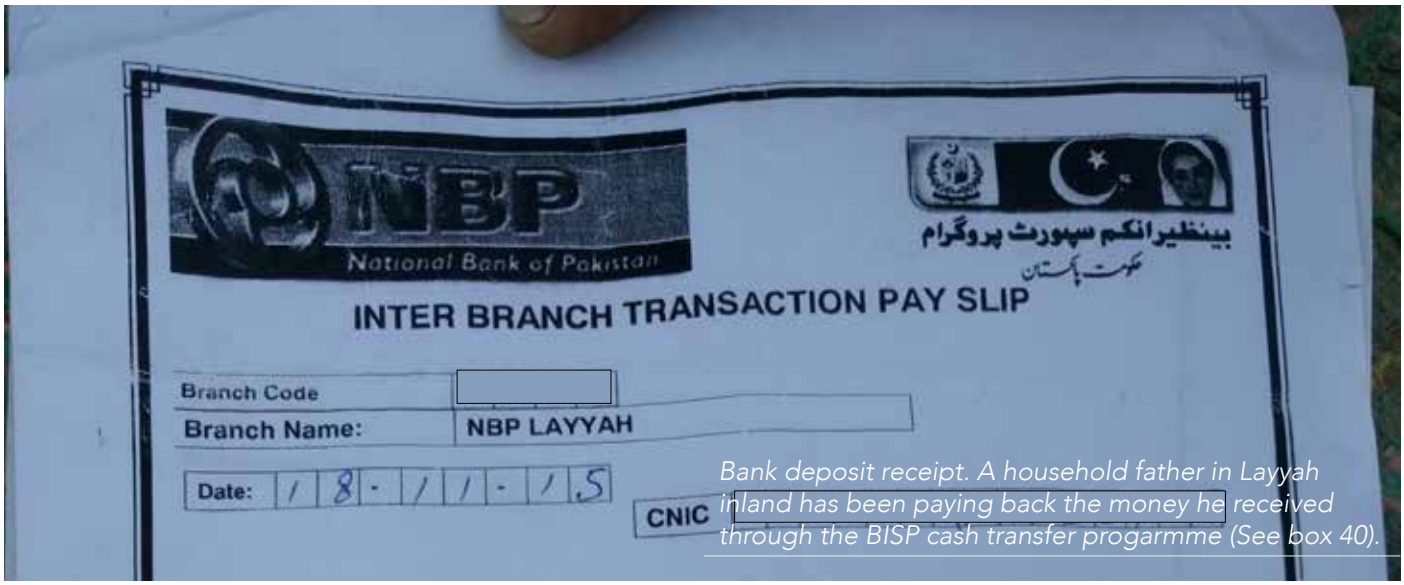
Box 39: The 'NGO' worker

While I was at the BHU talking to the medical technician, he mentioned a 'NGO' worker who was '*stirring problems with people from the villages*'. He said that this 'NGO' worker was going around telling people in the villages that '*if the BHU was not checking your temperature or blood pressure, it means that they are not checking you properly*'. The medical technician said because of this everyone who came to the BHU, even a 16 year-old with body pain, wanted their blood pressure checked.

He shared that last month the doctor was away on a 15-day leave and it was just him and the midwife on duty at the BHU. After the doctor had been away on leave for a few days, the medical technician's own father passed away. He informed the BHU management and took a leave. As a result of this only the midwife remained at the BHU. People in the villages found out and started making Facebook posts to protest that the BHU was not functioning because there was no staff there. The medical technician said he didn't care because both him and the doctor were on official leave but later when he came back he found out that it was this 'NGO' worker who had told people to use Facebook to complain.

In another instance, the 'NGO' worker came to the BHU one day and said that he had a verbal directive from the DHO to move the complaint box from outside the doctor's room to the outside of the BHU building. He added that he would also change the lock and keep the key with himself. The medical technician said that he was very angry at this and refused to let the complaint box be moved outside, after which the 'NGO' worker left. The medical technician said he was very frustrated with this 'NGO' worker because he was '*interrupting government work by coming all the time*'.

Field notes, Nowshera hill



Bank deposit receipt. A household father in Layyah inland has been paying back the money he received through the BISP cash transfer progarmme (See box 40).

Box 40: Poor information about social assistance schemes

People in eight out of eleven locations told us they had the Benazir Income Support Programme (BISP) cards and while not all of our families had these cards, those that did had received PKR 5000 in two months (one family in Mardan inland A1) and PKR 3000 every two months (Sahiwal far). A few women in Mardan hill told us they had participated in a survey two years ago after which they had been told they would get the card, but had not yet received it, while others shared that they had voted in the last election hoping they would get the BISP card but had not got them.

One of our household mothers in Sahiwal far had applied for the BISP when a government team came to the village last December (2016). They had taken everyone's details down including their names and numbers. When she went to Sahiwal city to see if she had got the card, her 'points' were slightly above the needed cut-off point to receive the card. She did not know what these 'points' were based on. She said it was up to the *Numbardar* if one got the card, *'if he said you were needy, you would get the card'*.

Another one of our families in Layyah inland had moved to the village in 2005 after their house in another village had been destroyed in the floods. They received PKR 270,000 as assistance from BISP in 2011. The father had thought this money '*was a gift*' because he had lost his home and livestock in the floods and had bought his motorcycle-rickshaw and two cows with this money. Two years ago he began getting calls from a man from the programme asking him to return the money otherwise they would put him in jail. Becoming worried he deposited two instalments of PKR 8,500 at the BISP account in the bank in Layyah. The man called him again and told him he would have to deposit the entire sum otherwise he would be jailed. He then deposited a sum of PKR 11,300. He said he did not know he was going to have to return the money. He is using his savings from the motorcycle-rickshaw business to pay back the money now.

Only a few of our families in the Mardan inland and Nowshera locations had received the Sehat Insaf Health cards. In Nowshera hill, men told us they had not been informed when the cards were being distributed at the BHU and people said those who knew the MPA were the ones who got the cards. There was no registration for these cards. One man from the village had received this card but did not know how and when to use the card and what was covered under it.

In Nowshera river C1, people thought the health card was given to those who had voted for the political party that had won the provincial elections, while others said this was given to those families who already had the BISP card. One security guard at the school who had received this card told us he had no idea how to use the card. He said one teacher at the school had helped him understand how to use the card, but when researchers asked, he was only able to tell us that the card covered 'specific diseases' and that it cannot be used in a private hospital.

In Mardan inland A1 two of our families had the health card. While one family said they kept the card '*in a safe place*' they did not know how or where to use the card. They had heard that it was for chronic diseases, but were not sure if it could be used for cancer. Another family told us they will '*wait for the neighbours to use it*' before using it themselves as they too did not know when it could be used.

Box 41
Where do people get information?

Across locations we saw that people did not have information about the different services and provisions at not just the BHUs but also when seeking services from private providers.. This box details the kinds of information people have access to and how they access these in the different study locations.

While there were TVs in all of our study locations, not all of our families had one (see annex 4) and as mentioned above many women in the Layyah desert location had no access to a TV. People in different locations told us they remembered snippets of information by watching TV. One family in Sahiwal near knew there had been a hailstorm in London because they usually watched the news together after listening to the morning prayers on TV. Other people shared that they had heard health related information, like the family in Sahiwal near E2 who knew about the 1122 Rescue service from the TV. In Layyah desert a few old men who used to watch TV at the shop everyday shared that they knew the polio team would come to the village soon after the polio advertisements started coming on TV and the medical technician at the Nowshera hill told us that people had started using contraception in recent years because there were '*religious men on TV who talked about family planning and gave people confidence that it* (contraception) *was not against our religion*'.

All of our families had mobile phones, and about half of them owned Smart phones. The phones were typically kept with the male members of the family. Women in the Mardan and Nowshera hill location told us they were not permitted the use of mobile phones, though women in the other locations used their husband's or brother's phones when they wanted to call relatives. Some women, particularly in the Punjab locations, also had their own mobile phones. In the Nowshera hill and Mardan locations we saw a few young men use Facebook on their smart phones and a lot of men in Mardan inland shared political information they had got from Facebook with our researchers. Others were also watching movies and dramas on their Smart phones and a few men would listen to the radio from their phones.

People told us they mostly got information about the different activities that were to happen in the village (social mostly, but also health related in case of immunization drives) from the announcements made in the mosque. Women told us they could generally hear these announcements from their homes, or would hear it from their husbands or neighbours later. A lot of the information women received was word-of-mouth including which spiritual healers or private doctors to visit for ailments.

While there were many posters related to different diseases (malaria, dengue, cholera, black cough, pneumonia etc.) and nutrition, hygiene and family planning practices in all the BHUs, no one except for the BHU staff or other medical practitioners mentioned these posters to us. In one instance, researchers in the Mardan hill location noted one polio poster which was in English.

Except for two instances where our researchers saw people reading newspapers (one security guard in Nowshera river C1 and another newspaper at a shop in Layyah inland), people did not read newspapers in any location.

A newspaper with advertisement for vaccination in Layyah inland. As people rarely read newspapers, such advertisements mostly go unnoticed.

How people make decisions

While a few of our families told us they made decisions '*which affected the family*' jointly, the final decision, women said, was usually the man's. In some cases women explained that while they tend to be in charge of buying things for the home, this is mostly limited to smaller things like utensils, food items and clothes which they buy in the village shops or from vendors who come to the village. A few women in Mardan hill who were living alone while their husbands worked outside told us that although they could make everyday purchases, they had to wait for their husbands to give them the money and often the men would return with food items and clothes. While men make the bigger decisions about buying, selling or renting land and livestock, what to plant and where to send children to school, women in most families told us they were in charge of taking children to the BHU or *chota doctor* or needing to go themselves (see box 42). Unless the shopping or visiting a doctor required travelling outside the village, women could go accompanied by children or other women, otherwise going outside the village means that men had to accompany them.

In one of our families in Sahiwal far, the mother who is a widow influences all of the decisions including what to plant, while another family which has a 65 year-old woman as head of the family said the mother and three sons (mid 20s to 30s) '*discuss and decide things jointly*'. In contrast to this, one of our mothers in Mardan hill who was a widow was not allowed by her 19 year-old son to work in the field (see box 43).

Box 42: Husband makes all decisions

The daughter-in-law of 'my family' told me that her husband made every decision in the family since her father-in-law was getting older. When I asked her what kinds of decisions her husband made she told me that even before her daughter (now 19) was born, her husband had started looking for a match for her from among his relatives. When the daughter was two years old, he confirmed her marriage with a boy who was 13 years older than her. The daughter is now 19 and going to be married with this man in the next few years.

Field notes, Mardan inland A1

Box 43: Not allowed by her son to work outside with other women

When we were in 'our village' it was wheat harvesting time. I saw many women of different ages working in the field. In 'my family' grandma who is 60 would go to harvest the wheat but 'my mother' (40) remained at home. When I asked mother why that was she told me that after her husband died four years ago, her son took on the role of the household head as the grandfather was blind. The son, who was now 19 years old, had forbidden her to work outside the home as he was worried that the villagers would talk about the family if mother went out to work. As he was the head of the household, mother listened to him and would only do chores around the house.

Field notes, Mardan hill

Political decision making

As people in our villages were already discussing the up-coming general elections (2018), it was usually difficult for researchers to avoid getting into partisan political discussions with them. While most of the political discussion in all locations was centred around voting, in Mardan and Nowshera people were also interested in the current provincial government. In these locations, women particularly thought that the majority party in the provincial government is '*working very well*' because they have installed *'a system that took fingerprints'* at schools which means '*teachers cannot leave in the middle of the day to go fishing'* (woman, Mardan hill) and want the party to win the general elections next year '*so other services like the BHU could improve'* (woman, Mardan inland A1).

Most people told us that voting was a family decision, or sometimes done in accordance with their patronage. Men explained that they consulted other men in the family when deciding whom to vote for and typically the entire family vote for the same political party.. A few men in Nowshera hill and Mardan hill, however, told us that '*things were not as before'* and that '*fathers and sons now voted for different parties'* because they thought differently from each other. Even though people in Mardan inland laughed when they told us their landlord changed political parties frequently, they told us they always vote for the same party as he does because '*he has power and we are on his land'* and said they consult him about whom to vote for before

every election. In Sahiwal far, a few men told us they switched allegiance to '*whichever party was able to pay us more'* and one of our families in Mardan inland told us they had sold '*seven votes for PKR 500 each in the last election*'.

People agreed that women in the family are always instructed by the men and, barring a few instances, always vote for the same political party as their husbands or fathers. Men told us women are usually informed of whom they should vote for as there are family discussions before the election day and their wives '*never went against our opinion'* (Father, Nowshera river). Others in Nowshera hill told us they guided their women because '*they were uneducated and don't know who is good or bad*'.

'We tell them to go and put the stamp on a symbol and they do that.'

Men in Nowshera hill about women voting

Many of the women we met in all of the locations said they had voted in the last election and for some in Nowshera hill 2013 had been the first time they had voted because there had not been separate polling stations for women earlier in the village. Most of the women too echoed what the men in their village told us and said that they usually follow what the men in the family told them to do. One grandma in Mardan hill told us she had voted for a specific political party because her grandson, whom she loved, had voted for them; others shared that if 'we *have an identity card we vote for whom the men tell us'* while one woman in Nowshera river C1 told us *'when you go to the polling station there are only other women in line with me. No one sees who I vote for,* ***then I just vote for the person I like and don't tell my husband'.***

Study Implications

As normally practiced for RCA studies, researchers do not provide recommendations as these imply a process of interpretation of findings and potential for etic (outsider) bias. Rather, RCA studies use grounded theory (inductive) approaches to the analysis of findings so that the conclusions or implications that emerge are those of the study participants rather than the researchers. The following implications are intended to be as faithful to the sentiments shared by families as possible and without our interpretation. However, the study implications also draw on the observations and direct experience from the immersion of researcher in communities and in ordinary families. The implications emerge from the in depth conversations and interactions with families living in poverty across the study locations and are organised according to 1) researcher observations, 2) quality of health care and 3) opportunities to engage with service providers. They are intended to provide a basis from which recommendations can be developed to support future programming, initiatives and research.

1. Observational

Two implications arise from observation rather than from what people shared.

Many people see themselves as 'ill'

Compared to experience of RCA studies in other countries, the research team felt that people in this study are unusually focused on their health, medicine and health services. They often describe themselves as ill, including with chronic diseases, which they named, like adult-onset diabetes, high blood pressure, and heart disease, among others. Despite knowledge of medically recognised conditions, people often share a poor understanding of the cause of these ailments or the most appropriate treatment. The extent to which these descriptions are actual medical diagnoses, or rather common ailments which people had come to identify with, was unclear.

More broadly, people across locations often struggle to discuss what is and is not healthy. We observed that they paid little attention to preventative healthcare, beyond eating fruits and drinking milk. Similarly, people rarely discussed seeking out routine medical services to maintain health and rarely connected poor sanitation with health and illness. The significant exception to this relates to practices for pregnant women and new-born babies and people often have clear ideas about what should and should not be done. Nevertheless, women across locations

commonly shared problems with pregnancies and most families had experienced child mortality or knew someone who had, though largely attributed this loss to '*fate*'.

The preoccupation with illness could be related to the prevalence of private providers, whose interests would also lie more in curative than preventative healthcare. Preventive healthcare remains poorly practiced. The knowledge of good practices in pregnancy, people explained, were not as a result of current programmes but handed down from earlier generations suggesting possibly effective maternal and child extension work in the past.

Conservatism impacts both men and women

We also observed strong, largely unspoken and unquestioned rules and norms shaping acceptable behaviour for each gender. This included various forms of purdah, which often created distinctly 'male' and 'female' spaces. For men, this included house courtyards, mosques and communal spaces like *hujras*, while for women this was largely inside the walls of their homes.

In many locations, this separation resulted in limited interaction between men and women, leading to distinct bodies of information and expertise obtained by each. For instance, people shared that information was most commonly disseminated through gender-separated meetings. In almost all circumstances, men owned the mobile phones held by each family, though at times allowed women to use them. These distinct streams of information was compounded by the fact that very few written publications or informational posters were present in villages, and unlike in many RCAs, very few people watched television or listened to the radio.

Though at times people explained this separation in terms of conservative Islamic values, they also consistently returned to the concepts of trusted (known) individuals - and suspicious (unknown) individuals, when explaining this separation. This impacts who people sought help from, both when seeking health services as well as in seeking to improve service provision. Men and women equally seemed to define acceptable spaces and relationships for women in terms of trusted individuals, limiting these to family members and other women.

High levels of suspicion of strangers and their intentions implies the need to work within coalitions of known people in villages. This includes providing information to communities, expanding access and service use, and creating outlets for engaging with policy makers, taking into account the separate spheres and bodies of knowledge occupied by men and women.

2. Choice

People have a huge range of health providers to choose from, and choose based on the perceived severity of their illness. Across locations, people preferred private health providers, seeking the services of the BHU as a last resort. People across locations shared the impression that paying for services guaranteed better quality, despite noting that private local providers often lacked credentials. People viewed public and private hospitals, located in towns and cities, as providing the best quality care, though acknowledged the often significant travel expense associated with a visit. In almost all cases, people told us that men would accompany women to visit health providers outside the village, and in some cases speak with doctors on their behalf.

Similarly, people overwhelmingly viewed BHUs as providing poor quality health care. This was often explained based on BHU's lack of medicine. People commonly shared that rather than getting the hoped for free medicines patients would often be given a prescription from the BHU and told to purchase medicine from outside. Other complaints about BHU quality often related to their lack of 'modern' facilities, including those providing ultrasonography, c-sections, and routine injections, which people consistently felt constituted 'good' medical care, though often could not explain why. As a result, only the poorest people we met had to rely on the free BHU health care for their medical care, while all others opted to pay for private providers. This pattern compounded the widely held view that paid services are inherently better than free services, used only by the poor.

Beyond these perceptions of the quality of care, people also highlighted the importance of their personal relationships with private health providers in their preference for them over BHUs. They often described local private health providers as their 'neighbours', who they trust to provide home services, are available 24/7 and, and even extend credit when needed. In contrast, doctors and other professionals in the BHU were often from outside the community, who people viewed as distant. People emphasised that these relationships with private providers made them more comfortable to seek their

services, despite often acknowledging that many lack medical or pharmaceutical training.

3. Voice

People across all locations shared that they experienced poor quality of care from the BHU, or that they viewed the quality of care to be poor. Despite this, few people said they would ever complain about the BHU, nor did they know of a place or person they could visit to help them do so. People explained this saying that there was no point in complaining, as it was a hassle and little progress was likely to be made because *'people don't listen to the poor.'*

Beyond this, people often equated the idea of complaining about health care and other public services to asking for a favour, rather than demanding an entitlement. Often, people looked to the most influential individuals in their community for such favours, which varied hugely from location to location. In some instances this was a landlord or *Nazim*, while in other cases this was a businessman, political or religious leader or members of a particularly well connected family or caste group. These individuals largely derived their influence from their relationships and broader networks, which, in turn, shaped how this influence could be use used to bring about change. This was clearest when influential people had access to local discretionary budgets, which people explained had helped bring new roads and schools to their villages and even upgrading BHU facilities, but could often not be used to address people's most significant complaints related to the health system: improving medicine supply and doctors within the health system. People often shared that these individuals are very powerful, which made them want to minimise the number of 'favours' to be asked and avoiding confrontation at all costs, lest they tarnish a relationship that could be useful in the future.

Any efforts to complain about health services were complicated by people's often poor understanding of how various aspects of BHU health services are managed and by whom. For instance, people often attributed their concerns over infrastructure (like BHU buildings and adjoining roads), as well as the lack of staff, medicines and equipment in the BHU to the doctors themselves. In other cases, people blamed the local *Nazim* or other political figures for this. In most cases these individuals were not empowered to address these concerns directly, further compounding people's views that complaining was futile. People often blamed doctors' and BHU staff's interest in profit through collusion with private providers for the lack of medicine in the BHU. Additionally, staff at some BHUs operated private clinics, for example, providing ultrasound facilities, consultation and medicines, and out of vested interest were directing people to these facilities. However, people seldom discussed confronting BHU staff about this issue and rarely had the opportunity to engage with doctors or other BHU staff in public meetings or fora. This compounded people's suspicion of BHU staff, further pushing them toward private providers.

These factors suggest the need for more opportunities for local communities to engage with doctors and BHU staff constructively to improve their understanding of the service providers' roles, as well as more engagement with communities to clarify roles and responsibilities regarding the public health system. People's understanding of health entitlements, particularly with reference to BHUs, remains low and affects their willingness to complain. However, people's lack of access to television and radio (or preference against these forms of media), suggests that these sources are not likely to serve as a significant source of information on these issues for the poorest people. This indicates a need to link improved understanding of these rights with non-confrontational, solution-oriented approaches to raising issues with service providers. The variation in local power holders, further suggests the need to take a context specific approach to identifying who is most influential in each community and facilitate links with duty bearers, particularly those who are part of the health system, in each community.

Annexes

Study Team

Team Leader
Danielle Stein

Co-team Leaders
Neha Koirala
Rizqan Adhima

Technical Advisor
Dee Jupp

Team Members
/Mardan/
Allah Rakhi
Aftab Ahmad
Farida Almas
Jalal Shahzada

/Nowshera/
Muhammad Ijaz
Milad Khattak
Sana Tajuddin
Shehla Said

/Sahiwal/
Mariam Rafique Vadria
Iftikhar Ahmad
Maham Tawqeer
Muhammad Fawad

/Layyah/
Sana Tajuddin
Muhammad Sarim Imran
Waqas Ashfaq Qureshi
Ihtesham Gul

Researchers engaging with people in different study locations.

Areas for Conversations

Chat, explore, probe, present scenarios 'what if', introduce debate 'some people think', listen, draw, explain, dream, play

Context: village and family context, profile, family/gender dynamics, social cohesion, assets, livelihoods, basic expenses – income, access to facilities (esp. health), ethnicity, religion, groups (savings, mothers, forums), who is most/ least powerful, whose life is easier/harder, what doing well/ not doing well means (incl. type of house, possessions, education, family support, health), seasonal changes/ poverty, who needs help, who can help

Use and experiences of services: preference for health services (public, private, self-managed, informal, community providers – lady health workers, home remedy, etc), who provides the service at each? Who do you trust? who decides within the family, who influence, when to go, expectations and entitlements of health (medicine, facilities, conditions, staff, etc), experience of services for different people (pregnant, children, elderly, religion, caste, gender), satisfaction, what did the service provide (medicine, check up, lab test, advice, referral, blessing, other traditional healing, etc), sources of information about services (poster, TV, radio, community/ neighbors, NGOs, etc)

Participation and accountability: type of participation (cultural events, meeting, gathering), who's involved, who's excluded, trend. what happens when you want services to change/improve (for health and other services)? Who raise issues/ complains or doesn't (fear, stigma, effort, nothing will happen), When/ what circumstances? Ways to complain, safe place & timing, Who can help? Who listens? What happens after (resolution, response time, repercussion)? When do you feel satisfied/disappointed? Community groups (who participates, reasons for non-participation, paid/unpaid), views of engagement with local government, media, religious leaders etc., views on ability to influence services (who can/ can't), sources of information, who votes, engagement with political processes

Aspirations and consequences: what they want to improve; support needed; future dreams and plans for themselves and children, concerns, worries for the future, what does good change look like, what is helping/hindering, changes over time- best and worst, coping with changes

Access and quality to health services: types of services available (public, private, traditional, drug store, etc.), opening hours, views on services available (best/worst), quality of services (availability of medicines, etc.), cost (fee for service, transport cost, bribe, transit time, waiting) negative image/stigma, who can/can't access, male/ female space, formal support available (vouchers, insurance, government programmes, cash transfer; criteria for receiving assistance; does it help?), informal support available (family, relative, loan, relationships, etc), distance, staff (attitude, availability and attendance), other barriers. Family planning, birth space.

Health conditions – what is healthy? What is sick/ill? current health condition, main health concerns, explanations for these problems (medical, beliefs, superstition), injuries, water source (drinking, washing, toilet), soap, what people eat (good or lucky/bad food), what should pregnant women do/eat (check-ups, ultra sound, delivery), what should be done with babies and mothers (breastfeeding, weaning, first food), preventing / transmitted disease (vaccination, check-up), keeping healthy

People Met During the Study

Category	M	F
HHH adults (above 18)	61	44
HHH children (5 - 18)	43	30
HHH toddlers (under 5)	11	14
FHH adults	254	100
FHH children	93	49
FHH toddlers	15	9
Traditional/spiritual healers	1	7
Hakim	2	0
Traditional birth attendant	0	4
Chota doctors	37	1
Doctors	5	4
Nurses	2	0
Lady health workers	1	11
Medical shop owners	13	0
Imam	10	0
Madrassa teachers	7	3
Nazim	7	0
Local government officers	5	2
Community group leaders	10	2
Community group members	37	7
Police	9	0
Teachers	27	7
Shop owners	43	14
Transportation providers	12	1
Landlords	23	4
Others (security, tailor, enumerator, beggar)	34	7
Total	762	320
	1082 people	

Host Families

We lived with **25 host families**

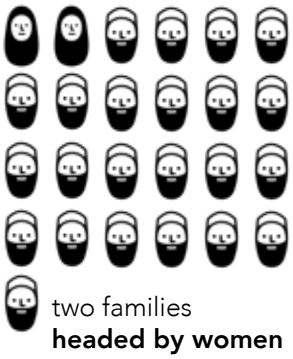
four generations = 1 family

three generations = 12 families

two generations = 12 families

No. of family members:

5	4 families
6	2 families
7	5 families
8	5 families
9	2 families
10	1 family
12	1 family
14	1 family
16	1 family
26	1 family
27	1 family
42	1 family



two families
headed by women

All but one, derive their income from **two or more sources:**

21
Agriculture (farming, tenant and renting out)

9
Daily-waged labourer

8
Rearing livestock

4
Selling milk

3
Teacher

3
Taxi driver

2
Donkey cart operator

2
Slate mining

2
Mechanic

2
Migrant worker

1
Bee keeping

1
Tailor

1
Blacksmith

1
Traditional birth attendant

1
Clerk

1
Selling snack and groceries

House types:
- 7 mud houses
- 7 semi mud-
- concrete houses
- 5 concrete brick houses
- 2 stone houses

Electricity:
- 20 have electricity connections
- 3 use solar panel
- 2 use diesel generators

Toilet:
- 20 have toilet inside (simple latrine) for women, men go outside
- 3 shared toilet with neighbours
- 2 have no toilet

Mobile phones:
- All have mobile phones, 7 families own smart phones

Television:
- 8 have TV

Host Family with..

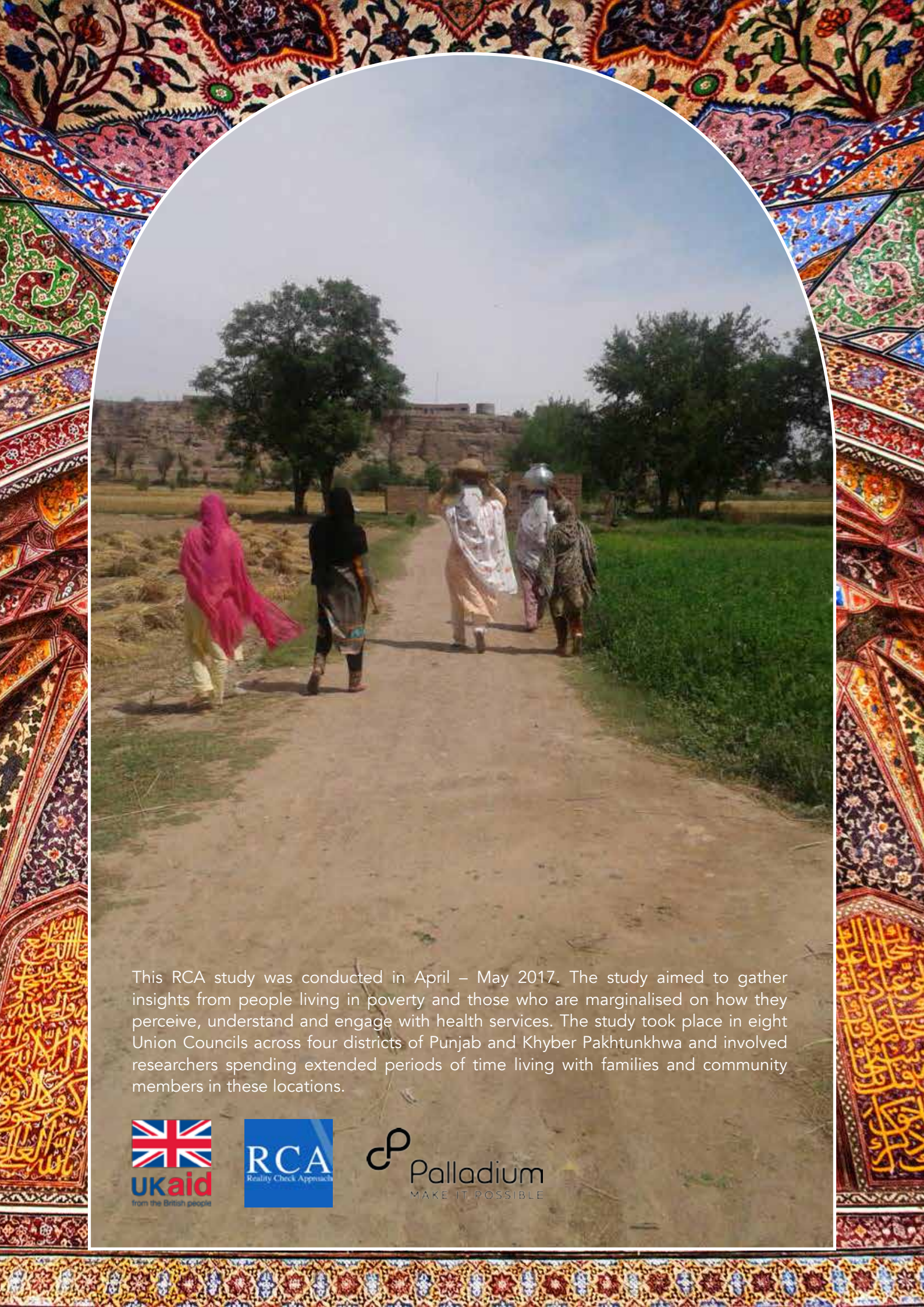
Long term health conditions

Diabetes 7 families	Blood pressure 5 families	Lung 3 families	Heart 1 family	TB 1 family

Asthma 1 family	Polio 1 family	Cancer 1 family	Epilepsy 1 family

Babies dying

Still born 2 families	Few days / weeks 4 families



This RCA study was conducted in April – May 2017. The study aimed to gather insights from people living in poverty and those who are marginalised on how they perceive, understand and engage with health services. The study took place in eight Union Councils across four districts of Punjab and Khyber Pakhtunkhwa and involved researchers spending extended periods of time living with families and community members in these locations.

UKaid
from the British people

RCA
Reality Check Approach

Palladium
MAKE IT POSSIBLE